NHS
Leeds West
Clinical Commissioning Group

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

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ANNUAL REPORT

The annual report and 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 Group Accounting Manual issued by the Department of Health. The Group Accounting Manual complies with the requirements of the Government Financial Reporting Manual, which the Department of Health Group Accounts are required to comply with.

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

The report is broken down 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

CHAIR AND ACCOUNTABLE OFFICER'S FOREWORD

It's fair to say that this year has been one of the most challenging for the NHS locally and nationally. We've had one of the toughest winters for services and all parts of the health and care system are having to address the difficult financial picture facing us. At the same time we're all working to address the three gaps identified to help deliver the NHS Five Year Forward View. These are: health and wellbeing; care and quality; and funding and efficiency.

We want to start our reflection on the past year by acknowledging the sterling efforts of all health and care staff working under extreme pressure. This includes our member GP practices, our CCG staff, our providers, our local authority care colleagues and our voluntary sector partners. Without their support and resilience, in the face of escalating demands, we wouldn't be in a position where Leeds health and care performance continues to do well in the face of extreme pressures.

Along with our fellow CCGs, NHS Leeds North CCG and NHS Leeds South and East CCG, we've been quick to respond to the changing commissioner and provider environment and have been looking at how we can work together better to achieve this.

As a result, we end the year with an agreement to work even closer together as CCGs and in the wider health and social care economy. From 1 April 2017 we have one Accountable Officer for the three CCGs. This is part of a programme of work we call One Voice.

In the past 12 months we've been a key partner in putting together the West Yorkshire and Harrogate Sustainability Transformation Plan (STP). This shows how we'll be working on a regional level to address the three gaps outlined in the NHS Five Year Forward View. Alongside this we've also worked with our citywide partners to develop the Leeds Plan to show how we can deliver some of the STP at a local level while also achieving the ambitions of the Joint Leeds Health and Wellbeing Strategy.

We're pleased with how we're working together on a regional basis and this is demonstrated by a memorandum of understanding we've signed to set up a joint commissioning committee. Once up and running, the committee will make decisions about how STP-wide services are commissioned. However before this happens we'll need NHS England to approve amendments to the constitutions of the 11 CCGs in our STP area.

Our focus now will be to ensure we actively engage with all those who have an interest in how we deliver truly transformational changes that are sustainable and cost effective. When we say all those who have an interest in our proposals we mean everyone – it's important we hear from patients, carers, clinicians, our political partners, community groups. In fact anyone who lives or works in Leeds as you're all likely to need the support of the NHS at some point.

To help us with this we are already working with Healthwatch Leeds and their equivalents in each respective area of our STP. The first area for engagement is stroke services. Across West Yorkshire and Harrogate, health and care services are working together to ensure stroke services are fit for the future.

Before decisions are made, Healthwatch in our region have been asked to find out what people think about the services that are currently provided and what would be important to them now and in the future should they have a stroke, or care for someone who has.

This covers the whole stroke pathway from prevention, the first 72 hours of care, through to rehabilitation and community support. The engagement report will help us firm up our proposals for the future of stroke services at a regional level so that people can access the necessary expertise quickly to ensure they receive prompt treatment and ongoing care.

Other areas we'll be working on across the STP area include cancer care, urgent and emergency care, mental health and specialised commissioning. Again we'd like to reiterate that no decisions will be made until we're satisfied we've taken into account the views of everyone concerned.

We'd like to encourage you to keep up to date with the latest developments on our website, social media or newsletters. Equally important is that we continue an ongoing dialogue with our local patients. This means we can actively build a picture of your experience of health and care services to identify any areas of excellence or issues that need addressing.

Residents at 13 Leeds care homes are benefitting from a pilot scheme, funded by NHS England as part of the West Yorkshire and Harrogate Acceleration Zone, allowing health and care staff to remotely monitor their health using Telehealth.

The West Yorkshire and Harrogate Acceleration Zone received £5.4million revenue and £3.2million capital funding from NHS England until the end of March 2017. The area was chosen as a pilot because it has a history of partnership working across the area on urgent and emergency care.

The funding is being used to demonstrate rapid improvement in these key areas of care. For example when a person needs to attend A&E, they may see a GP rather than an A&E doctor, where deemed more appropriate.

As active members of the Leeds Health and Wellbeing Board we were pleased to support the development of a refreshed Joint Health and Wellbeing Strategy for Leeds. It's important that the strategy fits in with the demands facing us in the face of delivering the STP, the Leeds Plan and our own CCG's strategic priorities.

Our Health and Wellbeing Strategy is about how we put in place the best conditions in Leeds for people to live fulfilling lives – a healthy city with high quality services. The vision of the joint Health and Wellbeing Strategy is to improve the health of the poorest, the fastest. This is a vision we are fully subscribed to.

Now it's time to look back on some of our key achievements over the previous year. We want to start by once again acknowledging the valuable support of our GP member practices that have enabled us to be a truly clinically-led organisation. We want to say thanks to our locality chair GPs and clinical leads GPs for their ongoing support that have helped us develop innovative projects that improve the health of our communities. We've been delighted with the overall results of recent inspections undertaken by the Care Quality Commission within our member practices. Out of those assessed to date 97% have received an outstanding or good rating. This includes five practices being rated as outstanding. One of our practices has been identified as requires improvement and we'll be working closely with them so that they can ensure they're compliant with the key areas of action identified.

In November 2014 we established a ground-breaking programme that gave our practices the opportunity to deliver extended access including seven day appointments. At the time this enabled the majority of practices to offer Monday to Friday access either 7am-7pm or 8am-8pm and weekend access for approximately 50% of our population.

Since then we've been delighted with the progress made and the partnerships formed by our 37 member practise that enables patients to access GP primary care services. This means that all patients in our CCG area are now able to access GP appointments at the weekend in locations close to home.

Due to the financial pressures we're under we've had to make the difficult decision of scaling back the amount of investment we can put into the scheme. This means that there will a significant impact in accessing seven day GP services for our population. Although we're confident that we'll still have better access than we have done historically it will not match the ambition of our previously funded scheme from November 2014. Naturally we're disappointed to have had to make this decision but it was needed based on the realities of future finances available to us.

Access to primary care is a challenge even with extended access which is why it's important that patients keep or cancel appointments. We've been running two campaigns to ensure patients are informed of the importance of booking and cancelling appointments.

Our #forgetfulfriend campaign was launched last summer after local insight suggested around 40% of people failing to attend their appointment claimed they'd forgotten about it. The campaign reminded people that a missed appointment means that someone else cannot be offered that slot.

We've also been encouraging patients to use GP online services. This allows people to book and cancel appointments as well as order repeat prescriptions. The service is available to all patients.

We're working closely with the Leeds West Primary Care Network, a group made up of clinical leaders and managers, to look at how we'll deliver New Models of Care which is another key component of the NHS Five Year Forward View. We've continued to make progress in our first pilot site in Armley bringing together the different providers and the local community. From this we'll look to establish care teams that can deliver services closer to home, reducing the need for hospital-based treatment. Four additional sites are being established in Morley, Holt Park and Woodsley, Aire Valley and Pudsey.

Our GP-led enhanced care home scheme has been running for two years and in that time we've seen improvements in the health of care home residents that fall under the project. In particular, the timely access to a GP and support from therapy teams has been highlighted as one of the success factors. This has resulted in a drop in avoidable hospital admissions at care homes taking part in the pilot.

We've also completed the first year of co-commissioning primary care services with NHS England and our neighbouring CCGs – NHS Leeds North CCG and NHS Leeds South and East CCG. We've used this partnership to develop a local plan in response to the GP Five Year Forward View. Some of the areas we'll be looking at for development includes ensuring all our practices are in premises that are fit for purpose. Other areas we'll be working on are recruitment and retention of staff, improving access to services and better use of technology to drive improvements in care and self management.

We've already touched on the importance of engaging and involving patients and community groups in the work we do. This allows us to develop and provide services that most closely match the needs of local people within the budget available to us.

We've developed our patient champion programme, previously called patient leaders, into a citywide engagement hub. This means we've now established a partnership agreement involving the Leeds CCGs along with Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust.

As a result we're now offering a range of training opportunities to help patients involved in the work we do. This includes supporting commissioners to design and procure new services as well as being expert patients on citywide project steering groups.

Medicines prescribing is one of the biggest areas of expenditure for the NHS. We actively review policies and national guidance to ensure we can get the best value possible for the taxpayer. The Leeds CCGs have started a consultation that runs until May 2017 asking for people's views about proposals to change the way we prescribe certain items.

What are we proposing to change? Our proposal is to work to significantly reduce the number of prescriptions for gluten free food and over-the-counter medication – all of which can be purchased at a lower cost than a prescription. We propose to routinely commission the prescribing of non-branded products unless there is a medical reason to prescribe a branded product.

Healthwatch Leeds organised an event looking at what the future of health and care might look like in the city which we participated in.

At our AGM, in August 2016, we asked one of our patient champions to speak about his involvement with the work we do. Kevin Bray addressed the audience highlighting some of the work we do and the fact that he's been asked to represent our CCG at a national event organised by the Royal College of General Practitioners (RCGP). This demonstrates that our innovative and forward thinking approach is being recognised at a national level.

We've already mentioned how our GP practices have done in their recent CQC inspections but it's also worth noting that our provider organisations have also undergone the inspection process. We're delighted to report back that Leeds Teaching Hospitals NHS Trust has now been rated good following a previous rating of requires improvement. However Leeds and York Partnership NHS Foundation Trust received a requires improvement rating so we'll work with them to see how they can address the issues identified. We're still awaiting results of the CQC inspection of Leeds Community Healthcare NHS Trust.

What the CQC inspection reports will not show is the work that our providers did alongside Leeds City Council to help us make our way through one of the most difficult winters the system has faced.

On the face of it our A&E performance may have dipped slightly below the target but this doesn't take into account the much higher than anticipated demand on services. It also doesn't take into account how other system partners helped support colleagues at A&E by offering to extend the availability of services. This includes community rehabilitation support or nursing staff from all our organisations undertaking additional shifts to help us manage demand.

We also wanted to highlight how Leeds continues to be a centre of innovation and a forerunner in delivering world-class services. In particular we're recognised for delivering high quality cancer care services through the Leeds Cancer Centre, based at St James's Hospital and associated support services.

This has been recognised by national and regional partners, including Macmillan and Yorkshire Cancer Research, with funding secured to help deliver our ambitious Leeds Cancer Strategy. The strategy aims to deliver significant changes to the way cancer patients are diagnosed, treated and the after care they receive. What really strikes a chord with us is how the strategy is looking to change the perception of cancer so that it's seen as a long-term condition by 2020.

To do this we're making improvements to the way people are diagnosed. The earlier we catch cancer the better the treatment options. So we're trialling a number of diagnostic (testing) pathways that provide quicker access. This includes rapid tests for those who may not display the well-known symptoms of cancer but other health factors suggest there may be a suspicion of cancer. We also want to ensure people attend their routine screening appointments.

For those who have been affected by cancer we want to help them live with and beyond cancer. One of the pilots we're setting up, funded by Macmillan, is a cancer care review nurse working with four GP practices initially in the Aireborough area. She'll work with around 200 patients helping them to self-manage their condition or signposting them to appropriate community services.

The Leeds Cancer Centre is already home to excellent facilities and leading clinical experts in their field. However we'll be working with patients and healthcare professionals to see how we can further modernise the centre as well as looking at how we can deliver some services within the community.

Tackling health inequalities is something that our CCG, and we as healthcare leaders, are very passionate about.

One of the programmes we're proud of is the patient empowerment project (PEP). PEP offers a social prescribing service where GPs can refer to community groups and support services that can help patients whose health issues are caused by non-medical reasons. For example, the burden of debt and its impact on mental health.

Our PEP project continues to evaluate well and we're really moved by some of the patient stories we've heard. As a result of the impact the project has made we've continued to fund it until August 2019. We will be working with NHS Leeds North CCG and NHS Leeds South and East CCG to align and standardise all social prescribing schemes in 2018-19.

We know how important early years are to the future success and health of children as they make their way through life. We're coming to the end of two projects which have changed the behaviours of children and adults who they connect with, such as parents/carers, their teachers or frontline health and care staff.

The first project was set up to address issues around childhood obesity. To do this we've been working with primary school pupils in west Leeds encouraging them and their families to introduce more fruit and vegetables to their diet. The second project has been set up to reduce the impact and risk of hospital admission due to asthma.

Both projects have involved our clinical leads partner organisations as well as schools and pupils to develop co-produced actions that improve health.

You can find out more about what we've done to improve the health of some of our most vulnerable patients and communities on pages 36-40.

We started our foreword by stating what a tough year it has been. However we hope that you can see we've achieved a lot and continue to make great strides to improve quality and access to healthcare services. This means we can continue to support you and your loved ones to enjoy the best possible care.

We know that we can't achieve any of our ambitious plans without your support so we'll be counting on you to help us deliver in years to come.

With best wishes.

Dr Gordon Sinclair
Clinical Chair

Philomena Corrigan
Accountable Officer

THE NATURE AND PURPOSE OF NHS LEEDS WEST CLINICAL COMMISSIONING GROUP

NHS Leeds West Clinical Commissioning Group (CCG) has successfully completed its fourth year of operation as a statutory body.

NHS Leeds West Clinical Commissioning Group is one of three clinical commissioning groups which are collectively coterminous with Leeds City Council's boundaries. The CCG's commissioning activities are in line with its statutory responsibilities as outlined in the CCG's Constitution.

The CCG has not changed in its statutory format since its inception (e.g. mergers etc.), remains a single statutory entity operating from a single address, and has no branches or affiliated entities in addition to it. Moreover:

- The CCG has made / received no political or charitable donations since its inception;
- There are no balance sheet events to report; and
- We certify that the CCG has complied with HM Treasury's guidance on cost allocation and setting of charges for information.

Our CCG is made up of 37 member GP practices in the west and parts of outer north west and south west Leeds. We are the largest of three CCGs in Leeds, covering a registered population of around 375,000 people.

Our vision is **'working together locally to achieve the best health and care in all our communities'** which we developed by working with our member practices, our staff and local people.

The CCG operates from single premises which it leases through NHS Property Services, and is co-located with a number of local businesses within WIRA Business Park at: Units B5-B9, WIRA House, West Park Ring Road, Leeds, LS16 6EB.

The three CCGs in Leeds operate a collaborative approach towards commissioning, with NHS Leeds West CCG leading on behalf of the city for the negotiation, performance management and reporting of all acute sector contracts (both NHS and non-NHS) for all three CCGs.

Working with our partner CCGs in Leeds we commission a range of services for adults and children including planned care, urgent care, NHS continuing care, mental health and learning disability services and community health 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 kidney care.

The following healthcare providers / areas of spending cover 83% of the CCG's commissioning budget:

	£ million
Leeds Teaching Hospitals NHS Trust	157
Mid Yorkshire Hospitals NHS Trust	12
Harrogate and District Foundation NHS Trust	4
Bradford Teaching Hospitals NHS Foundation Trust	4
Nuffield Health	6
Spire Healthcare	3
Yorkshire Clinic	3
Yorkshire Ambulance Services NHS Trust	10
PTS/111 and WYUC	5
Leeds & York Partnership NHS Foundation Trust	36
Leeds Community Healthcare NHS Trust	40
Prescribing recharges from the Prescription Pricing Authority	52
Primary care co-commissioning	
Main Areas of Commissioned Spend	**375**
Other Smaller Contracts	**79**
Total Commissioning Cost (Programme Budget)	**454**

A full list of contracts with providers is available on request. There have been no significant changes to services contracted by the CCG during 2016-2017 other than the delegated primary care co-commissioning budget which transferred from NHS England from 1 April 2016.

"Working together locally to achieve the best health and care in all our communities"

OUR BUSINESS MODEL

The CCG is responsible for the strategic planning, procurement (contracting), monitoring and evaluation of the performance of a prescribed set of services that are delivered by a range of NHS, independent and third sector health and care providers in order to meet the needs of our local population.

These services provide a range of hospital treatments, rehabilitation services, urgent and emergency care, community health services, mental health and learning disability services.

Each year the CCG undertakes a planning process that provides the key mechanism for ensuring our plans are meeting our population's needs and will continue to do so within available resources. This planning process is increasingly being undertaken within the context of the development of wider 'place based' plans known as Sustainability and Transformation Plans (STPs). The following outlines our approach to the planning process below.

A. **Development of local planning priorities framework:** Our Governing Body review:
   - National standard requirements (e.g. NHS Constitution and NHS Mandate) and our performance against those requirements;
   - Delivery of national NHS planning priorities
   - The health needs of our population identified through the Joint Strategic Needs Assessment (JSNA) and as agreed through the Joint Leeds Health and Wellbeing Strategy;
   - Priorities for health and services identified by our clinicians, patients and the public; and
   - Priorities identified through working with wider Leeds and West Yorkshire health and care system.

B. **Review of impact of existing transformation and service change programmes:** The CCG and partners have a number of ongoing programmes of work. Each year we review whether these existing programmes and other initiatives are helping to deliver our priorities and ensure that they will continue to do so. If we feel this is not the case we outline actions/changes required to rectify this. Increasingly these transformation plans will include those developed within the West Yorkshire and Harrogate Sustainability Transformation Plan (STP) and Leeds Plan.

C. **Investment planning:** Development of investment proposals for new initiatives that will support the CCGs and citywide priorities.

D. **Agree investment profile:** Prioritising investments to ensure we target any available resources at those initiatives that will have the greatest impact on delivering our priorities.

E. **Sign off:** Our Clinical Commissioning Committee, a sub-committee of our Governing Body, reviews and ensures our plans fit with our strategic priorities making recommendations to our Governing Body. The Governing Body formally signs off our plans on the basis that the plans will deliver both our service and financial objectives.

This process allows us to agree our service development and investment programme for the coming year and potentially over the strategic timeframe.

OUR STRATEGY

In August we published our revised five year strategy 'Better Lives, Stronger Communities 2016-2021'. We continue to pursue ambitious plans so that we can help improve the health of our local communities and meet the Leeds Health and Wellbeing Board's vision of improving the health of the poorest, the fastest. Our strategy is available on our website www.leedswestccg.nhs.uk

We've highlighted our five key ambitions below.

1. In five years, services based in the community will work as one team for each local area, based around local communities, rather than around individual organisations. This is sometimes referred to as new models of care.
2. In five years, hospital services that could be better provided in the community will be delivered as part of the local teams. Our investment into acute (hospital) services will decrease and investment into the community will increase.
3. In five years, services based in the community will be commissioned by local clinical leadership teams in the most appropriate way for their local populations and based on local need.
4. In five years, working with people in west Leeds, we will have established a culture of shared responsibility for improved personal health and wellbeing.
5. Over the next five years, with our partners and for our population we will continue to work towards reducing health inequalities.

Our strategy also identifies the three key challenges which we must address that reflect those identified in the NHS Five Year Forward View.

Health inequalities

We know that there are significant health inequalities in our area. The life expectancy gap between our most affluent and most deprived areas is 6 years. Those living in our most deprived areas are much more likely to develop cancer and cardiovascular diseases and suffer from mental illness. Our challenge locally is to close these gaps.

Quality of care

Peoples' health and wellbeing needs are changing and so the way health and care services are delivered needs to change to meet them. People are living for longer and with more long-term conditions, meaning people need a wider range of care from different sources over a longer period of time. The traditional divide between primary care, community services and hospitals needs to be removed so that people can more easily access services that care for all their needs. We also need to focus on prevention and early intervention.

Financial

Our system-wide challenge is that our health services are not affordable in their current form in the longer term. We need to work together with our residents and patients, our local health and social care providers and commissioning colleagues. This will help us transform local services so that we can maintain and improve the quality of services, changing them to meet the developing needs of our population.

Throughout our annual report you'll see examples of work we have done to address these challenges.

PERFORMANCE REPORT

IN THIS SECTION

OVERVIEW OF PERFORMANCE – STATEMENT FROM THE ACCOUNTABLE OFFICER

In an incredibly challenging year for the NHS at a local and national level we've still managed to perform well against the key indicators we're measured against. When compared against other CCGs with a similar population, our performance is favourable in comparison and often above average.

One area that we're incredibly proud of is our financial control as we consistently met and exceeded our 2% surplus target set by NHS England. Thanks to our strong financial position we've been able to commit funding for projects that have evaluated well to date. This includes our social prescribing scheme called the patient empowerment project and our enhanced care home scheme.

Another area in which the CCG is leading the way is in improving access to primary care GP services. All our patients registered with any of our 37 member practices can now access appointments seven days a week. We were one of the first CCGs to set up seven day access and have received national acknowledgement for our work. Due to financial pressures we're under we've had to make the difficult decision of scaling back the amount of investment we can put into the scheme.

Thanks to the relationships we've built up with primary care and with our provider organisations we've also started work on setting up a new models of care pilot in the Armley area. This means we're looking to offer services closer to home thereby reducing the need for hospital-based treatment except where really needed.

This year we welcomed the Care Quality Commission (CQC) who undertook inspections at the majority of our GP practices and our provider organisations. We're delighted that five practices received an outstanding rating and 30 were rated as good. We also had one practice rated as requiring improvement.

In addition we're pleased that Leeds Teaching Hospitals NHS Trust has moved from requires improvement to good. However we were disappointed that Leeds and York Partnership NHS Foundation Trust were rated as requires improvement. We're still awaiting the rating for Leeds Community Healthcare NHS Trust.

The pressures facing the NHS have been well documented and Leeds was not immune. We saw demand for accident and emergency and emergency admissions increase by 3%. This resulted in us being unable to achieve the four hour A&E target to see and treat or discharge patients. Like many areas we failed to hit the 95% four hour wait target and our ambulance response times have also fallen below the expected standard.

The increase in demand has meant that our providers have had to cancel certain elective (planned) procedures to maintain appropriate staffing levels in emergency care wards. As a result our referral to treatment times target of 18 weeks has narrowly been missed although we compare favourably with the England average.

The CCG has a legal duty to involve patients and once again I'm pleased with our efforts to actively involve and engage patients and the wider public. Our patient champion programme has been adopted by Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust. This means patients can access free training and support to help them play an influential role in decisions taken at both commissioning and provider level. We've also continued to seek the support of patient champions on project steering groups including the patient empowerment project, childhood obesity programme and redesign of the chronic pain service.

One of the highlights for me has been how we've involved children and young people in our childhood asthma campaign. Thanks to their efforts we've been able to produce entertaining and informative video clips that remind children to carry their medication with them at all time. Special thanks to the pupils at Sacred Heart Primary School in Kirkstall.

The CCG has a legal duty to tackle health inequalities and again we've shown great progress in doing this. Our approach to improving access to cancer diagnostics (tests) means that we've consistently been able to allow GPs to seek urgent two week referrals to hospital for diagnosis. This means that patients they suspect have symptoms that indicate they may have cancer can be diagnosed quickly and if needed, treated sooner.

We've also been working with a range of communities to look at how they'd like to access cancer services in the future. This included talking to patients and their loved ones to find out more about their cancer journey as well as the wider communities we work with. As a result we've already made improvements to the breast diagnostic pathway.

Our pioneering work means that we have received national funding for a number of pilot projects, results of which will have implications for cancer care locally and nationally.

It would be fair to say that over the coming years the NHS is facing real pressure to deliver against the demands being placed upon us. Our performance for 2016-2017 shows that despite this, the systems and more importantly the staff we have, are ready to face these challenges head on. While being mindful that we've narrowly missed some targets, our overall performance has once again been strong. I fully expect us to maintain this position in 2017-2018 and beyond.

Philomena Corrigan
Accountable Officer, NHS Leeds West CCG

FINANCIAL OUTLOOK

Details of how we met our key financial performance indicators can be found in the annual accounts section.

As in previous years, the CCG has again successfully contained its expenditure within its planned position for the year, ending its fourth financial year with its inherited recurrent 2% surplus position from Leeds Primary Care Trust (PCT) in 2013 intact. We achieved our planned efficiency targets and remained within our allocated cash limit for the financial year as required by NHS England. In 2016-17 we were also directed to increase our surplus position from PCT inherited level of 2% to 3% in support of the overall finances of the NHS. We have also achieved this in 2016-17.

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. Although the CCG has not formally signed up to the Prompt Payments Code our performance in paying bills on time is excellent, with over 98% of our bills being paid on time.

Non NHS trade invoices

	Number	Value (£)
Total Non NHS trade invoices paid in the year	2,748	44,744
Total Non NHS trade invoices paid within target	2,719	44,689
Percentage of Non NHS trade invoices paid within target time		98.94%
Percentage of Non NHS trade £value invoices paid within target		99.88%

NHS trade invoices

	Number	Value (£)
Total NHS trade invoices paid in the year	3,568	279,264
Total NHS trade invoices paid within target	3,516	279,263
Percentage of NHS trade invoices paid within target time		98.54%
Percentage of NHS trade £value invoices paid within target		100%

The CCG's running costs envelope is set by NHS England at around £22.07 per head of the expected population that the CCG will commission healthcare services for. This resource is to cover all aspects of the administration and running of the CCG as a Statutory Body. Our total running costs envelope during 2016-17 was £7.6 million. Our total spend was £7.5 million.

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 CCG has been assessed to be over its target financial allocation under the new CCG allocation formula introduced by NHS England during 2013-14, and received minimum inflationary allocation increases for both 2014-15 and 2015-16. As a result of this, the CCG moved closer to its target allocation levels and for 2016-17, the CCG received an allocation increase of 3% against the national average of 3.4%, with some CCGs receiving as little as 1.4%.

From 2015-16, the three CCGs in Leeds collectively pooled £50 million of NHS resources with Leeds City Council, of which our CCG's share was just over £20 million. This is as part of the Better Care Fund. Whilst this is potentially a source of additional risk to the NHS, it is also a unique opportunity to integrate health and social services across the city for the benefit of improved patient care and with the added potential to reduce duplication between those services.

The same funding envelopes will be in place again for 2017-18 until further information is received around changes to social care funding arrangements currently anticipated.

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.

1. Better Health: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population.
2. Better Care: focus on how CCGs are supporting redesign of care, performance of constitutional standards, and improving health outcomes with a specific focus on 6 clinical areas: mental health, dementia, learning disabilities, cancer, maternity and diabetes.
3. Sustainability: how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends.
4. Leadership: assessment of the quality of the CCG's leadership and strength of its governance, including the quality of its plans 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

HEALTHCARE 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 at a national level. 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: for example, early diagnosis of cancer and number of falls as compared to the rest of England. 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 partner organisations in hospitals, ambulance services, community health services, member practices and other healthcare providers to help them work towards achieving them.

2016-17 has been a challenging year both nationally and locally. Demand for emergency services has continued to grow with rates of attendance at A&E growing by over 3% with similar increases in the need for emergency admission. This demand is being seen at a time when funding for public services is being constrained. This has resulted in demand outstripping capacity in our main providers.

The impact of this imbalance can be seen through the deterioration in performance across a range of constitution standards. This includes delivery of the A&E four hour wait standard. This means 95% of patients must be seen, treated, and admitted or discharged in under four hours. We've seen challenging performance in the 18 week referral to treatment times and ambulance response times. We have also experienced some challenges in meeting the 62 day cancer referral to treatment waiting time standard in some specialities.

My NHS

My NHS is a website where organisations, professionals and the public can compare the performance of services across health and care, over a range of measures, and on local and national levels. 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're rated as being well-led and perform well in cancer care, mental health and in patient experience of GP services. Areas where our performance needs improvement include maternity care, learning disabilities and dementia. In our annual report you'll see steps we've taken to address this or mitigating circumstances leading to our score. For example a recent review by NHS Digital on dementia diagnosis data suggests that the Leeds CCGs would now be meeting national targets.

Areas of Achievement

- Cancer Waits: The waiting time standard for receiving an outpatient appointment within two weeks following urgent cancer care referrals continues to be achieved. Leeds is one of the few areas in the country where patients with suspected cancer are consistently given an urgent two week wait referral to diagnostic services from their GP. In addition Leeds CCGs continue to meet the 31 day diagnosis to treatment cancer waiting time standard.
- Referral to treatment: Whilst the CCG narrowly missed the 92% target for the

number of patients remaining on waiting list not seen within 18 weeks, Leeds compares favourably with national and West Yorkshire overall performance. As a result fewer patients in Leeds wait over 18 weeks than the average for England.

- Primary Care Access: As a result of the investment in primary care our CCG also performs well in terms of extended hours access to General Practice.

Improving our performance

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. The CCG remains fully committed to ensuring that we put plans in place to maximise the potential to deliver our NHS Constitution commitments, as well as making progress on improving the quality of our services and improving health outcomes for patients.

The key areas of priorities for action are outlined below.

Referral to treatment times (RTT)

NHS Leeds West CCG remains committed to meeting the national standard for RTT and was very close to achieving the standard in 2016-17. However achieving the delivery of this target has been impacted as a result of emergency admission pressures over the winter months. This resulted in a high number of cancellations and lack of capacity to maintain routine surgical operating capability. Maintaining the standards is highly dependent on the degree to which the whole health system will be able to transform and change to reduce demand for emergency services and reduce need for emergency hospital beds. If emergency demand continues to grow capacity for routine elective surgery will be restricted. Surgical capacity within paediatric services is also a major constraint. Some specialties also have pressures within their outpatient settings, particularly for regional specialties such as spines. There are a number of key specialties at risk as a result as follows:

- General surgery;
- Plastic surgery;
- Trauma and orthopaedics (including spinal surgery;)
- Urology;
- ENT; and
- Paediatric and dental specialties.

Work is being undertaken through the joint Elective Care Working Group with Leeds Teaching Hospitals NHS Trust (LTHT) 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.

Cancer

Whilst our CCG has not delivered on the 62 day performance from GP referral to treatment, performance has improved over the year. Constraints around some diagnostic pathways and some theatre capacity have been the primary reasons for longer waits. Work is ongoing to improve local and regional pathways to speed diagnosis and treatments.

Emergency Care Standard (ECS)

The four hour ECS target is in simplest terms 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 most appropriate service that meets their needs.

Leeds as a health system has failed to deliver the Emergency Care Standard (4 hour target) since September 2015.This is a national problem with very few health systems now able to maintain a consistent flow of patients through the system to consistently deliver the standard. Nationally there are varying factors that contribute to the failure of the performance including increasing demand and complexity of patients, shortages and skill mix of health and social care staff as well as delays in discharge and the availability of community health and social care capacity.

The Leeds System Resilience Assurance Board (local A&E delivery board), a senior level multi-agency board, coordinates both provider and commissioner functions to improve systems and processes to ensure a whole systems approach to delivering high quality resilient services all year round.

Leeds has an Urgent Care Strategy which, along with the West Yorkshire and Harrogate Sustainability Transformation Plan (STP) and the local Leeds Plan, sets out the vision for the future provision of services supporting the transformation of the whole urgent and emergency care system. Initiatives include:

- to simplify the system to improve access for people;
- changes to the role of ambulance services (see below);
- developing integrated primary, community services and hospital services;
- long term redesign of services to respond to urgent needs in health and social care;
- implementing the integrated discharge services; and
- supporting the care home sector.

Yorkshire Ambulance Service NHS Trust (YAS)

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

Yorkshire Ambulance Service (YAS) continues to trial new innovative ways of working through their improvement programme aligned to the West Yorkshire Urgent and Emergency Care Vanguard and Accelerator Zone programmes. Additional resources identified include using other providers such as St John's Ambulance Service and private providers.

NHS Wakefield CCG, as lead contractor, have established a Joint Strategic Commissioning Board (JSCB) to facilitate the shift from a focused contracting approach to a more commissioning and improvement approach to support local and regional STP plans.

YAS continues to work with the fire service to trial service delivery using the wider emergency services.

Local Leeds city improvement plans include those listed below:

- YAS has key representation at the Leeds A&E Delivery Board to support local developments.
- Developments in the Leeds Care Record in the future to facilitate more timely information for YAS to ensure patients are directed to the most appropriate service within in their own home, community or hospital.

Mental health Parity of Esteem

Nationally there is increased scrutiny on local investment in mental health services with the introduction of Mental Health Investment Standards. This requires reporting against 15 investment lines. Each CCG in

Leeds has achieved an increased investment in mental health during 2016-17 – although some of this has been through national transformation monies, or other non-recurrent funds.

Mental health (IAPT)

Improving Access to Psychological Therapies (IAPT) is a key element of the national strategy to improve support for those suffering with mental health issues. There are a number of measures used to assess how well CCGs are doing in supporting access. Whilst Leeds performs well in some areas compared to national averages local IAPT access rates still remain lower than required. In 2016 the Leeds system identified a number of changes that could be made to improve uptake of the service.

Leeds CCGs will put greater focus during 2017-18 on a range of measures in order to improve the flow of the right people to IAPT and increase service efficiency. We are aiming to improve the efficiency of our IAPT service in 2017-18 by implementing a range of measures that include:

- introduction of a new public facing information system (MindWell) that provides online access to IAPT;
- piloting primary care liaison roles to offer extended assessment and brief intervention as an alternative to IAPT for those who have been referred but did not take up the offer;
- working with community mental health teams to offer IAPT to those suitable;
- work on the findings of local IAPT/long-term condition pilot to improve mental health training, screening and take up of IAPT for those in long-term condition pathways;
- improved integration of psychiatric liaison outpatient service with IAPT service; and
- participation in an employment advisor IAPT initiative.

IAPT performance against targets 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% against a target of 95%
- IAPT waiting times - less than 6 weeks, our performance was at 98% against a target of 75%
- Seven day follow up following discharge, our performance was at 97.8% against a target of 95%

Performance below target

- IAPT recover rate, our performance was 45.9% against a target of 50%
- Early Intervention in Psychosis within two weeks, our performance fell just short at 49.6% against a target of 50%

Dementia diagnosis rates

NHS Digital has reviewed the methodology for estimating dementia diagnosis rate, and from April 2017 it will use registered practice population rather than estimated resident population, to ensure it is statistically robust. Data provided by the regional clinical network indicates that this will mean Leeds West still has a diagnosis rate above 71%. However, the change evens out random 'boundary effects', and means that all three Leeds CCGs will achieve the 66.7% ambition, for the first time

www.yhscn.nhs.uk/media/PDFs/mhdn/Dementia/Dementia%20Diagnosis/2016/Estimated%20diagnosis%20rate%20by%20CCG.XLSX

RESEARCH STUDIES

The NHS Constitution contains pledges that the NHS is committed to achieve. Pledges represent a commitment by the NHS to provide comprehensive high quality services.

Section 3a. Patients and the public – your rights and NHS pledges to you

Respect, consent and confidentiality:

- to inform you of research studies in which you may be eligible to participate (pledge)

This pledge aims to give people better access to the potential benefits of participating in research studies including clinical trials. Information that identifies you will not be given to researchers unless you have given your consent or the research has been given approval under the Health Service (Control of Patient Information) Regulations 2002.

The research annual report highlights that the CCG is achieving all of the national research governance metrics in relation to research, and in fact exceeding them in some cases.

- In 2016-17 NHS Leeds West CCG had 76% of practices actively recruiting patients, this far exceeds the NIHR Clinical Research Network (CRN) primary care Higher Level Objective 6c of 35% for the proportion of GP sites recruiting into portfolio studies. This also exceeds the national figure of 42% of General Medical Practices being research active in 2015-16. This has led to a recruitment of 443* patients into research trials.
- Within Leeds Community Healthcare NHS Trust, 706* patients have been recruited into research trials.
- Within Leeds and York Partnership NHS Foundation Trust, 812* patients have been recruited into research trials.
- Within Leeds Teaching Hospitals NHS Trust, 10,885* patients have been recruited into research trials. This contributes over 1.5% to the National recruitment target
- The CCG is currently supporting twelve studies that carry an excess treatment cost. This support extends into the coming financial years.

*Data cut NIHR CRN 10/04/2017

QUALITY AND SAFETY

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

There are five elements which drive the work of the quality team:

- patient safety;
- patient experience;
- clinical effectiveness;
- responsiveness; and
- 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 to commissioning health services.

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

Key programmes undertaken in 2016-17 include:

- Development of the Leeds multi agency healthcare associated infections (HCAI) improvement group and Clostridium difficile (CDI) review panel
- Reviewing how we maintain an overview of the quality standards in all key provider organisations. 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
- Development of a citywide patient insight working group to review patient experience and identify areas for action
- In collaboration with the governance team a process has been developed to monitor incidents reported in primary care
- Working with partners across the city to improve oversight of care delivery in care homes across the city

HCAI improvement

The Leeds multi agency healthcare associated infection improvement group was established to achieve a consistent and united approach. This approach covers local community and hospital care organisations to advance improvements and identify concerns relating to healthcare associated infections (HCAI). The group agreed annual priorities to focus the work of the group. On a quarterly basis the group hosts a Clostridium difficile infection review panel. The meeting has representation from CCGs, Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Tust, independent hospitals and public health (Leeds City Council).

The level of Clostridium difficile infection in Leeds Teaching Hospitals NHS Trust has reduced in 2016-17, though community associated infection remains above the threshold set by NHS England.

Pressure ulcer improvement

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

Leeds Community Healthcare NHS Trust has undertaken a comprehensive review of the skills and competencies of all staff in the neighbourhood teams. This helps to understand the education, development and training needs to enable safe and effective care delivery. The progress against this new work stream is being monitored through the provider quality meetings and the commissioning and contracting structures in place.

Patient insight

The quality and governance teams work together to ensure that the Patient Insight Working Group reviews and analyses patient experience activity. The group:

- Monitors all patient experience activities, ensuring that activity is captured on a dedicated patient experience database
- Identifies trends and themes from patient experience reviewed by the CCGs
- Ensures that patient experience feedback is used to improve services and informs the planning and designing of new services
- Ensures links identified with complaints, Patient Advice and Liaison Service (PALS) and social media information are made and that the information is used to continuously improve healthcare services
- Ensures feedback is given as a result of gathering and using experience data
- Escalates concerns where they are identified from patient experience as appropriate

Friends and Family Test

The Friends and Family Test is now in use across every provider and the quality team monitor response rates and results of 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 a genuine means of helping improve our services. Outcomes from complaint investigations are used to make changes where required to systems and processes to improve 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 queries, resolve concerns or signpost people to 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 organisations in reporting, investigating and learning from serious incidents which occur within a provider of NHS healthcare. A panel is tasked with reviewing submitted reports and action plans from our providers to gain assurance that a robust investigation has been completed, reasons for the incident occurring 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 practice.

We also review incidents reported by GP practices to identify any key themes/trends and to share learning across the city. This involves close collaboration with primary care and medicines optimisation teams to provide support where it is needed. The CCG continues to help facilitate learning on a city wide basis to help reduce the likelihood of incidents recurring.

Care home quality monitoring

The emergence of concerns regarding quality of care in a number of homes following CQC inspection visits prompted a review of how we can ensure that there are clear processes for reporting and escalating concerns through the CCG's governance structures.

There are a number of established mechanisms in place for the monitoring and oversight of quality in care homes, and there is good multi agency working through 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, the quality and governance teams will be working with partners to develop and strengthen health and social care quality and governance mechanisms. This will ensure that there is appropriate oversight at each level in the organisations.

Provider monitoring visits

A programme of visits to our local care providers to observe care delivery is developed annually. Visits generally take place with the prior agreement and notification to 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 are 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)

The 2016-17 CQUIN schemes in Leeds combine a number of national and local indicators.

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

Improving respiratory and cardiology pathways are examples of local schemes in 2016-17. We worked with partners in the hospital and community care trusts to review the current pathways of care for a number of different health conditions. This was to make sure that people receive the care that is recommended by expert bodies such as National Institute for Health and Care

Excellence (NICE). Teams involved in this care pathway work together to improve the care and experience of those people living with these conditions.

Other examples of CQUIN schemes in Leeds in 2016-17 are:

- Developing and embedding integrated neighbourhood teams in Leeds Community Healthcare NHS Trust;
- Embedding positive behavioural support within Leeds and York Partnership NHS Foundation Trust's community learning disability teams; and
- Reducing delays and achieving better care in outpatient follow-ups at Leeds Teaching Hospitals NHS Trust.

In addition to the work detailed above, the quality team have reviewed work streams against the Public Health Outcomes Framework 2017, and identified progress against the following metrics below.

Cancer Patient Experience (Metric from the Public Health Outcomes Framework 2017: Better Care)

The CCG reviewed the National Cancer Patient Experience Survey published in July 2016 in 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 8.7.

Neonatal mortality and stillbirth (Metric from the Public Health Outcomes Framework 2017: Better Care)

Quality and safety in local maternity services is closely monitored by the quality team through regular meetings with members of the hospital team that provides inpatient and community services. The quality team also monitor patient safety incidents occurring within the service and ensure we are satisfied that these are being thoroughly investigated. The Leeds Maternity Strategy is led by NHS Leeds South and East CCG and sets out priorities for Leeds maternity services from 2015-2020. Ensuring there is opportunity for informed choice for parents, and promoting a culture of learning from comments, complaints and incidents are key priorities of the strategy.

Maternal smoking at delivery (Metric from the Public Health Outcomes Framework 2017: Better Health)

To support a reduction in the number of pregnant women smoking at the time of delivery, the CCG developed a CQUIN with colleagues in Leeds Teaching Hospitals NHS Trust. Key components of this work are to embed carbon dioxide monitoring in antenatal appointments and refer to Fresh Air Babies, a service run by specially trained advisors to help pregnant women in Leeds stop smoking. Benefits from stopping smoking include a reduced risk of miscarriage, reduced risk of premature birth and low birth weight, and babies are less likely to die from cot death or stillborn.

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 commissioning and contracting for general practice services. This is in addition to our existing statutory responsibilities relating to improving the quality of our member practices.

As a members led organisation, we have been mindful of the need to separate some of our functions and ensure conflicts of interest are appropriately managed. We've taken the opportunity to review our internal systems and processes to ensure we discharge our functions appropriately.

Some of the achievements in the first year of our delegated responsibilities include:

- Co-producing a proposal for the investment of Personal Medical Services;
- Funding and prioritising an Ethnicity and First Spoken Language Enhanced Service;
- Supporting an application from a practice to close a branch surgery practice following extensive patient engagement and work with local stakeholders; and
- Achieving 97% of practices receiving a rating of good or outstanding from the Care Quality Commission (CQC).

Some specific examples of primary care schemes projects and schemes are included below.

Care Quality Commission (CQC) inspections

During 2016-17 in preparation for the CQC inspections, our primary care team put plans in place to proactively visit our member practices. This was to help prepare practices ahead of their CQC inspection; a risk profile tool was developed to support the visits. This covered all aspects of the CQC's inspection including the domains of safe, well led and effective. It was used to identify areas of good practice and also areas where the practices may wish to look how they could improve and support each other.

The inspections started in November 2015, with the majority of the inspections completed by the end of March 2017.

We are extremely proud that five practices received a rating of overall outstanding, higher than the national average. A further 30 have received a rating of good with five of these having areas identified as outstanding within their reports. The main areas highlighted for outstanding were in the responsive, well led and caring domains.

One practice has been identified as requires improvement; we'll be working with this practice, CQC and NHS England. We'll assist the practice to put a plan in place to support a turnaround programme to ensure improvements are made.

It is positive to see that 97% of practices inspected achieved a rating of good or outstanding. We'll be continuing to work with all our practices with a programme of support to ensure we maintain these exceptional CQC ratings.

Improving access to primary care GP services

In November 2014 our member practices started a programme to extend access to general practice over seven days a week. At the time this enabled the majority of practices to offer Monday to Friday access either 7am-7pm or 8am-8pm and weekend access for approximately 50% of our population.

Our practices also accessed national funding, as part of the GP Access Fund, to look at using technology to improve access. This included offering patients more choice in how they access the practice and have their care delivered.

In 2016-17 NHS England offered all GP Access Fund sites funding to continue to offer these extended services which has enabled roll out of seven day access across all 37 practices. All patients in our CCG area are now able to access GP appointments at the weekend in locations close to home.

The most recent data available shows that on average an additional 14,000 patient contacts have been delivered under this scheme which is an increase in GP appointments of 11.5%. The latest GP survey results show that 83% of our patients, compared to 75.9% nationally, are satisfied with their GP practice opening hours.

Our practices are proud to be able to offer this level of services to patients in advance of the government's stated aim of seven days access being fully rolled out nationally by 2020. Across localities the service is being designed to meet the needs of patients locally with one hub, for example, offering patients access to physiotherapists in addition to GPs.

We look forward to working with our practices in 2017-18 to continue to deliver and develop this service. However we're aware that financial pressures mean that we'll have to look at the way extended access is provided. We're working closely with our member practices to see how we can continue our efforts to improve access while ensuring we do this within the budget available.

Integrated quality and performance report

In 2016-17 we extended our existing Primary Care Integrated Quality and Performance Report to meet the CCG's new responsibility for commissioning general practice services. The report enables the CCG to understand areas of good practice but also identify any areas that could be improved.

The report has been produced so that each practice has their own 'practice level' version of the report that they receive on a quarterly basis. We share the report with our practices working closely with them to review and understand where there may be opportunities to make positive changes or indeed celebrate and share best practice.

Collaborative care and support planning

We're increasing the number of people with a long-term condition who are able to access results of tests before they have a consultation with their healthcare professional. Our practices are introducing this approach to ensure that patients are prepared for their appointments. This means they can have more meaningful conversations about what's important to them and get the expert advice they need to help them manage their condition. The approach known as Collaborative Care and Support Planning comes from the Year of Care (YOC) model to support care planning for people with long-term conditions, in primary care. Working in this way has led to many people feeling more in control of their condition. Evidence shows this reduces complications as well as enabling patients to seek help when they need it.

31 of our 37 practices are in the process of adopting this approach with 143 members of staff attending training to help them to implement the changes needed to make the approach successful.

In the future we want to offer everyone with a long-term condition the opportunity to be more involved in their care. To support this we're moving towards people accessing their results in the way they choose including through online options or by email.

Clinical care coordinators

Older people living with frailty make up between 9% and 25% of the population. They are the highest users of services across health and social care and have the highest levels of unplanned admission to hospital. Evidence suggests that between 20% and 30% of these admissions could be prevented with proactive care and support planning and by using services outside the hospital.

Our GP practices have introduced care coordinators who forge links across community services and hospital. This helps people to access the help and support they need to help them stay at home rather than being admitted to hospital.

They have worked very closely with community services including those provided by voluntary organisations because very often the problems uncovered were those of loneliness and lack of confidence. People's confidence increases when they start linking into community groups as well as building key relationships. This means they can deal with their problems using the support networks they have built up rather than relying on their GP or calling an ambulance.

What our patients say

- 'I don't know what I would have done without my mum's care coordinator she made it easy to get advice for my mum which was such a life line.'
- 'I always knew she was just a phone call away. It was so reassuring.'
- 'It was so nice to receive a call from my care coordinator just checking on me it made me feel more confident.'

Our future plans will see care coordinators working increasingly closely with the hospital team as well as the community team to ensure people have the support they need to get them home from hospital.

Premises

In 2016-17 the citywide Leeds Estate Transformation Programme has been developed to ensure that estate related expenditure is controlled effectively and strategically managed. The programme of work has been developed through the Leeds Strategic Estates Group which includes representatives from NHS Property Services, Leeds City Council, Leeds and York Partnership NHS Foundation Trust, Leeds Community Healthcare NHS Trust and Leeds Teaching Hospitals NHS Trust. We've worked jointly on putting together a Strategic Estates Plan and an agreed vision to future estate management. The plan includes key principles to ensure that we are using estate more effectively, reducing running costs, sharing property with social care and the wider public sector and providing a fit for purpose and modern estate.

The Strategic Estates Group has facilitated local estates workshops to undertake a systematic review of the public sector estate within our CCG. This has allowed the CCG to explore opportunities for future co-location, improved use of existing space/ estate and potential disposal and savings within the public sector estate. It also gave us an opportunity for our current proposals for primary care premises development to be considered within the wider estate planning.

Community Ventures was commissioned to develop a Primary Care Estates Strategy. The strategy is underpinned by the results of '6 facet surveys' which provide a comprehensive review of the condition of primary care premises across Leeds. This informs the suitability of existing estate for future service planning and identifies where services can potentially develop under new models of care. The strategy includes an evaluation of the impact of housing development within the CCG locality and the impact this will have on demand for services in the current GP footprint.

In June 2016 we submitted recommendations to NHS England for investment from the Estates and Technology Transformation Fund, a multi-million pound programme to accelerate the development of infrastructure to improve services for patients. Through this funding route we have had the opportunity to support five GP practices to bid for funding to develop their premises. We also included one technology bid to support mobile working and to deliver clinical services away from the practice to improve service delivery.

We are currently awaiting the final confirmation of approval and outcome of due diligence check but are optimistic work will be underway during 2017-18 to improve facilities for our population.

Medicines optimisation

The medicines optimisation team consists of pharmacists and pharmacy technicians who support all of our 37 GP practices to ensure that medicines are used in a safe, evidence based and cost effective way for our patients. Additional resource has been provided for our areas of deprivation.

Our medicines optimisation team has been working with our GP practices to proactively manage patients with one or more long-term condition. This includes patients with diabetes, atrial fibrillation (a heart condition that causes an irregular and often abnormally fast heart rate) and those with respiratory conditions.

The team ensured all treatments adhered to local guidance as well as those issued nationally by the National Institute for Health and Care Excellence (NICE). The reviews help reduce the risk of patient harm from medicines, for example through incorrect use or prescribing errors. In total 587 patients with a long-term condition received a medicines review in 2016-17 and as a result savings of £257,376 were made on the prescribing budget.

A separate project has been developed to provide additional support for patients with respiratory conditions. The project involves 24 community pharmacies, 14 GP practices and Leeds Teaching Hospitals NHS Trusts lead pharmacist. In total 876 reviews took place including 184 done virtually which meant they were done without the patient having to leave home.

The team has been supporting the work of the CCG's enhanced care home scheme by taking their prescribing expertise to residents in care homes. A total of 358 reviews resulted in savings of £82,932 as well as contributing to the wider success of the scheme in reducing unplanned hospital admissions.

Experts are predicting that antimicrobial resistance is one of the biggest threats facing healthcare in the coming years. Concern is growing that overuse of antibiotics and drug-resistant bugs mean that currently treatable infections could kill in the future.

As a result the CCG has committed to working with prescribers to reduce the number of preventable healthcare associated infections. In addition it has also been working with GP practices to reduce antibiotic prescribing. In 2016-17 all our 37 GP practices achieved their antibiotic prescribing target by working closely with the medicines optimisation team.

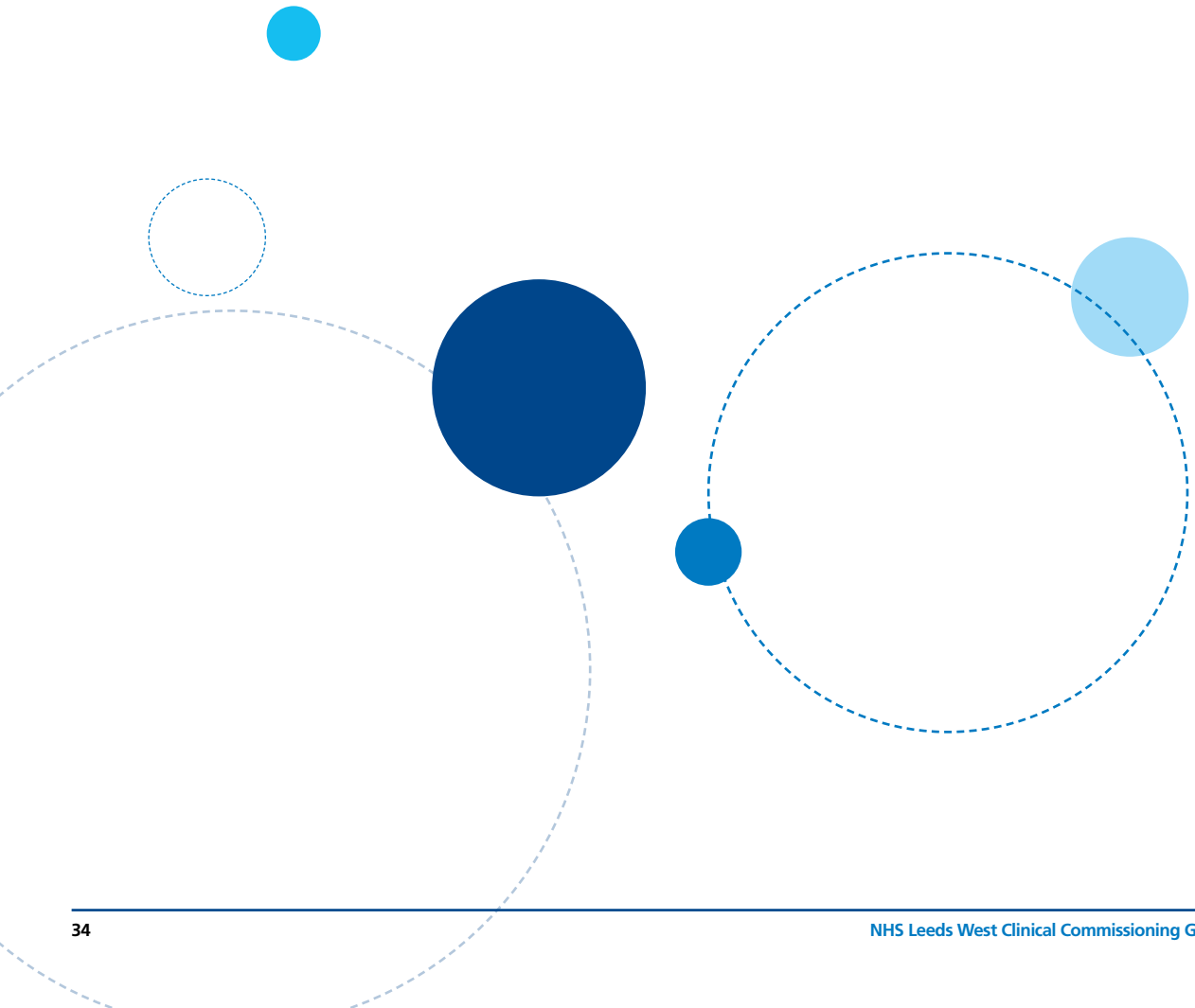
Reporting incidents helps ensure improvements are made to the way healthcare is provided, this includes medicines related incidents. The latest available figures, covering 1 April – 21 December 2016 show that 741 incidents were reported against a target of 345. This demonstrates that an effective safety culture is being developed to reduce the risk of medicines-related harm.

The medicines optimisation team have installed and supported an evidence-based IT solution that integrates with GP systems.

Optimise Rx delivers guidance to prescribers at the point of prescribing and interventions to support efficiency, safety and quality that are patient specific.

By using Optimise Rx we have saved £716,886. Whilst cost savings have been impressive, it is the safety messages that are of the utmost importance.

The medicines optimisation team have reviewed prescribing to ensure cost effective choices are made; in 2016-17 savings of £611,277 have been achieved.



REDUCING HEALTH INEQUAILTIES

Reducing health inequalities is a priority for us as we seek to address the life expectancy gap in some of our neighbourhoods. We want to ensure local people get the support they need to help them make healthy lifestyle choices and to work in partnership to address the wider determinants (causes) of ill health. Our work in this area links in with the Leeds Health and Wellbeing Strategy, the West Yorkshire and Harrogate Sustainability and Transformation Plan and the linked Leeds Plan.

Our varied population covers parts of the most affluent and parts of the most deprived areas of Leeds, and includes communities with some of the lowest average life expectancy rates in the city. On average, women in west Leeds live 3.4 years longer than men. The overall difference between the most affluent and most deprived areas is six years.

Demographics

- We currently cover a population of around 375,000. By 2020 we expect a 2% increase in our local population, with the number of people aged 65 and over set to increase by 5%. As the number and proportion of older people increases, so does need and service use.
- Overall, our area has a less diverse population than the Leeds average, though wards such as Armley, Calverley and Farsley, Headingley, Hyde Park and Woodhouse and Weetwood are more ethnically diverse.
- Around 37,000 people now live in an area of west Leeds ranking in the 10% most deprived of the country. This has increased from 7% to 11%.
- There is a wide range of educational attainment in the schools in west Leeds. On average 51% of children in Leeds achieve five A* - C GCSEs including Maths and English. In our area this ranges from 22% to 75%.

Health and lifestyle

- Cancer, cardiovascular disease and respiratory disease are the leading causes of premature and avoidable mortality. Cases of these are almost double for men.
- There is a strong link between years of life lost and deprivation. Rates of potential years of life lost in west Leeds are similar to the citywide average and show a similar reduction. Rates are around 60% higher in our most deprived areas. However, overall rates and the gap have reduced.
- Some of the key lifestyle information for our area shows that one in five people are obese and one in five people smoke. Admissions to hospital due to alcohol are 4% lower in our area than the city average.
- Rates of hypertension and chronic obstructive pulmonary disease, often referred to as COPD (the name given to a range of respiratory conditions), vary in west Leeds. However, average rates are in line with the average citywide rates.
- Over 25% (more than one in four) of adults in our area have one or more long-term conditions.
- Around 16% of children and young people under the age of 16 have asthma.

We've been working on a number of initiatives to help us reduce the health inequalities that affect people in our area. We've highlighted these below.

Supporting people with learning disabilities

We've been developing and implementing the Leeds Transforming Care Partnership (TCP) and local plan to deliver the national three year plan "Building the Right Support". The plan 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, specialised assessment and treatment or continuing rehabilitation and recovery hospitals.

The TCP is a partnership consisting 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 is to be completed by March 2019. One of the key principles is ensuring service users and families are at the centre of the programme of work. To support this co-production is an essential component of the delivery plan. A workshop with service users and families was held to agree the model and approach supporting the delivery of the plan. In addition seven work streams have been identified and agreed to deliver the strategic objectives of the all-age plan by the TCP.

Work to improve the health and wellbeing of people with learning disabilities has also been a focus of work this year. The Making Time Pharmacy Project is a new initiative to support improved access to local pharmacies for people with learning disabilities. The initiative facilitates protected time with pharmacists to identify health needs and develop a health action plan to promote an individual's health and wellbeing. The project has been recognised nationally winning two awards for innovation.

Gypsy and Traveller health improvement project

The project includes a range of initiatives to improve our understanding of the health needs of this community, to develop culturally appropriate service/services and to improve access to primary care.

Working with Gypsy and Travellers, Leeds GATE (a Gypsy and Traveller Advocacy Group) and York Street Practice, we developed and recruited an Outreach Nurse. The Outreach Nurse started in January 2017 building relationships between the Gypsy and Traveller community and primary care, providing health advice and revised health checks. Gypsy and Traveller residents from Cottingley Springs and Leeds GATE were members of the recruitment panel for the Outreach Post. They've also co-designed the approach to the project and evaluation. Links have been established across the Leeds clinical commissioning groups to share learning from the project.

Other initiatives to support the project include:

- Providing healthy lifestyle sessions and revised health checks at the Lee Gap Fair - a traditional Gypsy and Traveller Horse Fair held annually in West Ardsley;
- Cultural awareness training commissioned for primary care staff with initial sessions delivered in the Morley locality;
- Cottingley Springs residents linked to targeted health improvement work such as screening and cancer awareness; and
- Developing an academic partnership with Leeds Beckett University to support evaluation.

Enhanced care homes project

The enhanced care homes project has focused on ensuring all our CCG's care home residents have access to a multi-professional clinical team to deliver proactive care. Examples include working with residents to enhance their quality of life and promote independence with access to timely support from a therapy team. Working alongside staff and family carers, training has been provided to staff to improve care and to reduce hospital attendances and admissions.

Key findings from the scheme have shown;

- Better care experiences perceived by residents and family carers;
- A 5% reduction in hospital admissions and attendances; and
- More effective communication, relationships and joined up working for care home staff including clinical staff.

PEP (Patient Empowerment Project)

We've recognised the impact of wider determinants that can affect the health and wellbeing of our population. As a result we've invested in a partnership collaboration of local third sector organisations to offer social prescribing for vulnerable patients.

PEP is a social prescribing project enabling patients and communities to actively self-manage their health issues through peer support and access to local third sector groups and services. The main aim is to improve the wider health and wellbeing of patients and to enable GPs to have an alternative to the traditional medical based models of care.

PEP has supported extensive links and service connections for patients to a wide range of local community and voluntary services such as healthy living services, financial inclusion, housing, domestic abuse and drugs and alcohol agencies.

Following successful evaluation the PEP service has been funded until August 2019. A full procurement process was undertaken in 2016 and the three year contract was awarded to BARCA-Leeds.

The new specification has supported PEP to align with the primary care-led new models of care work in the Armley area; PEP has worked closely with the Community Mental Health Team to improve mental health pathways locally. The peer-led support group programme has developed during 2016-17, and the service is seeing an increasing number of self-referrals. The PEP service works in partnership with social prescribing schemes across the Leeds clinical commissioning groups.

Year two evaluation provides evidence of improvements in patient-reported measures of mental wellbeing. Patients also felt improvements in health related quality of life and health related self-efficacy and health management following engagement with PEP. For those patients with the most data collected, analysis indicates that at nine and 12 months post intervention there is a decrease in the number of finished primary care appointments; further analysis of year three data will help us understand how robust an effect PEP has had.

Mental health

We understand the importance of ensuring people have access and support when they are experiencing mental ill-health or distress. In 2016-17 we've been working on a number of projects to help support people access treatment and advice quickly.

- MindWell, the new citywide mental health information and self management website, was launched on World Mental Health Day in October 2016. It has been developed through an extensive co-production process and is increasingly being used by GPs and other professionals as well as the general public as the "first port of call" for information. In recognition of its work with services users, MindWell won a patient engagement award.
- With funding from NHS England's West Yorkshire Vanguard project we've established crisis cafés. We've commissioned two third sector agencies to establish the Well Bean Café running

on Saturday, Sunday and Monday evening from 6pm- midnight in Lincoln Green near St. James's Hospital. It offers a non-clinical alternative to A&E.

- We've been working with Leeds and York Partnership NHS Foundation Trust to deliver the CORE 24 standards. An agreed reconfiguration has been agreed to improve access for all ages, but further investment is required to deliver the 24 hour cover and one hour response times.
- We have a well-established cross sector crisis care partnership group that includes West Yorkshire Police, Yorkshire Ambulance Service NHS Trust, staff working in mental health or A&E, and community and voluntary sector organisations. The group has continued to meet to work on continual improvements to the mental health crisis pathway.
- As part of the Leeds Maternity Strategy we have worked jointly to develop the new citywide perinatal mental health pathway – bringing improved connection between existing services and including perinatal information on MindWell.
- The Early Intervention in Psychosis has been expanded in 2016-17 to extend the age range up to 65.
- We've 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 reduction in out of area placements consistently since September 2016 with only 90 bed days (eight people) in total for quarter three. This compares to 424 bed days (25 people) for quarter two. Quarter four figures won't be available by 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 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. Currently there are around 10 new practitioners working across the city creating a more multi-disciplinary approach that also includes pharmacist advice and guidance. The primary purpose is to get the patient to the right place first time and avoid unnecessary referrals.
- A public health specialist has been working across the system to refresh the mental health needs assessment due for publication in April 2017.
- Service users in partnership with clinicians have developed a set of "I Statements" for mental health services which clearly state how they wish to treated by mental health services. These were signed off by the citywide user group in September 2016 and adopted by commissioners who have made them part of all service specifications for 2017-18.

Dementia

- We improved dementia diagnosis from 2,348 people on GP registers with a diagnosis (end March 2016) to 2,386 (end February 2017). The diagnosis rate (recorded diagnosis as a proportion of estimated prevalence) increased from 78.7% to 79.0%. The methodology for calculating the indicator will change from April 2017, to give a more realistic, and still excellent, figure of c.71.5%. The methodology from 2015-17 created some random variation caused by patient registrations not matching geographic boundaries, which have worked in favour of our reporting figures.
- Despite this, we were judged as "Needs Improvement" for dementia in NHS England's first publication of the CCG Improvement and Assessment Framework,

based on diagnosis rate and the number of people receiving an annual face-to-face review. However, at this first publication, the "performance" regarding annual reviews essentially represents random variation above the 70% criteria at which the GP QOF awards maximum points. Prior to this, CCGs had had no notice to focus on improving annual dementia reviews, so it is doubtful whether it should be used to judge performance until CCGs have had an opportunity to engage with practices and improve.

- GP-hosted memory clinics opened during 2016-17 at Leigh View Medical Centre and West Lodge Surgery, in addition to the established clinic at Woodhouse Medical Centre. This is giving patients and carers an alternative to attending outpatient clinics delivered by Leeds and York Partnership NHS Foundation Trust (LYPFT) at St Mary's Hospital. LYPFT will evaluate these in 2017-18, but initial feedback from consultants is that the sessions are working well, and patients and carers find the GP-hosted venues much more convenient.
- The memory support worker service completed its first 12 months of operation in October 2016, and established itself very quickly as an 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, including economic evaluation. It has been shortlisted for a Health Service Journal award for 'Clinical Value', from a large number of high quality entrants; the winners will be announced in May 2017.
- The CCG continues 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 continue providing support to people from black and minority ethnic (BAME) communities; although again funding remains short-term and sustaining services remains a challenge. We recognise and applaud the excellent work of local community organisations who are addressing the needs of people with dementia, often using independent fundraising and voluntary effort.

Maternity and Children's Services

Our CCG continues to work with our neighbouring CCGs to implement the Leeds maternity strategy. Working groups have established a new pathway to improve the identification and support of emotional and mental health needs of pregnant women and women who have just had a baby. The groups are now meeting to ensure pathways are communicated and embedded.

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.

Furthermore, the CCGs have jointly funded, alongside the Department of Health and Leeds City Council, the embedding of the award winning Best Beginnings "Baby Buddy", and the incorporation of specific "Understanding your Baby" with perinatal mental health content. This interactive digital app provides useful support and key health promotion information, as well as local service details throughout the woman's pregnancy.

NHS Leeds South and East CCG leads on commissioning services for children and young people. In December 2016 Ofsted and CQC inspected Leeds partners on their delivery of responsibilities for children and young people with Special Educational Needs and Disabilities (SEND) as referred to in the Children and Families Act (2014). The Inspectors noted a number of key strengths in Leeds 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. Also the strength of the partnership was noted. Areas requiring some development were also identified. These included the need to ensure Education, Health and Care Plans (EHCP) were child centred and outcome focussed and an improvement of the educational outcomes achieved by this cohort of young people.

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 Local Transformation Plan 2016-2020' strategy was launched. There have been some significant achievements including the embedding of the Single Point of Access, the reduction in CAMHS waiting times, and the establishment of a distinct Community Eating Disorder Service for children and young people. There has been the launch of the MindMate champions programme for schools and the development of MindMate Lessons (PHSE curriculum for emotional and mental health).

'Best Start' to life

The Leeds Best Start programme aims to ensure a good start for every baby, with early identification and targeted support for vulnerable families. During 2016-17, the CCG has worked with Leeds City Council and other partners to develop and support the delivery of a local Best Start plan in Bramley. This work has focused on raising awareness of existing services, identifying gaps in services and providing targeted support for vulnerable families. Examples include taking a local smoking cessation service out to people's homes and working with parents to support healthy cooking. Best Start Hyde Park launched in March 2017.

Childhood obesity

During 2016-17, the CCG has worked collaboratively with schools and Leeds City Council to deliver an evidence-based childhood obesity prevention programme. This programme aims to increase fruit and vegetable intake and reduce intake of foods and drinks high in sugar and fat. The programme has been implemented in five cluster areas (20 primary schools in total) in response to two areas of concern identified through the National Child Measurement Programme. It first looked at areas with levels of childhood obesity that are significantly higher than the national average; secondly, it concentrated on areas where the prevalence of childhood obesity, whilst not above the national average, appears to be increasing.

New Models of Care – community wellbeing

In our CCG area, general practices are working with community, acute and third sector providers. They are developing and delivering new models of care which respond to the needs of priority populations within a given locality. Joint leadership teams are being developed and supported to enable provider joint working. We believe this will lead to improved outcomes and increased satisfaction for patients and in improvements to the working lives of front line staff through better working relationships.

For example a 'Community Wellbeing Leadership Team' has been established in

the Armley locality. Membership is local leaders drawn from general practice, (representing five GP practices in the area), Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, adult social care (Leeds City Council), the Armley One Stop Centre and the local voluntary sector.

The key aims are to improve relationships, develop local leadership and promote integration. The group aims to improve the aspirations of people in Armley. The group have identified priorities around mental health, self-care and delivery of care. The group also want to roll out coaching training to all front line clinical and non clinical staff so that all people in the area will receive a consistent response when accessing all services.

Helping to deliver the Leeds Health and Wellbeing Strategy

We've been working on a number of projects that closely link with some of the key objectives set out in the Leeds Health and Wellbeing Strategy. These look to address some of the issues that affect people's quality of life and impact on their overall health and wellbeing.

Key citywide statistics from the Leeds Health and Wellbeing Strategy

- Over the next 25 years the number of people who live in Leeds is predicted to grow by over 15 per cent. The number of people aged over 65 is estimated to rise by almost a third to over 150,000 by 2030
- 164,000 people in Leeds live in areas ranked amongst the most deprived 10 per cent nationally. One in five children in Leeds live in poverty
- 34% of children aged 11 in Leeds have an unhealthy weight
- It is estimated around 37,000 older people experience social isolation or loneliness
- Physical inactivity is our fourth largest cause of disease and disability. Figures show that around one in five adults in Leeds is inactive
- Cancer deaths account for over 30% of the life expectancy gap between Leeds and the rest of England
- People with severe mental illness die on average 15-20 years earlier than the rest of the population
- 105,000 people in the city suffer from anxiety and depression

Avoidable years of life lost – cancer

We've worked alongside Leeds City Council and Cancer Research UK to improve the early diagnosis of lung cancer. This includes working with pharmacies in areas of west Leeds with high smoking prevalence to increase awareness of symptoms of lung cancer, and encourage self-referral for chest x-ray in appropriate patients. GPs were incentivised to improve bowel cancer screening uptake as part of quality premium improvement scheme.

Leeds is one of six pilot sites nationally involved in the ACE (accelerate, co-ordinate, evaluate) project. This is funded nationally by Cancer Research UK. The aim of the pilot is to develop and implement a referral pathway for patients with non specific but concerning symptoms where there is a suspicion of cancer. In developing this new pathway it is anticipated that patients that don't usually meet the criteria on to a two week wait referral pathway, will be able to be referred earlier for diagnostic tests.

The patient's GP will be able to refer the patient for a range of blood tests and then make an onward referral into Leeds Teaching Hospitals NHS Trust using an ACE referral

form. Patients are then booked for a nurse-led assessment, following which results are discussed at a multi-disciplinary centre and an onward referral decision is made. This could be further investigations/tests, onward referral within the hospital, or discharge back to GP. This new pathway is being piloted nationally and actual referral activity and intelligence will inform the future model development and resource requirements. The following outcomes are expected:

- Better informed and supported GPs in decision making and earlier referral;
- Improved integration of primary and secondary care systems for patients with non specific but concerning symptoms;
- Improved patient safety;
- Focus on continuity and quality of care for patients; and
- Improved cost effectiveness use of diagnostic resources.

Leeds is one of five pilot sites involved in the 28 days to faster diagnosis project, funded by NHS England. This is a key National Cancer Taskforce recommendation that all patients should receive a 'definitive' diagnosis of cancer or have cancer 'definitely' ruled out within 28 days of an initial referral (and 50% within 14 days). This project will achieve the following outcomes:

- Improved patient safety with improved access to earlier appropriate diagnostics;
- Improved patient experience with faster communication of diagnosis for patients; and
- Improved links and integrated working between primary and secondary care.

We're pleased to see Leeds being above the national average for diagnosing cancer at stage 1 or 2. Our performance of 56% against the national average of 50% is for the following cancer sites:

- invasive malignancies of breast, prostate, colorectal, lung, bladder, kidney, ovary and uterus; and
- non Hodgkin lymphoma and invasive melanoma of skin.

Avoidable years of life lost – cardiovascular disease (CVD)

The Atrial Fibrillation (AF) programme has been focusing on identifying the numbers of people across the CCG area with AF in order to reduce the number of people affected by stroke. Programme findings the below.

- At the start of the programme, there was a 37% treatment gap in identifying patients with AF. This is now 23%.
- Training provided to manage AF has increased knowledge, skills and confidence among GPs.
- Shared decision making tools are available to support the conversation with patients around decision making.
- There's been a 50% reduction on patients who previously have been taking aspirin.
- Novel oral anticoagulants (NOACs) are a new class of anticoagulant drug. There has been a substantial increase for patients on NOACS with approximately 600 patients now receiving NOACS.

Supporting people into employment

In 2016-17 we match-funded the development of a community–led local development (CLLD) strategy for west Leeds. This looks at how people furthest away from the labour market in the most deprived communities can be supported into employment. The strategy was submitted to the European Social Fund and the European Regional Development Fund and was successful in going forward to full

application. The result will be €1.5million funding into the area to fund such schemes. We're members of the local action group who will make decisions on how the funding is used.

Unnecessary time spent in hospital

All partners in Leeds are committed to ensuring that patients only spend as much time as they need in hospital. In October 2016, health and social care partners in Leeds established an integrated discharge service within Leeds Teaching Hospitals NHS Trust. The service brings together expertise from across health, social care and the third sector (Age UK) to identify patients that need support from health and social care commissioned services in the community to facilitate their discharge. The service operates seven days a week from 8 till 8 to coordinate the assessment of patients' needs and arrange ongoing care. Our analysis to date is that the service is helping patients to avoid unnecessary stays and, when they're admitted, reducing the time that they need to stay.

Preventable hospital admissions – childhood asthma

Over the last two years, the CCG has funded the delivery of a community-based children's asthma service, which aimed to raise awareness, improve care and reduce hospital admissions. Key components of the project included providing asthma education in schools and early years' settings, developing a risk-stratification tool to identify children most at risk of exacerbation, and developing and implementing protocols and a clinical recording template in primary care to standardise care and reduce variation in care. Local children co-produced a number of resources aimed at raising awareness of the importance of carrying their inhalers at all times.

Preventable hospital admissions – clinical care co-ordinators

In 2016-17 we've continued to fund GP practice based clinical care co-ordinators. The care co-ordinators are hosted by GP practices but link out into the community, working closely with neighbourhood teams and primary and community healthcare services.

The clinical care co-ordinator:

- is responsible for the initial assessment of patients and the formulation and review of a personalised care plan;
- collects data relating to specific patient outcomes - these will be dependent on the patient's requirements;
- is a key contact along with the named accountable GP for the patient;
- is a key person for building and managing the relationship between practices and neighbourhood teams;
- attends case management meetings;
- identifies when patients have been admitted/attended A&E and reviews care plans accordingly; and
- supports discharge planning for patients who are admitted to hospital.

INVOLVING OUR PATIENTS

"…the health service needs to change, arguing for a more engaged relationship with patients, carers and citizens so that we can promote wellbeing and prevent ill-health. We need to ensure that patients and the public are an integral part of our governance, decision making forums, service improvement, re-design and assurance. It is vital that the patient and public voice is embedded in all of our commissioning process."

Five Year Forward View,
NHS England, October 2014

Under the Health and Social Care Act we have a legal duty to engage and involve our local population in decisions that affect them:

- Involve patients and carers in decisions relating to their care and treatment.
- Involve the public in the planning and buying of healthcare services.

In addition to being a statutory duty we believe that meaningful patient and public participation can help us to develop and deliver services that are safe, effective and efficient. 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 participation groups (PPGs);
- ensure that involvement is representative of all our communities; and
- share and build on best practice across Leeds and our involvement work will be consistent with all our partners.

We recognise that people want to get involved at different levels and in different ways. Most 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 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.

We have organised this section of the report to reflect the three categories in the NHS England 'Transforming Participation in Health and care' document www.england.nhs.uk/participation/involvementguidance .

This report outlines the structures and processes we have put in place to support meaningful involvement. We will also give examples of good practice and outline how we are working with our partners to ensure that we are reaching diverse, potentially excluded and disadvantaged groups.

Involving our patients: individual participation

'Patients and carers are involved in managing their own health, care and treatment. This means being involved in decisions about their care and having choice and control over the NHS services they receive.'

Collaborative care and support planning

More people who are living with a long-term condition in west Leeds are being given the opportunity to receive results of tests before they have a consultation with their health care professional. GP surgeries are introducing this approach which aims to ensure that patients are prepared and can have more meaningful conversations about what's important to them and get the expert advice they need to help them manage their condition. The approach known as collaborative care and support planning comes from the Year of Care (YOC) model to support care planning for people with long-term conditions, in primary care. It changes routine consultations to make them more meaningful. Working in this way has led to many people feeling more in control of their condition which has been shown to reduce complications as well as enabling patients to seek help when they need it.

Involving our patients: public participation

'Every part of our health and care system is shaped and improved by involving those who use and care about our services. Everyone contributes their distinctive perspective, especially those who face the greatest health disadvantage and the poorest health outcomes.'

Patient Assurance Group (PAG)

We established our Patient Assurance Group (PAG) in 2012. This is a group of local people who look at commissioning plans and proposals, and offers advice and comments to say 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 read more about our PAG here: www.leedswestccg.nhs.uk/get-involved/how/patient-assurance-group/.

We have worked with our PAG members and commissioners to develop an engagement plan template. This template supports commissioners to develop their engagement plans in a way that meets our statutory duty to ensure the effective participation of the public in the commissioning process, so that services provided most closely reflect the needs of local people. The planning template also supports our PAG by providing information in a clear and coherent manner.

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 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. You can read the report from the event and the recommendations here: www.leedswestccg.nhs.uk/content/uploads/2015-07/VAW-evaluation-report-Oct-2016-FINAL.pdf

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 group of people who, while not representative, do recognise, understand and embrace equality and

difference. 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.

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; and
- Providing tools and resources to patient champions and staff.

We currently have 44 patient champions in the programme, 12 of whom are actively involved in 12 different commissioning steering groups.

You can read more about the programme here: www.leedswestccg.nhs.uk/get-involved/how/patient-champion/

Patient participation groups (PPGs)

We believe that our member GP practices' PPGs should be the bedrock of healthcare engagement in our communities. This place-based approach offers an opportunity to support PPG members to champion the views of local people. While we understand that running a PPG is now a contractual obligation for our practices, we also recognise the challenges and pressures that are faced by primary care. We have invested in our PPGs by:

- Offering visits each year to all 37 PPG groups in our CCG;
- Developing a range of tools and resources to support PPGs;
- Promoting engagement events and activities with our PPGs; and
- Developing and delivering regular training for PPG members and practice staff.

You can see all the tools, resources and reports on our PPG page here: www.leedswestccg.nhs.uk/get-involved/how/patient-participation-group/

Patient, carer and public network

We recognise the importance of developing a diverse and engaged group of local people to support our commissioning decisions. We have invested in a searchable database which allows us to promote engagement activities in a more coordinated and targeted manner. Working in this way has reduced correspondence and increased participation. Our network members also receive a copy of our quarterly magazine and a monthly e-newsletter.

Engage magazine

Our community magazine has proved very popular with local people. In our most recent addition we have included three articles written by patients and voluntary organisations from across the city. Contributions from local people include features on PPGs, a dementia garden and The Real Junk Food Project. Electronic copies of the magazine can be downloaded from our website: www.leedswestccg.nhs.uk/engage

Working with our partners

We are committed to working with the voluntary, community and faith sector to ensure that we hear and respond to the most vulnerable members of our community. We recognise that our team does not have the experience, knowledge or 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 the other CCGs in Leeds, 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 by offering a range of training and peer support. Involving our partners has enabled us to expand the range of training we can offer.
- We've worked closely with Leeds City Council, and other members of the Leeds Health and Wellbeing Board, to capture views prior to developing the Leeds Health and Wellbeing Strategy 2016-2021.

Involving our patients: insight and feedback

'The NHS Constitution is clear that every individual deserves to have as good an experience of the NHS as we can possibly provide. To ensure this happens, we need to listen to people in order to understand what they need and what works for them. This is what we mean by insight and feedback. Any service industry listens to the people it serves and the NHS should be no different. Insight is an important way of understanding the need and experiences of all communities and a key tool in tackling health inequalities.'

Patient Participation groups (PPGs)

We have worked hard 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. PPGs now have access to the results of the national GP survey and population data in the practice profile data. We also share primary care updates which includes patient experiences trends and themes. This information helps them to set their plans and priorities based on the needs and preferences of the wider community, especially potentially excluded and disadvantaged groups.

Friends and Family Test

We continue to use feedback from our providers that they get through the Friends and Family Test to suggest areas for improvement as well as highlight areas of best practice. You can find out more about how we've used the Friends and Family Test in 2016-2017 by reading our improving quality and safety section.

Involving our patients: future plans

- We will continue to support our PPGs and PAG by working with our partners at the Engagement Hub
- We will work with the other CCGs in the city to continue developing our 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.

Involving our patients: case studies

The closure of Holt Park Branch Surgery

In July 2016 Abbey Grange Medical Practice approached their PPG with a proposal to close the branch surgery within Holt Park Health Centre. The PPG agreed to support the practice with its engagement and the decision was made to apply to our CCG, in our capacity as co-commissioners, for permission to engage with patients

We advised the practice about its the engagement exercise. It was agreed that the practice would engage with the whole practice population rather than just those who were accessing Holt Park. The practice and their PPG developed an engagement document that was sent to all patients registered at Abbey Grange Medical Centre. The practice also held three engagement events.

The practice used feedback to shape the way they delivered services:

- People said: 'It is difficult to park at the other two sites'. The practice said: 'We asked all staff not to park at the practice so that all the spaces were available to patients', 'We arranged for a dedicated disabled parking bay at Abbey Grange', and ' We arranged for additional parking at a local school'
- People said: 'It is not easy to access the other sites by public transport especially from Cookridge'. The practice said: 'We have increased telephone consultations and will introduce other ways for people to access care from home', 'We will work closely with our social prescribing project so that people feel more supported to self-manage their condition' and 'We will continue to provide home visits to people with long-term ill health or mobility problems'

Training courses

During an audit in 2015, patient champions asked for training on the co-production approach. In 2016 we co-produced a co-production training session with one of our patient champions. The session was developed for patient champions and staff and ran for the first time in February 2017. The session was attended by patient champions and healthcare professionals and was well received. We'll be running the session a further two times in 2017.

An attendee said: 'I just wanted to write and say a big thank you for allowing us to participate in your co-production training. It was a really valuable learning experience and so helpful to see what a more established service user engagement programme might look like. It is inspiring to see the commitment and energy people are willing to give, when properly supported.'

Member of the voluntary sector

Our patient champions also asked for training on equality and diversity so that they better understood the needs and preferences of people who are often not represented at patient groups.

As a result we developed the 'knowing your community' training 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. It is part of a package of training delivered by the Engagement Hub, a citywide NHS collaboration. The training is constantly evaluated and developed using patient feedback.

People said: 'The best part of the training was sharing real examples. Understanding the power of the patient champion and the influence they can have'

'The best part of the training was understanding the role of the patient champion and the quiz learning about deaf people'

'The best part of the session was the facts and figures that provided a more informed overview of our city'

Patient champions

Our patient champion programme supports local people to develop the skills to provide assurance that we are engaging in the right ways and with the right people. The programme involves 10 different training sessions, regular peer support groups and individual support.

There are currently 44 people on the programme, 12 of whom are actively involved in 12 different projects.

- **Patient Empowerment Project:** Our social prescribing project helps primary care staff refer people to local non-clinical services for support with their social health. Our patient champion has been involved in this project for almost three years. They helped to ensure that we engaged well with local services and that feedback was used to develop the service. They also were involved in the procurement of the new service by helping develop the engagement part of the purchasing process. They attend regular meetings to help ensure that we constantly evaluate the project and respond to patient feedback.
- **Chronic Pain Service:** In 2014 we started a project to explore how we could improve chronic pain services in Leeds. We recruited two patient champions to the project and three years on they are still supporting the steering group. The patient champions helped to ensure that the recommendations in the engagement report reflected the views of patients and the public. They have used the report to champion the views of the wider population throughout the life of the project. Our patients helped to develop a patient leaflet outlining chronic pain self-management and are currently supporting the CCG to write an engagement update for people involved in the initial engagement. The update will clearly outline how the project has responded to patient feedback.

The Engagement Hub

Patients attending their PPG, the PAG and providing patient representation on steering groups asked NHS Leeds West CCG for more support to develop them in their role. The engagement team carried out a needs assessment to identify areas where patients' need support. Over the last three years we've been working on an initiative which is now called the patient champion programme.

The training for patients and staff was set up by NHS Leeds West CCG in 2014. The project consists of peer support and various training sessions. All the sessions were developed following a needs assessment with PPG and PAG members.

As the project grew it has become increasingly important to work with our partners to meet patient need and so we developed the Engagement Hub, a collaboration between the Leeds hospitals, mental health trust and CCGs. Working as a partnership we have been able to expand and improve our training. The partnership has also allowed us to use venues across the city so that our training is more accessible.

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. A wide range of topics have been discussed at the meetings including:

- 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	We did
Patient champion training is not accessible to people who work traditional working hours	We improved accessibility to the training and now offer eight of the ten sessions at the weekend.
There are no articles in the Engage magazine that are written by patients.	The last Engage magazine featured three articles written by patients.
We need a citywide event to meet and share good practice in the city.	We set up a citywide event for NHS volunteers that was attended by 31 people.

WORKING WITH OUR PARTNERS

Clinical commissioning groups

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

Discussions have been taking place about how the three CCGs can work together more collaboratively. To support this a project called One Voice has been established. As part of this a joint leadership structure is being set up with one Chief Executive Officer overseeing the work of the three CCGs. Another important role that has been established is that of a Chief Officer for System Integration.

Work is underway to establish citywide committees to cover governance, quality, finance and patient assurance which will be established to 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. These constitutions are in the process of being updated so that the transitional arrangements can be implemented.

On an operational level the Leeds CCGs have been looking at key citywide healthcare services. Our plans are set in the context of national guidance as well as the West Yorkshire and Harrogate Sustainability Transformation Plan (STP) and the Leeds Plan.

The Leeds CCGs have taken on joint responsibility with NHS England to co-commission primary care (GP) services. This means we're working with our respective member GP practices to look at how we can improve access and quality in primary care GP services.

To support this the Leeds CCGs have put together a five year plan in direct response to the NHS GP Five Year Forward View. We have six ambitions that will help us to deliver the GP Five Year Forward View. These are:

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

You can find out more by reading our plan: www.leedswestccg.nhs.uk/content/uploads/2016/06/Leeds-GPFV-Plan-Final-Version.pdf

Ensuring that children enjoy the best possible start to life is a citywide priority as outlined in the Joint Health and Wellbeing Strategy. As part of our efforts to support this the Leeds CCGs are reviewing maternity services. This is an ongoing long-term review that has to date involved a number of key partners as patients and their families. This links in with the Leeds Maternity Strategy 2015-2020: www.leedswestccg.nhs.uk/about/publications/maternity-strategy-for-leeds-2015-2020/

Our city's Joint Health and Wellbeing Strategy prioritises the mental health of citizens in Leeds. We've been continuing to invest in services that improve the mental health and wellbeing of people.

For children and young people we've continued to invest in child and adolescent mental health services (CAMHS) in direct response to feedback from service users and their families. We acknowledge that waiting times for services are high however our investment is beginning to make a difference. We've also continued to work with children and young people to further develop Mindmate. Mindmate is a website

offering advice and support as well as signposting information for children and young people, parents/carers and frontline professionals.

Issues affecting access to mental health services are not restricted to children and young people. Therefore we've increased our efforts to ensure adults can get the support they need at times of mental ill-health. We've increased investment leading to improved capacity to deliver IAPT (improving access to psychological services).

Similar to our work with children and young people, we've involved citizens to help us develop a new single point of access website for adult mental health, Mindwell. MindWell is the single 'go to' place for information about mental health in Leeds. It provides a portal for anyone living or working in Leeds, including GPs and other professionals, to get quick and easy access to up-to-date mental health information.

Antimicrobial resistance is one of the biggest threats to the health and wellbeing of people with scientists warning that if more isn't done then there's a risk that antibiotics will no longer work. We've been working with our partners to improve understanding of antimicrobial resistance among healthcare professionals and the wider public. This includes working with prescribers to reduce the prescribing of antibiotics where they're not needed and developing awareness campaigns so that the public are aware of the risks of the overuse of antibiotics. We're also promoting linked messages to reduce the spread of infections such as effective hand washing and spotting the signs of sepsis.

West Yorkshire and Harrogate Sustainability and Transformation Plan (STP)

The West Yorkshire and Harrogate Sustainability and Transformation Plan (STP) published during the year, aims to address the health and wellbeing gap with a focus on supporting people to live longer, healthier lives and ensuring a good and equitable service for all, no matter where people live. It also stresses the importance of improving people's health, through better co-ordination of services, while improving the quality of care received.

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: www.southwestyorkshire.nhs.uk/west-yorkshire-harrogate-sustainability-transformation-plan/

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: and
- Urgent and emergency care and rapid response.

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) using a range of information and local and national statistics to identify the current health and wellbeing needs of our communities and highlighting health inequalities that can lead to some people dying prematurely in some parts of Leeds compared to other people in the city. The findings from the JSNA fed into the Joint Health and Wellbeing Strategy for Leeds 2016-2021: www.leeds.gov.uk/docs/Health%20and%20Wellbeing%202016-2021.pdf

We consult regularly on a formal and informal basis with the HWB, its membership and its Chair. In particular, we consult with the HWB on our strategies and plans, and how these contribute to the delivery of the health and wellbeing strategy for Leeds. For example, in preparation for the submission of plans for 2017-2018 we have provided a full analysis of how our plans and priorities meet the HWB's vision for health and care in the city. Prior to submitting our annual report to NHS England we consulted with our Health and Wellbeing Board as part of our formal requirements to do so.

The Joint Health and Wellbeing Strategy has 12 priority areas:

- A child friendly city and the best start in life;
- An age friendly city where people age well;
- Strong, engaged and well-connected communities;
- Housing and the environment enable all people of Leeds to be healthy;
- A strong economy, with 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 condition;
- 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.

Listed below are some examples of the progress we have made this year.

- We've kept members of the Health and Wellbeing Board informed of our work around the West Yorkshire and Harrogate Sustainability Transformation Plan and the linked Leeds Plan. This included highlighting current and anticipated pressures on the health and care system, efforts to address these and wider system resilience.

- Agreement on the Better Care Fund for 2016-17. Plans included how partners will work to meet national conditions for social care, a joint approach to assessment and care planning including integrated care and a local plan to reduce delayed transfers of care.

- Tackling health inequalities and wider issues (determinants) that can lead to ill health. This included looking at issues such as poverty, air quality and taking action to reduce incidences of domestic abuse. However the Health and Wellbeing Board noted the continued funding cuts for public health and the impact this has on

prevention initiatives leading to concerns about the impact this will have on health inequalities.

- There are over 250,000 people in Leeds under the age of 25. 10% of these young people 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 improvements can be made to the emotional and mental health of children and young people in Leeds. This included outlining plans on improving the support provided to children with Special Educational Needs and Disabilities (SEND). A copy of the strategy can be downloaded: www.leedswestccg.nhs.uk/about/publications/future-mind-leeds-local-transformational-plan-2016-2020/
- Carers play a valuable role in helping health and social care services often at great personal cost – both financially and emotionally. As a result the Health and Wellbeing Board signed up to the Leeds Commitment to Carers. The commitment has been supported by 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 (Adult Social Services, Public Health, NHS) reviews and scrutinises the performance of Adult Social Services, Public Health and the local NHS. The Scrutiny Board 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 assure we meet our duties to consult as outlined in the NHS Act (2006).

As co-commissioners we received our first proposal from a GP practice looking to close a branch surgery. Abbey Grange Medical Practice submitted an application to close their branch practice at Holt Park. We advised the practice on how they would need to engage with their registered patients. In addition we informed the Scrutiny Board and kept them updated on the latest position. This included confirmation that the CCG's primary care commissioning committee had accepted the application to close the branch surgery.

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

- Work on developing the West Yorkshire and Harrogate Sustainability Transformation Plan and associated Leeds Plan.
- Primary care including co-commissioning of services with NHS England
- Concern was raised around cancer waiting times in some specialities. However the Board was informed of the progress made in this area and how Leeds has some of the quickest access to diagnostic services.
- 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.

- Leeds' response to the NHS GP Five Year Forward View.
- One voice collaborative approach being adopted by the Leeds CCGs.

Our NHS providers

We are pleased to be able to commission services from three NHS trusts in Leeds alongside other service providers. We lead on commissioning services from Leeds Teaching Hospitals NHS Trust, with NHS Leeds North CCG leading on commissioning services from Leeds and York Partnership NHS Foundation Trust and NHS Leeds South and East CCG taking the lead on Leeds Community Healthcare NHS Trust. Our ambulance services are provided by Yorkshire Ambulance NHS Trust who also are the provider of NHS 111 for our region. In addition to this we fund services from a number of neighbouring providers so that we can uphold the rights of our patients to choose where they go for treatment where it is appropriate to do so.

Some of the highlights from the year include those highlighted below.

- Working with Leeds Teaching Hospitals NHS Trust, as well as community partners and academics, to look at how cancer pathways can be improved. This covers all parts of the pathway from diagnosis, treatment and ongoing care. The work we've done has helped set up the Leeds Cancer Strategy 2016-2021.
- Working with a range of partners including Leeds Community Healthcare NHS Trust and Leeds and York Partnership NHS Foundation Trust to set up a community wellbeing leadership team in Armley. This will help establish integrated care that is delivered within the community as well as encouraging people to self-care.

You can find out how well our NHS providers are doing in the performance section of the annual report. Further details can also be found on our website as we publish an integrated quality and performance report for each Governing Body meeting: www.leedswestccg.nhs.uk/about/governing-body/meetings/

Leeds City Council

Leeds City Council commissions care and support services and is responsible for public health, which is a body of work that seeks to protect and improve health and wellbeing.

The future direction of health and care services set out in the NHS Five Year Forward View is around closer integration of health and social care services. These services would be delivered at a locality or neighbourhood level by care teams working together rather than working to their own organisation's boundaries. We've already started making progress in setting up one of the 'New Models of Care' and in 2017-18 we've made significant progress in establishing our first pilot site in Armley. As a result we now have a community leadership team that will help us deliver our plans to bring co-ordinated care closer to home, reducing the need for hospital-based care. To do this we've been working with a range of partners including Leeds City Council.

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 to take part in initiatives to protect their health, such as the NHS Health Check, the flu jab or cancer screening.

We worked with Leeds City Council and community organisations to launch a strategy to reduce the number of suicides in the city. The Leeds Suicide Prevention Strategy is based on an audit of detailed findings of suicides 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.

We have also been working closely with Leeds City Council to deliver key public health campaigns. In the last year we have been promoting a campaign encouraging patients to dispose of medicine waste, such as syringes, safely to reduce the risk of injury to environmental waste officers and members of the public. We've also worked with the council to run a winter wellbeing campaign encouraging people to make the best use of NHS resources as well as accessing support from services such as meals on wheels.

Community and voluntary sector organisations

The role of the community and voluntary sector (often referred to as the third sector) is crucial not only for the delivery of services but also to provide us with an opportunity to engage with some community groups who are sometimes referred to as 'seldom heard groups.'

Over the past 12 months we have been working with local community groups to run a number of engagement events and activities so that we can continue to develop services that meet local needs.

Our patient empowerment project (PEP) provides social prescribing options for GPs so that they can refer people to PEP, who in turn puts patients in touch with community groups and services that can help them. Social prescribing looks at wider issues that can affect a person's health that are not medical reasons such as debt or bereavement. A social prescription then links a patient in with services that can help tackle the root cause of their ill health. Our PEP project is delivered by a consortia of community and voluntary sector organisations including BARCA-Leeds, Leeds Mind and Better Leeds Communities.

A decision was undertaken to cease funding for non-medical circumcision services. To help inform members of the public, we worked with families who had used the service, local religious leaders, local GP practices and other services who work with families.

We've worked with our community and voluntary sector partners to develop a new approach to the NHS Equality Delivery System in the engagement and assessment of grades. This is a uniform approach adopted by all Leeds NHS organisations and has been developed by taking in the views of key partners including Healthwatch Leeds, Voluntary Action Leeds, Leeds Involving People and Forum Central.

The new Mindwell mental health website for Leeds was developed in conjunction with a range of community groups co-ordinated by Volition, allowing us to work with people to co-produce the site. Volition is a network of third sector, not-for-profit organisations that support people's mental health and wellbeing in Leeds.

We were delighted that our partners Carers Leeds won a prestigious Health Service Journal Award for the work they do to advocate on behalf of the city's carers. Carers Leeds won an Integrated Commissioning for Carers award in recognition of its integrated approach to carers support. Carers Leeds have also helped the city to develop a 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. We have worked with Healthwatch Leeds to gather patient

insight on local health services including an extensive survey and interviews to capture the experiences of patients as part of our extended access to primary GP services scheme.

Healthwatch Leeds have also undertaken a number of reviews of services and published subsequent reports with recommendations. We'll be looking at how we can use the recommendations from these reports to influence how services are provided in the future. The reports are for the following:

- review of sexual health clinics in Leeds;
- service users' experience of Aspire, providing care and support services for adults with learning disabilities; and
- home care services for people receiving support in their own home.

Care Quality Commission

The Care Quality Commission (CQC) is the registration body responsible for monitoring standards of care, and undertakes announced and unannounced inspections to providers either as a matter of routine or in response to concerns raised by patients and staff. To support sharing of information and intelligence on quality and standards of care the Leeds Quality Surveillance Group, represented by all three CCGs, also includes a representative from the CQC.

In 2016-17 the CQC inspected all our 37 member GP practices and reports for 36 of them had been received at the time of writing. We were pleased that five of our practices received an outstanding rating and 30 were rated as good. Unfortunately one of our practices was rated as requires improvement.

The CQC also undertook inspections of three NHS provider trusts in the city. At the time of writing we received reports for two of the three. We're pleased that Leeds Teaching Hospitals NHS Trust has moved to a good rating from its previous position of requires improvement. However Leeds and York Partnership NHS Foundation Trust was rated as requires improvement.

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.

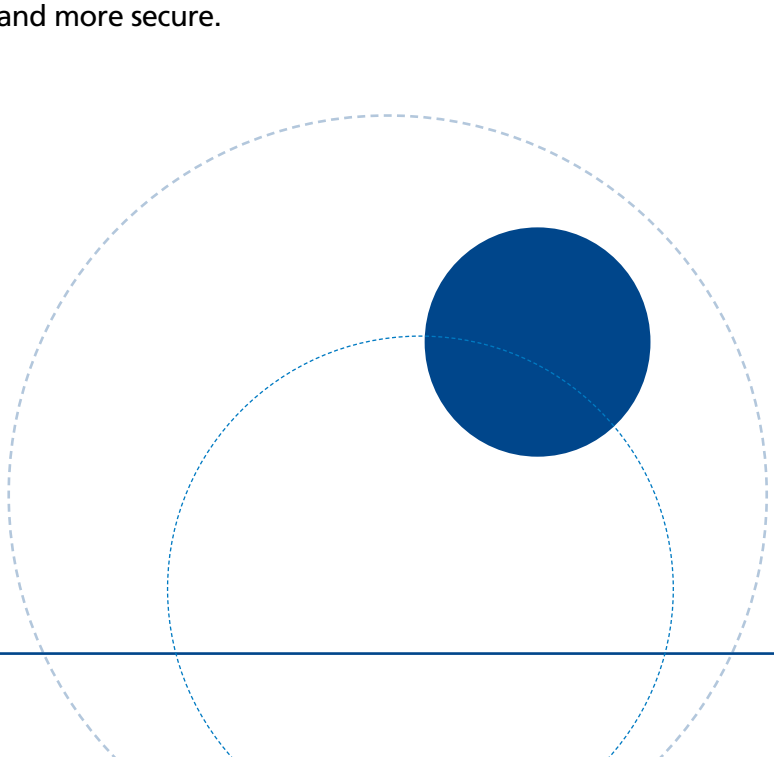
Leeds Informatics Board

The Leeds Informatics Board (LIB) is responsible for the governance framework 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 is helping to deliver the ambitions of the city. During the year a wide range of achievements have been developed under the leadership of LIB outlined below.

- Leeds Local Digital Roadmap was produced in conjunction with the West Yorkshire and Harrogate Sustainability Transformational Plan and in collaboration with other Local Digital Roadmaps across West Yorkshire. It provides a consolidated view of the plans describing a five-year digital vision, a three-year journey towards becoming 'paper free at the point of care' and two-year plans for progressing a number of predefined 'universal capabilities'.

- Another major achievement has been the inclusion of adult social care and community information to the Leeds Care Record. Leeds Care Record now covers five major care settings viewing and contributing information across the city including GPs, hospital, mental health, adult social care and community. We have also significantly increased to 4,000 active users, a huge leap from April 2016 when there were 2,500 users.
- Leeds Intelligence Hub continues to drive change in commissioning by providing system wide data analysis and insight.
- Excellent progress has been made on some national targets including electronic prescribing between GPs and pharmacists. GPs in Leeds are quick adopters of the national electronic prescription service (EPS) making prescribing and dispensing medicines more efficient and convenient for patients and NHS staff. 100 GP practices in Leeds (over 95% of 104) can digitally send prescriptions directly to the patient's preferred pharmacy through their own IT system, removing the need to write paper prescriptions. Patients are now able to collect their repeat prescriptions from the pharmacy without the need to visit the GP practice. It also means that patients don't have to worry about losing their paper prescription, making the process safer and more secure.
- Patients and healthcare professionals visiting nearly all of the GP surgeries in Leeds can now connect to the internet using free WiFi.
- Six care homes in Leeds are involved in a pilot scheme which allows health and care staff to remotely monitor the health of residents and reduce the need to admit residents to hospital as an emergency.
- Leeds is now transferring patients' electronic health records directly, securely and quickly between their old and new practices when they change GPs. The system called GP2GP helps improve patient care by making full and detailed medical records available to practices, for a new patient's first and later consultations.
- Leeds Health Pathways has standardised clinical pathways, medication and guidance to all care professionals in the city. It is managed and supported by Leeds Teaching Hospital NHS Trust and replaces the Map of Medicine which was used by primary care. It's a great example of how collaborative working across organisations can create impressive results that help to ensure that consistent care and pathways are available across the city.



SAFEGUARDING

We have a legal responsibility to ensure 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.

NHS Leeds South and East CCG hosts the citywide safeguarding team. The 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 partners in Leeds.

The CCG Safeguarding Children and Adults at Risk Committee meets bi-monthly; membership includes commissioners, head of quality, designated nurses, designated doctors, and the directors of nursing and quality. The safeguarding committee reports into each CCG's individual governance structure. The safeguarding committee leads work on behalf of all three Leeds CCGs through an agreed action plan and monitors compliance of agreed safeguarding standards through a performance framework and audit programme.

Key highlights for 2016-17 include:

- Revised CCG training 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. The training helps practitioners to safeguard vulnerable people from being radicalised to support 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. The template is compatible with both EMIS and SystmOne, the two IT systems used by GP practices in Leeds.
- Continued commitment to work 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, or a victim, of domestic violence or abuse (DVA) and records the outcome of the routine enquiry.
- Additional investment in the CCG safeguarding team to increase its capacity and resources to respond to the co-commissioning of primary care.
- Strong commitment to the development of the Front Door Safeguarding Hub and full integration between the health economy and social care. The Front Door Safeguarding Hub acts as a contact centre for health and care practitioners to identify an appropriate response where there are concerns about the welfare or the safety

of a child or young person. The Hub also offers a co-ordinated and consistent response to domestic violence cases.

- Strong commitment to partnership working and support for the work 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 the 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 professional lead/DoLS manager within Leeds Adult Social Care to identify patients who;
  - receive care in their own homes
  - are funded through continuing healthcare
  - require a Court of Protection Order.
- Involvement in the cross CCG work to 'Break the Cycle: opportunities to reduce the risk of children entering care'.

Challenges for 2017-18 include:

- To continue to support health's contribution to the Front Door Safeguarding Hub. There is a recognised gap in health economy representation however, a project to scope out what is required to ensure the full integration between health and social care is currently under way.
- To continue to support and manage 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.
- Co-commissioning of primary care from April 2016: although the safeguarding team has had increased investment this year there remains the challenge in relation to the increased responsibilities and workload. For example from 1 April 2016 NHS England no longer commissions GP report authors for serious case reviews, lessons learned reviews, safeguarding adults reviews and domestic homicide reviews.
- Continuing to embed learning into practice from national and local safeguarding reviews. This includes the 'Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015'.
- To further the understanding of the early help approach and the work of the clusters and targeted service leaders within general practice. Early help is the term used by agencies in Leeds to describe our approach to providing support to potentially vulnerable children, young people and their families as soon as problems start to emerge or when there is a strong likelihood that problems will emerge in the future.
- CCGs and other NHS providers are preparing for The Independent Inquiry into Child Sexual Abuse, however there is currently very little guidance available from central government.

- 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 likely to have significant implications for CCGs with possible changes for the responsibility for identifying a DoL shifting from providers of care to the commissioners. The safeguarding team and MCA lead will continue to work with colleagues in Leeds City Council and CCGs to contribute to future consultations and address and embed any changes which impact upon the CCGs.

"This model fully integrates and reflects the *'Think Family, Work Family'* approach adopted by partners in Leeds.

EQUALITY AND DIVERSITY

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. The Duty also expects us to advance equality of opportunity; and foster good relations between people with one or more protected characteristic, both in relation to our commissioning responsibilities and our workforce. In addition the specific duties mean that we have to publish equality information annually. The reports demonstrate how we have met the general public sector equality duty in regard to both the workforce (for organisations with 150+ staff) and the population. We prepare and publish one or more equality objectives, at least every four years.

We recognise the diversity of our communities, both citywide and in our CCG's geographical area. We are committed to eliminating unlawful discrimination and promoting equality of opportunity when commissioning healthcare services and in creating a workforce that broadly represents the population we serve. We make sure that equality and diversity is a priority when designing, planning and commissioning local healthcare, and in respect of our workforce.

We are committed to listening to and respecting the voices of our diverse communities throughout the commissioning stages of healthcare services. We value and respect our staff and aspire to be an inclusive employer of choice.

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. It helps NHS organisations to 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 the equality performance within the NHS and embed equality into mainstream business planning processes. We use the EDS to support our organisation in 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 the EDS process. 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. We developed a new approach to the EDS engagement and assessment process during 2015-16 and this was implemented in 2016-17.

Following the review and refresh of all the evidence, the 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 being held for Goal Three "Empowered, engaged and well-supported staff" and Goal Four "Inclusive Leadership at all Levels" in February 2017.

All workshops held so far, have been attended by representatives from all six NHS organisations, in addition to representatives from Voluntary Action Leeds, Leeds Involving People, Forum Central, Healthwatch Leeds and Leeds City Council. The workshops were very successful; with a number of key areas

for improvement being identified. The equality leads, together with colleagues from each of the six NHS organisations and our key stakeholders, will continue to work in partnership with the aim of improving performance in relation to the EDS during 2017-18.

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

Equality Objectives

In 2013 we agreed to sign up to the city wide NHS equality objectives and continue to work with all NHS organisations in Leeds to improve performance.

Leeds citywide NHS equality objectives:

- 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; and
- To improve access to NHS services for protected groups.

Each year we provide a performance update on our progress in relation to the equality 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 city wide 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 Public Sector Equality Duty Report is available on our website: www.leedswestccg.nhs.uk/about/policies/equality-diversity/

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. The indicators are a mix of NHS workforce data, staff survey data and include a specific indicator to address low levels of BME members at Board level.

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

Our WRES report 2016, showed for each of the nine indicators that no major concerns were identified 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 and Diversity Group.

Our WRES report 2016 is available on our website: www.leedswestccg.nhs.uk/about/policies/equality-diversity/

Monitoring NHS provider organisations

As a commissioner of health care, we have a duty to ensure that all of our local healthcare 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 award being made.

Work during 2016-2017

- 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 city wide workshops.
- We have continued to hold bi-monthly Equality and Diversity Steering Group meetings. This provides 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 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 providers of healthcare in relation to compliance with the requirements of the standard.
- Working across the three CCGs we have developed an equality analysis and engagement plan template. Work is underway to integrate the assessment of equality impact within the engagement update template when commissioning new work or updating existing pathways.

SUSTAINABLE DEVELOPMENT

Leeds CCGs have been addressing the environmental impact of our activities since our inception in 2013. In 2016-17 NHS Leeds South and East CCG, NHS Leeds North CCG and NHS Leeds West CCG came together to agree a shared Sustainable Development Management Plan (SDMP).

Our SDMP focussed on developing our approach in a range of areas including:

- Increasing local recycling;
- Efficient use of energy;
- Developing a framework for commissioning for social value; and
- Encouraging the use of IT to reduce travel.

We all recognise the great responsibility that comes with our roles as commissioners. We must continue to offer services that meet local demands, but do so 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.

In 2016-17 the CCG worked with other commissioners and providers to support the development of the West Yorkshire Sustainability and Transformation Plan (STP) and an underpinning Leeds Plan. These plans together describe how services will be transformed in the coming years to ensure sustainable services that continue to improve the health outcomes and quality of services for our population.

These transformation plans will require significant change to how we commission and provide services in the future, and provide an excellent opportunity to ensure that we embed the social, environmental and economic value as we move forward with our plans.

Commissioning for Social Value

We continue to be involved in a programme that examines health and social value within a citywide context, where we are in the process of developing a common approach to commissioning for social value across Leeds. This partnership approach has resulted in a commitment to a social value charter from partners including the three Leeds CCGs, health commissioners from Leeds City Council, and a range of third sector organisations in the city.

The CCGs have worked together during 2016-17 to develop a framework of metrics that can contribute to the measurement of social value.

Our environmental impact

By monitoring our activity throughout the year we are able to calculate our annual resource use and our associated carbon footprint. We are continually working to improve our environmental data and are now able to measure the amount of water that we consume. We adjust our energy, water and waste impacts according to our occupancy rates and will improve our systems to ensure that rail mileage can be recorded in the future.

We recognise that the UK faces a legally binding EU target to reduce the quantity of carbon dioxide (CO2) emissions at a national level by 34% by 2020, and then reaching 80% by 2050. This is a reduction measured from a 1990 baseline.

As NHS Leeds West CCG was established in 2013 we use this as our baseline year. In this situation the Sustainable Development Unit recommends a 28% reduction in CO2 emissions by 2020 in order to abide by the Climate Change Act (2008).

As the table below highlights, we are close to reaching our 28% CO2 reduction target; although our performance in 2016-17 dipped This will be achieved through the ongoing implementation of activities within our Sustainable Development Management Plan (SDMP).

In September 2016 we moved offices and one of the areas that was carefully considered during the office move was our environmental impact. As a result we worked with the landlords to introduce technology that helps reduce our energy usage. This includes motion sensitive lighting and insulation where possible to reduce heat loss. However our energy usage has shown an increase and this is something we'll look into.

Our Carbon Footprint

NHS Leeds West CCG		Consumption					CO_2 Emissions (tonnes CO2e)				
Item	**Unit**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**% Change from 2013-16**	**2013-14**	**2014-15**	**2015-16**	**2016-17**	**% Change from 2013-16**
Electricity use	KWh	61,093	52,220	46,400	66,077	+8%	34.21	32.34	23.03	32.80	-4%
Gas use	KWh	63,354	57,732	51,667	96,700	+53%	13.44	12.11	10.57	19.73	+47%
Water use	m^3	N/A	N/A	359	583	+62% (2015 -16)	N/A	N/A	0.38	0.62	+62% (2015 -16)
Travel by car	Miles	21,918	30,637	28,119	30,289	+38%	6.77	9.46	8.68	9.35	-38%
Travel by rail	Miles	1,473	Data unavailable		0.14	N/A	0.14	Data unavailable			N/A
General waste	Tonnes	13	13	5	5	-62%	2.93	2.93	2.32	2.11	-28%
Recyclable waste	Tonnes	3	3	1	1	-67%	0.06	0.06	0.02	0.02	-65%
						Total CO2 Emmissions:	57.55	56.90	45.00	64.62	+12%
						Total CO2 Reduction:	N/A	-1%	-21%	+44%	

REQUESTS FOR INFORMATION

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: www.leedswestccg.nhs.uk/foi/publication-scheme/

In 2016-17 we received 219 requests under the Freedom of Information Act – compared to 222 in 2015-16. We responded to 215 of these requests within the mandatory 20 working days, with one response which was late and 3 requests which were withdrawn.

Actual YTD Position:	FOI requests received	Requests responded to within 20 days	Late	% on time	% missed deadlines
April	26	26	0	100%	0.0%
May	22	22	0	100%	0.0%
June	20	20	0	100%	0.0%
July	15	14	1	93.3%	6.7%
August	17	17	0	100%	0.0%
September	17	16	1	94%	6.0%
October	13	13	0	100%	0.0%
November	16	16	0	100%	0.0%
December	12	12	0	100%	0.0%
January	21	19	2	90.4%	9.6%
February	18	18	0	100%	0.0%
March	22	22	0	100%	0.0%
Total	**219**	**215**	**4**	98%	2.0%

INFORMATION SECURITY AND GOVERNANCE

In the last financial year there have been no serious incidents within the CCG relating to data loss or security. None of the reported incidents have been of a level to warrant formal external reporting although the organisation has actively shared learning from near-misses. We are fully committed to ensuring ongoing improvements in Information Governance (IG), supported by the regular review of an IG work programme to maintain and improve existing process and procedures.

The self-assessment for 2016-7 against the revised national IG toolkit (audited by our Internal Auditors) demonstrated that the organisation continues to make good progress in upholding high standards in how we handle information. The organisation is in a good position to prepare for the imminent implementation of new data protection legislation and national guidance regarding data security, consent and opt-out.

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

CORPORATE GOVERNANCE

Members' Report

From 1 April 2013, NHS Leeds West CCG became a statutory NHS body.

Our 37 GP member practices are as follows:

Provider	Locality	Address
Abbey Grange Medical Centre	North	Norman Street, LS5 3JN
Armley Medical Practice	South	Armley Moor Health Centre, 95 Town Street, Leeds,LS12 3HD
Beechtree Medical Centre	South	178 Henconner Lane, Leeds, LS13 4JH
Burley Park Medical Centre	North	273 Burley Rd, LS6 4DN
Burton Croft Surgery	North	Headingley Medical Centre, St Michael's Court, Leeds, LS6 2AF
Craven Road Medical Practice	North	60 Craven Road, Leeds, LS6 2RX
Drighlington Medical Centre	South	Station Road, Drighlington, Bradford, BD11 1JU
Fieldhead Surgery	North	65 New Road Side, Horsforth, LS18 4JY
Fountain Medical Centre	South	Little Fountain Street, Morley, LS27 9EN
Gildersome Health Centre	South	Finkle Lane, Gildersome, LS27 7HL
Guiseley & Yeadon Medical Practice	North	17,South View Road, LS197PS
Hawthorn Surgery	South	Wortley Beck Health Centre, Ring Road, Leeds, LS12 5SG
Highfield Medical Centre	South	Highfield Road LS13 2BL
High Field Surgery	North	Holt Park Holtdale Approach, LS16 7ST
Hillfoot Surgery	South	126 Owlcotes Road, Pudsey, LS28 7QR
Hyde Park Surgery	North	Woodsley Road, LS6 1SG
Ireland Wood & Horsforth Medical Practice	North	Iveson Approach, Leeds, LS16 6FR
Kirkstall Lane Medical Centre	North	216 Kirkstall Lane, Leeds, LS6 3DS
Laurel Bank Surgery	North	216B Kirkstall Lane, Leeds, LS6 3DS
Leeds Student Medical Practice	North	4 Blenheim Court, Blenheim Walk, LS2 9AE
Leigh View Medical Practice	South	Bradford Road, Tingley, Wakefield, WF3 1RQ
Manor Park Surgery	South	Bell Mount Close, LS13 2UP
Menston & Guiseley Medical Practice	North	44 Park Road, Guiseley, LS20 8AR
Morley Health Centre	South	Corporation Street, Morley, Leeds, LS27 9NB
Priory View Medical Centre	South	2a Green Lane, Leeds, LS12 1HU
Pudsey Health Centre	South	18 Mulberry Street, Pudsey, Leeds, LS28 7XP
Rawdon Surgery	North	11 New Road Side, LS19 6DD
Robin Lane Health & Wellbeing Centre	South	Robin Lane, Pudsey, LS28 7DE
South Queen Street Medical Centre	South	The Surgery, South Queen Street, Morley, LS27 9EW
Sunfield Medical Centre	South	Sunfield Place, Leeds, LS28 6DR
The Gables Surgery	South	231 Swinnow Road, Pudsey, LS28 9AP
Thornton Medical Centre	South	Green Lane, Leeds, LS12 1JE
Vesper Road Surgery	North	43 Vesper Road, LS5 3QT
West Lodge Surgery	South	New Street, Farsley, LS28 5DL
Whitehall Surgery	South	Wortley Beck Health Centre, Ring Road, Leeds, LS12 5SG
Windsor House Surgery	South	Windsor House Surgery, Corporation Street, Morley, Leeds, LS27 9NB
Windsor House Surgery	South	Branch 1 Shenstone House Surgery, Elland Road, Churwell, Leeds, LS27 7PX
Windsor House Surgery	South	Branch 2 Adwalton House Surgery, 1-3 Wakefield, Road, Drighlington, BD111DH
Yeadon Tarn Medical Practice	North	Suffolk Court, Silver Lane, LS19 7JN

Our Governance structure is headed by the Governing Body to which our 37 member practices have formally delegated their statutory responsibilities within our Constitution.

The role of our Governing Body is to:

- oversee and ensure that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the CCG's principles of good governance (its main function); and
- make sure that decisions about changes to local health services are made in an open and transparent way.

Our member practices are grouped into two main localities which meet together monthly. These meetings are chaired by elected GP locality leads and attended by representatives from all member practices within those localities. The GP locality leads are members of our Governing Body and these meetings constitute the formal route by which member practices engage in the work of our Governing Body.

Our Governing Body is supported by the following sub-committees, the Terms of Reference for each having been defined by the Governing Body:

- Audit Committee;
- Remuneration Committee;
- Assurance Committee; and
- Clinical Commissioning Committee.

As of 1 April 2016, the CCG also has a Primary Care Commissioning Committee to oversee delegated responsibilities for primary care co-commissioning.

Members of the Governing Body are as follows:

- Clinical Chair – Dr Gordon Sinclair
- Four locality representatives of member practices – Dr Simon Hulme, Dr Julianne Lyons (from 09.05.16), Dr Mark Liu (one vacancy)
- Director of Nursing and Quality – Jo Harding
- Three lay members (one to lead on governance matters; one to lead on patient and public participation matters; and one to lead on assurance matters) – Christopher Schofield, Angela Pullen, Dr Stephen Ledger
- A secondary care specialist doctor – Dr Peter Belfield (up to 31.03.17)
- Chief Officer – Philomena Corrigan
- Chief Finance Officer – Visseh Pejhan-Sykes
- Medical Director – Dr Simon Stockill
- Director of Commissioning, Strategy and Performance – Susan Robins
- The Public Health representative of the Director of Public Health in Leeds – Dr Fiona Day (up to 31.08.16), Dr Ian Cameron (from 01.09.16)

As a CCG, we feel it is important that decisions which affect our patients and the public are taken in an open and transparent manner. We therefore hold formal Governing Body meetings in public, which includes opportunities for members of the public to raise questions with Governing Body members on agenda items and issues of concern to them.

Information regarding public meetings of the Governing Body is published in the press one week in advance and can be found on the CCG website at: www.leedswestccg.nhs.uk We also provide live commentary from these meetings through Twitter. Our account is @NHSLeedsWest using #LWBoard.

Audit Committee

The Audit Committee, which is accountable to the Governing Body, provides the Governing Body with an independent and objective view of the CCG's system of internal control for financial governance, corporate governance and clinical governance.

The Audit Committee is chaired by the lay member of the CCG Governing Body with a lead role in overseeing key elements of audit and governance; the other members are the CCG's Secondary Care Consultant and a GP representative. Each member of the Audit Committee is also a member of the Governing Body. In attendance at each meeting is the CCG Chief Finance Officer as well as representatives from internal audit, external audit and counter fraud.

The work of the Audit Committee includes ensuring that there is an effective internal audit function, reviewing the work and findings of the external auditors, ensuring that the clinical commissioning group has adequate arrangements in place for countering fraud, monitoring the integrity of the financial statements of the clinical commissioning group, and overseeing risk management and information governance arrangements.

Details of the membership of all Governing Body Committees are included in the Annual Governance Statement. Details of the membership of the Remuneration Committee are also included in the Remuneration Report.

Conflicts of Interest

NHS Leeds West CCG wishes to ensure that decisions made by the CCG are taken and seen to be taken without any possibility of the influence of external or private interest. The CCG has therefore put arrangements in place to ensure that conflicts of interest are appropriately managed with transparency and proportionality. We have established a Register of Interests which is outlined within the CCG's policy on Managing Conflicts of Interest. This register is reviewed by the CCG Governing Body and Audit Committee. All Governing Body members, committee members, employees and member practices are asked to complete a Declarations of Interest form to identify any potential conflicts of interest. CCG Governing Body members are also asked to declare any conflicts of interest with regards to agenda items at each Governing Body and Committee meeting. The CCG Register of Interests can be viewed on the CCG website at: www.leedswestccg.nhs.uk

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

- That they know of no information which would be relevant to the auditor for the purposes of their audit report, and of which auditor is not aware; and
- That the member has taken all the steps that they ought to have taken as a member in order to make themselves aware of any relevant audit information and to establish that the Clinical Commissioning Group's auditor is aware of that information.

Governing Body Profiles

Dr Gordon Sinclair
Clinical Chair

Gordon qualified from Leeds University and undertook postgraduate training around the Yorkshire region before taking up a partnership as a GP in 1993 at Burton Croft Surgery in Headingley. He was a GP Trainer before becoming interested in GP led commissioning in 2005. He has been closely involved with the development of NHS Leeds West CCG and is the current Chair of the organisation. In this role he is a founder member of the Leeds Health and Wellbeing Board.

Dr Sinclair is responsible for ensuring good governance across the organisation with a particular focus on clinical leadership in commissioning decision-making, a clear commitment to public and patient involvement at all levels and the development of strong relationships with other key organisations in the Leeds Health and Social Care community.

Philomena Corrigan
Chief Executive

Phil started her nursing career in 1982 and worked in a range of clinical areas such as intensive care, surgical services and older people's services in Leeds. She then moved into a research, audit and educational role, co-writing two books on improving the quality of care in the NHS. She was Director of Nursing in an acute trust and then moved to a Primary Care Trust (PCT) in Bradford as Director of Community Services and Nursing.

She joined Leeds PCT in 2006 and in 2009 was appointed as Director of Commissioning/Director of Nursing and led on transformation, performance and improving quality of care for three years. She was appointed Accountable Officer of NHS Leeds West CCG in April 2012 and remains committed to ensuring patient services in Leeds are first class and deliver the best outcomes for those who use them.

Visseh Pejhan-Sykes
Chief Finance Officer

After qualifying as a Chartered Accountant with Grant Thornton in Sheffield, Visseh started her NHS career at the Royal Hallamshire Hospital in Sheffield (now part of the Sheffield Teaching Hospitals NHS Foundation Trust) in a dual role as Financial Accountant and Directorate Accountant. Since then she has held a number of senior finance roles at both Deputy Director and Board level across a range of NHS organisations, including Mental Health, Ambulance Service, Primary Care Trust and the NHS Executive Regional Office in Trent.

In addition to her professional qualifications, Visseh has a Bachelor's Degree in Economics and a Master's Degree in Computer Studies.

Dr Simon Stockill
Medical Director

Dr Simon Stockill grew up in Yorkshire, before studying medicine at Imperial College London and University College London. After qualifying as a GP he worked as a lecturer in general practice at Imperial College, London, served on the Board of Westminster Primary Care Trust and was an elected member of Westminster City Council.

He has a post-graduate degree in public health from the University of York, was Clinical Chair of NHS Leeds Primary Care Trust before becoming Medical Director of NHS Leeds West Clinical Commissioning Group.

He was a founder of the Leeds Institute of Quality Healthcare and takes a specialist interest in quality improvement and clinical leadership.

Simon spent over 10 years as a GP in Leeds. In April 2016 he moved to a new practice near Whitby in order to remove any conflicts of interest, as the CCG took over responsibility for commissioning primary care medical services.

Outside medicine he is a Trustee of the National Youth Theatre and enjoys running and walking on the beaches and moors of Yorkshire.

Susan Robins
Director of Commissioning, Strategy and Performance

Sue qualified as a nurse in 1983 and subsequently gained experience and qualifications in Child and Adolescent

Mental Health Services (CAMHS) and health visiting, and has worked in a wide range of community services as a practitioner and as a manager. She also spent time abroad working with the British Red Cross.

Sue has 20 years community services and primary care management experience in West Yorkshire. She was the Deputy Director of Nursing and the Director of Diagnostic and Treatment Services for the Bradford South & West PCT. In 2009 Sue supplemented her primary care management experience with five years acute hospitals work as a General Manager at Bradford Teaching Hospitals NHS Foundation Trust. Sue will be using all her varied clinical and management experience to develop first class commissioning for the population.

Joanne Harding

Director of Nursing and Quality

Jo qualified as a registered nurse in 1992 and subsequently as a registered health visitor practising clinically in Leeds and York. She has strategically and operationally managed a full range of acute and community-based services over the past 15 years across North Yorkshire and York at director level. In 2012 Jo joined NHS Hambleton, Richmondshire and Whitby Clinical Commissioning Group as the Executive Nurse (helping the CCG work towards being a formal statutory body on 1 April 2013) with a range of statutory responsibilities including safeguarding, and a broad commissioning portfolio.

Jo has a Master's Degree in Leading Innovation and Change and seeks to develop and encourage effective leadership at every level of the healthcare system. She joined NHS Leeds West CCG in summer 2015 and is passionate about improving the quality of services for the residents of Leeds with an emphasis on transforming the whole NHS system to a model of high quality integrated health and social care.

In her spare time, Jo keeps herself busy with her six step grandchildren, cooking, reading and chairing the local social committee designing an annual programme of family events.

Dr Peter Belfield

Lay Member (Secondary Care Consultant)

Peter became a medical student in Leeds in 1973 and has been working in health here ever since. Appointed as consultant geriatrician at Leeds General Infirmary in 1987, he with others, transformed hospital based elderly care to a person centred acute care service. Peter has held a wide range of clinical leadership roles over two decades both in Leeds and nationally. Some of these include Chairmanship of the British Geriatric Society Policy Committee and he was proud of his development of public and patients' views in the work of this group. Peter has also had prominent leadership roles in education and training, both locally and at the Royal College of Physicians London, first as Deputy Medical Director of the Joint Royal Colleges of Physicians Training Board (2006-2009) and then more recently as College Censor which has an influence on training strategy and policy for all physicians. Peter has also recently been appointed as a Trustee of St Gemma's Hospice which coincides with a longstanding interest in end of life care and quality service provision.

Peter has a passion for the development of joint working between all sectors of health and social care and believes that this is how patients will receive high quality, timely care in an appropriate setting. This is exemplified in work Peter authored in 1996 called "when I grow in Leeds" which talked about how older peoples' services should change - much of which is at the heart of the current Leeds Health and Social Care transformation programme.

Following Peter's retirement from Leeds Teaching Hospitals NHS Trust as

Medical Director, he contributed to the commissioning landscape in Leeds as an active Governing Body member for the CCG.

Out of work, family and friends are key and vital elements of Peter's life and he has found a passion for cycling which he hopes will keep him fit and healthy into older age!

Angela Pullen
Lay Member
(Patient and Public Involvement)

Angie is the Epilepsy Services Manager at Epilepsy Action, the member led charity. She works to improve services for people with epilepsy and manages a helpline, a specialist nursing scheme and a research portfolio. Angie is Deputy Chair of NHS Leeds West Clinical Commissioning Group and a member of the NHS England Neurosciences Clinical Reference Group.

Angie holds a Masters in Public Health, a Masters in Organisation Development and is currently involved in research relating to patient education programmes, services for people with learning disabilities and epilepsy and mental health issues in young people with epilepsy. Previously Angie managed service improvement projects for the National Child and Adolescent Mental Health Services (CAMHS) Support Service, the Yorkshire and Humber Improvement Partnership, and was Head of Staff Development at Leeds Teaching Hospitals NHS Trust.

In her spare time Angie enjoys visits to the theatre and takes part in guerrilla gardening as well as using her spare time at weekends fundraising and campaigning for charity.

Christopher Schofield
Lay Member (Governance)

Chris was educated at Bradford Grammar School and Cambridge University. He trained at Hammond Suddards and was an Associate Partner at Dibb Lupton Broomhead (specialising in corporate finance) before being appointed General Counsel, Company Secretary and a Director of Filtronic PLC. Chris is the Senior Partner of Schofield Sweeney LLP, an award winning law firm which he founded in 1998. The firm has offices in Leeds, Bradford and Huddersfield and has approximately 100 staff. His practice includes advising businesses and other organisations on Mergers and Acquisitions, Corporate Finance and Corporate Governance issues. Chris is a recipient of the Yorkshire Lawyer of the Year (Corporate) award, and has recently been appointed trustee at St. Gemma's Hospice.

Chris is married with three daughters and lives in Guiseley. His interests outside work include sailing, keeping fit, walking, reading and theatre.

Dr Steve Ledger
Lay Member (Assurance)

Steve qualified from Leeds University Medical School in 1979 and after 5 years gaining experience in various hospital posts, was appointed a principal in General Practice in Morley. Prior to his retirement in September 2014, Steve was senior partner at the Fountain Medical Centre, which has been at the forefront of providing near-patient services/care in the last decade or so.

He spent over 20 years involved in the delivery of post-graduate medical education until becoming involved in commissioning work in the last few years. His main clinical interests remain in the fields of consultation skills, dermatology, mental health and substance misuse.

Out of work, he runs the very successful Leeds Medics and Dentists Football Club which has four teams competing in the FA affiliated Yorkshire Amateur League, a student team in the University league and two women's teams.

Locality GP Representatives

Dr Simon Hulme

Simon was brought up in Buckinghamshire before moving up to Yorkshire to study medicine at Leeds University. He qualified in 1997 and went on to pursue a career in general practice. He completed his GP training in Barnsley which included a six month post working half the time in public health where he completed a Health Needs Assessment for Diabetes. He started work as a GP at Leigh View Medical Practice in Tingley where he has been a partner since 2002.

Simon has had experience as a GP trainer and then became involved with commissioning as the clinical lead for learning disabilities at the former practice based commissioning group called H3Plus. His clinical interests include dermatology, heart disease, learning disability and rheumatology. He is now a member of NHS Leeds West CCG Governing Body as a representative for practices in the South Locality.

Dr Mark Liu

Dr Mark Liu qualified as a doctor in Dublin in 1988, and subsequently has worked in Manchester and Lancashire as part of his training before settling down as a GP in Leeds 18 years ago. He is now the senior partner at Abbey Grange Medical Practice in Kirkstall.

Mark was a clinical lead in the former practice based commissioning group called H3Plus.

Outside work, Mark enjoys playing tennis and walking in the countryside.

Dr Julianne Lyons

Julianne qualified in Glasgow in 1988 and completed her GP training in the West of Scotland, where she was a partner in an inner city practice in Glasgow. When she relocated to Yorkshire in 2002 she worked in various practices before joining Leeds Student Medical Practice, where she is now a partner. Her clinical interests are sexual and reproductive healthcare and mental health.

She has a Masters degree in Healthcare Management and is keen to become involved in improving care for patients locally. She is involved in medical education for doctors, nurses and physicians' associates. She is also interested in medical law and ethics and its impact on service provision for patients.

Outside work Julianne enjoys spending time with her family and their puppy and travelling.

Dr Fiona Day

Consultant in Public Health Medicine (to 31.08.16) / Associate Medical Director

Dr Fiona Day is the CCG's Associate Medical Director three days a week and she was also employed as a Consultant in Public Health Medicine at Leeds City Council until August 2016. Fiona provided public health leadership to the CCG as part of this council role. After growing up in Leeds, Fiona trained to be a doctor in Edinburgh, returning to the area in 2004 as a public health registrar. Fiona brings her experience of improving health and wellbeing outcomes for populations, medical leadership, and reducing health inequalities to the CCG and has particular interests in improving outcomes in vulnerable populations, and in commissioning high quality services which meet patient needs and are of high value.

Dr Ian Cameron

Public Health Consultant

Dr Ian Cameron is the Director of Public Health at Leeds City Council. As part of his role he provides public health leadership and advice to the CCG on health improvement,

health protection and public health. Ian has been Director of Public Health for Leeds since 2006 and is a member of the Leeds Health & Wellbeing Board and Chair of the Leeds Health Protection Board.

Ian qualified from Liverpool University and became Consultant in Public Health in Leeds in 1992 with a focus on mental health, physical disabilities and learning disabilities. In 2002 Ian became Director of Public Health for North West Primary Care Trust.

Ian has significant experience of working within public health nationally, and internationally and in 2008 was made visiting Professor at the Institute of Public Health, Lahore, Pakistan for his work on tobacco control.

Personal Data Related Incidents

The CCG has not reported any personal data related incidents to the Information Commissioner's Office during 2016-17.

Modern Slavery Act 2015 – Transparency in Supply Chains

NHS Leeds West 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.

REMUNERATION AND STAFF REPORT

Our Staff

Our workforce strategy has been developed to ensure best practice in the management and development of all staff, encompassing human resources, workforce information and intelligence, and learning and development. Our strategy supports directly employed staff and the wider workforce including governing body members and GP leads.

Progress continues to be made against our four key strategic workforce objectives:

- being a well governed and effective organisation;
- being a collaborative organisation;
- supporting a healthy, happy, motivated and highly performing workforce; and
- being an employer of choice.

Employee consultation

We hold regular team briefs delivered by the senior management team to communicate key messages and allow staff to feed back. The Leeds CCG wide Social Partnership Forum continues to operate between management and recognised trade union representatives. The purpose of the forum is to inform, consult and sometimes negotiate with trade unions on key issues.

We have also developed and conducted our annual local staff survey achieving a 70% response rate which is much improved from last years' 61% response rate. Further work will be considered by the workforce and diversity management group on areas of success and where we can work to continually improve what we do.

Training

We achieved an average of 75% compliance for statutory and mandatory training for directly employed staff against a target of 100%. This position shows a significant change from last year where we achieved a compliance rate of 95%. One of the key factors for this was a change in the IT system used to access training with a number of staff unable to use the site. We fully expect this compliance rate to be at or near our target next year now that the majority of the IT issues have been resolved.

A number of staff have undertaken a variety of learning and development opportunities linked to their role and our strategic objectives. The Personal Development Review, based on objectives and behaviours, has been embedded and is aligned with changes to incremental pay progression for staff on Agenda for Change terms and conditions and also applies to those on non-Agenda for Change terms and conditions. This system enables staff to feel motivated and supported to achieve high performance in relation to our strategic objectives and priorities.

Sickness absence data

In 2016-17 we lost a total of 300.5 days to sickness absence. With total staff years available of 76, this gives the average number of working days lost as 4 per employee. Line managers are committed to providing support to staff through the Managing Sickness Policy to provide excellent working conditions, balancing the health needs of staff against the needs of the organisation.

Equality of opportunity

We are committed to eliminating unlawful discrimination and promoting equality of opportunity by creating a workforce that is broadly representative of the population we serve. We make sure that equality and diversity is a priority when planning and commissioning local healthcare and in respect of our workforce.

Policies

To ensure that our staff members do not experience discrimination, harassment and victimisation we ensure equality is integrated across all our employment practices and have a range of policies including:

- Acceptable Standards of Behaviour Policy (this includes dignity at work);
- Equal Opportunities and Diversity in Employment Policy;
- Managing Sickness Absence Policy; and
- Recruitment and Selection.

Furthermore, in 2016-17 we reviewed our Retirement Policy and the Long Service Award Scheme.

Equality impact assessments have been carried out on all relevant policies. We value diversity and aim to support protected groups and recognise that in order to remove the barriers experienced by disabled people we need to make reasonable adjustments for our disabled employees. We do this on a case by case basis and involve occupational health services as appropriate. Reference to reasonable adjustments is made in all relevant polices.

Equality training

CCG staff members have participated in mandatory equality and diversity training. Senior management team members, Board Members, Patient Assurance Group members and staff directly involved in commissioning work have attended a face to face training session, which describes the implications of the Public Sector Equality Duty for people commissioning health services. All other staff have completed an e-learning course. In addition regular briefings and one to one guidance and support are provided on Equality Impact Assessments and equality analysis and in relation to the commissioning of healthcare. We will ensure that all records are updated to ensure compliance among all staff, Governing Body members and the Patient Assurance Group.

ANNUAL WORKFORCE REPORT

Number of senior managers by band

	Total
Band 8c	5
Band 8d	2
Band 9	-
Very Senior Managers (VSM)	5
Governing body	9
Any other Spot Salary	1
Total	**22**

Staff numbers and costs

	2016-17		2015-16	
	Permanent	**Other**	**Permanent**	**Other**
Senior Manager	17.94	-	18.62	-
Manager	9.31	-	7.20	0.28
Clerical and Administrative	56.39	2.99	57.74	0.94
Maintenance and works	-	-	-	-
Total	**83.64**	**2.99**	**83.56**	**1.22**

	2016-17		2015-16	
		£'000		**£'000**
	Permanent	**Other**	**Permanent**	**Other**
Senior Manager	1,192	-	1,119	-
Manager	616	-	465	31
Clerical and Administrative	2,235	116	2,240	86
Maintenance and works	-	-	-	-
Total	**4,043**	**116**	**3,824**	**117**

Gender breakdown

	Female	Male
Directly employed Governing Body	3	6
VSM	4	1
Any other Spot Salary	-	1
All other employees (including apprentices)	63	14
Total	**70**	**22**

Sickness absence

	Total
Average sickness %	1.0%
Total number of FTE days lost	300.5

REMUNERATION REPORT

Details of our Remuneration Committee's membership, number of meetings during the year and individual attendance records are provided in our Annual Governance Statement on page 88.

On one occasion an external person or body was co-opted by the committee to provide specialist support or advice during the course of the year.

Policy on Remuneration of Senior Managers

The remuneration of Senior Managers was originally set by the shadow Remuneration Committee in February 2013 through a combination of:

- national guidance on CCG Director level remuneration www.england.nhs.uk/wp-content/uploads/2012/06/Remuneration-guidance-final.pdf; and
- benchmarking data from merging CCGs in the area and across the country;

and presented to the committee by the Chief Officer for consideration.

In April 2016, a consolidated uplift of 1% was agreed in line with Agenda for Change staff.

For 2017-18:

- benchmarking data is being collated to inform pay levels;
- the outcomes of individual appraisal reviews will be taken into consideration; and
- the application of a consolidated pay uplift of 1% has been agreed in April 2017, in line with the Agenda for Change uplift.

Our Senior Managers' Pay is not subject to any Performance Related Pay considerations.

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, durations, notice periods and termination payments. Standard notice periods are currently 3 months.

Name of Senior Manager	Date of contract	Terms	Notice Period
Philomena Corrigan*	18/01/13	Permanent	6 months
Joanne Harding	17/08/15	Permanent	3 months
Susan Robins	27/01/14	Permanent	3 months
Visseh Pejhan–Sykes*	18/01/13	Permanent	3 months
Dr Simon Stockill*	01/04/13	Permanent	3 months
Dr Gordon Sinclair (Chair)*	01/04/13 (start of tenure 01/03/12)	Permanent	6 months
Angela Pullen	01/08/13 (start of tenure 01/08/12, reappointed 01/08/15)	3 years	3 months
Christopher Schofield	01/08/13 (start of tenure 01/08/12, reappointed 01/08/15)	3 years	3 months
Dr Stephen Ledger	20/10/14 - as Lay Member – Assurance	3 years	3 months
Dr Peter Belfield	01/04/13 (reappointed 01/04/16, resigned on 31/03/17)	3 years	N/A
Phillip Lewer	01/04/16	1 year	3 months
Dr Simon Hulme	03/11/14	3 years	3 months
Dr Mark Liu	03/11/14	3 years	3 months
Dr Julianne Lyons	09/05/16	3 years	3 months
Dr Fiona Day	01/04/13 (resigned from the governing body on 31/08/16)	3 years	N/A
Dr Ian Cameron (Honorary Contract)	01/09/16	N/A	N/A

*acted as member of Senior Managers team for Shadow CCG

No individuals employed by the CCG have received or are due any kind of awards or severance, compensation or early termination payments.

Salaries and Allowances (AUDIT)

REMUNERATION - NHS Leeds West CCG Board

Name and title	Salary (bands of £5,000)	Expense Payments (taxable) (to the nearest £100)	Performance Pay and Bonuses (bands of £5,000)	Long-term Performance Pay and Bonuses (bands of £5,000)	All Pension Related Benefits (bands of £2,500)	2016-17 Total (bands of £5,000)	2015-16 Total (Bands of £5,000) RESTATED - Note 1	Gross Reimbursements from GP Practice - Note 2	Comments
	£'000	£'00	£'000	£'000	£'000	£'000	£'000	£'000	
EXECUTIVE DIRECTORS									
Philomena Corrigan - Chief Executive	135 - 140	1	-	-	25 - 27.5	160 - 165	145 - 150	-	
Visseh Pejhan-Sykes - Chief Finance Officer	105 - 110	1	-	-	30 - 32.5	135 - 140	125 - 130	-	
Jo Harding - Director of Nursing & Quality	80 - 85	1	-	-	65 - 67.5	150 -155	115 - 120	-	
Sue Robins - Director of Commissioning, Strategy & Performance	85 - 90	2	-	-	17.5 - 20	105 - 110	90 - 95	-	
Dr Simon Stockill - Medical Director	75 - 80	-	-	-	30 - 32.5	110 - 115	90 - 95	-	
Dr Gordon Sinclair - Clinical Chair	10 - 15	1	-	-	0 - 2.5	15 - 20	10 - 15	90 - 95	6 sessions per week
Dr Fiona Day - Public Health Consultant - resigned from governing body 31 August 2016	50 - 55	-	-	-	50 - 52.5	100 -105	50 - 55	-	
Dr Ian Cameron - Public Health Consultant -Note 3	-	-	-	-	-	-	-	-	
GP MEMBERS									
Dr Simon Hulme - Locality GP	5 - 10	-	-	-	-	5 - 10	5 - 10	20 - 25	1.5 sessions per week
Dr Mark Liu - Locality GP	5 - 10	-	-	-	-	5 - 10	5 - 10	20 - 25	1.5 sessions per week
Dr Julianne Lyons - Locality GP	5 - 10	-	-	-	-	5 - 10	-	20 - 25	Started 9th May 2016 1.5 sessions per week
LAY-MEMBERS									
Chris Schofield - Lay member (Governance)	10 - 15	-	-	-	-	10 - 15	10 - 15	-	
Angela Pullen - Lay member (Patient & Public Involvement)	10 - 15	-	-	-	-	10 - 15	10 - 15	-	
Dr Peter Belfield - Lay member (Secondary Care Consultant) - resigned 31 March 2017	5 - 10	-	-	-	-	5 - 10	10 - 15	-	
Dr Stephen Ledger - Lay member (Assurance)	5 - 10	-	-	-	-	5 - 10	5 - 10	-	
Philip Lewer - Lay member (Assurance)	0 - 5	1	-	-	-	0 - 5	-	-	

Notes

Note 1: Due to recent clarification in the Department of Health Accounting Guidance for the calculation of All Pension Related Benefits, the prior year totals have been restated.

Note 2: The CCG has reimbursed the relevant practices to release GP members of the Governing Body for their clinical expertise to support the CCG's Commissioning activities such as transformation and whole system pathway review and redesign. These recharges cover the cost of backfill for these GPs rather than direct additional renumeration to the named GP.

Note 3: Dr Ian Cameron began work as Public Health Consultant in the year but receives no renumeration for this.

Payment for Loss of Office (AUDIT) - Not applicable

Payment to Past Senior Managers (AUDIT) - Not applicable

Pension Benefits (AUDIT)

DIRECTORS PENSION ENTITLEMENT

Name and title	Real Increase in Pension at Pension Age (bands of £2,500)	Real Increase in Pension Lump Sum at Pension Age (bands of £2,500)	Total Accrued Pension at Pension Age at 31 March 2017 (bands of £5,000)	Lump sum at Pension Age Related to Accrued Pension at 31 March 2017 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 1 April 2016	Real increase in Cash Equivalent Transfer Value	Employer's Contribution to Stakeholder Pension (rounded to nearest £00)
	£000	£000	£000	£000	£000	£000	£000	£
EXECUTIVE DIRECTORS								
Philomena Corrigan - Chief Executive	0 - 2.5	5 - 7.5	45 - 50	145 - 150	912	852	41	-
Visseh Pejhan-Sykes - Chief Finance Officer	0 - 2.5	0 - 2.5	30 - 35	75 - 80	450	480	26	-
Jo Harding - Director of Nursing and Quality	2.5 - 5	5 - 7.5	30 - 35	80 - 85	490	408	63	-
Sue Robins - Director of Commissioning, Strategy and Performance	0 - 2.5	2.5 - 5	25 - 30	75 - 80	535	494	29	-
Dr Simon Stockill - Medical Director	0 - 2.5	0 - 2.5	15 - 20	45 - 50	301	258	31	-
Dr Gordon Sinclair - Clinical Chair	0 - 2.5	0 - 2.5	5 - 10	20 - 25	156	146	10	-
Dr Fiona Day - Associate Medical Director	2.5 - 5	2.5 - 5	15 - 20	45 - 50	282	229	43	-
Dr Ian Cameron - Public Health Consultant	-	-	-	-	-	-	-	-

Notes

Note 1: As Non-Executive members do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

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 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 the 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 the 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.

Pay Multiples (AUDIT)

Reporting bodies are required to disclose the relationship between the renumeration of the highest-paid director/Member in their organisation and the median remuneration of the organisation's workforce. The figures are shown below:

PAY MULTIPLES

Year	Highest paid Director Mid point of £5,000 salary band	Median salary	Ratio
	£	£	
2015-16	137,500	36,614	3.76
2016-17	137,500	38,616	3.56

In 2016-17 and 2015-16 no employees received remuneration in excess of the highest paid director. Full time equivalent remuneration ranged from £8K to £138K (2015-16: £4K-£139K). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

The median salary of employees in the CCG has been calculated using payroll information at the end of the financial year. From this a basic salary on a full time basis has been calculated.

The median salary of employees in the CCG has increased due to incremental pay increases and a consolidated 1% pay rise agreed by NHS employers, while the salary of the highest paid director has remained within the same band leadng to a decrease in the pay multiple ratio.

Off Payroll Engagements (AUDIT)

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

2016-17	Number
Number of existing engagements as of 31 March 2017	**18**
Of which, the number that have existed:	
For less than 1 year at the time of reporting	3
For between 1 and 2 years at the time of reporting	4
For between 2 and 3 years at the time of reporting	5
For between 3 and 4 years at the time of reporting	6
For 4 or more years at the time of reporting	-

Confirmation that all existing off-payroll engagements 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.

Off payroll engagements are a mix of ongoing part time clinical leads, and some specialist human resources/organisational development advice on an ad hoc basis (which in some cases is on behalf of all 3 Leeds CCGs).

2016-17	Number
Number of new engagements, or those that reached 6 months in duration, between 1 April 2016 and 31 March 2017	**3**
Number of new engagements which included contractual clauses giving Leeds West CCG the right to request assurance in relation to income tax and National Insurance obligations	**3**
Number for whom assurance has been requested	**3**
Of which:	
Assurance has been received	3
Assurance has not been recieved	-
Engagments terminated as a result of assurance not being received	-

2016-17	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	-
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.	**See Remuneration Report**

Consultancy Expenditure

During the year the CCG incurred expenditure totalling £154k (2015-16: £116k).

Philomena Corrigan
Accountable Officer

24 May 2017

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). NHS England has appointed the Chief Officer to be the Accountable Officer of the Clinical Commissioning Group.

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for 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) and for safeguarding the Clinical Commissioning Group's assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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 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 entity's auditors are unaware, and that as Accountable Officer, I have taken all the steps that I ought to have taken to make himself or herself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.
- that the annual report and accounts as a whole is 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

ANNUAL GOVERNANCE STATEMENT 2016-2017

Introduction and context

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

The Clinical Commissioning Group'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 Clinical Commissioning Group is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

NHS Leeds West CCG is made up of 37 GP practices in the west and parts of outer north west and south west Leeds. We are one of three CCGs in Leeds and are the largest, covering a population of around 375,000 people. This union of GP practices ensures that primary care participation is at the heart of everything NHS Leeds West 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.

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Clinical Commissioning Group'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 Clinical Commissioning Group 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 clinical commissioning group as set out in this governance statement.

Governance arrangements and effectiveness

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states:

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

Our Constitution has been formally agreed by our member practices and sets out our arrangements for discharging our statutory responsibilities for commissioning care on behalf of our population. It describes 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 interest of patients and the public.

More specifically, our Constitution includes:

- our Membership;
- the area we cover;
- the arrangements for the discharge of our functions and those of our Governing Body (including roles and responsibilities of members of the Governing Body);
- the procedures we follow in making decisions and to secure transparency in decision making;
- arrangements for discharging our duties in relation to managing conflicts of interest; and
- arrangements for securing the involvement of persons who are, or may be, provided with services commissioned by the CCG in certain aspects of those commissioning arrangements and the principles that underpin these.

The Governing Body

Our governance structure is headed by the Governing Body to which our 37 member practices have formally delegated their statutory responsibilities within our Constitution.

Our member practices are grouped into two main localities which meet together monthly. These meetings are chaired by elected GP Locality Leads and attended by representatives from all member practices within those localities. The GP Locality Leads are members of our Governing Body and these meetings constitute the formal route by which member practices engage in the work of our Governing Body.

Our Governing Body is supported by the following sub-committees, the Terms of Reference for each having been defined by the Governing Body:

- Audit Committee
- Remuneration Committee
- Assurance Committee
- Clinical Commissioning Committee

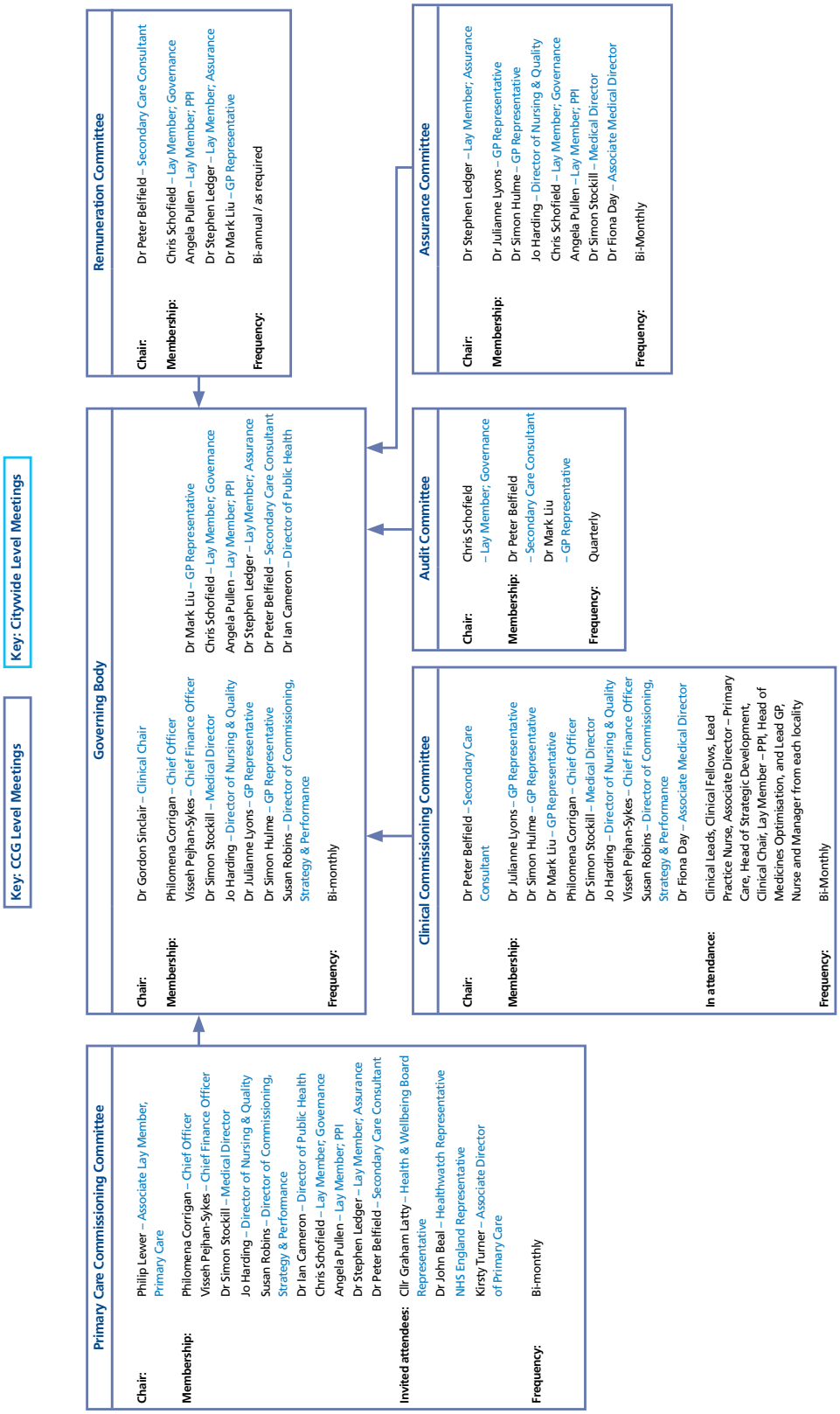
As of 1 April 2016, the CCG also has a Primary Care Commissioning Committee to oversee delegated responsibilities for primary care co-commissioning.

Members of the Governing Body are as follows:

- Clinical Chair – Dr Gordon Sinclair
- Four locality representatives of member practices – Dr Simon Hulme, Dr Julianne Lyons (from 09.05.16), Dr Mark Liu (one vacancy)
- Director of Nursing and Quality – Jo Harding
- Three lay members (one to lead on governance matters; one to lead on patient and public participation matters; and one to lead on assurance matters) – Christopher Schofield, Angela Pullen, Dr Stephen Ledger
- A secondary care specialist doctor – Dr Peter Belfield (up to 31.03.17)
- Chief Officer – Philomena Corrigan
- Chief Finance Officer – Visseh Pejhan-Sykes
- Medical Director – Dr Simon Stockill
- Director of Commissioning, Strategy and Performance – Susan Robins
- The Public Health representative of the Director of Public Health in Leeds – Dr Fiona Day (up to 31.08.16), Dr Ian Cameron (from 01.09.16)

Our Governing Body and Committee structure is set out below:

NHS LEEDS WEST CLINICAL COMMISSIONING GROUP GOVERNING BODY AND SUB COMMITTEE STRUCTURE



Meetings Attended 01/04/2016 to 31/03/2017

Member Name	Governing Body	Assurance Committee	Audit Committee	Clinical Commissioning Committee	Remuneration Committee	Primary Care Commissioning Committee
	9 Meetings	7 Meetings	5 Meetings	6 Meetings	3 Meetings	7 Meetings
Dr Gordon Sinclair Clinical Chair	9/9	N/A	N/A	5/6*	N/A	N/A
Dr Julianne Lyons GP representative	7/9	6/6	N/A	5/5	N/A	N/A
Dr Simon Hulme GP representative	8/9	7/7	N/A	6/6	N/A	N/A
Dr Mark Liu GP representative	9/9	N/A	5/5	6/6	N/A	N/A
Jo Harding Director of Nursing & Quality	8/9	5/7	N/A	4/6	N/A	5/7
Christopher Schofield Lay member; Governance	9/9	4/7	5/5	N/A	3/3	6/7
Angela Pullen Lay member; PPI	8/9	7/7	N/A	6/6*	3/3	6/7
Dr Stephen Ledger Lay member; Assurance	9/9	7/7	N/A	N/A	3/3	6/7
Dr Peter Belfield Secondary Care Consultant	7/9	N/A	5/5	5/6	3/3	2/7
Philomena Corrigan Chief Officer	9/9	N/A	N/A	2/6	3/3*	7/7
Visseh Pejhan-Sykes Chief Finance Officer	9/9	N/A	5/5*	5/6	N/A	6/7
Dr Simon Stockill Medical Director	9/9	3/3**	N/A	6/6	N/A	7/7
Susan Robins Director of Commissioning, Strategy and Performance	7/9	6/7*	N/A	6/6	N/A	6/7
Dr Fiona Day Public Health Consultant/ Associate Medical Director	4/5	4/4**	N/A	4/6	N/A	1/3
Ian Cameron Director of Public Health	4/4	N/A	N/A	N/A	N/A	0/4

*Attendance as a Committee attendee rather than a Committee member

**The Medical Director and Associate Medical Director alternate attendance

Meetings of the Governing Body are held in public – other than for business deemed to be confidential. Arrangements accord with the Public Bodies (Admission to Meetings) Act 1960.

Audit Committee

The Audit Committee, which is accountable to the Governing Body, provides the Governing Body with an independent and objective view of the CCG's system of internal control for financial governance, corporate governance and clinical governance.

The Audit Committee is chaired by the lay member of the CCG Governing Body with a lead role in overseeing key elements of audit and governance; the other members are the CCG's Secondary Care Consultant and a GP representative. Each member of the Audit Committee is also a member of the Governing Body. In attendance at each meeting is the CCG Chief Finance Officer as well as representatives from internal audit, external audit and counter fraud.

The work of the Audit Committee includes ensuring that there is an effective internal audit function, reviewing the work and findings of the external auditors, ensuring that the CCG has adequate arrangements in place for countering fraud, monitoring the integrity of the financial statements of the CCG, and overseeing risk management and information governance arrangements.

Remuneration Committee

The Remuneration Committee makes determinations about pay and remuneration for members of the Governing Body/Clinical Leads of the CCG and people who provide services to the CCG, and allowances under any pension scheme it might establish as an alternative to the NHS pension scheme.

The Committee meets at least twice a year. The Committee is made up of the Secondary Care Consultant, three lay members and one GP representative. The Governing Body ensures that all the members appointed remain independent.

Assurance Committee

The focus of the Assurance Committee is to receive and monitor assurances relating to the quality and performance of commissioned services. The Committee has responsibilities to oversee specific areas including safeguarding, patient safety, complaints and claims and emergency planning arrangements.

The work of the Committee has included the review and challenge of the integrated performance and quality report (IQPR) and quality and performance risks rated as red or high amber. The Committee has reviewed and approved policies relating to complaints, individual funding requests and human resources. The Committee has also undertaken 'deep dive' session in relation to system resilience arrangements. The Committee's Terms of Reference were updated in July 2016 to include responsibilities for patient assurance and insight. The Committee therefore receives an update and assurance on these areas at each meeting.

Clinical Commissioning Committee

The Clinical Commissioning Committee (CCC) advises the Governing Body with regards to the strategic direction of the organisation, ensuring that the strategy has clinical input. The Committee also acts as a clinical consultation body in the development of business cases.

Primary Care Commissioning Committee

The Primary Care Commissioning Committee was established in April 2016. It is a committee of the CCG (rather than the Governing Body), 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. The Committee has approved the CCG's local primary care scheme for 2017-18, a proposal for reinvestment of the Personal Medical Services (PMS) premium based on deprivation, ethnicity and non-English speaking populations, and a branch closure proposal.

Performance and Assessment of Effectiveness

Each Committee has completed a self-assessment of its performance and effectiveness throughout the year. The outcome of the assessments was reported to the Governing Body on 29 March 2017. The reviews were positive overall, but some issues were highlighted including the need to further clarify the relationship between the committees. This is being taken into account as part of the current governance changes being implemented within the CCG.

Sub-committees and joint committees established by the clinical commissioning group constitution

Leeds Integrated Commissioning Executive

NHS Leeds West Clinical Commissioning Group 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 and Wellbeing Board.

Leeds CCG Network

Additionally NHS Leeds West Clinical Commissioning Group has entered into joint arrangements with NHS Leeds North Clinical Commissioning Group and NHS Leeds South and East Clinical Commissioning Group via the Leeds CCG Network. This is not a committee of the Clinical Commissioning Group 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.

UK Corporate Governance Code

NHS Bodies are not required to comply with the UK Code of Corporate Governance. However, we have reported on our corporate governance arrangements by drawing upon best practice available, including those aspects of the UK Corporate Governance Code we consider to be relevant to the CCG and best practice.

Discharge of Statutory Functions

During establishment, the arrangements put in place by the Clinical Commissioning Group and explained within the Corporate Governance Framework were developed with extensive expert external legal input, to ensure compliance with the all relevant legislation. That legal advice also informed the matters reserved for Membership Body and Governing Body 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.

Risk management arrangements and effectiveness

The Accountable Officer and Directors of the CCG 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 as well as a risk management process for risks. 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; and
- 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 Governing Body Assurance Framework (GBAF). The CCG Risk Management Strategy was reviewed and a revised version covering 2015-17 was approved by the Governing Body in 2015.

Risk management is embedded within the CCG and into the wider working through a number of different routes. For example the CCG operates a city wide incident reporting system which facilitates the review of incidents to identify any as a potential risk to the CCG.

The CCG has two risk management processes in place as described in the risk management strategy; the risk register and the Governing Body Assurance Framework (GBAF).

The Governing Body Assurance Framework (GBAF) 2016-17

The Governing Body Assurance Framework (GBAF) sets out how the CCG manages the principal risks to delivering its strategic objectives. The CCG Governing Body owns and determines the content of the GBAF, identifying the strategic risks to achieving the CCG's objectives and monitoring progress throughout the year.

The GBAF provides an effective focus on strategic and reputational risk rather than operational issues, highlighting any gaps in controls and assurances. It provides the Governing Body with confidence that the systems and processes in place are operating in a way that is safe and effective. 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 Governing Body. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards reducing the potential risk.

Risk Register

The risk register is a record of all the significant risks faced by the organisation. In summary the risk 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 the management of the risk.

A web-based risk register system, Datix, is in place within the CCG which enables all staff to access and record risks. Staff have access to a standardised risk assessment form for the recording of risks and the Risk Management Strategy provides a standard risk scoring matrix for risk owners to use to score the level of each particular risk to ensure consistency. All risks that are added to the system are reviewed and approved by the identified risk owner Director before being accepted as an active risk on the CCG risk register. There are a number of risk reporting training sessions delivered on an annual basis for all staff to attend. This is it ensure 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 Governing Body.

The operational risks are managed within directorates with support from the city wide governance team. When risks increase in score, red 15 or above, these 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 Governing Body. Corporate and 'high amber' risks (those scored at 12 or above) are reported every two months to the relevant CCG committee. Responsible managers utilise 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 city wide. City wide 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. It is the combined city-wide and local risks that form the CCG Risk Register.

Developing a city wide risk management system has supported the collaborative working approach and highlights risks that may affect multiple organisations but also ensuring that local priorities are addressed.

Capacity to Handle Risk

The CCG fully appreciates its statutory obligations towards risk management and the Governing Body, Executive Directors, managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding and challenging risk and providing opportunities for the analysis of risk and discussions on risk across the whole organisation.

We have appointed an Executive Director lead for risk management who reports to the Governing Body on the risk management process.

Risk management is a key task of both the Audit Committee and the Assurance Committee, of which both are chaired by a lay member.

Risk Assessment

The CCG recognises the need for a robust focus on the identification and management of risks and therefore places risk within an integral part of our 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 organisation'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 Governing Body as at 31st March 2017 are summarised as follows:

Risk ID	Risk Title	Current Score
466	**The achievement of the national ambulance target** 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
532	**18 week Referral To Treatment Time** Commissioner and/or Lead provider fails to achieve the operational standard for the 18 week Referral to Treatment Time.	16
286	**Outpatient follow-up waiting list** Failure to be seen in outpatient clinics by the date given by their consultant causing potential risk to patient safety, particularly in colorectal surgery and gastroenterology.	16
587	**Co-commissioning: Future sustainability of practices** There is a risk that a number of practices in Leeds West CCG will be unsustainable due to resource implications both in terms of funding investments and resources such as workforce. Specifically, the equitable funding review will have a negative impact on a number of Leeds West CCG practices along with the potential reduction in local funding to support GP Access (which is being superseded by the GPFV funding).	16

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

The 2016-17 GBAF describes the CCG's principal risks as:

Objective	Risk	Assurances	Score
To tackle the biggest health challenges in West Leeds, reducing health inequalities	Failure to improve health outcomes and reduce health inequalities through improving the health of the poorest the fastest	• CCG Strategic Plan • Memorandum of Understanding in place with Leeds City Council for Public Health • Joint Health and Wellbeing Strategy • CCG representation at HWB Board • CCG Clinical Leads and Public health representatives • Healthy living services • Leeds Plan • Integrated quality and performance reports includes population outcome measures	9
To transform care and drive continuous improvement in quality and safety	Providers fail to meet quality standards, leading to poor quality and unsafe care	• Joint provider contract and quality and performance meetings • Contracts and KPIS in place • Commissioning for Quality and Innovation scheme • West Yorkshire Quality Surveillance Group • Patient Insight Group • Quality visit schedule • Quality Impact Assessment tool • Primary care dashboard	12

Summary of CCG's GBAF principal risks 2016-17 (continued)

Objective	Risk	Assurances	Score
To use commissioning resources effectively	The cessation of the YHCSY will create a great deal of instability for CCGs which could in turn impact on the CCGs ability to deliver on its responsibilities	• Contract monitoring and performance review meetings • Yorkshire and Humber wide services to increase consistency • Transition Oversight group • Contingency plans in place • KPIS and service specifications in place	12
	The governance arrangements for collaboration, partnership working, risk sharing and commissioning across the Leeds CCG network, Local Authority, NHSE and other partner agencies are not robust	• City wide risk management strategy and financial risk sharing • Integrated Commissioning Executive • Leeds Institute for Quality Healthcare • Partnership Executive Group • Healthy Futures Board • One Voice programme	4
	System resilience shortfalls leading to a failure to meet patient needs	• System Resilience Assurance Board • Leeds Plan/STP on urgent care and rapid response • Leeds resilience forum • Surge and escalation plan • System resilience plan • Urgent care group • Community beds strategy • A&E delivery plan	16
	Failure to achieve financial stability and sustainability	• Financial plan • Monthly reporting and set budgets • Detailed financial policies and budgetary control framework • Financial risk sharing agreement • Detailed scheme of delegation • Better care fund	16

Summary of CCG's GBAF principal risks 2016-17 (continued)

Objective	Risk	Assurances	Score
To use commissioning resources effectively	Failure to achieve financial stability and sustainability	• Monthly finance report to SMT, Audit Committee and Governing Body identifying any current financial risks • Prescribing finance position included in monthly finance updates • Monthly budget reports are issued and discussed at budget holder meetings • Budgetary control framework in place • Scheme of financial delegation and detailed financial policies • Lead commissioner monthly forecasts • Internal and external audit reports • Transformation board oversees and monitors 5 year plan • NHS England assurance meetings	16
To work with members to meet their obligations as clinical commissioners at practice level and to have the best developed workforce we possibly can	Lack of member engagement and primary care capacity will impact on the development and implementation of the CCG strategy	• Locality leadership team • Leeds West Primary Care Network • GP governing body members and clinical leads • Additional funding to support transformation including prime ministers GP access fund • Locality development sessions • TARGET • Primary care improvement group • Local quality improvement schemes • GP forward View	20

The above risks are the strategic risks to CCG which are captured within the Governing Body Assurance Framework and the high scoring red risks held on the CCG risk register. The risks are presented to each CCG committee for review and assurance, and then reported to the Governing Body in the public meeting. The GBAF and risk register can be found within the papers published on the CCG website for the public to review.

OTHER SOURCES OF ASSURANCE

Internal Control Framework

A system of internal control is the set of processes and procedures in place in the Clinical Commissioning Group 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.

We have assigned both internal and external auditors to provide the Governing Body 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 continue to be undertaken to review the effectiveness of governance systems. The finalised reports and agreed action plans 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 a senior manager with responsibility to complete within the designated timescales. Managers are held to account by the Audit Committee for completion of all actions. To date, all of the completed Internal Audit Reports for the CCG have been given a rating of significant or full assurance.

The Governing Body Assurance Framework and the Corporate Risk Register are standing agenda items on the Governing Body and Audit Committee agendas. This allows the CCG Governing Body members to cross-check current identified risks with any other significant developments that may arise on these agendas to ensure any identified problems are appropriately recorded on the risk register.

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 audit of conflicts of interest audit took place during quarter 4 of 2016-17. The overall rating for this audit was 'significant assurance' which reflects the robust arrangements in place at the CCG. A number of recommendations were made to further strengthen the arrangements, which are being implemented.

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. All of the Governing Body Committees were reviewed in March 2017 and no concerns were raised regarding data quality. The Assurance Committee and Governing Body have noted continued improvements in the CCG's Integrated Quality & Performance Report.

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, part of which involves data security. The CCG has a suite of approved IG policies and has provided the associated staff awareness. 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 undertook an assessment of its IG arrangements through completion of the Information Governance Toolkit (IGT). This included a review of key factors via our internal auditor. The CCG reached the required level in all the requirements. The CCG will be renewing approvals to continue to be an Accredited Safe Haven (ASH). This will mean the CCG is approved to provide a safe environment for the processing of information containing NHS numbers.

The CCG has a governing body-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 governing body-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 information governance roles and responsibilities. Overall compliance remains above the required target level.

There is an Information Governance Committee which reports to the Audit Committee. These are formal meetings with associated 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 the Health and Social Care Information Centre (HSCIC) 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. All 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 Office for National Statistics population forecasting are also classed as business critical, though not provided internally or via a Service Level Agreement. The CCG has experience of robustly challenging the quality and accuracy of such external models.

Third party assurances

We seek assurance from third party providers about some of the services we receive. The most recent controls assurance report relating to the Payroll Service provided by Leeds Teaching Hospitals NHS Trust provided full assurance that there is a sound system of internal control.

Control Issues

The CCG did not identify any control issues within the 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 Governing Body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically. The ratings for the Quality of Leadership indicator of the CCG Improvement and Assessment Framework are published on MyNHS (www.nhs.uk/service-search/scorecard/results/1175). The latest data available is for Quarter 2 of 2016/17, and the CCG is rated as 'Green'. The year end results will be available from July 2017.

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 financial plan was developed for 2016-17, and budgets set within this plan, and signed off by the Governing Body prior to the start of the financial year. These budgets were subsequently communicated to managers and budget holders within the organisation. The Chief Finance Officer and their team have worked closely with managers to ensure robust annual budgets were prepared and delivered.

Monthly finance reports are presented to the Executive Management Team and Governing Body each month, with a copy being presented to each meeting of the Audit Committee. Alongside the financial position, performance against statutory duties, risks and actions to mitigate risks are reported and discussed. 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 Governing Body.

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.

CCG is actively engaged in discussions in this regard 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 also recognises the need to achieve cost reductions through improved efficiency and productivity and work is ongoing to develop schemes to achieve the Quality, Innovation, Productivity and Prevention (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 where 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 Local 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'.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the clinical commissioning group, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the clinical commissioning group's system of risk management, governance and internal control. The Head of Internal Audit concluded 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

Audit	Assurance Level
Management of Conflicts of Interest	Significant
Budgetary Control and Key Financial Systems	Full
Continuing Healthcare	Significant
Primary Care Co-commissioning	Full
Compliance with Procurement Regulations	Significant
QIPP – City wide	Fieldwork underway
Commissioning for Quality and Innovation (CQUIN)	Full
Infection Control	Significant
Information Governance Toolkit	Significant
System Resilience Group	Significant

REVIEW OF THE EFFECTIVENESS OF GOVERNANCE, RISK MANAGEMENT & INTERNAL CONTROL

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditor and the executive managers and clinical leads within the clinical commissioning group who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditor in their management letter and other reports.

The Governing Body Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles 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 Governing Body, the Audit Committee and the Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

We have assigned both internal and external auditors to provide the Governing Body with independent assurance of its process 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 a senior manager with responsibility to complete within the designated timescales. Managers are held to account by the Audit Committee for completion of all actions.

The Governing Body Assurance Framework and the Corporate Risk Register are regular agenda items on the Board and Audit Committee agendas. This allows the CCG Governing Body members to triangulate current identified risks with any other significant developments that may arise on these agendas to ensure any identified problems are appropriately recorded on the risk register.

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 and from the Auditors of the CCG's principal provider of Commissioning Support Services (eMBED Health Consortium) in respect of their internal controls.

Conclusion

No significant internal control issues have been identified.

Philomena Corrigan
Accountable Officer

24 May 2017

INDEPENDENT AUDITOR'S REPORT TO THE MEMBERS OF THE GOVERNING BODY OF NHS LEEDS WEST CCG

We have audited the financial statements of NHS Leeds West CCG for the year ended 31 March 2017 on pages 109 to 143 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 that is subject to audit.

This report is made solely to the Members of the Governing Body of NHS Leeds West 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 set out on page 87, 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 West CGG 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
Sovereign Square
Leeds, LS1 4DA

26 May 2017

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	**(3,621)**	**(3,276)**
Other operating income	2	**(39)**	**(33)**
Total Operating Income		**(3,660)**	**(3,309)**
Staff costs	4	**4,159**	**3,941**
Purchase of goods and services	5	**460,085**	**403,886**
Depreciation and impairment		**-**	**-**
Provision expense	5	**708**	**(168)**
Other operating expenditure	5	**110**	**162**
Total Operating Expenditure		**465,062**	**407,821**
Net Operating Expenditure		**461,402**	**404,512**
Financing			
Finance income		-	-
Finance expenditure		-	-
Net Expenditure for the Financial Year		**461,402**	**404,512**
Net (Gain)/Loss on Transfer by Absorption		-	-
Total Net Expenditure for the Financial Year		**461,402**	**404,512**
Other Comprehensive Net Expenditure			
Net (gain)/loss on revaluation of property, plant & equipment		-	-
Net (gain)/loss on revaluation of intangibles		-	-
Movements in other reserves		-	-
Net (gain)/loss on available for sale financial assets		-	-
Net (gain)/loss on assets held for sale		-	-
Net actuarial (gain)/loss on pension schemes		-	-
Reclassification Adjustments:		-	-
On disposal of available for sale financial assets		-	-
Total Comprehensive Net Expenditure for the Financial Year		**461,402**	**404,512**

The notes on pages 114 to 143 form part of this statement.

Statement of Financial Position as at 31 March 2017

	Note	31 March 2017 £'000	31 March 2016 £'000
Non-current Assets		-	-
Property, Plant & Equipment		-	-
Intangible Assets		-	-
Investment Property		-	-
Trade & Other Receivables		-	-
Other Financial Assets		-	-
Total Non-Current Assets		-	-
Current Assets			
Inventories		-	-
Trade & Other Receivables	8	**2,026**	**1,220**
Other Financial Assets		-	-
Other Current Assets		-	-
Cash & Cash Equivalents	9	**70**	**137**
Non-current Assets Held for Sale		-	-
Total Current Assets		**2,096**	**1,357**
Current Liabilities			
Trade & Other Payables	10	**(20,815)**	**(14,538)**
Other Financial Liabilities		-	-
Other Liabilities		-	-
Borrowings		-	-
Provisions	11	**(234)**	**(116)**
Total Current Liabilities		**(21,049)**	**(14,654)**
Total Assets less Current Liabilities		**(18,953)**	**(13,297)**
Non-current Liabilities			
Trade & Other Payables		-	-
Other Financial Liabilities		-	-
Other Liabilities		-	-
Borrowings		-	-
Provisions	11	**(691)**	**(203)**
Total Non-current Liabilities		**(691)**	**(203)**
Total Assets Employed		**(19,644)**	**(13,500)**
Financed by Taxpayers' Equity			
General Fund		**(19,644)**	**(13,500)**
Revaluation Reserve		-	-
Other Reserves		-	-
Charitable Reserves		-	-
Total Taxpayers' Equity		**(19,644)**	**(13,500)**

The notes on pages 114 to 143 form part of this statement.

The financial statements on pages 109 to 143 were approved by the Governing Body on 24 May 2017 and signed on its behalf by:

Philomena Corrigan
Accountable Officer

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2017

Changes in Taxpayers' Equity for 2016-17	General Fund	Revaluation Reserve	Other Reserves	Total
	£'000	£'000	£'000	£'000
Balance as at 1 April 2016	**(13,500)**	**-**	**-**	**(13,500)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted Balance as at 1 April 2016	**(13,500)**	**-**	**-**	**(13,500)**
Changes in Taxpayers' Equity for 2016-17				
Net operating costs for the financial year	**(461,402)**	**-**	**-**	**(461,402)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total Revaluations against Revaluation Reserve	**-**	**-**	**-**	**-**
Net gain/(loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain/(loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to/(from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised Expenditure for the Financial Year	**(461,402)**	**-**	**-**	**(461,402)**
Net Funding	**455,258**	**-**	**-**	**455,258**
Balance as at 31 March 2017	**(19,644)**	**-**	**-**	**(19,644)**

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2017 *(continued)*

Changes in Taxpayers' Equity for 2015-16	General Fund	Revaluation Reserve	Other Reserves	Total
	£'000	£'000	£'000	£'000
Balance as at 1 April 2015	**(13,696)**	**-**	**-**	**(13,696)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted Balance as at 1 April 2015	**(13,696)**	**-**	**-**	**(13,696)**
Changes in Taxpayers' Equity for 2015-16				
Net operating costs for the financial year	**(404,512)**	**-**	**-**	**(404,512)**
Net gain/(loss) on revaluation of property, plant and equipment	-	-	-	-
Net gain/(loss) on revaluation of intangible assets	-	-	-	-
Net gain/(loss) on revaluation of financial assets	-	-	-	-
Total Revaluations against Revaluation Reserve	-	-	-	-
Net gain/(loss) on available for sale financial assets	-	-	-	-
Net gain/(loss) on revaluation of assets held for sale	-	-	-	-
Impairments and reversals	-	-	-	-
Net actuarial gain/(loss) on pensions	-	-	-	-
Movements in other reserves	-	-	-	-
Transfers between reserves	-	-	-	-
Release of reserves to the Statement of Comprehensive Net Expenditure	-	-	-	-
Reclassification adjustment on disposal of available for sale financial assets	-	-	-	-
Transfers by absorption to/(from) other bodies	-	-	-	-
Reserves eliminated on dissolution	-	-	-	-
Net Recognised Expenditure for the Financial Year	**(404,512)**	**-**	**-**	**(404,512)**
Net Funding	**404,708**	**-**	**-**	**404,708**
Balance as at 31 March 2016	**(13,500)**	**-**	**-**	**(13,500)**

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 costs for the financial year		**(461,402)**	**(404,512)**
Depreciation and amortisation		-	-
Impairments and reversals		-	-
Movement due to transfer by modified absorption		-	-
Other gains/(losses) on foreign exchange		-	-
Donated assets received credited to revenue but non-cash		-	-
Government granted assets received credited to revenue but non-cash		-	-
Interest paid		-	-
Release of PFI deferred credit		-	-
Other gains & losses		-	-
Finance costs		-	-
Unwinding of discounts		-	-
(Increase)/decrease in trade & other receivables	8	**(806)**	**376**
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	10	**6,277**	**(172)**
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	11	**(102)**	**(151)**
Increase/(decrease) in provisions	11	**708**	**(168)**
Net Cash Inflow/(Outflow) from Operating Activities		**(455,325)**	**(404,627)**
Cash Flows from Investing Activities			
Interest received		-	-
(Payments) for property, plant and equipment		-	-
(Payments) for intangible assets		-	-
(Payments) for investments with the Department of Health		-	-
(Payments) for other financial assets		-	-
(Payments) for financial assets (LIFT)		-	-
Proceeds from disposal of assets held for sale: property, plant and equipment		-	-
Proceeds from disposal of assets held for sale: intangible assets		-	-
Proceeds from disposal of investments with the Department of Health		-	-
Proceeds from disposal of financial assets		-	-
Proceeds from disposal of financial assets (LIFT)		-	-
Loans made in respect of LIFT		-	-
Loans repaid in respect of LIFT		-	-
Rental revenue		-	-
Net Cash Inflow/(Outflow) from Investing Activities		-	-
Net Cash Inflow/(Outflow) before Financing		**(455,325)**	**(404,627)**
Cash Flows from Financing Activities			
Net funding received		**455,258**	**404,708**
Other loans received		-	-
Other loans repaid		-	-
Capital elements of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT		-	-
Capital grants and other capital receipts		-	-
Capital receipts surrendered		-	-
Net Cash Inflow/(Outflow) after Financing Activities		**455,258**	**404,708**
Net Increase/(Decrease) in Cash & Cash Equivalents	9	**(67)**	**81**
Cash & Cash Equivalents at the Beginning of the Financial Year		**137**	**56**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year		**70**	**137**

The notes on pages 114 to 143 form part of this statement.

NOTES TO THE ACCOUNTS SECTION

Note 1 – Accounting Policies

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 Financial Statements have been prepared on the going concern basis.

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 Financial Statements 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 a 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' Financial Statements.

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.

1.7.1 Critical Judgements in Applying Accounting Policies

Where critical judgements have been made, or estimates used, details are provided in the relevant note to the accounts.

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 have been authorised 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 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 nd 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 revalued 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 revalued 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 of 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 IAS 17. 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% (2015-16: minus 1.55%)
- Timing of cash flows (6 to 10 years inclusive): minus 1.95% (2015-16: minus 1.00%)
- Timing of cash flows (over 10 years): minus 0.80% (2015-16: 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 expenditure 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 group contribute annually to a pooled fund, which is used to settle the claims. This contribution is treated as expenditure in the period in which it is paid.

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 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.

Associates 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 from Contracts with Customers (application from 1 January 2018); and
- 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.

Note 2 – Other Operating Revenue

	2016-17	2015-16
	£'000	£'000
Recoveries in respect of employee benefits	-	-
Patient transport services	-	-
Prescription fees and charges	-	-
Dental fees and charges	-	-
Education, training and research	28	8
Charitable and other contributions to revenue expenditure: NHS	-	-
Charitable and other contributions to revenue expenditure: non-NHS	-	-
Receipt of donations for capital acquisitions: NHS Charity	-	-
Receipt of Government grants for capital acquisitions	-	-
Non-patient care services to other bodies	3,593	3,268
Continuing Health Care risk pool contributions	-	-
Income generation	-	-
Rental revenue from finance leases	-	-
Rental revenue from operating leases	-	-
Other revenue	39	33
Total	**3,660**	**3,309**

Revenue in this note does not include cash received from NHS England, which is drawn down directly into the bank account of the Clinical Commissioning Group (CCG) and credited to the General Fund.

Collaborative arrangements exist between the Leeds CCGs whereby each CCG leads on an area of commissioning on behalf of all the CCGs:

- NHS Leeds South and East CCG leads on continuing health care and community services;
- NHS Leeds West CCG leads on acute services; and
- NHS Leeds North CCG leads on mental health and urgent care.

£2.8m (2015-16: £2.9m) of revenue classified as 'Non-patient care services to other bodies' relates to these collaborative arrangements.

Note 3 – Revenue

Revenue is totally from the rendering of services. The CCG receives no revenue from the sale of goods.

Note 4 – Employee Benefits

4.1 – Employee Benefits Expenditure Total	2016-17 Total	Permanent	Other	2015-16 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**3,349**	3,236	113	3,232
Social security costs	**356**	355	1	270
Employer contributions to the NHS Pension Scheme	**454**	452	2	439
Other pension costs	**-**	-	-	-
Other post-employment benefits	**-**	-	-	-
Other employment benefits	**-**	-	-	-
Termination benefits	**-**	-	-	-
Gross employee benefits expenditure	**4,159**	**4,043**	**116**	**3,941**
Less: Recoveries in respect of employee benefits	**-**	-	-	-
Total net employee benefits expenditure including capitalised costs	**4,159**	**4,043**	**116**	**3,941**

4.2 – Average Number of People Employed	2016-17 Total Number	Permanent Number	Other Number	2015-16 Total Number
Total	**87**	84	3	85
Number of whole time equivalent people engaged on capital projects	**-**	**-**	**-**	**-**

4.3 – Staff Sickness Absence and Ill health retirements	2016-17 Number	2015-16 Number
Total FTE days lost	**271**	**324**
Total staff years	**84**	**83**
Average working days lost	**3.2**	**3.9**
Number of persons retiring on ill health grounds	**-**	**-**

Due to the national timescales stipulated by NHS England for publishing these accounts, the nationally published staff sickness and absence information provided by the Department of Health and disclosed under note 4, provides data for the period from January 2016 to December 2016.

4.4 Exit Packages agreed in the Financial Year

The CCG has not agreed any exit packages in the financial year.

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 CCG 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 £454k were payable to the NHS Pensions Scheme (2015-16: £439k) at the rate of 14.3% (2015-16: 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.

Note 5 – Operating Expenses

	2016-17 Total £'000	2015-16 Total £'000
Gross Employee Benefits		
Employee benefits excluding governing body members	3,458	3,247
Executive governing body members	701	694
Total gross employee benefits	**4,159**	**3,941**
Other Costs		
Services from other CCGs and NHS England	25,108	24,162
Services from Foundation trusts	49,001	47,585
Services from other NHS trusts	230,493	223,687
Services from other NHS bodies	-	-
Purchase of healthcare from non-NHS bodies	55,329	53,259
Chair and Non-Executive Governing Body Members	91	102
Supplies and services – clinical	39	(1)
Supplies and services – general	1,600	617
Consultancy services	154	116
Establishment	798	543
Transport	17	39
Premises	690	309
Impairments and reversals of receivables	-	-
Inventories written down	-	-
Depreciation	-	-
Amortisation	-	-
Impairments and reversals of property, plant and equipment	-	-
Impairments and reversals of intangible assets	-	-
Impairments and reversals of financial assets	-	-
Impairments and reversals of investment properties	-	-
Impairment and reversals of non-current assets held for sale	-	-
Audit fees	77	77
Other non-statutory audit expenditure		
• Internal audit services	-	-
• Other services	-	-
General dental services and personal dental services	-	-
Prescribing costs	51,279	51,299
Pharmaceutical services	-	-
General ophthalmic services	49	65
GPMS/APMS and PCTMS	43,451	191
Other professional fees excl. audit	1,225	697
Grants to other public bodies	-	-
Clinical negligence	-	-
Research and development (excluding staff costs)	19	-
Education and training	319	102
Change in discount rate	-	-
Provisions	708	(168)
Funding to group bodies	-	-
CHC Risk Pool contributions	456	1,139
Other expenditure	-	60
Total other costs	**460,903**	**403,880**
Total operating expenses	**465,062**	**407,821**

Services from other CCGs and NHS England includes £24.6m (2015-16: £22.1m) which relates to the three Leeds CCG collaborative arrangements described in Note 2 to these financial statements.

Note 5 – Operating Expenses (continued)

£888k (2015-16: £597k) of 'other professional fees' expenditure relates to clinical leadership reimbursements to GP Practices.

Note 6 – Better Payments Practice Code

6.1 – BPPC	2016-17 Number	2016-17 £'000	2015-16 Number	2015-16 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	2,748	44,744	2,418	46,758
Total Non-NHS trade invoices paid within target	2,719	44,689	2,398	46,754
Percentage of Non-NHS trade invoices paid within target	**98.94%**	**99.88%**	**99.17%**	**99.99%**
NHS Payables				
Total NHS trade invoices paid in the year	3,568	279,264	3,886	273,417
Total NHS trade invoices paid within target	3,516	279,263	3,819	273,279
Percentage of Trade invoices paid within target	**98.54%**	**100.00%**	**98.28%**	**99.95%**

The Better Payment Practice Code requires the CCG to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

Note 7 – Operating Leases

7.1 – As Lessee	2016-17 Land	2016-17 Buildings	2016-17 Other	2016-17 Total	2015-16 Total
7.1.1 – Payments recognised as an Expense	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Minimum lease payments	-	129	16	**145**	192
Contingent payments	-	-	-	-	-
Sub lease payments	-	-	-	-	-
Total	**-**	**129**	**16**	**145**	**192**

	2016-17 Land	2016-17 Buildings	2016-17 Other	2016-17 Total	2015-16 Total
7.1.2 – Future Minimum Lease Payments	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
No later than one year	-	117	2	**119**	21
Between one and five years	-	385	1	**386**	3
After five years	-	-	-	**-**	-
Total	-	**502**	**3**	**505**	**24**

The CCG occupies property leased and managed by NHS Property Services Ltd. The current lease was signed in July 2016.

Note 8 – Trade and Other Receivables

8.1	Current 31-Mar-17 £'000	Non-Current 31-Mar-17 £'000	Current 31-Mar-16 £'000	Non-Current 31-Mar-16 £'000
NHS receivables: Revenue	785	-	127	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	956	-	960	-
NHS accrued income	206	-	50	-
Non-NHS receivables: Revenue	5	-	1	-
Non-NHS receivables: Capital	-	-	-	-
Non-NHS prepayments	66	-	74	-
Non-NHS accrued income	5	-	7	-
Provision for the impairment of receivables	-	-	-	-
VAT	3	-	1	-
Private finance initiative and other public partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables	-	-	-	-
Total	**2,026**	**-**	**1,220**	**-**
Total receivables current and non-current	**2,026**		**1,220**	

The majority of trade is with NHS England and other NHS organisations. As NHS England is funded by Government to provide funding to CCGs to commission services, no credit scoring of them is considered necessary.

8.2 – Receivables past their due date but not impaired	31-Mar-17 £'000	31-Mar-16 £'000
By up to three months	195	-
By three to six months	-	-
By more than six months	-	-
Total	**195**	**-**

Note 9 – Cash and Cash Equivalents

	31-Mar-17	31-Mar-16
	£'000	£'000
Balance at 1 April	137	56
Net change in year	(67)	81
Balance at 31 March	**70**	**137**
Made up of:		
Cash with the Government Banking Services	70	137
Cash with Commercial Banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in Statement of Financial Position	**70**	**137**
Bank overdraft: Government Banking Services	-	-
Bank overdraft: Commercial Banks	-	-
Total bank overdraft	**-**	**-**
Balance at 31 March	**70**	**137**

Note 10 – Trade and Other Payables

	Current	Non-Current	Current	Non-Current
10.1	31-Mar-17	31-Mar-17	31-Mar-16	31-Mar-16
	£'000	£'000	£'000	£'000
Interest payable	-	-	-	-
NHS payables: Revenue	1,164	-	914	
NHS payables: Capital	-	-	-	-
NHS accruals	1,538	-	1,259	-
NHS deferred income	-	-	17	-
Non-NHS payables: Revenue	1,380	-	410	-
Non-NHS payables: Capital	-	-	-	-
Non-NHS accruals	16,019	-	10,888	-
Non-NHS deferred income	41		-	
Social security costs	51	-	42	-
VAT	-	-	-	-
Tax	45	-	43	-
Payments received on account	-	-	-	-
Other payables	577	-	965	-
Total trade and other payables	**20,815**	**-**	**14,538**	**-**
Total payables current and non-current	**20,815**		**14,538**	

Other payables include outstanding pension contributions at 31 March 2017 of £66k for staff (31 March 2016: £64K) and £501K for GPs (31 March 2016: £nil)

10.2 – Deferred Income	31-Mar-17	31-Mar-16
	£'000	£'000
Balance at 1 April	17	8
Amounts utilised during the year	(17)	(8)
Amounts deferred during the year	41	17
Balance at 31 March	**41**	**17**

Note 11 – Provisions

	Current 31-Mar-17 £'000	Non-Current 31-Mar-17 £'000	Current 31-Mar-16 £'000	Non-Current 31-Mar-16 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	234	391	116	203
Other	-	300	-	-
Total	**234**	**691**	**116**	**203**
Total current and non-current	**925**		**319**	

	31-Mar-17 £'000	31-Mar-16 £'000
Balance at 1 April	**319**	**638**
Arising during the year	810	186
Utilised during the year	(102)	(151)
Reversed unused	(102)	(354)
Unwinding discount	-	-
Change in discount rate	-	-
Transfer (to)/from other public sector body	-	-
Balance at 31 March	**925**	**319**
Expected timing of cash flows:		
Within one year	234	116
Between one and five years	691	203
After five years	-	-
Balance at 31 March	**925**	**319**

The Continuing Care provision relates to potential costs for continuing care case reviews, where the uncertainty and timings relate to outcomes of the individual case reviews.

The Other provision relates to future dilapidation costs for the leased building the CCG occupies.

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 the establishment of clinical commissioning groups. However, the legal liability remains with the CCG. The total value of legacy NHS Continuing Healthcare provisions accounted for by NHS England on behalf of this CCG at 31 March 2017 is £275k (31 March 2016: £1,888k).

Note 12 – Financial Instruments

12.1 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.

As the CCG 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 CCG 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 CCG in undertaking its activities.

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

12.1.1 Currency Risk

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

12.1.2 Interest Rate Risk

The CCG borrows from government for capital expenditure, subject to affordability as confirmed by NHS England. The borrowings are for between 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 CCG has not borrowed funds for capital expenditure, therefore has low exposure to interest rate fluctuations.

12.1.3 Credit Risk

Because the majority of the CCG's revenue comes from parliamentary funding, the CCG has low exposure to credit risk. The maximum exposure as at the end of the financial year is in receivables from customers, as disclosed in the trade and other receivables note.

12.1.4 Liquidity Risk

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

Note 12 – Financial Instruments (continued)

12.2 – Financial Instruments

Financial Assets	At 'fair value through profit and loss'	Loans and Receivables	Available for Sale	Total
	£'000	£'000	£'000	£'000
Embedded derivatives	-	-	-	**-**
Receivables				
• NHS	-	991	-	**991**
• Non-NHS	-	10	-	**10**
Cash at bank in hand	-	70	-	**70**
Other financial assets	-	-	-	**-**
Total at 31 March 2017	**-**	**1,071**	**-**	**1,071**
Embedded derivatives	-	-	-	**-**
Receivables				
• NHS	-	177	-	**177**
• Non-NHS	-	8	-	**8**
Cash at bank in hand	-	137	-	**137**
Other financial assets	-	-	-	**-**
Total at 31 March 2016	**-**	**322**	**-**	**322**

Financial Liabilities	At 'fair value through profit and loss'	Other	Total
	£'000	£'000	£'000
Embedded derivatives	-	-	**-**
Payables:			
• NHS	-	2,702	**2,702**
• Non-NHS	-	17,976	**17,976**
Private finance initiative, LIFT and finance lease obligations	-	-	**-**
Other borrowings	-	-	**-**
Other financial liabilities	-	-	**-**
Total at 31 March 2017	**-**	**20,678**	**20,678**
Embedded derivatives	-	-	**-**
Payables:			
• NHS	-	2,173	**2,173**
• Non-NHS	-	12,263	**12,263**
Private finance initiative, LIFT and finance lease obligations	-	-	**-**
Other borrowings	-	-	**-**
Other financial liabilities	-	-	**-**
Total at 31 March 2016	**-**	**14,436**	**14,436**

Note 13 – Operating Segments

The CCG considers that it has only one segment: commissioning of healthcare services.

Note 14 – Pooled Budgets

The Clinical Commissioning Group has entered into pooled budget arrangements with Leeds City Council and the other Leeds Clinical Commissioning Groups. The Pools are hosted by Leeds City Council and Leeds South and East CCG respectively. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund. The contributions made by Leeds West Clinical Commissioning Group in the financial year are as follows:

Pooled Budget Fund 1 CCG Hosted s75 Agreements	2016-17	2015-16
	£'000	£'000
Income	8,383	4,675
Expenditure	8,383	4,600

Pooled Budget Fund 2 Leeds City Council Hosted s75 Agreements	2016-17	2015-16
	£'000	£'000
Income	8,822	1,560
Expenditure	8,822	1,594

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 CCGs (Leeds North CCG and Leeds South and East CCG) has been put in place that describes the commissioning arrangements for a range of health and social care services. The BCF Partnership Agreement is based on the national template developed by NHS England and Bevan Brittan. All funds are overseen by a joint BCF Partnership Board. A summary is tabled below (this includes the Pooled Funds shown in the figures above):

2016 -17 Contributions		Leeds South & East CCG 2016-17	Leeds West CCG 2016-17	Leeds North CCG 2016-17	Leeds City Council 2016-17	Total 2016-17
				£'000	£'000	£'000
Fund 1	CCG Hosted services	7,586	8,383	5,011	-	**20,980**
Fund 2	Council Hosted services	7,309	8,822	5,717	8,775	**30,623**
Total		**14,895**	**17,205**	**10,728**	**8,775**	**51,603**

2015 -16 Contributions		Leeds South & East CCG 2015-16	Leeds West CCG 2015-16	Leeds North CCG 2015-16	Leeds City Council 2015-16	Total 2015-16
		£'000	£'000	£'000	£'000	£'000
Fund 1	CCG hosted s75 Agreements	4,125	4,675	2,766	-	**11,566**
Fund 2	Council Hosted s75 Agreements	1,396	1,560	922	3,144	**7,022**
Fund 3	CCG Hosted Non-Pooled Funds	5,392	5,871	3,522	-	**14,785**
Fund 4	Council Hosted Non-Pooled Funds	5,887	7,266	4,822	4,802	**22,777**
	Contingency	551	733	633	-	**1,917**
Total		**17,351**	**20,105**	**12,665**	**7,946**	**58,067**

2016 - 17 Expenditure		Leeds South & East CCG 2016-17	Leeds West CCG 2016-17	Leeds North CCG 2016-17	Leeds City Council 2016-17	Total 2016-17
				£'000	£'000	£'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**

2015 - 16 Expenditure		Leeds South & East CCG 2015-16	Leeds West CCG 2015-16	Leeds North CCG 2015-16	Leeds City Council 2015-16	Total 2015-16
		£'000	£'000	£'000	£'000	£'000
Fund 1	CCG hosted s75 Agreements	4,053	4,600	2,720	-	**11,373**
Fund 2	Council Hosted s75 Agreements	1,425	1,594	941	3,144	**7,104**
Fund 3	CCG Hosted Non-Pooled Funds	5,435	5,912	3,549	-	**14,896**
Fund 4	Council Hosted Non-Pooled Funds	5,887	7,266	4,822	4,802	**22,777**
	Contingency	551	733	633	-	**1,917**
Total		**17,351**	**20,105**	**12,665**	**7,946**	**58,067**

Note 15 – Related Party Transactions

During the year the following key individuals of the CCG were either related to, or were themselves members of medical practices or other organisations with which the CCG had material transactions concerning the provision of medical services and the purchase of healthcare. The total value of transactions with these organisations are listed below:

15.1 – Income and Expenditure with Related Parties	Payments to Related Party 2016-17 Co-Commissioning	Payments to Related Party 2016-17 Excl. Co-Commissioning	Receipts from Related Party 2016-17	Payments to Related Party 2015-16	Receipts from Related Party 2015-16
	£'000	£'000	£'000	£'000	£'000
St. Gemma's Hospice (Dr Peter Belfield)	-	996	-	985	-
Leeds West Primary Care Network Ltd (Dr Simon Hulme, Dr Mark Liu, Dr Mark Fuller and Dr Chris Mills)	-	-	-	-	-
Abbey Grange Medical Centre (Dr Mark Liu)	1,023	200	-	309	-
Burton Croft Surgery (Dr Gordon Sinclair)	1,265	320	-	409	-
Craven Road Medical Practice (Dr Gaye Sheerman-Chase)	1,373	374	-	415	-
Leeds Student Medical Practice (Dr Julianne Lyons)	3,438	695	-	488	-
Leigh View Medical Practice (Dr Simon Hulme)	1,774	287	-	278	-
Manor Park Surgery (Dr Jamie O'Shea, Dr Mark Fuller and Dr Mark Liu)	1,522	341	-	384	-
Rawdon Surgery (Dr Chris Mills and Dr Gwyn Elias)	886	290	-	303	-
Vesper Road Surgery (Dr Bryan Power)	633	183	-	224	-

Note 15 – Related Party Transactions (*continued*)

15.2 – Balances with Related Parties	Amounts owed to Related Party	Amounts due from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	31-Mar-17	31-Mar-17	31-Mar-16	31-Mar-16
	£'000	£'000	£'000	£'000
St. Gemma's Hospice (Dr Peter Belfield)	-	-	-	-
Leeds West Primary Care Network Ltd (Dr Simon Hulme, Dr Mark Liu, Dr Mark Fuller and Dr Chris Mills)	254	-	-	-
Abbey Grange Medical Centre (Dr Mark Liu)	44	-	5	-
Burton Croft Surgery (Dr Gordon Sinclair)	70	-	6	-
Craven Road Medical Practice (Dr Gaye Sheerman-Chase)	42	-	6	-
Leeds Student Medical Practice (Dr Julianne Lyons)	52	-	15	-
Leigh View Medical Practice (Dr Simon Hulme)	70	-	8	-
Manor Park Surgery (Dr Jamie O'Shea, Dr Mark Fuller and Dr Mark Liu)	67	-	8	-
Rawdon Surgery (Dr Chris Mills and Dr Gwyn Elias)	48	-	4	-
Vesper Road Surgery (Dr Bryan Power)	32	-	4	-

Note 15 – Related Party Transactions (*continued*)

During the year the CCG had transactions with the following member practices, in respect of the purchase of healthcare:

15.3 – Income and Expenditure with Other Member Practices	Payments to Related Party 2016-17 Co-Commissioning	Payments to Related Party 2016-17 Excl. Co-Commissioning	Receipts from Related Party 2016-17	Payments to Related Party 2015-16	Receipts from Related Party 2015-16
	£'000	£'000	£'000	£'000	£'000
Armley Medical Practice	1,725	331	-	303	-
Beechtree Medical Centre	217	14	-	47	-
Burley Park Medical Centre	1,239	241	-	376	-
Drighlington Medical Centre	366	59	-	66	-
Fieldhead Surgery	460	97	-	143	-
Fountain Medical Centre	2,129	303	-	338	-
The Gables Surgery	544	88	-	95	-
Gildersome Health Centre	338	60	-	59	-
Guiseley and Yeadon Medical Practice	1,581	193	-	321	-
Hawthorn Surgery	868	99	-	144	-
High Field Surgery, Holt Park	807	145	-	227	-
Highfield Medical Centre, Bramley	559	81	-	110	-
Hillfoot Surgery	745	166	-	114	-
Hyde Park Surgery	991	158	-	262	-
Ireland Wood and Horsforth Medical Practice	2,917	610	-	864	-
Kirkstall Lane Medical Centre	699	165	-	258	-
Laurel Bank Surgery	657	124	-	194	-
Menston and Guiseley Medical Practice	1,090	192	-	309	-
Morley Health Centre	239	8	-	24	-
Priory View Medical Centre	1,213	161	-	203	-
Pudsey Health Centre	800	128	-	143	-
Robin Lane Health and Wellbeing Centre	1,495	665	-	714	-
South Queen Street Medical Centre	374	11	-	27	-
Sunfield Medical Centre	493	65	-	66	-
Thornton Medical Centre	1,119	196	-	234	-
West Lodge Surgery	1,880	340	-	241	-
Whitehall Surgery	1,222	182	-	196	-
Windsor House Group Practice	1,876	286	-	148	-
Yeadon Tarn Medical Practice	706	137	-	182	-

Note 15 – Related Party Transactions (continued)

15.4 – Balances with Other Member Practices	Amounts owed to Related Party 31-Mar-17 £'000	Amounts due from Related Party 31-Mar-17 £'000	Amounts owed to Related Party 31-Mar-16 £'000	Amounts due from Related Party 31-Mar-16 £'000
Armley Medical Practice	70	-	7	-
Beechtree Medical Centre	14	-	-	-
Burley Park Medical Centre	44	-	6	-
Drighlington Medical Centre	14	-	2	-
Fieldhead Surgery	32	-	3	-
Fountain Medical Centre	85	-	8	-
The Gables Surgery	22	-	3	-
Gildersome Health Centre	17	-	3	-
Guiseley and Yeadon Medical Practice	58	-	6	-
Hawthorn Surgery	30	-	4	-
High Field Surgery, Holt Park	42	-	5	-
Highfield Medical Centre, Bramley	20	-	3	-
Hillfoot Surgery	46	-	4	-
Hyde Park Surgery	49	-	5	-
Ireland Wood and Horsforth Medical Practice	160	-	12	-
Kirkstall Lane Medical Centre	33	-	4	-
Laurel Bank Surgery	28	-	4	-
Menston and Guiseley Medical Practice	58	-	6	-
Morley Health Centre	16	-	2	-
Priory View Medical Centre	43	-	6	-
Pudsey Health Centre	41	-	4	-
Robin Lane Health and Wellbeing Centre	87	-	7	-
South Queen Street Medical Centre	34	-	-	-
Sunfield Medical Centre	48	-	3	-
Thornton Medical Centre	55	-	6	-
West Lodge Surgery	79	-	9	-
Whitehall Surgery	39	-	5	-
Windsor House Group Practice	65	-	8	-
Yeadon Tarn Medical Practice	31	-	4	-

Note 15 – Related Party Transactions (continued)

The Department of Health is regarded as a related party. During the year the CCG has had a significant number of material transactions with entities for which the Department is regarded as the parental Department. These entities are listed below:

- NHS England;
- NHS North of England CSU;
- Leeds Teaching Hospitals NHS Trust;
- Mid Yorkshire Hospitals NHS Trust;
- Harrogate and District NHS Foundation Trust;
- Bradford Teaching Hospitals NHS Foundation Trust;
- Leeds and York Partnership NHS Foundation Trust;
- Leeds Community Healthcare NHS Trust;
- Yorkshire Ambulance Service NHS Trust;
- NHS Leeds South and East CCG; and
- NHS Leeds North CCG.

In addition, the CCG has had a number of material transactions with other Government and other local Government bodies, the majority of which have been with Leeds City Council.

Note 16 – 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:

	31-Mar-17	31-Mar-16 Restated
	£'000	£'000
In not more than one year	-	-
In more than one year but not more than five years	2,035	3,554
In more than five years	-	-
Total	**2,035**	**3,554**

This commitment relates to the contract for commissioning support services that the CCG holds. The prior year has been restated as it was omitted from the prior year financial statements.

Note 17 – Losses and Special Payments

The total number and value of the CCG's losses and special payment cases were as follows:

17.1 – Losses	Total No. of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000	Total No. of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Administration write-offs	-	-	1	60
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book keeping losses				
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Other losses	-	-	-	-
Total	**-**	**-**	**1**	**60**

17.2 – Special Payments	Total No. of Cases 2016-17 Number	Total Value of Cases 2016-17 £'000	Total No. of Cases 2015-16 Number	Total Value of Cases 2015-16 £'000
Compensation payments	-	-	-	-
Extra contractual payments	-	-	-	-
Ex gratia payments	-	-	-	-
Extra statutory regulatory payments	-	-	-	-
Special severance payments	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 18 – Financial Performance Targets

	Maximum £'000	Performance £'000	Duty Achieved
Expenditure not to exceed income	477,257	465,062	Yes
Capital resource use does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use on specified matters does not exceed the amount specified in Directions	473,597	461,402	Yes
Capital resource use on specified matters does not exceed the amount specified in Directions	-	-	Yes
Revenue resource use on specified matters does not exceed the amount specified in Directions	-	-	Yes
Revenue administration resource use does not exceed the amount specified in Directions	7,592	7,511	Yes

As set out in the 2016-17 NHS Planning Guidance, CCGs were required to hold a 1% 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 West CCG has released its 1% reserve to the bottom line, resulting in an additional surplus for the year of £4.5m. This additional surplus has been carried forward for drawdown in future years.

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