NHS
Leeds West
Clinical Commissioning Group

NHS Leeds West Clinical Commissioning Group **Annual Report and Accounts 2015–2016**

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ANNUAL REPORT

The annual report and accounts for the year ended 31 March 2016 have been prepared as directed by NHS England in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006. The directions issued by NHS England require clinical commissioning groups to comply with the requirements laid out in the Manual for Accounts issued by the Department of Health. The Manual for Accounts complies with the requirements of the Government Financial Reporting Manual, which the Department of Health Group Accounts are required to comply with.

ACCOUNTABLE OFFICER'S FOREWORD

The last 12 months have been about preparing to meet the challenges that we face in the coming years while ensuring we continue to plan and fund (commission) the best possible services for our local communities.

Before I reflect on the key developments over the last year I wanted to say thank you to our staff, our 37 member GP practices and all our partners. In particular I'd like to thank our patients and wider public who have continued to have their say in the way we shape health and care services.

The Government is pursuing its goal of giving people access to seven day primary care services. Here at our CCG we are proud to say that we've already made great progress in extending access to primary care services for our 370,000 patients registered at our 37 member practices.

At the time of writing 19 practices, covering a population of 184,000 patients, offered appointments seven days a week. The remaining 18 practices, covering a population of 186,000 patients, now offer extended services five days a week from 7am – 7pm or 8am – 8pm.

Our relationship with our 37 member practices has been key to the way we've developed our extended access scheme. We were delighted to welcome Sir Bruce Keogh, Medical Director for NHS England, to one of our locality development sessions to find out more about our scheme.

Sir Bruce heard directly from GPs and other practice staff, as well as CCG colleagues, about how we've worked together to set up the programme. He also found out how we've continued to engage clinicians and patients so that we can continue to make improvements and promote the extended opening hours.

Our strong relationship with our member GP practices will be key as, from 1 April 2016, we'll be co-commissioning primary care services with NHS England. We'll be doing this in collaboration with our neighbouring CCGs in Leeds – NHS Leeds North CCG and NHS Leeds South and East CCG.

It has now been 18 months since NHS England published the Five Year Forward View for the NHS. We're making good progress in implementing some of the core elements of the NHS Five Year Forward View so that we can meet the challenges of an ageing population, rising demand for services and increasing costs for treatment.

The NHS Five Year Forward View sets out how local health and care systems can develop integrated services referred to as new models of care. The key principles of the new models of care are that organisational boundaries are eroded. This leads to locality (neighbourhood) based care that is provided by a single care team made up of lots of different health and care professionals.

We've already started taking steps to set up a pilot in the Armley and New Wortley area to see how new models of care can be implemented locally. We're working with local care providers including GPs and colleagues at Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust and Leeds City Council to see how we can set up a single care team for this locality.

Before we make any firm arrangements we've already started discussions with local community and voluntary groups, patients and political colleagues. In addition, we held a deliberative event in March attended by over 70 local people so that we could understand what their pressing needs and concerns are with our suggested approach. We'll be continuing this engagement with community members, staff and clinicians before firming up our plans.

Each health and care system in the country is being asked by NHS England to put together a sustainability and transformation plan (STP). The STP is designed to support health and care systems to deliver the NHS Five Year Forward View.

The STP challenges system leaders to deliver sustainable change that can drive through transformation of care.

We've got a strong base to build from as health and care organisations in Leeds have been working together for some time. We've already been recognised for our pioneering way of delivering integrated care. This is being backed up by the roll out of the Leeds Care Record so we can remove some of the IT frustrations that can get in the way of frontline professionals looking to deliver the best possible care.

The guidance for developing a STP makes it clear that it's not just organisational boundaries we need to remove, there's also a need to move away from geographical boundaries. This means trying to work out how we can deliver critical services at scale while ensuring everyone has equal access to them.

Again we're already making progress on this as West Yorkshire is one of the 'vanguard' sites for urgent and emergency care. The vanguard sites for the new care models programme are one of the first steps towards delivering the Five Year Forward View and supporting improvement and integration of services.

I now want to share some key developments that have taken place over the last year at a more local level. We're active members of the Leeds Health and Wellbeing Board which is responsible for setting the direction for health and wellbeing through the Joint Health and Wellbeing Strategy. The strategy is now being refreshed as it was designed to cover the years 2013-2015.

We've been asking local people about what they'd like to see as being the city's priorities for health and wellbeing before we put together the next Joint Health and Wellbeing Strategy for Leeds. The strategy will also need to take into account national guidelines such as those in the NHS Five Year Forward View. In addition, there's clinical guidance that comes from bodies such as National Institute for Health and Care Excellence (NICE) and Public Health England as well as meeting key duties set out by healthcare regulators such as the Care Quality Commission (CQC).

Like many other areas of a similar size and with similar communities, we've experienced challenges with meeting our referral to treatment times for cancer. However we've been actively working with our partners on developing an integrated approach to cancer services.

We've managed to secure funding from the ACE early diagnosis programme set up by NHS England. In March we held an event featuring leading health and care professionals in the city and patients to explore options for how we can develop quicker testing (diagnostic) routes for patients.

We've already got access to a range of national evidence and have been working with patients locally as well to find out more about their current experiences, what worked well and what could have been improved. I'm confident that over the coming years we'll be able to establish patient-centred cancer services that will mean people are seen, diagnosed and treated quickly to reduce the impact cancer has on lives here in Leeds.

We've been working with Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds City Council (Adult Social Care) and community and voluntary organisations such as the British Red Cross to tackle delayed discharges from hospital. Delayed discharges happen when a person is medically fit to leave hospital but is unable to do so as appropriate care is not in place for when they return back to where they normally live.

Our discharge to assess pilot came to an end in March 2016 and we'll be looking at the evaluation of the scheme to see how we could implement the key recommendations. There are occasions where a patient's discharge process is delayed because they need to have an assessment of their needs.

We've found that some patients can have this done at home because they're medically fit to leave hospital and have adequate care waiting for them at home. This means they don't need to wait for the assessment by hospital-based healthcare professionals before being discharged.

We've continued to work with Leeds and York Partnership NHS Foundation Trust (LYPFT) to see how we can continue to give mental health equal levels of support as we do for all other aspects of healthcare. As part of this we've been supporting the Man Up campaign by LYPFT which encourages men to open up about how they're feeling.

We also continue to work with community organisations in the LS12/LS13 area to reduce the risk of suicide among local people. The LS12/LS13 area has seen higher than expected suicide rates, particularly among men. Our partners are helping to provide suicide resilience training for health and care staff as well as continuing to offer peer support groups for men identified as being at risk.

I'm delighted to report that we've agreed to continue funding the Patient Empowerment Project (PEP). PEP gives our GP practices immediate access to community and voluntary groups and services that could help patients with issues affecting their health, such as debt management. We've been sharing learning from the PEP project with local and national commissioners, including a poster presentation at the national Patient Experience Network Awards and Conference.

We've been working with the city's three universities to run a student welfare campaign. The 'we're here to make you feel better' campaign encourages students to make greater use of their local pharmacies for advice and support with common conditions and illnesses.

We developed the campaign by involving local students throughout the planning and implementation of the campaign. This meant the designs were appropriate to young people, and the messages were clear and delivered where students were most likely to see them. In total over 1,000 students have fed back their views on the initial and follow up campaign.

As a CCG it's important that we understand and can empathise with the communities we work with so that we can tackle health inequalities. I was really pleased to hear that staff in our CCG took part in a 'skip lunch, save a life' one day fast that also raised money for Save the Children. The idea was for staff members to fast during working hours so that they could understand how it feels for people who have to abstain from food for religious reasons. This gave staff a great understanding about some of the issues patients, as well as colleagues, may face when they're fasting.

Our CCG is committed to involving and actively seeking the views of patients, carers and the wider public. We've made great progress on this in the three years since we became a formal statutory body.

We're currently in the process of revising the CCG's strategy and I was pleased to welcome our patients to an informal meeting involving our senior management team. This was the first step we took but a significant one and it was essential we involved patients from the beginning.

I wanted to highlight our patient leader programme as an example of our innovative approach to getting patients involved throughout the commissioning process. This means that our patient leaders sit on steering groups for a number of our key projects including the chronic pain pathway, childhood asthma and childhood obesity.

Patients are expected to bring an objective viewpoint to the meetings they attend so that our commissioners can understand how any proposals they're developing could impact on our diverse communities. One example I wanted to highlight was for the new chronic pain pathway that was launched in April 2015.

The revised pathway enabled patients with chronic pain to access an app to help them understand and manage their pain reducing the need for support from a healthcare professional. One of our patient leaders identified that the app was only available to users of an iPhone or iPad and not other digital devices. As a result we've worked with software providers to ensure people using other smartphones and tablets can also access the app.

You can read more about the patient leader programme and other ways we've been working with local communities in our performance report from page 16-60.

In Leeds, healthcare organisations, including our CCG, have signed up to Dr Kate Granger's 'hello my name is…' campaign for compassionate care. I wanted to reflect on the time I've spent recently on a number of wards at Leeds Teaching Hospitals NHS Trust. I saw first hand how caring the nurses on the wards are with patients and the positive effect this has on their relationship with those they care for. As a registered nurse it fills me with great pride to see that our profession continues to demonstrate the value of compassionate care.

We have some tough challenges in front of us, and as we prepare ourselves I wanted to end by once again thanking everyone who has helped the CCG prepare for what lies ahead.

So I must say thank you to our staff, our member practices, our partners and above all our patients and the wider public. I'm confident that with your ongoing support we'll continue to develop the best possible services while ensuring value for the public funds we are trusted with.

Thank you.

Philomena Corrigan
Accountable Officer

CHAIR'S MESSAGE

We've been established for three years now and I'm immensely proud of how far we've come in such a short time. I know that Phil Corrigan, our chief executive, has outlined some of our key achievements from this year. You'll also find more details about how well we've been performing throughout the annual report. As a GP, as well as Chair of the CCG, I wanted to reflect on how we've maintained a focus on getting clinical support and input in the work we do and the way we plan services.

You'll know from both Phil's Foreword and through the introduction to this annual report from our member practices that we've been working tirelessly to implement our extended access to primary care scheme.

This now means that all our registered patients covered by our CCG have improved access to primary care (GP) services. However the key point, and one that could easily be forgotten, is the role our practices have played in enabling this innovative scheme to be established and work as well as it has done.

Thanks to their collaborative approach we're now seeing alliances being forged where we may once have seen healthy competition. We're seeing practices actively coming together to look at solutions to local health issues not just access to appointments but how we can better deliver healthcare services locally, such as diabetes prevention.

What does this mean? It means we're in a good position to start looking at how we can implement new models of care as outlined in the NHS Five Year Forward View. The only sustainable healthcare system of the future must involve local, population-based services and teams delivering services without the restrictions of organisational boundaries. I'm really pleased to report that we're already well underway with setting up our first local integrated service pilot in the Armley area.

The work in Armley involves the local GP practices collaborating with other partners including community and mental health as well as social care services and the voluntary sector. This demonstrates the progress the CCG has made that we can have such positive discussions with all our key partners to make the Armley vision a reality.

It also means making sure we involve the most important partners of all - our patients and the communities we work in. Empowerment is an often overused term but NHS professionals recognise the enormous contribution that informed, motivated individuals, families and communities can bring to successfully managing their own health conditions. This is a key component for future planning and I would like to give a special mention to our innovative patient leader programme which is helping to champion this approach.

The challenges that the NHS is facing are well documented and we will need significant resolve, determination and skill to continue developing a new approach to healthcare delivery but I believe that we now have the necessary relationships and foundations in place to meet those challenges head on. I would like to take this opportunity to thank all our hardworking staff, our supportive member practices and above all those patients and individuals who voluntarily commit their time and expertise to help us improve the health of all our communities. I look forward to working with you all in 2016-2017.

Dr Gordon Sinclair
Clinical Chair

INTRODUCTION TO THE CCG'S ANNUAL REPORT FROM OUR MEMBER PRACTICES

2015-2016 has been a very productive year that has seen our member practices orientate towards innovative change in a difficult financial climate. We have received national attention resulting in a visit from Sir Bruce Keogh (Medical Director, NHS England) and Rosamond Roughton (Director of NHS Commissioning, NHS England). They expressed enthusiasm and support for the aspirations of our member practices.

There have been great strides made towards collaborative working between practices and with other partners in community care that address priorities at both local and national level. One good local example of this is the better care that patients in care homes have received through the enhanced care home scheme. Practices have been working closely with pharmacists, community therapists and care homes to provide high quality proactive and holistic care to this vulnerable patient group.

As part of the national objective priorities, NHS Leeds West CCG boldly commissioned an enhanced primary care access scheme where member practices were given the opportunity to provide 12 hour weekday general practice opening, combined with collaborative weekend appointment provision.

At the end of December 2015 the scheme had delivered an additional 120,000 appointments for patients in the CCG area. These appointments have been delivered either through a patient's own GP practice or by a hub located close to home.

Patient satisfaction with primary care has risen as a result of the scheme with satisfaction rates relating to access to GP practices above the England average. For example, in the latest patient survey 77.2% of patients were satisfied with their opening times compared with 74.8% for the rest of England.

We are committed to developing a service that builds on the solid foundations of clinician and managerial commitment, IT innovations and creative use of estates from the existing enhanced scheme. The challenge is to provide a truly seven day transformative service for all patients of the CCG.

The member practices were delighted to have been given an award from the GP Access Fund (formerly known as the Prime Minister's Challenge Fund). This will transform patient access through innovative use of IT solutions. Our vision to improve health outcomes will see patients interacting with primary care through online services with bespoke websites providing access to self-help, e-consultations, online appointments, prescription ordering and access to their own records. All practices will be Wi-Fi enabled to provide virtual consultations, multi-disciplinary team meetings, video and telehealth communications with care homes.

The GP Access Fund award has enabled practices to develop a leadership team to manage this fund and also assist the implementation of other transformational work. We look forward to this leadership team being pivotal to the integration of work that has already been done to improve access for our patients through the extended hours, the care home scheme and novel IT solutions. We are heartened by NHS England's commitment to further fund these schemes.

Collaborative working between practices has enabled partnership working with other community based providers. The Armley GP Federation (Armley Medical Practice, Priory View Medical Centre and Thornton Medical Centre), initially formed to deliver the care home scheme to the area, is now piloting a new model of working. This will bring the GP practices together with the local authority, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation

Trust, third sector organisations and community representatives to deliver care in a different way that focuses on local health and wellbeing needs and priorities. This initiative is already leading to similar discussions in the other localities of our CCG.

In 2016-17 our CCG will be working with the two other Leeds CCGs to co-commission primary care services with NHS England. We see this as an opportunity to further our ambitions to transform primary care for our patients. Co-commissioning offers the opportunity as an enabler to attain our vision for primary care. During the year there has been much discussion amongst the membership about this and there was majority support for the organisation to apply for Level 3 co-commissioning. We, on behalf of the member practices, look forward to working with the CCG to realise its full potential.

The Health and Social Care Act 2012 imposes a duty for CCG members to improve the quality of primary care. We are confident that our members have discharged this duty over the last year through the locality development sessions, the quality improvement scheme and the medicine optimisation scheme.

We have held 10 locality development sessions over the last year. The main emphasis and focus of the sessions has been to look at how we could provide locally responsive primary care at scale, seven days a week.

This year we continued with a funded quality improvement scheme, the membership focusing on local need and working in localities. Practices are to be commended on the improved outcomes that were delivered under the 2014-15 scheme that were not available at the time of the last publication.

We include an example of a practice's achievements who sought to improve early diagnosis of cancer and in turn patient outcomes.

- Increase in uptake of bowel cancer screening by 21.7% by the end of the year.
- Uptake of cervical smears more than doubled by the final quarter of the year.
- Implementation of a safe process for suspected cancer referrals, so that all those who did not attend hospital following referral were either re-referred or reviewed again by a GP.

Before we conclude our introduction it's time to say thanks to two of our locality chairs. Dr Andrew Sixsmith and Dr Philip Dyer. They have been GP representatives since the inception of the CCG, and their terms ended at the end of March 2016. We wish to express our gratitude to them for all their contribution and hard work, they will be missed.

The CCG's annual report and accounts provide further detail on how the CCG has performed against its strategic objectives as well as delivering against nationally mandated targets. In our role as representatives of the 37 member practices of the CCG our introduction is designed to assure local people that the CCG has continued to engage with local clinicians and its member practices. This means our strategy and our commissioning plans are based on the latest clinical advice and both local and national evidence.

Drs Dyer, Hulme, Liu and Sixsmith
Locality Chairs on behalf of the NHS Leeds West CCG Membership

THE NATURE AND PURPOSE OF NHS LEEDS WEST CLINICAL COMMISSIONING GROUP

NHS Leeds West Clinical Commissioning Group (CCG) has successfully completed its third 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's Constitution has been reviewed and updated over the course of the 2015-16 financial year.

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 is one post balance sheet event to report relating to the CCG being approved under delegated commissioning arrangements; 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 370,000 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.

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.

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: Suites 2-4 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.

We do not commission primary care services such as GP services, dental care, pharmacy or optometry (opticians) which is done by NHS England (West Yorkshire), the local area team for NHS England. However, from 1 April 2016, the CCG will be co-commissioning GP primary care services with NHS England. NHS England also has the responsibility for commissioning specialised services such as kidney care.

The following healthcare providers / areas of spending cover 82% of the CCG's commissioning budget:

	£ million
Leeds Teaching Hospitals NHS Trust	151
Mid Yorkshire Hospitals NHS Trust	12
Harrogate and District Foundation NHS Trust	4
Bradford Teaching Hospitals NHS Foundation Trust	4
Nuffield	6
Spire	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	39
Prescribing recharges from the Prescription Pricing Authority	52
Main Areas of Commissioned Spend	**325**
Other Smaller Contracts	**72**
Total Commissioning Spend (Programme Budget)	**397**

A full list of contracts with providers is available on request. There have been no significant changes to services contracted by the CCG during 2015-2016.

"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 to be delivered by a range of NHS, independent and third sector providers of healthcare to meet the needs of the local population.

The services that we are responsible for include hospital treatment, rehabilitation services, urgent and emergency care, community health services and 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. We have outlined our 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 standards;
- 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; and
- Priorities for health and services identified by our clinicians, patients and the public.

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.

C. **Investment planning:** Development of investment proposals for new initiatives that will support the CCG's 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 the 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.

IN THIS SECTION

OVERVIEW OF PERFORMANCE – STATEMENT FROM THE ACCOUNTABLE OFFICER

As a CCG I'm confident that we've now established robust key performance indicators and measurement systems to see how well we're performing. Our regular assurance meetings with NHS England continue to show that the CCG is a well managed and well performing organisation and I'm pleased with the progress we've made to date.

We have again met our financial targets, meeting our original 2% surplus target. We also negotiated a further 1% surplus increase to carry forward into 2016-17 that allows us to invest in our extended access to primary care scheme for 2016-17.

The local healthcare system is doing well in meeting 18 week targets for elective treatments and the cancer standards are generally being achieved. Our extended access to primary care (GP) services scheme has helped create an additional 120,000 appointments for local patients. We've performed well in reducing the costs of prescribed treatments again bringing cost savings throughout the year.

Once again we've seen unprecedented demands on urgent and emergency care further impacted on by delayed discharges of care. Overall we've maintained good performance against national A&E waiting time targets however we're aware that challenges remain and our overall performance has fallen slightly below the 95% target.

We're working with our partners to reduce the risk of healthcare associated infections. However we've been unable to meet our target of eliminating these infections. In addition we've had a higher than expected number of never events reported to us.

Our performance against our key strategic objectives is on track and we continue to implement initiatives that reduce the impact that local health and care organisations have on the environment.

We've been leading the way locally on patient and public involvement particularly through our patient leader programme. We've also continued to establish strong relationships with community and voluntary sector partners to ensure we hear the views of those communities that can sometimes be marginalised or vulnerable. This means we've been able to identify and respond to gaps in services for those belonging to the most vulnerable groups, including the gypsy and traveller community or those with learning disabilities.

There are challenges around waiting times that we will need to focus on over the coming year as well as establishing new models of care. Overall I can report back that NHS Leeds West CCG is in a strong position to meet the key performance challenges we expect in 2016-17.

Philomena Corrigan
Chief Executive, NHS Leeds West CCG

> "I can report back that NHS Leeds West CCG is in a strong position to meet the key performance challenges"

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 third 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.

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 99% of our bills from trade suppliers being paid on time.

Non NHS trade invoices

	Number	Value (£)
Total Non NHS trade invoices paid in the year	2,418	46,758
Total Non NHS trade invoices paid within target	2,398	46,754
Percentage of Non NHS trade invoices paid within target time		99.17%
Percentage of Non NHS trade £value invoices paid within target		99.99%

NHS trade invoices

	Number	Value (£)
Total NHS trade invoices paid in the year	3,886	273,417
Total NHS trade invoices paid within target	3,819	273,279
Percentage of NHS trade invoices paid within target time		98.28%
Percentage of NHS trade £value invoices paid within target		99.95%

The CCG's running costs envelope is set by NHS England at around £22.50 per head of the population the CCG commissions 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 2015-16 was £8.3 million. Our total spend was £7.6 million, the balance of the resources having been transferred to commissioning budgets for patient care.

In its first three 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. By the end of the current one year planning cycle, the CCG is estimated to be 2% above its target allocation as at 31 March 2016. As a result of the CCG moving closer to its target allocation levels, for 2016-17, the CCG is to receive 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. 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. A number of pilot schemes were initiated during 2015-2016 which are currently being evaluated for patient impact and value for money.

The same funding envelopes will be in place again for 2016-17.

CCG ASSURANCE FRAMEWORK

CCGs were established on 1 April 2013 and are clinically-led organisations at the heart of the NHS system. The CCG authorisation process established CCGs as statutory bodies to commission local healthcare services. The assurance process ensures that CCGs are commissioning safe, high quality and cost effective services, to achieve the best possible outcomes for patients.

Under the Health and Social Care Act (2012), NHS England makes an annual assessment of CCGs each financial year. CCGs can be Fully Assured, Assured with Support or Not Assured. In 2014-15 NHS Leeds West CCG was Fully Assured by NHS England.

The CCG assurance framework for 2015-16 set out five components that reflected the key elements of well-led and effective clinical commissioning groups as follows:

1. Well led organisation;
2. Performance: delivery of commitments and improved outcomes;
3. Finance;
4. Planning; and
5. Delegated function (N/A for our CCG during the financial year).

At the time of writing we had not formally received our score for 2015-16. However we have had verbal confirmation from the NHS England Area Team that (subject to the national review process) the CCG can expect an overall rating of "Good" for the 2015-16 financial year, with some aspects of its performance achieving an "Excellent" rating.

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. These indicators cover a range of issues, such as the time a patient has to wait for hospital treatment or the number of operations cancelled. 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). We continue to monitor all the key standards and support partner organisations in hospitals, ambulance services, community health services, member practices and other healthcare providers to help them work towards achieving them.

At the time of publishing this report, our own performance reporting shows how we are performing against the commitments outlined in the NHS Constitution and this information has been shared with NHS England (West Yorkshire) as part of the assurance process for CCGs.

Some of the highlights for 2015-16 are detailed below.

- As part of the drive to eliminate waits for treatment, whether at hospital or with any other service, we aim to see that nobody waits over 18 weeks from initial referral to the time treatment starts. In 2015-16 the CCG ensured that it delivered the standards outlined by NHS England with regards to waiting times for elective treatment.
- Waits for urgent cancer care referrals continue to be achieved. The wait standards include those for urgent referrals where cancer is suspected, time to treatment where a diagnosis is made and the whole pathway from referral to actual treatment. 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.
- Numbers of healthcare associated infections continue to improve against previous years although we have not achieved the targets set. The CCG exceeded its target for the maximum number of MRSA infections for 2015-16. There were six MRSA cases in total that were allocated to the CCG against a threshold of zero. The CCG was set a tighter annual threshold than in previous years (90 cases in 2015-16 from the previous target of 97 cases in 2014-15) and this has been exceeded at the time of reporting.
- The performance figures around the waits for an ambulance have shown a dip over the last year especially during the winter months when demand for ambulance services was significantly higher than expected. Despite this almost 98% of Category A calls were responded to within 19 minutes against a target of 95%.

Improving our performance

It is clear that some performance challenges remain and we are fully committed to meeting these. We constantly monitor and review performance across all services, making necessary improvements that will ensure patients receive high quality care in a timely manner. There are a range of key priorities for sustained action that are outlined below.

Referral to treatment times (RTT)

NHS Leeds West CCG continues to meet the national standard for RTT and has achieved the target for 2015-2016. However the risk to ongoing delivery of this target has increased as a result of cancellations associated with winter pressures and the junior doctors' strike actions. In addition, there is ongoing uncertainty about how to improve emergency flows (deciding whether to admit or discharge patients) and the threat of further industrial action. Industrial action has led to cancelled outpatient appointments, and therefore longer waiting times before a decision to admit can be made. There has also been considerable growth in restorative dentistry waits, which are not commissioned by the CCGs but are reported against CCG performance within an 'other specialties' category. Key CCG commissioned specialties at risk in the foreseeable future include:

- General surgery
- Plastic surgery
- Trauma and orthopaedics (including spinal surgery)
- Urology
- ENT (this is a relatively new risk)

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.

Delivery of the RTT is significantly impacted by demand on outpatients and theatres/beds as a result of emergency admissions.
The ability of RTT will therefore depend on:

- a system wide approach to reducing demand on A&E;
- smoothing flows into and out of hospital; and
- securing out of hospital capacity that reduces bed occupancy associated with acute illness.

Emergency Care Standard

Leeds Teaching Hospitals NHS Trust failed to deliver the Emergency Care Standard (4 hour target) in the last six months of 2015-2016. The target has been difficult to achieve as a result of:

A. Difficulties with staffing
B. Increasing demand
C. Increasing acuity of patients

The Trust has worked with all Clinical Service Units to update internal delivery plans. Access to medical and nursing staff in critical care and emergency departments continues

to be a major challenge. The Trust is also dependent upon the support of partners to ensure that patients can be discharged in a timely manner to free up capacity and ensure smooth flows both from A&E and post admissions.

All partners across the city recognise that delivery of a sustainable emergency care service is dependent upon cross agency working. Learning from this winter has identified the need for closer operational coordination and as a result a new Operational Resilience Group (a subgroup of the Systems Resilience Group – SRG) is being established. The group will coordinate provider and commissioner activities with the aim of smoothing capacity and demand across the urgent and emergency care system. The group will be chaired by Sue Robins, NHS Leeds West CCG's Director of Commissioning and Strategy.

Yorkshire Ambulance Service NHS Trust (YAS)

Regional improvement plans have been agreed by NHS Wakefield CCG as lead contractor, the key elements are outlined below.

A regional governance and structure review by YAS of their services:

- Additional resources identified such using as other providers including St John's Ambulance Service and private providers
- Making efficient use of central resilience funding
- Workforce improvement plan, looking at the core workforce as well as new role development opportunities
- Performance improvement plan (PIP) - overseen by NHS Wakefield CCG, specifically looking at the core national targets
- Working with the fire service to trial service delivery using the wider emergency services

Local Leeds city improvement plans including:

- Meeting with key YAS colleagues with a focus on local development for Leeds
- Ensuring YAS get a better understanding of, and works to Leeds care pathways
- Setting up an urgent care practitioner scheme
- Involvement in citywide workforce meetings as part of a move towards integrated services and place based models of care
- Working on a falls service pilot during winter in 2015-2016 with Leeds Community Healthcare NHS Trust
- Ongoing discussions around commissioning intentions and future contract model

Improving access to psychological therapies (IAPT)

The service remains underperforming in both numbers accessing service and in recovery rates. The following actions are being undertaken to address performance issues.

- At the request of commissioners, NHS England's Intensive Support Team is in the final stages of a desktop review of the service and initial feedback was provided in January 2016. This highlighted the elements of the service that require attention, in particular increasing staff productivity, addressing high overhead rates and higher levels of patient acuity than the national average which impact on the likelihood of recovery.
- Work is already taking place to address each of the issues. There was nothing fundamentally that stood out that required significant change. The review stated that the CCG's financial allocation is sufficient to achieve mandated targets. NHS England's Intensive Support Team arranged a follow up workshop in February 2016 to support the service to review their current clinical pathway with a view to improving capacity/flow through the service and reducing waiting times for Step 3 one to one therapies.
- The range of marketing activities to increase awareness continues. This is having a positive impact with a 19% increase in referrals based on the most recently available figures at the time of writing.
- The service website has been updated and has allowed full assessments to be completed online since January. This has already started to have a positive impact with an average of 100 online assessments being completed each week.

"range of marketing activities to increase awareness continues"

RESEARCH STUDIES

The NHS Constitution contains pledges that the NHS is committed to achieve. Pledges go above and beyond legal rights. This means that pledges are not legally binding but 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.

To this end within the CCG area the following levels of research has occurred.

The research annual report highlights that the CCG is achieving all of the national research governance metrics in relation to research, and in fact they are being exceeded in NHS Leeds West CCG.

- To ensure that research is made available as quickly as possible, the CCG works towards the National Institute for Health Research (NIHR) local process target of 15 days to grant NHS permission for 80% of all valid applications. Currently the median number of days for NHS Leeds West CCG is 8 days for 100% of all applications to the CCG.
- In 2015-16 NHS Leeds West CCG had 50% of practices actively recruiting patients, this far exceeds the NIHR Clinical Research Network (CRN) primary care speciality specific target of 5% for the proportion of GP sites within an individual CCG being research capable. This has led to a recruitment of 332 patients into research trials.
- Within Leeds Community Healthcare NHS Trust, 382* patients have been recruited into research trials. This equates to 76%* of the NIHR CRN 2015-16 year-end target.
- Within Leeds and York Partnership NHS Foundation Trust, 775* patients have been recruited into research trials. This equates to 136%* of the NIHR CRN 2015-16 year-end target.
- Within Leeds Teaching Hospitals NHS Trust, 9,566* patients have been recruited into research trials. This equates to 75%* of the NIHR CRN year-end target.
- The CCG is currently supporting five studies that carry an excess treatment cost. This support extends to an additional study in the next financial year.

*Data cut NIHR CRN 28/02/2016

QUALITY AND SAFETY

The CCG continues to place quality at the core of all its functions and commissioning practices, and at the centre of all our discussions with providers. We do this through making our expectations clear to providers and closely monitoring key quality standards.

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

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

Organisations from which we commission care are required to meet essential standards of quality and safety as defined through Care Quality Commission (CQC) standards. As commissioners we set out quality requirements for our providers that are above the essential requirements defined by the CQC. We work closely with our acute, mental health and community services to ensure that they meet these requirements and standards and we monitor them throughout the year, providing challenge where standards are not as expected or required.

To drive our quality agenda we have refreshed our Quality Strategy which sets out the process and mechanisms by which we are assured of the quality of care that we commission in support of the above domains. We have agreed the strategy in conjunction with partner CCGs in Leeds and it is published on our website.

Our Assurance Committee, which meets on a bi-monthly basis, has established robust terms of reference and a standing agenda to ensure that all quality issues across the health economy in Leeds have the appropriate oversight. Quality updates are also provided for the Committee and subsequently the Governing Body, ensuring that at the highest level within the CCG quality receives the attention and scrutiny required to give assurance.

Key programmes undertaken in 2015-16.

- Continuing the work started in 2014-15 to work closely with Adult Social Care partners, Yorkshire Ambulance Service and urgent care, primary care, care homes, contracting teams and medicines management to look at quality within care home settings.
- Continuing the schedule of programmed visits with providers across the city to maintain an overview of the quality standards in all key provider organisations. We speak to patients, managers and staff as well as reviewing the care provided.
- Reviewing all serious incidents and never event investigations from providers to ensure that learning is identified and shared to prevent recurrence.
- Working collaboratively with partners to reduce the prevalence of pressure ulcers in Leeds.
- Involvement in an NHS England/Macmillan project to support CCGs in commissioning for a better patient experience.

Healthcare Associated Infections

We are continuing to work with provider and primary care colleagues to reduce the persistently high levels of Clostridium difficile (C. diff), both in the acute hospital and some areas of the community in Leeds. Much of this work focuses on strategies to reduce antibiotic demand from members of the public, and GP prescribing.

In our CCG area, Clostridium difficile (C. diff) cases have risen since 2014-15. We continue to work closely with partners in the medicines optimisation and Leeds Community Healthcare NHS Trust infection prevention teams to understand the reasons behind this. In addition to the increased burden of infection, the CCG was set a tighter annual threshold than in previous years (90 cases in 2015-16 down from a target of 97 cases in 2014-15) and this has been exceeded at the time of reporting.

Six cases of MRSA blood stream infection have been reported in NHS Leeds West CCG patients; one more than in 2014-15. Each case receives a multidisciplinary post infection review to determine factors which may have contributed to the infection and identify learning which will prevent recurrence.

Harm-free care: NHS Safety Thermometer

Our main providers are required to conduct a monthly audit of all patients for prevalence of the four most common types of harm:

- Falls
- Pressure ulcers
- Catheter-acquired urinary tract infections
- Venous thrombo-embolisms (the formation of blood clots in the vein)

In January 2016 Leeds Teaching Hospitals NHS Trust provided over 95% harm-free care which is an improvement on last year and above the national average. The CCG regularly monitors the Safety Thermometer results of Leeds Teaching Hospitals NHS Trust at the provider quality meeting.

Leeds and York Partnership NHS Foundation Trust are participating in the Mental Health Safety Thermometer. The tool audits harm more likely to occur in a mental health setting and includes incidents of self-harm, how safe patients feel, occurrences of violence and aggression, and whether restraint has been used.

Serious incidents

The CCG governance team receives notification of any serious incident that has occurred within a provider of NHS healthcare in Leeds. The team is responsible for risk assessing any immediate impact on the organisation and informing directors of what has happened. The provider organisation is then monitored in reporting, investigating and learning from the incident. In 2015-16 a total number of 278 serious incidents have been reported to the CCG involving patients from Leeds. 131 of these serious incidents were pressure ulcers category 3 and 4. The CCG serious incident review panel is tasked with reviewing submitted reports and action plans from the providers to gain assurance that the provider concerned has undertaken a robust investigation, identified the reasons for the incident occurring and put in place actions to prevent something similar from happening again.

Never Events

Certain types of serious incident are termed Never Events. These are incident types that, if the necessary safety systems are in place and operating effectively, are expected not to occur. Never Events are nationally defined and most apply primarily to acute hospital care.

These types of incident are subject to further detailed scrutiny from the CCG and work is ongoing to ensure learning from all investigations is introduced and embedded in practice. The following table describes the seven Never Events that have occurred within Leeds healthcare providers or involving Leeds patients during 2015-16:

Provider	Never Event Type
Nuffield Hospital	Wrong site surgery x1
Claremont Hospital Sheffield	Wrong site surgery x1
Leeds Teaching Hospitals NHS Trust	Wrong implant x1 Wrong site surgery x3 Retained foreign object x1

Patient experience

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.

Responding to concerns and complaints

We take complaints seriously as they are a genuine means of helping to improve services. They also help us to manage our performance and highlight any areas where closer monitoring may be needed. In 2015-16 we managed 39 formal complaints. 29 of these complaints related to provider services commissioned by the CCG and 10 related directly to the CCG. As well as providing a response to the individual complainants all lessons learned from complaints are reviewed with a view to making changes in practice, systems and processes to improve the future experience for everybody.

Principles for good complaint handling

We are aware of, and apply all six principles of remedy when handling all complaints as outlined in the CCG complaints policy. All complaints are dealt with on an individual basis as per the person's requirements, who are provided with advice on how to access local advocacy services for support. We liaise with our partner organisations to ensure that the appropriate information is obtained in a coordinated and timely manner. The CCG Chief Officer reviews and responds to all complaints received within the CCG ensuring that they are aware of any issues and can ensure that wider learning can be adopted to improve our services.

Patient Advice and Liaison Service

People's views have been gathered through our Patient Advice and Liaison Service (PALS). The service aims to answer queries, resolve any concerns people may have or signpost people to appropriate services, as well as providing 'on the spot' non-medical advice to patients. They have recorded compliments, comments and concerns in relation to

patients' experience of local healthcare services and these are used to improve local services. The main issues discussed were access to NHS services, waiting times for appointments and clinical care or treatment.

The quality team continue to work collaboratively across the city to share patient feedback and support the triangulation of key sources of patient experience data. This includes intelligence received from the PALS service, feedback from websites such as Patient Opinion and NHS Choices and complaints information.

To support us in using our patient feedback in an effective way, we are one of 10 CCGs working with NHS England and Macmillan on a project called 'Commissioning for a Better Patient Experience'. One result of this work will be the development of some consensus statements to promote discussion about how to achieve this. We also hope to work more closely with providers across the city to understand our individual responsibilities and develop some shared, citywide goals for how we seek, use and share patient experience.

Clinical effectiveness

We have close working relationships with healthcare providers to ensure quality commitments are open, transparent and being actioned. For example:

- Implementation of NICE guidance relevant to the organisation and having an action plan where delay occurs.
- Action required following Care Quality Commission inspections; we continue to have oversight of action plans in relation to the Leeds Teaching Hospitals NHS Trust (LTHT) inspection of 2014.
- Monitoring the quality of urgent care services provided by Yorkshire Ambulance Service NHS Trust; the Trust is the provider for ambulance services across the whole of Yorkshire and it is important that we are able to monitor quality for the population of Leeds alongside the population of Yorkshire. Although we are not the lead commissioner for the Yorkshire Ambulance Service we actively participate in the quality meetings hosted by the commissioning CCG.

CQC visits

Leeds Teaching Hospitals NHS Trust was rated as 'requires improvement' by the Care Quality Commission (CQC) in 2014 and a further visit will take place in May 2016. NHS Leeds West CCG has been supporting the Trust in working to improve areas highlighted by the inspection, and has oversight of the resulting action plan. We work positively and proactively with our providers with a 'high support, high challenge' approach and will engage with the CQC to ensure that a transparent inspection takes place.

REDUCING HEALTH INEQUAILTIES

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.

In our part of Leeds, fewer children with asthma, diabetes and epilepsy are admitted to hospital as an emergency. Compared with the country as a whole we do have a reasonable life expectancy in west Leeds. People in our area with long term conditions have a better quality of life and more people feel supported to manage their condition. Our GP practices know their registered patients really well and they develop and put in place individual projects which make a difference locally.

We know that if we are to make a real difference to the lives of people in our communities we have a number of health issues that we have to tackle. For instance:

- the average life expectancy of a person who lives in the most deprived areas of west Leeds is over six years fewer than it is for a person who lives in the most affluent area;
- in parts of west Leeds we have some of the highest smoking rates and alcohol related hospital admissions and see more people who are overweight than anywhere else in Leeds;
- we have communities with very particular needs such as offenders, gypsies and travellers and most of the university student population of Leeds – around 65,000 students;
- we have a higher than the average number of people aged under 75 dying from cancer, cardiovascular disease (heart) and respiratory (lung) disease;
- more people in our area are admitted to hospital as an emergency with alcoholic liver disease;
- the rates of healthcare acquired infections (MRSA and Clostridium Difficile) are higher than average;
- patients in our area say their experience of GP out of hours services has improved but there is still room for improvement;
- we have a higher than average rate of depression and suicide in some of our communities; and
- we have higher rates of emergency admission to hospital than in the previous years.

NHS Leeds West CCG has some populations who experience some of the worst health inequalities in the country, and we are committed to reducing the health of the poorest the fastest. Over the last year we have worked hard with our local populations and partners to address the wider determinants of health, healthy lifestyles and to increase access to NHS services for our more vulnerable and or deprived populations.

We have continued to invest in and to develop our 'patient empowerment project' which has now received over 900 referrals since the project first started in October 2014. This project links primary care to the voluntary and community sector and

provides a bridge between medical and social needs. The number of assessments represents people from areas of high disadvantage and the project supports people to identify their own goals and priorities including debt management, housing, work or education. We have also worked closely with Leeds City Council to extend this model into high rise buildings in the New Wortley area as a key deprived population.

We have worked closely with the Gypsy and Traveller population, identifying health needs and longer term solutions, as well as awareness raising sessions including cancer screening, and NHS Health Checks. We have developed a new outreach nurse post with residents, local third sector organisations and practices in the area to support the health of this population group, and are in the process of developing culturally appropriate training for practice staff.

We have supported a primary care 'TARGET' training session on domestic abuse, working with the citywide team, to raise awareness and skills in this important area of reducing health inequalities. We have also supported focused smoking cessation and awareness raising in our more deprived areas, a key cause and consequence of health inequalities, and have supported work on increasing the uptake of bowel cancer screening. We also believe that good mental health is key to reducing health inequalities and have worked to reduce the risk of suicide through innovative projects in the LS12/13 areas, such as courses for the population, and training for primary care staff.

"This project links primary care to the voluntary and community sector and provides a bridge between medical and social needs."

MEETING OUR STRATEGIC OBJECTIVES

We are committed to upholding and promoting the principles of the NHS Constitution as well as the founding principle of the NHS itself – healthcare free at the point of need. In addition to this we recognise our responsibilities to deliver the core objectives of the NHS Mandate and the NHS Operating Framework. We are also active partners on the Leeds Health and Wellbeing Board and have contributed to the development and delivery of joint strategic needs assessments (JSNAs). These JSNAs have then helped partners to develop the Leeds Joint Health and Wellbeing Strategy 2013-2015, which is currently being refreshed and will cover 2016-2021.

We recognise that as the CCG responsible for covering the population of west Leeds we have a number of objectives to meet. Some of these are citywide and we will continue to work with partners including NHS Leeds North CCG and NHS Leeds South and East CCG.

In 2015-16 our strategic objectives are to:

- tackle the biggest health challenges in west Leeds, reducing health inequalities;
- transform care and drive continuous improvement in quality and safety;
- use commissioning resources effectively; and
- work with members to meet their obligations as clinical commissioners at practice level and to have the best developed workforce we possibly can.

We have been working on our one year operational plan 2016-17 which at the time of writing was awaiting approval from NHS England. We are also developing a new strategy and a new set of strategic objectives for the CCG for 2016-17 onwards which reflects our ambition to develop place-based care systems.

We understand that our objectives are set against the challenging environment we operate in as we look to make significant savings locally to help the NHS in England close its anticipated budget gap of £30 billion by 2020. There are also the demands of meeting the needs of an ageing population, rising costs for treatment and drugs and the need to pool resources with Leeds City Council to further integrate health and social care.

As part of our local approach we have made significant investments in **enhancing access to primary care** in order to respond to developments such as seven day opening for GP practices. We believe we are one of only a few CCGs nationally who have made such an investment and it is testament to the relationships we have built with member practices that we have been able to achieve this. The initial investment was made for a 17 month period until 31 March 2016 and will be robustly evaluated to assess the impact of our approach with member practices and patients. We are currently working with our member practices to develop a future scheme for 2016-17 onwards which builds on the achievements to date and helps us to move towards place-based care systems.

Reducing health inequalities is a priority for us as we have a wide 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 of health.

We have also been supporting activity that helps people with long term conditions take greater control of their own health through **self-care**. In order to support improved consultations we have supported practices to implement the Year of Care (House of Care) approach to care planning for people with long term conditions. The approach is evidence based and is designed to change the relationship between patients and clinicians. This makes routine consultations between clinicians and people with long term conditions truly collaborative through care planning. Patients are supported to set their own goals and take control of their own care to support effective management of their long term condition. The sharing of clinical information prior to a care planning consultation, changes the relationship between the patient and health care professional. This means the patient is in the driving seat giving them the appropriate support and confidence to manage their condition.

We have also invested locally in a scheme to support the identification of **care coordinators** at practice level to support the proactive management of patients, through effective care and case management. These posts are GP practice based but link out into the community. The care coordinators work closely with the neighbourhood teams and primary and community services to ensure patients are supported in the community without the need for admission to hospital.

Improving urgent care services is a priority for all Leeds health and care partners, and an area of concern nationally. This is because it is recognised that there is a need to reduce pressure on A&E departments as well as other parts of the health economy, including primary care. There has been a commitment from NHS England to review the way urgent and emergency care services are delivered and this includes exploring the availability of seven day primary care services.

In response to high rates of **emergency admissions for alcoholic liver disease** in our area, the CCG has increased local capacity for specialist alcohol treatment services to address local need for services for dependent drinkers over the past three years, in partnership with our public health colleagues.

We have worked with Leeds University Union (LUU) over the last two years to commission an innovative alcohol harm awareness programme. This included developing an alcohol harm online resource aligned to national policy which is now accessible to all students at the University of Leeds and will be available to students at Leeds Trinity University and Leeds College of Music in the new academic year (2016). Findings from the 2015 LUU large student survey noted a reduction in self reported binge drinking from 82% (2012 survey) to 70.8% in 2015.

Prescribing medicines is the single biggest expenditure incurred by the NHS after staff costs. Therefore we have been actively looking at ways of helping patients make the best use of their medicines by undertaking medicine use reviews.

In response to **higher than expected suicide rates** among men in LS12 we are continuing our targeted work to address this. In 2013 we commissioned a mental health employment worker and mental health resilience workers to work with men at risk

of becoming unemployed. We also delivered suicide awareness training to staff working in practices in higher risk areas. In 2014 we commissioned a two year project to provide counsellor led 'positive communication groups' in the LS12 and 13 areas of Leeds. These groups deliver a holistic mental health support service and aim to improve the quality of life, health and wellbeing and reduce the risk of harm in vulnerable, isolated and socially excluded people. This work remains a priority for us.

Leeds is committed to being among the first **'dementia friendly'** cities in England and we have a citywide strategy in place, developed with support from clinicians, patients and carers, to help us achieve this. Significant developments have taken place this year to support this including the launch of the Leeds Dementia pathway; GP-hosted Memory Clinics; 13 Memory Support Workers have been employed and are working alongside GP practices to provide support to those who have been diagnosed with dementia.

Locally we have offered four "Dementia Friends" sessions to staff across NHS Leeds West CCG to improve knowledge and raise awareness of dementia. In addition we are members of the Leeds Institute of Quality Healthcare dementia work stream and are involved in a project which seeks to improve referrals to the memory service. This in turn will lead to an improvement in patients who receive a timely dementia diagnosis.

In 2015-16 we implemented our local **care homes** scheme which will run until July 2017. Based on evidence from The British Geriatric Society the scheme delivers regular proactive care to older people who live in residential and nursing homes through an integrated community multi-disciplinary team (MDT) approach. Residents will have better access to this MDT as part of this scheme. A core principle of the scheme is to promote patient experience with appropriate clinical outcomes with residents to be at the centre of decisions about their care. It is anticipated that there will be fewer emergency and unplanned hospital admissions from care homes as a result of the scheme.

The aim is to achieve this through developing integrated services with enhanced primary and nursing care coupled with dedicated input from geriatricians and community teams.

There is collaboration between clinical teams locally and better working relationships are developing. There is an aspiration for universality with care to be equitable and available to all people aligned to practices in west Leeds living in care homes receiving proactive care.

We worked on developing **improved cancer pathways** that has led to the reduction of patients presenting and being diagnosed late. This includes a change in the two week wait referral pathway so that GPs can refer any patients who they suspect have cancer. We are working on developing the Leeds Integrated Cancer Service. We have established a two week wait diagnostic service with Leeds Teaching Hospitals NHS Trust. We also worked with Leeds City Council who funded three local cancer screening awareness campaigns.

We want to work with partners to ensure that we develop dignified, respectful and responsive **end of life care** that supports patients and their loved ones. We have been

supporting the roll out of the electronic palliative care system and the consolidation of associated workstreams. We have collected feedback from bereaved families and friends across primary, community and secondary care to improve patient experience of end of life care.

Working with Carers Leeds we commissioned extra support for carers of people with dementia which has provided additional support and education for carers, increasing awareness of the needs of carers and streamlining access to carer support.

We are committed to using commissioning resources effectively and our medicines management team continue to help ensure our prescribing budget is used wisely.

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.

Atrial fibrillation (AF) is a contributing factor for 20% of strokes. We can reduce the risk of stroke by two thirds by giving oral anticoagulation (designed to reduce the risk of blood clots) medication for patients with AF as recommended by new National Institute for Health and Care Excellence (NICE) guidance. The AF work at the CCG aimed to reduce this treatment gap to reduce the incidence of stroke and resulting complications and avoidable deaths due to stroke.

Medicines optimisation pharmacists have supported practices with these clinical reviews and led training sessions on AF and the new novel oral anticoagulants (NOAC).

We've introduced clinical reviews by a consultant pharmacist to **improve medicines optimisation for older people and reduce medicines-related readmissions to hospital.** This ensures a more rapid medicines review for patients post-discharge from hospital. Electronic discharge letters and GP records are reviewed before visiting the patients either in their own homes or in their long-term care facility.

Now in its second phase, following further specialist training, our medicines optimisation pharmacists are now undertaking some of the clinical medication reviews. This should increase review numbers and timeliness. The consultant pharmacist continues to review patients with complex health needs.

From the 34 clinical medication reviews completed by the consultant pharmacist, 179 pharmacist contributions have been made, 86 medicines have been stopped, 11 medicines have been started, 36 dose changes have been made and 3 formulation changes have occurred. This equates to an average of 2.5 medicines stopped, 0.3 medicines started, 1.1 dose change and 5.3 contributions made per patient reviewed.

The National Patient Safety Agency (NPSA) guidance; Seven Steps to Patient Safety for Primary Care advises that **patient safety incident reporting** is fundamental to support learning from errors and highlight what is contributing to patient harm.

Across the whole city the objective of the work was to increase the number of medicines related patient safety incident reports that general practices submitted to the CCGs to above 1 per 100,000 head of patient population.

The CCGs jointly launched a programme of support for general practices. Working closely with GP practices, the medicines optimisation team played a key role in the success of the reporting of incidents on a system we use called DATIX. Our CCG achieved the highest level of DATIX reporting out of the three CCGs in Leeds and the success of this has been published in 'Commissioning Review'. The citywide medicines optimisation team also received a nomination for the Health Service Journal awards.

Prescribing harbours opportunities to improve cost effectiveness and safety. 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 already saved £609,000. Whilst cost savings have been impressive, it is the safety messages that are of the utmost importance and Optimise Rx has been used to learn from DATIX reports and share this learning.

"By using Optimise Rx we have already saved £609,000"

OUR PLANS FOR 2016-17

We have identified a number of key areas for action to help support the delivery of our operational plan, which at the time of writing was awaiting approval from NHS England.

Our plans are flexible enough to build in contingencies for any as yet unforeseen changes in national policy or guidance and are designed to link in with the citywide five year sustainability and transformation plan (STP) that is being developed jointly by the three Leeds CCGs.

At the time of writing we were working on a draft copy of the STP to be submitted to NHS England with the aim of having this approved in summer 2016. From 2016-2018 we will be focusing on the priorities identified below to help us achieve our vision.

New models of care

As a CCG we want to build on the recent achievements of general practices who are now working well together in localities, following CCG investment in enhanced access from 2014. We also need to respond to national policy around further integration and localisation of care and services and self-care and management over the next five years.

This work will be a significant part of how we will deliver the Joint Health and Wellbeing Strategy for Leeds.

Over the past six months local providers have come together to explore the development of a population health management approach and are keen to prototype this approach starting in Armley, our community of highest deprivation, but with an ambition to then implement in other areas.

The CCG will support the development of this new approach with local providers in the first instance through building relationships between front line staff in different organisations, and between local people and front line staff, mindful of our role being to 'create the conditions for change to occur'.

Improving quality of life for people with long term conditions

Over the next five years we will be looking at improving the quality of life of people with long term conditions. To do this we will continue to embed a care planning approach to deliver primary and community care. We will focus on delivery of new approaches to long term condition management through our place-based care systems work and working with our member practices to develop services closer to people's homes. We will continue to focus in particular on the cardio vascular disease (CVD) spectrum (core prevention and management of diabetes, atrial fibrillation and hypertension) as this is the most significant cause of Potential Years Life Lost (PYLL) in our area.

PEP (patient empowerment project)

In order to recognise the impact of the wider determinants of health on the health and wellbeing of our population, we have invested in a partnership collaboration of local third sector organisations to offer social prescribing for vulnerable patients. PEP is an innovative 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.

Alcohol related harm

Alcohol misuse is a key priority set out in the joint Health and Wellbeing Strategy for the city. Both the city and the area covered by NHS Leeds West CCG have high levels of emergency admissions when compared to national benchmarks of mortality and admissions as a result of alcoholic related liver disease. As a result of this and feedback from the public, our member practices have identified reduction in alcohol related harm as a key priority for NHS Leeds West CCG. We will look to build on the work we have already started in reducing the impact of alcohol related harm, in partnership with Leeds City Council. To support this activity we have invested £178,000 in local detox and support services for dependent drinkers since 2013 and have secured continued equivalent capacity going forward.

Childhood asthma and obesity

We have identified asthma as one of the greatest causes of unplanned activity for children and, following an engagement exercise in schools, we have recruited a clinical lead nurse for childhood asthma.

Evidence shows that improved inhaler technique is the key intervention to better manage childhood asthma and reduces the need for hospital admission. The aim is to work closely with schools and member practices to implement improved inhaler technique and National Institute for Health and Care Excellence (NICE) gold standards for asthma care, including every child having an asthma care plan.

In order to address the higher than average obesity rates in some of our primary school aged children we have commissioned a new programme. It is a schools-based intensive behaviour changing food programme that works with both children and their families in key target school clusters and will begin to be delivered in 2015-16. The investment is for two years and aims to be self-sustaining after the initial period. This service is currently being implemented with a wide range of partner organisations; education, public health, GP practices and caterers as part of the team.

Vulnerable groups

Working with Leeds GATE, Gypsy and Traveller advocacy organisation, we have developed a programme for an outreach nurse to support improved access to healthcare. The outreach nurse will work closely with primary care and the evaluation will inform the CCG's approach to working with our vulnerable communities.

INVOLVING OUR PATIENTS

Under the Health and Social Care Act we have a legal duty to engage and involve our local population in the planning and buying of healthcare services. We also believe it's the right thing to do.

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 leaders 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.

Engagement in Action: Working with the wider public to seek views on our strategy and commissioning plans.

We held a deliberative event in March 2016 that encouraged constructive discussion and feedback, with a representative cross-section of our population to develop our new strategy. We recruited 71 people who live or are registered with a GP in the CCG area, according to representative quotas (by gender, age group, working status and spread across all area postcodes) to attend this event. We now have a conclusive report which gives us a basis on which to develop robust plans for our new models of care to meet the challenges ahead.

This was part of our wider engagement with a range of stakeholders to develop our strategy, which also included an event for local elected members and a 'timeout' for our senior management team attended by four of our patient leaders.

Engagement in Action: Sharing information with patients, carers and the wider public so that they are aware of service changes and are able to make informed choices about their health.

As part of our efforts to raise awareness of the extended opening hours offered by our 37 member GP practices we launched a publicity campaign. As part of this we direct mailed an information booklet to 120,000 households in our CCG's area. In addition we did outdoor advertising, face to face activities and provided information resources to be displayed within our member GP practices.

We have supported a citywide campaign to encourage people to make the best use of local services available to them. This was done as part of a local and national drive to reduce unnecessary attendances at accident and emergency units. Linked to this is a campaign specifically targeting students that raises awareness of how pharmacies could help them with common health conditions.

We have also worked closely with public health colleagues at Leeds City Council to encourage people to take steps to improve

their lifestyles. This includes promoting the new One You campaign for people aged over 40; supporting efforts to encourage patients to take up invites for cancer screening and helping people make informed decisions about their drinking habits.

Engagement in Action: Asking people for their views about local services through surveys and events.

In September 2015 we completed the first stage of a project to improve access to primary care for people living with learning disabilities. We used an easy read survey to collect people's views and these surveys were posted to patients registered with a learning disability. 232 people contributed to the engagement and we are developing a local action plan to respond to the findings and will recruit a patient leader to work alongside us.

We have been working with Leeds Teaching Hospitals NHS Trust to get the views of patients who have used the endoscopy service. We want to understand more about the experiences of patients and their carers to help us identify any opportunities for improvements in the way services are provided.

Engagement in Action: Involving patient leaders in commissioning projects to provide assurance that our engagement is robust.

We recruit patient leaders to our commissioning project steering groups. Their role is to provide assurance that patients, carers and the wider public have been engaged in the service change and that their views are being used to develop the service. We have a patient leader on our 'enhanced care home' steering group. The project aims to improve the care that care home residents receive. There are similar projects being run in the other CCGs in Leeds.

The patient leader explained that there was lots of evidence that patients, carers and the public wanted healthcare commissioners to work better together. They identified gaps in partnership working for this project and asked the CCGs to demonstrate how they would work together to evaluate the programme and inform people about the changes in care homes.

In response to the comments the project group developed a citywide leaflet that could be used with any patient, regardless of which CCG they belonged to. Involving all three CCGs in Leeds gives much clearer messages to patients, carers and staff in care homes. The project also worked with the other CCGs to develop a citywide evaluation. This citywide approach will help us gather consistent feedback and will enable us identify best practice.

One of our patient leaders on the chronic pain steering group identified an issue with a new app we rolled out to support the revised chronic pain pathway. The patient felt that because the app was only available to people using Apple products (iPhone/iPad) that it would unfairly discriminate against those who use other devices. Since then we worked with the system providers to ensure the app is now available on a range of devices.

Engagement in Action: Feeding back to local people so that they can see how their experiences and feedback have helped to shape services

You said	We did
I work in the day and I can't get to patient training or peer support between 9-5.	We now run our patient training and peer support in the evening and on different days of the week, including the weekend. This makes it more accessible to people who are employed or have other commitments during traditional working hours.
Following a patient experience survey linked to our extended GP opening hours, a number of comments were made that people were not aware of the greater availability of appointments.	We undertook a promotional campaign that included mailing every household in our CCG area, outdoor advertising and producing information materials for our GP practices.
Some staff are not aware of the patient leader programme or how they can support patient leaders.	We have run two learning lunches for staff. They were attended by senior commissioners and patient leaders. We will continue to run these sessions throughout the year. We have also developed a short guide to patient leaders for our staff.
Why are you not running learning lunches for staff at other CCGs?	We have offered to attend the other CCGs to run the patient leader learning lunches for their staff.
Lots of patients don't have access to a smartphone so the chronic pain app to help people manage their health should be available on desktop/laptop computers too.	We worked with the developers of the app and it is now available on smartphones and computers.
It's difficult to read the hand-outs from the training sessions.	We now provide large scale hand-outs for people attending the session who have a visual impairment.
The 'Introduction to the NHS' training session has too much information squeezed in, it needs to be longer.	We restructured the training and now run it over six hours. This has given us more space to explore issues through group work and discussion.

Christmas card competition

In July 2015 we launched a children's Christmas card competition for local children aged 4-12 who lived or went to school in the west Leeds area. From over 300 entries, three designs were chosen and made into Christmas cards which were then sold on behalf of the Leeds Children's Hospital Appeal. Working with the Leeds west community and Leeds Teaching Hospitals NHS Trust staff a final total of £925 was raised.

Patient assurance group (PAG)

Over the last year the PAG made real progress. An away day in the summer gave the group an opportunity to take stock of their progress so far and identify areas for improvement and development. The away day also gave us the opportunity to improve our tools for assessing engagement plans as well as learning more about engaging 'easily ignored' groups and equality and diversity. The group continues to meet every month to assess engagement plans from commissioners. Over the next year we plan to recruit new members to the group.

Patient leaders programme

One of the six principles for new care models is recognising that volunteering and social action are key enablers. The patient leader volunteering programme demonstrates our commitment to these principles by providing assurance throughout the commissioning process that the patient voice has been heard, understood and acted on. The programme is also founded on principle two, that 'services are created in partnership with citizens and communities'.

The programme started in 2014 and in the last year it has developed significantly. We now have over 40 people signed up to the objective patient leader approach and we have developed new resources and guidance. The programme also now has an established training programme made up of five different sessions and a regular peer support group meeting. Staff from across the organisation are now involved in the programme and provide specialist input into our training sessions. One of the sessions explores equality and diversity and helps show how we are committed to the principle of narrowing inequalities.

Patient participation groups (PPGs)

Supporting the patient groups at our member practices is an essential part of our work to develop new care models in Leeds. Meaningful and effective PPGs will play an important role in driving change and ensuring that the patient voice is at the centre of our decision making. Over the last year we have visited the majority of our PPGs and offered support and guidance to their staff and members. PPGs also now have access to our patient leader resources such as the training and peer support. These activities help empower PPGs by giving members the skills, knowledge and confidence to meaningfully influence local change.

Engage quarterly magazine

We continue to produce Engage, our quarterly magazine giving local people a chance to find out more about the work we do. The magazine features consumer advice, lifestyle issues and interviews with well known local faces. We've also asked members of our local community to contribute articles for the publication including pupils from a local school who have, to date, reviewed a film and a book.

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. To do this the CCGs have representatives on Provider Management Groups.

Provider Management Groups oversee the delivery of internal provider cost improvement plans on behalf of the Leeds Health and Social Care Transformation Board, reviewing quality impact assessments as part of this process for:

- Leeds Teaching Hospitals NHS Trust;
- Leeds and York Partnership NHS Foundation Trust; and
- Leeds Community Healthcare NHS Trust.

The Leeds Health and Social Care Transformation Programme was formed in 2010 and is a citywide agreement between health and social care partners to work together to deliver the challenges ahead, including increasing quality, innovation, productivity and prevention (QIPP). The Transformation Board oversees the delivery of the programme and links in with the Leeds Integrated Health and Social Care Programme.

Discussions have been taking place about how the three CCGs can work together more collaboratively. To support this work a joint leadership group has been set up with key senior staff from each of the Leeds CCGs represented. The collective aim is to get the best value from commissioning and manage the common resources that are available to us.

The joint leadership group will consider what our commissioning priorities will be, and also what services we will no longer need to commission. Our joint, local commissioning strategy will need to align with the Leeds sustainability transformation plan (STP) which we need to submit to NHS England in June 2016. Work has already begun on the STP. The STP is designed to support health and care systems to deliver the NHS Five Year Forward View.

On an operational level the Leeds CCGs have been looking at key citywide healthcare services.

We've been working together to develop a revised mental health framework for Leeds. This has been developed to ensure 'parity of esteem' for mental health services in line with physical health services. This means that people experiencing mental ill-health can have access to services which enable them to maintain both their mental and physical wellbeing.

Work has continued on making Leeds a dementia friendly city. As part of this we've committed to employing memory support workers to help those with dementia. We've also worked with our partners so that we can make services dementia friendly. One of the examples of this is that Leeds Teaching Hospitals NHS Trust has signed up to John's Campaign. This means that people who have a family member in hospital with dementia can stay with them.

We've been working on a citywide approach to improving child and adolescent mental health services (CAMHS). This follows feedback from local people that our current level of support, although of a good standard, needed to be improved.

We've also continued to promote the Improving Access to Psychological Therapies (IAPT) service. IAPT offers support for those who are experiencing depression and anxiety disorders. IAPT is also referred to as talking therapies.

In Leeds a maternity strategy for the city has been developed to support mums and mums-to-be, as well as their loved ones, to enjoy access to the best possible care throughout pre and post-birth. This maternity strategy sets out our nine priorities for what we need to do to provide safe, high quality maternity care, which meets the needs of all families in the city. You can read the strategy here: www.leedswestccg.nhs.uk/about/publications/maternity-strategy-for-leeds-2015-2020/.

From 1 April 2016 the three CCGs in Leeds have become responsible for co-commissioning GP primary care services with NHS England. We've worked together to develop a shared approach to commissioning services that continue to allow access to GP primary care services, often many people's first route into NHS services.

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 is also 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 when it is appropriate to do so.

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 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 (2013-2015). The strategy is currently being revised and will be published in Spring 2016.

The current Leeds Joint Health and Wellbeing Strategy (JHWBS)'s vision is that Leeds will be:

- A healthy and caring city for all ages;
- Where people who are the poorest will improve their health the fastest. To do this, the strategy identified a range of priorities to be addressed by all health and care partners in the city, and during 2015-2016 we continued to work with our partners which included the local authority, through the Health and Wellbeing Board (HWB), and the Leeds Transformation Board. Our

joint plans aimed to address, contribute and deliver those priority areas of the JHWBS, in delivering accessible, integrated health and wellbeing services that are safe and effective for the population of Leeds. Plans included:

- Promoting the NHS Health Check, helping people to reduce and manage their risk of heart disease, stroke, kidney disease and diabetes;
- Providing a range of services that support people to adopt healthy lifestyles;
- Continuing to move towards increased integration of health and social care services;
- Increasing access to a range of community mental health services e.g. Improving Access to Psychological Therapies (IAPT);
- Developing screening services and working with primary care to encourage greater uptake to support early detection of cancer;
- Developing a range of partnerships with the third sector that support communities to improve their wellbeing e.g. services that reduce social isolation; provide opportunities for volunteering; act as a "gateway" to advice, information, and services; and promote health and wellbeing; and
- Securing capacity across a range of acute and community services that ensures that our population receives timely diagnosis and treatment, so that if people do get ill, that they have the best chance of recovery.

Building on many of the priorities of the last strategy, our CCG plans for 2016-2017 onwards have been developed with the Health and Wellbeing Board (HWB), with this in mind, and we will continue to support both the existing and emerging priorities outlined in the new strategy.

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 2016-2017 we have provided a full analysis of how our plans and priorities meet the HWB's vision for health and care in the city. While there is no formal requirement to consult on the production of the annual report, we can demonstrate that the content of our annual report has the support of the HWB.

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

- We're working to refresh the Joint Health and Wellbeing Strategy for Leeds which has reached the end of its two year cycle. As part of this work we've been engaging with patients, partners including the community and voluntary sector and frontline staff. The feedback will be used to develop the Joint Health and Wellbeing Strategy 2016-2021. You can see what people told us here: www.inspiringchangeleeds.org/gathering-your-views-leeds-health-and-wellbeing-strategy-2016-2021/.

- Tackling health inequalities is a key area of concern for all members of the Board. Unfortunately due to the current economic climate and an in year spending cut announcement by the Government we've had to consider how Leeds City Council can save £3 million pounds from the public health budget by March 2016. This was an unexpected announcement and one that affects other areas across the country. As well as considering in year spending cuts, the Board has also had to start making plans for savings to the public health budget for the coming years.
- We've signed up to the Every Disabled Child Matters Charter. An audit has been done to help us identify any gaps so that we can meet the key outcomes stated in the charter.
- Joined Up Leeds is a project that involved local people in a conversation about how the NHS in Leeds and Leeds City Council could share data. In 2014 people were asked about their views about data sharing, what concerns they had and who they feel should be able to share data and how this could be done safely. We've now followed this up with Joined Up Leeds 2 so that we can understand if views in the city have changed. This will help support future technology approaches in the city.
- Concerns had been raised that children's and young people's emotional and mental health services in the city were fragmented and unclear to both services users and care professionals. The Board has worked with commissioners from the NHS and Leeds City Council to develop a set of recommendations that have supported the revised approach to delivering these services.

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 2015-2016 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).

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 2016-17 we expect the first pilot to be established in the Armley area. To do this we've been working with a range of partners including Leeds City Council.

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 'Leeds smiles' campaign that has been designed to combat the increasing number of children who have tooth decay.

In addition, we've been supporting a number of alcohol awareness campaigns to encourage responsible drinking and we promoted the 'get comfortable' initiative that encouraged Leeds residents to be more open to talking about domestic violence.

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. We worked with Leeds Involving People to undertake surveys on a range of topics including how endoscopy services are provided at Leeds Teaching Hospitals NHS Trust. We attended a third sector event that looked at how the CCG could work with key community partners in the city as part of our engagement to develop a revised strategy. The main focus of the event was to consider how community organisations could support our efforts to set up 'place-based systems of care' which is part of the new models of care approach.

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 interviewsto capture the experiences of patients as part of our extended access to primary GP services scheme.

Healthwatch Leeds has 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:

- access to dental care for people with HIV;
- carers' experience of respite care in Leeds;
- children and young people's mental health services in Leeds; and
- a review of day services at Wheatfields Hospice.

Inspiring Change – Leeds Health and Social Care Transformation Programme

Inspiring Change is the name for the Leeds Health and Social Care Transformation Programme which aims to make Leeds the best city for health and wellbeing. Over the coming years Inspiring Change will help support partners in implementing changes to health and care in Leeds. The changes aim to make care better and fairer, while helping to address the financial challenges faced by all publicly funded health and care services and reflect the priorities of the Joint Leeds Health and Wellbeing Strategy.

In 2015-16 Inspiring Change has worked on the following:

- facilitatin discussions to develop a Leeds Health and Social Care Workforce Plan 2016-2021;
- supporting Joined Up Leeds 2 to find out more about the views of Leeds citizens about data sharing within public services;
- setting up a pilot project called 'discharge to assess' to see how we can get people home sooner after being admitted to hospital;
- developing a citywide approach to diabetes prevention and care;
- helping to encourage people to get involved in shaping the revised Leeds Health and Wellbeing Strategy; and
- promoting the work of the newly established Leeds Health and Care Partnership Executive Group.

Leeds Health and Care Partnership Executive Group

The partnership group is made up of the chief executives and accountable officers from each of the key organisations in Leeds that are going to try and make the changes we need in the health and care system in the city. Like everywhere in the country we face some big issues – things like our ageing and growing population and more people living longer with complex needs and long-term conditions. This creates a changing set of challenges in the system to make sure we can give everyone the personalised, individual care they want in a way that feels like it comes from one joined-up service, rather than lots of different organisations. It's about how we can remove the boundaries to make that happen and this is where the partnership group will help. The group is relatively new so updates on its progress will be provided in our CCG's annual report for 2016-17.

Care Quality Commission

The Care Quality Commission 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.

The CQC has started inspecting our 37 member GP practices, however, at the date of writing, we've not had any reports published. We will work with our member practices to support them with any recommendations for improvement should any have been identified by the inspectors.

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 Chief Executive has overall responsibility for Safeguarding. The Director of Nursing and Quality is the executive lead for safeguarding. The revised Working Together to Safeguard Children (HM Government 2015) was published in 2015. The citywide Leeds CCG safeguarding team reviewed the document and considered and actioned the implications for the Leeds CCGs.

The Assurance and Accountability Framework (NHS England 2015) was reviewed and published in July 2015. As a consequence the safeguarding team had additional investment in early 2016 to ensure it has the capacity and resources to contribute and engage with statutory guidance, and to ensure compliance with the additional safeguarding responsibilities for CCGs through fully delegated co-commissioning for primary care.

The team has a head of safeguarding/senior designated nurse for safeguarding children and adults at risk who provides strategic leadership for safeguarding and advice across the health agencies. This role is supported by a deputy head/designated nurse for safeguarding children and adults at risk, a deputy designated nurse for safeguarding children and adults at risk/Mental Capacity Act, Deprivation of Liberty Safeguard lead and a named GP for safeguarding children who provides leadership and support within primary care. The team is currently recruiting two named nurses for safeguarding children and adults at risk. This model fully integrates and reflects the 'Think Family, Work Family' approach adopted by Leeds.

The CCG Safeguarding Children and Adults at Risk Committee meets bi-monthly, and membership includes commissioners, 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.

Summary of achievements in 2015-16 and emerging themes

Overall, 2015-16 has seen an expansion of the safeguarding agenda nationally, regionally and locally. The safeguarding agenda now has additional responsibilities including: human trafficking, modern slavery, forced marriage, domestic violence, female genital mutilation (FGM), Deprivation of Liberty Safeguard (DoLS) in the community, Prevent (the Government's programme to combat extremism) and the designated adult safeguarding manager (DASM) role. The safeguarding team are making good progress in responding to the additional demands of the safeguarding agenda. Under delegated arrangements of primary care co-commissioning, CCGs will be responsible for ensuring that the GP services commissioned have effective safeguarding arrangements and are compliant with the Mental Capacity Act (MCA). NHS England will require assurance that such arrangements are in place before CCGs take on responsibility. The overall effectiveness of CCGs in discharging their safeguarding and MCA duties will also be monitored as part of the CCG assurance process.

In summary, the key achievements and emerging themes for 2015-16 and the key challenges for 2016-17 are highlighted below.

Achievements

- Revised training strategy and training programme to reflect the amended Working Together to Safeguard Children (HM Government 2015) and Safeguarding Children and Young People: roles and competences for health care staff (Royal College of Paediatrics and Child Health 2014).
- Restructure of the safeguarding team to ensure we can meet our statutory obligations.
- Improved engagement with young people through the Children's Commissioner's Takeover Day. We've also worked with a range of partners including the Cupboard Project who helped us develop Mindmate a dedicated web resource to support emotional health and wellbeing.
- More robust monitoring of the safeguarding standards and key performance indicators by attending our providers' quality and performance meetings.
- The appointment of a Named Nurse for Safeguarding Children and Adults to the citywide Leeds CCGs' Safeguarding Team.
- We have been involved in ensuring health representation within the Children's Social Care Duty and Advice Team, the Front Door Safeguarding Hub, and the Safe Project – a multi-agency team tackling child sexual exploitation.
- Further investment in implementing the key principles of the Mental Capacity Act across health services.
- We have dealt with a significant rise in Deprivation of Liberty Safeguard applications following a landmark judgement by the Supreme Court known as the 'Cheshire West' case.
- Working with the Leeds Safeguarding Adults Board to implement the Care Act and Making Safeguarding Personal, an outcomes based approach to safeguarding across the health system.
- A large increase in the numbers of health staff accessing Prevent training, and subsequent awareness of factors influencing those who are a risk of being radicalised into terrorism.
- Full involvement from CCG and health providers in the domestic homicide review (DHR) process and lessons learned being implemented.
- Raising the profile of Safeguarding, Mental Capacity Act, Deprivation of Liberty Safeguards, Prevent and domestic abuse in primary care.
- There is a strong commitment to improving GP engagement with the child protection process.
- Robust systems are in place for the cascading of lessons learned from Serious Case Reviews and Learning Lessons reviews.

Emerging themes

- Strong multi-agency partnership working including internal and external partners at both operational and strategic level.
- Commitment to single and multi-agency training and development.
- Commitment to the work of the Leeds Safeguarding Children's Board and Leeds Safeguarding Adults Board sub-groups.
- Increased support for the domestic violence agenda including the Front Door Safeguarding Hub and the domestic homicide review (DHR) process.
- Commitment to manage and support the expanding field of safeguarding including Prevent, human trafficking, child sexual exploitation, forced marriage and female genital mutilation.
- Commitment to improving access to emotional and mental health support and services for children and young people in Leeds.
- Commitment to the development of the enhanced health offer to care leavers.
- Commitment to providing support to the Lead GPs for Safeguarding Children through GP peer support group meetings.
- The designated nurses continue to provide supervision to named nurses across the health economy. The named GP offers supervision for GPs as requested. The designated doctors provide supervision for the named doctors within provider agencies and the named GP.
- A strong commitment to improving GP engagement with the child protection process.

Challenges for 2016-17

- To continue to promote and support engagement with the child protection process among GPs.
- To continue to support the domestic violence agenda, including supporting the domestic homicide review (DHR) process while addressing the challenges around capacity and resources.
- To continue to support and manage the expanding field of safeguarding including the Prevent agenda, human trafficking, child sexual exploitation, forced marriage, modern slavery, domestic violence and female genital mutilation (FGM).
- To continue to support the local authority and health providers to ensure that all Deprivation of Liberty Safeguard applications are made and authorised within legal timeframes.
- Make applications to the Court of Protection for deprivation of liberty authorisations for those who receive care in their own homes and are funded through continuing healthcare.
- To continue to support health's contribution to the multi-agency 'Front Door' arrangements, including the Front Door Safeguarding Hub and the Safe Project – multi-agency child sexual exploitation team and consider identified challenges of the interface between the 'Front Door' and primary care.
- To continue to improve engagement with children, young people and adults at risk.
- To continue to meet the challenges of increased number of training sessions required to meet the needs of primary care.

- To continue to support and embed the 'Early Help' approach and the 'Think Family, Work Family' guidance across the health economy.
- To promote the Student Leeds Safeguarding Children's Board poster to raise awareness on how children and young people can make a complaint about health and care services.
- Implementing a system for flagging domestic abuse in GP records.
- Supporting the development and restructuring of the Leeds Safeguarding Adults Board.
- Working with NHS England to support GP practices to comply with all aspects of the primary care safeguarding assurance framework.
- Implementing the Safeguarding Adults: Roles and Competences for Health Care Staff - Intercollegiate Document (NHS England 2016).
- Ensuring safeguarding arrangements are robust as part of the co-commissioning of GP primary care services, particularly as we move towards fully delegated arrangements.

"We are committed to eliminating unlawful discrimination and promoting equality"

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

We welcome the requirements of the Equality Act 2010 and recognise the many different characteristics that make up our diverse communities, both citywide and in our CCG's geographical area. We are committed to eliminating unlawful discrimination and promoting equality of opportunity in respect of the way we commission healthcare services and in relation to 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.

One of the ways we aim to achieve this is through proactive engagement and consultation with service users and carers, and engaging with local communities and stakeholders to understand their needs and how best to commission the most appropriate services to meet those needs. In addition we consider the needs of all staff who work within our organisation.

NHS Equality Delivery System

The Equality Delivery System (EDS) is a framework that helps NHS organisations to improve the services they commission or provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS. It is based on four goals, with 18 specific outcomes.

As part of the EDS process, NHS organisations engage with their patients, local voluntary organisations and their staff in order to grade their equality performance, identify where improvements can be made and act on their findings.

We have recognised that the EDS process in Leeds was established four years ago, and so working in partnership with the third sector, a review of the EDS assessment process started in 2015. Whilst still valuing the views and interaction with all members of the current assessment panel, the review has identified a number of areas for improvement in the way each organisation's performance against the four goals is assessed and how they are challenged about performance. Gaps have also been identified in relation to how the EDS process links strategically across the city to inform work to address health inequalities; for example through the Leeds Health and Wellbeing Board. Work is currently ongoing to develop a process with a particular focus on meaningful engagement with communities, including feedback on progress.

For our 2015 EDS engagement event, we recruited members of our Patient Assurance Group, Leeds Involving People and Healthwatch Leeds to help us with our assessment of evidence and grades for the EDS. We have, once again, improved our grades and during 2016-17 we will be working towards continually improving our performance and outcomes in relation to equality.

Equality objectives

In 2011, NHS organisations in Leeds worked to consider and develop evidence of the health inequalities affecting people from the Equality Act "protected groups". Using the evidence gathered through engagement with local interests, staff engagement events, in addition to the NHS Equality Delivery System evidence and grades, four citywide equality objectives were developed.

We agreed to sign up to the citywide NHS equality objectives and priorities and 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 ongoing involvement and engagement of protected groups and "local interests" including patients, carers, staff, third sector and local authority.
- To improve access to NHS services for protected groups.

Each year we provide a performance update on our progress in relation to the equality objectives and identify priorities for the following year.

We will be working with all NHS organisations in Leeds to review and revise the citywide NHS equality objectives and develop new objectives for 2016-2020.

Further information 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 and local workforce data comparing the experience of black and minority ethnic (BME) and white staff. Our first WRES report was published in July 2015.

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 Public Sector Equality Duty. As well as regular monitoring of performance, patient experience and service access we will work with them to consider their progress on their equality objectives, the NHS Equality Delivery System (EDS) and the NHS Workforce Race Equality Standard (WRES). 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 with the Public Sector Equality Duty, their performance in relation to the NHS EDS and the WRES within their contracts and we have developed and agreed systems to monitor their equality performance.

When procuring new services, we ensure that service specifications include the need 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.

Examples of work during 2015-16:

- We continue to be members of the Leeds NHS Equality Leads Forum, working with NHS organisations in Leeds to improve health inequalities for our communities in relation to the commissioning and provision of healthcare and 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, working collectively and collaboratively to ensure a fair and inclusive society for people in Leeds. The network works collectively to identify and address inequalities that exist in Leeds. The network's focus for 2015 and throughout 2016 is new and emerging communities in Leeds.
- Working in partnership with all NHS organisations in Leeds, Voluntary Action Leeds, Leeds Involving People and Healthwatch Leeds we have started a review of the Leeds NHS Equality Advisory Panel. This will inform a subsequent development of a revised structure for engagement and assessment for the Equality Delivery System.
- Having recruited equality and diversity champions from all Leeds CCGs, equality and diversity steering group meetings have been held throughout the year. This offers members a chance to share their current knowledge of the equality agenda, discuss ideas for sharing good practice, and consider future development opportunities and potential challenges within each CCG.
- We produced and published our first NHS Workforce Race Equality Standard Report.
- An equality and diversity briefing session was delivered to members of our Patient Assurance Group (PAG) and patient leaders who attended our away day in November 2015. The briefing session included an overview of equality and diversity in relation to commissioning healthcare and the role of PAG members and patient leaders, the NHS Equality Delivery System, and the Accessible Information Standard, recently introduced by NHS England.
- A training session "Equality and Diversity: Engaging with our diverse communities" has been developed as part of our patient leader training programme, which will continue to run throughout 2016-17.
- We were an active member of the International Day of Older People steering group preparing for the International Day of Older Persons events for 2015. Following the assessment of the small grant submissions there were 21 successful organisations. The theme for 2015 was Health and Wellbeing. Community events, which were a great success, were held between 1 and 10 October 2015.
- We continue to be an active member of the Adult Social Care black and minority ethnic (BME) sub group in the preparation for a conference, held in April 2016. The title of the conference is "BME - Our Health-Our Conversations". The agreed themes for the conference include: dementia, end of life, and men's health.
- Working with our primary care transformation team we continue to provide assistance and support to GP practices to ensure they are ready to implement the Accessible Information Standard which comes into force in July 2016.
- Briefing sessions were delivered during 2015-16, providing an opportunity for colleagues to understand why equality and diversity is important in relation to our commissioning responsibilities, the requirements we have in relation to equality legislation and to discuss the equality impact assessment process.

SUSTAINABLE DEVELOPMENT

All three Leeds CCGs have been addressing the environmental impact of our activities since our inception in 2013. This is the first time NHS Leeds South and East CCG, NHS Leeds North CCG and NHS Leeds West CCG have come together to agree a shared Sustainable Development Management Plan (SDMP).

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 2015-16 we worked in partnership with the two other Leeds CCGs and with Leeds City Council for a more joined up approach. Our focus has been on areas with potential for significant environmental and social improvements.

This has included continuing to work with the Health and Social Value Programme and to continue the cross sector partnership beyond the support time the national programme offers.

Through this programme we have established a range of initiatives that ensure that we:

- develop a common approach to commissioning for Social Value;
- engage and empower communities to be more involved in local services;
- develop and evaluate models for co-production; and
- develop a Leeds charter for employment.

As a result the city of Leeds has now developed a Social Value Charter which has been signed up to by all partners in city.

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 already very close to reaching our 28% CO2 reduction target; however we must ensure that sustainable activity is continued over

the next four years in order to maintain this reduction. This will be achieved through the ongoing implementation of activities within our Sustainable Development Management Plan (SDMP).

Our SDMP underpins how we will continue to increase the sustainability of our organisation and for the first time this document has been produced in partnership with NHS Leeds North and NHS Leeds South and East CCGs. This joint approach will increase efficiency and knowledge sharing, whilst reducing any duplication.

Our Carbon Footprint

NHS Leeds West CCG		Consumption				CO_2 Emissions			
Item	Unit	2013-14	2014-15	2015-16	% Change (2013-14 to 2015-16)	2013-14	2014-15	2015-16	% Change (2013-14 to 2015-16)
Electricity use	KWh	61,093	52,220	46,400	-24.05%	34.21	32.34	23.03	-32.68%
Gas use	KWh	63,354	57,732	51,667	-18.43%	13.44	12.11	10.57	-21.35%
Water use	m^3	N/A	N/A	359	N/A	N/A	N/A	0.38	N/A
Travel by car	Miles	7,242	9,645	8,252	13.95%	2.68	3.54	2.53	-5.60%
Travel by rail	Miles	1,473	Data unavailable		N/A	0.14	Data unavailable		N/A
General waste	Tonnes	13	13	5	-61.54%	2.93	2.93	2.32	-20.82%
Recyclable waste	Tonnes	3	3	1	-66.67%	0.06	0.06	0.02	-66.67%
					Total CO2 Emmissions:	53.46	50.98	38.85	-27.32%
					Total CO2 Emmissions:	N/A	-2.48	-12.13	-14.61

Looking ahead

Our 2016-17 SDMP marks a significant step forward, allowing us to build upon the progress we have already made together, increase the efficiencies within our sustainable activity and reduce duplication across the partnership.

In 2016-17 we will undertake in-depth analysis to establish where our own organisations and our providers can make the greatest and most cost effective CO2 savings. Implementing recommended carbon reduction measures will increase energy security, improve the health of the population and make the organisations involved fit for the future as it will reduce our overall use of resources.

We will continue to work together as a partnership, to reduce negative health impacts of travel and transport emissions, while realising cost, CO2 and time efficiencies. We will integrate Social Value into decision making to create wider community benefits and investigate how the sustainability of care pathways could be improved.

Our objectives for 2016-17 are to:

- recognise and deliver the connection between financial, social and environmental sustainability;
- reduce negative health impacts of travel and transport emissions, while realising cost, CO2 and time efficiencies;
- integrate social value into decision making to create wider community benefits;
- understand how the sustainability of care pathways could be improved;
- engage staff and key stakeholders in our sustainability journey and encourage them to take more responsibility for their own impacts; and
- identify improvement areas and continue to set and achieve our targets and goals.

We will continue to work in partnership with the two other Leeds CCGs and will extend this partnership with Leeds City Council for a more joined up approach. This year has been about testing the water, seeing what works and what doesn't and developing tools and activity that will maximise sustainable development. 2016-17 will be about implementation on a wider scale, and focussing on areas with potential for significant environmental and social improvements.

"2016-17 will be about implementation on a wider scale, and focussing on areas with potential for significant environmental and social improvements."

REQUESTS FOR INFORMATION

The Freedom of Information Act enshrines the public's right to know. It also obliges each public body to respond to a Freedom of Information (FOI) request within 20 working days. Year on year, the use of Freedom of Information amongst the media, companies, charities, students and private individuals has continued to grow.

In 2015-16 a total of 222 FOI requests were submitted to NHS Leeds West CCG. This is an increase of 14 on 2014-15. Of the 222 requests, five were withdrawn and therefore were not completed; as a result these are not counted as part of our annual reporting of FOI requests. No requests breached the 20 days response timescale, which is one fewer than in 2014-15.

Actual YTD Position: Totals Received FOIs	Number Received	Sent within 20 day deadline	Late	% on time	% missed deadlines
April	13	13	0	100%	0.0%
May	12	12	0	100%	0.0%
June	19	19	0	100%	0.0%
July	32	32	0	100%	0.0%
August	21	20	0	100%	0.0%
September	14	14	0	100%	0.0%
October	18	16	0	100%	0.0%
November	16	16	0	100%	0.0%
December	16	15	0	100%	0.0%
January	22	22	0	100%	0.0%
February	22	22	0	100%	0.0%
March	17	16	0	100%	0.0%
Total	**222**	**217**	**0**	100%	0.0%

DATA LOSS

In the last financial year there have been no serious incidents relating to a data loss by the CCG or unlawful disclosure of sensitive personal information. We are fully committed to ensuring there are ongoing improvements in Information Governance (IG) and work programmes were established for 2015-16 to maintain and improve existing IG processes and procedures.

Our self-assessment for 2015-16 against the revised national IG toolkit (which is audited by our Internal Auditors) shows that the CCG has made good progress against its plan. This is a continuing journey for the CCG as IG awareness continues to be raised through a combination of ongoing training, regular bulletins and timely alerts.

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

18 May 2016

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	Branch1 Shenstone House Surgery, El-land Road, Churwell, Leeds, LS27 7PX
Windsor House Surgery	South	Branch2 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 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.

Members of the Governing Body are as follows:

- Clinical Chair – Dr Gordon Sinclair;
- Chief Executive – Philomena Corrigan;
- Chief Finance Officer – Visseh Pejhan-Sykes;
- Medical Director – Dr Simon Stockill;
- Director of Commissioning, Strategy and Performance – Susan Robins;
- Director of Nursing and Quality – Diane Hampshire (from 1 April 2015 to 26 August 2015), Jo Harding (from 17 August 2015);
- A secondary care specialist doctor – Dr Peter Belfield;
- Four locality representatives of member practices – Dr Andrew Sixsmith (term ended 31 March 2016), Dr Philip Dyer (term ended 31 March 2016), Dr Simon Hulme, Dr Mark Liu; and
- Three lay members - (one to lead on governance matters; one to lead on patient and public participation matters; one to lead on assurance matters) – Christopher Schofield, Angela Pullen, Dr Stephen Ledger.

In addition to the membership, Governing Body meetings include in an attendee capacity:

- Public Health representative of the Director of Public Health in Leeds – Dr Fiona Day (became a voting member of the Governing Body from 23 November 2015)

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 and consists of one other lay member 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 and external audit.

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

Our Audit Committee members are:

- Lay member, Governance - Christopher Schofield (Chair);
- Secondary Care Consultant - Dr Peter Belfield (Deputy Chair); and
- GP representative - Dr Mark Liu.

Details of the membership of all Governing Body Committees are included in the Annual Governance Statement.

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 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 auditors for the purposes of their audit report, and of which auditors are 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 has led on transformation, performance and improving quality of care for three years. She was appointed Chief Executive 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 is a GP in Leeds (until 31 March 2016). He grew up in Yorkshire before studying medicine at St Mary's Hospital Medical School, London. After qualifying as a GP and before moving back up north, he worked as a lecturer in general practice at Imperial College London and served on the Board of Westminster Primary Care Trust. He has a post-graduate degree in public health from the University of York and has co-authored an award winning book on medical careers. His main clinical interests include emergency care, sexual health, and children and young peoples' medicine.

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 17 years community services and primary care management experience in the Bradford and Airedale area. She was the Deputy Director of Nursing at South Leeds Primary Care Trust (PCT) and was also 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 is using all her varied clinical and management experience to develop first class commissioning for the population.

Joanne Harding, Director of Nursing and Quality (from 17 August 2015)

Jo qualified as a registered nurse in 1992 and subsequently as a registered health visitor practicing 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.

Diane Hampshire, Director of Nursing and Quality (from 1 April 15 to 26 August 2015)

Diane qualified as a nurse at Dewsbury Hospital in 1981, working in the acute sector of the NHS before qualifying as a midwife and later a health visitor. She managed a community nursing team for a number of years whilst completing a

Master of Arts Degree in Child Welfare and Law. Diane worked in the NHS in Leeds from 2004 in a senior role in safeguarding children. In 2010, Diane added safeguarding adults to her portfolio.

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 believes that he has much to add to the commissioning landscape in Leeds and is an active Governing Body member.

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 and Bradford 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.

Chris is married with three daughters and lives in Guiseley. His interests outside of 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 five 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 Andrew Sixsmith
(term ended 31 March 2016)

Andrew Sixsmith was raised in Leeds. He worked in commercial print for several years before deciding to convert to a career in medicine. He graduated from Leeds University School of Medicine in 1994. He is now a General Practitioner in New Wortley working at a five partner practice. He is a GP Trainer and has been a Training Programme Director at the Leeds GP Specialist Training Scheme. His interests include medical education and law. He is a medical referee to Leeds crematoria and does GP expert work for the coroner's courts. He was appointed a board member of H3Plus Practice Based Commissioning Group in 2009. He is also the current education lead at NHS Leeds West Clinical Commissioning Group.

Dr Philip Dyer
(term ended 31 March 2016)

Dr Philip Dyer qualified as a doctor in 1983 in Bristol and after junior hospital posts in the south west moved back to Leeds, where he was educated, to complete his GP training. He has worked as a GP in Leeds for the last 24 years, for most of that time in Woodhouse and Headingley, as a partner in Craven Road Medical Practice. He is also a partner at Fieldhead Surgery in Horsforth. He is a member of NHS Leeds West Clinical Commissioning Group board on behalf of the GPs in the northern locality of the CCG. He has been involved with NHS Leeds West CCG and its predecessor incarnations since the inception of clinical commissioning.

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

Dr Fiona Day, Consultant in Public Health Medicine / Associate Medical Director

Dr Fiona Day is the CCG's Associate Medical Director two days a week and she is also employed as a Consultant in Public Health Medicine at Leeds City Council the remaining time, Fiona provides 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. She has particular interests in improving outcomes in vulnerable populations, and in commissioning high quality services which meet patient needs and are of high value.

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 61% response rate which is lower than last year's 78% response rate. One of the main reasons behind the low response rate is that the CCG was given less time in which to complete the survey, due to the availability of resources from the service provider. Last year the CCG had an extension of three weeks in addition to the normal lead time of three weeks in which to return the survey. Further work will be considered by the Workforce and Diversity Management Group to understand how we improve the response rate in 2016-17 by engaging with our staff.

Training

We achieved an average of 95% compliance for statutory and mandatory training for directly employed staff against a target of 100%. This position shows no change from the previous year. In addition, employees and governing body members have access to a full suite of IT training modules and other soft skills modules through an internal training system.

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 reflecting 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 2015 we lost a total of 324 days to sickness absence. With total staff years available of 83, this gives the average number of working days lost as 3.9 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.

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.

Gender equality

The table on page 72 provides a breakdown of our staff and governing body by gender.

Disability equality

Breakdown of staff by disability status, age and pay band (figures exclude directly employed Governing Body members and bank staff) is on page 72.

Gender Breakdown

	Female	Male
Directly employed Governing Body	1	8
Staff (numbers) employed by the CCG as at 31 March 2016 (inc. Very Senior Managers)	65	17

Disability status of staff

	FTE	Headcount	%
No	67.1	74	90%
Not Declared	3.9	5	6%
Yes	3.0	3	4%

Staff age breakdown

	FTE	Headcount	%
20 - 24	1.0	2	2%
25 - 34	17.1	17	21%
35 - 44	17.3	20	25%
45 - 54	17.0	23	28%
55 - 64	16.5	19	23%
65 - 74	1.0	1	1%

Staff numbers by agenda for change pay band

	FTE	Headcount
Band 3	4.5	5
Band 4	6.0	6
Band 5	13.4	15
Band 6	2.1	3
Band 7	13.1	14
Band 8A	18.5	20
Band 8B	5.9	6
Band 8C	4.7	5
Band 8D	1.6	2
Very Senior Managers (VSM)	4.9	6
Total:	74.7	82

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 80.

No external persons or bodies were 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 2015, an annual non-consolidated uplift of 1% was agreed in line with Agenda for Change staff.

For 2016-17:

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

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
Diane Hampshire*	26/11/12 (resigned on 26/08/15)	Permanent	N/A
Susan Robins	27/01/14	Permanent	3 months
Visseh Pejhan–Sykes*	18/01/13	Permanent	3 months
Dr Bryan Power*	01/04/13 (resigned on 30/06/14)	Permanent	N/A
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)	3 years	3 months
Christopher Schofield	01/08/13 (start of tenure 01/08/12)	3 years	3 months
Dr Stephen Ledger	01/03/14 (resigned on 30/09/14) – as locality representative of member practices	3 years	3 months
	20/10/14 - as Lay Member – Assurance	3 years	3 months
Dr Peter Belfield	01/04/13	3 years	3 months
Dr Philip Dyer	01/04/13 (term ended 31/03/16)	3 years	3 months
Dr Simon Hulme	03/11/14	3 years	3 months
Dr Mark Liu	03/11/14	3 years	3 months
Dr David Murray	01/04/13 (resigned on 11/09/14)	3 years	N/A
Dr Andrew Sixsmith	01/04/13 (term ended 31/03/16)	3 years	3 months
Dr Fiona Day	01/04/13	3 years	N/A (Honorary Contract)

*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 & Fees (bands of £5,000)	Expense Payments (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)	2015-16 Total (bands of £5,000)	2014-15 Total (bands of £5,000)	Gross Recharges from GP Practice - Note 1	Comments
	£000	£00	£000	£000	£000	£000	£000	£000	
EXECUTIVE DIRECTORS									
Philomena Corrigan - Chief Executive	135 - 140	1			27.5 - 30	165 - 170	180 - 185		
Visseh Pejhan-Sykes - Chief Finance Officer	105 - 110	1			32.5 - 35	140 - 145	120 - 125		
Diane Hampshire - Director of Nursing & Quality	30 - 35	1			0 - 2.5	30 - 35	115 - 120		Left on 31st August 2015
Jo Harding - Director of Nursing & Quality	50 - 55	nil			75 - 77.5	125 - 130	nil		Started on 17th August 2015
Sue Robins - Director of Commissioning, Strategy & Performance	85 - 90	2			17.5 - 20	105 - 110	115 - 120		
Dr Bryan Power - Joint Medical Director (Quality & Performance)	nil	nil			nil	nil	25 - 30		Left on 30th June 2014
Dr Simon Stockill - Joint Medical Director (Transformation)	80 - 85	1			25 - 27.5	105 - 110	130 - 135		
Dr Gordon Sinclair - Clinical Chair	10 - 15	1			0 - 2.5	15 - 20	10 - 15	95 - 100	6 sessions per week
Dr Fiona Day - Associate Medical Director	50 - 55	1			nil	50 - 55	15 - 20		
GP MEMBERS									
Dr Philip Dyer - Locality GP	5 - 10					5 - 10	5 - 10	30 - 35	2 sessions per week
Dr Andrew Sixsmith - Locality GP	5 - 10					5 - 10	5 - 10	30 - 35	2 sessions per week
Dr Simon Hulme - Locality GP	5 - 10					5 - 10	0 - 5	20 - 25	1.5 sessions per week
Dr Mark Liu - Locality GP	5 - 10					5 - 10	0 - 5	20 - 25	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)	10 - 15					10 - 15	10 - 15		
Dr Stephen Ledger - Lay member (Assurance)	5 - 10					5 - 10	0 - 5		

Notes

Note 1: The CCG has been charged via invoices from their 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 remuneration to the named GP.

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 2016 (bands of £5,000)	Lump Sum at Pension Age Related to Accrued pension at 31 March 2016 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 1 April 2015	Real increase in Cash Equivalent Transfer Value	Empliyer'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	2.5 - 5	45 - 50	140 - 145	852	813	31	0
Visseh Pejhan-Sykes - Chief Finance Officer	0 - 2.5	(0 - 2.5)	25 - 30	75 - 80	480	455	21	0
Diane Hampshire - Director of Nursing & Quality	0 - 2.5	0 - 2.5	35 - 40	105 - 110	0	693	(700)	0
Jo Harding - Director of Nursing & Quality	2.5 - 5	5 - 7.5	25 - 30	75 - 80	408	357	48	0
Sue Robins - Director of Commissioning, Strategy & Performance	0 - 2.5	2.5 - 5	20 - 25	70 - 75	494	468	21	0
Dr Bryan Power - Joint Medical Director (Quality & Performance)	0	0	0	0	0	0	0	0
Dr Simon Stockill - Joint Medical Director (Transformation)	0 - 2.5	(0 - 2.5)	15 - 20	45 - 50	258	243	12	0
Dr Gordon Sinclair - Clinical Chair	0 - 2.5	0 - 2.5	5 - 10	20 - 25	146	142	3	0
Dr Fiona Day - Associate Medical Director	(0 - 2.5)	(2.5 - 5)	15 - 20	45 - 50	229	236	(10)	0

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 remuneration 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
	£	£	
2014-15	137,500	32,898	4.18
2015-16	137,500	36,614	3.76

In 2015-16 and 2014-15 no employees received remuneration in excess of the highest paid director. Remuneration ranged from £4K to £139K (2014-15: £1K-£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. This does not take into account any agency staff payments made by the CCG, since this is not a significant part of pay spend.

The median salary of employees in the CCG has increased due to incremental pay increases and a non 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)

2015-16	Number
Number of existing engagements as of 31 March 2016	**20**
Of which, the number that have existed:	
For less than 1 year at the time of reporting	5
For between 1 and 2 years at the time of reporting	3
For between 2 and 3 years at the time of reporting	12
For between 3 and 4 years at the time of reporting	-
For 4 or more years at the time of reporting	-
Number of new engagements, or those that reached 6 months in duration, between 1 April 2015 and 31 March 2016	**5**
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	**2**
Number for whom assurance has been requested	**5**
Of which:	
Assurance has been received	5
Assurance has not been recieved	-
Engagments terminated as a result of assurance not being received	-

Consultancy Expenditure
During the year the CCG incurred expenditure totalling £116k (2014-15: £90k).

Philomena Corrigan
Accountable Officer

18 May 2016

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 Manual for Accounts 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 Manual for Accounts 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

18 May 2016

ANNUAL GOVERNANCE STATMENT 2015-2016

Governance Statement by the Chief Officer as the Accountable Officer of NHS Leeds West Clinical Commissioning Group (CCG)

Introduction and context

The CCG was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the NHS Act 2006. As at 1 April 2015, the CCG was licensed without conditions.

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 370,000 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 Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the CCG's policies, aims and objectives, whilst safeguarding the public funds and assets for which I am personally responsible, in accordance with the responsibilities assigned to me in Managing Public Money. I also acknowledge my responsibilities as set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

I am responsible for ensuring that the CCG is administered prudently and economically and that resources are applied efficiently and effectively, safeguarding financial propriety and regularity.

Compliance with the UK Corporate Governance Code

We are not required to comply with the UK Corporate Governance Code. 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.

The Clinical Commissioning Group Governance Framework

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 Registers of Interests and managing Conflicts of Interests; 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.

Our Constitution is a living document and was updated twice during 2015-16 following consultation and sign up by our membership. We have ensured that our Constitution continues to correlate to our Detailed Financial Procedures.

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 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

Members of the Governing Body are as follows:

- Clinical Chair – Dr Gordon Sinclair
- Four locality representatives of member practices – Dr Andrew Sixsmith (term ended 31 March 2016), Dr Simon Hulme, Dr Philip Dyer (term ended 31 March 2016), Dr Mark Liu
- Executive Registered Nurse – Diane Hampshire (from 1 April 2015 to 26 August 2015), Jo Harding (from 17 August 2015)
- 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

- Chief Officer – Philomena Corrigan
- Chief Finance Officer – Visseh Pejhan-Sykes
- Medical Director – Dr Simon Stockill
- Lead Commissioning Officer – Susan Robins

Attendee to the Governing Body:

- The Public Health representative of the Director of Public Health in Leeds – Dr Fiona Day (became a voting member of the Governing Body from 23 November 2015)

Our Governing Body and Committee structure is set out below:

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

Key: CCG Level Meetings

Key: Citywide Level Meetings

Senior Management Team (SMT)

Chair: Philomena Corrigan – Chief Officer

Membership: Visseh Pejhan-Sykes – Chief Finance Officer
Dr Simon Stockill – Medical Director
Jo Harding – Director of Nursing & Quality
Susan Robins – Director of Commissioning, Strategy & Performance
Dr Fiona Day – Consultant in Public Health Medicine / Associate Medical Director Heads of Service

Frequency: Bi-weekly

Governing Body

Chair: Dr Gordon Sinclair – Clinical Chair

Membership: Philomena Corrigan – Chief Officer
Visseh Pejhan-Sykes – Chief Finance Officer
Dr Simon Stockill – Medical Director
Susan Robins – Director of Commissioning, Strategy & Performance
Jo Harding – Director of Nursing & Quality
Dr Andrew Sixsmith – GP Representative
Dr Phil Dyer – GP Representative
Dr Simon Hulme – GP Representative
Dr Mark Liu – GP Representative
Chris Schofield – Lay Member; Governance
Angela Pullen – Lay Member; PPI
Dr Stephen Ledger – Lay Member; Assurance
Dr Peter Belfield – Secondary Care Consultant
Dr Fiona Day – Consultant in Public Health Medicine

Frequency: Bi-monthly

Remuneration Committee

Chair: Dr Peter Belfield – Secondary Care Consultant

Membership: Chris Schofield – Lay Member; Governance
Angela Pullen – Lay Member; PPI
Dr Stephen Ledger – Lay Member; Assurance
Dr Phil Dyer – GP Representative

Frequency: Bi-annual / as required

Clinical Commissioning Committee

Joint Chair: Dr Simon Stockill – Medical Director & Dr Peter Belfield – Secondary Care Consultant

Membership: Dr Andrew Sixsmith – GP Representative
Dr Philip Dyer – GP Representative
Dr Simon Hulme – GP Representative
Dr Mark Liu – GP Representative
Diane Hampshire – Director of Nursing & Quality
Visseh Pejhan-Sykes – Chief Finance Officer
Susan Robins – Director of Commissioning, Strategy & Performance
Angela Pullen – Lay Member; PPI
Dr Fiona Day – Associate Medical Director

In attendance: Clinical Leads, Clinical Fellows, Lead Practice Nurse, Associate Director – Primary Care, Head of Strategic Development, Clinical Chair, Consultant in Public Health Medicine, Head of Medicines Optimisation

Frequency: Monthly

Audit Committee

Chair: Chris Schofield – Lay Member; Governance

Membership: Dr Peter Belfield – Secondary Care Consultant
Dr Mark Liu – GP Representative

Frequency: Quarterly

Assurance Committee

Chair: Dr Stephen Ledger – Lay Member; Assurance

Membership: Dr Phil Dyer – GP Representative
Dr Simon Hulme – GP Representative
Diane Hampshire – Director of Nursing & Quality
Chris Schofield – Lay Member; Governance
Dr Peter Belfield – Secondary Care Consultant
Angela Pullen – Lay Member; PPI
Dr Simon Stockill – Medical Director
Dr Fiona Day – Associate Medical Director

Frequency: Bi-Monthly

Patient Insight Group

Chair: Jo Harding – Director of Nursing & Quality

Frequency: Monthly

Commissioning of Medicines Group

Chair: Helen Liddell - Head of Medicines Optimisation, LSE CCS

Frequency: Monthly

Health & Safety Committee

Chair: Jo Harding – Director of Nursing & Quality

Frequency: Bi-monthly (Leeds West CCG & Leeds South & East CCG only)

Information Governance Committee

Chair: Alastair Cartwright – Director of Informatics

Frequency: Quarterly

Patient Assurance Group

Chair: Angela Pullen – Lay Member; PPI

Frequency: Monthly

Locality Meetings

Chair(s): Dr Andrew Sixsmith
Dr Phil Dyer
Dr Simon Hulme
Dr Mark Liu

Membership: GP and Manager Lead from each of our 38 member practices

Frequency: Monthly except August & December

Serious Incident Panel

Chair: Joanna Howard – Head of Governance

Frequency: Bi-monthly

Safeguarding Committee

Chair: Maureen Kelly – Head of Safeguarding Children & Adults

Frequency: Bi-monthly

Meetings Attended 01/04/2015 to 31/03/2016

Member Name	Governing Body	Assurance Committee	Audit Committee	Clinical Commissioning Committee	Remuneration Committee
	7 Meetings	6 Meetings	5 Meetings	11 Meetings	3 Meetings
Dr Gordon Sinclair Clinical Chair	7/7	N/A	N/A	9/11*	N/A
Dr Andrew Sixsmith Locality representative of member practices (term ended 31 March 2016)	6/7	N/A	N/A	9/11	N/A
Dr Phil Dyer Locality representative of member practices (term ended 31 March 2016)	7/7	5/6	N/A	9/11	3/3
Dr Simon Hulme Locality representative of member practices	6/7	6/6	N/A	9/11	N/A
Dr Mark Liu Locality representative of member practices	7/7	N/A	4/5	10/11	N/A
Diane Hampshire Executive Registered Nurse (from 01/04/15 to 26/08/15)	2/3	3/3	N/A	3/4	N/A
Joanne Harding Executive Registered Nurse (from 17/08/15)	4/4	3/3	N/A	3/7	N/A
Christopher Schofield Lay member; lead on governance matters	7/7	5/6	5/5	N/A	4/4
Angela Pullen Lay member; lead on patient and public participation matters	6/7	6/6	N/A	11/11	4/4
Dr Stephen Ledger Lay member; lead on assurance matters	7/7	6/6	N/A	N/A	4/4
Dr Peter Belfield Secondary Care Consultant	6/7	4/6	4/5	7/11	4/4
Philomena Corrigan Chief Officer	6/7	N/A	N/A	9/11	4/4*
Visseh Pejhan-Sykes Chief Finance Officer	7/7	N/A	5/5*	10/11	N/A
Dr Simon Stockill Medical Director	5/7	3/3**	N/A	9/11	N/A
Susan Robins Director of Commissioning, Strategy and Performance	7/7	2/6*	N/A	7/11	N/A
Dr Fiona Day Consultant in Public Health Medicine	6/7	N/A	N/A	8/11	N/A

*Attendance as a Committee attendee rather than a Committee member

**Alternates attendance with the Associate Medical Director

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 and consists of one other lay member 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 arrangements. The Committee also receives copies of all approved policies for information and approves governance related policies such as Declarations of Interest and Counter Fraud.

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 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 information governance, safeguarding, patient safety, complaints and claims and emergency planning arrangements.

The work of the Committee has included the review and challenge of the integrated quality and performance report (IQPR), quality and performance risks rated as red or high amber, the CCG's Francis Report action plan and provider Care Quality Commission (CQC) inspection action plans. The Committee has also reviewed and approved policies relating to information governance, safeguarding, individual funding requests and HR.

The Committee has also undertaken 'deep dive' sessions, including system resilience, delayed follow ups and cancer performance.

The Assurance Committee agenda is supported by four sub-groups that report into the Committee; the Health and Safety Committee, the Information Governance Committee, the Safeguarding Committee and the Serious Incident Panel.

Clinical Commissioning Committee

The Clinical Commissioning Committee (CCC) is tasked with developing and continually improving the Clinical Commissioning Strategy on behalf of the Governing Body. The CCC advises the Governing Body with regards to the strategic direction of the organisation, ensuring that the Clinical Commissioning Strategy is co-produced with members and with patients and the public. The Committee also acts as a clinical consultation body in the development of business cases.

The Clinical Commissioning Committee agenda is supported by four sub-groups that report into the Committee; the Patient Assurance Group, the Patient Insight Group, the Locality Development Sessions, and the Commissioning of Medicines Group. The Committee also receives regular updates on the city's transformation programme, and from the acute, mental health and community provider management groups.

Performance and Assessment of Effectiveness

Each Committee has completed a self-assessment of its performance and effectiveness throughout the year. It has been agreed that the purpose, format and membership of the Clinical Commissioning Committee will be reviewed to ensure that it is aligned with the CCG's refreshed strategy. The outcome of the Audit, Assurance and Remuneration Committee effectiveness reviews was positive but some actions have been agreed, including shadowing other Audit Committee meetings, ensuring that relevant staff attend meetings to present reports and clarifying the Assurance Committee, Primary Care Commissioning Committee and Primary Care Improvement Group's role in relation to providing and seeking assurance on quality in primary care, as the CCG is taking on delegated authority for primary care co-commissioning from 1 April 2016.

By working closely together the Directors and I lead the risk management process, to ensure an integrated and holistic approach to the CCG's governance decisions and risk management activities. Throughout the reporting period there have been a number of Governing Body workshops that reviewed the effectiveness and development of a range of governance requirements.

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

Leeds Integrated Commissioning Executive
The CCG has a joint committee 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, the CCG 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 sub-committee of the CCG but a cross-city working group. A documented Memorandum of Understanding is in place describing the joint commissioning arrangements within the Leeds health economy including the sharing of local commissioning strategies, the identification of commonalities and the delegation of contracting responsibilities.

In January 2016 the format and membership of this forum was reviewed and it is now known as the Joint Leadership Group, with a focus on improved collaborative working.

THE CLINICAL COMMISSIONING GROUP RISK MANAGEMENT FRAMEWORK

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;
- 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 CG to meet its strategic objectives are recorded on the Governing Body Assurance Framework (GBAF). The CCG Risk Management Strategy 2015-17 was reviewed and a revised version was approved by Governing Body in May 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) 2015-16

The Governing Body Assurance Framework (GBAF) sets out how the CCG manages the principle 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 and 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 the Governing Body, Assurance Committee and Audit Committee meetings. The controls, assurances and gaps in controls and assurance are scrutinised along with any actions required to work towards improving the potential risk.

Risk Registers

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 a Director before being accepted as an active risk on the CCG risk register.

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 presented and reviewed by the CCG committees and the Governing Body at each meeting. Responsible managers will use various data streams to regularly assess the levels of risk they are managing and update the risks to ensure that an accurate position is presented.

The Datix risk management system enables risks to be captured at a local level as well as 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.

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.

We are compliant with the Secretary of State's Directions for counter fraud and the requirement for the provision for a Local Counter Fraud Specialist (LCFS). The activities undertaken by the LCFS during the year have been delivered to ensure that they are risk-based and in line with the latest thought-leadership and emerging methodologies, including the Government's National Fraud Strategy and Chartered Institute of Public Finance and Accountancy (CIPFA) 'Managing the Risk of Fraud' document which are considered best practice when countering fraud.

Risk Assessment

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 2015-16 NHS Leeds West CCG Corporate Risks, as at 31 March 2016, are summarised below:

Risk ID	Risk Title	Current Score
541	There is a risk to the acute trusts ability to maintain elective, urgent and cancer activity affecting the quality of care provided to our patients	15
466	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.	20

The CCG Governing Body Assurance Framework (GBAF) 2015-16 describes the CCG's principal risks to achieving its objectives. A summary of the GBAF risks can be found below:

Summary of CCG's GBAF principal risks 2015-16

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	• Integrated Quality and Performance Report (IQPR) has population outcome measures including key health inequalities measures • Memorandum of Understanding in place between the CCG and Leeds City Council to deliver Public Health Healthcare Advisory Service, annual plan documents and delivery against action plan is monitored • Evidence of improving trends to reduce health inequalities • Regular public health reports to CCG	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	• Contract Management Board (CMB) receives quality update briefing from Providers • Minutes of all provider and quality meetings are shared with the Governing Body to provide assurance that quality standards are being monitored and any emerging issues are escalated • Commissioning for Quality & Innovation (CQUIN) update reports presented and discussed at CMB and provider quality meetings to demonstrate achievement of local and national standards • IQPR incorporates provider data and presented to assurance committee and Governing Body to report current performance against quality standards • Assurance Committee receives updates from Quality Surveillance Group (QSG) regarding any emerging issues within West Yorkshire Providers • CCC receives regular patient experience updates from Patient Insight Group (PIG) • Evaluation of provider quality visits reported to Assurance Committee • Reports from Care Quality Commission (CQC) visits received and action plans reported to provider quality meetings and areas of concern highlighted with mitigation identified	12

Summary of CCG's GBAF principal risks 2015-16

Objective	Risk	Assurances	Score
To use commissioning resources effectively	The cessation of the Yorkshire & Humber Commissioning Support Unit will create a great deal of instability for CCGs which could in turn impact on the CCG's ability to deliver on its responsibilities	• Favourable assurance report from 2014-15 Commissioning Support Unit (CSU) audit • Monthly meetings with Customer Relationship Manager to monitor progress against action plan • Chief Finance Officer report to governing body includes CSU updates and performance data • Minutes of CSU transition Board are circulated to Senior Management Team (SMT)	12
	The governance arrangements for collaboration, partnership working, risk sharing and commissioning across the Leeds CCG network, Local Authority, NHS England and other partner agencies are not robust	• Minutes and action logs of all network meetings shared with the CCG and reported to governing body via Chief Officer's report • Detailed internal audit review of lead and associate contract governance arrangements • Evidence from Senior Finance Network meetings reported to NHS Leeds West CCG Chief Finance Officer where financial risks are assessed • Integrated Commissioning Executive (ICE) and 10CC meeting minutes reported to CCG and to Governing Body via the Chief Officer's report as well as monthly 10CC programme board progress report • Chief Officer provides monthly verbal update to the Clinical Commissioning Committee of transformation arrangements • Review and financial assessment of collaborative teams • Clear action plan created from outputs of Price Waterhouse Coopers review	4
	System resilience shortfalls leading to a failure to meet patient needs	• Information from the local urgent healthcare system and operational urgent care group fed to the System Resilience Group (SRG) • Minutes of SRG reported to CCG • Table top exercises are arranged as required • System resilience updates presented to Assurance Committee • Training in place for on-call managers and executive team • Buddying system in place for new managers on call • Annual self-assessment against national Emergency Care Standards • Major Incident Plans in place and supporting incident specific plans are tested as part of multi-agency exercises and peer reviews • Positive internal audit reports on current system	16

Summary of CCG's GBAF principal risks 2015-16

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 Body	• Quality update provided quarterly to Assurance Committee • Progress reviewed at local Quality Surveillance Group reporting to Assurance Committee • Completion by every practice of the Local Education and Training Board (LETB) workforce tool • Participation of practices in the Advanced Training Practice programme (ATP) • Member sign up to local scheme and evaluations reported to CCC • Practice visits • Primary care quality dashboard • Annual members review, 360 Survey and LDS and Target session feedback • Evaluation of schemes	12

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.

THE CLINICAL COMMISSIONING GROUP 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.

We also seek assurance from other areas 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.

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 auditors. 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 Assurance Committee. These are formal meetings with associated minutes and action tracking. The CCG has bought in an expert IG practitioner and advisory service from the Yorkshire and Humber Commissioning Support Unit. From 1 April 2016 this arrangement is replaced by a new contractual arrangement with 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 - the Yorkshire and Humber Commissioning Support Unit (YHCSU). From 1 April 2016 this arrangement is replaced by new contractual arrangements with eMBED Health Consortium and the North East Commissioning Support Unit (NECS). The required Data Processing Agreements are in place. YHSCU provided the IT facilities required to store the data needed for CCG business. The CCG does not hold 'local' data. YHCSU were approved by the Health and Social Care Information Centre (HSCIC) to process confidential data on the CCG's behalf. This contract moves to NECS from 1 April 2016. 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.

Data Quality

The CCG receives a business intelligence service from the Commissioning Support Unit and data is checked by informatics and planning staff within the CCG. All of the Governing Body Committees were reviewed in March 2016 and no concerns were raised regarding data quality. The Assurance Committee and Governing Body have noted improvements in the CCG's Integrated Quality and Performance Report.

Pension Obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within

the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

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 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 2015-16, 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 Senior Management Team and Governing Body, 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. The 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 QIPP targets and savings from whole system transformation which form part of future financial plans.

Feedback from delegation chains regarding business, use of resources and responses to risk

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.

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

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control within the clinical commissioning group.

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.

Review of Effectiveness

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 auditors 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 auditors 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 (Yorkshire and Humber Commissioning Support) in respect of their internal controls.

As a result of Yorkshire and Humber Commissioning Support (YHCS) not securing a place on the Lead Provider Framework for commissioning support services in February 2015, YHCS is not in a position to provide commissioning support services to the CCG beyond March 2016. Therefore, the CCG has re-procured its commissioning support services through the Lead Provider Framework and the contract has been awarded to eMBED Health Consortium from 1 April 2016 for four years.

Head of Internal Audit Opinion

Following completion of the planned audit work for the financial year for the CCG, the Head of Internal Audit issued an independent and objective opinion on the adequacy and effectiveness of the CCG's system of risk management, governance and internal control. The Head of Internal Audit concluded 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. However, some weaknesses in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.**

During the year, Internal Audit issued the following audit reports which identified governance, risk management and/or control issues which were significant to the organisation:

Not Applicable.

Business Critical Models

The CCG has reviewed the Macpherson report on government analytical models and has concluded that it does not currently create any analytical models that fit the criteria within that report and hence need to be notified to the Analytical Oversight Committee.

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 CCG's statutory duties.

Conclusion

No significant internal control issues have been identified.

Philomena Corrigan
Accountable Officer

18 May 2016

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 2016 on pages 104 – 139 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies 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 78-79, 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 2015, 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 2016.

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 2016 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 2016.

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

25 May 2016

Statement of Comprehensive Net Expenditure for the Year Ended 31 March 2016

	Note	2015-16 £'000	2014-15 £'000
Administrative Costs			
Other Operating Revenue	2	**(670)**	**(621)**
Gross Employee Benefits	4	**3,531**	**3,348**
Others Costs	5	**4,723**	**4,835**
Net administration costs before interest		**7,584**	**7,562**
Programme Costs			
Other Operating Revenue	2	**(2,639)**	**(1,896)**
Gross Employee Benefits	4	**410**	**414**
Other Costs	5	**399,157**	**389,891**
Net programme costs before interest		**396,928**	**388,409**
Net Operating Costs for the Financial Year		**404,512**	**395,971**
Financing			
Investment Revenue		-	-
Other (Gains)/Losses		-	-
Finance Costs		-	-
Net Operating Costs for the Financial Year		**404,512**	**395,971**
Net Gain/(Loss) on Transfer by Absorption		-	-
Retained Net Operating Costs for the Financial Year		**404,512**	**395,971**
Other Comprehensive Net Expenditure			
Impairments & reversals		-	-
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		**404,512**	**395,971**

The notes on pages 109 to 139 form part of this statement.

Statement of Financial Position as at 31 March 2016

	Note	31 March 2016 £'000	31 March 2015 £'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	**1,220**	**1,596**
Other Financial Assets		-	-
Other Current Assets		-	-
Cash & Cash Equivalents	9	**137**	**56**
Non-current Assets held for Sale		-	-
Total Current Assets		**1,357**	**1,652**
Current Liabilities			
Trade & Other Payables	10	**(14,538)**	**(14,710)**
Other Financial Liabilities		-	-
Other Liabilities		-	-
Borrowings		-	-
Provisions	11	**(116)**	**(262)**
Total Current Liabilities		**(14,654)**	**(14,972)**
Total Assets less Current Liabilities		**(13,297)**	**(13,320)**
Non-current Liabilities			
Trade & Other Payables		-	-
Other Financial Liabilities		-	-
Other Liabilities		-	-
Borrowings		-	-
Provisions	11	**(203)**	**(376)**
Total Non-current Liabilities		**(203)**	**(376)**
Total Assets Employed		**(13,500)**	**(13,696)**
Financed by Taxpayers' Equity			
General Fund		**(13,500)**	**(13,696)**
Revaluation Reserve		-	-
Other Reserves		-	-
Charitable Reserves		-	-
Total Taxpayers' Equity		**(13,500)**	**(13,696)**

The notes on pages 109 to 139 form part of this statement.

Philomena Corrigan
Accountable Officer

The financial statements on pages 104 to 139 were approved by the Governing Body on 18 May 2016 and signed on its behalf by:

Statement of Changes in Taxpayers' Equity for the Year Ended 31 March 2016

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 Changes in Taxpayers' Equity for the Year Ended 31 March 2016 *(continued)*

Changes in Taxpayers' Equity for 2014-15	General Fund	Revaluation Reserve	Other Reserves	Total
	£'000	£'000	£'000	£'000
Balance as at 1 April 2014	**(13,794)**	**-**	**-**	**(13,794)**
Transfer between reserves in respect of assets transferred from closed NHS bodies	-	-	-	-
Adjusted Balance as at 1 April 2014	**(13,794)**	**-**	**-**	**(13,794)**
Changes in Taxpayers' Equity for 2014-15				
Net operating costs for the financial year	**(395,971)**	**-**	**-**	**(395,971)**
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 CCG Expenditure for the Financial Year	**(395,971)**	**-**	**-**	**(395,971)**
Net Funding	**396,069**	**-**	**-**	**396,069**
Balance at 31 March 2015	**(13,696)**	**-**	**-**	**(13,696)**

Statement of Cash Flows for the Year Ended 31 March 2016

	Note	2015-16 £'000	2014-15 £'000
Cash Flows from Operating Activities			
Net operating costs for the financial year		**(404,512)**	**(395,971)**
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	**376**	**71**
(Increase)/decrease in other current assets		-	-
Increase/(decrease) in trade & other payables	10	**(172)**	**123**
Increase/(decrease) in other current liabilities		-	-
Provisions utilised	11	**(151)**	**(242)**
Increase/(decrease) in provisions	11	**(168)**	-
Net Cash Inflow/(Outflow) from Operating Activities		**(404,627)**	**(396,019)**
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		**(404,627)**	**(396,019)**
Cash Flows from Financing Activities			
Net funding received		**404,708**	**396,069**
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) from Financing Activities		**404,708**	**396,069**
Net Increase/(Decrease) in Cash & Cash Equivalents	9	**81**	**50**
Cash & Cash Equivalents at the Beginning of the Financial Year		**56**	**6**
Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies		-	-
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		**137**	**56**

The notes on pages 109 to 139 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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in the Manual for Accounts 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

These accounts have been prepared on the going concern basis.

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

From 2014-15, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.6 Pooled Budgets

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

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

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

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

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

1.7 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.7.1 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 and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

1.11.2 Valuation

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

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

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

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

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

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

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

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

1.11.3 Subsequent Expenditure

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

1.12 Intangible Assets

1.12.1 Recognition

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

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

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

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

1.12.2 Measurement

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

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

1.13 Depreciation, Amortisation & Impairments

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

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

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

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit are taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.14 Donated Assets

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

1.15 Government Grants

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

1.16 Non-current Assets Held For Sale

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

- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,

- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

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

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

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

1.17 Leases

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

1.17.1 The Clinical Commissioning Group as Lessee

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

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

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

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

1.17.2 The Clinical Commissioning Group as Lessor

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

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.18 Private Finance Initiative Transactions

HM Treasury has determined that government bodies shall account for infrastructure Private Finance Initiative (PFI) schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The clinical commissioning group therefore

recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

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

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

1.18.1 Services Received

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

1.18.2 PFI Asset

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

1.18.3 PFI Liability

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

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

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

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

1.18.4 Lifecycle Replacement

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

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

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

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

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

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

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

1.19 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

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 1.55% (2014-15: minus 1.90%)
- Timing of cash flows (6 to 10 years inclusive): minus 1% (2014-15: minus 0.65%)
- Timing of cash flows (over 10 years): minus 0.80% (2014-15: plus 2.20%)

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

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

1.22 Clinical Negligence Costs

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

1.23 Non-clinical Risk Pooling

The clinical commissioning group participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the clinical commissioning group pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.24 Continuing Healthcare Risk Pooling

In 2014-15 a risk pool scheme was introduced by NHS England for continuing healthcare claims, for claim periods prior to 31 March 2013. Under the scheme clinical commissioning 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.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

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.

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

1.35 Joint Ventures

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

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

1.36 Joint Operations

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

1.37 Research & Development

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

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

The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2015-16, all of which are subject to consultation:

- IFRS 9: Financial Instruments
- IFRS 14: Regulatory Deferral Accounts
- IFRS 15: Revenue from Contracts with Customers

The application of the Standards as revised would not have a material impact on the accounts for 2015-16, were they applied in that year.

Note 2 – Other Operating Revenue

	2015-16 Total	Admin	Programme	2014-15 Total
	£'000	£'000	£'000	£'000
Recoveries in respect of employee benefits	-	-	-	-
Patient transport services	-	-	-	-
Prescription fees and charges	-	-	-	-
Dental fees and charges	-	-	-	-
Education, training and research	8	8	-	1
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	3,268	661	2,607	2,487
Continuing Health Care risk pool contributions	-	-	-	-
Income generation	-	-	-	-
Rental revenue from finance leases	-	-	-	-
Rental revenue from operating leases	-	-	-	-
Other revenue	33	1	32	29
Total	**3,309**	**670**	**2,639**	**2,517**

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.

There are three CCGs in Leeds; NHS Leeds South and East CCG, NHS Leeds West CCG and NHS Leeds North CCG. Collaborative arrangements exist 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.

£2.9m (2014-15: £1.7m) of revenue classified as 'Non-patient care services to other bodies' relates to these collaborative arrangements. The increase from 2014-15 levels is as a result of an increase in Individual Funding Requests and Acute care recharged to the NHS Leeds CCGs.

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	2015-16 Total	Permanent	Other	2014-15 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**3,232**	3,116	116	3,096
Social security costs	**270**	270	-	258
Employer contributions to the NHS Pension Scheme	**439**	439	-	408
Other pension costs	**-**	-	-	-
Other post-employment benefits	**-**	-	-	-
Other employment benefits	**-**	-	-	-
Termination benefits	**-**	-	-	-
Gross employee benefits expenditure	**3,941**	**3,825**	**116**	**3,762**
Less: Recoveries in respect of employee benefits (note 4.1.3)	**-**	-	-	-
Total net employee benefits expenditure including capitalised costs	**3,941**	**3,825**	**116**	**3,762**

4.1.1 – Employee Benefits Expenditure Admin	2015-16 Total	Permanent	Other	2014-15 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**2,887**	2,839	48	2,749
Social security costs	**248**	248	-	235
Employer contributions to the NHS Pension Scheme	**396**	396	-	364
Other pension costs	**-**	-	-	-
Other post-employment benefits	**-**	-	-	-
Other employment benefits	**-**	-	-	-
Termination benefits	**-**	-	-	-
Gross employee benefits expenditure	**3,531**	**3,483**	**48**	**3,348**
Less: Recoveries in respect of employee benefits (note 4.1.3)	**-**	-	-	-
Net employee benefits expenditure including capitalised costs	**3,531**	**3,483**	**48**	**3,348**

4.1.2 – Employee Benefits Expenditure Programme	2015-16 Total	Permanent	Other	2014-15 Total
	£'000	£'000	£'000	£'000
Salaries and wages	**345**	277	68	347
Social security costs	**22**	22	-	23
Employer contributions to the NHS Pension Scheme	**43**	43	-	44
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Gross employee benefits expenditure	**410**	**342**	**68**	**414**
Less: Recoveries in respect of employee benefits (note 4.1.3)	-	-	-	-
Net employee benefits expenditure including capitalised costs	**410**	**342**	**68**	**414**

4.1.3 – Recoveries in respect of Employee Benefits	2015-16 Total	Permanent	Other	2014-15 Total
	£'000	£'000	£'000	£'000
Salaries and wages	-	-	-	-
Social security costs	-	-	-	-
Employer contributions to the NHS Pension Scheme	-	-	-	-
Other pension costs	-	-	-	-
Other post-employment benefits	-	-	-	-
Other employment benefits	-	-	-	-
Termination benefits	-	-	-	-
Total recoveries in respect of employee benefits	-	-	-	-

4.2 – Average Number of People Employed	2015-16 Total Number	Permanently Number	Other Number	2014-15 Total Number
Total	85	84	1	72
Number of whole time equivalent people engaged on capital projects	-	-	-	-

4.3 – Staff Sickness Absence and Ill health retirements	2015-16 Number	2014-15 Number
Total days lost	324	221
Total staff years	83	65
Average working days lost	3.9	3.4
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 Jan 2015 to Dec 2015.

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 2015-16, employers' contributions of £439k were payable to the NHS Pensions Scheme (2014-15: £408k) at the rate of 14.3% (2014-15: 14.0%) 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 in June 2014. These costs are included in the NHS pension line of note 4.1.

Note 5 – Operating Expenses

	2015-16 Total	2015-16 Admin	2015-16 Programme	2014-15 Total
	£'000	£'000	£'000	£'000
Gross Employee Benefits				
Employee benefits excluding governing body members	**3,247**	2,837	410	3,109
Executive governing body members	**694**	694	-	653
Total gross employee benefits	**3,941**	**3,531**	**410**	**3,762**
Other Costs				
Services from other CCGs and NHS England	**24,162**	2,713	21,449	23,951
Services from Foundation trusts	**47,585**	30	47,555	47,437
Services from other NHS trusts	**223,687**	7	223,680	222,407
Services from other NHS bodies	**-**	-	-	-
Purchase of healthcare from non-NHS bodies	**53,259**	-	53,259	38,212
Chair and Non-Executive Governing Body Members	**102**	102	-	90
Supplies and services – clinical	**(1)**	-	(1)	5
Supplies and services – general	**617**	334	283	8,770
Consultancy services	**116**	44	72	90
Establishment	**543**	397	146	436
Transport	**39**	11	28	16
Premises	**309**	246	63	214
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	-	102
Other non-statutory audit expenditure				
• Internal audit services	**-**	-	-	37
• Other services	**-**	-	-	-
General dental services and personal dental services	**-**	-	-	-
Prescribing costs	**51,299**	-	51,299	50,758
Pharmaceutical services	-	-	-	-
General ophthalmic services	**65**	-	65	54
GPMS/APMS and PCTMS	**191**	-	191	377
Other professional fees excl. audit	**697**	647	50	713
Grants to other public bodies	**-**	-	-	-
Clinical negligence	**-**	-	-	-
Research and development (excluding staff costs)	**-**	-	-	20
Education and training	**102**	115	(13)	718
Change in discount rate	**-**	-	-	-
Provisions	**(168)**	-	(168)	(242)
Funding to group bodies	**-**	-	-	-
CHC Risk Pool contributions	**1,139**	-	1,139	561
Other expenditure	**60**	-	60	-
Total other costs	**403,880**	**4,723**	**399,157**	**394,726**
Total operating expenses	**407,821**	**8,254**	**399,567**	**398,488**

5. Operating Expenses

Services from other CCGs and NHS England includes £22.1m (2014-15: £21.8m) which relates to the three Leeds CCG collaborative arrangements described in Note 2 to these financial statements.

£597k (2014-15: £696k) of 'other professional fees' expenditure relates to clinical leadership recharges from GP Practices.

Local authority expenditure, inclusive of the Better Care Fund, has been allocated to the heading 'Purchase of Healthcare from non-NHS bodies' rather than 'Supplies and services – general' as this reflects better the nature of the expenditure in this year.

Note 6 – Better Payments Practice Code

6.1 – BPPC	2015-16 Number	2015-16 £'000	2014-15 Number	2014-15 £'000
Non-NHS Payables				
Total Non-NHS trade invoices paid in the year	2,418	46,758	2,422	38,402
Total Non-NHS trade invoices paid within target	2,398	46,754	2,372	38,155
Percentage of Non-NHS trade invoices paid within target	**99.17%**	**99.99%**	**97.94%**	**99.36%**
NHS Payables				
Total NHS trade invoices paid in the year	3,886	273,417	3,032	270,858
Total NHS trade invoices paid within target	3,819	273,279	2,979	270,685
Percentage of Trade invoices paid within target	**98.28%**	**99.95%**	**98.25%**	**99.94%**

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	2015-16 Land	2015-16 Buildings	2015-16 Other	2015-16 Total	2014-15 Total
7.1.1 – Payments recognised as an Expense	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Minimum lease payments	-	183	9	**192**	149
Contingent payments	-	-	-	-	-
Sub lease payments	-	-	-	-	-
Total		**183**	**9**	**192**	**149**

	2015-16 Land	2015-16 Buildings	2015-16 Other	2015-16 Total	2014-15 Total
7.1.2 – Future Minimum Lease Payments	**£'000**	**£'000**	**£'000**	**£'000**	**£'000**
Not later than one year	-	15	6	**21**	67
Between one and five years	-	-	3	**3**	190
After five years	-	-	-	**-**	1
Total	-	**15**	**9**	**24**	**258**

The CCG occupies property owned and managed by NHS Property Services Ltd. The current leases come to an end in June of 2016; a new lease is currently under negotiation for alternative suites, also in WIRA house, that would better accommodate the needs of the CCG at an annual rental of c£188k.

Note 8 – Trade and Other Receivables

	Current 2015-16	Non-Current 2015-16	Current 2014-15	Non-Current 2014-15
	£'000	**£'000**	**£'000**	**£'000**
NHS receivables: Revenue	127	-	314	-
NHS receivables: Capital	-	-	-	-
NHS prepayments	960	-	1,021	-
NHS accrued income	50	-	96	-
Non-NHS receivables: Revenue	1	-	50	-
Non-NHS receivables: Capital	-	-	-	-
Non-NHS prepayments	74	-	48	-
Non-NHS accrued income	7	-	-	-
Provision for impairment of receivables	-	-	-	-
VAT	1	-	67	-
Private finance initiative and other public partnership arrangement prepayments and accrued income	-	-	-	-
Interest receivables	-	-	-	-
Finance lease receivables	-	-	-	-
Operating lease receivables	-	-	-	-
Other receivables	-	-	-	-
Total	**1,220**	**-**	**1,596**	**-**
Total receivables current and non-current	**1,220**		**1,596**	

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.

Note 9 – Cash and Cash Equivalents

	2015-16	2014-15
	£'000	£'000
Balance at 1 April	56	6
Net change in year	81	50
Balance at 31 March	**137**	**56**
Made up of:		
Cash with the Government Banking Services	137	56
Cash with Commercial Banks	-	-
Cash in hand	-	-
Current investments	-	-
Cash and cash equivalents as in Statement of Financial Position	**137**	**56**
Bank overdraft: Government Banking Services	-	-
Bank overdraft: Commercial Banks	-	-
Total bank overdraft	**-**	**-**
Balance at 31 March	**137**	**56**

Note 10 – Trade and Other Payables

	Current 2015-16	Non-Current 2015-16	Current 2014-15	Non-Current 2014-15
	£'000	£'000	£'000	£'000
Interest payable	-	-	-	-
NHS payables: Revenue	914	-	1,459	-
NHS payables: Capital	-	-	-	-
NHS accruals	1,259	-	1,025	-
NHS deferred income	17	-	8	-
Non-NHS payables: Revenue	410	-	170	-
Non-NHS payables: Capital	-	-	-	-
Non-NHS accruals	10,888	-	10,358	-
Non-NHS deferred income	-	-	-	-
Social security costs	42	-	-	-
VAT	-	-	-	-
Tax	43	-	-	-
Payments received on account	-	-	-	-
Other payables	965	-	1,690	-
Total trade and other payables	**14,538**	**-**	**14,710**	**-**
Total payables current and non-current	**14,538**		**14,710**	

Other payables include £64k (2014-15: £nil) outstanding pension contributions at 31 March 2016.

10.1 – Deferred Income	2015-16 Total £'000	2014-15 Total £'000
Balance at 1 April	**8**	8
Amounts Utilised during the year	(8)	(8)
Amount deferred during the year	17	8
Balance at 31 March	**17**	**8**

Note 11 – Provisions

	Current 2015-16 £'000	Non-Current 2015-16 £'000	Current 2014-15 £'000	Non-Current 2014-15 £'000
Pensions relating to former directors	-	-	-	-
Pensions relating to other staff	-	-	-	-
Restructuring	-	-	-	-
Redundancy	-	-	-	-
Agenda for change	-	-	-	-
Equal pay	-	-	-	-
Legal claims	-	-	-	-
Continuing care	116	203	262	376
Other	-	-	-	-
Total	**116**	**203**	**262**	**376**
Total current and non-current	**319**		**638**	

	2015 -16 £'000	2014-15 £'000
Balance at 1 April	**638**	**880**
Arising during the year	186	-
Utilised during the year	(151)	(242)
Reversed unused	(354)	-
Unwinding discount	-	-
Change in discount rate	-	-
Transfer (to)/from other public sector body	-	-
Balance at 31 March	**319**	**638**
Expected timing of cash flows:		
Within one year	116	262
Between one and five years	203	376
After five years	-	-
Balance at 31 March	**319**	**638**

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

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 2016 is £1,888k (2014-15: £2,579k).

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.

Because 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 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 exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

12.1.3 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.

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	-	177	-	**177**
• Non-NHS	-	8	-	**8**
Cash at bank in hand	-	137	-	**137**
Other financial assets	-	-	-	**-**
Total at 31 March 2016	**-**	**322**	**-**	**322**
Embedded derivatives	-	-	-	**-**
Receivables				
• NHS	-	314	-	**314**
• Non-NHS	-	50	-	**50**
Cash at bank in hand	-	56	-	**56**
Other financial assets	-	-	-	**-**
Total at 31 March 2015	**-**	**420**	**-**	**420**

Financial Liabilities	At 'fair value through profit and loss'	Other	Total
	£'000	£'000	£'000
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**
Embedded derivatives	-	-	**-**
Payables:			
• NHS	-	2,492	**2,492**
• Non-NHS	-	12,218	**12,218**
Private finance initiative, LIFT and finance lease obligations	-	-	**-**
Other borrowings	-	-	**-**
Other financial liabilities	-	-	**-**
Total at 31 March 2015	**-**	**14,710**	**14,710**

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 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	2015-16	2014-15
	£'000	£'000
Income	4,675	-
Expenditure	4,600	-

Pooled Budget Fund 2 Leeds City Council Hosted s75 Agreements	2015-16	2014-15
	£'000	£'000
Income	1,560	-
Expenditure	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 four funds are hosted by either Leeds City Council or one of the Leeds CCGs. The BCF Partnership Agreement is based on the national template developed by NHS England and Bevan Brittan, and it includes Pooled funds (Section 75) and Non-pooled funds (Section 256/ Section 76), which in totality make up the Leeds Better Care Fund for 2015-16. 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):

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 s 75 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**

No contributions were made in 2014-15.

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 s 75 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 – Intra Government and Other Balances

	Current Receivables	Non-Current Receivables	Current Payables	Non-Current Payables
	£'000	£'000	£'000	£'000
Balances with:				
• Other Central Government bodies	-	-	149	-
• Local Authorities	6	-	3	-
Balances with:				
• NHS bodies outside the Departmental Group	96	-	175	-
• NHS Trusts and Foundation Trusts	1,041	-	2,015	-
Total of balances with NHS bodies	**1,137**	**-**	**2,190**	**-**
• Public Corporations and trading funds	-	-	-	-
• Bodies external to Government	77	-	12,196	-
Total balances at 31 March 2016	**1,220**	**-**	**14,538**	**-**
Balances with:				
• Other Central Government bodies	67	-	-	-
• Local Authorities	48	-	142	-
Balances with:				
• NHS bodies outside the Departmental Group	141	-	211	-
• NHS Trusts and Foundation Trusts	1,290	-	2,281	-
Total of balances with NHS bodies	**1,431**	**-**	**2,492**	**-**
• Public Corporations and trading funds	-	-	-	-
• Bodies external to Government	50	-	12,076	-
Total balances at 31 March 2015	**1,596**		**14,710**	**-**

Note 16 – Related Party Transactions

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

	Payments to Related Party 2015-16	Receipts from Related Party 2015-16	Payments to Related Party 2014-15	Receipts from Related Party 2014-15
	£'000	£'000	£'000	£'000
St. Gemma's Hospice (Dr Peter Belfield)	985	-	1,133	-
Leeds Community Healthcare (Dr Bryan Power – resigned 30 June 2014)	40,805	-	39,236	-
Leeds City Council (Dr Fiona Day)	21,791	207	17,581	302
Leeds Teaching Hospitals NHS Trust (John Tatton)	155,039	-	155,573	-
Locala Community Partnerships (Rebecca Barwick)	23	-	8	-
University of Leeds (Dr Adrian Rees and Dr Simon Stockill)	46	-	495	-
Abbey Grange Medical Centre (Dr Mark Liu)	309	-	165	-
Burton Croft Surgery (Dr Gordon Sinclair)	409	-	412	-
Craven Road Medical Practice (Dr Phillip Dyer – term ended 31 March 2016)	415	-	399	-
Fieldhead Surgery (Dr Phillip Dyer – term ended 31 March 2016)	143	-	151	-
Fountain Medical Centre (Dr Steve Ledger – retired 30 September 2014)	338	-	292	2
Hawthorn Surgery (Dr Hillary Devitt)	144	-	112	-
Hillfoot Surgery (Dr Andrew Sixsmith – term ended 31 March 2016)	114	-	137	-
Kirkstall Lane Medical Centre (Dr Simon Stockill and Dr Keith Miller)	258	-	249	-
Leeds Student Medical Practice (Dr David Murray – retired 11 September 2014)	488	-	521	10
Leigh View Medical Practice (Dr Simon Hulme)	278	-	287	-
Manor Park Surgery (Dr Jamie O'Shea, Dr Mark Fuller and Dr Mark Liu)	384	-	306	-
Moor Grange Surgery (Dr Mark Liu)	-	-	115	-
Rawdon Surgery (Dr Chris Mills)	303	-	311	-
Thornton Medical Centre (Dr Andrew Sixsmith – term ended 31 March 2016)	234	-	226	-
Vesper Road Surgery (Dr Bryan Power – resigned 30 June 2014)	224	-	232	-
Windsor House Group Practice (Dr Jeanette Turley – resigned 30 June 2015)	148	-	149	8
Yeadon Tarn Medical Practice (Dr Adrian Rees)	182	-	242	-

	Amounts owed to Related Party 2015-16	Amounts due from Related Party 2015-16	Amounts owed to Related Party 2014-15	Amounts due from Related Party 2014-15
	£'000	£'000	£'000	£'000
St. Gemma's Hospice (Dr Peter Belfield)	-	-	-	-
Leeds Community Healthcare (Dr Bryan Power – resigned 30 June 2014)	20	-	15	-
Leeds City Council (Dr Fiona Day)	-	4	141	-
Leeds Teaching Hospitals NHS Trust (John Tatton)	993	923	106	-
Locala Community Partnerships (Rebecca Barwick)	1	-	10	-
University of Leeds (Dr Adrian Rees and Dr Simon Stockill)	-	-	-	-
Abbey Grange Medical Centre (Dr Mark Liu)	5	-	5	-
Burton Croft Surgery (Dr Gordon Sinclair)	6	-	8	-
Craven Road Medical Practice (Dr Phillip Dyer – term ended 31 March 2016)	6	-	8	-
Fieldhead Surgery (Dr Phillip Dyer – term ended 31 March 2016)	3	-	5	-
Fountain Medical Centre (Dr Steve Ledger – retired 30 September 2014)	8	-	13	-
Hawthorn Surgery (Dr Hillary Devitt)	4	-	6	-
Hillfoot Surgery (Dr Andrew Sixsmith – term ended 31 March 2016)	4	-	6	-
Kirkstall Lane Medical Centre (Dr Simon Stockill and Dr Keith Miller)	4	-	6	-
Leeds Student Medical Practice (Dr David Murray – retired 11 September 2014)	15	-	19	-
Leigh View Medical Practice (Dr Simon Hulme)	8	-	12	-
Manor Park Surgery (Dr Jamie O'Shea, Dr Mark Fuller and Dr Mark Liu)	8	-	12	-
Moor Grange Surgery (Dr Mark Liu)	-	-	5	-
Rawdon Surgery (Dr Chris Mills)	4	-	6	-
Thornton Medical Centre (Dr Andrew Sixsmith – term ended 31 March 2016)	6	-	9	-
Vesper Road Surgery (Dr Bryan Power – resigned 30 June 2014)	4	-	7	-
Windsor House Group Practice (Dr Jeanette Turley – resigned 30 June 2015)	8	-	54	-
Yeadon Tarn Medical Practice (Dr Adrian Rees)	4	-	8	-

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

	Payments to Related Party 2015-16 £'000	Receipts from Related Party 2015-16 £'000	Payments to Related Party 2014-15 £'000	Receipts from Related Party 2014-15 £'000
Armley Medical Practice	303	-	569	-
Beechtree Medical Centre	47	-	35	-
Burley Park Medical Centre	376	-	382	-
Drighlington Medical Centre	66	-	41	-
The Gables Surgery	95	-	79	-
Gildersome Health Centre	59	-	57	-
Guiseley and Yeadon Medical Practice	321	-	335	-
High Field Surgery, Holt Park	227	-	223	-
Highfield Medical Centre, Bramley	110	-	75	-
Hyde Park Surgery	262	-	283	-
Ireland Wood and Horsforth Medical Practice	864	-	690	-
Laurel Bank Surgery	194	-	187	-
Menston and Guiseley Practice	309	-	297	-
Morley Health Centre	24	-	36	-
Priory View Medical Centre	203	-	166	-
Pudsey Health Centre	143	-	128	-
Robin Lane Health and Wellbeing Centre	714	-	566	-
South Queen Street Medical Centre	27	-	20	-
Sunfield Medical Centre	66	-	66	-
West Lodge Surgery	241	-	301	-
Whitehall Surgery	196	-	162	-

	Amounts owed to Related Party 2015-16	Amounts due from Related Party 2015-16	Amounts owed to Related Party 2014-15	Amounts due from Related Party 2014-15
	£'000	£'000	£'000	£'000
Armley Medical Practice	7	-	12	-
Beechtree Medical Centre	-	-	17	-
Burley Park Medical Centre	6	-	9	-
Drighlington Medical Centre	2	-	3	-
The Gables Surgery	3	-	6	-
Gildersome Health Centre	3	-	3	-
Guiseley and Yeadon Medical Practice	6	-	13	-
High Field Surgery, Holt Park	5	-	6	-
Highfield Medical Centre, Bramley	3	-	6	-
Hyde Park Surgery	5	-	6	-
Ireland Wood and Horsforth Medical Practice	12	-	19	-
Laurel Bank Surgery	4	-	4	-
Menston and Guiseley Practice	6	-	9	-
Morley Health Centre	2	-	3	-
Priory View Medical Centre	6	-	9	-
Pudsey Health Centre	4	-	7	-
Robin Lane Health and Wellbeing Centre	7	-	10	-
South Queen Street Medical Centre	-	-	17	-
Sunfield Medical Centre	3	-	22	-
West Lodge Surgery	9	-	14	-
Whitehall Surgery	5	-	6	-

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;
- Department of Health;
- West and South Yorkshire and Bassetlaw Commissioning Support Unit;
- 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 17 – Events after the Reporting Period

NHS England recently announced details of the CCGs approved to take on greater delegated responsibility or to jointly commission GP services from 1 April 2016. The new primary care co-commissioning arrangements are part of a series of changes set out in the NHS Five Year Forward View.

NHS Leeds West CCG has been approved under delegated commissioning arrangements which mean that the CCG will assume full responsibility for contractual GP performance management, budget management and the design and implementation of local incentive schemes from 1 April 2016. The CCG has received notification that its allocation for these activities will be £42.9m for the 2016-17 financial year.

Note 18 – Losses and Special Payments

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

18.1 – Losses	Total No. of Cases 2015-16	Total Value of Cases 2015-16	Total No. of Cases 2014-15	Total Value of Cases 2014-15
	Number	£'000	Number	£'000
Administration write-offs	1	60	-	-
Fruitless payments	-	-	-	-
Store losses	-	-	-	-
Book keeping losses				
Constructive loss	-	-	-	-
Cash losses	-	-	-	-
Claims abandoned	-	-	-	-
Other losses	-	-	-	-
Total	**1**	**60**	**-**	**-**

18.2 – Special Payments	Total No. of Cases 2015-16	Total Value of Cases 2015-16	Total No. of Cases 2014-15	Total Value of Cases 2014-15
	Number	£'000	Number	£'000
Compensation payments	-	-	-	-
Extra contractual payments	-	-	-	-
Ex gratia payments	-	-	-	-
Extra statutory regulatory payments	-	-	-	-
Special severance payments	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 19 – Financial Performance Targets

	Maximum	Performance	Duty Achieved
	£'000	£'000	
Expenditure not to exceed income	420,494	407,821	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	417,185	404,512	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 sue does not exceed the amount specified in Directions	8,279	7,584	Yes

The CCG underspent on its running cost budget by £0.7m (2014-15: £2m), non-recurrently transferring this resource in year to commission additional healthcare as permitted under the NHS virement rules. £0.6m of the £0.7m (2014-15: £1.1m of the £2m) is as a result of a national requirement to show quality premium budgets as part of the Administration allocation whilst the expenditure is shown within Programme costs.

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