Annual Report and Accounts
2018-19
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About our annual report

The annual report and accounts for the year ending 31 March 2019 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 and Social Care. The Manual for Accounts complies with the requirements of the Government Financial Reporting Manual, which the Department of Health and Social Care Group Accounts are required to comply with.

The structure closely follows that outlined in the guidance and includes:

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

**Change to Chief Executive / Accountable Officer role**

Philomena Corrigan was the CCG’s Chief Executive and Accountable Officer during 2018-19 and continued in her role until 30 April 2019. However, as the final version of this report was not formally approved by the CCG Governing Body until after she stepped down, it has been signed by the new Chief Executive and Accountable Officer, Tim Ryley, who took over on 1 May 2019.

**A note about abbreviations**

Throughout this report, we use a number of abbreviations. These are always explained in full the first time they appear, but the most common ones are:

- CCG - Clinical Commissioning Group
- DHSC - Department of Health and Social Care
- LCC - Leeds City Council
- LCH - Leeds Community Healthcare NHS Trust
- LCP - Local Care Partnership
- LTHT - Leeds Teaching Hospitals NHS Trust
- LYPFT - Leeds and York Partnership NHS Foundation Trust
- NHSE - NHS England
- YAS - Yorkshire Ambulance Service
In 2018 the NHS celebrated its 70th anniversary and it’s fair to say a lot has changed since the NHS was set up.

Although the changes that have taken place since 5 July 1948 have seen health services revolutionised and some awe inspiring advances in medicines and technology, sometimes the change process can feel uncomfortable.

Leeds has been at the heart of some key advances in medicine that mean patients now live longer than they did when the NHS was established, have access to world class healthcare and have benefitted from some pioneering treatments.

In 1952 Maurice Ellis became the first accident and emergency consultant to be appointed in the UK, possibly the world, making Leeds the birthplace of emergency medicine. Just five years later Consultant Cardio-Thoracic Surgeon Geoffrey Wooler led one of the greatest surgical advances, when his team performed a successful open heart operation. More recently, in 2013, the UK’s first hand transplant took place at Leeds General Infirmary (LGI) and in 2016, the first double hand transplant was carried out at the LGI.

The recently launched NHS Long Term Plan will see a further period of change that’s designed to secure the future sustainability of the NHS. While this may feel like a daunting prospect for patients and staff alike, it’s important to recognise that in Leeds we continue to be ahead of the game.

The Long Term Plan has an expectation that all areas in England will have established primary care networks by July 2019 - encouraging more collaboration between GPs, their teams and community services. We are confident that we have already created the conditions and relationships in the city to do this.

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We have worked with our member GP practices, the GP federations and the new Leeds GP Confederation to prepare for this. In addition we have been developing local care partnerships with our primary care colleagues alongside frontline professionals from Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust, Leeds City Council and a range of community and voluntary sector organisations.

The Long Term Plan talks about the importance of integrated services and integrated teams. Again Leeds has been leading the field in this area and has long been recognised as one of the leading cities (gaining pioneer status) for its work on integrated services.

We have a well-established Health and Wellbeing Board that’s developed an ambitious health and wellbeing strategy where we aim to be the best city for health and wellbeing. This is supported by the Leeds Health and Care Plan, which is currently being refreshed, that talks about the importance of prevention, self-care and self-management so that people in Leeds only need to go to hospital for emergency or specialist care.

The Long Term Plan talks about the importance of developing our workforce with the skills and capabilities to meet current and future demand. In Leeds we’ve been working closely with our partners to establish the Leeds Academic Health Partnership, and the Leeds Health and Care Academy was launched on 1 April 2019. We are using the same principle of thinking of our collective budgets in Leeds as the ‘Leeds pound’ with our staff under the banner of ‘one workforce’.

We are working with other partners across our region as part of the West Yorkshire and Harrogate Health and Care Partnership. The Long Term Plan talks about the key role that integrated care systems (ICS) will play in delivering the ambitions, and our partnership is one of just 14 in England that are working towards developing an integrated care system. You can find out more about the work of the West Yorkshire and Harrogate Health and Care Partnership in section 2.9.2.
While we’ve been planning for the future, it’s important to reflect on how the CCG continues to meet its duty as a commissioner (an organisation that plans and funds services).

It is fair to say that winter 2017-2018 saw unprecedented pressures faced by the health and care system in Leeds, which were reflected in the performance across our partners. We worked hard to ensure that we wouldn’t see a repeat of this in 2018-2019. We benefitted from the insights provided by an organisation called Newton Europe who helped us identify issues, particularly around patient flow that was leading to delayed discharges. In addition the Care Quality Commission undertook a review of the health and care system over autumn. Again we welcomed the findings of the review, which identified that we had a robust system and partnership arrangements that just needed further finessing.

This winter we have worked together as one system and we have demonstrated the benefits of a truly joined up approach. Although we may not have met the national targets, our performance has been consistent and we have addressed many of the issues that confronted us previously. We had no patients in non-designated areas and significantly reduced the number of delayed discharges. We have maintained a consistent performance around the four hour A&E target, especially when compared with other cities with similar populations.

Over the winter period we launched a campaign called the ‘Big Thank You’ which encouraged people to say a message of thanks to anyone who helps them get through the winter months and beyond. At the time of writing we had nearly 1600 messages submitted to www.bigthankyouleeds.co.uk On behalf of the CCG we’d like to say a ‘big thanks’ to everyone who has helped us this winter and throughout the year. This includes our community and voluntary groups and people in Leeds who do their bit to keep the city going. And we’d like to say a very personal thank you to staff at the CCG for their continued support and commitment to the work we do.

Talking of winter campaigns and the importance of us pulling together, the West Yorkshire and Harrogate Health and Care Partnership launched the ‘Looking out for our neighbours’ campaign in March 2019 (www.ourneighbours.org.uk). The campaign, which has received the backing of over 300 organisations, was launched by Kim Leadbeater, the sister of Jo Cox MP, who was tragically killed in 2016. It aims to encourage people to champion togetherness in an effort to reduce social isolation and loneliness in our communities.

At the beginning of our foreword we talked about how Leeds has led the way in developing advances in treatment. This year we saw the launch of a tele-dermatology service as part of the Macmillan-funded Leeds Cancer Programme. The service allows GPs to take a picture of any concerning skin lesions and send them from a smartphone directly to hospital consultants. If the consultants feel it’s appropriate, they ask a patient to attend an assessment clinic, and within 48 working hours they can provide the results of the test. This has dramatically increased the speed of diagnosis as well as providing greater convenience for patients and healthcare staff.

Our nationally recognised work with providing support for people with mental ill health continues apace. Our MindMate and Future in Mind programme and website (www.mindmate.org.uk) has been making great strides to improve the support available to children and young people. Meanwhile we have ensured that we raise the profile of MindWell (www.mindwell-leeds.org.uk), the one stop mental health portal for adults and professionals to access advice and support.

The Long Term Plan talks about the importance of prevention and how we can work with people to encourage changes in lifestyle to reduce the risk of developing long-term conditions. In addition, it also highlights the importance of those with an existing condition taking greater
Throughout our annual report you’ll see examples of the great work going on in Leeds. It’s thanks to the work of our colleagues who have, at times, had to take brave decisions to fund initiatives that are innovative that we continue to be seen as a city that leads the way in healthcare.

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We want to end our foreword by saying thanks once again to those that make the CCG such a great organisation for us to work to lead - our staff and our member practices.

We will make sure that we continue to work with all of you so that we can meet the ambitions laid out in the NHS Long Term Plan.

Gordon & Phil

Dr Gordon Sinclair, Clinical Chair
Philomena Corrigan, Chief Executive.

A personal message from Philomena Corrigan

This is my last year as chief executive for NHS Leeds CCG as I’ll be stepping down at the end of April 2019. I wanted to say a very personal message of thanks to colleagues across the CCG and our partners for all your support that has seen the CCG consistently meet its statutory duties.

Furthermore I’d like to extend my message of thanks to my executive team, our clinical leads, member practices and our Governing Body. We continue to be rated as a ‘Good’ CCG and that could not happen without your support.

While I’ll be sad to be leaving the CCG I know I’ll be handing over to a very capable colleague - Tim Ryley, who I’m sure will continue to steer the CCG through the coming years as we move through a changing commissioning landscape towards an integrated care system.

care of their own health with the appropriate support. There are many examples of how we have supported work around prevention; one of the areas we’ve been working on is support for people with diabetes.

We have been developing a diabetes strategy for the city, which looks at how services can support those with the condition on self-management. Throughout the year we have been working on a number of campaigns to raise awareness of the condition and elements of self-care. This includes the importance of foot care to reduce the risk of complications that could include amputations.

We earlier recognised the work we’ve done with our member practices. We now want to acknowledge the work that the general public do to help ensure that we commission services that most closely meet local needs. We want to start by saying thank you to people who take time out of their busy lives to volunteer with their GP practice’s patient participation group (PPG). PPGs play a critical role in helping us to understand more about neighbourhood level needs and identify any areas of concern. We have provided a small amount of funding to PPGs in the city to support the work they do.

We recognise the value of the ‘patient voice’ and we have actively involved local people in shaping decisions about future services. We want to say thanks to all those who have taken part in our activities - either through volunteering for us, completing a survey, attending focus groups or through any other means. You can find out more about how your views have made a difference in section 2.4.
1. Performance report - overview

1.1 Purpose of overview section
Welcome to the 2018-19 annual report for NHS Leeds Clinical Commissioning Group (CCG). The overview section of this report highlights our approach and achievements during the year ended March 31 2019. It gives a snapshot of who we are, what we do, the challenges we have faced and what we have done as a result.

1.2 Statement from the chief executive
The past year has again presented the NHS and our partner organisations with significant challenges in terms of meeting growing demands for health and social care and the increasing costs of commissioning those services. These challenges are not unique to NHS Leeds CCG, and we have worked together locally and regionally to achieve the best outcomes for local people.

Leeds is one of a number of areas in England where separate clinical commissioning groups are coming together to form single organisations. On 1 April 2018, the three former Leeds CCGs formally merged to become a new statutory organisation, NHS Leeds CCG, and in the following months, all our staff moved into a single premises. Further change followed, as two of our provider-facing teams, primary care development and clinical pharmacy, became embedded in the newly formed Leeds GP Confederation where they continue to support our member GP practices and help the Confederation to improve the health of the people of Leeds by strengthening and sustaining primary care.

As a result of previous additional investment, national funding and the support of the Confederation, we’ve made great progress in improving access to general practice, with all GP surgeries in the city now offering evening and weekend appointments. We’re confident that this improved access, combined with our work to develop urgent treatment centres, the emerging primary care networks and our continued work to help people choose the right care, will help relieve pressures on our hospitals and emergency services.

Leeds is not immune from the intense pressure faced by the NHS, and although this winter was less challenging than the previous year, the pressure has remained almost constant. We have seen an increase in the number of people attending A&E this year and although fewer patients waited more than four hours to be seen, treated or discharged compare to last year, the nationally expected performance standard continues to go unmet. We have also observed an increase in the number of people waiting for treatment to begin due to specialist capacity constraints, predominantly associated with both spinal and colorectal surgery.

As people become older and develop greater needs of support to leave hospital, capacity shortages in community-based support have contributed to bed occupancy rates and length of stay in hospital increasing. System-wide initiatives to reduce delayed transfers of care are beginning to take effect, but we recognise there is still more to do to improve upon patient experience and outcomes delivered, particularly for patients with severe mental health conditions and for people living with dementia. We also recognise that our performance associated with accessing services for adult anxiety disorders and depression continues to be significantly below the expected standard and we have taken action to improve upon service capacity to resolve this issue in the near future.

For most of the year, we met expected levels of performance for cancer diagnosis, referrals and treatment, which are crucial for patients’ physical and emotional health wellbeing. We’re also collaborating with partners to develop new ways to improve patient experience using new technologies, such as the teledermatology scheme mentioned in the foreword. This new approach is already freeing up capacity and improving patient care. In addition, we’re performing above the national average in
dementia diagnosis, which is helping improve people’s ability to access treatment, care and support.

One area to highlight is the work we do to engage with patients and the wider public to make sure they have a say in the services we provide. During the past year, we carried out a wide range of activities and events to ensure we heard from as many people as possible on service developments including diabetes, social prescribing, frailty, mental health and urgent treatment centres. We also played a key role in the Big Leeds Chat, a system wide approach to engaging with people in Leeds about the things that matter to them.

During the year we continued to work with children and young people to develop our fantastic mental health resource, MindMate - www.mindmate.org.uk - which is specifically for young people, their families and the professionals who support them. In 2018, we worked with them to run a series of events and activities to raise awareness of young people’s mental health issues and the resources available to support them. We are especially grateful to the MindMate ambassadors for their willingness to share publicly their personal experiences of mental health and for their continued work to develop a first class resource for young people in Leeds.

Over the coming years, the NHS will face real pressure to deliver against the demands being placed upon us but there are also real opportunities to meet these demands in new ways. Our performance for 2018-19 shows that our systems and our people are ready to face these challenges head on and have an appetite for innovation. Although we have missed some targets, our overall performance has once again been strong, and for this, I’d like to thank all our staff, member practices and partner organisations, including the local authority, providers and third sector.

Tim Ryley
Chief Executive (Accountable Officer), NHS Leeds CCG

The past year has again presented the NHS and our partner organisations with significant challenges in terms of meeting growing demands for health and social care and the increasing costs of commissioning those services. These challenges are not unique to NHS Leeds CCG, and we have worked together locally and regionally to achieve the best outcomes for local people.
1.3 The nature and purpose of our organisation

NHS Leeds Clinical Commissioning Group (CCG) has successfully completed its first year of operation as a statutory body, following the merger of the three previous CCGs in the city (NHS Leeds West, NHS Leeds South and East and NHS Leeds North) on 1 April 2018. Our commissioning activities are in line with the statutory responsibilities outlined in our Constitution.

The CCG is made up of 100 member GP practices (as at 31 March 2019) covering the whole of the city of Leeds, with a registered population of more than 885,000 people.

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

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

We commission a range of services for adults and children including community health services, planned care, acute services, NHS continuing care, mental health and learning disability services. We co-commission GP primary care services with NHS England. We do not commission other primary care services such as dental care, pharmacy or optometry (opticians) which is done by NHS England through their local area team more commonly referred to as NHS England (West Yorkshire). NHS England also has the responsibility for commissioning specialised services such as kidney care.

The following healthcare providers / areas of spending cover 85% of the CCG’s commissioning budget:

<table>
<thead>
<tr>
<th>Provider / Area</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leeds Teaching Hospitals NHS Trust</td>
<td>420</td>
</tr>
<tr>
<td>Mid Yorkshire Hospitals NHS Trust</td>
<td>27</td>
</tr>
<tr>
<td>Harrogate &amp; District Foundation Trust</td>
<td>27</td>
</tr>
<tr>
<td>Bradford Teaching Foundation Trust</td>
<td>5</td>
</tr>
<tr>
<td>Nuffield</td>
<td>11</td>
</tr>
<tr>
<td>Spire</td>
<td>9</td>
</tr>
<tr>
<td>Yorkshire Clinic</td>
<td>4</td>
</tr>
<tr>
<td>Yorkshire Ambulance Services NHS Trust</td>
<td>30</td>
</tr>
<tr>
<td>PTS/111 and WYUC</td>
<td>14</td>
</tr>
<tr>
<td>Leeds &amp; York Partnership NHS Foundation Trust</td>
<td>100</td>
</tr>
<tr>
<td>Leeds Community Healthcare NHS Trust</td>
<td>98</td>
</tr>
<tr>
<td>Prescribing recharges from the Prescription Pricing Authority</td>
<td>119</td>
</tr>
<tr>
<td>Primary care co-commissioning</td>
<td>112</td>
</tr>
<tr>
<td>Better Care Fund (Leeds City Council)</td>
<td>23</td>
</tr>
<tr>
<td>Funded nursing care</td>
<td>8</td>
</tr>
<tr>
<td>Mental health learning disabilities</td>
<td>27</td>
</tr>
<tr>
<td><strong>Main areas of commissioned spend</strong></td>
<td><strong>1,034</strong></td>
</tr>
<tr>
<td>Other smaller contracts</td>
<td>178</td>
</tr>
<tr>
<td><strong>Total net commissioning spend (programme budget)</strong></td>
<td><strong>1,212</strong></td>
</tr>
</tbody>
</table>

A full list of contracts with providers is available on request. There have been no significant changes to services contracted by the CCG during 2018-19.

1.4 Our business model

The CCG is responsible for the strategic planning, procurement (contracting), monitoring and evaluation of the performance of a prescribed set of services that are delivered by a range of NHS, independent and third sector health and care providers in order to meet the needs of our local population.
These providers offer a range of hospital treatments, rehabilitation services, urgent and emergency care, community health services, mental health and learning disability services.

Each year the CCG undertakes a planning process that provides the key mechanism for ensuring our plans are meeting our population’s needs and will continue to do so within available resources. This planning process is increasingly being undertaken within the context of the development of wider ‘place based’ plans known as integrated care systems (ICS). The following outlines our approach to the planning process:

a) Development of local planning priorities framework - our Governing Body review:
   • Our performance against a set of nationally set NHS standards as set out in the NHS Planning Guidance (including NHS Constitution standards);
   • The health needs of our population identified through the Joint Strategic Assessment (JSA) and as set out within the Leeds Health and Wellbeing Strategy;
   • Priorities for health and services as identified by our clinicians, patients and the public; and
   • Priorities identified through working with wider Leeds and West Yorkshire health and care system.

b) Review of the 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 and other initiatives are helping to deliver our priorities and to ensure that they will continue to do so. If we feel this is not the case, we outline any actions or changes required. Increasingly these transformation plans include those developed within the West Yorkshire and Harrogate Health and Care Partnership (formerly Sustainability Transformation Partnership) and the Leeds Plan.

c) Investment planning: developing investment proposals for new initiatives that will support the CCG’s and citywide priorities.

d) Agree investment profile: prioritising investments to ensure we target resources on those initiatives that will have the greatest impact on delivering our priorities.

e) Sign off: the Governing Body formally signs off our plans on the basis that they will deliver both our service and financial objectives.

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

During 2019-20, the CCG and partners will be working to develop plans that support the delivery of the NHS Long Term Plan. The publication of the plan signalled the increases in investment that the NHS and NHS Leeds CCG will receive over the next five years. This will provide an exciting opportunity for us to begin planning for the longer term and within that, for the delivery of the CCG strategy as published in 2018.

1.5 Our strategy

We continue to pursue ambitious plans so that we can help improve the health of our local communities; our priorities reflect those of the Leeds Health and Wellbeing Strategy 2016-2021, the Leeds Plan and the West Yorkshire and Harrogate Health and Care Partnership. Our collective ambition is that “Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest.”

To deliver this ambition we will focus resources to:
   • Deliver better outcomes for people’s health and well-being
   • Reduce health inequalities across our city

We will also work with our partners and the people of Leeds to:
   • Support a greater focus on prevention and the wider determinants of health
• Increase their confidence to manage their own health and well-being
• Deliver more integrated care for the population of Leeds
• Create the conditions for health and care needs to be addressed around local neighbourhoods.

We want specifically to see improvements in:
• Avoidable years of life lost
• Number of people supported to manage their health condition
• Number of people with a serious mental illness dying early
• Unnecessary time patients spend in hospital
• Numbers of preventable hospital admissions
• Numbers of repeat emergency visits to hospital.

Throughout our annual report you’ll see examples of how we are doing this.

1.6 Financial performance and outlook

1.6.1 Financial performance during 2018-19

The financial duties of a CCG are set out by NHS England and can be found in the annual accounts (note 20). The CCG has delivered against all of these duties.

For the 2018-19 financial year, the CCG has again contained expenditure within its in-year resource allocation as well as being able to provide £5m of resource to NHS England to support the wider healthcare system. The provision of this resource will enable the CCG to draw down both this £5m plus a further £5m of its historic accumulated surplus in 2019-20 to provide £10m of non-recurrent resource to pump prime efficient transformational service changes for the benefit of the health and social care system in Leeds.

### Better Payment Practice Code

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.

#### Better Payment Practice Code - measure of compliance 2018-19

<table>
<thead>
<tr>
<th>Better Payment Practice Code - Measure of Compliance</th>
<th>2017-18</th>
<th>2017-18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000s</td>
</tr>
<tr>
<td>Non-NHS Creditors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills paid in the year</td>
<td>17,635</td>
<td>320,899</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>17,259</td>
<td>317,925</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>97.87%</td>
<td>99.07%</td>
</tr>
<tr>
<td>NHS Creditors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total bills paid in the year</td>
<td>5,177</td>
<td>780,456</td>
</tr>
<tr>
<td>Total bills paid within target</td>
<td>5,115</td>
<td>780,053</td>
</tr>
<tr>
<td>Percentage of bills paid within target</td>
<td>98.80%</td>
<td>99.95%</td>
</tr>
</tbody>
</table>

The CCG’s running cost envelope is set by NHS England at £21.75 per head of the expected population that the CCG will commission healthcare services for. This resource is to cover all aspects of the administration and running of the CCG as a statutory body. The running cost envelope for NHS Leeds CCG for 2018-19 financial year was £17.5 million. The total actual spend was £14.7 million.

As a condition of the merger of the three previous CCGs in Leeds, the newly established NHS Leeds CCG was required to plan to underspend on its running cost envelope by 20% between 2018 and 2020. The agreed target for 2018-19 was 16.4%. The actual underspend achieved was 16.0%.
**Better Care Fund**

The CCG has entered into a partnership arrangement with Leeds City Council in relation to the Better Care Fund (BCF). A partnership agreement between the two organisations describes the commissioning arrangements for a range of health and social care services.

The two funds are hosted by either Leeds City Council or the CCG. The BCF partnership agreement is based on the national template developed by NHS England and Bevan Brittan. All funds are overseen by a joint BCF Partnership Board. A summary is tabled below.

### Contributions

<table>
<thead>
<tr>
<th>Fund</th>
<th>Hosted by</th>
<th>NHS Leeds CCG £000</th>
<th>Leeds City Council £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fund 1</td>
<td>CCG Hosted s75 Agreements</td>
<td>22,389</td>
<td>-</td>
<td>22,389</td>
</tr>
<tr>
<td>Fund 2</td>
<td>Council Hosted s75 Agreements</td>
<td>22,312</td>
<td>9,272</td>
<td>31,584</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>44,701</strong></td>
<td><strong>9,272</strong></td>
<td><strong>53,973</strong></td>
</tr>
</tbody>
</table>

### Expenditure

<table>
<thead>
<tr>
<th>Fund</th>
<th>Hosted by</th>
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</tbody>
</table>

### 1.6.2 Financial outlook

NHS Leeds CCG will have an allocation of £1.3bn for the 2019-20 financial year. The growth received amounts to 5.47% for core allocations; this is less than the national average (5.7%) because the CCG has been assessed to be over its target financial allocation.

2.6% of this growth relates to a number of pre-commitments, including nationally agreed staff pay increases and ‘pass through’ funding for healthcare service providers. Of the remainder, there are a number of pre-commitments, cost pressures and demand growth pressures.

This results in a positive but nevertheless challenging financial outlook as we move into 2019-20, highlighting the importance of more efficient transformational service changes for the benefit of the health and social care system in Leeds.

The CCG simultaneously operates on the Leeds and West Yorkshire footprint, both of which are amongst the largest in the country, with risks and opportunities that are commensurate with this magnitude. It is therefore even more important that the CCG continues to fully engage at a strategic level with Leeds City Council, NHS England Specialised Commissioning and West Yorkshire partner organisations to develop a joined up approach to commissioning health care services for the population of Leeds.

The greatest challenge facing the CCG is to ensure that the population of Leeds continues to benefit from the best and most efficient use of the NHS resources allocated to them each year.

Information on the CCG’s approach to managing risks in relation to the EU Exit plan are included in section 1.7.2 below. The financial impact on the CCG directly will be contained within the general system resilience and demand risks included in the 2019-20 financial plan.

### 1.7 Key issues and risks

The governing body assurance framework - GBAF - is the key mechanism for identifying and ensuring the management of risks affecting the achievement of our strategic objectives. It draws together the high level risks from a variety of sources and enables the governing body to focus on making sure that the impact of these risks is minimised through appropriate management action.
The GBAF is supported by a risk register that provides a local record of all potential or actual organisational risks. More details are in section 3.3.6 of the annual governance report.

As at 31 March 2019 the key risks faced by the CCG were:

- Not maintaining a sustainable primary care workforce due to difficulties recruiting GPs and practice nurses;
- EU Exit - potential impact on availability of workforce, demand for healthcare as a result of changes to reciprocal healthcare arrangements, continuation of research and clinical trials, interruption to data sharing, processing and access to data and increased costs of supplies;
- Risk to cyber security impacting on availability of systems and data;
- Capability to manage demand and discharge volumes during times of high demand;
- Completeness of medication incident reporting.

1.7.1 Emergency preparedness

We certify that NHS Leeds CCG 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 attend the West Yorkshire Urgent and Emergency Care Programme Board and engage with West Yorkshire wide urgent care projects as required.

1.7.2 EU exit

The CCG has established a response plan based on Department of Health and Social Care Guidance. In line with these requirements, a command and control approach has been adopted by the CCG with a nominated core team to monitor the situation and ensure a co-ordinated response.

The CCG Emergency Preparedness Resilience and Response team is participating within national, regional and local forums with a health and social care focus and ensuring links with the wider system through Leeds City Council.

1.8 Performance summary

CCGs are accountable for how they spend public money. Reflecting upon our overall performance over the year, we are performing particularly well in a number of areas such as cancer care, maternity and dementia, where we are meeting or exceeding national standards.

However, increased demand for NHS services has presented a significant challenge. Although we had planned to meet all national planning standards and commitments in 2018-19, this has not been possible for some of our commissioned services. We will continue to closely monitor performance in relation to waiting times, mental health, learning disabilities and diabetes, while working with our partners to improve next year.

In our annual report you’ll see steps we’ve taken to address this or mitigating circumstances.

Tim Ryley
Chief Executive (Accountable Officer)
22 May 2019
2. Performance analysis

2.1 Progress on priority areas

2.1.1 Healthcare performance in Leeds

Clinical commissioning groups (CCGs) were established on 1 April 2013 and are clinically led organisations at the heart of the NHS system. They are driven by the pursuit of improving the health and wellbeing of the whole population; reducing health inequalities; delivering better quality for all patients; and, securing better value for taxpayers in a financially sustainable system.

One of our main duties is to commission efficient and effective healthcare services that meet the needs of the population of Leeds who require NHS healthcare. The services we commission are monitored locally, regionally and nationally through a range of performance indicators. These indicators include performance against NHS priorities, including the NHS Constitution standards, along with a set of benchmark indicators specified within the CCG Improvement and Assessment Framework.

These indicators cover many areas from access targets, such as the time a patient has to wait for hospital treatment, to measures of effectiveness of our services - for example, rates for early diagnosis of cancer and number of beds occupied as a result in delays in hospital discharge processes. Indicators also monitor quality standards such as the rate of healthcare associated infections.

CCGs are monitored against these indicators by NHS England. We routinely monitor our performance against all the key standards and where appropriate work with our partner organisations in hospitals, ambulance services, community health services, member practices and with Leeds City Council to agree the support and changes required within the health and care systems to ensure we can achieve them.

2018-19 has been a challenging year both nationally and locally for health and care services. The success over many years in increasing life expectancy means that people are living longer and an ageing population means that we have increasing demand for primary, community, social and hospital care.

2.1.2 CCG Improvement and Assessment Framework

NHS England has a statutory duty (under the Health and Social Care Act (2012)) to conduct an annual assessment of every CCG. The assurance process aims to ensure that CCGs are commissioning safe, high quality and cost effective services, to achieve the best possible outcomes for patients. However, whilst legislation requires an annual assessment of each CCG, commissioning and other arrangements, including assurance, increasingly take place at a multi-organisational level.

The CCG Improvement and Assessment Framework (CCG IAF) was introduced in March 2016 and provides a focus on assisting improvement alongside the statutory assessment function of NHS England. It aligns with NHS England’s mandate and planning guidance, with the aim of unlocking change and improvement in a number of key areas. This approach aims to reach beyond CCGs, enabling local health systems and communities to assess their own progress from ratings published online.
The framework draws together the NHS Constitution, performance and finance metrics and transformational challenges. It underpins the delivery of the Five Year Forward View and sets out four domains that reflect the key elements of well-led and effective CCGs as listed below:

- **Better health**: this section looks at how the CCG is contributing towards improving the health and wellbeing of its population.

- **Better care**: focus on how CCGs are supporting redesign of care, performance of constitutional standards, and improving health outcomes with a specific focus on six clinical areas: mental health, dementia, learning disabilities, cancer, maternity and diabetes.

- **Sustainability**: how the CCG is remaining in financial balance, and is securing good value for patients and the public from the money it spends.

- **Leadership**: assessment of the quality of the CCG’s leadership and strength of its governance, including the quality of its plans and how the CCG works with its partners.

The 2018-19 framework includes a set of 58 indicators, although data for five indicators is not currently in publication.

The 2017-18 annual assessments determined each of the three former Leeds CCGs to be rated as ‘good’. The rating for Leeds CCG for 2018-19 will be known in July 2019 and will be published on the My NHS website: [www.nhs.uk/mynhs](http://www.nhs.uk/mynhs).

### 2.1.3 My NHS

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

The Five Year Forward View set out national ambitions for transformation in a number of clinical priority areas and the assessment rating of these areas are also published on the My NHS website.

The six clinical priority areas are:

- Cancer
- Maternity
- Mental health
- Dementia
- Learning disabilities
- Diabetes

Assessment ratings for the clinical priority areas are determined by considering performance across a small number of key measures and independent panels establish the thresholds for each rating. Our assessment ratings for cancer, maternity and dementia were “good”; however, mental health and learning disabilities were rated as “requires improvement” and diabetes was rated as “inadequate”.

We are currently developing a five-year commissioning plan which will outline our strategic intentions to deliver the best outcomes at the lowest cost. It will include a focus on how we intend to achieve this ambition for each of the six clinical priority areas listed above.

### 2.1.4 Areas of achievement

Based on our performance to date in 2018-19, we are expecting to achieve some of the NHS Constitution Standards which are listed below. Where relevant, we have included reference to Leeds Teaching Hospitals NHS Trust (LTHT) since the vast majority of Leeds patients receive hospital-based care by this provider.

#### Waiting times for diagnostic tests

A diagnostic test is a test or procedure used to identify a person’s disease or condition and which allows a medical diagnosis to be made. Shorter waiting times are beneficial, as they help people get quicker access to the treatments they need.

The national operational standard is for less than 1% of patients to wait six weeks or longer for their diagnostic test. During the majority of 2018-19, we have achieved the expected level of performance, although in recent months (November 2018 to January 2019) performance has deteriorated a little, but actions are in place at LTHT to support recovery.
Waiting times for urgent cancer referrals
If a GP suspects symptoms that may indicate a patient has cancer, they may request an urgent appointment with a specialist to undertake further investigation. Access to timely and effective cancer services is crucial for patient experience and outcomes.

At least 93% of patients urgently referred with suspected cancer by their GP to a specialist are expected to receive an appointment within two weeks of referral. During April to September 2018, the expected level of performance was not achieved. This has predominantly been due to a constraint in specialist capacity to undertake further investigations for symptomatic breast patients (where cancer was not initially suspected) at LTHT. However, performance has improved significantly in recent months due to breast capacity being improved, and consequently, we believe performance against these standards will be achieved for 2018-19.

Waiting times for first and subsequent cancer treatments
Where cancer is diagnosed and a decision to treat has been made, the first definitive treatment is expected to be delivered within 31 days for at least 96% of people. Similarly, where subsequent treatment is required, the operational standard is for 98% of patients to be treated within 31 days of the decision to treat date where the treatment is an anti-cancer drug regime, 94% where the treatment is radiotherapy and 94% where the treatment is surgery.

Performance against these four standards has generally been positive during 2018-19. The expected performance standards have been achieved each month for both subsequent drug regime and radiotherapy treatment options; in those months where standards were not achieved for first definitive treatment and subsequent surgical treatment, the level of underperformance has been marginal and not sustained for long periods.

Dementia diagnosis rate
Approximately three-quarters of the people estimated to be living with dementia in Leeds have been diagnosed with the condition, which helps improve their ability to cope and access treatment, care and support. This level of performance exceeds the national ambition of having at least 66.7% of the dementia prevalent population diagnosed.

2.1.5 Improving upon our performance
The CCG remains fully committed to ensuring that we put plans in place to maximise the potential to deliver all NHS Constitution commitments, as well as making progress on improving the quality of our services, improving health outcomes and reducing health inequalities for our patients. However, it is clear that there have been a number of performance challenges in 2018-19 and many of these challenges are expected to continue into the following year.

The key priority areas requiring action are outlined below.

Referral to treatment times
In 2012 it became a statutory requirement for at least 92% of patients waiting to start treatment (known as being on an incomplete pathway) to wait no longer than 18 weeks from being referred. Although the Government’s mandate to NHS England for 2018-19 did not include an objective for this 18-week target to be met during the year, but instead was included as an “overall 2020 goal”, we have continued to monitor Leeds performance against a 92% target.

Whilst we are expected to narrowly miss the 92% target for the proportion of patients waiting 18 weeks for treatment to start, Leeds compares favourably with national and West Yorkshire performance.

Furthermore, in 2013-14, NHS England set an operational standard to ensure that no one waits more than 52 weeks for treatment. However, due to increasing pressure on the healthcare system (locally and nationally), the number of patients
waiting more than 52 weeks for treatment to start has been increasing. Consequently, NHS England set an expectation for the number of patients waiting 52+ weeks to have halved by March 2019 compared to the previous year. Unfortunately, we will not achieve this ambition in 2018-19.

Waiting times for cancer referral to starting treatment

Access to timely and effective cancer services is crucial for patient experience and outcomes. Consequently, we monitor performance on nine cancer measures against expected performance standards. For the majority of these measures, performance is generally positive; however, we have struggled to achieve the three measures associated with waiting 62 days for treatment to start following a referral, although nationally this has also been difficult to achieve in 2018-19.

The recent pressures we have observed on the local health and social care system, in addition to an increased number of people presenting with cancer symptoms, have contributed towards our levels of underperformance, with over half of urgent cancer transfers to LTHT being received late (after 38 days in a 62 day pathway). This has led to additional pressure on their ability to achieve the standard for all patients.

Improving Access to Psychological Therapies

Around one in six adults in England have a common mental health disorder, such as depression or anxiety. Improving Access to Psychological Therapies (IAPT) is a key element of the national strategy to improve support and outcomes for those with common mental health issues. There are a number of measures used to assess how well CCGs are doing in respect of this area.

75% of patients waiting for IAPT support are expected to wait no longer than six weeks, with 95% of patients expected to wait less than 18 weeks. For the vast majority of 2018-19, these waiting time standards have been met. Furthermore, at least 50% of patients who access IAPT support are expected to achieve a significant level of health improvement to warrant the judgement that the person has recovered. In Leeds, this is usually the case for patients accessing support.

However, we have struggled to provide sufficient capacity within IAPT services to cope with the demand for support. The expected standard for 2018-19 is that 19% of people who may benefit from IAPT can access the service, yet we forecast this to be closer to 14%. We have undertaken an assessment of current delivery and are working towards improving service provision in 2019-20.

2.2 Sustainable development

Sustainable development is commonly described as “…development that meets the needs of the present, without compromising the ability of future generations to meet their own needs…” - The Brundtland Commission, United Nations; Our Common Future, 1987

The concept of sustainable development requires organisations to focus on ‘three pillars’: social, environmental and economic. We recognise the great responsibility that comes with our roles as commissioners and providers of public services. As such, we continue to strive to offer services that meet local demands, but do so in a way that maximises wider positive impacts. Adding social, economic and environmental value will benefit our workforce, our providers, our local communities, the Leeds economy and the natural environment.

In 2016-17, we worked with other commissioners and providers to support the development of the West Yorkshire Sustainability and Transformation Plan (STP) and an underpinning Leeds Plan. Since then, we have continued to work with partners to develop and deliver these plans to ensure the transformation of services so that we are able to improve the health outcomes and quality of services for our population.
In 2018 the NHS published its Long Term Plan. This plan provides greater certainty as to the direction of the NHS for the next 10 years and the funding that will be available to the NHS over the next five years to support the delivery of that plan.

Our transformation plans, the NHS Long Term Plan and the changes signalled within that plan will require CCGs and their partners to take forward significant changes with regards to how we commission and provide services in the future. These changes provide an excellent opportunity for the CCG to make the changes that will secure increasing social, environmental and economic value as we move forward with our plans.

2.2.1 Our sustainable development management plan

The three former Leeds CCGs worked together to develop a shared Sustainable Development Management Plan (SDMP) as part of the development of the NHS Leeds CCGs Partnership. The new CCG will continue to develop our existing SDMP, focusing on a range of priorities, including:

- Reducing negative health impacts of travel and transport emissions, while realising cost, CO₂ and time efficiencies
- Implementing measures to reduce the level of resources used within the CCG building in an effort to lower CO₂ emissions and energy bills
- Ensuring that social value is embedded into our decision making to create wider community benefits
- Developing partnerships with Leeds City Council to support improvements to healthcare delivery
- Encouraging sustainable behaviour change through staff
- Working with partners to engage in wider sustainability initiatives:

With the establishment of the new CCG, staff have now relocated onto a single site. At the same time we have taken the opportunity to embed a range of new working practices that have had a number of benefits:

- Reduction in travel to work through improved remote working technology
- Reduction of travel between CCG sites
- Reduced travel between NHS and Leeds City Council sites due to improved networking and introduction of Skype for Business
- Reduced workspace footprint as a result of hot desks being introduced on all sites

2.2.2 Our environmental impact

The UK faces a legally binding EU target to reduce the quantity of CO₂ emissions emitted at a national level by 34% by 2020 and 80% by 2050. This reduction is measured from a 1990 baseline.

The NHS Sustainable Development Unit recommends a 28% reduction in CO₂ emissions by 2020 in order to abide by the Climate Change Act (2008). In recent years, our organisations have worked hard to reduce emissions and we hope to continue to make improvements.

Over the next year we will build on the opportunities to reshape our SDMP to reflect both changes to our organisation and to the wider NHS. In the short term that means we will focus on three areas:

- Ensuring we maximise the opportunities we have for reducing business and commuting travel through agile and remote working
- Ensuring we maximise the reduction in travel through the use of new technologies, such as Skype, to minimise the need for travel to meetings and the need for meeting spaces
- Reviewing the opportunities to reduce the use of electricity, gas, water and waste at Wira House.

2.2.3 Summary performance

By monitoring our activity throughout the year we are able to quantify our annual resource use and calculate our associated carbon footprint. These factors are important aspects
of environmental sustainability. Because we are a new organisation, a comparison between NHS Leeds CCG now and the previous organisation based at WIRA House, NHS Leeds West CCG, is presented in this report.

The move to WIRA House in May 2018 for all staff from the former Leeds CCGs has entailed a significant increase in area that the CCG occupies, as well as an increase in the number of people based in, and activities carried out on, the premises. WIRA House has a floor space of 10,600m² building; the previous premises had a floor space of 5,891m². This has therefore impacted on the electricity and gas required to power and heat the premises, which has had a detrimental impact on our carbon performance.

Between 2017-18 and 2018-19 electricity use increased by 29,862 kWh. However, because CO₂e emissions have been decreased by the UK Grid, the CCG’s CO₂e emissions from electricity have decreased by just under 10 tonnes over the past year.

Gas consumption fell by 30,051 kWh between 2017-18 and 2018-19 and associated CO₂e emissions reduced by 6.13 tonnes over this period. Water consumption has increased substantially from 865m³ in 2017-18 to 6,901m³ in 2018-19. This resulted in an additional emission of almost 7 tonnes CO₂e over this time period. The additional water consumption likely reflects the additional number of people working at the premises now.

Overall, when comparing 2017-18 with 2018-19, the total CO₂e emissions at the CCG have fallen by 14%, despite the increase in numbers of staff working at WIRA House. This decrease is primarily due to the “greening” of the UK electricity supply, as opposed to any specific actions taken by the CCG.

When compared to the 2013 baseline of NHS Leeds West CCG, overall CO₂e emissions have increased by 24% from 57.55 tonnes to 67.52 tonnes. However, this is to be expected considering the merger of three previously separate organisations into one larger organisation.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Consumption</th>
<th>CO₂ emissions (tonnes CO₂e)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Electricity kWh</td>
<td>61,093</td>
<td>52,220</td>
</tr>
<tr>
<td>Gas m³</td>
<td>69%</td>
<td>63,354</td>
</tr>
<tr>
<td>Water m³</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Car Travel Miles</td>
<td>21,918</td>
<td>30,637</td>
</tr>
<tr>
<td>Total CO₂ Emissions (tonnes CO₂e)</td>
<td>57.55</td>
<td>56.90</td>
</tr>
<tr>
<td>Annual CO₂ Change (%)</td>
<td>N/A</td>
<td>-1%</td>
</tr>
</tbody>
</table>

*CO₂ emissions have been calculated using the DEFRA carbon factors which are available here: www.gov.uk/government/collections/government-conversion-factors-for-company-reporting\conversion-factors-2018

These factors are revised each year in line with the carbon intensity of power, fuel and prevailing waste management practices. The use of these Government conversion factors explains why in some cases consumption does not change at the same rate as emissions.
2.3 Improving quality

We place quality at the core of the way we commission and monitor health care services for the population of Leeds. We do this by working in partnership with those who provide services for our population to define, monitor and update standards.

Organisations from which we commission care must meet essential standards of quality and safety, as defined by the Care Quality Commission (CQC), as well as locally developed standards which often exceed these essential requirements. We work closely with our acute, mental health and community services throughout the year to ensure that they meet these standards, tackling challenges with openness and integrity to ensure we enable the best outcomes for our population.

Five key elements drive the work of the quality and clinical governance team:

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

Based on the five key elements we have developed a framework to support processes and mechanisms by which we assure ourselves of the quality of care that we commission.

The Quality and Performance Committee continues to develop a collaborative approach to monitoring quality across the whole Leeds health economy. The committee reports directly to the governing body via the chair’s summary and integrated quality and performance report, ensuring that quality of care receives attention and scrutiny at the highest level within the CCG.

2.3.1 HCAI improvement

The multiagency Leeds healthcare-associated infection (HCAI) improvement group has continued to achieve a consistent and united approach to reducing avoidable harm from healthcare associated infections. The group has recently reviewed its work plan and has a range of priorities aimed at identifying concerns relating to HCAI and highlighting learning that can be shared across organisations to make improvements and ultimately reduce infections. The group works collaboratively with representation from the CCG, Leeds Teaching Hospital NHS Trust (LTHT), Leeds Community Healthcare NHS Trust (LCH), Leeds and York Partnership NHS Foundation Trust (LYPFT), three independent hospitals, public health and Leeds City Council health improvement team.

The group hosts a Clostridium Difficile Infection (CDI) review panel, and at the time of writing, the cases of avoidable CDI are within the agreed trajectory and cases of avoidable MRSA across the health economy in Leeds are also reducing. A collaborative sub-group to focus on reducing gram negative bacteraemias is also hosted by the group, as this is a key priority locally and nationally. This subgroup has achieved regional recognition for its work and success in raising awareness of e-coli infections.

A new cross city sepsis forum was established in 2018, led by LCH and supported by the CCG and Leeds City Council. This has membership from organisations across the city including the independent sector, primary care, out of hours GPs and the ambulance service. This group is looking to promote a consistent approach to the early identification and appropriate management of sepsis in Leeds and will work to support education, training and awareness in line with the national sepsis indicators.

2.3.2 Quality visits

We have a statutory responsibility to commission high quality services for the population of Leeds and are committed to working with providers to identify opportunities to support the provision of better care. To support our quality assurance and improvement processes we have visited provider organisations and services that we commission throughout the year. This provides an opportunity to see at first hand the quality of care being provided to our patients.
During 2018-19 we revised our quality visit process, ensuring we worked with providers to develop a comprehensive programme of visits to observe care delivery and the environment that it is being provided in. The quality visits have supported our quality assurance and improvement processes but have also provided an opportunity for providers to demonstrate service improvements and showcase areas of innovative practice.

During 2019-20 we will continue to develop our process as the move towards population health management and an outcomes-based approach to commissioning develops. This will require a tailored approach to visits as part of a pathway and include transition into and between services, professionals and levels of care.

2.3.3 Quality improvement

We have traditionally focused on quality assurance in order to realise quality improvements (QI) within the services we commission, usually in relation to improving performance of defined constitutional and other quality standards. During 2018-19 we have focused on redesigning patient pathways in a much more integrated way with an emphasis on improving longer term outcomes through QI. For example, we have employed QI methods and principles through the 10 High Impact Changes for General Practice and the Enhanced Health in Care Homes (EHCH) through dedicated teams.

In addition, we have used QI techniques to support wider improvements to the community care bed scheme across Leeds, in conjunction with Leeds City Council. During 2019-20 we will evaluate the work to see how teams can continue to work together to deliver similar QI training packages and how this can be replicated in other services.

2.3.4 Care home quality monitoring

During 2018 we developed and implemented the CCG care home procedure document to ensure we had robust quality assurance, improvement and support mechanisms in place to support care homes within Leeds. This has enabled us to work proactively with the Care Quality Commission and Leeds City Council to ensure high quality care within care homes. This work is coordinated through the Leeds Care Home System Delivery Group and overseen by the Leeds Care Home System Oversight Board.

2.3.5 Incident monitoring

The quality and clinical governance teams monitor our partner organisations in reporting, investigating and learning from serious incidents which occur within a provider of NHS healthcare. During 2018-19, 233 serious incidents were reported to the CCG. Of those serious incidents, eight were classified as “Never Events.” These are serious incidents that are entirely preventable because national guidance or safety recommendations providing strong systematic protective barriers is available and should have been implemented by all healthcare providers. The Never Events, by category included:

- One wrong site surgery
- One wrong implant
- One misplaced nasogastric tube
- Two unintentional connections of a patient requiring oxygen to an air flowmeter
- Three retained foreign objects

A panel is tasked with reviewing submitted reports and action plans from our providers to gain assurance that a robust investigation has been completed, reasons for the incident have been identified, and recommendations have been actioned to prevent something similar from happening again. The panel reviewed 120 investigation reports during 2018-19. We work with our partners to ensure learning and actions from all investigations are embedded in practice and shared on a wider basis.

Work continues with our providers to review pressure ulcer management and we are committed to supporting trusts to improve their outcomes. There is a city pressure ulcer management group which we contribute to
and support from a care home perspective, contributing to the gathering of data to support the delivery of projects that enable a collaborative approach to pressure ulcer management. During 2019-20 we hope to implement the ‘react to red’ train the trainer model across all care homes in Leeds to provide a consistent and standardised approach to identifying and managing pressure ulcers.

During 2018-19 we reviewed 3425 incidents reported by Leeds GP practices to identify key themes or trends so that we can disseminate learning across primary care. This involves close collaboration with primary care and medicines optimisation teams to provide support where needed. We continue to facilitate learning across the city to help reduce the likelihood of incidents recurring.

2.3.6 Patient experience

We are committed to delivering healthcare using an integrated approach with our local partners to improve not only the safety and effectiveness of care but also the experience of care for our patients and service users. During 2018-19 we developed our Patient Experience Framework, ensuring a robust framework to support the collation, review and analysis of patient experience feedback that is used to support and inform commissioning decisions. This is supported by the Patient Insight Group, made up of teams across the CCG, which reviews information, including soft intelligence, and identifies areas that require additional focus or targeted action. During 2018-19 the group undertook a significant amount of work to help support a better patient experience. This has included:

• Reviewing the choose and book e-referral system following an increase in negative patient feedback.
• Working with commissioners to understand the pain management and musculoskeletal (MSK) pathway and how patients are supported to understand the pathways.
• Working with our engagement team to consider the role of the patient participation groups within GP practices and how the groups can use patient experience to inform improvements within their local practice.
• Working with our children and maternity team and GPs to ensure that issues with MindMate (www.mindmate.org.uk) referrals were resolved.
• Reviewing the community care bed scheme to identify any issues following feedback from patients, carers and their families.
• Continuing to develop our framework to provide additional support to the care home assurance process by gathering feedback from residents, staff, visitors and visiting professionals, in conjunction with the care home visit schedule.

2.3.7 Complaints

During 2018-19, we received 252 complaints which related to commissioning activity as well as our service providers. We take complaints seriously as they are a genuine means of helping improve our services. Outcomes from complaint investigations are used to make changes where required to systems and processes and improve the future experience for everybody. We ensure the six principles of remedy (www.ombudsman.org.uk/about-us/our-principles/principles-remedy) are applied when handling complaints and work closely with our partner organisations to ensure that the appropriate information is obtained in a coordinated and timely manner. We are an active member of the Leeds Complaints Forum, which is hosted and chaired by Healthwatch Leeds, and includes members from our provider organisations as well as Leeds City Council.

This group works together to improve the experience of making a complaint within Leeds and continues to operate a ‘no wrong door’ policy.
2.3.8 Mortality review

We have a role to ensure that our providers have appropriate governance arrangements and processes in place to review, investigate and report deaths, ensuring that they share and act upon any learning from these processes, as outlined in *A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care*.

The local area contact is hosted by the CCG, and has a pivotal role in the learning disabilities mortality review programme (LeDeR). The LeDeR programme aims to make improvements to the lives of people with learning disabilities by reviewing the modifiable factors that may be associated with a person’s death.

During 2018-19 we have continued to develop the supporting process of the programme with a focus on the learning. For example, the reviews identified that people with a learning disability in Leeds were not all having an annual health check with their GP. We worked with LYPFT colleagues to improve the uptake of these important checks and held a number of learning events for GP colleagues to raise awareness of the checks as well as the requirements for reasonable adjustments and the LeDeR Programme. The learning event included how to implement effective health checks, including easy read documentation.

2.4 Engaging people and communities

2.4.1 Governance and assurance

We believe that a strong framework for patient and public involvement is essential if we are to continue developing health services in Leeds that meet the needs and preferences of local people. The CCG has a range of structures, processes and assurance methods to support our involvement work:

**The CCG constitution**

Our constitution sets out the arrangements we have to meet the legal duty to involve patients and the public in our work. The constitution outlines:

- the key ways we involve the public in commissioning
- a statement of the principles we will follow in involving the public
- how we will ensure transparent decision making

You can read our constitution on our website: [www.leedsccg.nhs.uk/content/uploads/2019/02/NHS_LeedsCCG_Constitutionv1.1.pdf](http://www.leedsccg.nhs.uk/content/uploads/2019/02/NHS_LeedsCCG_Constitutionv1.1.pdf)

**Patient and public involvement (PPI) lay person on our governing body**

We have appointed a public and patient involvement lay person so that the voice of the public is championed at our governing body. You can read more about our PPI lay person on our website: [www.leedsccg.nhs.uk/about/governing-body/meet/angela-collins](http://www.leedsccg.nhs.uk/about/governing-body/meet/angela-collins)

**Our commissioning for value framework**

Our commissioning for value framework ensures that all our commissioning activity achieves the best outcomes for people accessing healthcare in Leeds at the lowest cost. Understanding the health outcomes patients wish to achieve is vital if we are to provide services which cater to their needs and preferences that support them to achieve the things which matter most to them. The commissioning for value programme requires us to undertake appropriate engagement with communities when considering designing new, or developing existing healthcare services. This ensures our strategic commissioning direction is informed by the views and outcomes of engagement with residents of Leeds. We have developed a simple model to outline how we assure meaningful engagement throughout the commissioning cycle.
Patient assurance group

Our patient assurance group (PAG) is made up of patient representatives. It meets monthly and provides assurance that our commissioning plans include meaningful engagement. There is more about our PAG on our website: www.leedsccg.nhs.uk/get-involved/pag

CCG volunteer programme

We worked with Healthwatch Leeds to recruit 12 CCG volunteer patient representatives who champion the voice of the public throughout the commissioning cycle. Information about our CCG volunteers is on our website: www.leedsccg.nhs.uk/get-involved/ccg-volunteer

Patient participation groups (PPGs)

We value the relationship we have with our GP PPGs. When the provider of GP services at Middleton Park, New Cross and Swillington practices in south Leeds gave notice on their contract, the PPGs at these practices supported our engagement to develop a new model for their GP services. They were involved in planning and promoting the engagement and feedback from local people directly influenced the development of local services. PPG members were involved in the procurement process for a new GP service and supported the CCG to develop a contract that reflected patient views. They also contributed to writing the engagement, access and equality questions for bidders, evaluated responses and supported our consensus meetings to decide on a new provider. You can read more on page 11 in the spring 2019 edition of Engage magazine: www.leedsccg.nhs.uk/content/uploads/2019/02/EngageSpring2019.pdf

<table>
<thead>
<tr>
<th>Stage of the commissioning cycle</th>
<th>Assurance mechanisms</th>
<th>Example</th>
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<tbody>
<tr>
<td>Analyse and plan</td>
<td>We carry out engagement with local people to find out what matters to them. This is one of the ways we understand the needs and preferences of people in Leeds</td>
<td>Big Leeds Chat <a href="http://www.healthwatchleeds.co.uk/our-work/bigleedschat">www.healthwatchleeds.co.uk/our-work/bigleedschat</a></td>
</tr>
<tr>
<td></td>
<td>We use feedback from local communities to develop our plans and priorities. We use public events to ‘test’ our plans with local people</td>
<td>Local care partnerships deliberative event <a href="http://www.leedsccg.nhs.uk/get-involved/your-views/lcp-event-2018">www.leedsccg.nhs.uk/get-involved/your-views/lcp-event-2018</a></td>
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<tr>
<td>Design pathways</td>
<td>When we make changes to services our PAG make sure that our engagement plans are meaningful</td>
<td>PAG <a href="http://www.leedsccg.nhs.uk/get-involved/pag">www.leedsccg.nhs.uk/get-involved/pag</a></td>
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<tr>
<td>Specify and procure</td>
<td>When we buy health services our CCG volunteers make sure that feedback from local people is used to shape the new service</td>
<td>Primary care mental health services <a href="http://www.leedsccg.nhs.uk/content/uploads/2018/06/CCG_vol_report_2019_03.pdf">www.leedsccg.nhs.uk/content/uploads/2018/06/CCG_vol_report_2019_03.pdf</a></td>
</tr>
<tr>
<td>Deliver and improve</td>
<td>Our CCG volunteers sit on project steering groups to ensure that services are using people’s feedback to improve patient experience</td>
<td>Social prescribing <a href="http://www.leedsccg.nhs.uk/content/uploads/2018/05/CCG_vol_report_2019_02.pdf">www.leedsccg.nhs.uk/content/uploads/2018/05/CCG_vol_report_2019_02.pdf</a></td>
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Structures to enable participation

The CCG provides a range of ways to support people to get involved in our work:

• Our patient network provides local people with information about the CCG’s work and opportunities to influence our decision making. Network members receive a monthly e-newsletter and a quarterly magazine, Engage. You can join our public network here: www.leedsccg.nhs.uk/get-involved/join

• We worked with patients and partners to coproduce and deliver a range of free training. The training provides information about NHS services, equality and supports patient representatives to champion the voice of the public in strategic forums such as steering groups and PPGs. More about our training is here: www.leedsccg.nhs.uk/get-involved/training

• We worked with members of the public to jointly produce a range of engagement tools and resources. These include a PPG leaflet, a PPG quality indicator and volunteer resources. You can access our PPG resources here: www.leedsccg.nhs.uk/get-involved/patient-participation-group

• Our volunteers support us to embed engagement throughout the commissioning cycle. They attend procurement training so that they can support our procurement process.

2.4.2 The impact of participation

Demonstrating the impact of patient and public involvement is important to us. We work hard to show how people’s involvement helps shape local health services and have a number of approaches to improve how we do this. These include:

• A ‘making a difference’ section in our public magazine which outlines how we have responded to people’s feedback

• A ‘you said, we did’ section on our website for every engagement

• Producing an infographic about each engagement to outline key headlines in a simple and accessible format.

Annual report on engagement

Our annual report on involvement, ‘Involving You’, outlines our engagement activities and the impact these have had on decision-making. ‘Involving You’ is produced with patients to ensure that it is accessible, and we formed a steering group to help decide on its content and design. You can read Involving You 2017-18 on our website: www.leedsccg.nhs.uk/content/uploads/2018/03/1868_InvolvingYou.pdf

Social prescribing

Supported by our patient steering group, we carried out an engagement to inform the development of a single citywide social prescribing scheme (see section 2.5.5 for more about social prescribing). We used what people told us to develop the service specification, and our CCG volunteers were involved in the procurement process to ensure that bidders understood their engagement responsibilities. The social prescribing contract has been awarded and you can see how patients were involved in their report: www.leedsccg.nhs.uk/content/uploads/2018/05/CCG_vol_report_2019_02.pdf

Supporting our patient participation groups (PPGs)

We encourage participation at all levels of the CCG, including in our GP practices. We work closely with PPGs so that they have the knowledge, skills and resources to champion involvement. Following comments from PPG members, we secured funding that PPGs could apply for to carry out local engagement work. All applications were reviewed by patients on our PPG network. One of the successful applicants was Crossley Street PPG, who used the funding to develop a children’s reading area at the practice that is now used for story-telling. Read more about the PPG funding here: www.leedsccg.nhs.uk/get-involved/patient-participation-group/ppgfunding

We carried out an engagement to understand what support parents and carers need if a child or young person they care for requires mental health
support. People told us that they wanted support for their children while they were waiting to be seen by a clinician. We commissioned an online counselling service, Kooth, which is available to children and young people aged 11-18 and provides them with access to free, anonymous mental health and well-being support. Kooth offers timely and easy access to online mental health and well-being support, giving them access to articles, moderated forums and self-help resources 24 hours a day. You can read about the impact of this engagement here: www.leedsccg.nhs.uk/get-involved/your-views/mental-health-support-parents-carers.

Frailty - what matters to people living with frailty

The way we plan and pay for health services is changing, and we are working with partners such as Leeds City Council, providers and the third sector to move away from paying for activity to focus more on outcomes. Our engagement looked at what was important to people living with frailty. We produced an engagement approach with 14 voluntary sector organisations and two local care homes. We used people’s feedback to identify a tool that measures the outcomes of care from an individual perspective. You can read more here: www.leedsccg.nhs.uk/get-involved/your-views/frailty-what-matters.

2.4.3 Using patient experience

It is important that we use existing information about the needs and preferences of our local population to avoid duplication and continually asking people the same questions.

Understanding the needs and preferences of our local population

There are lots of reports and information about what services local people need and the way people want to access those services. We use this to inform our plans and priorities and make decisions about service change. When we identify gaps in our knowledge we carry out engagement with specific groups and on specific topics. We use a variety of different data sets to inform our work, including:

- Friends and Family Test
- Joint Strategic Assessment
- NHS Choices
- Care Opinion

Using patient experience for commissioning

Our patient experience team collects patient experience from local people through complaints and compliments, Friends and Family Test, Care Opinion and NHS Choices. The team responds directly to individual concerns and theme experiences to support our commissioning work. The patient insight group brings together commissioners to identify and respond to patient experience themes and trends. You can read more about our patient experience work in section 2.3.6.

Supporting patient participation groups (PPGs) with practice profiles and the national GP survey

We encourage our PPGs to use patient experience to shape their annual plans. We share practice profiles and national GP survey results and encourage them to use local feedback to understand the needs and preferences of their registered population. All the resources we share with our PPGs are available on our website: www.leedsccg.nhs.uk/get-involved/patient-participation-group

Sharing information in an accessible way

We have developed an infographics system that enables us to present data in a way that is easy to understand and clearly outlines changes. We use this system as one way to illustrate the results of engagement. You can see an example here: www.leedsccg.nhs.uk/get-involved/your-views/primary-care-the-light.
2.4.4 Working with diverse, potentially excluded and disadvantaged groups

Leeds is a diverse city with more than 85 different languages spoken. Ten percent of our population identify as lesbian, gay, bisexual or trans and almost twenty percent are Black or from a minority ethnic group. We know that some communities in Leeds are ‘seldom-heard’ and we need to be proactive to ensure we understand the needs and preferences of some communities. Homeless people, working people, people whose first language is not English and people with a disability are all groups that might be considered ‘seldom heard’.

Identifying communities that are ‘seldom-heard’

As part of our engagement process we use equality analysis to identify the groups who are ‘seldom heard,’ least likely to be heard, or experience the worst health outcomes. We use this information to plan our engagement and use a variety of different methods to engage with our diverse communities. You can find our engagement plans on our consultation pages: www.leedsccg.nhs.uk/get-involved/consultations

Engaging the deaf community in our urgent treatment centre engagement

As part of our urgent treatment centre engagement, we identified the deaf and hard of hearing community as a group who are least likely to be heard and experience poor health outcomes. We worked with Leeds Society of Deaf and Blind People to hold two events, and we also produced a video specifically for the deaf community which outlined the engagement using British Sign Language interpreters: www.leedsccg.nhs.uk/get-involved/your-views/urgent-treatment-centres

PPG network event

We hold an annual PPG network event, organised with PPG members, as an opportunity to network and share best practice. Before our event in October 2018 we asked PPG members how we could make the event accessible to all our local communities. In response to people’s feedback, we provided disabled parking, taxis for people with mobility issues, BSL interpreters and information in large print. You can read the report from our most recent PPG network event here: www.leedsccg.nhs.uk/content/uploads/2019/03/2018_Citywide_PPG_Event_Evaluation-V1.2.pdf

Leeds Voices

We commission Voluntary Action Leeds (VAL) to support our engagement with seldom-heard groups, the wider public and working people. VAL complements and enhances our engagement with potentially excluded and disadvantaged groups by using an asset-based approach. This approach recognises the value of our colleagues in the voluntary sector who are uniquely placed to engage with groups who can be ‘seldom-heard’ or more likely to experience poor health outcomes. You can read more about their work on their website: www.doinggoodleeds.org.uk/leeds-voices

2.4.5 Working with our partners

We work closely with our public and voluntary sector partners to ensure a system-wide approach to our engagement work in Leeds.

NHS Equality Delivery System (EDS2)

We have clear links between our communications and engagement strategy and the work we do in relation to EDS2. We continue to work in partnership with our NHS provider trusts and have a city wide panel of “trusted partners” who help us with the engagement and assessment process associated with EDS2 each year. More information about this is in section 2.7

People’s Voices Group

We are a member of the People’s Voices Group (PVG) in Leeds. The group was set up by Healthwatch and the Leeds Health and Wellbeing Board and brings together engagement leads from health and social care commissioners, providers and the voluntary sector.
Over the last year the group developed a citywide approach to engagement called the Big Leeds Chat. We are working on several projects to make sure that we take a citywide approach to putting patients at the heart of our decision making. You can read more about the work of the PVG on the Healthwatch Leeds website: healthwatchleeds.co.uk/our-work/pvg

The Big Leeds Chat
The Big Leeds Chat (BLC) is a system wide approach to engaging with people in Leeds about the things that matter to them. The first BLC event was in October 2018 at Leeds Kirkgate Market. It was jointly organised by over 20 different public and voluntary organisations and was attended by senior leaders from across Leeds. We spoke to around 500 local people about the things that mattered to them. The partnership themed the feedback we received and this is now being used at the Health and Wellbeing Board to shape future health services in the city. You can read more about the BLC at healthwatchleeds.co.uk/our-work/bigleedschat

Engagement training for our providers
Providers of NHS services have a statutory duty to engage with patients and the public about the services they offer. The CCG has a responsibility to hold providers to account for their engagement activity. We use the standard NHS contract for all provider service contracts, which includes requirements in relation to communicating with and involving service users, the public and staff.

We offer training to support our providers with their statutory engagement duties. In March 2019 we provided training to staff at Leeds and York Partnership NHS Foundation Trust (LYPFT). The training outlined the engagement responsibilities of commissioners and providers. We provided examples of good practice and facilitated group work which allowed LYPFT to identity gaps in their engagement framework and develop approaches to support participation.

Leeds engagement hub
We coordinate an initiative to provide free training to patients and staff across the city. Working with our provider partners, we have jointly produced 14 different training sessions at venues across the city. This supports local people to get involved in our work and provides staff with an opportunity to understand engagement and meet patient representatives. You can read more about our engagement hub here: www.leedsccg.nhs.uk/get-involved/training

2.4.6 Communicating with our patients
We want to keep local people informed and ensure that everyone has an opportunity to share their views when we make changes to services.

Engage magazine
We use engagement activity and social media to encourage local people to sign up to our public and patient network. Members receive a monthly newsletter outlining our engagement activities. We also produce a quarterly magazine for local people which is shared with all our network members. The magazine has a general health focus but also features articles of local interest. It includes a regular section which outlines how people’s feedback has influenced the decisions we make about local health services. You can subscribe to our free magazine here: www.leedsccg.nhs.uk/get-involved/magazine

Using social media to promote our events and activities
We use Twitter and Facebook (@nhsLeeds) to supplement our other promotion activities. Our accounts are monitored throughout the week and are used to share information about our work and opportunities to get involved.

Messaging often challenges the public with a call to action to prompt emotional responses from our audience. The calls to action vary depending on the campaign but will usually focus on encouraging members of the public to get actively involved in an on-going campaign in some way, for example by sharing their views
with us electronically via online surveys or in person by attending drop-in sessions and or events.

We also use paid-for social targeting to ensure that our messages are reaching the desired audiences. Paid-for advertising allows us to better focus our messaging by pinpointing members of the public based on geography, age, interest, and so on. With this approach we can ensure that our engagement goals are being seen by those most likely to be affected by our current and future plans. For example, recognising that young men were not engaging with our MindMate resources as much as young women, we created a specific campaign targeting that demographic. This bespoke and targeted approach helps ensure the messages we send reach the correct audiences.

**Using Scribble Live to promote our PPG work**

The CCG uses a content management platform to promote and encourage engagement activity in Leeds. Scribble Live enables people to follow live events online and pulls in feed from other sources such as Twitter and Facebook so that content is in one continuous stream. Scribble Live enables people to interact with the event remotely, which makes our engagement events more accessible to working people, parents of young children, carers and people with mobility issues. You can see an example of our Scribble Live service here: www.leedsccg.nhs.uk/ppgevent2018

**2.4.7 Making a difference**

It is important to us to demonstrate how people’s feedback shapes local services. Over the last year we have worked hard to improve how we let people know about the difference their involvement has made.

**Featuring ‘making a difference’ in our public magazine**

We outline how people’s feedback impacts on the decisions we make in our quarterly public magazine, Engage.

In the March 2019 edition of Engage ([www.leedsccg.nhs.uk/content/uploads/2019/02/EngageSpring2019.pdf](www.leedsccg.nhs.uk/content/uploads/2019/02/EngageSpring2019.pdf)) we outline how we involved local people and PPGs in decisions about a GP practice in Swillington. One of the CCG’s proposals was to close Swillington Health Practice and register patients at other local practices, partly because the building was struggling to meet the health needs of local people. People told us that closing Swillington would have a negative impact on local people, especially older people who might struggle to travel to other local practices. Following this feedback, the CCG made arrangements to keep Swillington Health Practice open as a branch site of Oulton Medical Centre and carry out work to make the building more accessible. The feedback also told us we needed to improve access for patients. As a result the practice now provides more appointments, and patients are able to access a wide range of services and visit Oulton and Rothwell sites for their care.

**2.4.8 Future plans**

We work with our partners, key stakeholders and local people to constantly review our approach to engagement. Together we have identified a number of ways we would like to improve the way we involve local people.

**The Big Leeds Chat (BLC)**

Over the next year we will regularly review the feedback people shared at the 2018 BLC. We will use this to influence system leaders in our city and ensure that we inform local people about the impact their comments had. We will ask senior leaders in the city to use videos to tell local people how they have responded to the BLC.

We want to build on the success of last year’s BLC and provide more opportunities for local people to share what matters to them. We are working with providers, the voluntary sector and Healthwatch Leeds to plan another BLC at the end of 2019. The next event will take place over a week and will expand on last year’s by opening the BLC up to different areas in Leeds.
We will work closely with local care partnerships and system leaders to provide opportunities for people all over Leeds to contribute to a citywide conversation about health and care. You can follow our progress on the BLC at healthwatchleeds.co.uk/our-work/bigleedschat

**Leeds engagement hub**

The CCG is currently reviewing the engagement hub and will present the findings to the Healthwatch Leeds People’s Voices Group. We will use feedback about the training and peer support to develop a sustainable partnership model that provides local people with the skills, knowledge and networks to champion the voice of the wider public.

**CCG volunteer programme**

We are in the process of reviewing our volunteering programme. We will use people’s feedback to develop and expand the programme.

**The development of urgent treatment centres (UTCs) in Leeds**

Our engagement with local people about UTCs in Leeds will be completed in April 2019. People’s views will be used to decide on a location for one of our five UTCs and will help us to decide the opening times for our community based centres. You can follow the project here: www.leedscgc.nhs.uk/get-involved/your-views/urgent-treatment-centres

**Outpatients**

There are already a number of innovations taking place in outpatient services in Leeds, and during 2019-20 we will explore patient and staff views on potential new outpatient models. However, before we begin any new work, it’s important that we understand the insight work that has already taken place and combine what we already know, the implications of these findings, gaps in current knowledge, and how those gaps could be addressed.

**Long Term Plan**

Following the publication of the NHS Long Term Plan, Healthwatch organisations across the country have been given funding by NHS England to provide extra support to integrated care systems (ICS) to develop their five year strategy. Healthwatch Leeds has the coordinating role for West Yorkshire and Harrogate ICS. Digitalisation and personalisation are key parts of the Long Term Plan and are also two of the West Yorkshire and Harrogate ICS enabling programmes. We will be supporting Healthwatch Leeds to undertake initial public conversations and local engagement in Leeds.

**People’s Voices Group**

In 2019 we will be exploring ways to work better in partnership by developing a citywide public network, an acceptable standards of behaviour charter and a repository of engagements for Leeds.

**2.5 Reducing health inequalities**

Under section 14T of the Health & Social Care Act 2012, the CCG has a duty to reduce health inequalities. We recognise that health services themselves contribute around 15-20% towards people’s health and wellbeing, with the majority of factors being the wider determinants of health. While we are committed to working with partners to contribute to the wider determinants of health, we are clear that our specific role is to focus on making sure that directly commissioned health services are doing what they can to reduce health inequalities. In this section of our report, we outline some of the many ways we are doing this.

Avoidable health inequalities are by definition unfair and socially unjust. A person’s chance of enjoying good health and a longer life is determined by the social and economic conditions in which they are born, grow, work, live and age. These conditions also affect the way in which people look after their own health and use services throughout their life.
Addressing such avoidable inequalities and moving towards a fairer distribution of good health requires a life course approach and action to be taken across the whole of society. The NHS Five Year Forward View set out the need to address the health and wellbeing gap, preventing any further widening of health inequalities. To do so requires a move towards greater investment in health and health care where the level of deprivation is higher.

The CCG’s strategic plan clearly echoes the overarching ambition of the Leeds Health and Wellbeing Strategy 2016-2021: ‘Leeds will be a healthy and caring city for all ages, where people who are the poorest improve their health the fastest’. We are therefore committed to delivering this ambition and our strategic plan sets out how ‘we will focus resources to reduce health inequalities across our city’ as one of two high level strategic commitments.

Our specific role is to

- Ensure that there is equitable access to health services with a particular focus on marginalised groups who may need additional attention.
- Ensure targeted funding is directed into neighbourhoods with the highest levels of deprivation.
- Facilitate integrated care focused around our local neighbourhoods.
- Work to make sure that people do not spend unnecessary time in hospital.
- Work to make sure that we reduce the number of people dying from conditions amenable to healthcare.
- Support our system to develop a ‘culture of learning.’

2.5.1 Key statistics

Around 785,000 people live in Leeds, and this is expected to rise to 814,000 by 2024. In the same period, the population aged 65 and over is expected to rise by over 6%. Our city has a diverse population, with around 15% from Black, Asian and Chinese ethnic communities, with wards such as Gipton and Harehills, Little London and Woodhouse, Chapel Allerton and Hunslet and Riverside representing areas with the highest ethnic diversity.

The health and wellbeing of the city continues to improve; however, there are still huge challenges and inequalities across the city. Over 206,000 people in Leeds live in areas within the most deprived 10% in England, and almost half of all these people live within four wards: Gipton and Harehills, Burmantofts and Richmond Hill, Middleton Park and Hunslet and Riverside.

Levels of poor mental health and wellbeing are inextricably linked with deprivation within the city, and there is evidence that some mental health problems are becoming more prevalent, particularly amongst older people and people with a physical illness.

Over the last four years there has been a five percent increase in the number of people with learning disabilities, particularly younger people with profound needs for care.

Additionally, there is a wide range of education attainment in school. On average, 40.9% of Leeds pupils achieved a strong pass (grade 9-5) in English and maths at Key Stage 4. This is an improvement on 2017. However the city is 2.6% behind the national average. Variation within Leeds is very wide, ranging from 58.7% to 23.8% in the best and worst performing wards.
This variation can be described in other ways - fewer pupils eligible for free school meals, with special educational needs, or who speak English as an additional language achieved the strong pass measure than the city average. Results also varied by ethnicity with as much as a 34% gap between groups.

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 to tackle. For example, in our GP registered population, we have the following recorded prevalence of long term conditions, cancer and smoking:

- Prevalence of smoking (18+) varies between almost 30% in Burmantofts and Richmond Hill, down to 9% in Harewood ward. The overall Leeds rate is 19%.
- Prevalence of diagnosed chronic obstructive pulmonary disease (COPD, all ages) in Leeds is 2% but varies between 3.5% and 0.5% in wards. Middleton Park has the largest prevalence.
- Prevalence of cancer (all ages) in Leeds is 3.2%. Rates of cancer vary considerably at ward level, with Little London and Woodhouse having the lowest rate at 0.6%. (Cancer prevalence is generally higher in less deprived areas, thought to be due to improved survival rates achieved with earlier diagnosis).
- Prevalence of obesity (16+) is 22.4%, varying between 9.3% and 30.2% in different wards.
- Prevalence of hypertension (16+) is 15% for the city.
- 34.7% of our GP registered population (all ages) have one or more long term conditions; this is quite strongly related to population ages and varies from 11% in student areas to over 43% in Otley.
- There were 4,757 alcohol-specific admissions to hospital from Leeds in 2017-18; the rate is worse than that of England, although closer to national levels now than in the past.

2.5.2 Targeted funding

**Weighted funding for general practice**

The national funding formula for general practice is already weighted according to deprivation. The CCG reflect this formula when investing discretionary funding into general practice; this does not necessarily represent additional funding for the most deprived but more recognition that a weighted approach is needed to ensure equal access in deprived areas.

**Supporting local care partnership development**

The CCG has supported the development of local care partnerships (LCPs) in particular by investing in a locality leadership infrastructure from general practice, and by supporting the development of the Leeds GP Confederation as an organisation. This is in recognition that general practice needed to go on the greatest journey to be able to engage in the integration agenda on a level playing field with other providers. At the heart of the vision for LCPs are coordinated services that know their local communities well and can support them to access care or self-care. In addition, LCPs offer an infrastructure that will allow targeted investment in the future.

2.5.3 Targeted interventions

The CCG currently commissions targeted interventions with the aim of reducing health inequalities. Some examples are:

**Maternity strategy and pathway work**

- Targeting vulnerable groups (at risk of poorer outcomes) - specific support and pathways have been further developed and evaluated for women with learning disabilities, young parents, and parents experiencing perinatal mental health issues.
- Specific engagement has been undertaken by the maternity voices partnership (MVP) to mitigate against any disproportionate disadvantage for specific communities as the service moves towards digital medical notes with online access.
• Changes in midwifery teams, including work towards continuity of carer, prioritised in areas of greater deprivation, working closely with children centres and health visiting teams.

**General practice quality improvement scheme (QIS)** - The CCG invests in general practices through a quality improvement scheme. Included in the scheme are a number of targeted identification, primary prevention and intervention elements that aim to reduce deaths from treatable conditions.

**Bowel screening champions programme** - the 50 most deprived practices have been targeted to increase uptake of screening.

**Breathe easy groups** - supports people with respiratory conditions in the most deprived communities.

**Accelerate, Coordinate, Evaluate (ACE) approach** - aims to promote early diagnosis of cancer to support the NHS outcome of preventing people from dying prematurely. We have selected the practices with greatest deprivation to work with initially.

**Cancer specialist nurses** - in place in most deprived areas, carrying out cancer care reviews and working to ensure that practices are able to address the specific needs of cancer patients.

**First contact practitioners** - as part of the work to increase the primary care workforce, we are testing out first contact practitioners (senior physios in primary care), which gives access to the most appropriate clinician at first contact. These are based in the areas where private treatment is most out of reach and the impact of being off work is greatest.

**Children’s and young people’s mental health local transformation plan** - there is targeted work focusing on mental health for young people from specific priority groups who are at greater risk of experiencing mental illness. Additionally, children and adolescent mental health service (CAMHS) professionals are based in multi-disciplinary teams for specific groups at risk of poorer outcomes.

A formula is in place to allocate funds to school clusters based on need or demand - referrals come from schools and from GPs to the MindMate single point of access.

**Young parents** - Over the last year, a young parents action group, which is co-chaired by a young parent, has helped make several improvements in services. These include a jointly produced pathway that clearly shows young parents and professionals which services are available and appropriate; the introduction of post-natal contraception delivered by teenage midwives; and the introduction of joint visits with teenage midwives and health visitors, to maintain and build relationships with the young parents.

### 2.5.4 Access to urgent care services

We understand that urgent care services can be confusing and difficult to access, widening health inequalities, and that people who are the most deprived access urgent care services more often, so we aim to improve access to services.

**GP access scheme** - We have a commissioned general practice extended access scheme operating in Leeds. This means that practices, working in locality based hubs, provide evening and weekend access to general practice across the city.

**Urgent treatment centres** - There is a national programme to improve access to urgent care by establishing urgent treatment centres (UTCs). The aim is to standardise urgent (non-emergency) care services and make them simpler to access so that people better understand where to go when they have an urgent health care need. There is more information about Leeds proposals for UTCs in section 2.8.10.

**Single point of access for all health and care services** - There is an aim to establish a single point of access for all health and care services that will provide a coordinated entry point to unplanned services. People will be encouraged to “talk before you walk” by calling 111, where they will be connected to a clinical advice service who will be able to advise, refer or signpost to the most appropriate service.
2.5.5 Improving overall health and wellbeing

Social prescribing

Social prescribing is a way of enabling GPs, nurses and other health and care professionals to refer patients with social, emotional or practical needs to a range of local, non-clinical services, often provided by the voluntary and community sector. There are currently three social prescribing schemes covering all GP practices in the area, receiving over 5000 referrals each year. Delivered by three lead voluntary sector providers - Community Links, BARCA Leeds and Leeds Mind - the schemes aim to reduce health inequalities and are more active in areas of higher deprivation. Through spending time listening to what matters to people, our social prescribing schemes have proved particularly effective at improving well-being and reducing social isolation and loneliness. The schemes provide people with an opportunity to identify their social and health needs and jointly agree solutions with a wellbeing coordinator; the coordinator can link patients to local third sector and community organisations to address other factors that may be affecting their health, for example debt and loneliness.

The schemes have been evaluated using nationally validated tools and results show significant improvements in people’s mental and physical wellbeing, as well as in their ability to manage their long term conditions. People report feeling better, physically and emotionally, as well as less isolated and less anxious:

“I no longer feel like a shell in my own home. I feel useful and wanted… hopefully one day I will find paid work.”

“You have got me out of this rut, learning new things and meeting people. I’m the happiest I have been in a long time”.

The schemes have enabled people to become more independent and involved in their communities and have made sure that those who need it have been provided with advice and support for issues such as debt management, employment or housing concerns.

Patient experience has been key to developing the current social prescribing services, and engagement continues to be an important part in commissioning and developing a single citywide social prescribing service due to start in September 2019.

More information on each scheme can be found here:

- Connect Well - www.commlinks.co.uk/services/leeds/connect-well
- Connect for Health - www.connectforhealthleeds.org.uk
- PEP - www.barca-leeds.org/health-and-wellbeing/west-leeds-pep-patient-empowerment-project

Primary care alcohol services

Leeds has above national rates of people drinking at above low risk levels and a higher prevalence of dependent drinkers. In response to this, we commission additional alcohol services from Forward Leeds, the city’s drug and alcohol service. Based in GP practices in areas of higher deprivation, alcohol workers have forged strong links with practice staff and patients have better access to services in their communities. This is resulting in an effective route into treatment and improved outcomes.

Barca outreach support service

The aim of the Barca outreach support service is to look at the underlying reasons for frequent attendance across all urgent care services in Leeds and to work with patients to resolve the root causes, thereby reducing their use of these services. We have found that not all contacts with urgent care services require a medical prescription or admission to hospital and that often the reasons for the use of urgent care services are socially determined in the most frequent attenders. It is also assumed that there is no one single reason why service users misuse urgent care services and no single prescription that suits all, which leads to the need for a holistic approach to the case management of these patients.
The service has provided a number of benefits for the Leeds system after three months of working with patients:

- Reduction in the number of attendances at A&E by 77% for a cohort of 52 people
- Reduction of time spent in hospital through short stay admissions reducing by 58%
- Reduction in the number of conveysances by Yorkshire Ambulance Service by 43%

**Improving access for the Gypsy and Traveller community**

Working closely with Leeds GATE, a Gypsy and Traveller advocacy organisation, and Leeds Community Healthcare NHS Trust (LCH), we developed an outreach nursing role to improve health care for this vulnerable group. The outreach nurse has helped improve access to health visiting services for roadside families and has worked with primary care teams to improve their knowledge and understanding of the community. This is supporting quicker access to health services including GP practices and health screening. The outreach nurse role has been well received by the Gypsy and Traveller community and is reaching the right people at earlier stages to support improved health outcomes. The evaluation of the scheme has informed further work with other vulnerable groups across the city, for example, homeless people, where we’re working with services to help them understand the issues they face and identify barriers in their systems.

**Work with men leaving prison**

The West Yorkshire Community Chaplaincy project is based at HMP Leeds and has more than 10 years’ experience of supporting men to rehabilitate after prison. Supported by a grant from the CCG, they have developed their work to deal with a wide range of health issues on the men’s transition from prison to the community and for as long as needed following release. They support men to register with, and access, GPs and dentists, ensure they receive prescriptions to maintain their medication, support them in accessing secondary healthcare and managing long term health conditions. They also help with a range of wider issues that can affect health and wellbeing, for example getting and maintaining housing tenancies and accessing benefits. This work is unique in supporting men with health issues ‘through the prison gate’.

**Intensive positive behaviour service**

In 2018, the Intensive Positive Behaviour Service was established in Leeds, using an invest to save delivery model, jointly funded by the CCG and Leeds City Council. The service strongly supports the key aims and principles of local and national strategies to improve the lives of children and young people who have a learning disability and/or autism.

The purpose of the service is to ensure that children and young people in Leeds, with learning disabilities and/or autism with behaviours that challenge, and who are most at risk of permanent placement outside the home and outside of the city, live as normal a life as possible, staying with their family and in their community. The service works restoratively with young people and their families to ensure a consistent positive behaviour approach both inside and outside the home.

**Work with young carers**

During 2018-19 we did a lot of work to raise awareness of young carers in Leeds including peer-led social media campaigns. Young carers pages on the MindMate website - www.mindmate.org.uk - have been created. These pages were developed with several young carers, led by two of our MindMate Ambassadors who are both young carers themselves. Additionally, young carers have written blogs for the MindMate website, and one of our MindMate Ambassadors has also been involved in the development of the draft Leeds Young Carers Strategy.
Improving social, emotional mental health of children and young people

The Future in Mind: Leeds Strategy 2016-2020 and Local Transformational Plan (LTP) sets out our vision, progress and next steps to improve the social, emotional, mental health and wellbeing of children and young people aged 0-25. Our vision is to develop a culture where talking about feelings and emotions is the norm, where it is acceptable to acknowledge difficulties and ask for help and where those with more serious problems are quickly supported by people with skills to support their needs. Both the strategy and LTP have been approved by the Leeds Health and Wellbeing Board. The LTP is refreshed annually and reported on a quarterly basis to NHS England.

The aim of the LTP is to deliver whole system change to children and young people’s emotional and mental health support and service provision in the city. The plan incorporates priorities from primary prevention through to specialist provision and focuses on improving both children and young people’s experience and outcomes.

One of the priority areas of work is to ensure that vulnerable children and young people receive the support and services they need. We are very aware how difficult it often is for social workers to access mental health support for Leeds children in care, who are placed outside Leeds. From spring 2017 the Therapeutic Social Work Service (TSWS) was (with funding from the LTP) commissioned to offer oversight and support to Leeds children and young people placed outside Leeds (within 80 miles). There is a new senior social worker in post to enhance the capacity of the team, though all members of the team are involved in providing this service. The primary issues for the children and young people referred in to the TSWS are consistently around experiences of emotional harm, neglect, physical and sexual abuse. Approximately one third of young people have been exposed to domestic violence.

Diabetes

There are currently 43,830 people registered with diabetes in Leeds: 3,395 have Type 1, while most have Type 2. A small number have other forms of the condition.

During the past year, we’ve continued to work with people living with diabetes and their carers, colleagues from other parts of the NHS, public health and voluntary sector organisations to improve outcomes for people with all types of diabetes. Part of that work has been to co-produce our first diabetes strategy for 2019-2024, which has been shaped by a number of stakeholder workshops and engagement activities; you can find out more about these here: www.leedsccg.nhs.uk/get-involved/your-views/diabetesstrategyforleeds

Our aim has been to create an ambition for people and carers, focusing on the whole person, not just their condition. We recognise that people with diabetes live with their condition all day, every day and face many things in everyday life that impact on their health and wellbeing, as well as their diabetes care. The strategy describes our response to people of all ages - regardless of background and circumstances whether they are at risk of or living with diabetes, or caring for someone with diabetes - and describes our intentions over the next five years to improve outcomes for all. The strategy also extends to the staff and volunteers who work across the diabetes service in Leeds, including healthcare professionals working in community, primary and secondary care, and our partners in public health. We want to build on what we do well in Leeds, address any gaps that we identify, and focus on both the care we provide as well as improve the support to people to self-manage, using our existing resources better. You can read the strategy here: www.leedsccg.nhs.uk/publications/leeds-diabetes-strategy-2019-2024
During 2018-19, we have continued to receive NHS England treatment and care transformation funding (£677,000) and since last year have been able to impact the lives of people in Leeds through:

**Self-management and skills development programme** (improving uptake of Leeds programme for people living with Type 2 diabetes)

- 129 courses offered during the year
- 76% people completed the course
- 48% of attendees were from deprived areas of the city
- 49% were men over 40 years of age
- 51% were from BAME groups
- 100% participants reported improved confidence to manage their diabetes after completing the course

**Improved diabetes foot pathway** - in addition to the Foot Protection Service supporting 2517 new patients with either moderate or high risk feet, we have also produced a film for people living with diabetes which provides tips for looking after their feet and reducing the risk of amputation. The film is available online at [https://youtu.be/2vko8udZbxE](https://youtu.be/2vko8udZbxE)

**Diabetes inpatient specialist nurses** - have helped reduce the average length of stay in hospital from 4.3 to 3.5 days.

### 2.5.6 Mental health

Leeds is a city that values people’s mental wellbeing equally with their physical health. Our shared ambition is for people to be confident that others will respond to our mental health needs without prejudice or discrimination and with a positive and hopeful approach to our future recovery, wellbeing and ability. The city’s current mental health framework has five key overarching priorities:

**Priority 1: Keep people well - to build resilience and self-management ensuring the public profile of information is high and people know where to go for help**

Our information portal “MindWell” - [www.mindwell-leeds.org.uk](http://www.mindwell-leeds.org.uk) - was developed in collaboration with members of the public, service users and carers, people working in mental health services, adult social care, the third sector, libraries and businesses. MindWell is a key tool in communicating accurate, timely and safe information about all aspects of mental health including what to do at times of mental health crisis. There are over 7,500 MindWell contacts each month, the main user group is 18 - 35 year olds and most hits are on the anxiety and depression pages.

**Mentally Healthy Leeds** is a new service currently being commissioned by Leeds City Council public health to help reduce health inequalities by focusing on the wider determinants that can affect resilience and impact negatively on mental health. The overall aim is to reduce health inequalities and improve the mental health and wellbeing of communities most at risk of poor mental health.

**Wellbeing space and support service** is a new service that focuses on providing more opportunities for those living in the 10% most deprived areas in south Leeds to access services promoting positive mental health. It will provide a community drop-in, with the aim of improving protective factors, reducing risks around poor mental health and reducing social isolation.

To support older people’s well-being and reduce isolation, the CCG and city council have increased the funding for [neighbourhood networks](http://www.leedscgh.nhs.uk) and awarded longer-term grants to ensure third sector partners can plan and sustain activities. Our social prescribing services and memory support workers enable people and carers to live well with long-term health conditions, including dementia.
Priority 2: Mental health and physical health services will be better integrated by improving the competency of all services to work with both physical and mental health issues as part of a person centred approach to care.

We are piloting primary care liaison services, which so far have worked with over 3000 people reducing use of GP appointments and increasing the options for treatment getting people to the right service first time.

We have commissioned psychiatric liaison services in LTHT, which provide psychiatric assessment and interventions to people in A&E, wards and outpatients.

During 2018-19, we re-procured Improving Access to Psychological Services (IAPT), with primary care mental health expanded to people with long term conditions.

Priority 3: Mental health services will be transformed to be recovery and outcome focused.

We have developed a recovery college which aims to offer high quality educational opportunities to people who use mental health services and who might otherwise find it difficult to access education. University students have an opportunity to work alongside people with mental health difficulties, enhancing their employability and ‘real world’ experience.

Priority 4: We will ensure access to high quality services informed by need.

We have ensured people’s experience is at the centre of service development, and quality statements they have designed are used to monitor how the services are performing, including take up by marginalised and priority groups such as young people, students, BAME and older people.

The development of the Leeds crisis café and high volume service user’s project have reduced the number of inappropriate repeat admissions to hospital at times of crisis. This helps make sure that when someone’s health or independence rapidly deteriorates, they have speedy access to appropriate and effective urgent care and support, including effective alternatives to hospital.

Joint commissioning arrangements are in place between the CCG, Leeds City Council and West Yorkshire Police (WYP) that enable the funding of two mental health nurses based within the WYP Leeds District Control Room to provide immediate advice and support to police who are in contact with people with mental health issues, including on live calls.

We jointly commission with Leeds City Council employment, accommodation and community support through a wide range of voluntary and community sector organisations for people with mental health needs. We have also developed joint arrangements for Section 117 services for people who require specialist care services after hospital stay. This ensures that timely funding decisions are being made and the right care package is put in place to support recovery and independence for people with severe mental health illness.

Priority 5: We will challenge stigma and discrimination.

Leeds was the first regional time to change hub and oversees a bespoke grants programme and citywide action plan jointly with third sector partners. To give employers increased confidence to work with mental health issues, the city’s Mindful Employer service continues to support people to maintain or secure employment.

Mental health liaison services support general hospital teams to work with people with primary mental health needs or when those needs are accompanied by physical health problems.

We ensure that the Mental Health Investment Standard and parity of esteem between physical and mental health services is maintained by increasing investment in services. Mental health and wellbeing are integrated into NHS and council policies, and there is a member lead for mental health across the local authority.
In 2019-20, we will be working with NHS and local authority colleagues to develop a new strategic plan for the city. Much of the work to assess need and engage communities, service users and practitioners has already been completed, either through the Leeds Mental Health Needs Assessment process, or through engagement carried out as part of recent mental health service reviews and procurement.

The strategy will cover the full breadth of mental health and illness, from prevention to specialised in-patient treatment, and it will complement strategies that already exist across the system. The mental health strategy is likely to address identified issues in the city, such as mental health inequalities, stigma, and the need for better integration of mental health and physical health services. It will be aspirational - focused on bolstering prevention ‘upstream’ and reducing mental ill health, whilst clearly focused on improving mental health services and support.

2.5.7 Learning disabilities

During 2018-19, there has been a focus on the transforming care partnership with our local authority colleagues, creating new roles that aim to reduce length of stay in inpatient settings, prevent inappropriate hospital admissions and provide support closer to home for people who have a learning disability, autism or both and require support for mental health issues. This is being addressed in a number of ways including:

Care and treatment reviews - we have completed 52 care and treatment reviews in this past year. This has resulted in many people being discharged from hospital into a new home and some people avoiding hospital by receiving better care in the community. Where people have needed to stay in hospital, plans are made to improve quality of life, including numerous cases where people’s medication has been reduced or stopped, in line with the STOMP agenda (stopping over-medicating people with a learning disability). The STOMP agenda is routinely explored in each and every care and treatment review to promote the awareness of overmedicating people with learning disabilities. There has also been a shift from the traditional route of moving people from secure services to locked rehabilitation. Over the past year, people have been moving from secure hospitals, straight into their own home in Leeds, radically shortening hospital stays.

Community support register - we have worked across agencies in health and social care to develop a register of people who need extra support to help them continue to live in the community. This ensures early intervention for people who may be at risk of a hospital admission and ensure the right support is put in place. A new role has been commissioned, an intensive support practitioner, to help support people on the register and ensure a care and treatment review is offered if needed.

There is now an enhanced supported living framework, made up of 11 providers, who offer bespoke care for people with highly specialist needs. This will enable Leeds citizens currently living outside the area to move back to Leeds into their own homes with the right care.

Our future plans include:

Intensive support team - in response to reducing hospital stays and reducing inappropriate admissions for people who have a learning disability, autism or both, community services need to offer more specialist care and interventions. Plans are in motion to establish an intensive support team that will run alongside community learning disability services.

Forensic outreach liaison service - a new service is being developed collaboratively across West Yorkshire to provide specialist community care for people who have a history of offending. There are plans to open a new service in Leeds for people with autism who need highly bespoke environments to enable them to move back to the community. It will also provide short-term stays for people with autism who need extra help as an alternative to hospital.
Annual health checks - we want to ensure that Leeds is a place where people who have learning disabilities are supported to meet all their health needs. We therefore work in collaboration with local partners to increase our understanding about who has a learning disability and to provide support to GP practices to increase the number and quality of annual health checks.

2.6 Performance in primary care

The CCG’s delegated and statutory functions relating to primary care commissioning are delivered through the Primary Care Commissioning Committee (PCCC). This work is underpinned through a range of sub-committees and groups led by the primary care team and in conjunction with the quality directorate. They include a primary care operational group, quality surveillance group, primary care estates group, GPFV workload group, QIS operational group and care home working group.

During 2018-19 the primary care team has led, supported and delivered the following changes to the primary care landscape:

2.6.1 GP practice changes

Procurement of alternative primary care medical services contracts

To create sustainability across primary care and deliver quality care and outcomes for patients, we have procured primary care services for four registered lists this year. Each procurement has been informed by a review of the service specification requirements, in line with the characteristics of the registered population.

For three of the procurements, the outcome has been delivered through a local process which has led to three Leeds providers taking on the registered lists. The remaining procurement for a city centre population is currently underway, with the new contract expected to start in May 2019. All procurement work has been supported by robust patient and stakeholder engagement plans so that patient feedback is incorporated within the service specification and procurement requirements.

Mergers of local practices

This year, we have seen two practices merge (Bramley and Cottingley). These mergers were supported to ensure resilience and sustainability of primary care and continued delivery of quality care and outcomes to patients. Again these were underpinned by patient and stakeholder engagement. Two separate proposed mergers have been supported by the team and PCCC. Of these, two practices are currently undergoing patient and stakeholder engagement, whilst the other two practices merged to one list on 1 April 2019.

We continue to use the quality surveillance process to monitor practice service delivery and associated functions. This is underpinned through regular meetings with the respective providers for those practices that have merged and those changed as a result of procurement. This has resulted in the number of practices in Leeds reducing from 104 to 100. Once the mergers have formally taken place by 1 April 2019, the total number of practices in Leeds will be 97.

List closures

The team has supported list closures for two practices in response to CQC reports, pressures associated with workforce challenges and quality improvement requirements associated with systems and processes. Both lists will remain closed until summer 2019. Surrounding practices have supported the closures and have not raised any concerns.

2.6.2 Contract breaches

During the year the team has issued several remedial and contract breaches to two practices; these were issued alongside CQC regulation breaches and enable the CCG to be assured regarding the contractual requirements. Both practices have responded positively to the breaches and we do not expect any long term implications.
2.6.3 Quality
We support all our practices with regards to quality. We have devised a risk profile for practices to use to support them around CQC, and the team work with practices to identify areas of good practice or areas that may need to be improved. This gives a framework for the practice to build any improvements or changes required. Leeds has a history of providing high quality services, with 98% of practices being rated as good or outstanding by CQC and we are constantly looking for improvement.

Our work is underpinned with a surveillance process that mirrors that across the organisation. We hold a monthly quality surveillance group in which we review practices based on performance, soft intelligence, CQC, and primary care intelligence based on the practice quality improvement (PQI) and primary care web tool.

The surveillance process, which has been shared with practices, identifies when a practice is going into formal surveillance. There are four different levels:

- Routine - all practices are subject to routine surveillance
- Routine+ - if a concern has been identified through routine surveillance or there has been a trigger such as a safeguarding concern, incident, CQC inspection outcome, negative patient feedback or contract breaches
- Enhanced - if there are significant concerns or other issues identified through routine+ surveillance
- Formal action

The team works with practices that are identified as routine+ or enhanced with the aim of getting them back into routine surveillance.

2.6.4 Primary care workforce development
During 2018-19, the CCG and the Leeds GP Confederation have driven forward the primary care workforce development agenda, recognising that a strong and sustainable workforce is crucial to delivering the Leeds Health and Care Plan.

We carried out a survey of the primary care workforce in Leeds with an excellent response rate of 94%. The results are directing the work of the Leeds Primary Care Workforce Development Group. Priority areas are GP and practice nurse recruitment and retention; however we are also looking at increasing joint recruitment, induction, training and development and developing attractive career paths across all health care roles.

In terms of the wider context, the workforce development group feeds into the One Leeds Workforce Group led by the Leeds Health and Care Academy and also links into the West Yorkshire and Harrogate Primary and Community Care Workforce Group.

2.6.5 Protected time for learning
We have continued to deliver ‘protected time for learning’ for all clinical general practice staff across the city and provide out of hours GP cover so that people can attend. The scheme is known locally as Time for Audit, Review, Guidelines, Education and Training (TARGET) and provides education and training to support continuous quality improvement.

During 2018-19, we provided:

- Five practice-based TARGET sessions for each practice. Increasingly to support the primary care network (PCN) agenda, these are being organised on a PCN basis
- Four externally delivered TARGET sessions for each practice
- A city-wide primary care conference bringing together all general practices in Leeds

Through 2018-19 the external TARGET programme delivered training and education on priority topics including end of life care, wound care, chronic obstructive pulmonary disease (COPD), frailty, annual health checks for people with a learning disability, lifestyle medicine and women’s health.
2.6.6 Quality improvement scheme

The scheme was developed to bring together the three former CCG engagement schemes and respond to the CCG priorities identified through RightCare programmes. The three year scheme supports practices to make permanent changes to working practices and patient outcomes, with a particular focus on long term conditions, building on aspects of the three historic schemes. This has been set into sections associated with:

- Targeted prevention of long term conditions to reduce the prevalence gap and increase early diagnosis for atrial fibrillation, COPD and hypertension
- Better management of long term conditions to enable practices to implement a patient-focused collaborative care planning approach: patients receive information in advance of the care planning discussion and the focus is shifting towards “What matters most to me”. The concept has been recognised nationally in the NHS Long Term Plan and GP contract reform.

All GP practices in Leeds (excluding the Safe Haven service) are committed to delivering the 2018-19 quality improvement scheme (QIS). Two CCG steering groups oversee the scheme, and its release was supported with a set of reports to enable practices to identify work to do and monitor their progress, whilst providing the CCG with a performance position. The latest information from December 2018 demonstrates progress on all but one indicator, but it should be noted that this reflects only four months of reporting and we anticipate changes to the position at the end of the year.

The strategic group has started to develop priorities for the second year of the scheme. This will build on year one and will again be supported with appropriate searches to support the work programme.

2.6.7 Enhanced care home scheme

The CCG rolled over the historic schemes from the previous three CCGs in 2018-19, with a view to developing a city wide scheme for release in April 2020. All schemes require practices to provide a proactive ward round for the care homes beds within their area. However, there has not been an increase in GP practices providing the enhanced service under these schemes: there are currently 94 residential and nursing homes for older people in the city with approximately 4550 beds (2517 nursing beds and 2033 residential beds). Currently, 46 practices participate in the scheme, with approximately 74% of the beds receiving the enhanced specification provision.

We established a care home working group, bringing together colleagues and clinical leaders to develop a new scheme for 2019-20 and to provide a monitoring function in time. A single citywide one year scheme has been developed bringing together the best components of each scheme. This is only a one year scheme due to the proposed release of a national care home specification in April 2020.

2.6.8 Health inequalities scheme

As a newly formed CCG, we want to continue to promote the Leeds Health and Wellbeing Strategy and work towards the vision that “Leeds will be a healthy and caring city for all ages, where people who are the poorest will improve their health the fastest.”

Our data shows that Black, Asian and Minority Ethnic (BAME) and non-English speaking people are visiting primary care more frequently, and that consultations are longer and more complex due to English not being their first language, including when translation services are used.

We looked at data around health inequalities and disease prevention, recognising that some practices have to work harder in order to deliver these outcomes for their populations. To support this work, we identified that GP staff could carry out public health interventions to encourage and support patients to make positive differences to their health and well-being.
The Leeds Health and Care Plan outlines how such interventions can encourage prevention at scale. Smoking is the single largest cause of health inequalities and premature death, responsible for 17% of all deaths in people aged over 35. The annual cost of smoking to the public is estimated to be £13.8 billion in England. Evidence shows that patients who are encouraged to stop smoking by their GP practice are more likely to try to quit than individuals who do not receive any advice from their GP practice. We also wanted to support patients who have newly been diagnosed with cancer and to ensure that referrals are sent in a timely manner in line with the two week wait referral process.

To support these areas, we set up a health inequalities enhanced scheme for practices to participate in. This included:

**Ethnicity and first spoken language** - increase the recording of ethnicity and first spoken language to understand what their practice populations are. Practices were also required to identify what procedures they have in place to support BAME and non-English speaking populations.

**Smoking** - review smoking data on the PQI dashboard and plan how they would support patients to quit smoking. Staff support this process by completing the ‘very brief advice on smoking’ training provided by the national centre for smoking cessation.

**Cancer** - support patients with a new diagnosis of cancer and ensure they receive their diagnosis as quickly as possible. The uptake for the scheme has been overwhelmingly positive, with 99% of practices signing up and engaging with the CCG where required for information. The scheme started in June 2018 and will run until May 2019, when it will be fully evaluated.

2.6.9 Extended access to primary care services

All Leeds residents can now access seven-day primary care services through our extended access hubs; this compares to 50% of the population in 2017-18, thanks to universally available national funding. GP practices have worked together under the umbrella of the Leeds GP Confederation to share learning, infrastructure and realise economies of scale so that the majority of funding can be invested in more appointments for patients. Primary care services are now available seven days a week, 12 hours a day Monday-Friday with some local variation according to patient need.

The latest GP survey results from March 2018 shows that Leeds had a higher positive response rate to the question ‘were you offered choice of appointment?’ with 64% for Leeds compared to 62% nationally. We would anticipate that this will improve further as results become available for 2018-19.

Through the extended access hubs, patients also now have access to a greater range of primary care services, including GPs, nurse and pharmacy appointments, both face to face and by telephone. In 2018-19 an additional 125,610 appointments will have been offered through extended access.

2.6.10 GP Forward View (GPFV) work programmes

The GPFV work programmes encapsulate a range of programmes designed to support general practice and enable them to contribute to and implement programmes that support the 10 High Impact Actions (HIAs)

**Active signposting** - training has been offered to all practices to support reception and practice staff to help direct patients to the most appropriate source of help or advice. This allows patients to choose an alternative service which may include services in the community as well as within the practice. We continue to provide opportunity for patient feedback through planned patient engagement events throughout the year. To date, 66 % of practices have undertaken the training and we are continuing to support practice implementation.
New ways of working - the CCG organised a deliberative event in September 2018 attended by 64 patients, which explored their reactions to and ideas for solutions that would work for four of HIAs, specifically active signposting, reducing missed appointments, supporting self-care and developing the team.

Clinical correspondence - training has been offered to help practices manage correspondence more effectively and reduce pressure on GP time by redirecting correspondence away from the GP when it can be handled safely and more efficiently by another member of the team. To date 65% of practices have undertaken the training and are implementing the changes.

Online consultations - as part of the digital transformation to the way services are provided, CCGs are expected to work with their practices to ensure that by March 2020, 75% of practices are offering online consultations to their patients. In Leeds, eight practices now actively offer online consultations; a further 21 have access to the platform but have not yet implemented it. We have now selected a supplier for further roll out of online consultations and are currently finalising the contract so that we can implement them across the city.

Group consultations - group consultations are medical appointments delivered by a clinician within a supportive peer group setting and are designed to replace routine one to one appointments. This potentially increases productivity and access to routine care and follow up appointments. To date, 16 practices in Leeds have had formal training to develop the appropriate skills to provide group consultations and plans are in place to begin delivery of sessions in April 2019.

2.6.11 Developing quality improvement (QI) expertise

The primary care commissioning team has collaborated closely with the time for care programme (an initiative to promote QI tools and techniques and support the implementation of the 10 High Impact Actions), facilitated by the sustainable improvement team from NHS England. The team has started to build a community of QI champions across primary care in Leeds and intend to extend their work to include partners from across the city’s health and care system under the umbrella of Leeds Initiative for Quality Healthcare (LIQH). In 2018-19, the team delivered a number of elements, including:

- **Fundamentals of change and improvement** - two day programme with an opportunity to explore the key components needed for successful change, using the change model for health and care. Eight practice managers and ten staff from the primary care team have undertaken this programme.

- **Productive general practice quick start programme** - the NHSE sustainable improvement team offer on-site, hands-on, short term (8-10 weeks) support that helps practices change systems and processes to free-up clinical time for care and develop the skills and confidence to lead local improvement. Twenty-three Leeds practices have completed this programme, with forty more due to finish in March 2019. Outcomes have been positive with practices demonstrating significant improvements and time saved.

- **Learning in action programme** - a series of workshops that provide practices with the opportunity to gain more insight and practical application of QI tools and techniques. The workshops are facilitated by the NHSE team and offer support for practice or locality projects. Seven practices have participated in this programme.

2.6.12 Primary care development

The primary care development team, now working as part of the Leeds GP Confederation, has been continuing to support the integration agenda by helping to create the environment for new ways of working. The team’s remit is to support both the General Practice Forward View, which aims to achieve sustainability and
transformation of general practice, and also the recently published NHS Long Term Plan, which will see the further development of general practice working collaboratively to provide more services to their local populations.

During 2018-19, this has been developing on two levels:

- Practices have been working more collaboratively in their localities (known going forward as primary care networks). The team have been supporting 18 localities which cover footprints of 30,000 - 80,000 people in geographical areas across Leeds.
- Local care partnerships have been meeting to bring together a wider range of health, care and system partners so as to have an impact on the wider determinants of health, in line with delivering the Leeds Health and Wellbeing Plan.

The team is supporting these partnerships to form, meet regularly and review and respond to the local populations needs. A key focus has been to work closely with GP localities to identify local need and gaps in services, review the evidence base and help partners to design and set up new small scale projects and ways to work better together to help form new relationships and improve care.

Some of the 2018-19 projects aiming to integrate and improve the quality of care include:

**Otley Leg Club** - the leg club meets every Wednesday afternoon at a local community centre and is supported by local practice nurses and LCH district nurses. The club promotes a social model of care for patients with leg ulcers. People with leg problems can become very isolated as they are less mobile, so the club aims to improve healing rates, decrease social isolation and enable healed legs to be maintained with a “well leg” regime of care. The club celebrated the first anniversary in March 2019 with the number of patients increasing from 10 to 160 over the year. Patients who have not historically engaged well with their care are regularly attending the leg club, and patients report feeling a bit more involved in the community. The model seems to be showing a saving in practice nurse hours, so helping with workforce pressures in general practice as well as improving quality in wound care.

**Supporting the frail elderly and working collaboratively** - in Otley and Wetherby, GP practices are testing new ways to work collaboratively and considering the populations needs jointly.

The Otley Frail Elderly Service is a good example of how practices are working more collaboratively by sharing new staff roles and moving towards proactive care. A small clinical team triage and manage routine home visits day to day as well as take proactive oversight of the local housebound population. Patients are reviewed holistically, which reduces the duplication that can happen if they are assessed by both GP and community services. A personalised care plan is agreed between the health professional and the patient, and patients on the frailty register are less likely to be admitted to hospital unnecessarily when reviewed and supported by the team. The team links in closely with the local neighbourhood team.

In Wetherby, the practices cover a wide rural area where older residents often require more home visits. In response, the practices have developed a shared GP led home visiting model. Patients report feeling that they have a longer assessment with the dedicated GP and practices also report that this has freed up valuable clinical time within individual practices which allows the GPs to carry out other tasks.

**Child and family health hubs** - the Pudsey, Beeston and Chapeltown and Harehills localities are part of the first wave of local care partnerships (LCPs) introducing child and family health hubs. This brings together general practice, community and the hospital and aims to provide better care and coordination for those with adverse childhood experiences (ACEs). ACEs are stressful or traumatic experiences in childhood
Our rotational paramedics project started in June 2018 and over the first 30 weeks, the team had made 2,282 visits to 1,440 individual patients.

Rotational paramedics - 15 practices in Pudsey, north and central Leeds have worked with Yorkshire Ambulance Service on a pilot that sees specially trained paramedics working in GP practices to focus on making house calls. The specialist paramedics work in groups of five, rotating between general practice, responding to 999 calls in rapid response cars, and working in the 999 Emergency Operations Centre in Wakefield. The project started in June 2018 and over the first 30 weeks, the team had made 2,282 visits to 1,440 individual patients - and that number continues to grow. Having the paramedic service dedicated to people who are housebound means that more home visits are possible, which relieves pressure on GPs and means that patients can start any treatment much earlier. Working so closely with practices also means that the specialist paramedics can develop skills and experience that will benefit them when they go back to their roles in the ambulance service.

Pudsey locality domiciliary phlebotomy service - in the first five months of the service, the phlebotomist carried out 446 home visits. This equates to 24 per week.

However, this is not the full picture, as they also support the locality nursing teams by running clinics if there are not many home visits on a day. The model works so well that it is currently being replicated in another locality.

2.6.13 Medicines optimisation commissioning

The medicines optimisation commissioning team work closely with other healthcare professionals within the CCG, primary care, secondary care and the West Yorkshire and Harrogate Health and Care Partnership. The team supports a collaborative approach, commissioning new services and pathways to maximise the beneficial clinical outcomes for patients, with an emphasis on safety and cost effectiveness, aiming to optimise the care and use of medicines across both the Leeds and West Yorkshire and Harrogate health economies.

The team ensures that medicines are commissioned safely and effectively through active participation at clinical working groups and other CCG, citywide and health care professional meetings. These include antimicrobial resistance, dermatology, cardiovascular disease, diabetes, musculoskeletal, mental health, long term conditions, respiratory and dressings formulary groups.

The team represents the CCG at a number of local, regional and national medicine-related meetings including the Shared Management of Medicines Group (SMOM), South West Yorkshire Area Prescribing Committee (SWY APC), Regional Medicines Optimisation Procurement Committee (MOPC), West Yorkshire and Harrogate Pharmacy Leadership Group (PLG), National High Cost Drugs Group and the NICE Associates Group.

The team also bring medicines commissioning expertise to other meetings, including emergency preparedness resilience & response (EPRR), Primary Care Operational Group, Quality Surveillance Group and the Optimisation Secondary Care Board.
**Commissioning of Medicines Group (COMG)**

The team hosts the Commissioning of Medicines Group (COMG), a citywide partnership chaired by the head of medicines optimisation with representation from the GP Confederation, secondary care, CCG finance and commissioning. The group looks at commissioning of both primary and secondary care medicines, high cost drugs and how new medicines are implemented. The group’s work during 2018-19 includes:

**Biosimilars** - the team worked closely with the pharmacy procurement team and clinicians at LTHT to ensure the timely, effective and safe introduction of biosimilar Adalimumab into the Leeds health economy. This has resulted in significant cost savings.

**Freestyle Libre** - Freestyle Libre (FSL) is a sensor-based system that continually measures glucose levels that became available on NHS prescription in November 2017 for the management of Type 1 diabetes. However, the cost of the sensors resulted in a potential cost for the CCG of over £1.5million a year. The team worked with the clinical specialists from the CCG, LTHT and the community diabetes team to identify those groups of patients who would gain most health benefit from using Freestyle Libre, whilst keeping it affordable for the NHS. Criteria were developed and a policy was successfully launched in July 2018. Other CCGs in West Yorkshire have subsequently based their guidance on this.

**Growth hormone** - the team worked with LTHT endocrinology nurses and primary care colleagues to switch adult patients where appropriate to a more cost effective growth hormone product and to ensure consistent prescribing. Processes were put in place through an agreed standard operating procedure to switch adult patients by the end of 2018-19.

**Leeds Area Prescribing Committee (LAPC)**

This is a citywide meeting chaired by the principal medical adviser for medicines optimisation with representation from the CCG, GP Confederation, hospital and community trusts, local medical council and Community Pharmacy West Yorkshire.

The group takes a strategic overview of medicines optimisation, focusing on policy, guidance and pathway approval, as well as implementation of national guidance.

The medicines optimisation commissioning team have also worked collaboratively across the Leeds health economy to implement a range of medicines related projects and services:

**Medicines of potential misuse prescribing review**

The team have worked closely with a wide range of stakeholders to systematically address the problem of addiction to opiates by ensuring opiate reduction services are at the core of commissioned chronic pain services. A joint working template ensures that organisations are able to work collaboratively to support patients to access the most appropriate services.

**Oral nutritional supplements (ONS) pathway review**

The team have contributed to the review and update of guidelines and templates to support practices with reviewing their malnourished patients.

**Review of stoma prescribing across Leeds**

In 2016-17, the CCG spent around £3.9 million on stoma-related products and accessories. The team reviewed what was being prescribed and used national best practice to develop a ‘fair use’ guide to help create substantial savings.

**Stock on shelves dressings project**

Following a successful pilot during 2017 to provide formulary dressings direct to practice and community nursing teams, the team implemented a more cost effective system of supplying them to the nursing teams direct from the NHS supply chain. This project has been implemented within thirteen community nursing hubs and two community care bed units across the city, which has resulted in the patient receiving their supply of dressings quicker, nurses changing treatment sooner and a reduction in waste.
Joint wound formulary
The team worked with primary and secondary care clinicians to produce and implement a cost effective, high quality joint wound formulary, which is expected to save £200,000 across the city.

Stopping over medication of people with a learning disability (STOMP)
Following the NHSE Call to Action in July 2015 and the STOMP guidelines published in 2016, the team were successful in securing NHSE funding to implement a one year pilot project to address STOMP within Leeds. A mental health pharmacist and a pharmacy technician were recruited to liaise with GPs to review patients with learning disabilities and / or autism who may have been inappropriately prescribed antipsychotics, antiepileptic and antidepressant medications. Following a successful pilot, additional funding was secured to roll out the project across the city.

Mental health pharmacy liaison service
Following a successful pilot of the service in north Leeds, the team have worked with LYPFT and other CCG colleagues to ensure the service is rolled out across the city. The service consists of a multi-disciplinary team (incorporating pharmacists, pharmacy technicians, nurse liaison and psychiatric wellbeing officer) to review appropriateness of psychotropic medications (anti-depressants, anti-psychotics, anti-epileptics) to patients on the serious mental illness register and those with learning disabilities and autism.

Inhaler check service
The team secured funding to offer a new service by community pharmacists aimed at helping people with asthma or chronic obstructive pulmonary disease (COPD) use their inhalers more effectively and so better manage their symptoms. Offered at 50 community pharmacies across the city, the service checks how well people are using their inhalers and shows them better techniques to optimise the use of their inhaler; 288 reviews have been carried out to date.

Pharmacy First
The Pharmacy First service is commissioned to provide patients with rapid access to a pharmacist who can give self-care advice on a range of minor ailments, releasing capacity in general practice and providing an appropriate alternative to the use of general practice or other health care (for example, A&E, out of hours or urgent care). Funding was secured to extend the service for a further 12 months to support the implementation of NHSE guidance on conditions for which over the counter items should not routinely be prescribed.

Antimicrobials
The team have reviewed all community assigned C Diff cases on the LCH Infection control database to identify those where a lapse in primary care may have been a factor. This information is shared with the Leeds GP Confederation clinical pharmacy team to follow-up in practice, encourage the practices to review the cases as a significant event analysis and enter learning on Datix (a system used in Leeds to identify themes of shared learning from events). Reviews of unavoidable secondary care C Diff cases presented by LTHT are completed to confirm that the CCG agree there has been no lapse in care.

Public health outbreak and resilience planning
The team worked closely with the CCG primary care engagement team, Local Care Direct, and LTHT pharmacy to establish a mechanism for the prescribing and dispensing of anti-viral medicines in care homes, within and outside flu season, as required by Public Health England. At the request of Public Health England, the team also commissioned a service whereby community pharmacies are able to supply antiviral medication in response an avian flu outbreak.

Medicines safety
The team continuously reviews medication-related Datix incidents reported by GP practices to identify emerging themes and trends and increase awareness of medicines safety messages.
through the production of ‘safety snippets’ and other safety communications across provider organisations. These have included fire risks associated with emollients, flu vaccination incidents and development of a policy for practices to improve their procedures following a series of cold chain incidents (when vaccines aren’t kept at the recommended temperature).

The team also hosts a citywide medicines safety exchange, with membership from organisations including LTHT, LCH, LYPFT, primary care, community pharmacy, hospices and private hospitals. The group focuses on promoting medicines safety across the city and have recently started to work collaboratively to ensure Medicines and Healthcare products Regulatory Agency (MHRA) alerts are implemented across all organisations within the set timescales.

A medicines safety officer (MSO) is a national requirement required of all NHS organisations. This role is carried out by the CCG’s medicines risk and safety manager, who has responsibility for overseeing prescription security issues, particularly in relation to the prescribing of controlled drugs; maintaining and monitoring the risk register for the team; and reviewing and approving national patient group directions for use across Yorkshire and Humber.

**Medicines safety in care homes**

Medicines safety in care homes has been a main priority for the team, and a specialist technician has been actively involved in numerous care home inspections and safeguarding investigations, observing medicine administration processes and giving feedback and recommendations for improvement to help address concerns raised by CQC or other agencies. The specialist technician worked closely with council colleagues and CCG contracting colleagues to improve standards and ensure a consistent approach across the city. The specialist technician has also developed and delivered training to care home staff around medication use to ensure compliance with NICE guidance and help reduce future incidents.

**Joint work with the West Yorkshire and Harrogate Health and Care Partnership**

**NHSE medicines optimisation in care homes**

- in April 2018, the CCG volunteered to host the first joint West Yorkshire and Harrogate Health and Care Partnership project - medicines optimisation in care homes. We were successful in securing funding from NHSE for the project and each CCG within the partnership signed up to a two year project to focus on local medicines optimisation plans for care homes. These include the principles of patient-centred medicines optimisation, and specific care home initiatives such as reducing medicines waste and the implementation of homely remedies policies. Following a successful recruitment campaign, the project has now been handed over to the GP Confederation for implementation.

**Liothyronine joint commissioning statement**

- following new guidance, the team worked closely with clinical specialists and pharmacists across the area to produce the first partnership commissioning statement for liothyronine. Further work is continuing across the partnership to produce a shared care guidance to support the commissioning statement.

Further collaborative work across the partnership continues to ensure consistent prescribing.

**2.6.14 Clinical pharmacy**

Part of the CCG’s medicines optimisation team has been working as a provider function since April 2018 and became embedded as the clinical pharmacy team within the Leeds GP Confederation in October 2018. The team supports the Confederation to achieve an agreed set of outcomes and deliverables which will result in improved health and care for people in Leeds, greater sustainability of general practices in Leeds and the wider transformation of health and care services. The team continues to work to improve quality, efficiency and innovation in the use of medicines by health and care providers across Leeds.
**Locality working**

Within the team, a locality lead pharmacist has been assigned to each primary care network (PCN) in the city. These pharmacists have been developing strong working relationships with locality leaders, all locality practice members as well as the emerging local care partnerships and the wider system.

The pharmacists provide expert advice and guidance and support the development of action plans to address inequalities

**Proactive management of long term conditions with a focus on frailty**

The team have ensured improved treatment in line with NICE and local guidance by carrying out patient-centred, clinical medication reviews primarily with a focus on moderately frail patients. By focusing on this group, we are hoping to address under or over treatment of conditions and prevent further deterioration in frailty and reduce hospital admissions. In many practices the team have refined the moderately frail cohort to align with the needs and specific targets of that practice or locality. There has also been collaborative working with GPs, advanced nurse practitioners and practice pharmacists so certain patients are reviewed quicker. Some of our pharmacists run face to face clinics or telephone medication reviews with patients as well as completing paper based reviews.

The reviews help reduce the risk of patient harm from medicines, for example through incorrect use or prescribing errors, or by looking at specific groups of drugs to improve long term conditions or reduce the risk of falls. In total, the team is on track to have delivered 1400 medication reviews for patients with a frailty diagnosis 2018-2019. Based on consistent evidence that pharmacist-led medication reviews generate a net saving in annual medicines costs of £153, this would equate to savings of £214,200 in addition to significant cost savings resulting from hospital avoidance and increasing social care costs.

**Care home medication reviews contributing to admissions avoidance**

The provision of care home reviews has changed significantly. Whilst the team are still providing some care home reviews it was anticipated that the majority of the care home work would fall to the MOCH (Medicines Optimisation in Care Homes) project which began across the West Yorkshire and Harrogate Health and Care Partnership in September 2018.

Here, the initial focus was on learning disability homes but this has been met with mixed reception in different areas. So while continuing to work with these homes, the team are beginning to work also with older adult care homes.

The actual size of the MOCH team is a limit to the impact they can have across the STP, but so far the work is showing a positive impact on the homes they have worked with. The team has developed and submitted a commissioning intention to expand this work which would be expected to generate net savings of £900,000.

**Improving antimicrobial prescribing**

The recent publication of the UK 20-year Vision for Antimicrobial Resistance shows that antimicrobial resistance is one of the biggest threats facing healthcare in the coming years. Concern is growing that overuse of antibiotics and drug-resistant bugs mean that currently treatable infections could kill in the future. As a result the CCG and partners in Leeds have committed to working with prescribers to achieve a reduction in the number of preventable community C.Difficile and MRSA cases and improved concordance with Leeds antibiotic prescribing guidelines.

In 2018-19 GPs in Leeds again achieved their antibiotic prescribing targets for co-amoxiclav, cephalosporins and broad spectrum antibiotics by working closely with the medicines optimisation team and adhering to Leeds antimicrobial treatment guidelines.
94% of practices met quality premium indicators (PresQIPP), and the CCG has met the NHS England quality premium targets for antibiotic prescription reductions and lowering prescribing of trimethoprim for urinary tract infections. NHS Leeds CCG has the second lowest consumption of antibiotics measured by items/STAR-PU in West Yorkshire and Harrogate ICS area, and is below the ICS consumption rate. The clinical pharmacy team is also working with the University of Leeds on near patient testing in primary care, which involves the innovative use of new technologies to improve diagnostics.

Ensuring cost effective prescribing
We have continued to meet financial constraints on prescribing budgets, making significant savings by minimising the amount of medicines wasted while achieving safer, more effective prescribing. In the first three quarters of this year the team have made savings in excess of £1.7m. By using Optimise Rx to optimise medicines use at point of prescribing we have saved £0.38m from 1 April 2018 to 28 February 2019. Whilst cost savings have been impressive, it is the safety messages that are of the utmost importance. The medicines management facilitator (MMF) programme is a medicines waste project aimed at improving quality of prescribing. The MMF programme has improved quality of prescribing in Leeds, for example, ensuring all patients issued with sharps have a sharps bin prescribed on repeat following needle stick injuries reported by Leeds City Council. Direct cost-saving initiatives undertaken by the team have generated savings of £0.39m through review of 11,952 patients.

Optimising treatment of AF, asthma and diabetes
Using the 2018-2019 QIS scheme to promote improved care in respiratory conditions and diabetes has led to:

- 628 patients who have used over 12 short-acting beta agonists inhalers in the past year receiving an asthma review which incorporates an asthma control test and personalised action plan in line with NICE quality standards.
- 863 COPD patients prescribed a non-formulary inhaled corticosteroid/long acting beta agonist combination inhaler have been reviewed to ensure they are receiving optimal inhaled therapy and changed over to a formulary inhaler in line with Leeds COPD guidance where suitable.
- The proportion of all asthma patients receiving an asthma control test has consistently risen through the year from 14% to 21%, and the proportion receiving a personalised asthma plan has again risen from 21% to 26% during 2018-2019.
- 1,735 poorly controlled type 2 diabetic patients on oral monotherapy have been reviewed for diabetic control, advice and intensification of therapy where necessary.
- 886 type 2 diabetic patients taking an oral hypoglycaemic medication and at risk of hypos were reviewed where risks were managed, discussed and self-testing put in place to aid safety of their medications.

The atrial fibrillation treatment gap has remained relatively static between April and October 2018 at around 21%. The CCG has encouraged practices to identify patients with atrial fibrillation during 2018-2019, which has increased the numbers of patients requiring reviews for anticoagulation. To help with this extra demand, the clinical pharmacy team have received extra funding to appoint three pharmacists and provide two sessions per week of consultant anticoagulation pharmacist time. They provide training to all pharmacists within primary care to effectively review these patients and initiate anticoagulation where appropriate. Over the course of 18 months the team will use this resource to review over 3,000 patients across the city.

Patient safety
The team supports GP practices with Medicines and Healthcare products Regulatory Agency (MHRA) Safety alerts. In total 2,449 patients have been reviewed and 1,265 interventions to improve safety have been made by the team.
Examples of this include the recent MHRA Valproate alert which instructed practices not to prescribe Valproate unless patients had been assessed and prescribed appropriate contraceptives via the pregnancy prevention programme, and the MHRA alert for Hydrochlorothiazide with a risk to patients of non-melanoma skin cancer, particularly in long term use.

**Neptune roll-out across Leeds**

Neptune software, used to identify patients in GP practice who are overdue their drug monitoring tests, has been rolled out in 95% of practices in the city. The software supports practice recall systems by acting as a safety net for those patients using amber level 3 drugs which require significant blood and/or physical monitoring.

**Pharmacists within GP practices**

We have continued to work with GP staff to expand the roles of pharmacists within practices as part of new models of care outlined in the Five Year Forward View. The team has worked with partners to develop a clear and comprehensive set of values, vision statement, mission statement and strategic objectives for clinical pharmacy in general practice. This will ensure a citywide focus on delivering a pharmacy workforce that meets the demands of the new GP contract and NHS Long Term Plan and delivers real improvements on the use of medicine to improve outcomes for people in Leeds. By 2024-25 we aim to have six pharmacists working in general practice per 50,000 patient population.

**2.7 Equality and diversity**

The Equality Act 2010 introduced a Public Sector Equality Duty, which requires us to pay due regard to the need 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. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership (only with regards to eliminate discrimination), pregnancy and maternity, race, religion or belief, sex and sexual orientation. In addition each year we have to publish equality information demonstrating how we have met the general public sector equality duty with regard to both our staff and the population we serve. We have to prepare and publish one or more equality objectives at least every four years.

We recognise the diversity of our communities in Leeds. We are committed to eliminating unlawful discrimination and promoting equality of opportunity in the way we commission healthcare services and in creating a workforce that is broadly representative of the population we serve. We value and respect our staff and aspire to be an inclusive employer of choice. We make sure that equality and diversity is a priority when designing, planning and commissioning local healthcare and respect the voices of the diverse communities we serve. For example, one of the emerging communities in Leeds is people from Eastern European communities such as the Czech Republic, Romania and Poland. Following engagement with community leaders, we agreed to provide information about health services in Eastern European languages. This allows people from Eastern Europe to navigate health services in Leeds: healthinleeds.org.uk.

**2.7.1 NHS Equality Delivery System 2**

The NHS Equality Delivery System 2 (EDS2) is a performance framework that helps NHS organisations to improve the services they commission or provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS.

NHS organisations are required to assess and grade their equality progress using the NHS EDS2. The involvement of key stakeholders, representing the interests of our diverse communities, is an essential element of this.
A new approach to the EDS2 was agreed across all NHS organisations in Leeds during 2018. Rather than gathering a lot of evidence across a very broad range of services, as we have done previously, a decision was made to look in more depth at a smaller number of services so that the CCG can make real and measurable improvements that will benefit particular groups of patients, staff and communities. Rather than reviewing and grading all four EDS goals every year, we now do it on a three year cycle, with goal one in 2018, goal two in 2019 and goals three and four in 2020.

We continue to work in partnership with our NHS provider trusts and have a city wide panel of “trusted partners” who help us with the engagement and assessment process associated with the EDS2 each year. Our panel of trusted partners is made up of representatives from Healthwatch Leeds, Voluntary Action Leeds, Leeds Involving People, Forum Central, and Leeds City Council. During our annual assessment and engagement events our panel of trusted partners, who attend as representatives of communities in Leeds, help identify gaps/areas for improvement. A performance update on the gaps or areas for improvement is provided annually.

We held a citywide EDS2 engagement and assessment workshop for goal one, “better health outcomes for all,” in December 2018 where we showcased the work we are doing in relation to maternity and neonatal services, the diabetes strategy and in partnership with the provider trusts complaints and demographic monitoring.

2.7.2 Equality objectives

Working jointly with our NHS provider trusts in Leeds we reviewed progress in implementing our equality objectives for 2013 to 2017 and agreed a new set of equality objectives for 2017 to 2020. All NHS organisations in Leeds will continue to work in partnership to improve the collection, analysis and use of equality data and monitoring for protected groups and to improve access to NHS services for protected groups. In addition, the CCG will work to ensure implementation of the accessible information standard across all commissioned healthcare providers.

Each year we provide a performance update on our progress in relation to these objectives and identify priorities for the following year. This update report forms part of our Public Sector Equality Duty Report and is published on our website - www.leedsccg.nhs.uk/about/policies/equality-diversity

2.7.3 NHS Workforce Race Equality Standard

In April 2015, the NHS Workforce Race Equality Standard (WRES) became a mandatory requirement and now forms part of our assurance framework. It requires NHS organisations to demonstrate progress against nine indicators. Our fourth WRES report (July 2018) details performance for 2017-18 against each of the nine indicators, enabling us to identify specific areas for improvement. The report was presented to the Quality and Performance Committee and published on our website - www.leedsccg.nhs.uk/about/policies/equality-diversity. The key inequality identified in these reports is that Black Asian and Minority Ethnic (BAME) staff are under-represented at senior levels within the organisation. We will take action to reduce this inequality and use WRES data to measure progress on an annual basis.

Linked to the work we are doing in relation to the NHS Workforce Race Equality Standard, we held a BAME workshop in February. The themes included leadership and management; staff engagement and empowerment; learning and development; and wellbeing. The purpose of the workshop was to provide a safe environment for BAME staff to share their experiences and views and provided the opportunity to consider what’s going well and what we could do better. The outcomes from the workshops will contribute to the work that is taking place in relation to the NHS Workforce Race Equality Standard action plan.
2.7.4 Monitoring NHS provider organisations

As a commissioner of healthcare, we have a duty to ensure that all our local service providers are meeting their statutory duties under the Equality Act 2010 Public Sector Equality Duty. As well as regular monitoring of performance, patient experience and service access, we work with them to consider their progress on their equality objectives. This includes the NHS Equality Delivery System (EDS2), the NHS Workforce Race Equality Standard (WRES) and the implementation of the accessible information standard. Each provider organisation is subject to the Public Sector Equality Duty and has published its own data. When procuring new services, we ensure that service specifications include the requirement to have robust policies in place to ensure that the needs of the nine protected characteristics and other vulnerable groups are adopted. These policies are examined and approved by procurement teams and our equality lead prior to any contract being awarded.

2.7.5 Accessible information standard working group

The group continues to meet bi-monthly to ensure that we have a consistent approach implementing the standard across all GP practices and all commissioned healthcare in Leeds. Membership includes representatives from primary care teams, contract managers and quality managers, in addition to a patient representative and representative from Leeds City Council. The good practice checklist, produced by the working group, is included in the annual performance reports the NHS provider trusts produce and is used during quality visits to providers.

2.8 Delivering the Leeds Health and Wellbeing Strategy

In accordance with section 116B(1)(b) of the Local Government and Public Involvement in Health Act 2007, we have consulted with members of the Health and Wellbeing Board before completing and submitting this section of our annual report. This included an agenda item at the Health and Wellbeing Board meeting on 25 April 2019 as well as additional consultation with members on the draft text before final submission. Evidence of our attendance at the meeting is available at democracy.leeds.gov.uk/ieListDocuments.aspx?CId=965&MId=8235&Ver=4

The Health and Wellbeing Board has prioritised improving the health of the poorest the fastest and has an ambition to be the best city for health and care. The Health and Wellbeing Strategy is rooted in connecting people, communities and places and a social model of health. This means that in Leeds we recognise the role of the wider determinants of health alongside the need for excellent health services.

The CCG plays a key role in delivering the Health and Wellbeing Strategy. Since becoming a single CCG we have strengthened partnerships with a greater focus on prevention, early support and care closer to where people live where appropriate to do so. We support and lead on a number of local programmes that link in with the recently published NHS Long Term Plan - for example developing the embryonic local care partnerships - and we have part funded the city’s neighbourhood networks and older people’s networks in the community. Together with Leeds City Council, we are commissioning services in an integrated way, have several joint appointments and our working cultures and practices are increasingly aligned.

In keeping with our role in delivering the strategy, we ensure our work contributes to the Health and Wellbeing Strategy’s vision of “improving the health of the poorest the fastest” by ensuring that tackling health inequalities is embodied in
our commissioning strategy and supported by the CCG Governing Body - there is more information about this area of our work in section 2.5. We have also nominated and employed staff to specific roles within the organisation to support this area of work, including a specific clinical lead GP role for health inequalities and named leadership within strategy and planning. The CCG has signed up to actions aligned to the Strategy and the Leeds Health and Care Plan, some examples of which are outlined below.

2.8.1 A child friendly city and the best start in life

Over 10,000 babies are born in Leeds every year. Making the most of every child’s potential is an important goal in Leeds - we all want the best for our children to help them be happy, healthy and reach their potential. From conception to the age of two is a very important time as it makes the biggest difference to a baby’s future. We work with families and services to help all babies get the best start in life. In this regard, the citywide maternity strategy has achieved the following in 2018-2019:

Perinatal mental health problems can have significant and long lasting effects on the woman and her family. Our perinatal mental health pathway, which covers a range of services, has been evaluated and updated together with families in Leeds; resulting actions have included a new communications and training plan, including delivering training to all GPs around how to detect and address perinatal mental health issues.

Young parents are often disproportionately affected by adversity. To address this we have worked collaboratively to produce a pathway of services together with young parents. Where necessary we have changed services to provide more consistent relationships between young parents and their professionals, as well as developing specific MindMate content to support young parents with mental health problems.

We have worked collaboratively to develop plans to give women and families more continuity of carer through their pregnancy and beyond, and to encourage families to be empowered to make their own choices throughout the perinatal period. We have developed relationships across West Yorkshire and Harrogate in a local maternity system, providing more seamless pathways of care for families. We have also introduced electronic patient records for families going through maternity services, making services safer and helping families feel listened to rather than repeating their stories.

During the year, we carried out engagements on a range of issues including support for parents of children with autism, home birth, neonatal outpatient services and maternity pathways for young people. The results of these engagements are used by commissioners to plan and improve services that will give children born in Leeds the best start in life. For example, we have jointly commissioned an infant mental health service to promote positive attachment and have led on delivering an integrated perinatal mental health pathway. We are also piloting a new child family hub in Pudsey, which aims to improve access to specialist children’s doctors for families by bringing hospital-based paediatricians into the community.

For older children and young people, we have continued to develop the Future in Mind strategy, particularly through our award winning MindMate resource (www.mindmate.org.uk), which helps promote wellbeing and emotional resilience. During 2018-19, we invested in a major campaign to raise awareness of both young people’s mental health issues and the resources available to help them.

2.8.2 An age friendly city where people age well

We share a vision that Leeds will be the best city in the UK in which to grow old and appreciate that physical health is only one aspect of aging well. Anyone can access our social prescribing services; however some of the community-based services that social prescribing link workers refer
to are of particular benefit to older people, who are more likely to experience social isolation and loneliness, which can have a significant impact on both physical and mental health and wellbeing.

In 2018, we asked people living with frailty and their carers what mattered to them and their feedback is being used to help shape a citywide approach to supporting people who are medically described as being frail.

Our feedback showed us that people feel strongly about being called frail and this is something that we will look to address as part of our work with health and care professionals.

We have also worked with local GP practices and Leeds Community Healthcare NHS Trust (LCH) to pilot a ‘leg club,’ in Otley, which at the time was the first of its kind to open in the north of England. The club is a health and social group that follows a model developed by former district nurse Ellie Lindsay OBE, which sees patients treated by nurses in community settings. The leg club atmosphere encourages people with ulcers and other medical conditions to take more interest in their care and treatment, and when their legs heal, to keep them well and healthy. An important aspect of the club is the social element - as leg problems can limit mobility, being supported to attend every week helps reduce social isolation.

To further tackle the problem of loneliness, during the year, we worked with our colleagues in the West Yorkshire and Harrogate Health and Care Partnership on its first regional campaign, “looking out for our neighbours.” The campaign, which launched in March, encourages people to connect with their neighbours in a bid to reduce the problems caused by social isolation. People can download resources so that they too can contribute to increased social connections within their communities - www.ourneighbours.org.uk.

2.8.3 Strong, engaged and well-connected communities

Leeds is home to vibrant and diverse communities, well-established networks and a thriving third sector. It’s vital that we work together to keep our communities strong as they are essential for individual health and wellbeing.

Alongside Leeds City Council, we continued our commitment to fund the city’s neighbourhood and older people’s networks with an announcement in September confirming arrangements for a five year funding settlement. The neighbourhood networks support around 20,000 older people around the city, delivering support which helps reduce pressures on statutory health and care services, as well as enabling local people to get involved in using community assets in ways local people want. All of the neighbourhood network schemes are governed by local people who represent the communities they serve. These people steer the organisations so they best meet outcomes local older people want. The grants total value is £15m over the initial five years, with an annual value of £3m.

We are playing a lead role in setting up local care partnerships; leadership teams are in place and are helping deliver new ways of working in local communities, built around the needs of local populations. For example in the Armley and Lower Wortley area, professionals from a range of agencies are working together to improve mental health support within these communities.

Our final round of third sector grants has funded a diverse range of health projects aimed at improving health outcomes and build capacity in order to relieve pressure or demand elsewhere in the health system. A total of £2.3m funding was distributed through the health grants programme between 2015 and 2018. The time-limited funding was provided by the three former Leeds CCGs with a particular focus on the north and south and east of the city.
The grants programme may have come to an end; however the evaluation shows that local community groups benefitted from both the financial support but also by developing a better understanding of how to work with statutory bodies. We have also established a new fund for patient participation groups (PPGs) at GP practices to apply to for developing new health lifestyle projects or increased connections between the GP practice and its local community.

To encourage people take an active role in their health and care, we worked closely with colleagues from Healthwatch Leeds, Leeds City Council, NHS providers and the wider third sector to organise the Big Leeds Chat. This was the first ‘one system’ citywide engagement event in Leeds. It brought around 500 local people together with key decision makers and leaders, to have a conversation about what matters to them and to better understand their needs and preferences. We also carried out a number of engagements throughout the year, including on maternity services, urgent treatment centres, mental health services, local care partnerships, community respite care services and weight management services. More details on our engagement activity can be found in section 2.4.

Less formally, we involved local communities in activities to mark the 70th anniversary of the NHS, and our Big Thank You campaign (bigthankyouleeds.co.uk) encouraged Leeds residents to thank their winter hero for this or previous winters. The winter hero could be anyone from all walks of life, such as unpaid carers and community groups supporting people every day. The campaign was a partnership approach involving the city’s NHS organisations, Leeds City Council, West Yorkshire Police (Leeds District), British Transport Police and community and voluntary organisations who are recognising the dedication and hard work that staff do every year to help people through winter.

2.8.4 Get more people, more physically active, more often

We share an ambition for Leeds to be the most active big city in England. As well as supporting Public Health England campaigns such as One You, Active 10 and Change4Life, we have promoted One You Leeds, most recently as part of a West Yorkshire and Harrogate healthy hearts initiative, which aims to reduce the incidence of cardiovascular disease in the region.

We have also invested in further capacity in pulmonary rehabilitation, aimed at encouraging people to walk more and be more active, and we continue to support ‘Breathe Easy’ groups, which help people with respiratory conditions in some of the city’s most deprived areas.

2.8.5 Maximise the benefits of information and technology

New technology can give people more control of their health and care and enable more coordinated working between organisations. The Leeds Care Record continues to be rolled out and has been firmly established in the city, allowing health and care professionals to access records. This is a joined up, digital care record that enables clinical and care staff to view real time health and care information across care providers and between different systems. It is reducing the need for duplication, especially from a patient’s perspective, as they are no longer asked the same questions by different people looking after them.

Work continues on the person held records (HELM) project, giving people a chance to access personal information on health as well as council services.

All GP practices now have free patient wifi, and an increasing number are using social media to engage with patients. During the year, we provided training to help them do this more effectively.
Our continuing care team have worked to eliminate the need for ‘wet’ signatures for most hospices and GPs by designing electronic referral forms. You can find out more about how this works at rebrand.ly/DARTFeb2019

Along with colleagues at Leeds Teaching Hospitals NHS Trust (LTHT) and the Leeds Cancer Programme, we have helped develop a teledermatology service for patients with skin lesions or moles that could indicate the presence of cancer. You can find out more about this and other innovations in section 2.9.11.

2.8.6 A stronger focus on prevention

Targeting specific areas such as obesity, smoking, and harmful drinking can make a really big difference to preventing ill health. In 2018, we ran the #NoRegrets campaign with colleagues in public health (Leeds City Council) and Forward Leeds - noregretsleeds.co.uk.

This online campaign aimed at encouraging sensible drinking in 18-25 year olds was launched at the beginning of Alcohol Awareness Week in November and ran throughout the festive season. By the end of January 2019, almost two thousand people had accessed the site, with some blogs on the site having been viewed hundreds of times.

Recognising that health and wellbeing are determined by many factors, we have continued to develop our social prescribing service. Over 5,000 people have accessed services that support them to meet their personal goals in their own neighbourhoods. In 2018-2019 we worked on developing a citywide service moving from the previous model set up by the three predecessor CCGs in the city. It’s anticipated that the service will be running from April 2019. There’s more about the scheme in section 2.5.5.

Reducing incidence of cardiovascular disease is a national, regional and local priority; however, we know that far more people are at risk than realise it, and engaging with some of the most at risk isn’t straightforward. We have worked with the British Heart Foundation to test a community based approach to identify raised blood pressure in addition to increasing accessibility to blood pressure testing and lifestyle support. The project is targeting front-line council employees as well as people served by six community pharmacies in the 10% most deprived areas of the city. To date, there have been approximately 1,000 blood pressure tests undertaken and learning from this project will help shape future programmes. We have also worked with 35 community pharmacies to offer blood pressure checks. In addition, the NHS health check programme has been re-procured and will be delivered by the Leeds GP Confederation from April 2019. Embedding this important service within general practice, with extended access and out of hours hubs, will make it more accessible to people who may be less likely to access prevention services.

Raising awareness of how people can stay well and protect themselves from ill health is a key part of our prevention work. We have delivered campaigns to encourage people to take up cancer screening such as cervical smears and bowel cancer tests. We have also continued to develop our nationally-recognised ‘Seriously Resistant’ campaign to raise awareness of the risks of overuse of antibiotics. In 2019, we will be launching a new phase of the campaign, which will target parents and carers of young children, older people and health care professionals. We are also supporting Leeds City Council’s healthy schools team by providing Seriously materials to use in the classroom.

2.8.7 Support self-care, with more people managing their own conditions

Long term conditions are the leading causes of death and disability in Leeds and account for most of our health and care spending, so it’s vital that we support people to maintain independence and wellbeing within local communities for as long as possible.

With diabetes affecting around 44,000 in Leeds, and a further 32,000 at high risk of developing it, developing a system-wide diabetes strategy has been a priority this year.
The strategy has been co-produced with diabetes professionals from across the NHS, council and third sector, as well as people with the condition and carers. A summary version is available at [www.leedscrg.nhs.uk/publications/leeds-diabetes-strategy-2019-2024](http://www.leedscrg.nhs.uk/publications/leeds-diabetes-strategy-2019-2024) and the full version will be published over summer 2019. During the year, we also developed a range of resources to help people with diabetes take better care of their feet, in order to reduce the risk of amputation. Completion of the diabetes structured education (Type 2) course has continued to be above target (77% against a target of 60%). People are reporting an improved confidence in self-managing their condition, sustained at 100%. GP practices continue to be involved in referrals to the NHS diabetes prevention programme.

Along with colleagues in Community Pharmacy West Yorkshire, we have introduced free inhaler checks in 50 pharmacies across the city. The service is about making sure people with asthma and COPD are able to use their inhalers in the correct way and that they are appropriate for them. In Leeds we have recognised that some people with asthma or COPD have been prescribed an inhaler that they might find difficult to use. Unfortunately this can affect how well their respiratory condition is controlled. The community pharmacies help patients have easier access to inhaler checks, to ensure they are getting the most from their inhalers and that their asthma or COPD is well controlled. To further help people with respiratory problems better manage their conditions, 10 integrated Breathe Easy groups are now established, with a particular focus on disadvantaged groups and areas with high prevalence of COPD to promote independence and living a good life.

Use of collaborative care and support planning has continued within the city. The number of people having a collaborative care support plan (CSSP) has continued to increase, which is helping them manage their own condition by focusing on “what is important to them” with people working with their GPs to develop goals to work towards for 12 months before their next annual review.

2.8.8 Promote mental and physical health equally

The city’s ambitions for mental health are crucial for reducing health inequalities, and throughout the year, we have continued to fund and develop mental health services and resources.

MindMate - [www.mindmate.org.uk](http://www.mindmate.org.uk) - the online resource for young people, has continued to grow, and last summer, we delivered a major campaign aimed at raising awareness both of the resources available and of mental health issues affecting young people. For World Mental Health day, we partnered with British Transport Police and the local universities to further raise awareness. In addition, we have funded services such as Teen Connect to support children and young people in distress and there is now a single point of access to simplify referrals.

For adults, the MindWell website - [www.mindwell-leeds.org.uk](http://www.mindwell-leeds.org.uk) - has continued to be developed and has recorded 100,000 visitors since it launched. We have also evaluated and updated our perinatal mental health pathway together with families in Leeds. We contributed to the Yorkshire Evening Post ‘Speak Your Mind’ campaign, including a recent piece on looking after your mental health at Christmas and promotion of mental health drop-in sessions for the public across Leeds.

We are also making headway with a national initiative called STOMP which aims to stop the over medication of people with a learning disability, autism or both. We commissioned a STOMP team who have worked closely with GP practice, patients and their carers to make sure people get the right medicine for when they really need it.

There’s more information about mental health services in section 2.5.6.

2.8.9 A valued, well trained and supported workforce

In common with our NHS, council and third sector partners, we have a highly motivated, creative and caring workforce, who are working hard to deliver high quality care.
We are a founding partner of Leeds Academic Health Partnership (see section 2.9.10), which, through innovation and collaboration, is helping to ensure that Leeds is one of the best places in the UK to work in health and social care.

Following the creation of a single CCG, we have worked hard to engage our staff in a number of ways, including all staff events, professional and personal development opportunities and recognition events linked to NHS70. In a similar vein but for all partners, we helped develop the Big Thank You campaign - bigthankyouleeds.co.uk - which encouraged people across the city to say thank you to their winter heroes. At a time when frontline staff are under great pressure, this has been a very popular way to show how appreciated they are.

We have also invested in developing the primary care workforce, both with practical training and leadership development, and our safeguarding team continue to offer training, support and advice to primary care.

Over the coming 12 months we will support colleagues at Leeds Academic Health Partnership and those working on the Leeds Health and Care Plan to continue work on the ‘one workforce’ programme.

2.8.10 The best care, in the right place, at the right time

To help develop more effective, efficient health and care in the community, we have supported the establishment of local care partnership leadership teams, which are developing new ways of working locally, based on the needs of their local populations.

During 2018-19, the first urgent treatment centre was designated at St George’s Centre, aimed at reducing the number of people going to A&E. The mandate for establishing urgent treatment centres (UTC) across the country comes from NHS England as part of their drive to improve urgent and emergency care. UTCs help simplify the system, and we are currently carrying out an extensive engagement with local people to seek their views on proposals to expand the UTC offer in the city. As part of the UTC offer, direct booking has been tested. This allows NHS 111 to book an appointment at the UTC for the individual, therefore giving a better experience to the individual rather than having to wait their turn in the queue to be seen.

Since October 2018, all Leeds residents have had access to evening and weekend GP appointments, which will also help relieve pressures on other parts of the system. To further support this endeavour, we have run extensive awareness campaigns throughout the year aimed at encouraging people to cancel GP appointments if they no longer need them and to choose the right service, based on the national Help Us, Help You approach. In addition, we have helped new communities in Leeds to understand how to access healthcare in the city including working with the migrant access partnership.

We have piloted the Leeds Clinical Assessment Service. This allows people (within the pilot scope) to receive clinical advice over the telephone via NHS 111, by a range of local health professionals (such as GP, nurse, musculoskeletal specialist, pharmacist). This has reduced the need for people to have to attend a face to face appointment, when it was identified that a phone call was clinically appropriate.

2.8.11 Suggested priorities for our work against the priorities in 2019-20

We will continue to develop our approach to commissioning and delivering positive and enduring health and wellbeing outcomes for the people of Leeds. This includes sharing responsibility for outcomes and inequalities as a result of our health, care and support services and to work together to integrate care around population and community needs.
2.9 Working with our partners

2.9.1 Leeds GP Confederation

The Leeds GP Confederation is a ‘not for profit organisation’ working to improve the health and wellbeing of the people of Leeds. It does this by strengthening and sustaining primary care as well as working with the full health and care system to meet the objectives of the Leeds Health and Wellbeing Strategy 2016-2021.

The Confederation was established in March 2018 to represent the collective view of GP practices as providers in Leeds. It has evolved through shared working with the GP leadership and the existing three GP federations in Leeds. In October 2018, CCG staff working in the primary care development and clinical pharmacy teams became embedded within the Confederation and other staff from the CCG provide support as needed.

The Confederation aims to improve care in Leeds, principally through applying the local care partnership model in localities but also by helping spread best practice across the city. It exists to:

- Help practices remain sustainable by building on the attributes of primary care.
- Enable practices to play a full and active role in quality improvement, service integration and pathway development, aligned with the local care partnership vision.
- Create a governance system that enables practices be active in contributing to both local and citywide strategy.
- Create an organisational structure which is able to hold contracts and deliver services across general practice in Leeds and in partnership with other providers in the city.
- Listen and act.

During the past year, the Confederation has developed governance, leadership and staffing structures to meet its purpose; for example, contracts for extended access to GP services and NHS health checks are held by the Confederation. The Confederation has been key in the ongoing development of primary care networks, integrated nursing and digital developments. It has also engaged extensively with member practices about how the Confederation can support them with their priorities. This work has been developed to take into account the changing local and national context including the review of the Leeds Plan, workforce issues, new five year GP contract and the NHS Long Term Plan, particularly around the development of primary care networks. A new ‘offer’ is currently being developed to help mitigate risks and manage the workload of the new networks that will enhance the work the Confederation is already doing to support practices and localities.

2.9.2 West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership was formed in 2016 as one of 44 sustainability and transformation partnerships (STPs). It brings together all health and care organisations in our six places: Bradford District and Craven, Calderdale, Harrogate, Kirklees, Leeds and Wakefield to meet the needs of people as close to home as possible. NHS Leeds CCG is one of the partners which make up this unique partnership.

In February 2018, the partnership published ‘Our Next Steps to Better Health and Care for Everyone’. This document describes the progress made since the publication of the initial West Yorkshire and Harrogate plan in November 2016. You can read it at www.wyhpartnership.co.uk/publications/next-steps.

In order to realise the ambitions of the partnership, we need to recruit, train, develop and retain our skilled and caring workforce so that health and social care services are fit for the future - for generations to come. The partnership’s workforce plan ‘a healthy place to live, a great place to work’ can be found here: www.wyhpartnership.co.uk/our-workforce-strategy. This document describes the challenges we face and the work we will be doing together to address them.
The NHS Long Term Plan
The NHS Long Term Plan for the NHS gives formal backing to systems like West Yorkshire and Harrogate Health and Care Partnership. It gives a further boost to the priorities that partners have been working on locally and the help needed to deliver reductions in health inequalities and unwarranted care variation (often referred to as the post code lottery). For example, the focus on mental health services, cancer, preventing ill health, and primary care (GPs, district nurses and occupational therapists) will build on our approach and the progress we have already made. The recognition of workforce challenges is welcome and the partnership is keen to understand how the full workforce plan will further support local efforts to secure a workforce for the future. This is perhaps our biggest single challenge. Alongside the NHS long-term plan we will need additional resources and support for social care and for local government. Without these we cannot deliver our ambitions.

The way we work
The partnership includes nine CCGs, eight local councils, and services provided by a number of health and social care organisations, including hospitals, mental health care providers, the ambulance service, Healthwatch, and community organisations. These CCGs make up the West Yorkshire and Harrogate Joint Committee. They have a shared work plan and meet in public every other month. Our hospitals and mental health providers also work together on a shared work plan to further improve the care people receive. All partner organisations have now formally approved the partnership’s memorandum of understanding. A new partnership board will also bring NHS, councils and communities closer together. The first meeting in public will take place in June 2019.

Partnership priorities
Partners also work together on priority programmes for the whole of West Yorkshire and Harrogate, including mental health, hospitals working together, maternity, urgent and emergency care, preventing ill health and improving people’s wellbeing. This is done where it makes sense to share learning, expertise and workforce skills.

We all know that more needs to be done to prevent ill health. People’s life chances are shaped in their early years of life and with an ageing population, helping frail and older people stay healthy and independent, tackling loneliness, avoiding hospital stays unless needed and giving children and young people the best start in life are a priority.

We also know that not only hospitals and doctors keep people well; a person’s life choices and where they live are also important. Housing and health go hand in hand. Working alongside communities is therefore essential and our work with community and carer organisations is extremely important if we want to build on the good work taking place across the area.

What next?
The partnership has now developed programmes of work into clear plans for delivery and begun to deliver in these important areas. The plan will be refreshed in 2019 and will set out further goals for the next five years. These include improving access to GP services at weekends and evenings; reducing the number of people who take their own life; reducing waiting times for autism assessment; supporting people with learning disabilities better; helping children and young people with mental health concerns; tackling alcohol related harm; reducing the number of people who smoke; and identifying people at risk of diabetes, heart disease and stroke.

A key part of the partnership’s plans is rethinking the way urgent and emergency care is provided to ensure more options are available away from hospital, ensuring A&E departments are supported by better primary and social care for both children and adults. We are also working hard to return people home quickly and safely after a stay in hospital.
This way of working needs a joined up approach that is better suited to people’s needs and provided by NHS services, councils and community organisations working together.

Moving forward, the partnership will build on early successes in attracting £32m of transformation funding and £38m of capital funding last year and the £230m additional funding as part of the £963m of capital funding, announced by Matt Hancock, Health and Social Care Secretary of State in December 2018 to boost health facilities across England.

This additional funding will benefit three large acute and mental health care schemes including pathology and rehabilitation. This is particularly important to help reach our ambition for a more radical approach to empowering people to get the care and support they need as early and as locally as possible and to build up our community based services.

This is just a snap shot of some of the work that the partnership is doing. You can find out more at www.wyhpartnership.co.uk.

2.9.3 Scrutiny Board

The Leeds City Council Scrutiny Board (Adults, Health and Active Lifestyles) reviews and scrutinises the performance of health services and efforts around prevention of ill health (primarily through public health initiatives). The Scrutiny Board also reviews and scrutinises decisions taken by the council’s Executive Board relating to adult social care. Throughout 2018-19 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) and Health and Social Care Act (2012).

In 2018-2019 we updated the Scrutiny Board on the following areas:

• The integrated quality and performance report to demonstrate how well the healthcare system in Leeds is performing, areas of achievement and areas for further improvement.

• Services to support people experiencing mental ill health, particularly community-based services and improving access to psychological therapies (IAPT). The board has been regularly updated on proposed developments in this area. This includes a number of patient and public engagement exercises as well as changes to some community mental health services provided by Leeds and York Partnership NHS Foundation Trust.

• Members have been regularly updated, through the Health Services Development Group of the Scrutiny Board, on proposals to establish urgent treatment centres in the city based on a mandate from NHS England.

2.9.4 Our NHS providers

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

2.9.5 Unplanned care - winter planning

Our approach to winter this year has been influenced by the lessons learned last year, including a successful multi-agency discharge event, LTHT Perfect Week exercise and a diagnostic exercise by Newton Europe. We made extensive use of data and collaboration to robustly plan for winter pressures and support the wider system. Our partnership working resulted in a number of positive interventions:

• Weekly Operational Winter Group (OWG) - a system meeting with senior managers; the impact of this group is felt to have been significant.
• Operational Discharge Group (ODG) - front line managers from LTHT, LCH and adult social care meet three times a week to manage individual patients through the discharge process, with escalation themes, barriers and concerns taken to the OWG.
• Hospital Attendance Group (HAG) was established to focus on immediate intervention to support avoidance pathways sign off and implementation of the Transfer of Care Policy.
• Additional social workers to support additional winter beds (community and acute) to support maintained flow.
• Discharge transport booking times extended.
• Improved discharge processes in community care beds including dedicated transport, which has improved flow and maintained effective bed occupancy.
• Community care bed flexibility in terms of criteria, times of admissions to maximize use of bed base.
• Care home manager invited into the hospital to maximize use of beds in care homes that were previously difficult to fill.
• Recruited trusted assessor for the care home market.
• Urgent treatment centre (UTC) designation at St Georges, Middleton expanding capacity and providing direct bookable appointments from 111.
• Age UK collect and deliver medicines to further support patient discharge.
• Additional staff deployed to meet increased demand at the walk-in-centre at times of pressure through agreed mutual aid processes.
• Enhanced streaming within the LGI GP streaming service in A&E to increase flow through the service.
• Community services continue to supporting increases in referrals in additional pathways including respiratory, OPAT (outpatient parenteral antimicrobial therapy) and stroke; direct referrals are accepted from walk-in, minor injuries and urgent treatment centres.
• Leeds hospices undertaking in reach to LTHT.

• System wide mutual aid actions agreed and signed off by the System Resilience Assurance Board (SRAB).
• Improved system relationships and understanding of services, challenges and constraints.
• Weekly update to the system with a focus on front line staff to ensure good communication and receive feedback.

2.9.6 Unplanned care and rapid response programme
The unplanned care and rapid response programme is one of the four programme areas that sit within the Leeds Health and Care Plan. Throughout 2018-19 the Unplanned Care and Rapid Response Five Year Strategy has been developed and refined, with input from system partners. The strategy received final approval towards the end of 2018-19 by the Unplanned Care and Rapid Response Board members, who are representatives from across the Leeds health and care system partners. Examples of working in partnership include:

Leeds clinical assessment service pilot
The national vision for an integrated urgent care clinical assessment and advice service (CAS) offers an opportunity to deliver a model of urgent care access that will streamline and improve patient care through the implementation of a “consult and complete” model at NHS 111. This will be achieved by increasing the number of multidisciplinary clinicians offering consultations over the telephone to the public.

The integrated CAS approach ensures people will receive a complete episode of care concluding with either advice, a prescription, or an appointment for further assessment or treatment. This means as many clinically appropriate calls to NHS 111 as possible should be closed, following consultation with an appropriate clinician, negating the need for onward referral or additional signposting.
A single provider (Yorkshire Ambulance Service) currently delivers the core CAS function across the Yorkshire and Humber region. As it is new, the function is relatively small at the moment, but there is a national expectation for localities (or places) to develop their own services to support and link with the core CAS. Local Care Direct (LCD) offer clinical assessment and advice either over the phone, or through face to face contacts across West Yorkshire from qualified clinicians.

Due to the size of Leeds, we saw an opportunity to create a city-specific local CAS function, and to work with the newly procured NHS 111 services and the LCD virtual hub to develop links between the core, local CAS and the hub. Calls to NHS 111 by Leeds people registered with a pilot practice, which have not been closed down by a NHS 111 call handler, will be passed through to the pilot for further advice and assessment by the appropriate health or care professional, ensuring the person receives the most appropriate response to their perceived urgent care need.

The pilot is currently being evaluated; however early indications show that it has been a success, with local clinical advice being offered to the people who had rung NHS 111, reducing the number of people needing to go to a face to face appointment with a health care professional.

The providers were also successful in working together by being able to book appointments into one another’s appointment systems, when an individual needed to see a health care professional.

Development of St Georges Urgent Treatment Centre

Locally as well as nationally, it is recognised that people find the mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service, very confusing. This makes it difficult for people to know which service they should use when they have an urgent care need. Added to this confusion within and between these services, there is a confusing variation in opening times, in the types of staff present and what diagnostics may be available.

Therefore in July 2017, NHS England published a national requirement that stipulated by December 2018 each locality (or place) must have at least one urgent treatment centre (UTC). The aim of UTCs is to reduce the variation that exists by integrating services and standardising the urgent care offer for the public.

The CCG worked in partnership with a wide variety of health and care services to create the first urgent treatment centre in Leeds. This included setting up a steering group to oversee the work that was required, monitoring the delivery of this work, and collaborative working between providers to integrate the various services together. The centre was a success, as it was designated by NHS England in December 2018, one of the first in West Yorkshire. In February 2019, we began an extensive public engagement on proposals to develop five urgent treatment centres across the city. We will have the results of this engagement after April 2019.

2.9.7 Leeds City Council

Leeds City Council commissions care and support services and is responsible for public health, which 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 been working closely with all our partners over winter as part of our efforts to improve patient flow within the system and subsequently reduce demand and pressures on services. As part of this work we’ve been working closely with adult social care to look at how we improve commissioning services to improve discharge from hospitals as well as looking at how we fund support to meet current and anticipated demand.

We continue to work closely with Leeds City Council to make progress around prevention of ill health as part of our ambitions under the Leeds Health and Care Plan.
This includes funding neighbourhood networks so that they can continue to support older people in the city. In addition we’ve worked on a number of health awareness campaigns including our nationally recognised ‘Seriously’ initiative to educate people about the misuse of antibiotics.

Other campaigns include encouraging people aged 40-75 to attend their free NHS Health Check, a number of awareness activities to support people living with diabetes and campaigns over winter to ensure people are prepared for the season such as making sure they have had their flu jab.

We also continue to work closely with Leeds City Council and our other partners to establish local care partnerships (LCPs). These build on a strong history of the NHS, council and third sector staff working together. Approximately 18 LCPs cover Leeds, and, recognising the diversity of the city, they are tailored to local need and the features of that particular community. Some LCPs are already convened, whilst others are in development. All LCPs share the same key feature - a range of people working together, regardless of the employing organisation, to deliver joined-up collaborative care that meets the needs of the identified population.

2.9.8 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 those 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 - see more in our section on working with patients in section 2.4.

We continue to fund third sector organisations to provide our social prescribing schemes and have worked with a range of third sector partners to help patients leave hospital sooner especially over the winter months when demand is highest.

We are committed to tackling health inequalities. One of the groups we have been looking to help access health care is the city’s Gypsy and Traveller community.

We have continued to work closely with the Gypsy and Traveller Exchange (GATE) to provide quicker access to services including primary care and health screening. We have also worked with the city’s eastern European communities and other groups to help new immigrants understand how to access appropriate health care services.

In addition we worked with local community ambassadors to raise awareness of antibiotic resistance, increase understanding of mental health issues and increase take up of bowel cancer screening.

2.9.9 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 the health visiting service. We continue to attend the Healthwatch Leeds People’s Voices group and worked closely with them in developing the Big Leeds Chat. There’s more information about our partnership in section 2.4.6.

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

- Changes to older people’s mental health services
- Social, emotional and mental health (SEMH) in schools - feedback about the MindMate champions programme
- Young people’s healthcare rights.
2.9.10 Care Quality Commission
The Care Quality Commission (CQC) is the registration body responsible for monitoring standards of care, and undertakes announced and unannounced inspections to providers either as a matter of routine or in response to concerns raised by patients and staff. To support sharing of information and intelligence on quality and standards of care, a Quality Surveillance Group meets to monitor progress and pro-actively identified any areas where improvement may be required.

Leeds member practices continue to provide high quality services with 98% of practices rated good or outstanding with CQC and clear action plans in place for those where improvements have been identified.

In 2018, the CQC carried out a review of the Leeds health and care system with a particular focus on the experiences of local people, starting with what happens to help people stay at home, the experiences of those that require hospital treatment, through to the support provided to older people to help them regain independence in their normal place of residence. It also looked at support available for older people living with dementia.

CQC came to Leeds because they were concerned that when older people attended hospital, there were higher rates of admissions than the England average. When people were in hospital they were also concerned that they had a higher average length of stay.

CQC have praised our approaches to preventative care and supporting self-management, which is helping improve the health of older people in Leeds, and helping them stay at home. Other areas that CQC highlighted as good practice in Leeds include the support available for people living with dementia, the investment in joined-up services in local communities, and the strong relationships between frontline workers helping put patients at the heart of health and care.

However, they said Leeds needs to plan better to ensure it has the right workforce to take forward these approaches.

The report is available to view on the CQC website: www.cqc.org.uk/local-systems-review.

2.9.11 Leeds Academic Health Partnership
The CCG is a founding partner of Leeds Academic Health Partnership (LAHP). In what is one of the biggest partnerships of its kind in the UK, we work with other LAHP partners to bring together research evidence and experts to secure a healthy future for Leeds. Other LAHP partners are three Leeds universities, the city’s three NHS trusts and the City Council. Its wider membership includes the Yorkshire and Humber Academic Health Science Network, Yorkshire Cancer Research, St Gemma’s Hospice and Leeds City College.

Over the last year, the LAHP helped secure £7.5 million government funding to develop an electronic shared local health and care record for Yorkshire and the Humber. This regional record will make relevant information about people instantly available to everyone involved in their care and support, to help improve patient safety and quality of care.

The LAHP is part of a select Leeds City Region team on a prestigious leadership programme run by Massachusetts Institute of Technology (MIT), one of the world’s top universities. The two-year programme aims to bring about significant economic and social change for our region.

The Leeds Centre for Personalised Medicine and Health, an LAHP project, is working on various clinical trials to improve care and prevent ill health. For example, it has launched a groundbreaking new study in Leeds to better understand how proteins in people’s blood can help identify the risk of disease, such as diabetes. This will enable health professionals to decide on the right care to prevent it.
The LAHP is also working with the Leeds Palliative Care Network to transform the city’s approach to caring for people across the city who are nearing the end of their lives. Together, they are exploring how to use research findings from St Gemma’s academic unit of palliative care and the University of Leeds to make sure palliative care is designed around what really matters to the people of Leeds.

As part of the city’s bold ambition to create one workforce across all of its health and care services, the new Leeds Health and Care Academy launched on 1 April 2019. This is another LAHP project which brings together the learning and professional development for the city’s 57,000 health and care staff. The involvement of the universities in Leeds will position the Academy at the forefront of digitally-enabled learning and education, with a portfolio based on world-leading evidence and research. In recognising social mobility as a crucial determinant of health, it will work in local communities to improve access for local people to health and care careers. This will simultaneously help address workforce shortages in the sector, which is a national issue.

For more information, please visit www.leedsacademichealthpartnership.org.

2.9.12 Leeds Informatics Board

We are proud of our work in leading, and being part of, the place-based delivery of digital innovation across the health and care system in Leeds. The CCG and our partners have a strong city-wide commitment to improve the health and wellbeing of all the people of Leeds and digital is a core element in making this happen. This involves coordinating the delivery of the city Health And Care Informatics Strategy via a formal delivery programme, ensuring strong links to our health and care providers, as well as regional and national developments.

By working collaboratively, we have created strong partnerships across the public sector, business sector and the city universities. This includes close working with Leeds-based national organisations that have an important strategic digital role such as NHS Digital and NHS England.

We form part of the Leeds Informatics Board (LIB), which is chaired by Dr Alistair Walling, our Chief Clinical Information Officer. LIB is supported by a number of sub-committees, including a cross-city information governance steering group and city technical architects group.

Leeds Care Record

Integrated care in Leeds has been nationally revered during the last four years with our showpiece patient record, the Leeds Care Record (LCR), being quoted as an exemplar in many articles. This patient record is now actively used by over 6,200 clinical and care staff to support integrated care across the city. It contains data contributions from all five key groups - GPs, hospital, community, mental health and social care. It now includes children’s services data. During the last 12 months other partners, such as Local Care Direct, are accessing the LCR.

Leeds health and care intelligence hub

We have created a health and care intelligence hub across the NHS in Leeds and the council to support the delivery of strategic commissioning and place based intelligence. We are leading on population health management and are one of four national pilot sites working with Optum and NHS England. We ensure that all data used is secure and meets the stringent information governance rules and data protection regulation. We have achieved this by being one of the organisations which can link health and social care data.

Govroam in GP surgeries

All GP surgeries in Leeds now have Govroam available, enabling staff across the public sector to connect to the free-WiFi provision and work across multiple sites.
Patient access to online GP facilities
In Leeds nearly 186,000 registered patients in GP surgeries are using and benefitting from online facilities offered by their practice. Patients can order repeat prescriptions and book or cancel GP appointments without the need to call or visit their practice, which makes it easier for patients and more efficient for GPs. The rate of take up exceeds what is happening elsewhere in country.

IT refresh
A number of information technology (IT) investments have been managed by the CCG and funded out of earmarked NHS England capital schemes. IT equipment in all 100 GP surgeries across Leeds is being refreshed in a programme of work that started in April 2018. Managed by the informatics team, it has involved replacing and refreshing devices. Over 300 laptops were deployed, enabling GPs to work remotely and from patients’ homes. The work also includes replacing and installing 740 desktop PCs and securely disposing of the old obsolete desktop PCs. Eighty consulting rooms in GP practices were set up with dual screens and 20 practices are now live on a unified communication system. This provides integrated telephony and enables the practices to work more closely to provide enhanced services.

As part of the merger of the three former Leeds CCGs, we adopted an IT flexible working policy and replaced all desktops with laptops.

RAIDR
We identified the benefit of having all primary care regular reporting from the CCG and practices in a single online portal to improve access and insights for practices while also freeing up analytical capacity to be better used in more advanced analytics. It includes coverage of Leeds-specific primary care schemes such as quality improvement scheme, medical optimisation scheme, NHS health checks. Case finding tools identify patient cohorts to work with to drive performance and better patient care.

Risk stratification options allow task breakdown into manageable milestones. Patient identifiable lists drive efficiency and ensure better case management.

RAIDR urgent and emergency care
A live, single view of urgent and emergency care demand and delivery is now live across the Leeds system.

GDPR
The General Data Protection Regulation (GDPR) came into effect on 25 May 2018. In order to ensure that the CCG was compliant, all members of staff were required to attend briefing sessions advising of the changes and the implications of being non-compliant with the regulation. An audit of our compliance with the regulation has been carried out by Audit Yorkshire and an opinion of ‘significant’ assurance has been awarded. With the introduction of the data security and protection toolkit (previously the IG toolkit), a working party was set up to ensure that the CCG was able to meet all the assertions and provide sufficient evidence to support compliance. The CCG will be submitting a ‘standards met’ statement for the toolkit.

West Yorkshire and Harrogate Strategic Partnership
We continue to build strong long lasting relationships with our colleagues across the region. This is achieved by strong governance and leadership at the regional West Yorkshire and Harrogate strategic partnership.

Working to a city-wide approach and standards
In developing digital solutions, we:
- put people at the heart of everything we do
- are developing a connected digital infrastructure and tools for the city so that professionals can seamlessly work together.
• are creating an accessible health and care record, using accurate data analytics about people to help improve their health and wellbeing.
• prioritise projects and solutions that help the poorest improve their health the fastest.
• work in an inclusive way with stakeholders to prioritise what we do.

2.9.13 Leeds Cancer Programme

Cancer services in Leeds received an additional funding boost from Macmillan in 2018 for a one year extension to the Leeds Cancer Programme - www.leedscancerprogramme.org.uk - until March 2020.

The team behind the ambitious programme oversee and manage the delivery of a range of service and transformation projects that call for integration and re-design of cancer services at a system level rather than within individual organisations.

Working in partnership, the team focus on prevention, raising awareness of risk factors and signs or symptoms of cancer, earlier detection and diagnosis of disease, and ultimately initiatives to support people to live with and beyond their cancer. In addition, the high quality modern services work stream ensures we make the best use of our collective resources including data and information sharing to improve decision making for patients. This collaboration of staff from across NHS providers and commissioning, public health cancer charities and voluntary sector organisations is an example of system integration at its best. Partners are signed up to a dynamic shared vision of an ambition to improve cancer care for the people of Leeds with an understanding of how each part of the system contributes and their role in delivery.

Addressing inequalities

We know that cancer incidence rates in Leeds are likely to increase as the population grows and ages. We also know that cancer is a significant cause of health inequalities, and risk factors for cancer incidence and mortality include smoking; alcohol use; obesity; and a lack of awareness of and/or uptake of cancer screening programmes and cancer symptoms and signs. These risks are linked to poverty and deprivation, and to cultural and language barriers to accessing prevention, screening and treatment. As the population demographic changes we have to ensure that delivery of cancer services adapt to reflect the complex and varied needs of our population. Across the Leeds Cancer Programme, interventions are focused on more deprived, hard to engage communities to ensure they are given every opportunity to access cancer services local to them, and to help them access services as early as possible to aid earlier detection and diagnosis. During 2018-19, the Leeds Cancer Programme team has been working with member practices to use locality level cancer data to identify where initiatives need to be targeted and to seek opportunities for improvement of cancer outcomes.

The prevention, awareness and increasing screening uptake work stream of the Leeds Cancer Programme is co-ordinated by colleagues within public health at Leeds City Council. During 2018-19, the CCG funded a primary care cancer screening champions project, targeted in 50 of the most deprived practices across Leeds with an initial focus on bowel screening. As at January 2019 this targeted work had resulted in 704 people who had previously not completed their bowel screening now completing this after being contacted by a practice screening champion.

In addition, the unique community cancer awareness service, funded by public health and the CCG, has held over 4600 brief advice cancer conversations, almost 150 awareness raising events and has worked with a team of 42 volunteers to increase awareness of risk factors, signs and symptoms of cancer with our most deprived communities.
Our cancer care review (CCR) project, which is part of our living with and beyond cancer work stream has throughout 2018 been delivering support to patients following a cancer diagnosis within their local community. Following a successful pilot in Aire Valley Medical Group, we extended this service to LS9 central practices in the city during 2018. This service has evaluated extremely well and offers increased medical-based support to people. Our cancer care reviews have highlighted a whole range of unmet needs. From April 2019 with CCG funding, the programme will be rolled out across Leeds to develop a community based model to meet individual and local community needs.

2.10 Safeguarding

The CCG has a legal responsibility to ensure the needs of children and adults at risk of or suffering abuse are addressed in all the work that we undertake and commission on behalf of the people of Leeds. The chief executive officer has overall responsibility for safeguarding and the director of quality and safety governing body nurse is the executive lead.

The safeguarding team is comprised of a head of safeguarding/designated nurse for safeguarding children and adults at risk, who provides strategic leadership for safeguarding and advice across the health economy; a deputy designated nurse for safeguarding children and adults at risk, who is also the lead for the Mental Capacity Act and Deprivation of Liberty Safeguards; and a designated doctor for safeguarding children. There are two named nurses for safeguarding children and adults at risk, a specialist safeguarding practitioner, and a named GP for safeguarding children who provides leadership and support within primary care. This model fully integrates and reflects the ‘think family, work family’ approach adopted by Leeds.

The CCG Safeguarding Children and Adults at Risk Committee leads work on behalf of the CCG through an agreed action plan and monitors compliance of agreed safeguarding standards through a performance framework and audit programme. The committee meets bi-monthly and members include commissioners, designated nurses, designated doctors, the executive director of quality and safety/governing body nurse and her deputy. The Safeguarding Committee reports into the CCG Quality Committee.

In June 2018, the CQC completed a review of health services for looked after children and safeguarding in Leeds. The review explored the effectiveness of health services for looked after children and the effectiveness of safeguarding arrangements within health for all children. It used a range of methods to gather information both during and before the visit, including document reviews, interviews, focus groups and visits. Inspectors concluded that:

- The CCG has invested in additional safeguarding posts to increase capacity and resources in the safeguarding team with two additional named nurse posts. This has enabled additional support for safeguarding work within primary care and the work of the front door safeguarding hub.
- The CCG safeguarding team has developed a tool to audit record keeping across primary care. The team has audited the completion of GPs’ report writing and presentation of evidence to child protection conferences, improving the standard of defensible documentation and record keeping across primary care in Leeds.
- Leadership provided by safeguarding professionals across Leeds is good. The CCG safeguarding team provides visible and active leadership. The designated professionals for safeguarding children are proactive and influential in the city’s safeguarding leadership.
- The front door safeguarding hub has good engagement and participation from health through provision of a full-time CCG safeguarding nurse. This facilitates sharing of health information and effective liaison, which promotes the safeguarding of children and young people.
The CQC made a total of 36 recommendations across the whole health economy, including two for the CCG. These related to the role of the designated nurse for looked after children and whether this should sit with the CCG or providers, and operational oversight of looked after children work. We have led on developing an action plan addressing the recommendations with providers, with key actions being implemented and monitored, including a number of actions that have already been achieved. The CCG actions are now complete.

Ofsted also completed an inspection of children’s social care services in October 2018. Although the focus was on children’s social care, inspectors also reviewed partnership working. The inspection found that children in Leeds are encouraged to keep themselves healthy, and their health needs are reviewed regularly. The report highlighted that there is a comprehensive offer to young people and carers in relation to accessing support for mental health and emotional well-being, and that this is service strength. It noted the MindMate website, which has been developed with young people and signposts them to services and support. The report also highlighted that GPs have a single access point for child and adolescent mental health support services (CAMHS), in addition to the cluster network of support to schools.

The therapeutic social work team, with support from clinical psychologists, further enhances the response to mental health needs by offering direct intervention to the young person or providing advice to the allocated worker. This reduces delays in children being able to access the support required to meet their needs and is leading to positive outcomes for most children who access this service. The inspection found that there was consistent involvement of health agencies in strategy discussions and this is an area of work that is being taken forward across the health economy.

In terms of adult safeguarding, over the last year the Leeds Safeguarding Board (LSAB), with support from partners including the CCG, has been reviewing multi-agency policy and procedures. The review process has been very thorough and has included practitioners, managers and strategic leads. It has sought to hear from as many people as possible about where we could all improve and how we could work better together. This includes, for the first time, listening to citizens about what good practice looks like and feels like for them.

The revised multi-agency policy and procedures was launched on 1 April 2019. Key to the Leeds approach is the principle, ‘talk to me, hear my voice’ - that will help to ensure we maintain a focus on the person, their wishes and desired outcomes. The new approach is to build the policy and procedures around citizen perspectives, which includes citizen-led guidance for practitioners, to help them focus on people’s experience of the support they receive.

2018-2019 also saw the CCG safeguarding team successfully apply for funding from the LSAB to deliver a multiagency self-neglect conference in October 2018 to develop a shared understanding of self-neglect. The conference was extremely well attended and evaluated very positively. As a result, we will hold another conference in May 2019.
2.11 Requests for information

The CCG is committed to being open and transparent. This includes meeting the statutory requirements of the Freedom of Information (FOI) Act. The FOI requires every public body to produce and regularly maintain a publication scheme. We have adopted the Information Commissioners Office’s model publication scheme for health bodies. Our aim is to increase openness and transparency about what we do, what we spend, our priorities, decisions and policies. We also aim to make it easier for members of the public to find the information they require without having to make a written request. Our publication scheme can be found here: www.leedscgg.nhs.uk/foi/publication-scheme

In 2018-19 we received 232 requests under the Freedom of Information Act, compared to 218 in 2017-18.

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Tim Ryley
Chief Executive (Accountable Officer)
22 May 2019
3. The Accountability Report

3.1 Corporate Governance Report

3.1.1 Members Report

From 1 April 2018, NHS Leeds CCG became a statutory NHS body.

3.1.2 Member 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 was involved with the development of NHS Leeds West CCG (April 2013 to March 2018) and was the 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 (Accountable Officer) to 30 April 2019**

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, leading on transformation, performance and improving quality of care for three years. She was appointed Chief Executive of NHS Leeds West CCG in April 2012 to March 2018, when she became the Chief Executive of NHS Leeds CCG. Phil is 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, NHS Executive Regional Office in Trent and NHS Leeds West CCG. In addition to her professional qualifications, Visseh has a Bachelors degree in Economics and a Masters Degree in Computer Studies.

**Dr Simon Stockill - Joint Medical Director**

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

He has a post-graduate degree in population health from the University of York, and was Clinical Chair of NHS Leeds Primary Care Trust before becoming Medical Director of NHS Leeds West Clinical Commissioning Group. He was a founder of the Leeds Institute of Quality Healthcare and takes a specialist interest in quality improvement and clinical leadership.

Simon spent over 10 years as a GP in Leeds. In April 2016 he moved to a new practice near Whitby in order to remove any conflicts of interest, as the CCG took over responsibility for commissioning primary care medical services.
Outside medicine he is a trustee of the National Youth Theatre and enjoys walking on the beaches and moors of Yorkshire.

**Jo Harding, Director of Quality and Safety (Governing Body Nurse)**

Jo qualified as a registered nurse in 1992 and subsequently as a registered health visitor practising clinically in Leeds and York. She strategically and operationally managed a full range of acute and community-based services for 15 years across North Yorkshire and York. 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 has continued her role as Director of Quality and Safety for NHS Leeds CCG. She 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.

**Tim Ryley, Director of Strategy, Performance and Planning (from 5 July 2018) / Chief Executive (Accountable Officer) from 1 May 2019**

Tim first started working in the NHS 16 years ago as a primary care service improvement manager looking at older people and medicines management. This followed work in the charity sector for Age Concern and as a priest in the Church of England. In the NHS he then worked in a number of general management roles including clinical governance and quality assurance, risk management and corporate governance, programme management, strategy and planning. Before coming to Leeds he was the Director for Strategy, Planning and Corporate at Stockport CCG with responsibilities that included information management and technology, communications and engagement, corporate affairs and governance along with strategy and also acted as the Programme Director for the Stockport Together partnership.

Tim is interested in exploring how strategy harnesses and adjusts to the fast moving digitally driven world we all now live in and how we can develop community assets to support health outcomes. He also has a strong commitment to distributive approaches to leadership both within systems and teams. He has an honour’s degree in Geography, and Masters degrees in Theology and Organisational Effectiveness and Total Quality Management.

Outside work he loves the outdoors whether on the beaches of Anglesey or in the mountains of Snowdonia. Tim lives in Greater Manchester with wife Julie and has four children, three grandchildren and a dog.

**Katherine Sheerin, Interim Director of Strategy, Performance and Planning (to 31 July 2018)**

Katherine has worked in the NHS for over 26 years, working in a number of roles in primary care development, commissioning and system redesign. She was Accountable Officer for Liverpool CCG from 2012 - 2017 where she led the ‘Healthy Liverpool’ Programme which set out to improve health outcomes, reduce inequalities, improve quality and sustain services clinically and financially. This had several successes including improving outcomes for people with cancer and reducing inequalities across the city, and significantly reducing avoidable hospital care. Prior to joining NHS Leeds CCG, Katherine worked for Leeds Teaching Hospitals NHS Trust as a strategic advisor, supporting them to understand their role in a more integrated system of care.
Dr Stephen 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, where he remained until his retirement in 2014.

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. He now is a Governing Body lay member, chairs the Quality and Performance Committee and also sits on the Primary Care Commissioning Committee.

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. He is a golfer and committee member at The Alwoodley Golf Club, Leeds.

Peter Myers, Lay Member (Audit and Conflicts of Interest Matters)
Peter is a Chartered Banker, and former building society Chief Executive, who has broad international financial services experience. This has been gained in the UK (Beverley Building Society, Yorkshire and Clydesdale Banks), Australia (National Australia Bank), New Zealand (Bank of New Zealand) and the USA (Michigan National Bank).

Peter has been a director on nine boards (two as an Executive Director and seven as a Non-Executive Director). As well as being on the Governing Body of NHS Leeds CCG, he is Chairman of the Equine and Livestock Insurance Group, and a Non-Executive Director of Finance Yorkshire.

Samantha Senior, Lay Member (Primary Care Co-Commissioning)
Samantha has experience of holding lay member roles within the NHS; however, for most of her career she has worked in the private sector covering a range of human resources (HR) roles, which include service management roles. She has experience of working on cross-functional projects and she is professionally qualified to MSC level in HR.

Samantha joined the CCG in April 2018 as Lay Member for Primary Care Co-Commissioning and Deputy Chair. Samantha is Chair of the Primary Care Commissioning Committee and the Remuneration & Nomination Committee; she is also a member of the Audit Committee.

Angela Collins, Lay Member (Patient and Public Participation)
Angela has worked in social research for over 18 years. In her previous role as a research director at an independent research organisation, she completed a range of research projects for the NHS, CCGs, local authorities and voluntary organisations. She developed her love of governance during her time as a trustee for York CVS and in her role of local consumer advocate for the Consumer Council for Water. In October 2017 Angela began a research council funded PhD in Social Policy and Criminology.

Angela joined the CCG in April 2018 and is Lay Member for Public and Patient Participation, as such she chairs the Patient Assurance Group. She is also a member of the Primary Care Commissioning Committee and the Quality and Performance Committee.
Dr Phil Ayres, Secondary Care Specialist
Doctor (from 1 June 2018)
A graduate of Leeds Medical School, Phil trained to be a GP at Airedale Hospital and was a partner in general practice in Leicestershire. After re-training in public health he took up a consultant post at St James’s Hospital in 1996, where he remained until March 2018. During that time Phil worked as a senior medical manager for nearly 20 years, as Associate and Deputy Medical Director to Leeds Teaching Hospitals NHS Trust. He was the Interim Medical Director at Leeds Community Healthcare NHS Trust immediately prior to joining the CCG. He has also worked as an Associate Medical Director at the Commission for Health Improvement (now the Care Quality Commission) and at the former Yorkshire and Humber Strategic Health Authority, where Phil led the implementation of medical revalidation (relicensing) for doctors in the region.

Phil’s main interests are around the role of doctors in leading health services to achieve best quality care, the development of collaborative relationships between providers and care, and professional standards for doctors.

Dr Jason Broch, Assistant Clinical Chair
Jason is a GP at Oakwood Lane Medical Practice. As Assistant Clinical Chair, he chairs the Council of Members and the Clinical Commissioning Forum. He is also a member of the Quality and Performance Committee.

Previously, Jason was Chair of NHS Leeds North CCG from 2013 until it merged into the current CCG in 2018. He has a keen interest in quality, transformation, population health management and healthcare technology. Previously acting as Chief Clinical Information Officer on behalf of the whole Leeds Health & Social Care economy, he developed successful projects such as the integrated Leeds Care Record and award winning integrated business analytics.

Jason has lived in north Leeds for all of his life, except for receiving his medical training at the University of Manchester. Jason lives with his wife and two children. He spends some of his spare time in lay leadership positions in two local schools.

Member representatives

Dr Ben Browning
Ben studied Medicine at Nottingham University, qualifying in 1992, before moving back to his home territory of Leeds to pursue a career in general practice in 1993. He has been a partner at Lofthouse Surgery for 22 years, delivering medical care to a large and diverse practice population. Ben has much relevant experience, both medically and in working within the world of commissioning. He has been the practice lead from a commissioning point of view since its earliest time, playing an active role in what was Leodis, working on developing ambulatory pathways and urgent care.

Ben worked as a non-executive director on NHS Leeds South and East CCG board (April 2013 to March 2018) in addition to his full time GP role. He is passionate about the provision of excellent quality medical care to his patients, responding to local needs, tackling health inequalities and working closely with secondary care providers.

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

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

Out of work Julianne enjoys spending time with family and their dog and travelling.
Dr Keith Miller (from 1 July 2018)
Keith was born and grew up in Leeds and completed a degree in English Literature in Durham before altering course to study medicine. He carried out his postgraduate training throughout Leeds and Yorkshire, and qualified as a GP in 2010. He has worked at Kirkstall Lane Medical Centre since qualification, and took up a partnership in the practice in 2012. He is a GP trainer, and has a particular area of clinical interest in the care of older people.

He previously held a role as a GP Extensivist in Greater Manchester. This involved designing and implementing a service aiming to improve health and wellbeing outcomes for people with complex healthcare needs, as well as providing clinical leadership as part of a multi-professional clinical team. Prior to that, he held a clinical lead position in Leeds, with a particular focus on improving holistic care for people living in care homes.

He has two young sons who keep him busy outside of work, has resorted to 6am workouts to get fit, and is an ever-suffering fan of Leeds United.

Sabrina Armstrong, Director of Corporate Services (from 24 May 2018)
Sabrina has a broad range of corporate NHS experience, having gained her skills in a diverse range of provider, regional and national NHS organisations over the past 20 years. A former journalist and communications professional by background, Sabrina has also gained extensive corporate and programme management skills, latterly working as a programme director in a national organisation. She has successfully led and managed a number of teams, overcoming challenges and developing staff into more senior roles.

Sabrina is committed to ensuring the involvement of patients and communities in their local health services and making sure they have a say in how services continue to be developed. As an executive coach and a certified practitioner in neuro-linguistic programming (NLP), Sabrina recognises the importance of staff development and uses these skills in doing so.

Dr Ian Cameron, Public Health Consultant / Secondary Care Specialist Doctor (to 31 May 2018)
Dr Ian Cameron is the Director of Public Health at Leeds City Council. As part of his role he provides public health leadership and advice to the CCG on health improvement, health protection and public health. Ian has been Director of Public Health for Leeds since 2006 and is a member of the Leeds Health and Wellbeing Board and Chair of the Leeds Health Protection Board.

Ian qualified from Liverpool University and became consultant in public health in Leeds in 1992 with a focus on mental health, physical disabilities and learning disabilities. In 2002 Ian became Director of Public Health for North West Leeds Primary Care Trust. Ian has significant experience of working within public health nationally, and internationally and in 2008 was made visiting Professor at the Institute of Public Health, Lahore, Pakistan for his work on tobacco control.

Sue Robins, Director of Operational Delivery
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 over 23 years management experience in both community and hospital services and adults and children's healthcare in West Yorkshire and has held a wide range of roles across Bradford and Airedale and for the last four years in Leeds. Her strengths are in operational delivery and Sue is delighted to continue to be a part of the new NHS Leeds CCG and she will be using all her varied clinical and management experience to develop our commissioning agenda and in improving care for the people of Leeds.

Governing Body non-voting attendees

Sabrina Armstrong, Director of Corporate Services (from 24 May 2018)
Sabrina has a broad range of corporate NHS experience, having gained her skills in a diverse range of provider, regional and national NHS organisations over the past 20 years. A former journalist and communications professional by background, Sabrina has also gained extensive corporate and programme management skills, latterly working as a programme director in a national organisation. She has successfully led and managed a number of teams, overcoming challenges and developing staff into more senior roles.

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3.1.3 Member practices
As at 31 March 2019, our 100 GP member practices are as follows:

- Abbey Grange Medical Practice
- Aireborough Family Practice
- Allerton Medical Centre
- Alwoodley Medical Centre
- The Arthington Medical Centre
- Ashfield Medical Centre
- Ashton View Medical Centre
- Austhorpe View Surgery
- The Avenue Surgery
- Beechtree Medical Practice
- Beeston Village Surgery
- Bellbrooke Surgery
- Bramham Medical Centre
- Bramley Village Health and Wellbeing Centre
- Burley Park Medical Centre
- Burton Croft Surgery
- Chapeltown Family Surgery
- Chevin Medical Centre
- Church Street Surgery
- City View Medical Practice
- Collingham Church View Surgery
- Colton Mill Medical Centre
- Conway Medical Centre
- Craven Road Medical Centre
- Crossley Street Surgery
- Drighlington Medical Centre
- East Park Medical Centre
- Fieldhead Surgery
- Foundry Lane Surgery
- Fountain Medical Centre
- The Gables Surgery
- The Garden Surgery
- Garforth Medical Centre
- Gibson Lane Practice
- Gildersome Health Centre
- Grange Medicare - Middleton Park
- Grange Medicare - New Cross Surgery
- Guiseley and Yeadon Medical Practice
- Hawthorn Surgery
- High Field Surgery
- Hillfoot Surgery
- Hyde Park Surgery
- Ireland Wood and Horsforth Medical Practice
- Drs Khan & Muneer, Hunslet Health Centre
- Kippax Hall Surgery
- Kirkstall Lane Medical Centre
- Laurel Bank Surgery
- Leeds City Medical Practice
- Leeds Student Medical Practice
- Leigh View Medical Practice
- Lincoln Green Medical Centre
- Lingwell Croft Surgery
- Lofthouse Surgery
- Manor Park Surgery
- Manston Surgery
- Meanwood Group Practice
- The Medical Centre
- Menston and Guiseley Medical Practice
- Moorfield House Surgery
- Morley Health Centre
- Newton Surgery
- North Leeds Medical Practice
- Nova Scotia Medical Centre
- Oakley Medical Centre
- Oakwood Lane Medical Practice
- Oakwood Surgery
- One Medicare (The Light)
- Oulton Medical Centre
- Park Edge Practice
- The Practice at Harehills Corner
- Priory View Medical Centre
- Pudsey Health Centre
- Rawdon Surgery
- Robin Lane Medical Centre
- The Roundhay Road Surgery
- Rutland Lodge Medical Practice
3.1.4 Composition of Governing Body

Members of the Governing Body are as follows:

- **Clinical Chair** - Dr Gordon Sinclair
- **Accountable Officer** - Philomena Corrigan (to 30.04.19) / Tim Ryley (from 01.05.19)
- **Chief Finance Officer** - Visseh Pejhan-Sykes
- **Secondary Care Specialist Doctor** - Dr Ian Cameron (to 31.05.18) / Dr Phil Ayres (from 01.06.18)
- **Director of Quality and Safety (Registered Nurse)** - Jo Harding
- **Four lay members:**
  - Audit and conflicts of interest matters - Peter Myers
  - Patient and public participation matters - Angela Collins
  - Assurance matters - Dr Stephen Ledger
  - Primary care co-commissioning - Samantha Senior
- **Assistant Clinical Chair** - Dr Jason Broch
- **Three Member Representatives** - Dr Ben Browning, Dr Julianne Lyons, Dr Keith Miller (from 01.07.18)
- **Director of Strategy, Performance and Planning** - Katherine Sheerin (to 31.07.18) / Tim Ryley (from 05.07.18 to 30.04.19)
- **Medical Director** - Dr Simon Stockill

Non-voting attendees:

- **Director of Operational Delivery** - Sue Robins
- **Director of Corporate Services** - Sabrina Armstrong (from 24.05.18)
- **Director of Public Health (Leeds City Council)** - Dr Ian Cameron

The Governing Body has responsibility for ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the principles of good governance.
3.1.5 Committees, including Audit Committee

The Audit Committee 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.

Details of all committees, including the Audit and Remuneration Committees, are included in the Governance Statement, section 3.3.3.

3.1.6 Register of Interests

NHS Leeds CCG wishes to ensure that decisions made by the CCG are taken and seen to be taken without any possibility of the influence of external or private interest. The CCG has therefore put arrangements in place to ensure that conflicts of interest are appropriately managed with transparency and proportionality. We have established a register of interests which is outlined within the CCG’s policy on managing conflicts of interest. This register is reviewed by the CCG Governing Body and Audit Committee. All Governing Body members, Committee members, employees and member practices are asked to complete a declarations of interest form to identify any potential conflicts of interest. CCG Governing Body members, 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.leedscrg.nhs.uk.

3.1.7 Personal data related incidents

The CCG has not reported any personal data related incidents to the Information Commissioner’s Office during 2018-19.

3.1.8 Statement of disclosure to auditors

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

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

3.1.9 Modern Slavery Act

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

3.2 Statement of Accountable Officer’s Responsibilities

The National Health Service Act 2006 (as amended) (the NHS Act 2006) 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 Executive (Tim Ryley) to be the Accountable Officer of NHS Leeds CCG.

The responsibilities of an Accountable Officer are set out under the NHS Act 2006, Managing Public Money and in the Clinical Commissioning Group Accountable Officer Appointment Letter. They include responsibilities for:

- The propriety and regularity of the public finances for which the Accountable Officer is answerable;
- Keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the CCG and enable them to ensure that the accounts comply with the requirements of the Accounts Direction);
• Safeguarding the CCG’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities);

• The relevant responsibilities of accounting officers under Managing Public Money;

• Ensuring the CCG exercises its functions effectively, efficiently and economically (in accordance with Section 14Q of the NHS Act 2006) and with a view to securing continuous improvement in the quality of services (in accordance with Section14R of the NHS Act 2006);

• Ensuring that the CCG complies with its financial duties under Sections 223H to 223J of the NHS Act 2006.

Under the NHS Act 2006 (as amended), NHS England has directed each CCG to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the CCG and of its income and expenditure, Statement of Financial Position and cash flows for the financial year.

In preparing the accounts, the Accountable Officer is required to comply with the requirements of the Government Financial Reporting Manual 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 Government Financial Reporting Manual have been followed, and disclose and explain any material departures in the accounts;

• Confirm that the Annual Report and Accounts as a whole is fair, balanced and understandable and take personal responsibility for the Annual Report and Accounts and the judgements required for determining that it is fair, balanced and understandable.

As the Accountable Officer, I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that NHS Leeds CCG’s auditors are aware of that information. So far as I am aware, there is no relevant audit information of which the auditors are unaware.

Tim Ryley
Chief Executive (Accountable Officer)
22 May 2019
3.3 Annual governance statement

3.3.1 Introduction and context

NHS Leeds CCG is a body corporate established by NHS England on 1 April 2018 under the National Health Service Act 2006 (as amended). The CCG’s statutory functions are set out under the National Health Service Act 2006 (as amended). The CCG’s general function is arranging the provision of services for persons for the purposes of the health service in England. The CCG is, in particular, required to arrange for the provision of certain health services to such extent as it considers necessary to meet the reasonable requirements of its local population.

As at 1 April 2018, the CCG is not subject to any directions from NHS England issued under Section 14Z21 of the National Health Service Act 2006.

3.3.2 Scope of responsibility

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

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

3.3.3 Governance arrangements and effectiveness

The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it exercises its functions effectively, efficiently and economically and complies with such generally accepted principles of good governance as are relevant to it.

The Governing Body

Our governance structure is headed by the Governing Body to which our 100 (as at 31 March 2019) member practices have formally delegated their statutory responsibilities within our constitution. The composition of the Governing Body is detailed in section 3.1.4.
The Governing Body met seven times during 2018-19:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Attendance (eligible to attend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Gordon Sinclair - Clinical Chair</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Dr Jason Broch - Assistant Clinical Chair</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Dr Julianne Lyons - Member representative</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Dr Ben Browning - Member representative</td>
<td>6 (7)</td>
</tr>
<tr>
<td>Dr Keith Miller - Member representative</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Peter Myers - Lay member, Audit &amp; Conflicts of Interest</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Angela Collins - Lay member, PPI</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Dr Stephen Ledger - Lay member, Assurance</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Samantha Senior - Lay member, Primary Care Co-Commissioning</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Philomena Corrigan - Chief Officer</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Visseh Pejhan-Sykes - Chief Finance Officer</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Jo Harding - Director of Quality &amp; Safety</td>
<td>6 (7)</td>
</tr>
</tbody>
</table>

*Deputy sent to 1

Katherine Sheerin, Interim Director of Strategy, Performance & Planning 3 (3)

Tim Ryley, Director of Strategy, Performance & Planning 5 (5)

Dr Simon Stockill - Medical Director 5 (7)

Susan Robins - Director of Operational Delivery 7 (7)

Ian Cameron - Director of Public Health 5 (7)

Sabrina Armstrong, Director of Corporate Services 5 (5)

There are four committees that formally report into the Governing Body.

Audit Committee

The Audit Committee 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 - Audit and Conflicts of Interest; the other members are the Lay Member - Primary Care Co-Commissioning and a Member Representative. Each member of the Audit Committee is also a member of the Governing Body. In attendance at each meeting is the CCG Chief Finance Officer as well as representatives from internal audit, external audit and counter fraud.

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

The Audit Committee met five times during 2018-19:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Attendance (eligible to attend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Julianne Lyons - Member representative</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Dr Keith Miller - Member representative</td>
<td>3 (3)</td>
</tr>
<tr>
<td>Peter Myers - Lay member, Audit &amp; Conflicts of Interest</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Samantha Senior - Lay member, Primary Care Co-Commissioning</td>
<td>4 (5)</td>
</tr>
</tbody>
</table>
Remuneration and Nomination Committee

The Remuneration and Nomination Committee makes decisions on the remuneration, including terms, conditions, pay and allowances (e.g. any pension scheme it might establish as an alternative to the NHS pension scheme) and redundancy/severance, of non-employee members of the Governing Body.

The Remuneration and Nomination Committee also makes recommendations to the CCG Governing Body on decisions about the remuneration, including terms, conditions, pay and allowances (e.g. any pension scheme it might establish as an alternative to the NHS pension scheme) and redundancy/severance, of all employees (including employee members of the Governing Body) and people who provide services to the CCG.

In respect of nomination, the committee ensures that there is balance of skills, experience and knowledge of the Governing Body, undertaking succession planning, overseeing the appointment process for Governing Body members and setting the terms of office for these members.

The committee is chaired by the lay member; primary care co-commissioning; the other members are the clinical chair, audit lay member, assurance lay member and a member representative.

The Remuneration and Nomination Committee met six times during 2018-19:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Attendance (eligible to attend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Jason Broch - Assistant Clinical Chair</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Dr Julianne Lyons - Member representative</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Dr Keith Miller - Member representative</td>
<td>3 (4)</td>
</tr>
<tr>
<td>Peter Myers - Lay member, Audit &amp; Conflicts of Interest</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Dr Stephen Ledger - Lay member, Assurance</td>
<td>5 (6)</td>
</tr>
<tr>
<td>Samantha Senior - Lay member, Primary Care Co-Commissioning</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Angela Collins - Lay member, PPI</td>
<td>1(1)</td>
</tr>
</tbody>
</table>

Quality and Performance Committee

The Quality and Performance Committee is responsible for the monitoring and oversight of:

- The quality and performance of commissioned services including patient experience, safety and clinical effectiveness;
- The effectiveness and performance of commissioned services;
- The performance of the CCGs and their delivery of agreed outcomes.

The membership includes at least three non-executive or lay governing body members, the Director of Quality and Safety, Director of Operational Delivery, Director of Strategy, Performance & Planning and Medical Director.

The committee receives the integrated quality and performance report at each meeting as well as regular updates on providers under enhanced quality surveillance, risks relating to quality and performance and patient experience.

In fulfilling its role the committee seeks reasonable assurance relating to the quality and performance of commissioned services.
The committee defines reasonable assurance as evidence that performance / quality is in line with agreed targets or trajectories, or where it is not, there is reasonable mitigation and an action plan to rectify any issues (the committee agrees on a case by case basis what constitutes reasonable mitigation).

Where the committee receives insufficient assurance, it challenges, assesses risks and escalates to the Governing Body or Primary Care Commissioning Committee if necessary.

The Quality and Performance Committee met six times during 2018-19:

<table>
<thead>
<tr>
<th>Member Name</th>
<th>Attendance (eligible to attend)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ben Browning - Member representative</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Angela Collins - Lay member, PPI</td>
<td>3 (6)</td>
</tr>
<tr>
<td>Dr Stephen Ledger - Lay member, Assurance</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Dr Phil Ayres - Secondary Care Specialist Doctor</td>
<td>4 (5)</td>
</tr>
<tr>
<td>Jo Harding - Director of Quality &amp; Safety</td>
<td>4 (6)</td>
</tr>
<tr>
<td>*Deputies sent to 2 meetings</td>
<td>5 (7)</td>
</tr>
<tr>
<td>Dr Simon Stockill - Medical Director</td>
<td>2 (6)</td>
</tr>
<tr>
<td>*Deputies sent to 4 meetings</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Susan Robins - Director of Operational Delivery</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Tim Ryley - Director of Strategy, Performance &amp; Planning</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Katherine Sheerin - Interim Director of Strategy, Performance &amp; Planning</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Jo Harding - Director of Quality &amp; Safety</td>
<td>6 (7)</td>
</tr>
<tr>
<td>*Deputy sent to 1</td>
<td></td>
</tr>
<tr>
<td>Katherine Sheerin, Interim Director of Strategy, Performance &amp; Planning</td>
<td>3 (3)</td>
</tr>
</tbody>
</table>

Primary Care Commissioning Committee

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

The membership consists of all Governing Body members apart from those who provide primary medical services in Leeds (to avoid conflicts of interest). The meetings are also attended by a representative of the local Health and Wellbeing Board, Healthwatch and NHS England. A Member Representative is also in attendance at meetings, but not a formal member of the Committee.

The Primary Care Commissioning Committee met six times during 2018-19:

<table>
<thead>
<tr>
<th>Member Name</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Samantha Senior - Lay Member, Primary Care Co-Commissioning</td>
<td>6 (6)</td>
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<tr>
<td>Peter Myers - Lay member, Audit &amp; Conflicts of Interest</td>
<td>4 (6)</td>
</tr>
<tr>
<td>Angela Collins - Lay member, PPI</td>
<td>5 (6)</td>
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<tr>
<td>Dr Stephen Ledger - Lay member, Assurance</td>
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<td>Philomena Corrigan - Chief Officer</td>
<td>6 (6)</td>
</tr>
<tr>
<td>Visseh Pejhan-Sykes - Chief Finance Officer</td>
<td>4 (6)</td>
</tr>
<tr>
<td>*Deputy sent to 1 meeting</td>
<td>7 (7)</td>
</tr>
<tr>
<td>Jo Harding - Director of Quality &amp; Safety</td>
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</tr>
<tr>
<td>*Deputy sent to 1 meeting</td>
<td>7 (7)</td>
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<td>Dr Simon Stockill - Medical Director</td>
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<td>Susan Robins - Director of Operational Delivery</td>
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<td>Katherine Sheerin - Interim Director of Strategy, Performance &amp; Planning</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Tim Ryley - Director of Strategy, Performance &amp; Planning</td>
<td>5 (5)</td>
</tr>
<tr>
<td>Dr Phil Ayres - Secondary Care Specialist Doctor</td>
<td>5 (5)</td>
</tr>
</tbody>
</table>
Performance and assessment of effectiveness
Each committee has completed a self-assessment of its performance and effectiveness throughout the year. The outcome of the reviews was largely positive, however some issues were raised, particularly in relation to the clarity of the relationship between the committees and the Governing Body, and the relationship between committees. This will be considered further at a Governing Body workshop as part of a wider review of governance arrangements during 2019-20.

The internal auditors reviewed the CCG’s governance and risk management arrangements during 2018-19 and the overall rating was high assurance.

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

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

In light of the 2013 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.

3.3.6 Risk management arrangements and effectiveness
The CCG has an agreed risk management strategy, which is published on the CCG’s website and staff extranet. The strategy is a consolidation of the strategies that were in place for the previous three Leeds CCGs, and provides a single strategy for NHS Leeds CCG following the merger. The strategy was approved by the Governing Body in July 2018.

Implementation of the strategy provides assurance to the Audit Committee and the Governing Body that operational and strategic risks are being managed and where necessary escalated to the Governing Body. The strategy aims to support:

- Identification and prioritisation of the risks to the achievement of the commitments of the CCG;
- Evaluation of the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically; and
- Management and reporting of risks.

The strategy sets out the CCG’s definition of risk, the roles and responsibilities in relation to risk management across the organisation and the principles of risk management. Risk management and monitoring responsibilities are also included in committee Terms of Reference.

Risks are identified from a broad range of sources including incidents, complaints, internal audit reports and reports by external bodies, identified risks are recorded on the CCG risk register. Risks that may affect the ability of the CCG to meet its strategic commitments are recorded on the Governing Body Assurance Framework (GBAF).
All operational risks are recorded on the risk register. Risks are evaluated using a risk assessment matrix which analyses the risk in terms of consequence and likelihood and evaluates it using a 5x5 matrix. The strategy sets levels of risk score that determine which risks are managed at operational level on the risk register and those that are overseen by committees or escalated to the Governing Body. The operational risks are managed within directorates with support from the Corporate Governance and Risk 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 Governing Body at each meeting. High amber and red risks are also reported to the relevant committee at each meeting.

The CCG is compliant with the Secretary of State’s directions for counter fraud and the requirement for the provision of 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.

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

During 2018-19 the Governing Body has been engaged in developing the risk appetite for the CCG, this was undertaken at a Governing Body workshop and the outcome was an agreed risk appetite statement supported by risk tolerance levels for individual risk impact categories. This will be implemented into the risk management strategy in 2019-20.

In addition to the operation of the risk management strategy, risk management is embedded in the CCG in a number of ways, 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 Governing Body and CCG employees receive training in Equality and Diversity and Equality Impact Assessments are completed for all strategy, policies and business cases so that the full impact on protected groups is identified and taken into account;
- Quality and equality impact assessments are also completed to assess the possible impact of commissioning decisions, QIPP plans and business cases and any mitigating actions are outlined in the assessment; and
- The CCG has policies in place to encourage employees to highlight risks and report concerns, for example through the Whistleblowing Policy.

The public are not directly involved in managing risk, but they are involved in commissioning decisions that affect them and therefore their views regarding the design of services are captured during engagement and consultation.

**Capacity to handle risk**

Risks identified by the CCG are recorded on risk registers and are allocated to senior officers and Governing Body members to take responsibility for the agreed mitigating actions. The risks are reviewed at each committee and Governing Body meeting via a standing agenda item. The steering groups, project groups and the committees provide progress and exception reports to the Governing Body which includes risks to delivery of projects and strategic commitments. The Governing Body is well sighted on risks and has held a workshop to develop the CCG risk appetite and on how to manage risks relating to commissioning for outcomes.
The appointment of a dedicated risk manager has increased the profile and awareness of risk management in the CCG during 2018-19. The risk manager provides guidance, support and training to staff appropriate to their authority and duties. The risk management strategy has been reviewed during 2018-19, to confirm and further incorporate good practice. The revised strategy will be implemented in 2019-20.

The Audit Committee has responsibility for ensuring the CCG has an effective risk management system. The Executive Management Team and the individual committees receive the high amber and red rated risks relevant to their remit.

**Risk assessment**

Risk is assessed in accordance with the risk management strategy. Risk assessment is undertaken using a risk assessment matrix included in the strategy. This ensures a consistent approach to risk assessment; the matrix reflects the organisations agreed risk levels and those at which escalation to senior managers and directors is required.

The CCG risk profile at the beginning of 2018-19 included a number of risks relating to the achievement of constitutional performance targets. A decision was taken during the year that because the constitutional targets included on the risk register had been breached they are performance issues and should not be included on the risk register. As at 31 March 2019 the key risks faced by the CCG were:

- Not maintaining a sustainable Primary Care workforce due to difficulties recruiting GPs and Practice Nurses.
- EU Exit - potential impact on availability of workforce, demand for healthcare as a result of changes to reciprocal healthcare arrangements, continuation of research and clinical trials, interruption to data sharing, processing and access to data and increased costs of supplies.
- Risk to cyber security impacting on availability of systems and data.
- Capability to manage demand and discharge volumes during times of high demand.
- Completeness of medication incident reporting.

All identified risks have details of key controls, how assurance will be given, gaps in controls and assurance, action plans to address gaps and the risk owner.

**3.3.7 Other sources of assurance**

**Internal Control Framework**

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

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

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. The majority of completed Internal Audit Reports for the CCG have been given a rating of significant assurance.
The Governing Body Assurance Framework and Corporate Risk Register are standing agenda items on the Governing Body and Audit Committee agendas. This allows the CCG Governing Body members to cross-check current identified risks with any other significant developments that may arise on these agendas to ensure any identified problems are appropriately recorded on the risk register.

**Annual audit of conflicts of interest management**

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

During the year, a annual audit of conflicts of interest has been undertaken. The overall rating for the audit was ‘significant assurance’ which reflects the robust arrangements in place at the CCG. Auditors recommended that the full and published versions of the Register of Interests should be fully completed to consistently state the action taken to mitigate risk when a declaration of interest (DOI) is made. We are now ensuring that all actions are being added to the register. In cases where individuals have not indicated actions on their DOI form, emails are sent to clarify what action is being taken and this is then added to the register. Emails are saved with the individual’s DOIs for audit purposes.

**Data quality**

During 2018-19, the CCG received a business intelligence service from its commissioning support provider (eMBED) and data is checked by informatics and planning staff within the CCG. All of the Governing Body committees were reviewed in quarter four of 2018-19 and no concerns were raised regarding data quality. The Quality and Performance Committee has noted continued improvements in the CCG’s integrated quality and performance report.

**Information governance**

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

The audit of the data security and protection toolkit (DSPT) has provided an opinion of significant assurance in relation to the evidence to support the CCG’s submissions of its DSPT self-assessment. This was based on a desk top review.

The CCG places high importance on ensuring there are robust information governance systems and processes in place to help protect patient and corporate information. The CCG takes its information governance (IG) responsibilities seriously. The CCG has a suite of approved IG policies and has provided the associated staff awareness. The CCG continues to use a specialist data centre to process any person identifiable data.

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. Data security training is mandatory for all staff, to ensure that staff are aware of their information governance roles and responsibilities.

There is an Information Governance Committee which reports to the Quality and Performance Committee. These are formal meetings with associated minutes and action tracking. The CCG has an IG team who provide expert advice and support.
This includes a data protection officer who is appointed to both the CCG and the Leeds City Council. Any breaches of security are managed within the CCG risk management strategy and incident management policy and reported using the Datix system.

The CCG has arrangements in place to ensure data security. The CCG has had contractual arrangements in place with an accredited IT provider - eMBED Health Consortium and the North East Commissioning Support Unit (NECS). The required data processing agreements are in place. The IT provider has provided the IT facilities required to store the data needed for CCG business. The CCG does not hold ‘local’ data. NECS were approved by the Health and Social Care Information Centre (HSCIC) to process confidential data on the CCG’s behalf. The CCG also uses national IT systems such as Oracle financials. These are operated under nationally stipulated security arrangements. All CCG staff have undertaken the required IG training to handle data securely.

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

Third party assurances
We seek assurance from third party providers about some of the services we receive. The most recent controls assurance report relating to the payroll service provided by Leeds Teaching Hospitals NHS Trust provided assurance that the service is properly controlled, managed and resourced.

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

3.3.8 Review of economy, efficiency & effectiveness of the use of resources
The governing body has overarching responsibility for ensuring that the CCG has appropriate arrangements in place to exercise its functions effectively, efficiently and economically.

The ratings for the quality of leadership indicator of the CCG Improvement and Assessment Framework are published on MyNHS (www.nhs.uk/service-search/performance/search). The latest data available is for quarter two of 2018-19, and the CCG is rated as ‘outstanding’. The year end results for 2018-19 will be available from approximately July 2019.

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 2018-19, and budgets were set within this plan and signed off by the Governing Body at 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.

Finance reports are presented to the Executive Management Team and at each Governing Body and Primary Care Commissioning Committee meeting, with a copy being presented to each meeting of the Audit Committee. Alongside the financial position, 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 CCG is actively engaged in discussions to ensure resources are prioritised in line with its strategic direction, including opportunities for developing new models of care across the spectrum of healthcare providers.

The CCG 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. A clear process has been developed to ensure monitoring and oversight of these schemes.

3.3.9 Delegation of functions

The CCG has 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 CCG, which makes recommendations in partnership with the council to the Health and Wellbeing Board for ratification.

Functions have been delegated to the West Yorkshire and Harrogate Joint Committee of CCGs to support the integrated care system and ensure joined up and efficient decision making.

Key responsibilities

The Joint Committee is part of the West Yorkshire and Harrogate Health and Care Partnership (‘the partnership’). The committee enables the West Yorkshire and Harrogate CCGs to work together effectively, making sure that when it makes sense, work is done once and is then shared across the area.

The committee has delegated authority from the CCGs to take collective decisions on agreed priorities. As well as taking formal decisions, the committee also makes recommendations to the CCGs when a joint approach will help to achieve better outcomes. The members of each CCG agree the committee’s terms of reference and its work plan, which sets out the decisions for which it is responsible.

Highlights of the committee’s work can be found in their annual report, which is available at www.wyhpartnership.co.uk/meetings/west-yorkshire-harrogate-joint-committee-ccgs

Working better together

The committee pioneered new approaches to enable the CCGs to work more efficiently and effectively together:

Quality and equality impact assessment - the committee approved a new approach to providing assurance that its decisions are supported by robust impact assessments, avoiding unnecessary duplication across the CCGs. We have already used this ‘do once and share’ approach to quality and equality impact assessment to assess new commissioning policies and will be exploring the potential for it to be used across the wider partnership.

Assuring public and patient involvement (PPI) - in November 2018, the Joint Committee formally established a PPI assurance group, made up of the PPI lay members from each CCG. The group built on the work of the informal lay members group. The role of the PPI Group is to assure the committee that the public and patient voice informs decisions on the planning, design and evaluation of commissioned services.

Commissioning development - at a series of workshops, the committee explored potential new ways of commissioning services across West Yorkshire and Harrogate. The committee will be building on this work during 2019-20 as it seeks to further develop collaborative working with commissioners and service providers.
**Governance** - during the year, CCG members agreed a refreshed work plan for the committee. In March 2019, CCG accountable officers signed off a 12-month extension of the memorandum of understanding which established the committee.

The committee maintains a register of members’ interests and declarations of interest are a standing item on all agendas. At each meeting, the committee reviews the significant risks to the delivery of its work programme and assesses how these risks are being mitigated.

In line with the principles of good governance, the committee evaluated its performance in March 2019. Whilst much of the feedback was very positive, members identified areas for further improvement, including how the committee focuses on:

- ensuring that accountability is clear for implementing agreed actions in our places and the wider health and care system
- reducing health inequalities and improving health and well being
- value for money, productivity and effectiveness
- promoting innovation

The committee will use the learning from the evaluation to help develop its work in 2019-20.

**3.3.10 Counter fraud arrangements**

The CCG has contracted with Audit Yorkshire who provide an accredited counter fraud specialist (LCFS) to undertake counter fraud work. The LCFS meets regularly with the Chief Finance Officer who is responsible for overseeing and providing strategic management and support for all anti-fraud, bribery and corruption work within the organisation. The LCFS also attends all Audit Committee meetings and provides a progress report on the work undertaken. This includes a report on the outcome of the self-assessment against the NHS Protect Standards for Commissioners: Fraud Bribery and Corruption. The last assessment was presented in April 2019 with an overall score of ‘green’.

**3.3.11 Head of Internal Audit Opinion**

Following completion of the planned audit work for the financial year for 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.

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

<table>
<thead>
<tr>
<th>Area of audit</th>
<th>Level of assurance given</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance and Risk management</td>
<td>High</td>
</tr>
<tr>
<td>Workforce Development and Management</td>
<td>Significant</td>
</tr>
<tr>
<td>Management of Conflicts of Interest</td>
<td>Significant</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>Significant</td>
</tr>
<tr>
<td>Patient Experience</td>
<td>High</td>
</tr>
<tr>
<td>Continuing Healthcare</td>
<td>Significant (draft)</td>
</tr>
<tr>
<td>Continuing Healthcare Finance</td>
<td>Significant (draft)</td>
</tr>
<tr>
<td>Personal Health Budgets</td>
<td>Significant</td>
</tr>
<tr>
<td>Individual Funding Requests (IFR)</td>
<td>High</td>
</tr>
<tr>
<td>Business Case Procedures</td>
<td>Significant</td>
</tr>
<tr>
<td>Performance Management</td>
<td>Significant</td>
</tr>
<tr>
<td>Stakeholder Engagement</td>
<td>High</td>
</tr>
<tr>
<td>Budgetary Control and Reporting and Key Financial Controls</td>
<td>High</td>
</tr>
<tr>
<td>QIPP</td>
<td>Significant</td>
</tr>
<tr>
<td>Data Security and Protection Toolkit</td>
<td>Significant</td>
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<tr>
<td>General Data Protection Regulation (GDPR)</td>
<td>Significant</td>
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<tr>
<td>Primary Medical Care Commissioning and Contracting</td>
<td>High</td>
</tr>
<tr>
<td>Confederation Governance</td>
<td>Limited</td>
</tr>
</tbody>
</table>
3.3.12 Review of the effectiveness of governance, risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers and clinical leads within the CCG 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 annual audit letter and other reports.

The CCG Governing Body Assurance Framework (GBAF) provides me with evidence that the effectiveness of controls that manage risks to the CCG achieving its principle 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, Primary Care Commissioning Committee, Audit Committee and the Quality & Performance 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 GBAF and Corporate Risk Register are regular agenda items on the Governing Body and Audit Committee agendas. This allows the CCG Governing Body members to triangulate current identified risks with any other significant developments that may arise on these agendas to ensure any identified problems are appropriately recorded on the risk register.

The CCG also seeks assurance from other areas about some of the services it receives. Annual assurance statements are received from the CCG’s payroll provider and from the auditors of the CCG’s principal provider of commissioning support services (eMBED Health Consortium) in respect of their internal controls.

Conclusion
No significant internal control issues have been identified.

Tim Ryley
Chief Executive (Accountable Officer)
22 May 2019
3.4 Remuneration and staff report

3.4.1 Remuneration report

**Remuneration Committee**
Details of our Remuneration and Nomination Committee’s membership, number of meetings during the year and individual attendance records are provided in our Governance Statement in section 3.3.3.

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

In 2018-19 benchmarking data was collated to inform pay levels. Our senior managers’ pay has not been 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 three months.

**Remuneration of very senior managers**
One senior manager is paid more than £150,000 per annum pro rata. The CCG has satisfied itself that this remuneration is reasonable via the Remuneration and Nomination Committee, which has assured itself that the remuneration is in line with national guidance set out in Clinical Commissioning Group Governing Body Members: Role Outlines, Attributes and Skills. This states that “All payments should be:

- evidently in line with the individual’s current earnings;
- commensurate with the average rate for their current employment or the specific role; or
- demonstrably required to provide backfill.”
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Notes</th>
<th>Salary (bands of £5,000)</th>
<th>Expense Payments (Rounded to the nearest £100)</th>
<th>Performance Pay and Bonuses (bands of £5,000)</th>
<th>Long Term performance pay and Bonuses (bands of £5,000)</th>
<th>All pension related benefits (bands of £2,500)</th>
<th>Total (Bands of £5,000)</th>
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</thead>
<tbody>
<tr>
<td>Philomena Corrigan</td>
<td>Accountable Officer</td>
<td></td>
<td>145 - 150</td>
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<td>-</td>
<td>-</td>
<td>57.5 - 60</td>
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<tr>
<td>Visseh Pejhan-Sykes</td>
<td>Chief Finance Officer</td>
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<td>115 - 120</td>
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<td>-</td>
<td>55 - 57.5</td>
<td>170 - 175</td>
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<tr>
<td>Dr Simon Stockill</td>
<td>Medical Director</td>
<td></td>
<td>80 - 85</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>30 - 32.5</td>
<td>115 - 120</td>
</tr>
<tr>
<td>Sue Robins</td>
<td>Director of Operational Delivery</td>
<td></td>
<td>95 - 100</td>
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<td>-</td>
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<td>57.5 - 60</td>
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<tr>
<td>Jo Harding</td>
<td>Director of Quality &amp; Safety</td>
<td></td>
<td>90 - 95</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>55 - 57.5</td>
<td>145 - 150</td>
</tr>
<tr>
<td>Katherine Sheerin</td>
<td>Interim Director of Strategy, Performance &amp; Planning to 31 July 18</td>
<td></td>
<td>35 - 40</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35 - 40</td>
</tr>
<tr>
<td>Tim Ryley</td>
<td>Director of Strategy, Performance &amp; Planning from 5 July 18</td>
<td></td>
<td>70 - 75</td>
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<td>32.5 - 35.0</td>
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<tr>
<td>Sabrina Armstrong</td>
<td>Director of Corporate Services from 21 May 18</td>
<td></td>
<td>70 - 75</td>
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<td>37.5 - 40.0</td>
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<tr>
<td>Ian Cameron</td>
<td>Interim Secondary Care Consultant 1 Apr 18 to 31 May 18</td>
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<td>-</td>
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<tr>
<td>Ian Cameron</td>
<td>Public Health Representation</td>
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<tr>
<td>Gordon Sinclair</td>
<td>Clinical Chair</td>
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<tr>
<td>Jason Broch</td>
<td>Assistant Clinical Chair</td>
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<tr>
<td>Dr Ben Browning</td>
<td>GP Member</td>
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<td>25 - 30</td>
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<tr>
<td>Dr Julianne Lyons</td>
<td>GP Member</td>
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<tr>
<td>Dr Keith Miller</td>
<td>GP Member</td>
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<td>20 - 25</td>
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<td>20 - 25</td>
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<tr>
<td>Phil Ayres</td>
<td>Secondary Care Consultant from 1 Jun 18</td>
<td></td>
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<tr>
<td>Peter Myers</td>
<td>Lay Member - Audit</td>
<td></td>
<td>15 - 20</td>
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<tr>
<td>Steve Ledger</td>
<td>Lay Member - Assurance</td>
<td></td>
<td>10 - 15</td>
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<tr>
<td>Angela Collins</td>
<td>Lay Member - Patient &amp; Public Involvement</td>
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<td>-</td>
<td>10 - 15</td>
<td>-</td>
</tr>
<tr>
<td>Sam Senior</td>
<td>Lay Member - Primary Care Commissioning Committee</td>
<td></td>
<td>15 - 20</td>
<td>2</td>
<td>-</td>
<td>-</td>
<td>15 - 20</td>
<td>-</td>
</tr>
</tbody>
</table>

Please note: 2018-19 is the first year of operation as a statutory body for NHS Leeds CCG, following the merger of the three previous CCGs in the city. Therefore prior year comparators are not applicable.

1. Taxable expenses and benefits in kind are expressed to the nearest £100. The values and bands used to disclose sums in this table are prescribed by the Cabinet Office through Employer Pension Notices and replicated in the HM Treasury Financial Reporting Manual
2. “All pension related benefits” is the annual increase in pension entitlement determined in accordance with the method set out in section 229 of the Finance Act 2004
3. Ian Cameron is Director of Public Health at Leeds City Council, who works for the CCG under a Memorandum Of Understanding. No remuneration is payable by the CCG.
4. Salary for J Broch includes the redundancy figure in a band of £5k - £10k in relation to his role as Clinical Chair of the former NHS Leeds North CCG
5. Salary includes employers pensions contributions made to GP Practitioner pension scheme paid by the CCG
### Pension benefits as of 31 March 2019 (subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Real increase in pension at pension age (bands of £2,500)</th>
<th>Real increase in pension lump sum at pension age (bands of £2,500)</th>
<th>Total accrued pension at pension age at 31 March 2019 (bands of £5,000)</th>
<th>Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value (CETV) at 1st April 2018</th>
<th>Real increase in CETV</th>
<th>CETV at 31 March 2019</th>
<th>Employer's contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philomena Corrigan</td>
<td>Accountable Officer</td>
<td>2.5 - 5</td>
<td>10 - 12.5</td>
<td>55 - 60</td>
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<td>170</td>
<td>1,233</td>
<td>-</td>
</tr>
<tr>
<td>Visseh Pejhan-Sykes</td>
<td>Chief Finance Officer</td>
<td>2.5 - 5</td>
<td>2.5 - 5</td>
<td>35 - 40</td>
<td>85 - 90</td>
<td>579</td>
<td>110</td>
<td>723</td>
<td>-</td>
</tr>
<tr>
<td>Simon Stockill</td>
<td>Medical Director</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>20 - 25</td>
<td>50 - 55</td>
<td>328</td>
<td>62</td>
<td>413</td>
<td>-</td>
</tr>
<tr>
<td>Sue Robins</td>
<td>Director of Operational Delivery</td>
<td>2.5 - 5</td>
<td>7.5 - 10</td>
<td>30 - 35</td>
<td>90 - 95</td>
<td>593</td>
<td>118</td>
<td>742</td>
<td>-</td>
</tr>
<tr>
<td>Jo Harding</td>
<td>Director of Quality &amp; Safety</td>
<td>2.5 - 5</td>
<td>5 - 7.5</td>
<td>35 - 40</td>
<td>90 - 95</td>
<td>532</td>
<td>108</td>
<td>676</td>
<td>-</td>
</tr>
<tr>
<td>Katherine Sheerin</td>
<td>Interim Director of Strategy, Performance &amp; Planning to 31 July 18</td>
<td>-</td>
<td>-</td>
<td>40 - 45</td>
<td>90 - 95</td>
<td>763</td>
<td>-</td>
<td>722</td>
<td>-</td>
</tr>
<tr>
<td>Tim Ryle</td>
<td>Director of Strategy, Performance &amp; Planning from 5 July 18</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>20 - 25</td>
<td>50 - 55</td>
<td>339</td>
<td>52</td>
<td>433</td>
<td>-</td>
</tr>
<tr>
<td>Sabrina Armstrong</td>
<td>Director of Corporate Services from 21 May 18</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>20 - 25</td>
<td>50 - 55</td>
<td>333</td>
<td>61</td>
<td>433</td>
<td>-</td>
</tr>
<tr>
<td>Clare Linley</td>
<td>Lead Nursing Officer - System Integration to 31 Jan 18 **</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>30 - 35</td>
<td>100 - 105</td>
<td>610</td>
<td>43</td>
<td>672</td>
<td>-</td>
</tr>
<tr>
<td>Katherine Sheerin</td>
<td>Interim Strategy Lead from 11 Dec 2017 **</td>
<td>0 - 2.5</td>
<td>0</td>
<td>45 - 50</td>
<td>115 - 120</td>
<td>714</td>
<td>38</td>
<td>763</td>
<td>-</td>
</tr>
</tbody>
</table>

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 (or other allowable beneficiary’s) pension payable from the scheme. CETVs are calculated in accordance with SI 2008 No.1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

**Real increase in CETV**

This reflects the increase in CETV that is funded by the employer. It does not include the increase in accrued pension due to inflation or contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement).

**Compensation on early retirement or for loss of office (subject to audit)**

The CCG did not make any payments for loss of office in the financial year.

**Payments to past directors (subject to audit)**

A contractual redundancy payment has been approved during 2018-19, totalling £160,000 relating to a former director of Leeds North CCG and is included in the exit packages table below.

**Pay multiples 2018-19 (subject to audit)**

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid member of the board in their organisation and the median remuneration of the organisation’s workforce.

The banded remuneration of the highest paid member of the Board in the financial year 2018/19 was £150k-£155k. This was 4.17 times the median remuneration of the workforce, which was £37k.

In 2018-19 no employees received remuneration in excess of the highest paid member of the Board. Remuneration ranged from £11k to £155k.
## Exit packages, including special (non-contractual) payments 2018-19 (subject to audit)

<table>
<thead>
<tr>
<th>Exit package cost band (inc. any special payment element)</th>
<th>Number of compulsory redundancies</th>
<th>Cost of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Cost of other departures agreed</th>
<th>Total number of exit packages</th>
<th>Total cost of exit packages</th>
<th>Number of departures where special payments have been made</th>
<th>Cost of special payment element included in exit packages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>5,951</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>5,951</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,000 - £25,000</td>
<td>1</td>
<td>22,822</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>22,822</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 - £50,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£50,001 - £100,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£100,001 - £150,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£150,001 - £200,000</td>
<td>1</td>
<td>160,000</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>160,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&gt;£200,000</td>
<td>3</td>
<td>188,773</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>188,773</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

These tables report the number and value of exit packages agreed in the financial year. Severance costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Terms and Conditions of Employment Handbook and/or associated employer obligations. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full, in the year of departure.

The Remuneration Report includes disclosure of exit packages payable to individuals named in that report.
## Employee benefits and staff numbers as at 31 March 2019

<table>
<thead>
<tr>
<th></th>
<th>Admin Permanent Employees</th>
<th>Programme Permanent Employees</th>
<th>Total Permanent Employees</th>
<th>Admin Other</th>
<th>Programme Other</th>
<th>Total Other</th>
<th>Admin Total</th>
<th>Programme Total</th>
<th>Total Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
<td>£'000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>N4A 6,427</td>
<td>N4B 359</td>
<td>N4C 6,786</td>
<td>N4D 4,917</td>
<td>N4E 259</td>
<td>N4F 5,176</td>
<td>N4G 11,344</td>
<td>N4H 618</td>
<td>N4I 11,962</td>
</tr>
<tr>
<td>Social security costs</td>
<td>704</td>
<td>-</td>
<td>704</td>
<td>510</td>
<td>-</td>
<td>510</td>
<td>1,214</td>
<td>-</td>
<td>1,214</td>
</tr>
<tr>
<td>Employer contributions</td>
<td>847</td>
<td>-</td>
<td>847</td>
<td>610</td>
<td>-</td>
<td>610</td>
<td>1,457</td>
<td>-</td>
<td>1,457</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Apprenticeship Levy</td>
<td>49</td>
<td>-</td>
<td>49</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>49</td>
<td>-</td>
<td>49</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>189</td>
<td>-</td>
<td>189</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>189</td>
<td>-</td>
<td>189</td>
</tr>
<tr>
<td>Gross Employee Benefits Expenditure</td>
<td>8,217</td>
<td>359</td>
<td>8,576</td>
<td>6,039</td>
<td>259</td>
<td>6,298</td>
<td>14,256</td>
<td>618</td>
<td>14,874</td>
</tr>
<tr>
<td>Less: Recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net employee benefits expenditure including capitalised costs</td>
<td>8,217</td>
<td>359</td>
<td>8,576</td>
<td>6,039</td>
<td>259</td>
<td>6,298</td>
<td>14,256</td>
<td>618</td>
<td>14,874</td>
</tr>
<tr>
<td>Less: Employee costs capitalised</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net employee benefits expenditure excluding capitalised costs</td>
<td>8,217</td>
<td>359</td>
<td>8,576</td>
<td>6,039</td>
<td>259</td>
<td>6,298</td>
<td>14,256</td>
<td>618</td>
<td>14,874</td>
</tr>
</tbody>
</table>
### Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N4Q</td>
<td>N4R</td>
<td>N4S</td>
</tr>
<tr>
<td>Total CCG</td>
<td>288</td>
<td>9</td>
<td>297</td>
</tr>
</tbody>
</table>

### Off payroll engagements

**Table 1: Off-payroll engagements longer than six months.**

Off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

- Number of existing engagements as at 31 March 2019: 8
- Of which, the number that have existed:
  - Less than 1 year at the time of reporting: 3
  - 1-2 years at the time of reporting: 3
  - 2-3 years at the time of reporting: 1
  - 3-4 years at the time of reporting: -
  - 4 or more years at the time of reporting: 1

**Table 2: New off-payroll engagements**

Off-payroll engagements as at 31 March 2019, for more than £245 per day and that last longer than six months:

- Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019: 9
- Of which:
  - No. assessed as caught by IR35: -
  - No. assessed as not caught by IR35: 9
  - No. engaged directly (via PSC contracted to the CCG) and are on CCG payroll: -
  - No. of engagement reassessed for consistency/assurance purposes during the year: -
  - No. of engagements that saw a change to IR35 status following the consistency review: -

### Table 3: Off-payroll board member/senior official engagements

Off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019:

- Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year: 1
- Total number of individuals on payroll and off-payroll that have been deemed “board members, and/or, senior officials with significant financial responsibility”, during the financial year. This figure should include both on payroll and off-payroll engagements: 19

### Consultancy expenditure

During the year, the CCG incurred expenditure totalling £63,445.71.

### 3.4.2 Our staff

Following discussions with colleagues throughout the year, we developed and approved our People and Organisational Development Strategy 2018 - 2021 to provide a framework for developing our new organisation and the people who work here.

Our approach is based on six people ambitions:

- Creating a high performing organisation - Looking for opportunities to continuously develop and offer stretch to our staff so that we can build an organisation that celebrates success and achieves our strategic ambitions.
- Leading the system - Effective management will remain a key role at the CCG, but we will increasingly use our position to shape the future model for health and care in Leeds.
- Working collaboratively - We already work closely with partners and stakeholders, but as the Leeds health and care model matures, we will increasingly become engaged in the co-production of plans. The CCG will also have a role in facilitating and stimulating this process and it will impact on some of our key approaches and decisions.
• Thinking city-wide - Looking beyond the CCG and its organisational focus to contributing to the wider vision for the city.
• Working flexibly - Using new ways of working to offer people greater flexibility, the principle of having a place to work, rather than a single place of work.
• Measuring outcomes - A focus on what is to be achieved rather than what activity has occurred.

**Staff consultation and engagement**

Prior to merging the three Leeds CCGs, we carried out extensive and detailed consultation with staff so we did not participate in the national staff survey in 2018. However, following the merger, we commissioned an independent temperature check and reported the results back at an all staff event in October 2018. The findings and recommendations in the temperature check helped shape our new People and Organisational Development strategy. We also carried out an internal communications survey, the results of which have been used to further improve the way we communicate with our staff. This has included two all staff events, which have included a mix of briefings about local and national issues affecting the NHS, motivational speakers, team building and networking opportunities and ‘question time’ with senior managers. Feedback from the events has been very positive.

Recognising the benefits of partnership working, the CCG continued to be a member of the North Yorkshire, Humber and Leeds, Yorkshire Social Partnership Forum during 2018-19.

The aim of the forum is to provide a formal negotiation and consultation group for the CCGs and trade unions to discuss and debate issues in an environment of mutual trust and respect.

In particular it:
• Engages employers and trade union representatives in meaningful discussion on the development and implications of future policy
• Provides a forum for the exchange of comments and feedback on issues that have a direct or indirect effect on the workforce
• Promotes effective and meaningful communication between all parties that can be subsequently disseminated across the membership

Our involvement in this group ceased with the end of the eMBED contract on 31 March 2019; we will establish new arrangements to continue to foster effective partnership arrangements with our trade unions.

A cross-section of colleagues, on behalf of their teams, are offered the opportunity to participate in consultation on policy development via our Workforce and Diversity Group.

The following policies have been reviewed and agreed in 2018-19:
• Acceptable standards of behaviour policy (previously harassment and bullying)
• Alcohol, drugs and substance misuse in the workplace (includes no smoking)
• Annual and special leave
• Disciplinary
• Equality and diversity (previously equal opportunities and diversity in employment)
• Flexible working
• Secondment
• Learning and development (previously education, training and development)
• Managing work performance
Staff recognition

In 2018, we recognised the achievements of our staff at our first awards ceremony, which we held as part of an all staff event. The awards, which were judged by an independent panel, recognised individuals and teams across several categories:

• Making a difference
• Living our values
• Above and beyond
• Working together
• Service innovation and transformation
• Putting patients first
• Team of the year

We also recognise employee long service when our staff retire from the NHS.

Training and appraisal

We achieved an overall compliance rate of 86% for statutory and mandatory training for directly employed staff against a target of 90%. This is a notable improvement since last year.

A number of staff have undertaken learning and development opportunities linked to their role via our learning and development application process, which was revised as part of the learning and development policy review.

We instigated an interim appraisal process during 2018-19 where we asked line managers and their direct reports to set objectives, hold a mid-year evaluation of progress and a final end-of-year review. Compliance towards this requirement improved to 59% at the end of March 2019. This process has been fully revised for 2019-20 and will also involve significantly enhancing our existing coaching and mentoring offer to staff. We have also extended our apprenticeship scheme to include management level opportunities in project management skills.

Workplace health, safety and wellbeing

The CCG has trained first aiders to support and promote health and wellbeing. We have management and self-referral to a counselling service and to occupational health, and we are also developing a mental health first aid programme to further support staff.

Sickness absence data

The table below (from data made available to us by DHSC) provides an analysis of the staff sickness absence reported on a calendar year basis for 2018.

<table>
<thead>
<tr>
<th>Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Total days lost</td>
<td>1,379</td>
</tr>
<tr>
<td>Total staff years</td>
<td>291</td>
</tr>
<tr>
<td>Average working days lost</td>
<td>4.7</td>
</tr>
</tbody>
</table>

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 building 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.

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.

CCG staff members are required to complete 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 and one to one guidance and support are provided on equality impact assessments and equality analysis and in relation to the commissioning of healthcare. We will ensure that all records are updated to ensure compliance among all staff, Governing Body members and the Patient Assurance Group.

Annual workforce report

Number of senior managers by band

<table>
<thead>
<tr>
<th>Pay band</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 8a</td>
<td>61</td>
</tr>
<tr>
<td>Band 8b</td>
<td>30</td>
</tr>
<tr>
<td>Band 8c</td>
<td>12</td>
</tr>
<tr>
<td>Band 8d</td>
<td>11</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
</tr>
<tr>
<td>Very senior managers</td>
<td>5</td>
</tr>
<tr>
<td>Governing body</td>
<td>17</td>
</tr>
<tr>
<td>Any other spot salary</td>
<td>16</td>
</tr>
</tbody>
</table>

Staff numbers and costs

<table>
<thead>
<tr>
<th>Assignment category</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent</td>
<td>301</td>
</tr>
<tr>
<td>Fixed term</td>
<td>59</td>
</tr>
<tr>
<td>Statutory office holders</td>
<td>0</td>
</tr>
<tr>
<td>Bank</td>
<td>0</td>
</tr>
<tr>
<td>Honorary</td>
<td>0</td>
</tr>
</tbody>
</table>

Gender breakdown

<table>
<thead>
<tr>
<th>Gender</th>
<th>Total (Female)</th>
<th>Total (Male)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Band 8a</td>
<td>44</td>
<td>17</td>
</tr>
<tr>
<td>Band 8b</td>
<td>23</td>
<td>8</td>
</tr>
<tr>
<td>Band 8c</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Band 8d</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>Band 9</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Very senior managers</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Governing body</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Any other spot salary</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>All other employees (including apprentice if applicable)</td>
<td>176</td>
<td>33</td>
</tr>
</tbody>
</table>

Trade union facility time, 2018-19

Table 1: Relevant union officials

<table>
<thead>
<tr>
<th>Number of employees who were relevant union officials during the relevant period</th>
<th>Full-time equivalent employee number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>279</td>
</tr>
</tbody>
</table>

Table 2: Percentage of time spent on facility time

<table>
<thead>
<tr>
<th>Percentage of time</th>
<th>Number of employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>1-50%</td>
<td>-</td>
</tr>
<tr>
<td>51%-99%</td>
<td>-</td>
</tr>
<tr>
<td>100%</td>
<td>-</td>
</tr>
</tbody>
</table>
Table 3: Percentage of pay bill spent on facility time

<table>
<thead>
<tr>
<th>Total cost of facility time</th>
<th>£179</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total pay bill</td>
<td>£12,558,773</td>
</tr>
<tr>
<td>Percentage of the total pay bill spent on facility time</td>
<td>0.0014%</td>
</tr>
</tbody>
</table>

Table 4: Paid trade union activities
As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities? 100%

3.5 Parliamentary accountability and audit report

NHS Leeds CCG is not required to produce a Parliamentary Accountability and Audit Report. There are no applicable disclosures with regard to remote contingent liabilities, losses and special payments, gifts, and fees and charges. An audit certificate and report is also included in this annual report.

Tim Ryley
Chief Executive (Accountable Officer)
22 May 2019
Report on the audit of the financial statements

Opinion

We have audited the financial statements of NHS Leeds Clinical Commissioning Group ("the CCG") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

• give a true and fair view of the state of the CCG's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

• have been properly prepared in accordance with the accounting policies directed by the NHS Commissioning Board with the consent of the Secretary of State as being relevant to CCGs in England and included in the Department of Health and Social Care Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the CCG in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accountable Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Accountable Officer’s conclusions we considered the inherent risks to the CCG’s operations, including the impact of Brexit, and analysed how these risks might affect the CCG’s financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor’s report is not a guarantee that the CCG will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.
Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

**Annual Governance Statement**

We are required to report to you if the Annual Governance Statement does not comply with guidance issued by the NHS Commissioning Board. We have nothing to report in this respect.

**Remuneration and Staff Report**

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

**Accountable Officer’s responsibilities**

As explained more fully in the statement set out on page 80, the Accountable Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the CCG’s ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the CCG without the transfer of its services to another public sector entity.

**Auditor’s responsibilities**

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor’s report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC’s website at [www.frc.org.uk/auditorsresponsibilities](http://www.frc.org.uk/auditorsresponsibilities)

**Report on other legal and regulatory matters**

**Opinion on regularity**

We are required to report on the following matters under Section 25(1) of the Local Audit and Accountability Act 2014.

In our opinion, in all material respects, 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.

**Report on the CCG’s arrangements for securing economy, efficiency and effectiveness in its use of resources**

Under the Code of Audit Practice we are required to report to you if the CCG has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.
Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 80, the Accountable Officer is responsible for ensuring that the CCG exercises its functions effectively, efficiently and economically. 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.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, 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. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General (‘the Code of Audit Practice’) to report to you if:

- 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.

We have nothing to report in these respects.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Members of the Governing Body of NHS Leeds 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, as a body, for our audit work, for this report or for the opinions we have formed.

Certificate of completion of the audit

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

Rashpal Khangura
for and on behalf of KPMG LLP
Statutory Auditor
Chartered Accountants
Leeds
23 May 2019
## 5. Annual accounts

### Statement of Comprehensive Net Expenditure for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>2018-19 £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from sale of goods and services</td>
<td>2</td>
</tr>
<tr>
<td>Other operating income</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td></td>
</tr>
<tr>
<td>Staff costs</td>
<td>4</td>
</tr>
<tr>
<td>Purchase of goods and services</td>
<td>5</td>
</tr>
<tr>
<td>Depreciation and impairment charges</td>
<td></td>
</tr>
<tr>
<td>Provision expense</td>
<td>5</td>
</tr>
<tr>
<td>Other operating expenditure</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total operating expenditure</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Net Operating Expenditure</strong></td>
<td></td>
</tr>
<tr>
<td>Finance income</td>
<td></td>
</tr>
<tr>
<td>Finance expense</td>
<td></td>
</tr>
<tr>
<td><strong>Net Expenditure for the year</strong></td>
<td></td>
</tr>
<tr>
<td>Net (gain)/loss on transfer by absorption</td>
<td>7</td>
</tr>
<tr>
<td><strong>Total Net Expenditure for the year</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Other Comprehensive Expenditure

#### Items which will not be reclassified to net operating costs
- Net (gain)/loss on revaluation of PPE -
- Net (gain)/loss on revaluation of intangibles -
- Net (gain)/loss on revaluation of financial assets -
- Actuarial (gain)/loss in pension schemes -
- Impairments and reversals taken to revaluation reserve -

#### Items that may be reclassified to Net Operating Costs
- Net (gain)/loss on revaluation of available for sale financial assets -
- Reclassification adjustment on disposal of available for sale financial assets -

**Sub total** -

### Comprehensive Expenditure for the year ended 31 March 2019

1,289,809

The notes on the following pages form part of this statement.
Statement of Financial Position as at 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 19</th>
<th>1 April 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Non-current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Property, plant and equipment</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intangible assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Investment property</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total non-current assets</strong></td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Current assets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9</td>
<td>6,426</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other current assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>10</td>
<td>122</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>6,548</td>
<td>4,797</td>
</tr>
<tr>
<td>Non-current assets held for sale</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total current assets</strong></td>
<td>6,548</td>
<td>4,797</td>
</tr>
<tr>
<td><strong>Total assets</strong></td>
<td>6,548</td>
<td>4,797</td>
</tr>
<tr>
<td>Current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>11</td>
<td>(58,179)</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Borrowings</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>12</td>
<td>(3,415)</td>
</tr>
<tr>
<td><strong>Total current liabilities</strong></td>
<td>(61,594)</td>
<td>(65,529)</td>
</tr>
<tr>
<td><strong>Non-Current Assets less Net Current Liabilities</strong></td>
<td>(55,046)</td>
<td>(60,732)</td>
</tr>
<tr>
<td>Non-current liabilities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Borrowings</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>12</td>
<td>(1,386)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(1,386)</td>
<td>(1,348)</td>
</tr>
<tr>
<td><strong>Assets less Liabilities</strong></td>
<td>(56,432)</td>
<td>(62,080)</td>
</tr>
<tr>
<td><strong>Financed by Taxpayers’ Equity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General fund</td>
<td>(56,432)</td>
<td>(62,080)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other reserves</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charitable reserves</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total Taxpayers’ Equity</strong></td>
<td>(56,432)</td>
<td>(62,080)</td>
</tr>
</tbody>
</table>

The balances as at 1 April 2018 relate to those transferred by absorption (note 7).

The notes on the following pages form part of this statement.

The financial statements on the following pages were approved by the Governing Body on 22 May 2019 and signed on its behalf by:

Tim Ryley
Chief Executive (Accountable Officer)
## Statement of Changes In Taxpayers’ Equity for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Changes in taxpayers’ equity for 2018-19</th>
<th>General fund £’000</th>
<th>Revaluation reserve £’000</th>
<th>Other reserves £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2018</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred from closed NHS bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impact of applying IFRS 9 to opening balances</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impact of applying IFRS 15 to opening balances</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Adjusted NHS Clinical Commissioning Group balance at 1 April 2018</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in NHS Clinical Commissioning Group taxpayers’ equity for 2018-19</th>
<th>General fund £’000</th>
<th>Revaluation reserve £’000</th>
<th>Other reserves £’000</th>
<th>Total reserves £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(1,227,729)</td>
<td>-</td>
<td>-</td>
<td>(1,227,729)</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of property, plant and equipment</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of intangible assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total revaluations against revaluation reserve</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on available for sale financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of other investments and Financial Assets (excluding available for sale financial assets)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net gain/(loss) on revaluation of assets held for sale</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial gain/(loss) on pensions</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers between reserves</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Release of reserves to the Statement of Comprehensive Net Expenditure</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reclassification adjustment on disposal of available for sale financial assets</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfers by absorption to/(from) other bodies</td>
<td>(62,080)</td>
<td>-</td>
<td>-</td>
<td>(62,080)</td>
</tr>
<tr>
<td>Reserves eliminated on dissolution</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Recognised NHS Clinical Commissioning Group Expenditure for the Financial Year</strong></td>
<td>(1,289,809)</td>
<td>-</td>
<td>-</td>
<td>(1,289,809)</td>
</tr>
<tr>
<td>Net funding</td>
<td>1,233,377</td>
<td>-</td>
<td>-</td>
<td>1,233,377</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>(56,432)</td>
<td>-</td>
<td>-</td>
<td>(56,432)</td>
</tr>
</tbody>
</table>

The notes on the following pages form part of this statement.
Statement of Cash Flows for the year ended 31 March 2019

<table>
<thead>
<tr>
<th>Note</th>
<th>£'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cash Flows from Operating Activities</strong></td>
<td></td>
</tr>
<tr>
<td>Net operating expenditure for the financial year</td>
<td>(1,227,729)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</td>
</tr>
<tr>
<td>Non-cash movements arising on application of new accounting standards</td>
<td>-</td>
</tr>
<tr>
<td>Movement due to transfer by absorption</td>
<td>7 291</td>
</tr>
<tr>
<td>Other gains/(losses) on foreign exchange</td>
<td>-</td>
</tr>
<tr>
<td>Donated assets received credited to revenue but non-cash</td>
<td>-</td>
</tr>
<tr>
<td>Government granted assets received credited to revenue but non-cash</td>
<td>-</td>
</tr>
<tr>
<td>Interest paid</td>
<td>-</td>
</tr>
<tr>
<td>Release of PFI deferred credit</td>
<td>-</td>
</tr>
<tr>
<td>Other gains &amp; losses</td>
<td>-</td>
</tr>
<tr>
<td>Finance costs</td>
<td>-</td>
</tr>
<tr>
<td>Unwinding of discounts</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in inventories</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>9 (1,920)</td>
</tr>
<tr>
<td>(Increase)/decrease in other current assets</td>
<td>-</td>
</tr>
<tr>
<td>Increase/(decrease) in trade &amp; other payables</td>
<td>11 (5,903)</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>-</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>12 (465)</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>12 2,471</td>
</tr>
<tr>
<td><strong>Net Cash Inflow//Outflow) from Operating Activities</strong></td>
<td>(1,233,255)</td>
</tr>
</tbody>
</table>

| 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 and Social Care | - |
| (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 and Social Care | - |
| Proceeds from disposal of other financial assets | - |
| Proceeds from disposal of financial assets (LIFT) | - |
| Non-cash movements arising on application of new accounting standards | - |
| 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 | (1,233,255) |

| Cash Flows from Financing Activities | |
| Net funding received | 1,233,377 |
| Grant in aid funding received | - |
| Other loans received | - |
| Other loans repaid | - |
| Capital element 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 | - |
| Non-cash movements arising on application of new accounting standards | - |
| **Net Cash Inflow/(Outflow) from Financing Activities** | 1,233,377 |

| Net Increase/(Decrease) in Cash & Cash Equivalents | 10 122 |

| Cash & Cash Equivalents at the Beginning of the Financial Year | |
| 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 | 122 |

The notes on the following pages form part of this statement.
Notes to the financial statements

1 Accounting Policies

NHS England has directed that the financial statements of clinical commissioning groups shall meet the accounting requirements of the Group Accounting Manual (GAM) issued by the Department of Health and Social Care (DHSC). Consequently, the following financial statements have been prepared in accordance with the Group Accounting Manual 2018-19 issued by the Department of Health and Social Care. The accounting policies contained in the Group Accounting Manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to clinical commissioning groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Group Accounting Manual permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the clinical commissioning group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the clinical commissioning group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Going Concern

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

1.3 Movement of Assets within the Department of Health and Social Care Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Government Financial Reporting Manual, issued by HM Treasury. The Government Financial Reporting Manual does not require retrospective adoption, so prior year transactions 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 and Social Care Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4 Pooled Budgets

The clinical commissioning group has entered into a pooled budget arrangement with Leeds City Council in accordance with section 75 of the NHS Act 2006. Under the arrangements, funds are pooled for Better Care Fund activities and the notes to the accounts provide details of the income and expenditure.

The pool is hosted by either the clinical commissioning group or Leeds City Council. The clinical commissioning group accounts for its share of the assets, liabilities, income and expenditure arising from the activities of the pooled budgets, identified in accordance with the pooled budget agreements.

1.5 Operating Segments

Income and expenditure are analysed in the Operating Segments note and are reported in line with management information used within the clinical commissioning group.

1.6 Revenue

The transition to IFRS 15 has been completed in accordance with paragraph C3(b) of the Standard, applying the Standard retrospectively and recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:

• As per paragraph 121 of the Standard, the clinical commissioning group will not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less.

• The clinical commissioning group is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard, where the right to consideration corresponds directly with the value of the performance completed to date.

• The FReM has mandated the exercise of the practical expedient offered in C7(a) of the Standard that requires the clinical commissioning group to reflect the aggregate effect of all contracts modified before the date of initial application.
Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

Payment terms are standard reflecting cross government principles.

The value of the benefit received when the clinical commissioning group accesses funds from the Government’s apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.7 Employee Benefits
1.7.1 Short-term Employee Benefits
Salaries, wages and employment-related payments, including payments arising from the apprenticeship levy, are recognised in the period in which the service is received from employees, including bonuses earned but not yet taken.

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

1.7.2 Retirement Benefit Costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are 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 schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a 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.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

1.8 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.

1.9 Grants Payable
Where grant funding is not intended to be directly related to activity undertaken by a grant recipient in a specific period, the clinical commissioning group recognises the expenditure in the period in which the grant is paid. All other grants are accounted for on an accruals basis.

1.10 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.

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

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

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

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

1.11 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.
1.12 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:

Early retirement provisions are discounted using HM Treasury’s pension discount rate of positive 0.29% (2017-18: positive 0.10%) in real terms. All general provisions are subject to four separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:

• A nominal short-term rate of 0.76% (2017-18: negative 2.42% in real terms) for inflation adjusted expected cash flows up to and including 5 years from Statement of Financial Position date.

• A nominal medium-term rate of 1.14% (2017-18: negative 1.85% in real terms) for inflation adjusted expected cash flows over 5 years up to and including 10 years from the Statement of Financial Position date.

• A nominal long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows over 10 years up to and including 40 years from the Statement of Financial Position date.

• A nominal very long-term rate of 1.99% (2017-18: negative 1.56% in real terms) for inflation adjusted expected cash flows exceeding 40 years from the Statement of Financial Position date.

All 2018-19 percentages are expressed in nominal terms with 2017-18 being the last financial year that HM Treasury provided real general provision discount rates.

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.

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

1.14 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 NHS Resolution 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.

1.15 Contingent Liabilities and Contingent Assets
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, contingent liabilities and contingent assets are disclosed at their present value.

1.16 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 amortised cost.
• Financial assets at fair value through other comprehensive income.
• Financial assets at fair value through profit and loss.
The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.

1.16.1 Financial Assets at Amortised cost
Financial assets measured at amortised cost are those held within a business model whose objective is achieved by collecting contractual cash flows and where the cash flows are solely payments of principal and interest. This includes most trade receivables and other simple debt instruments. After initial recognition these financial assets are measured at amortised cost using the effective interest method less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

1.16.2 Financial Assets at Fair Value through Other Comprehensive Income
Financial assets held at fair value through other comprehensive income are those held within a business model whose objective is achieved by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest.

1.16.3 Financial Assets at Fair Value through Profit and Loss
Financial assets measure at fair value through profit and loss are those that are not otherwise measured at amortised cost or fair value through other comprehensive income. This includes derivatives and financial assets acquired principally for the purpose of selling in the short term.

1.16.4 Impairment
For all financial assets measured at amortised cost or at fair value through other comprehensive income (except equity instruments designated at fair value through other comprehensive income), lease receivables and contract assets, the clinical commissioning group recognises a loss allowance representing the expected credit losses on the financial asset.

The clinical commissioning group adopts the simplified approach to impairment in accordance with IFRS 9, and measures the loss allowance for trade receivables, lease receivables and contract assets at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition (stage 2) and otherwise at an amount equal to 12 month expected credit losses (stage 1).

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds and Exchequer Funds assets where repayment is ensured by primary legislation.

The clinical commissioning group therefore does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies. Additionally DHSC provides a guarantee of last resort against the debts of its arm’s length bodies and NHS bodies, and therefore the clinical commissioning group does not recognise allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset’s gross carrying amount and the present value of the estimated future cash flows discounted at the financial asset’s original effective interest rate. Any adjustment is recognised in profit or loss as an impairment gain or loss.

1.17 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 derecognised when the liability has been discharged, that is, the liability has been paid or has expired.

1.17.1 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.

1.17.2 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.

1.17.3 Other Financial Liabilities
After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from the Department of Health and Social Care, 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.
1.18 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.

1.19 Foreign Currencies
The clinical commissioning group’s functional currency and presentational currency is pounds sterling and amounts are presented in thousands of pounds unless expressly stated otherwise. 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.

1.20 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).

1.21 Critical Accounting Judgements and Key Sources of Estimation Uncertainty
In the application of the clinical commissioning group’s accounting policies, management is required to make various judgements, estimates and assumptions. These are regularly reviewed.

1.21.1 Critical Accounting Judgements in Applying Accounting Policies
Where critical judgements, apart from those involving estimations that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements, details are provided in the relevant notes to the accounts.

1.21.2 Sources of Estimation Uncertainty
Where key estimations that management has made in the process of applying the clinical commissioning group’s accounting policies that have the most significant effect on the amounts recognised in the financial statements, details are provided in the relevant notes to the accounts.

1.22 Gifts
Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Accounting standards that have been issued but have not yet been adopted
The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption, with IFRS 16 planned for implementation in 2019-20, and the government implementation date for IFRS 17 still subject to HM Treasury consideration.

• IFRS 16 Leases - Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRS 17 Insurance Contracts - Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
• IFRIC 23 Uncertainty over Income Tax Treatments - Application required for accounting periods beginning on or after 1 January 2019.

The application of the Standards as revised would not have a material impact on the accounts for 2018-19, were they applied in that year.
## 2 Operating Income

<table>
<thead>
<tr>
<th>Description</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income from sale of goods and services (contracts)</strong></td>
<td></td>
</tr>
<tr>
<td>Education, training and research</td>
<td></td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>£269</td>
</tr>
<tr>
<td>Patient transport services</td>
<td></td>
</tr>
<tr>
<td>Prescription fees and charges</td>
<td></td>
</tr>
<tr>
<td>Dental fees and charges</td>
<td></td>
</tr>
<tr>
<td>Income generation</td>
<td></td>
</tr>
<tr>
<td>Other contract income</td>
<td>£516</td>
</tr>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td></td>
</tr>
<tr>
<td><strong>Total income from sale of goods and services</strong></td>
<td>£785</td>
</tr>
<tr>
<td><strong>Other operating income</strong></td>
<td></td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td></td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td></td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: NHS</td>
<td></td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td></td>
</tr>
<tr>
<td>Receipt of donations (capital/cash)</td>
<td></td>
</tr>
<tr>
<td>Receipt of government grants for capital acquisitions</td>
<td></td>
</tr>
<tr>
<td>Continuing health care risk pool contributions</td>
<td></td>
</tr>
<tr>
<td>Non cash apprenticeship training grants revenue</td>
<td>£2</td>
</tr>
<tr>
<td>Other non contract revenue</td>
<td>£1,804</td>
</tr>
<tr>
<td><strong>Total other operating income</strong></td>
<td>£1,806</td>
</tr>
<tr>
<td><strong>Total operating income</strong></td>
<td>£2,591</td>
</tr>
</tbody>
</table>

There was no impact of application of IFRS 15 on the assets or liabilities of the CCG at 1 April 2018.

There was also no impact of IFRS 15 on the revenue recognised during the year.
### 3 Disaggregation of Income - Income from Sale of Goods and Services (contracts)

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-patient care services to other bodies</td>
<td>Other Contract income</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>£’000</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Source of Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NHS</td>
<td>269</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non NHS</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>269</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>£’000</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Timing of Revenue</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point in time</td>
<td>269</td>
<td>516</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over time</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>269</td>
<td>516</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 3.1 Transaction price to remaining contract performance obligations

Contract revenue expected to be recognised in the future periods related to contract performance obligations not yet completed at the reporting date.

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Revenue expected from NHSE Bodies</td>
<td>Revenue expected from Other DHSC Group Bodies</td>
<td>Revenue expected from Non-DHSC Group Bodies</td>
</tr>
<tr>
<td><strong>£’000</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not later than 1 year</td>
<td>405</td>
<td>-</td>
<td>-</td>
<td>405</td>
</tr>
<tr>
<td>Later than 1 year, not later than 5 years</td>
<td>81</td>
<td>-</td>
<td>-</td>
<td>81</td>
</tr>
<tr>
<td>Later than 5 Years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td>486</td>
<td>-</td>
<td>-</td>
<td>486</td>
</tr>
</tbody>
</table>
4 Employee Benefits and Staff Numbers

4.1 Employee benefits

<table>
<thead>
<tr>
<th></th>
<th>Permanent Employees</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>11,344</td>
<td>618</td>
<td>11,962</td>
</tr>
<tr>
<td>Social security costs</td>
<td>1,214</td>
<td>-</td>
<td>1,214</td>
</tr>
<tr>
<td>Employer contributions to NHS Pension scheme</td>
<td>1,457</td>
<td>-</td>
<td>1,457</td>
</tr>
<tr>
<td>Other pension costs</td>
<td>3</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Apprenticeship levy</td>
<td>49</td>
<td>-</td>
<td>49</td>
</tr>
<tr>
<td>Other post-employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Termination benefits</td>
<td>189</td>
<td>-</td>
<td>189</td>
</tr>
<tr>
<td><strong>Gross employee benefits expenditure</strong></td>
<td><strong>14,256</strong></td>
<td><strong>618</strong></td>
<td><strong>14,874</strong></td>
</tr>
<tr>
<td>Less recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net employee benefits including capitalised costs</strong></td>
<td><strong>14,256</strong></td>
<td><strong>618</strong></td>
<td><strong>14,874</strong></td>
</tr>
<tr>
<td>Less employee costs capitalised</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net employee benefits excluding capitalised costs</strong></td>
<td><strong>14,256</strong></td>
<td><strong>618</strong></td>
<td><strong>14,874</strong></td>
</tr>
</tbody>
</table>

4.2 Average number of people employed

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Permanently employed</td>
</tr>
<tr>
<td></td>
<td>Number</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>288</td>
</tr>
</tbody>
</table>

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4.3 Exit packages agreed in the financial year

These tables report the number and value of exit packages agreed in the financial year. Severance costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Terms and Conditions of Employment Handbook and/or associated employer obligations. Exit costs are accounted for in accordance with relevant accounting standards and at the latest in full, in the year of departure.

The Remuneration Report includes the disclosure of exit payments payable to individuals named in that Report.

<table>
<thead>
<tr>
<th></th>
<th>Compulsory redundancies</th>
<th>2018-19</th>
<th>Other agreed departures</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
<td>Number</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>1</td>
<td>5,951</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>1</td>
<td>22,822</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£100,001 to £150,000</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£150,001 to £200,000</td>
<td>1</td>
<td>160,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3</strong></td>
<td><strong>188,773</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
<th>Departures where special payments have been made</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£</td>
</tr>
<tr>
<td>Less than £10,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£10,001 to £25,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£25,001 to £50,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£50,001 to £100,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£100,001 to £150,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>£150,001 to £200,000</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Over £200,001</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
4.4 Pension costs
Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies allowed under the direction of the Secretary of State in England and Wales. The schemes are 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 schemes are accounted for as though they were defined contribution schemes: the cost to the clinical commissioning group of participating in a scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

4.4.1 Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as at 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

4.4.2 Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.
## 5 Operating Expenses

### 2018-19 £’000

#### Purchase of goods and services

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>1,317</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>146,635</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>627,304</td>
</tr>
<tr>
<td>Provider Sustainability Fund (Sustainability Transformation Fund 17-18)</td>
<td>-</td>
</tr>
<tr>
<td>Services from other WGA bodies</td>
<td>-</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>194,511</td>
</tr>
<tr>
<td>Purchase of social care</td>
<td>-</td>
</tr>
<tr>
<td>General dental services and personal dental services</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>122,465</td>
</tr>
<tr>
<td>Pharmaceutical services</td>
<td>-</td>
</tr>
<tr>
<td>General ophthalmic services</td>
<td>74</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>110,878</td>
</tr>
<tr>
<td>Supplies and services – clinical</td>
<td>119</td>
</tr>
<tr>
<td>Supplies and services – general</td>
<td>3,612</td>
</tr>
<tr>
<td>Consultancy services</td>
<td>63</td>
</tr>
<tr>
<td>Establishment</td>
<td>2,538</td>
</tr>
<tr>
<td>Transport</td>
<td>31</td>
</tr>
<tr>
<td>Premises</td>
<td>1,448</td>
</tr>
<tr>
<td>Audit fees</td>
<td>69</td>
</tr>
<tr>
<td>Other non statutory audit expenditure</td>
<td>-</td>
</tr>
<tr>
<td>• Internal audit services</td>
<td>-</td>
</tr>
<tr>
<td>• Other services</td>
<td>1</td>
</tr>
<tr>
<td>Other professional fees</td>
<td>852</td>
</tr>
<tr>
<td>Legal fees</td>
<td>134</td>
</tr>
<tr>
<td>Education, training and conferences</td>
<td>296</td>
</tr>
<tr>
<td>Funding to group bodies</td>
<td>-</td>
</tr>
<tr>
<td>CHC Risk Pool contributions</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total purchase of goods and services</strong></td>
<td>1,212,347</td>
</tr>
</tbody>
</table>

#### Depreciation and impairment charges

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation</td>
<td>-</td>
</tr>
<tr>
<td>Amortisation</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of intangible assets</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of financial assets</td>
<td>-</td>
</tr>
<tr>
<td>• Assets carried at amortised cost</td>
<td>-</td>
</tr>
<tr>
<td>• Assets carried at cost</td>
<td>-</td>
</tr>
<tr>
<td>• Available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of non-current assets held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals of investment properties</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total depreciation and impairment charges</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

#### Provision expense

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in discount rate</td>
<td>-</td>
</tr>
<tr>
<td>Provisions</td>
<td>2,471</td>
</tr>
<tr>
<td><strong>Total provision expense</strong></td>
<td>2,471</td>
</tr>
</tbody>
</table>

#### Other operating expenditure

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chair and Non Executive Members</td>
<td>364</td>
</tr>
<tr>
<td>Grants to other bodies</td>
<td>-</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>-</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>9</td>
</tr>
<tr>
<td>Expected credit loss on receivables</td>
<td>7</td>
</tr>
<tr>
<td>Expected credit loss on other financial assets (stage 1 and 2 only)</td>
<td>-</td>
</tr>
<tr>
<td>Inventories written down</td>
<td>-</td>
</tr>
<tr>
<td>Inventories consumed</td>
<td>-</td>
</tr>
<tr>
<td>Non cash apprenticeship training grants</td>
<td>2</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>246</td>
</tr>
<tr>
<td><strong>Total other operating expenditure</strong></td>
<td>628</td>
</tr>
</tbody>
</table>

**Total operating expenditure** 1,215,446

Prescribing expenditure detailed above is reflective of a key estimated accrual for the final two months of the year and the impact of prior year accrual reversals. Prescribing accruals are based upon forecasted figures provided by the Business Services Authority and estimates undertaken by management based on information available at the end of the financial year, together with past experience.
6 Better Payment Practice Code

Measure of compliance 2018-19

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>£’000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>17,635</td>
<td>320,899</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid within target</td>
<td>17,251</td>
<td>317,886</td>
</tr>
<tr>
<td>Percentage of Non-NHS Trade invoices paid within target</td>
<td>97.8%</td>
<td>99.1%</td>
</tr>
<tr>
<td><strong>NHS Payables</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>5,177</td>
<td>780,456</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>5,115</td>
<td>780,053</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>98.8%</td>
<td>99.9%</td>
</tr>
</tbody>
</table>

7 Net Gain/(Loss) on Transfers by Absorption

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.

On 1 April 2018 NHS Leeds North, West, and South & East CCGs ceased to exist and NHS Leeds CCG was established. The figures shown below are disclosed after adjusting for balances between the three CCGs.

<table>
<thead>
<tr>
<th></th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
</tr>
<tr>
<td>Transfer of property, plant and equipment</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of intangibles</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of cash and cash equivalents</td>
<td>291</td>
</tr>
<tr>
<td>Transfer of receivables</td>
<td>4,506</td>
</tr>
<tr>
<td>Transfer of payables</td>
<td>(64,082)</td>
</tr>
<tr>
<td>Transfer of provisions</td>
<td>(2,795)</td>
</tr>
<tr>
<td>Net loss on transfers by absorption</td>
<td>(62,080)</td>
</tr>
</tbody>
</table>

As NHS Leeds CCG is the recipient in the transfer of a function, it has recognised the assets and liabilities received as at the date of transfer. These balances are disclosed within the Statement of Financial Position and accompanying notes as at 1 April 2018. The corresponding net debit reflecting the loss is recognised within income and expenses as disclosed within the Statement of Comprehensive Net Expenditure, but outside of operating activities.
8 Operating Leases

8.1 As lessee
The CCG occupies property leased and managed by NHS Property Services Ltd (NHS PS). The current lease was signed in March 2018.

8.1.1 Payments recognised as an expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>2018-19</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Land</td>
<td>Buildings</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------</td>
<td>-----------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Minimum lease payments</td>
<td>-</td>
<td>545</td>
<td>3</td>
<td>548</td>
</tr>
<tr>
<td>Contingent rents</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-lease payments</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>545</td>
<td>3</td>
<td>548</td>
</tr>
</tbody>
</table>

8.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>2018-19</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Land</td>
<td>Buildings</td>
<td>Other</td>
<td>Total</td>
</tr>
<tr>
<td>No later than one year</td>
<td>-</td>
<td>253</td>
<td>10</td>
<td>263</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>-</td>
<td>756</td>
<td>2</td>
<td>758</td>
</tr>
<tr>
<td>After five years</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>1,009</td>
<td>12</td>
<td>1,021</td>
</tr>
</tbody>
</table>

NHS Leeds CCG also has arrangements in place with NHS PS and Community Health Partnerships Ltd in respect of the utilisation of various clinical and non-clinical properties. Some of these charges relate to payments made in respect of void / vacant space in clinical properties.

Whilst these arrangements fall within the definition of operating leases, rental charges for future years have not yet been agreed. Consequently this note does not include future minimum lease payments for these arrangements.
9 Trade and Other Receivables

<table>
<thead>
<tr>
<th></th>
<th>31 March 19</th>
<th>1 April 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current £’000</td>
<td>Current £’000</td>
</tr>
<tr>
<td>NHS receivables: revenue</td>
<td>2,188</td>
<td>1,184</td>
</tr>
<tr>
<td>NHS receivables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments</td>
<td>2,444</td>
<td>2,429</td>
</tr>
<tr>
<td>NHS accrued income</td>
<td>640</td>
<td>118</td>
</tr>
<tr>
<td>NHS contract receivables not yet invoiced/non-invoice</td>
<td>113</td>
<td>-</td>
</tr>
<tr>
<td>NHS non contract trade receivables (i.e. pass through funding)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS contract assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and other WGA receivables: revenue</td>
<td>97</td>
<td>92</td>
</tr>
<tr>
<td>Non-NHS and other WGA receivables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and other WGA prepayments</td>
<td>496</td>
<td>416</td>
</tr>
<tr>
<td>Non-NHS and other WGA accrued income</td>
<td>266</td>
<td>77</td>
</tr>
<tr>
<td>Non-NHS and other WGA contract receivable not yet invoiced/non-invoice</td>
<td>49</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and other WGA non contract trade receivables (i.e. pass through funding)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS contract assets</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Expected credit loss allowance - receivables</td>
<td>(6)</td>
<td>(1)</td>
</tr>
<tr>
<td>VAT</td>
<td>115</td>
<td>168</td>
</tr>
<tr>
<td>Private finance initiative and other public private partnership arrangement prepayments and accrued income</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Interest receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Finance lease receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables and accruals</td>
<td>24</td>
<td>23</td>
</tr>
<tr>
<td><strong>Total trade &amp; other receivables</strong></td>
<td><strong>6,426</strong></td>
<td><strong>4,506</strong></td>
</tr>
</tbody>
</table>

As at 31 March 2019 there were no non-current trade and other receivables (none as at 1 April 2018).

There are no prepaid pensions contributions (none as at 1 April 2018).

9.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th></th>
<th>31 March 19</th>
<th>1 April 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DHSC Group Bodies £’000</td>
<td>Non DHSC Group Bodies £’000</td>
</tr>
<tr>
<td>By up to three months</td>
<td>1,653</td>
<td>28</td>
</tr>
<tr>
<td>By three to six months</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>By more than six months</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,659</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

There was no impact of application of IFRS 9 on the financial assets or loss allowances of the CCG at 1 April 2018.
10 Cash and Cash Equivalents

<table>
<thead>
<tr>
<th></th>
<th>31 March 19 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Balance at 1 April 2018</strong></td>
<td>291</td>
</tr>
<tr>
<td><strong>Net change in year</strong></td>
<td>(169)</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td>122</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service: 122
- Cash with commercial banks: -
- Cash in hand: -
- Current investments: -

**Cash and cash equivalents as in Statement of Financial Position**: 122

**Bank overdraft: Government Banking Service**: -
**Bank overdraft: commercial banks**: -

**Total bank overdrafts**: -

**Balance at 31 March 2019**: 122

11 Trade and Other Payables

<table>
<thead>
<tr>
<th></th>
<th>31 March 19 Current £'000</th>
<th>1 April 18 Current £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest payable</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS payables: revenue</td>
<td>2,252</td>
<td>4,078</td>
</tr>
<tr>
<td>NHS payables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals</td>
<td>3,631</td>
<td>4,914</td>
</tr>
<tr>
<td>NHS deferred income</td>
<td>-</td>
<td>10</td>
</tr>
<tr>
<td>NHS contract liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and other WGA payables: revenue</td>
<td>4,803</td>
<td>5,768</td>
</tr>
<tr>
<td>Non-NHS and other WGA payables: capital</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS and other WGA accruals</td>
<td>45,892</td>
<td>47,646</td>
</tr>
<tr>
<td>Non-NHS and other WGA deferred income</td>
<td>142</td>
<td>61</td>
</tr>
<tr>
<td>Non-NHS contract liabilities</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>208</td>
<td>184</td>
</tr>
<tr>
<td>VAT</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>185</td>
<td>184</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other payables and accruals</td>
<td>1,066</td>
<td>1,237</td>
</tr>
</tbody>
</table>

**Total trade & other payables**: 58,179 64,082

As at 31 March 2019 there were no non-current trade and other payables (none as at 1 April 2018).

Other payables include £1,053k outstanding pension contributions at 31 March 2019 (£1,184k at 1 April 2018).

There was no impact of application of IFRS 9 on the financial liabilities of the CCG at 1 April 2018.
### 12 Provisions

<table>
<thead>
<tr>
<th></th>
<th>31 March 19</th>
<th>1 April 18</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Current</td>
<td>Non-current</td>
</tr>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Continuing care</td>
<td>481</td>
<td>851</td>
</tr>
<tr>
<td>Other</td>
<td>2,934</td>
<td>535</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3,415</strong></td>
<td><strong>1,386</strong></td>
</tr>
<tr>
<td><strong>Total current and non-current</strong></td>
<td><strong>4,801</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Provisions

<table>
<thead>
<tr>
<th></th>
<th>Continuing Care</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td><strong>Balance at 1 April 2018</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Arising during the year</td>
<td>855</td>
<td>2,868</td>
<td>3,723</td>
</tr>
<tr>
<td>Utilised during the year</td>
<td>(347)</td>
<td>(118)</td>
<td>(465)</td>
</tr>
<tr>
<td>Reversed unused</td>
<td>(901)</td>
<td>(351)</td>
<td>(1,252)</td>
</tr>
<tr>
<td>Transfer (to)/from other public sector body under absorption</td>
<td>1,725</td>
<td>1,070</td>
<td>2,795</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2019</strong></td>
<td><strong>1,332</strong></td>
<td><strong>3,469</strong></td>
<td><strong>4,801</strong></td>
</tr>
</tbody>
</table>

**Expected timing of cash flows:**
- **Within one year**: 481, 2,934, 3,415
- **Between one and five years**: 851, 535, 1,386
- **After five years**: -

**Balance at 31 March 2019**: 1,332, 3,469, 4,801

---

### 12.1 Continuing care

The provision for Continuing Care relates to potential cost for continuing care reviews. There is uncertainty regarding the outcomes and timings of 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 2019 is £nil (1 April 2018: £51k).

### 12.2 Other

Other current provisions relate to: HMRC’s ongoing review of supplies made under the Lead Provider agreements £1.7m; VAT consideration with respect to transactions between Leeds CCG, the former Leeds CCGs, and the GP Federations/Confederations £1.2m; and VAT recovery subject to a HMRC clearance review £47k.

Other non-current provisions relate solely to future dilapidation costs for the leased building the CCG occupies.
13 Other Financial Commitments
The CCG has entered into non-cancellable contracts (which are not leases, private finance initiative contracts or other service concession arrangements) which expire as follows:

<table>
<thead>
<tr>
<th></th>
<th>31 March 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>In not more than one year</td>
<td>£6,130</td>
</tr>
<tr>
<td>In more than one year but not more than five years</td>
<td>-</td>
</tr>
<tr>
<td>In more than five years</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>£6,130</strong></td>
</tr>
</tbody>
</table>

14 Financial Instruments

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

Treasury management operations are carried out by the finance department, within parameters defined formally within the clinical commissioning group standing financial instructions and policies agreed by the Governing Body.

Treasury activity is subject to review by the clinical commissioning group and internal auditors.

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

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

14.1.3 Credit risk
Because the majority of the clinical commissioning group’s revenue comes from parliamentary funding, the clinical commissioning group has low exposure to credit risk. The maximum exposures as at the end of the financial year are in receivables from customers, as disclosed in the trade and other receivables note.

14.1.4 Liquidity risk
The clinical commissioning group is required to operate within revenue and capital resource limits, which are financed from resources voted annually by Parliament. The clinical commissioning group draws down cash to cover expenditure, as the need arises. The clinical commissioning group is not, therefore, exposed to significant liquidity risks.
## 14 Financial Instruments (continued)

### 14.2 Financial assets

<table>
<thead>
<tr>
<th>Financial Assets measured at amortised cost</th>
<th>31 March 2019</th>
<th>Equity Instruments designated at FVOCI</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Equity investment in group bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Equity investment in external bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loans receivable with group bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loans receivable with external bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other receivables with NHSE bodies</td>
<td>1,687</td>
<td>-</td>
<td>1,687</td>
</tr>
<tr>
<td>Trade and other receivables with other DHSC group bodies</td>
<td>1,254</td>
<td>-</td>
<td>1,254</td>
</tr>
<tr>
<td>Trade and other receivables with external bodies</td>
<td>412</td>
<td>-</td>
<td>412</td>
</tr>
<tr>
<td>Other financial assets</td>
<td>24</td>
<td>-</td>
<td>24</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>122</td>
<td>-</td>
<td>122</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td>3,499</td>
<td>-</td>
<td>3,499</td>
</tr>
</tbody>
</table>

### 14.3 Financial liabilities

<table>
<thead>
<tr>
<th>Financial Liabilities measured at amortised cost</th>
<th>31 March 2019</th>
<th>Other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>Loans with group bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Loans with external bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Trade and other payables with NHSE bodies</td>
<td>287</td>
<td>-</td>
<td>287</td>
</tr>
<tr>
<td>Trade and other payables with other DHSC group bodies</td>
<td>38,802</td>
<td>-</td>
<td>38,802</td>
</tr>
<tr>
<td>Trade and other payables with external bodies</td>
<td>17,488</td>
<td>-</td>
<td>17,488</td>
</tr>
<tr>
<td>Other financial liabilities</td>
<td>1,066</td>
<td>-</td>
<td>1,066</td>
</tr>
<tr>
<td>Private Finance Initiative and finance lease obligations</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total at 31 March 2019</strong></td>
<td>57,643</td>
<td>-</td>
<td>57,643</td>
</tr>
</tbody>
</table>
15 Operating Segments

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

16 Joint Arrangements

16.1 Interests in joint operations

The joint operations of the CCG relate solely to Pooled Budget BCF arrangements.

The clinical commissioning group has entered into pooled budget arrangements with Leeds City Council. The Pools are hosted by either the CCG or Leeds City Council. Under the arrangement funds are pooled under Section 75 of the NHS Act 2006 for the Better Care Fund.

The contributions made by NHS Leeds Clinical Commissioning Group in the financial year are as follows:

<table>
<thead>
<tr>
<th>Pooled Budget Fund 1 CCG Hosted s75 Agreements</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£000</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(22,389)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pooled Budget Fund 2 Leeds City Council Hosted s75 Agreements</th>
<th>2018-19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>£000</td>
</tr>
<tr>
<td>Expenditure</td>
<td>(22,312)</td>
</tr>
</tbody>
</table>

£22m was paid as a whole of Leeds direct grant to the local authority during 2018-19 as determined by the 2017 Spring Budget in relation to an increased allocation to the Improved Better Care Fund (iBCF). This was not included in the BCF Section 75 agreement between the local authority and the CCG during 2018-19 and therefore is not included in the above figures.

A further £7.5m, relating to non-elective admissions, also forms part of the BCF but is not included in the Section 75 agreement and is therefore also excluded from the above figures.
17 Related Party Transactions

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

<table>
<thead>
<tr>
<th>Payments to Related Party</th>
<th>Receipts from Related Party</th>
<th>Amounts owed to Related Party</th>
<th>Amounts due from Related Party</th>
</tr>
</thead>
<tbody>
<tr>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
</tbody>
</table>

Entities related to NHS Leeds CCG governing body members:

Lofthouse Surgery - Dr Ben Browning 1,365 - 38 -
Burton Croft Surgery - Dr Gordon Sinclair 1,510 - 60 -
Leeds City Council - Dr Ian Cameron 56,864 1,448 2,888 36
Oakwood Lane Medical Practice - Dr Jason Broch 1,923 - 49 -
Leeds Student Medical Practice - Dr Julianne Lyons 3,895 - 38 -
Kirkstall Lane Medical Centre - Dr Keith Miller 678 - 17 -

The DHSC 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 parent. These entities are listed below:

- Airedale NHS Foundation Trust
- Bradford Teaching Hospitals NHS Foundation Trust
- Harrogate and District NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Leeds Community Healthcare NHS Trust
- Leeds Teaching Hospitals NHS Trust
- Mid Yorkshire Hospitals NHS Trust
- NHS England
- Tees, Esk & Wear Valleys NHS Foundation Trust
- York Teaching Hospital NHS Foundation Trust
- Yorkshire Ambulance Service NHS Trust
18 Events After the End of the Reporting Period

There are no adjusting post balance sheet events which will have a material effect on the financial statements of the CCG.

19 Losses and Special Payments

The total number of losses and special payments cases, and their total value, was as follows:

19.1 Losses

<table>
<thead>
<tr>
<th>Category</th>
<th>2018-19 Total Number of Cases</th>
<th>2018-19 Total Value of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative write-offs</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Fruitless payments</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Store losses</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Book keeping losses</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Constructive loss</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Cash losses</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Claims abandoned</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
</tr>
</tbody>
</table>

19.2 Special payments

The CCG made no special payments in the year.

20 Financial Performance Targets

NHS Clinical Commissioning Groups have a number of financial duties under the NHS Act 2006 (as amended).

The CCG’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>Category</th>
<th>2018-19 Target £’000</th>
<th>2018-19 Performance £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Expenditure not to exceed income</td>
<td>1,235,405</td>
<td>1,230,320</td>
</tr>
<tr>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>1,232,814</td>
<td>1,227,729</td>
</tr>
<tr>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>17,562</td>
<td>14,713</td>
</tr>
</tbody>
</table>