Chair and Clinical Chief Officer’s Foreword

This is our first annual report in our capacity as Chair and Clinical Chief Officer of NHS Leeds South and East Clinical Commissioning Group (CCG). As a CCG we are committed to commissioning services that meet the needs of our population, and this wouldn’t be possible without the hard work of our staff; the active engagement of our member general practices; the commitment of our partner organisations; and the continuous learning of our key providers, so thank you for all your work throughout what has been a very busy and challenging, yet rewarding first year.

We would also like to acknowledge and say thank you to the previous body responsible for commissioning services for the people of Leeds; NHS Leeds (Leeds Primary Care Trust: PCT). Building on the foundations laid by Leeds PCT we have been able to support our providers in continuing to perform at a level that ensures our patients benefit from high quality, clinically effective care; care that is provided in a safe environment and in a timely manner.

As we contemplate and reflect on our first year as a statutory NHS organisation, we feel a sense of real achievement. With our 43 member general practices, the foundation of our organisation, we have come through the biggest reform in the history of the English health and care system. Despite some of the headlines you may have seen in the media, we are proud of the fact that the NHS both locally and nationally has continued, on the whole, to provide high-quality, safe services to our patients.

Throughout our Annual Report, we will share with you our key successes and achievements that have really stood out from 2013-2014. Our innovative work continues to draw interest both regionally and nationally, and we are really proud to be leading on behalf of the city the integration of health and social care services in Leeds. As a result of this ground-breaking work in 2013-2014 the city of Leeds became one of fourteen sites to be selected by the Department of Health (DoH) to be a ‘Pioneer’. A status that gives us tailored, national support to implement at scale and pace our plans for integrated care.

NHS Leeds South and East CCG also received national recognition for the work it was doing to improve care for residents in care homes. Our approach to proactive, patient centred care was featured in a new publication produced by NHS Clinical Commissioners.

We were also really pleased with the response we received to the Call to Action Leeds, which was part of the national NHS England Call to Action debate. We have reflected on the views of our patients, carers, the wider public, health and care professionals and our partners to help us develop a picture of where we are now and where we want to be in the future, to make a sustainable NHS for generations to come. Your views have helped us to understand more about what you value and what you expect, and this has in turn helped us when we have been working on our two year operational plan for 2014-2015-2016.

We will continue to work collaboratively with our key partners, member general practices and the population we serve, in the planning, commissioning and
development of services. By learning and working together, we can go a long way in achieving our vision of ‘improving the health and wellbeing of our local communities’.

We would like to take this opportunity to thank everyone again for their hard work, enthusiasm and commitment. We are proud to lead this organisation and we look forward to working in partnership with you all over the coming years in making Leeds a truly pioneering city for health and wellbeing.

Philip Lewer
Chair

Dr Andy Harris
Clinical Chief Officer
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1.0 Introduction

This has been my first year as Chair of NHS Leeds South and East Clinical Commissioning Group (CCG) and what a year it has been, one full of excitement and challenge, as we continue to commission high quality, safe services for the population of Leeds, where our predecessor Leeds Primary Care Trust left off.

I would like to start by saying thank you to everyone who has supported me in my new role, and who has made my first year as Chair so rewarding. Throughout my first year, I have made a conscious effort in meeting with as many of you as possible, from members of staff to key stakeholders and patients, to local councillors and members of parliament, and this is an aspect of my role as Chair I thoroughly enjoy and plan to continue throughout 2014-2015 and beyond. This will also be something I will continue to encourage members of the Governing Body to do too, as without listening to you, our staff, our key partners and patients, how do we know we are successfully fulfilling our duty in commissioning first-class health care services that really meet the needs of the population of Leeds.

In my role as Chair, I have been lucky to have been supported throughout 2013-2014 by a dedicated Governing Body made up of Executive Directors and Non-Executive Directors. It has been a pleasure working with a group of individuals who are so passionate about making a real difference to the health and wellbeing of the population of Leeds. I would like to thank in-particular one of the GP Non-Executive Directors – Dr Daniel Albert who has recently stepped down from his role as a member of the Governing Body, but whom I am sure will continue in providing an outstanding level of care for the patients he meets.

During 2013-2014 an external review of the effectiveness of the CCG’s governance arrangements, which included the Governing Body and its committee structures, was undertaken. A detailed action plan was put in place to deliver the changes necessary to achieve this objective and to further strengthen the systems to support effective governance across the CCG. Implementation of the changes was overseen by the Audit Committee and was widely consulted upon within the organisation. This resulted in a revised Governing Body Committee structure featuring the establishment of a Quality sub-committee and a Finance, Activity and Performance sub-committee. The new arrangements came into effect from 1 April 2014, and it is anticipated that the changes will increase the effectiveness of the Governing Body in a number of ways: by enabling increased scrutiny and challenge of quality and performance; providing learning and development opportunities for non-executives and supporting them in developing their understanding of the work of the CCG; and by strengthening the assurance the Governing Body receives on the achievement of the CCG strategic aims and statutory duties.

I am proud to work for an organisation that has begun to make real improvements to the health priorities of our local population in just twelve months of operating, by demonstrating progress in the following key areas:

- Integrated Health and Social Care – receiving national recognition and ‘pioneer status’ for our work in joining up services in health and social care in Leeds;
• The Better Care Fund – developing plans to help us put in place our innovative programmes of integration, transforming local health and social care services;
• Investment in public health and prevention measures; and
• Development of a Primary Care Strategy – improving the quality of primary care to meet the health needs of the people in south and east Leeds.

The Governing Body remains committed to operating in an open culture, meeting and discussing issues in the public domain. We know there have been occasions during the past twelve months where we have experienced extreme pressures on the system, but I believe by operating in a transparent culture, we can make a real difference in improving the quality of patient care.

Throughout 2013-14, the full Governing Body has been involved in a development programme with a focus on a range of areas including:

• The CCG operational plan;
• Safeguarding;
• Better Care Fund; and
• Communication, engagement and equality and diversity strategy.

As we go forward into 2014-2015, we are aware that our capability as an organisation will evolve over time and we are committed and passionate about becoming an excellent and leading CCG. We started the ball rolling in October 2013, when the Governing Body made a commitment to embed the principles of best practice through every area of our organisation and we will be using the Investors in Excellence standard to help us achieve our ambition of becoming a leading organisation of excellence. Initial areas of organisational improvement work have included the refresh of our values which were signed off in March 2014 by the Governing Body following staff and member engagement; development of an organisation wide behaviours framework that was developed with our staff to form a key part of performance development within the organisation; and the approach to the development of our two year Operational Plan from 2014-15. The Governing Body will be involved in further development and prioritisation of the range of organisational improvement programmes in 2014-15.

Once again, I would like to say a huge thank you to everyone who has supported me in my role. I hope my second year as Chair will continue as the first, full of opportunity, and I look forward to your continued support and working with you all.

Philip Lewer
Chair
2.0 Strategic Report

This is the first NHS Leeds South and East Clinical Commissioning Group (CCG) Annual Report and Accounts and covers the financial year 1 April 2013 to 31 March 2014.

2.1 About us

NHS Leeds South and East Clinical Commissioning Group (CCG) became a formal statutory body on 1 April 2013. We are one of three CCGs in the city responsible for planning and funding (commissioning) health services for the people in Leeds working in collaboration with NHS Leeds North CCG and NHS Leeds West CCG.

We took over the planning and funding of healthcare services from our predecessor body Leeds Primary Care Trust (NHS Leeds) which was abolished on 31 March 2013 as part of the government’s health and social care reforms. An NHS membership organisation, comprising 43 member practices in the south and east area of Leeds, we support a population of around 257,000 and in 2013-14 we had a programme (healthcare) cost allocation of £341.6 million.

Our area includes some of Leeds’ most deprived communities as well as some more affluent rural areas on the outskirts of the city. Over 20% of our population are from minority ethnic communities and there are a greater proportion of people within the CCG area living with existing health problems than the Leeds average. This means that in affluent areas of south and east Leeds, people can expect to live on average 10 years longer than in some of the more deprived areas. One of our key aims for 2013-14 has been to tackle the health inequalities affecting people living in south and east Leeds so that we can reduce the 10 year difference in life expectancy and this will continue to be one of our aims going into 2014-15 and beyond.

We believe that as an organisation one of our strengths is in our leadership. We are led by clinicians including healthcare professionals, GPs, nurses, and hospital consultants and by professional managers, and through this wealth of experience and range of skills we can make a real difference to local health services.

Our Constitution sets out our arrangements for discharging our statutory responsibilities for commissioning health care on behalf of our population. It describes our governing principles, rules and procedures that ensure probity and accountability in the day to day running of our CCG, clarifying how decisions are made in an open and transparent way and in the interest of our patients and the public. Our strategic aims describe how we will drive improvement in quality and outcomes and encourage innovation.

We are committed to involving patients, carers and the public in everything we do and look to actively engage with all sections of our diverse communities.

To find out more about the work we do and to download a copy of our patient prospectus and Clear and Credible Plan 2013-14 please visit: www.leedssouthandeastccg.nhs.uk
2.2 Our Business

Our vision is to “improve the health and wellbeing of our local population, to reduce inequalities and commission high quality, safe, sustainable health services for all”.

We know that there are a number of health issues affecting our communities including:

- There is a gap in life expectancy of almost 10 years between the most affluent and most deprived areas of south and east Leeds;
- The population of south and east Leeds has a lower average life expectancy than the population of Leeds as a whole;
- Only 25% of children, young people, families and adults are classified as healthy compared to 34% for Leeds as a whole;
- Over 19% of the south and east Leeds population have an existing health problem, which is above the England average;
- Rates of people with Chronic Obstructive Pulmonary Disease and asthma are higher than the national average;
- Rates of people with Coronary Heart Disease are higher than the national average;
- Mental health issues are higher in south and east Leeds than the national average;
- Infant mortality rates (the death of a child before it reaches one year old) are amongst the highest in Leeds;
- More people from south and east Leeds are admitted to hospital for alcohol-related liver disease; and
- Smoking, obesity rates and alcohol misuse are higher than the Leeds average.

Our Clear and Credible Plan for 2013-14 was developed based on our understanding of the health needs of our population, our understanding of the healthcare system in Leeds, national guidance and our contribution to citywide plans for Leeds.

The development and agreement of the five strategic aims and underpinning objectives involved engagement with member practices, stakeholders and with members of the Leeds south and east population. This engagement has continued throughout 2013-14. Clinical input to the plan comes through our engagement with member practices but also through the role of clinical commissioning leads. Our plans are developed and assured through the Clinical Commissioning Forum which brings together senior clinical, managerial and public health managers.
2.3 Strategic aims and objectives
The strategic aims and objectives were agreed as:

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<tr>
<th>Strategic Aim</th>
<th>Strategic Objectives</th>
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<td><strong>Strategic Aim</strong></td>
<td><strong>To improve prevention, detection, treatment, management and rehabilitation for Key Causes of Premature Mortality and Morbidity</strong></td>
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<td><strong>Strategic Objectives</strong></td>
<td><strong>To address lifestyle issues of smoking and obesity across the population of Leeds South and East.</strong></td>
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<td></td>
<td><strong>To improve detection, treatment, management and rehabilitation for Ischemic Heart Disease and Stroke</strong></td>
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<td></td>
<td><strong>To improve detection, treatment, management and rehabilitation for Chronic Obstructive Pulmonary Disease.</strong></td>
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<td><strong>To improve detection, treatment, management and rehabilitation for diabetes.</strong></td>
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<tr>
<td></td>
<td><strong>To improve, detection, treatment, management and care for mental and emotional health including dementia care</strong></td>
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<td><strong>To improve prevention, identification, management and detoxification for alcohol</strong></td>
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<td><strong>To improve infant and child health and address the needs of looked after children</strong></td>
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<td><strong>To improve End of Life Care</strong></td>
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<td><strong>To contribute to addressing issues of poverty and deprivation</strong></td>
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<td><strong>Strategic Aim</strong></td>
<td><strong>To improve the quality and safety and patient experience of commissioning, commissioned services and primary care.</strong></td>
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<tr>
<td><strong>Strategic Objectives</strong></td>
<td><strong>To ensure quality and safety of services</strong></td>
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<td><strong>To improve the health of the LSE population by optimising use of medicines</strong></td>
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<td><strong>To reduce unwarranted variation in Primary Care referrals to improve quality of referrals</strong></td>
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<td><strong>Strategic Aim</strong></td>
<td><strong>To develop patient and public empowerment, increase choice and personalisation of care.</strong></td>
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<td><strong>Strategic Objectives</strong></td>
<td><strong>Develop a robust programme to improve and expand Self Care</strong></td>
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<td><strong>Implement Patient and Public Engagement Strategy</strong></td>
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<td><strong>Strategic Aim</strong></td>
<td><strong>To Develop a Seamless Care System</strong></td>
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<td><strong>Strategic Objectives</strong></td>
<td><strong>To integrate Health &amp; Social Care teams – outlined in Section 4 Transformation</strong></td>
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<td><strong>To commission seamless and mutually supportive community and primary care services</strong></td>
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<td><strong>Strategic Aim</strong></td>
<td><strong>To deliver continuous improvement in health and social care within available resources</strong></td>
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<td><strong>Strategic Objectives</strong></td>
<td><strong>Ensure that spend of the CCG reflects the commissioning strategy, priorities and intentions.</strong></td>
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<td><strong>Develop and agree with providers a systematic plan for proposals service reviews and service development</strong></td>
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<td><strong>Develop market management strategy</strong></td>
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Table 1: Strategic aims and objectives
The strategic aims are underpinned by a number of objectives and workstreams, with detailed action plans to deliver them, which constitute the business plan for the organisation.

The Clear and Credible Plan 2013-14 also identified the key performance measures for each aim, objective and workstream. These measures reflect our responsibilities to deliver the NHS Constitution and NHS Outcomes Framework. This ensures that the plan delivers against local need and national priorities.

The CCG tracks performance using a comprehensive integrated performance report.

The delivery of the business plan involves a collaborative commissioning arrangement with NHS Leeds North CCG and NHS Leeds West CCG. Each of the Leeds CCGs leads on commissioning and contracting for one sector and hosts a collaborative commissioning and contracting team who deliver work on behalf of the three CCGs.

NHS Leeds South and East CCG has responsibility as the citywide lead on children and families services, community healthcare and continuing healthcare to ensure that patients can benefit from high quality and effective care. NHS Leeds South and East CCG also host the Safeguarding Children and Adults Team which provides a safeguarding service to staff across the three Leeds CCGs.

NHS Leeds South and East CCG is also the lead on Integration of Health and Social Care services. We have achieved pioneer status for this transformational work having been selected as one of fourteen sites nationally by the Department of Health (DH) to be given tailored, national support, in implementing our integration plans.

We have also worked with our partner CCGs to make sure that the needs and views of our diverse communities are recognised when they commission other citywide services. This means that we can ensure equitable access to hospital services, the development of mental health and learning disability services for adults that are effective and safe and urgent and emergency care that is easily accessible for all. The annual reports of our partner CCGs will include information on how they have lead on developing these services.

The business planning process was reviewed by internal audit in 2013-14 and the recommendations of that review have been addressed in the 2014-16 business planning process. A review of the strategic planning process is currently being undertaken. The CCGs own assessment of the business plans has led to revised strategic aims and workstreams for 2014-16 which are described in the ‘Looking to the Future’ section of this Annual Report. The review has taken account of feedback from the Governing Body, additional benchmarking analysis made available during 2013-14, additional public engagement and development of strong collaborative commissioning arrangements with NHS Leeds North CCG, NHS Leeds West CCG and Leeds City Council.

The 2014-16 Operational Plan will be delivered through the implementation of a corporate programme management structure with robust project planning.
2.4 Resources and how they are managed

NHS Leeds South & East CCG started the financial year forecasting a £6.8m surplus in the financial plan presented to the Shadow Governing Body in March 2013. Investment and resource plans were primarily focussed on priorities which would have the greatest impact on the health and wellbeing of the people of Leeds south and east. Accordingly, in a range of national and local priorities agreed with our partners, NHS Leeds South and East CCG set aside funds to invest in a number of key areas already highlighted in this annual report.

To help fund this significant investment a number of ambitious quality, innovation, productivity and prevention (QIPP) savings or cost avoidance schemes were identified to deliver a target of £6.1m. The CCG achieved this target.

The chart below provides a breakdown of the key areas of expenditure for the financial year 1 April 2013 to 31 March 2014.

Note:
(1) 2% Headroom meets the national requirement to commit 2% of the CCG's allocation non recurrently.
(2) National guidance requires the CCG to plan for an in year surplus.
This excludes CCG running costs, which are funded through a separate allocation. Values are in £000.

Figure 1: chart to show breakdown of expenditure for financial year 1 April 2013 to 31 March 2014
Further details of the CCG’s financial performance is shown in the annual accounts for the financial year ending 31 March 2014.

The Governing Body is responsible for maintaining a sound system of internal control that supports the achievement of the CCGs policies, aims and objectives. This is detailed further within the Annual Governance Statement.

2.5 Developing and investing in services in 2013-14

In 2013-14, we invested in a range of developments designed to drive improvements in quality and outcomes for our patients, their families and carers. This includes services that ensure our population has the best start in life, access to the right services at the right time throughout their lives, through to ensuring a dignified end of life. Our commissioning of services is based on the best available clinical evidence, input from a range of health and care professionals and feedback from our patients, carers and the wider public, and we have achieved a lot in our first year.

The below information details some of the key areas of progress across a range of service areas in 2013-14 covering:

- Children and maternity services
- Community services
- Continuing Care
- Safeguarding children and vulnerable adults

2.5.1 Children and maternity services

As one of the key priorities of the Leeds Health and Wellbeing Strategy, we are committed to ensuring everyone has the best start in life possible. A signatory of the Child Friendly Leeds initiative, we have achieved a lot in our first year in operation, working with our partners and a range of organisations that help us to listen to the views of children and young people and really make a difference.

Maternity services in Leeds

During 2013-14 a significant piece of engagement work was undertaken as part of a commissioning review of proposed changes to the current maternity and neonatal service. Following a comprehensive stakeholder analysis and a consultation of service users, Leeds commissioners are prioritising maternity services in developing a clear five-year strategy in 2014-15; this will build on the engagement feedback, and service user views will continue to be gathered to inform the strategy.

Infant Mental Health Services

During 2013-2014 a new Infant Mental Health Service (IMHS) was commissioned by the Leeds CCGs; during 2014-2015 this will become a jointly commissioned service with the local authority. This new specialist service provides expertise on parent/child attachment by providing training, consultancy and direct intervention for complex cases to those involved in delivering children's services including midwives, health visitors, children centres and family nurses. Next year this will expand to include more targeted stakeholders, such as foster carers of young infants and social workers who undertake pre-birth assessments.
Child and Adolescent Mental Health Services
We continue to see significant pressure on Child and Adolescent Mental Health Services (CAMHS) and have recognised that current waiting lists need addressing. As a result we have been undertaking an analysis of current service provision and demand to see how we can use CAMHS and other services we commission to support children and young people who are experiencing problems that affect their emotional wellbeing. We have already introduced or are working on improved pathways for health and care professionals so that they can ensure children and young people can quickly access the support they need. An innovative use of Commissioning for Quality and Innovation (CQUIN) as a lever during 2013-14 has delivered a clear pathway across community CAMHS and the emergency departments at Leeds Teaching Hospitals NHS Trust for the safe and effective management of young people presenting with self-harm.

Targeted Adolescent Mental Health Services
In an effort to address concerns around access to mental health services for young people directly from their GP a pilot project has been set up with two school clusters in south and east Leeds. A new referral form has been developed so that GPs can direct children attending the relevant schools to access a range of services including behaviour management, bereavement support and CAMHS in schools. As the one year pilot draws to an end we will look at the effectiveness of the programme before we consider future approaches to support GPs.

Young people who self-harm
Young people who self-harm have been identified by a wide range of professionals as an increasing concern. In an effort to address this we have commissioned a play that will be co-produced with young people and shown in 12 schools in 2014. This will be supplemented with a suite of information resources for a range of professionals including healthcare staff, teachers and school support staff. In 2014-2015 we will be working on developing online tools including a microsite to educate and inform children and young people about self-harm as well as providing signposting information for professionals and parents/carers.

Children who are Looked After and Care Leavers
We have been working with Leeds Community Healthcare NHS Trust and colleagues from children's services at Leeds City Council to offer timely and quality initial Health Needs Assessment (HNAs) for Children who are Looked After. Work is underway to commission the local health team within Leeds Community Healthcare NHS Trust to undertake review HNAs for Leeds children who are looked after and placed out of area but within a 40/50 mile boundary. During 2014-15 the commissioned health team for children who are looked after will expand its remit to provide a service offer for care leavers.

Children with complex needs and disabilities
The Children and Families Bill heralds a transformational change for the commissioning, provision and most importantly experience of services for children and young people with complex needs. Key drivers are personalisation, integration and more control for parents and disabled young people. During 2013-14 a programme of work began to ensure children with complex need get the best possible start in life. This programme of work is led by the CCGs and involves Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and
York Partnership NHS Foundation Trust, the third sector and key partners in the local authority. Work is also underway to define the processes and currency/prices for children continuing care packages - in readiness for the ‘right to request’ a personal budget from April 2014. We are also working with families to co-produce care pathways based on the principles of experience based design - so that the views of families and more importantly their experiences can help shape future delivery of care.

**Care leavers**
A new pathway was developed in 2013-2014 to look after care leavers as we identified them as a key vulnerable group with up to 80% of this cohort having emotional problems. We made two key investments to address this. We set funding aside for The Market Place to offer face to face counselling and a two year pilot project has been set up with Mindfulness to improve online counselling. In 2014-2015 we will be working with partners to advertise these new services and evaluating their effectiveness.

**2.5.2 Community health services**

In our first year we have been developing relationships with providers of community health services and have ensured that funding has been made available to fund existing services as well as commissioning new services where a need has been identified. Over the previous 12 months we have led on key pieces of work including end of life care, the Leeds Carers Strategy and bringing services closer to home.

**District nursing**
We have worked with Leeds Community Healthcare NHS Trust to address an identified need to increase the provision of district nursing in the city. As a result an extra 18 staff have been employed and a wider service review undertaken resulting in a new service specification. This investment was a direct response to patient and public feedback. We are currently piloting two sites, one within our CCG area in Hunslet and the other in Wetherby, looking at future mobile working options.

**Community dietetics eating and drinking service**
The Eating and Drinking Service has been recurrently funded to provide dietician led prescribing of oral nutritional supplements (ONS). Patients with signs of malnutrition are sometimes inappropriately prescribed ONS. The current annual spend on ONS in Leeds is approximately £1.7million for around 1500 patients. Our investment in the service is designed to improve the quality of patient care through nutritional intervention, and clinical and cost effective ONS usage to reduce the risk of patients being malnourished when they return to their home.

**Adult speech and language therapy**
We have invested in a citywide adult speech and language therapy service providing clinic and home (domiciliary) assessment and treatment. The service has increased access for adults across the city and is the first time a comprehensive community service has been widely available in Leeds. The aim of the service is to reduce the length of hospital stays for patients, to train health and social care teams to support patients more effectively and to develop more simplified care pathways.
Community falls services
Older people are more at risk from falling due to a number of health related conditions. The affect a fall can have not just on their mobility but also their ability to lead independent lives means it is important that they are supported should they experience a fall. It is equally important that they are aware of how they can prevent falls. This year additional resources were allocated to increase the capacity within the city wide falls service which provides rehabilitation support, falls prevention advice and a signposting service. Furthermore the recruitment of an additional physiotherapist enhanced the qualified therapist capacity.

Community stroke service
Having a stroke is a traumatic and life changing experience for a patient and their wider family and friend’s network. It is important that once a patient leaves hospital they have adequate support available to them in the community in an effort to aid the recovery process. We have set aside funding to increase the capacity of stroke services to meet the demand for services when a patient is discharged from hospital. This funding has improved access for patients to community stroke services and improved access to rehabilitation interventions.

Cardiac services
Investment in 2013-14 into the specialist cardiac nursing services means that patients can now access specialised support at weekends. This has already seen a decrease in the number of patients readmitted to hospital as a result of more responsive care within a community setting and has enabled patients with complex health needs to be treated within their own homes.

Chronic obstructive pulmonary disease management
One of the CCG's key aims is to improve the management of patients who have a collection of respiratory conditions often referred to as chronic obstructive pulmonary disease (COPD). We have increased community staff resource to work within a hospital setting, to support patients at home following early discharge from hospital and provide disease management advice and support. We have developed integrated care pathways for chronic disease management, acute management and supported early discharge scheme (SEDS) in partnership with respiratory clinicians across the community and hospital respiratory teams. These pathways will be implemented in 2014-2015.

Complex leg ulcer care
The development of complex leg ulcer clinics in the community has increased access for patients to specialist nursing assessment and treatment. Additionally it has increased the capacity of practice nurses who are now able to refer patients to these clinics. At present approximately 10-12 patients per week are travelling to Leeds General Infirmary's Dermatology Clinic with complex leg ulceration who could receive their assessment and care in the community. It is anticipated that the clinics will help reduce the current waiting times for an appointment in dermatology.
Discharge facilitators
Investment has been made to increase the number of in-reach discharge facilitators and therefore to increase the capacity of the early assessment discharge team at Leeds Teaching Hospitals NHS trust. This will:

- Improve the quality of the discharge process and ensure a smoother transition for patients;
- Reduce the length of stay for a patient in hospital and reduce the risk of readmission as a direct result of discharge planning or communication; and
- Reduce the amount of discharge related incidents.

Community antibiotics service
The Community Antibiotics Service has successfully managed to reduce length of stay for people being treated within hospital. Most patients with severe infections can be switched from IV (drips) antibiotics to tablets and sent home. Occasionally, some patients need to remain on IV treatment for many weeks, and until recently needed to stay in hospital. Outpatient or home antibiotic therapy (OPAT) has been used for many years in other hospitals in the UK. Leeds Teaching Hospitals NHS Trust and Leeds Community Healthcare NHS Trust received funding until the end of March 2014 to set up an OPAT service. The service means that community nurses visit patients in their own home to give antibiotics, and patients are reviewed by a consultant each week in the OPAT clinic at St James’s. Since it started at the end of October, 15 patients have completed treatment, saving an average of 10 bed days per patient (range 3 to 28). This equates to an extra two beds being permanently available for other patients.

End of life care
We have undertaken extensive engagement with patients, staff and service providers to get a better understanding of how the end of life processes currently work in Leeds and areas that we can improve on to ensure everyone has a dignified end of life experience that most closely meets their needs.

In the last 12 months we have been:
- Running an extensive engagement project to find out more about people’s understanding and experience of end of life care which led into a public health needs assessment for end of life care;
- Engaging with the Leeds hospices to develop a shared service specification to enhance choice at end of life and ensure an equitable standard of service across Leeds;
- Delivering additional palliative care education to nurses and doctors through a citywide education programme;
- Delivering additional palliative care education to GPs including identification of patients at end of life, care in the last days of life and communication skills;
- Setting up a pilot project to explore how hospices can improve the support to and care of patients nearing the end of life;
- Establishing a seven day Clinical Nurse Specialist Service for Palliative Care which has the flexibility to respond to the changing needs of patients within community and in-patient settings; and
- Developing a joined up plan including all our providers and staff in primary care, taking steps together to improve the quality of end of life care in line with National Institute of Health and Care Excellence (NICE) end of life standards.
We are now developing an end of life commissioning strategy building on the findings of our review and the health needs assessment to improve patient experience and choice at end of life.

Support for carers
We recognise how important carers are to the delivery of health and care services and the impact on health outcomes. We understand and appreciate the support of unpaid carers who have such a positive impact on the Leeds health economy. We could not manage the care of adults and children with health or other care needs or disabilities without them. That is why we are working with our partners to implement the Leeds Carers Strategy 2014-2017.

In 2013-2014 we have been:

- Working with Leeds City Council (Adult Social Care) to develop the health component in the Carers’ Strategy 2014-2017 to support carers aiming to reduce carer breakdown and reduce admissions to hospital;
- Jointly funding access to respite services both residential, at home and a new system that provides personal budgets for carers;
- Developing a two year pilot for carers at the heart of neighbourhood to support them at a time of crisis;
- Funding a one year pilot to provide a bereavement service for carers;
- Rolling out the ‘yellow card scheme’ so that GPs can identify carers and refer them on to Carers Leeds. All GP practices in Leeds have now signed up to the yellow card scheme.

2.5.3 Continuing care

NHS continuing healthcare is care outside of hospital that is arranged and funded by the NHS. It is only available for people who need ongoing healthcare and meet the eligibility criteria set out in a national framework developed by the Department of Health. The Leeds continuing care team is hosted by our CCG.

We have assessed and ensured appropriate care for 1057 people this year in line with the National Framework for Continuing Care. Following the development of new national guidelines we have improved the patient and carer information we provide.

From April 2014 parents of children and adults with physical and mental health disabilities who are eligible for continuing healthcare will have the opportunity to set up personal health budgets (PHB). In Leeds, since 2012, we have been running a two year pilot project to develop the necessary systems and processes to implement PHBs. As a result of which 10 continuing care eligible individuals have now been offered a PHB. Initial outcome focused reviews indicate that each individual has benefitted from having more say over how they want their care to be delivered and from being able to shape and personalise their care for the future. The direct payment has provided them with more control over their lives and more choice and flexibility over the care they now receive. The project end date has been extended and the project resourced for a further 12 month period until March 2015.

Future PHB activities will focus on the development of peer support networks, personal assistant (PA) training opportunities, workforce development and provider /
market expansion together with continuous evaluation and refinement of PHB systems and processes particularly in relation to higher level approval procedures.

A 3 year framework agreement with multiple providers of continuing care services has been developed, in order to update and refine the commissioning of home care packages for continuing healthcare eligible patients (excluding fast track and complex packages). Patients are referred to framework providers on the basis of available capacity, value for money, and patient preference.

We have implemented a preferred provider list to support highly complex continuing care patients in their own homes. The preferred provider list identifies a pool of high quality providers who can be approached to provide new complex domiciliary (home) care packages.

2.5.4 Safeguarding children and vulnerable adults

Leeds CCGs have a legal responsibility to ensure that the needs of children and adults at risk of abuse or suffering abuse are addressed in all the work that they undertake and commission on behalf of the people of Leeds. The CCGs work closely with providers and key partner organisations to ensure that services are effective and that staff are able to meet the needs of these vulnerable individuals.

The Safeguarding Children and Adult team is hosted within NHS Leeds South and East CCG and provide a safeguarding service for NHS Leeds West CCG and NHS Leeds North CCG.

A clear line of accountability for safeguarding is reflected in each CCG’s governance arrangements which include the Chief Officer, to Director of Nursing and Quality, the Head of Safeguarding/Senior Designated Nurse children and adults, Designated Nurse safeguarding children and adults and lead for Mental Capacity Act and Named GP.

The Safeguarding Children and Adults at Risk Committees for core CCG members and for key providers is a formal sub group of each Leeds CCG and reports through each CCG’s governance structures. The Safeguarding Committee leads work on behalf of Leeds CCGs through an agreed action plan and monitors compliance of agreed safeguarding standards through a performance framework.

There is a programme for safeguarding training in place for all Leeds CCG staff and independent contractors. The programme includes providing tailored education sessions accessible to GPs. The Leeds NHS CCG Safeguarding Training Strategy is aligned and complimentary to the Leeds Safeguarding Children Board (LSCB), the Leeds Safeguarding Adult Partnership Board training (LSAPB) and with NHS England Local Area Team.

Leeds CCGs remains committed to ensuring that the needs of children and adults at risk are central to our work and to that of our health providers. Senior members of staff from Leeds CCGs are key contributors to the work of the multi-agency Boards and their sub-groups, the Local Safeguarding Children Board, the Leeds Safeguarding Adult Partnership Board and the Safer Leeds Executive. These Boards are responsible for ensuring the effectiveness of partnership working around
safeguarding children and adults at risk of abuse and domestic violence across Leeds.

Leeds CCG Safeguarding Team is committed to working with NHS England Area Team through safeguarding forums to drive improvements in safeguarding practice and providing expert advice to NHS England.

A joint Safeguarding children and adults at risk safeguarding commissioning policy has been developed and regionally agreed standards for children and adults have been included in all contracts for 2014-2015. These standards are inclusive of ‘Prevent’ standards, the standards will be monitored by the CCG with providers.

**Children**

During 2013-14 there has been continued strengthening of services available to support children and families within Leeds. Some key progress continues to be made in partnership working and in integrating health services with the local authority children’s services department.

Key progress includes:

- Health representation at the duty and advice team of the children social work services;
- Co-location of Children Looked After nurses with social work team; and
- Co-facilitation of training and briefings with Local Safeguarding Children Board on lessons from Serious Case Reviews.

Leeds CCGs and key health providers undertake an annual audit of safeguarding standards through the Section 11 Audit (Children Act 2004). This process is coordinated by the LSCB and allows the organisation to monitor its progress against defined standards. The CCG is able to demonstrate its current position against those standards and how it is working to continually improve.

During the past year Leeds CCGs have contributed to work on one serious case review (SCR). These reviews are a statutory requirement, led by the LSCB and undertaken when there is a death or serious injury to a child or young person where abuse is thought to be a contributory factor. The learning from the completed review has been fed back to relevant staff groups and is being used to improve the commissioning and delivery of services. Three local learning lessons reviews (LLR) are in the process of being completed with the aim of learning from safeguarding incidents.

The CCGs have secured the expertise of designated doctors and nurses for safeguarding children and for looked after children and a designated paediatrician for unexpected deaths in childhood.

Eighty General Practices in Leeds have identified a lead for safeguarding children. The leads for safeguarding within the general practices are invited to attend quarterly safeguarding meetings facilitated by Named Doctor Safeguarding Children, a range of safeguarding subjects. A pilot to improve GP attendance at child protection case conferences commenced in January 2014.
Adults
A greater understanding is demonstrated by partners and providers of services of the Mental Capacity Act (MCA) and Deprivation of Liberty (DOL) safeguards. Awareness amongst health staff is demonstrated by the continued increasing numbers of applications in hospitals. The CCG Safeguarding Adult lead supported Leeds Community Healthcare NHS Trust to develop a highly successful MCA champions’ model. A smooth transition of the supervisory body for DOLs applications to the Local Authority was achieved in April 2013.

The CCG safeguarding team have supported the implementation of the West Yorkshire policies and procedures for safeguarding adults within health agencies.

New multi-agency Safeguarding Adult Review guidance has been developed to ensure appropriate cases with optimal learning are reviewed. Three multi agency Learning Lessons reviews commenced in 2013 and are currently being completed. This process is led by the LSAPB and its findings are being used to learn and improve the care provided to vulnerable individuals.

There have been three Domestic Homicides in Leeds in 2013 that have proceeded to full reviews. Leeds CCGs have contributed to the domestic homicide reviews and continue to work in partnership with Safer Leeds to learn lessons to improve services for adults experiencing or at risk of domestic abuse.

The CCGs’ role and responsibilities within the domestic violence agenda is being explored within the CCGs. Partnership working has been developed through the Domestic Violence Strategic Group to continue the CCGs contribution to the domestic violence agenda.
2.6 Key Performance Indicators


The report presents performance information through balanced scorecards and detailed trend data structured on the basis of the following:

- NHS Constitution
- Quality and Safety
- CCG Assurance Framework
- CCG performance on Quality Premium
- CCG Outcomes Framework
- CCG Strategic Aims

Performance highlights and exceptions are reported to the Executive Team, Finance, Activity and Performance Committee and the Governing Body. In addition to routine reporting specific ‘deep dive’ reports, for example Referral to Treatment Performance are provided to the Governing Body. Development of performance reporting and performance improvement has been ongoing throughout 2013-14 and will continue through 2014-15.

Given there is no previous year data at CCG level, the CCG has assessed trends on a month on month basis. In order to use performance data to inform CCG development, previous years PCT level data has also been used, as well as benchmarking data made available through Commissioning for Value packs, and analysis from the Public Health Observatory on key areas.
Some of the key performance indicators for 2013-2014 are detailed below in the following tables:

<table>
<thead>
<tr>
<th>Referral to Treatment Times – Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>18 weeks admitted- the percentage of admitted pathways within 18 weeks for admitted patients whose clocks stopped during the period on an adjusted basis</td>
</tr>
<tr>
<td>18 weeks non admitted – the percentage of non-admitted pathways within 18 weeks for non-admitted patients whose clocks stopped during the period</td>
</tr>
<tr>
<td>Incomplete pathways – the percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Referral to Treatment Times – Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>From April 2013 to January 2014 the number of CCG registered admitted patients seen within 18 weeks was just under the target of 90%. At the end of February 2014 the 90% target was achieved. The CCG, as part of the collaborative process, has worked with Leeds Teaching Hospitals NHS Trust as our main provider of planned care to achieve the 18 week target, and to put in place processes to sustain performance at a minimum of 90%. Performance for non-admitted and incomplete pathways has been consistently above target.</td>
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<thead>
<tr>
<th>Cancer - Indicators:</th>
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</thead>
<tbody>
<tr>
<td>Cancer 2 week – the percentage of patients seen within two weeks of an urgent GP referral for suspected cancer and percentage of patients seen within two weeks of an urgent referral for breast symptoms where cancer was not initially suspected</td>
</tr>
<tr>
<td>Cancer 62 day – the percentage of patients receiving first definitive treatment for cancer within 62 days of referral</td>
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</table>

<table>
<thead>
<tr>
<th>Cancer – Performance:</th>
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</thead>
<tbody>
<tr>
<td>Waiting times for cancer care continue to be addressed. Performance on 2 week wait from GP referral to first outpatient and on 62 day cancer wait times from GP referral to first treatment has been an issue throughout the year. Action plans to achieve consistent performance are in place with the main provider.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Accident &amp; Emergency (A&amp;E) – Indicator:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The percentage of A&amp;E attendances where the patient spent four hours or less in A&amp;E from arrival to transfer, admission or discharge</td>
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<table>
<thead>
<tr>
<th>Accident &amp; Emergency (A&amp;E) – Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The total year performance for 95% of patients attending Accident and Emergency departments (A&amp;E) being seen, treated, admitted to hospital or discharged within the four hour target has been achieved.</td>
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</table>

<table>
<thead>
<tr>
<th>Health Care Associated Infections – Indicators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA – incidence of healthcare-associated infection Methicillin-resistant Staphylococcus aureus (MRSA)</td>
</tr>
<tr>
<td>CDiff – Incidence of healthcare-associated infection C.Difficile</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Health Care Associated Infections – Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthcare associated infection rates continued to fall over the course of the year. Despite this, we exceeded the target for the maximum number of MRSA and Clostridium Difficile cases. This is due in part to higher than anticipated levels during the first half of the year from April onwards. More recent performance is now well within target but the higher figure from earlier in the year impacts on the whole year's figures. The main acute provider has implemented a range of improvements in the latter half of 2013-14 which are now reducing infection rates.</td>
</tr>
<tr>
<td>Improving Access to Psychological Therapies (IAPT) – Indicators:</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>The proportion of people referred for treatment (15%) and the proportion who complete treatment and are moving to recovery (50%).</td>
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<table>
<thead>
<tr>
<th>Improving Access to Psychological Therapies (IAPT) – Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieving the targets for eligible population entering treatment and for 50% recovery rate for IAPT has been very challenging for both Leeds city as a whole and for NHS Leeds South and East CCG. As CCG specific data has become available it has been identified that there are specific challenges for NHS Leeds South and East CCG in particular, in relation to the 50% recovery rate. In order to improve performance a review was completed which has identified that a key issue is the acuteness of condition for Leeds South and East CCG population referred to city wide services compared to the population of Leeds as a whole. Commissioning of additional IAPT and supporting community wrap around services is included within the 2014-15 plan.</td>
</tr>
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<thead>
<tr>
<th>Patient experience – Indicator:</th>
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</thead>
<tbody>
<tr>
<td>Whether people receiving NHS treatment would recommend the place where they received care to their friends and family</td>
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</table>

<table>
<thead>
<tr>
<th>Patient experience – Performance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Friends and Family Test asks a standardised question: ‘How likely are you to recommend our ward / A&amp;E department to friends and family if they needed similar care or treatment?’ It is a requirement for all acute providers. The national target is 15% and Leeds Teaching Hospitals NHS Trust has exceeded the target month on month since April 2013.</td>
</tr>
</tbody>
</table>

Table 2: Key Performance Indicators 2014-2015

The indicators listed above are national targets as defined within the CCG Outcomes Framework 2013-14, and in Everyone Counts – Planning for Patients 2013-14.

2.6.1 Financial performance indicators

Our position against key financial performance indicators in 2013/14 is strong with:

- Programme Costs being contained within the programme allocation, with a surplus of £6.8m delivered against a programme allocation of £341.6m.
- Running Costs contained within the Running Cost Allocation of £6.2m.
- Total Cash spend was kept below the maximum cash drawdown level set by NHS England.
- Performance against the Confederation of British Industry (CBI) Better Payment Practice Code was achieved both in terms of value and number. Details are shown in note 6.1 to the accounts.
2.7 Quality and safety

A single definition of quality for the NHS was first set out in High Quality Care for all in 2008, following the NHS Next Stage Review led by Lord Darzi, and has since been embraced by staff throughout the NHS and by successive Governments. This definition sets out the three dimensions to quality that must be present to provide a high quality service:

Clinical effectiveness – quality care is delivered according to the best evidence available that demonstrates the most clinically effective options available that are likely to improve a patient’s health outcomes.

Safety – quality care is delivered in a way that reduces the risk of any avoidable harm and risks to a patient’s safety.

Patient experience – quality care provides the patient (and their carers) with a positive experience of receiving and recovering from the care provided, including being treated according to what the patient (or their representatives) wants or needs, and with compassion, dignity and respect.

The reports published following the inquiry into poor care at Mid Staffordshire Hospitals have influenced how we monitor standards of care to ensure that patients are not put at risk and experience good quality care. We have undertaken a comprehensive assessment of ourselves against the recommendations of Sir Robert Francis’s report published in February 2013, as well as recommendations made in the Keogh, Berwick and Cummings reports, and have identified 56 recommendations that apply to the CCG against which an action plan has been developed and is monitored against the four commitments.

Organisations we commission care from are required to meet essential standards of quality and safety as defined by the Care Quality Commission (CQC). Contractually, as commissioners we also set out quality requirements for our providers that are above the essential requirements defined by the CQC through the development of locally agreed CQUIN indicators (Commissioning for Quality and Innovation), which are agreed with the provider at the beginning of each contractual year. Local CQUINs for 2013/14 included:

**Leeds Teaching Hospitals NHS Trust**
- Implementation of best practice bundles in emergency departments
- Implementation of a discharge checklist
- Assessment of patients for health risks relating to smoking, alcohol and obesity and the provision of healthy lifestyle advice
- Development and implementation of a comprehensive patient experience action plan
- Development of a joint A&E pathway for referral of young people who self-harm
- Reduction in the numbers of Category 3&4 pressure ulcers

**Leeds Community Healthcare NHS Trust**
- Development and implementation of a peer review process
- Improved engagement with Primary Care teams
• Development of a joint A&E pathway for referral of young people who self-harm
• Improvement in timescales for health assessment for looked after children

Leeds and York Partnership NHS Foundation Trust
• Improving access to advice for financial management and debt
• Improving clinical outcomes for older people through the introduction of an outcomes measurement tool
• Improving experience of referral into the crisis pathway
• Improving outcomes through effective discharge planning
• Improving the health and wellbeing of carers in learning disability services

We work closely with our acute, mental health and community services to make sure that they meet these requirements and standards and we monitor them throughout the year.

2.7.1 Never events

Certain types of serious incident are termed ‘Never Events’. These are incident types that, if the necessary safety systems are in place and operating effectively, are expected not to occur. Never Events are nationally defined and most apply primarily to acute hospital care. These types of incident are subject to further detailed scrutiny from the CCG and in some instances providers are penalised when they occur. In 2013-14 there were two Never Events that affected Leeds residents, and six Never Events that occurred within Leeds healthcare providers but affected residents of other CCGs outside of Leeds.

The CCG has worked with the provider relating to systems and processes in operating theatres across the Trust to ensure learning from the incident investigations is introduced and embedded in practice. In addition a significant project on a national level has been commissioned by NHS England in response to the number of retained surgical instrument incidents that have occurred nationally. This is the most commonly reported Never Event in the NHS.

It is clear that we are on a firm performance and quality footing and we will continue to build on this throughout 2014-2015.
### 2.8 Principal risks

The Annual Governance Statement describes the CCG Risk Management Framework and the three levels of risk reporting in the organisation; The Governing Body Assurance Framework; The Corporate Risk Register; and the Operational Risk Registers.

The principal risks and uncertainties facing the CCG in relation to being able to fulfil its strategic objectives, which are included within the Governing Body Assurance Framework (GBAF), are summarised below:

<table>
<thead>
<tr>
<th>Risk Title</th>
<th>Responsible Committee</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| CCG Culture and Approach         | Governing Body        | • Clear & Credible Plan  
• CCG Performance Report  
• National Assurance Framework |
| Sub-Optimal Quality              | Quality & Safety Committee | • Comprehensive quality report  
• Monitor CQC visits and action plans  
• Provider Management Groups in place |
| QIPP – Practice Engagement       | Executive Management Team | • Practice MOT and performance framework  
• QIPP Tracker |
| QIPP – Provider Squeeze and Grip | Executive Management Team | • QIPP plans and analysis  
• Provider Management monitoring  
• NTDA support plan  
• FT pipeline |
| QIPP – Transformation            | Governing Body        | • Performance Report  
• Transformation Board programme |
| CSU Performance                  | Executive Management Team | • Action plan progress report  
• Issues log and performance rating  
• Service Auditor Report |
| Leeds Network Model              | Governing Body        | • Leeds Network  
• Contract Board meetings  
• Performance reports against plan |
| Public Health/Health Inequalities| Governing Body        | • Monitoring of Public Health workplan |
| Finance                          | Governing Body        | • Governing Body finance report.  
• Risk sharing agreement in place. |

Table 3: Principle Risks facing the CCG
The corporate risks during 2013-14 contained within the Corporate Risk Register are summarised below:

<table>
<thead>
<tr>
<th>Risk Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer 2 week wait under achievement</td>
</tr>
<tr>
<td>CCGs unable to use personal identifiable data</td>
</tr>
<tr>
<td>Risk of increasing patient morbidity or mortality from MRSA infection</td>
</tr>
<tr>
<td>Providers fail to achieve the NHS Constitution Standards on 18 weeks and the associated operational standards</td>
</tr>
<tr>
<td>Risk of increasing patient morbidity or mortality due to C Difficile Infection</td>
</tr>
</tbody>
</table>

Table 4: Corporate Risks during 2013-2014

The Risk Management Strategy clearly sets out the roles and responsibilities of directors, managers and staff in relation to the management of identified risk and this is further described in the Annual Governance Statement.

2.9 Working with our member practices

We are committed to seeking the input of clinicians in the work we do and in particular we are dedicated to involving our member practices. We have established strong working relationships with our 43 member practices and have been actively involving them in the work we do. This section looks at some of the key developments in 2013-2014.

NHS England/NHS England (West Yorkshire)

The commissioning responsibility for independent contractors – GPs, pharmacists, dentists and optometrists – comes under the remit of NHS England. We have been supporting our member practices to understand how the new commissioning and contracting arrangements work and how they can contact NHS England’s local area team, NHS England (West Yorkshire). We work closely with NHS England to understand and disseminate any information that impacts upon our member practices.

As part of this change in commissioning responsibility for primary care there has been a new process put in place for patients wishing to feedback any thoughts, concerns, compliments or complaints about the care they have received. There is now a customer contact centre at NHS England which is responsible for handling patient feedback on any care they have received from independent contractors. The contact centre can be contacted on 0300 311 22 33. Due to this change we have issued new patient-facing information to all our member practices explaining how the new complaints process works and how people can still access the West Yorkshire Patient Advice and Liaison Service (PALS) for more general enquiries.

We supported the promotion of NHS England’s Call to Action programme which is an honest and frank debate about the future of the NHS. Call to Action asks patients, staff and the wider public how to build an excellent NHS for now and future generations in the face of a number of challenges including tighter finances, an ageing population and a greater demand on services. We also encouraged practices to take part in NHS England’s ‘improving general practice: a call to action.’ This was aimed to stimulate debate in local communities – amongst GP practices, area teams,
CCGs, health and wellbeing boards and other community partners – as to how best to develop general practice services. We will look to share the results and feedback of this debate among our member practices.

**Leeds integrated health and social care programme**
The support of our member practices on the Leeds integrated health and social care programme has been invaluable as we continue to make great strides in the city towards seamless health and care services that benefit our patients. Our member practices have continued to support the roll out of a number of approaches designed to bring services closer together.

We have selected a clinical lead to ensure the views, thoughts, ideas and experiences of our member practices are shared with the programme team. In addition to this we held two events last year for our member practices. One looked at risk profiling and case management designed to support patients who are greater risk of falling ill and being admitted to hospital. This is designed to improve the support they receive at home and in the community to reduce the need for hospital admission. The second event gave our member practices a chance to meet with and find out more about our partners involved in the programme including the neighbourhood teams and community and voluntary sector organisations.

The integration of services is a core element of our work and we will continue to work with our member practices so that we can continue to drive through real transformation of services. Next year we will look at how we can provide further help to patients with long-term conditions so that they can manage their own health more effectively as well as making greater use of services near where they live or access services within their home.

**Two-way engagement with our members**
Our member practices are being supported to take an active role in the work we do. We recognised that we needed to continue to develop systems that made it easier for our member practices to get in touch with us with their views and ideas.

Throughout 2013-14 we have continued holding our regular members' meetings where practices can participate in sessions designed to get their input in key clinical commissioning decisions. This year members have been asked for their views on:

- Our primary care strategy looking at the future role of primary care within the Leeds health and care system;
- The design of cancer pathways;
- How patients with long-term conditions can be better supported including a review of secondary care inpatient and referral activity;
- Agreeing an approach to risk profiling and case management of patients with complex long-term conditions to reduce the number of hospital admissions; and
- Helping finalise the key priorities for the CCG Operational Plan.

Feedback from our members has helped us to:

- Develop a citywide letter for patients so that they understand the process of the two week referral process for treatment of cancer;
• Contribute to a citywide campaign encouraging people to only use A&E when they really need to do so;
• Translation of leaflets into community languages explaining the range of services available to people should they fall ill or get injured in an effort to reduce the pressure on A&E; and
• Setting up a specific work programme for practice managers.

We have also set up dedicated pages with links to a number of resources on the CCG’s password-protected extranet site. We are currently looking at how the site is used and future options for interactive content so we can get real time feedback from practices. Members are also sent a copy of the CCG’s e-bulletin which captures the latest updates from the organisation as well as any important news and changes that relates to the provision of care or more general management of member practices.

To support member practices to understand how well they are performing we produce practice MOTs. The MOT looks at performance against a range of indicators including number of patients who get admitted to A&E, number of patients referred to hospital (secondary care) for treatment and prescribing costs. The practices are given a chance to review their MOT with members of the CCG’s primary care engagement team and we will look to build on this process to link in with the new primary care contracts and performance targets from NHS England.

Primary care engagement schemes help member practices to support the delivery of key clinical programmes designed to improve the health of our local communities.

In 2013-2014 we worked on the following four engagement schemes:

The practice engagement scheme: this is an annual scheme that encourages practices to link their work with the local commissioning agenda. This year we used the scheme to encourage practices to participate in peer review sessions, involve practices for public health campaigns so that people could take greater control of their lifestyles and the roll out of the risk stratification tool to identify patients at greater risk of being admitted to hospital.

Primary care enhanced engagement scheme: the CCG’s clear and credible plan identified a number of clinical priorities. These were treatment of patients with chronic obstructive pulmonary disease (COPD), supporting patients with diabetes and better diagnosis of currently undetected cases, development of dementia services and stroke prevention. Funding has been made available so that practices can start developing plans and buy clinical equipment to identify and treat patients with these conditions. In 2014-2015 we will continue to roll out the scheme until October 2014 before we evaluate the effectiveness of the work to date.

Flu vaccination programme: practices received funding from the CCG to invite eligible patients to get their annual flu vaccination. The cost of this was 50p per eligible patients and we have monitored the performance of our member practices. As a result we have contacted high performers to find out how they achieved higher uptake rates and have shared this learning with all our member practices.

Winter planning: the winter months traditionally see a surge in demand for health and care services due to a combination of weather-related illnesses and injuries and
outbreaks of winter bugs and viruses. Member practices were asked to undertake a review of all unplanned hospital discharges for patients aged over 65. The review considered a patient’s risk for re-admission and setting up a collaborative care plan for those at high risk of re-admission without intervention. The scheme enables practices to support patients, create capacity in secondary care and integrate with community and voluntary organisations.

The second winter scheme offered practices the opportunity to open on Saturday 28 December to address concerns around availability of primary care services over the Christmas holiday period. A total of 414 GP appointments were available on the 28 December across the 15 practices which had signed up to the scheme. Of the available 414 appointments, 127 appointments were filled. Feedback from patients who attended shows that a high number would have opted to go to A&E if the practice had not been open.

**Quality and safety**
We are committed to making sure all providers of health and care services are aware of their responsibilities on the quality and safety of the care they provide. Our member practices have been participating in two key reporting schemes designed to identify any issues affecting the quality and safety of care.

The quality Yellow Card System has been developed to capture patient views about the care and treatment they have received, by providers, in the GPs practice. This soft intelligence is not currently gathered by the Patient Advice and Liaison Services (PALS) or other complaints systems, is assimilated by the CCG for thematic feedback to the provider community and to inform the CCG of any future CQUINS. This system has been trialled by eight early implementer practices and in 2014-2015 we will roll this out to all member practices.

The CCG is committed to recording any type of incident that could have or has resulted in a patient or members of staff getting injured or falling ill. We are implementing a reporting system called Datix to capture any such incidents and have invested in a training and education programme for member practices so that they can use Datix. We will be looking to implement the use of Datix across all our member practices in 2014-2015 and this work will be supported by our primary care engagement and medicines management teams. We will be able to share the data collected to make quality improvements in primary care where this has been identified.

**Education and training**
We have been running a number of training events to ensure that clinicians and other staff at our member practices can continue to receive ongoing support to deliver high-quality care for our patients.

We reviewed the provision of our TARGET training events and as a result have appointed a GP to lead the development of the events supported by the CCG’s lead primary care nurse. In an effort to improve our member practices relationships with local agencies we will be inviting community and voluntary organisations and health providers to hold stalls at TARGET events.
We have been implementing the NHS England Workforce Tool working alongside Health Education England to obtain workforce data from primary care. The data will be used to shape future educational requirements for clinical and non-clinical staff groups at all levels. In 2013-14 26 of our member practices had submitted data with the remaining practices set to do this in 2014-15.

The primary care engagement team are working with public health colleagues to implement a year of care training course so that practices can support patients with existing conditions to self-manage their health. At present three member practices are acting as early implementers and we will work with them to see how they have embedded year of care principles within their practice.

**Reducing hospital admissions**

We want to help our patients stay healthy for longer so that they can live independent and active lives. For those patients who do need treatment and care we want to ensure as much of this is done within their home or close to their home and reduce the number of people being admitted to hospital.

In 2013-14 we continued a scheme set up by our predecessors, Leeds Primary Care Trust. The scheme allows patients who are due to undergo chemotherapy to collect their initial blood results from their GP practice rather than attending hospital. Take up of this scheme is lower than anticipated and we are now working with colleagues at NHS Leeds West CCG to investigate how this service could be incorporated in a combined NHS contract.

National evidence suggests that enhancing care in care homes without nursing (formerly known as residential homes) reduces emergency admissions and/or reduces excessive lengths of stay in hospital. Our enhance care programme for residents of care homes has been recognised nationally by NHS Clinical Commissioners. The scheme encourages primary care clinicians to take a proactive approach to ensuring that residents in care homes receive people-centred care plans that are responsive to their needs. The care plans are developed jointly by GPs, other health professionals, patients and their families or carers. We have agreed to continue this scheme in 2014-15.

**Practice nursing**

Practice nurses are highly skilled healthcare professionals that play a crucial role in delivering care to patients within GP practices and can offer advice, support and treatment for a range of conditions. The role of a practice nurse can vary depending on the GP practice they are employed by however they will have the skills to offer an alternative option for patients who might normally be seen by a GP or other healthcare professional in the community.

We have been keen to raise the profile of practice nursing both among peers as well as patients and the wider public. The CCG has appointed a lead primary care nurse who works alongside the Director of Nursing and Quality to champion the role of the profession.

In 2013-14 we were delighted to welcome Jane Cummings, the Chief Nursing Officer for NHS England, to the first ever conference held in Leeds for practice nurses in the city. The conference gave practice nurses an opportunity to share new ideas,
understand the role they can play in future commissioning (planning and funding of services) and how they can encourage more people to join the profession. Jane Cummings spoke about the role that practice nurses can play in clinical commissioning and how they can implement the 6Cs of nursing in their practice. Due to the success of the first event we will be holding a follow-up conference in September 2014.

Following on from the conference the three lead practice nurses for the three CCGs have agreed to take part in a Twitter chat organised by the highly respected @WeNurses around the role of practice nursing in commissioning.

We have set up a bi-monthly practice nursing forum to strengthen practice nurse engagement, review key issues and discuss relevant topics in practice. In 2014-15 we will be:

- Setting up an online forum for practice nurses on our extranet;
- Promoting practice nursing as a career choice to healthcare professionals and school leavers/graduates;
- Implement the 6Cs of nursing; and
- Run tailor-made education and development courses.

2.10 Medicines management

The key aim of the Medicines Management Team has been to optimise the use of medicines by ensuring that the right drug is obtained in the right quantity and form, at the right time, in the right setting.

Medicines management is therefore about: increasing patient health gain, reducing patient harm, improving cost efficiency (making the best use of our budget), applying national standards, and local standards across organisations to reduce local variations. Work has been undertaken across practices, across organisations, across professional groups and across the city to work towards these goals

Below we outline some of the main initiatives undertaken in 2013-14:

**Prescribing Support Service**
Pharmacists and technicians have been working with 40 member practices to maximise cost effectiveness through a range of audits, switches (moving patients from type of medication to another clinically and cost effective alternative) and close prescriber liaison to influence prescriber drug choice.

**Scriptswitch**
Scriptswitch is a computer decision support tool that promotes cost effective prescribing at the point of prescription generation. It is installed at 14 practices where clinicians have agreed to use it and where it likely to prove cost effective.

**Medicines Management Facilitator Programme**
Medicines Management Facilitators have been recruited from within 17 practices to embed medicines management activities within core practice staff and to identify savings opportunities from tackling issues of waste.
Medication Review Service
Targeted Medication Review has been undertaken to support the most frail and vulnerable patients so that they can get the maximum benefit from their medicines and risk of medicines-related harm is reduced. Patient groups that have been identified for this service include: patients in care homes; patients who are at the highest risk of readmission to hospital and patients recently discharged from hospital. Savings are made from drug treatments being stopped changed or amended. Savings are also made by avoiding hospital admissions and the costs incurred through unnecessary patient harms. Around half of the interventions made by our team are around improving quality and reducing harms.

Care Homes Service
In 2013-2014 75% of patients in care homes have received a medication review at least once within this financial year resulting in a total of 897 reviews.

Medication Review to support predictive Risk profiling
This has been initially targeted at patients with COPD as those likely to have most medicines management impact. Where possible the work has been linked with the predictive risk profiling, often referred to as risk stratification, required by practices through the primary care team. Twenty practices so far have been in receipt of this service with a projected number of 360 medication reviews being undertaken this year resulting in 860 interventions. All practices involved in this project have been asked to complete a survey to gain feedback and develop the service further in line with requirements.

Medicines reconciliation following patient discharge from hospital
Particular problems occur around medicine use when a patient is discharged from hospital and this is a focus of activity both nationally and within the CCG. This new service has initially been offered on a pilot basis to three practices. A total of 201 patients were reviewed with 450 recommendations being made. The work has been expanded recently to include referrals for medication review from practices involved in the CCG’s winter service scheme.

Headlice project
To improve the quality of care for patients with headlice and reduce unnecessary GP consultations for this condition we have developed a headlice identification and treatment service through our Community Pharmacies. An evaluation of this will be undertaken in 2014-15.

2.10.1 Prescriber and Stakeholder Engagement

Much of the success of the Medicines Management Team lies with the engagement of prescribers, of the wider primary care team and of the secondary care organisations who have significant influence on prescribing for our patients. Engagement has been undertaken through:

- Extranet – developing the Medicines Management pages on our password protected extranet;
- Medicines Management Newsletters – 18 newsletters and medicines management briefings were sent to our practices;
• prescribing leads meetings – nine meetings have been held this year with a meeting scheduled in each locality;
• City Wide Meetings – attendance, engagement and contributions to various groups to ensure coordinated strategic development of Medicines Management across the Leeds health economy including: Medicines Optimisation Group, Leeds Area Prescribing Committee, LTHT Drug and Therapeutics Committee, Shared Management of Medicines Group and Commissioning of Medicines Group; and
• Medicines Commissioning- agreeing commissioning position on medicines and also refining our commissioning process around medicines with our providers including actions around implementing NICE and the managed entry of new drugs.

2.10.2 Specific Input to Therapeutics Areas

Besides the general input of the team to Long Term Conditions through our medication review service Medicines Management have had significant input to some specific therapeutic areas - often because of their high medicines cost or because of high CCG focus. These include:

- Supporting the Leeds Eating and Drinking Service to impact on the once escalating costs of Oral Nutrition Supplements;
- Working with Leeds Community Healthcare NHS Trust’s tissue viability service to develop a wound care formulary and to manage dressing costs and wastage;
- Supporting the citywide palliative care team to implement safe and effective prescribing for End Of Life Care including access to palliative drugs out of hours; and
- Reviewing all patients with C Diff infection and undertaking practice and prescriber education sessions following route cause analysis of each event to reduce future harms from these infections.

2.11 Working with our partners

Effective collaboration is critical to support the achievement of our goals and delivery of our plans. We are committed to developing strong long-term strategic partnerships with a range of stakeholders and actively participate in the work of a number of partnership boards to deliver the best possible outcomes for our local communities. In 2013-2014 we have been building new alliances and continuing to build on the work of our predecessor body, NHS Leeds, to strengthen existing relationships so that we can make Leeds the best city for health and care. In this section we have highlighted some of the partnership arrangements in place and have provided a summary of two important pieces of joined-up work we are currently undertaking; the Leeds Integrated Health and Social Care Programme, and the Leeds Informatics Board.

Our partner Clinical Commissioning Groups

We have forged close working relationships with NHS Leeds North CCG and NHS Leeds West CCG so that we can deliver on an agreed aim to develop high quality, safe and accessible citywide services. As part of this commitment we will be
developing a joint five year commissioning strategy for Leeds sitting alongside our own individual two year operational plans from 2014.

At a regional level we are part of the 10CC group which is made up of representatives of the 10 CCGs in West Yorkshire allowing us to support regional services such as NHS 111 delivered by the Yorkshire Ambulance Service NHS Trust.

**NHS England**
The commissioning responsibility for independent contracts – GPs, pharmacists, dentists and optometrists – comes under the remit of NHS England. We work closely with NHS England to understand and disseminate any information that impacts upon our member practices.

We also work closely with NHS England in their assurance role as we demonstrate our delivery against the CCG Assurance Framework.

**Our NHS providers**
We are pleased to be able to commission services from three main provider NHS Trusts in Leeds alongside other service providers. We lead on commissioning services from Leeds Community Healthcare NHS Trust with NHS Leeds North CCG leading on commissioning services from Leeds and York Partnership NHS Foundation Trust, and NHS Leeds West CCG taking the lead on commissioning services from Leeds Teaching Hospitals NHS Trust. Our ambulance services are provided by Yorkshire Ambulance NHS Trust who also is the provider of NHS 111 for our region.

**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 opportunities to engage with some community groups who are sometimes referred to as ‘seldom heard groups.’ Over the past 12 months we have been working with local community groups to run a number of engagement events and activities.

**HealthWatch Leeds**
We are committed to involving our local communities and our patients in the work we do. One of the ways we are doing this is by working closely with HealthWatch Leeds. HealthWatch Leeds is represented on the Leeds Health and Wellbeing Board, giving patients and communities a voice in decisions that affect them. HealthWatch Leeds will feed back any views and concerns to Healthwatch England so that issues of national significance can also be raised at a national level. We have worked with HealthWatch Leeds to develop our communications, engagement and equality and diversity strategy. We have also benefitted from their findings around local health services including a spot check on children’s accident and emergency and a survey on people’s experience of using urgent and emergency care.

**Leeds Health and Wellbeing Board**
We are part of the Leeds Health and Wellbeing Board which has been established as a statutory committee of Leeds City Council and which has published a Joint Health and Wellbeing Strategy for Leeds (2013 – 2015). The overall vision is that
Leeds will be a healthy and caring city for all ages, with a principle in all outcomes that people that are the poorest will improve their health the fastest.

Health and Wellbeing Boards in every area ensure that services work together to respond to the needs and priorities of their communities. The Board involves people and community organisations, including elected representatives, in deciding what services the diverse communities we serve need – this will help CCGs in Leeds and Leeds City Council to commission (plan and fund) services that help us to deliver the joint Leeds Health and Wellbeing Strategy.

The Leeds Health and Wellbeing Board have developed a joint Health and Wellbeing Strategy for Leeds to ensure that people:

- Live longer and have healthier lives;
- Live full, active and independent lives;
- Experience a better quality of life;
- Are involved in decisions made about them; and
- Will live in healthy and sustainable communities.

The priorities have been identified through a process called the joint strategic needs assessment (JSNA). The JSNA uses a range of information and local and national statistics to identify the current health and wellbeing needs of our communities and highlights health inequalities that can lead to some people dying prematurely in some parts of Leeds compared to other people in the city.

**Leeds City Council**

Leeds City Council commissions care and support services and is now responsible for public health which is a body of work that seeks to protect and improve health and wellbeing. The council is using its knowledge of our communities to tackle public health challenges such as smoking, alcohol and drug misuse and obesity. Leeds City Council works together with CCGs and health and care providers, community groups and other agencies, to prevent ill health by encouraging people to live healthier lives.

One of the Best Council objectives is focused on providing high quality public health services. This will be measured by 5 indicators; an increase in successful completion of drug and alcohol treatment; increase in the number of people accessing stop smoking services; increase in HIV testing in men who have sex with men; increase in uptake of the NHS Health Check in areas of greatest health inequality; and that each council directorate and CCG business plan includes action that contributes to the health and well-being strategy priorities. To strengthen the links between the CCG and the public health teams at Leeds City Council we have a public health consultant who sits on our governing body and we also have a number of staff who are jointly employed by the local authority and ourselves.

In 2013-2014 we have been working with Leeds City Council on public health initiatives including:

- Developing cancer awareness programmes linking in with the national Be Clear on cancer campaigns as well as the local 'Got a cough? Get a check' lung cancer campaign and the 'your poo can save you' promotional activity for the bowel cancer test;
• Supporting the continued promotion of Leeds Let's Change a campaign, backed up by a one-stop website, providing advice on a range of topics and links to local services to help people make healthy lifestyle choices; and
• Encouraging local people, particularly those with an existing health condition, to get vaccinated against the flu.

2.11.1 Joint approach – focus on the Leeds integrated health and social care programme

Over the coming years, GPs, hospitals, health workers, social care staff and others will increasingly be working side-by-side, sharing information and taking a more co-ordinated approach to the way services are delivered. Older people and people with long-term health conditions are among the first to benefit from these changes. Our work on integrating services has drawn interest nationally and as a result it was announced in October 2013 that the Department of Health has selected Leeds as one of only 14 sites to pioneer integrated care. This means we will benefit from additional support over the next five years to develop this approach at an accelerated rate.

One of the reasons Leeds was chosen to be a pioneer site was as a result of the efforts the city has made in bringing health and social care professionals closer together. This means that patients are already benefitting from this joined up approach with projects such including:

• A programme to mix health visiting and children’s centres into a new Early Start Service across 25 local teams in the city;
• Twelve health and social care teams now work in Leeds to coordinate the care for older people and those with long-term conditions; and
• The NHS and Leeds City Council have opened a new joint recovery centre in an effort to prevent hospital admission, allow patients to go home quicker and promote independence. In its first month of operation, it saw a 50% reduction in length of stay at hospital.

More information about how health and social care are working together in Leeds is available at www.leeds.gov.uk/transform

The Leeds integrated health and social care programme involves all our partners including GP practices, our partner CCGs, Leeds City Council social care services, Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, Leeds and York Partnership NHS Foundation Trust and community and voluntary sector organisations from across the city. We also have strong arrangements in place to ensure we listen to and act on the views of patients, carers and the wider public.

In 2013-2014 we continued to make significant progress on the work that had already been done to bring services closer together. We have outlined the key achievements below.

• Co-located services: A fundamental aim of integrated health and social care is to give patients holistic and patient centred care close to home. To achieve
this, 12 co-located teams of front-line Healthcare staff and Social Care staff have been in place since April 2013.

A development programme has been established to support the teams on their journey to full integration, to realise the complete benefits of integrated care, and to better align these to GP practices with natural communities to improve practice and patient experience.

Commissioners are also supporting our community healthcare provider and social care services on a journey towards closer integration including the development of an integrated gateway, allowing referrals into all services.

Certain specialist services are being aligned to support the teams, including the provision of a Community Based Elderly Medical Workforce of Consultant Geriatricians as well as Dementia Professionals which has proven to be really beneficial in allowing the teams to manage complex and challenging cases. This model has drawn interest from national bodies such as the Kings Fund, who are visiting Leeds in April 2014 to develop a case study based on these roles.

Vital work is continuing to develop and provide support to primary care with the Leeds Risk Stratification Tool, which enables GPs and Integrated Neighbourhood Teams to identify any patients that are at high risk of becoming high risk patients, and plan their care appropriately.

Commissioners are working with health social care and voluntary sector partners to improve discharge processes from the hospital, to allow those patients who are well enough to be discharged, but not yet well enough to return home to move quickly and seamlessly into the care of other services.

- **Year of care**: we, along with all major health and social care partners in Leeds are continuing to contribute to a national programme to understand how the current system of care is delivered and where the money is spent in detail. This will inform the development of new systems of funding and contracting that will enable people to be discharged from hospital once they are medically stable and to receive the care they need outside of hospital; the money will follow the patient’s needs.

- **Community care beds**: developing access to a range of community bed bases is vital to the programme’s aims of reducing hospital admissions and reducing patient length of stay.

The South Leeds Independence Centre opened in April 2013 to provide health and social care rehabilitation, recuperation and reablement, enabling patients to recover and return home. The unit has been successful in supporting earlier discharge, preventing unnecessary admissions and effective in facilitating people’s return to their own home/community, therefore reducing the number of admissions to long term placements. All partners are now involved in developing robust and comprehensive monitoring to ensure the centre provides quality, cost effective care and understanding the wider impacts of this new service on the rest of the system.
Work has also started to determine what community beds will be required in Leeds to manage future needs. This is being informed by further analysis of need, demand and national benchmarking data.

- **Self-management and telehealth:** we are working with other partners across Leeds at changing the approach and culture of professionals so they work with individuals, enabling them to better manage their own health and care needs. We are also working to provide more community services that support people to live independent lifestyles and reduce social isolation. This includes evaluating the current use of remote monitoring of patients using telehealth software.

### 2.11.2 Joint approach – focus on the Leeds Informatics Board

In the world of ever-increasing integrated care, it is essential that information follows the patient in order for them to obtain the best possible care.

The Leeds Informatics Board is chaired by NHS Leeds North CCG’s Clinical Chair Dr Jason Broch and supported by Alastair Cartwright the Director of Informatics for the Leeds CCGs. The Board supports all health and social care organisations to develop and implement an IT and Information strategy to join up IT systems across the city, allowing for the safe and secure sharing of information necessary to support direct patient care.

The following achievements have been delivered during the year.

- **Improved IT systems for GPs** - For several years we have been aiming to move all GP Practices in the city (109 of them) to an IT system that is nationally approved and compatible with our long term aim to improve IT facilities for GP Practices and the breadth of clinical information available. In that regard, we implemented 6 new GP IT systems during 13-14, leaving only 2 GP Practices in the city yet to move to a strategic system.

- **GP access to test results** - The majority of GP Practices in the city implemented a new facility called Order Communications. This allows a GP to directly order a Pathology test or Radiology examination from the appropriate laboratory. Not only can the GP track the progress of the test but they can receive the test results electronically as soon as they have been verified. This is a significantly improved service for patients.

- **Pathway management** - Several GP Practices have implemented a facility called Map of Medicine. This allows a GP to ensure that they are following an approved clinical pathway for certain specialty services such as Musculoskeletal services. Following approved pathways will improve clinical outcomes for patients.

- **Leeds Care Record** – A major strategic initiative for Leeds is to support clinical care by ensuring GPs have improved access to hospital information and vice versa. This is within the framework of ensuring that information is only used by health professionals for care purposes that they have a direct relationship to. Good progress has been made in ensuring that technologies are in place to support this, alongside providing information for patients, practices and putting agreements that explain and guarantee how information
will be shared. As always, patients can opt out if they are not happy to share information, but this could affect their clinical care. This is being explored in a stepwise approach and 4 GP Practices are assisting in assessing such facilities.

- **The Summary Care Record** service is a facility that allows certain elements of information held in GP Practices to be shared for clinical purposes by other sectors such as hospital admissions and out-of-hours treatment. All Leeds GP Practices are now participating in this initiative and Leeds Teaching Hospital continues to use this information to ensure that patient medications are reconciled between those prescribed by a GP and within hospital. This leads to increased patient safety and reduced wastage.

- **Single ‘gateway’ service** for non-hospital referrals – as part of a major design piece for integrating health and social care services for adults in Leeds and working together to achieve better outcomes for people, less duplication and better use of resources, a single service for receiving referrals to community health workers and or social care has been implemented. This had a major technology component, physically re-locating staff and providing improved IT and telephone services. This will benefit patients and their access to services.

- **Secure email services** – During 2013-14 all 3 Leeds CCGs, Leeds Community Healthcare NHS Trust and Leeds City Council have moved to secure email systems that allow secure email exchange. GPs in Leeds were already using secure email. Whilst patient information will rarely flow to Commissioners, secure email is an essential facility for clinical services.

- **Improved information to support service delivery and commissioning** – In a non-patient-identifiable form we have been using new analytical facilities to look at the use of services provided across health and social care. This has allowed commissioners to evaluate whether specific commissioned services are proving beneficial to patient outcomes and providing value for money.

### 2.12 Involving patients and the public

We are committed to listening, learning and responding to our patients and the public. In our first year we have been developing our patient involvement groups to assure ourselves and member of our local communities that patients are at the heart of everything we do. We continue to involve service users to develop services which meet the needs of our local population.

We have also been establishing a number of groups and networks to actively involve carers, patients and patient representative groups in the work we do. To support us in capturing the views and experiences of local people we have been working closely with HealthWatch Leeds, the consumer champion for health and local community and voluntary groups.
We are using the same principles for patient participation as set out by NHS England:

- Individual participation: people in control of their own care
- Public participation: communities with influence and control
- Insight and feedback: understanding people’s experiences

**Source:** Transforming participation in health and care (NHS England: September 2013)

We want to thank all those who have got involved with the work we do. We will continue to strengthen our relationships with our patients, carers and the wider public so that we can listen and respond to views of our diverse communities to deliver real change to local services.

### 2.13 Our Staff

Reflecting back over our first year we recognise this has been a challenging yet rewarding time for our staff. Our team is made up of clinical and managerial leads, primary care development, medicines management, finance, governance and information, direct commissioning and also a key administration team supporting the whole workforce.

We employ a diverse workforce including a large collaborative workforce who work on a city-wide basis supporting the other two CCG’s in Leeds, including a small Safeguarding Team, Medicines Management Team and a large Continuing Care Team consisting of mainly nursing professionals.

Our Organisational Development Plan sets out an approach to create an effective and well governed organisation which is fit for purpose and reflects our vision and values.

In 2013-14 our staff and member practices have been involved in refreshing our values. Our values are central to everything we do as an organisation and as individuals and we will demonstrate our commitment to our values through our behaviours. Our values are:

- **Improving Lives:** we will be proactive and determined in our efforts to improve the health of our population and reduce health inequalities, now and in the future
- **Quality:** we will strive to continuously improve quality of commissioned services through improvements in safety, effectiveness and patient experience
- **Leadership:** we will optimise the skills of our staff and members and together we will shape and lead our organisation
- **Collaboration:** we will make the best use of public money by working collaboratively with our population, partners and key stakeholders when making decisions to transform and improve health services
- **Transparency:** we are committed to fostering a culture of open communication and accountability in all aspects of our work
- **Innovation and Improvement:** we will explore new and better ways of developing and delivering health services, to continually improve care for local people
At the end of March 2014 our directly employed workforce was 96.3 full time equivalents.

The following table gives a breakdown of the number of persons of each sex at the end of March 2014:

<table>
<thead>
<tr>
<th>Group</th>
<th>Female (number of people)</th>
<th>Male (number of people)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governing Body</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Grade VSM other than persons falling within the above disclose</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Employees of the CCG</td>
<td>91</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 5: Breakdown of staff numbers and sex

In 2014-15 we will complement our Organisational Development (OD) Plan by developing a ‘People Strategy’ which will ensure best practice in the management and development of all staff, encompassing human resources, workforce information and intelligence, and learning and development. Whilst our predominant workforce is made up of directly employed staff we also have a wider workforce including Governing Body members and clinical commissioning leads. We also consider the partnerships we have with other external organisations that provide a valuable contribution to the delivery of our objectives.

2.13.1 Policies

Over the last year we have focused on working in partnership with trade unions to review the suite of Human Resources (HR) policies to ensure these are legally compliant and fit for purpose under our new organisation. These policies support managers and staff with employment issues on a day to day basis.

Our HR policies ensure that our staff members do not experience discrimination, harassment and victimisation and we ensure equality is integrated across all our employment practices and have a range of policies including the following which is not an exhaustive list:

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

Equality impact assessments have been carried out on all relevant policies and over the next year we will be monitoring the impact of the implementation of our workforce policies on our staff to ensure that we are proactively identifying and addressing any inequalities.

We value diversity and aim to support protected groups, including disabled people and people who suffer from mental health issues. We recognise that in order to remove barriers experienced by disabled people, we need to make reasonable adjustments for our disabled employees, which we do on a case by case basis, involving occupational health services as appropriate. We were awarded the Positive About Disabled People Two Ticks status, a nationally recognised symbol which
demonstrates our positive attitude towards employing disabled people. In March 2014, we went on to sign the charter to be a Mindful Employer, a voluntary agreement to show our support and commitment to employers who suffer from mental health issues, and in 2014-15 we will be working to meet the Mindful Employer standard in becoming a healthy workplace for all our staff.

2.13.2 Training and development
During our first year we have focused on ensuring staff are compliant in statutory and mandatory training, working to a 90% compliance rate. We have made significant steps in our first year as a statutory organisation towards this target however, as a new organisation this has been challenging in some areas, and we will be looking to further improve this to meet and maintain the target across all areas in 2014-15.

CCG staff members have participated in mandatory equality and diversity training, with senior management team members and staff directly involved in commissioning work attending a two hour session, which describes the implications of the Public Sector Equality Duty for people commissioning health services, and all other staff given access to an e-learning course.

In addition, one to one guidance and support is provided on Equality Impact Assessments and equality analysis and in relation to the commissioning of healthcare.

We have also worked with staff to develop a new Personal Development Review system based on objectives and behaviours. This new system supports the national changes to incremental pay progression for staff on Agenda for Change Terms and Conditions and reflecting those on non-Agenda for Change terms and conditions. This system enables staff to feel motivated and supported to achieve high performance in relation to our strategic objectives and priorities.

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

2.15 Equality and diversity report
The Equality Act has two broad aspects. The first is to prohibit discrimination, harassment and victimisation against people with one or more protected characteristic. Secondly the Public Sector Equality Duty (PSED) places an obligation on public bodies including our CCG to proactively improve equality for people with one or more protected characteristics.

We welcome the requirements of the Equality Act 2010 and recognise the many different characteristics that make up our diverse communities, both citywide and in our CCG’s geographical area.
We are committed to eliminating unlawful discrimination and promoting equality of opportunity in respect of the way we commission healthcare services and in relation to creating a workforce that is broadly representative of the population we serve. We make sure that equality and diversity is a priority when planning and commissioning local healthcare and in respect of our workforce.

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

**NHS Equality Delivery System**

The Equality Delivery System (EDS) is a toolkit that helps NHS organisations improve the services they commission or provide for their local communities, consider health inequalities in their locality and provide better working environments, free of discrimination, for those who work in the NHS. It is based on four goals, with 18 specific outcomes. As part of the EDS process, NHS organisations engage with their patients, local voluntary organisations and their staff in order to grade their equality performance, identify where improvements can be made and act on their findings.

The aim of the NHS Equality Delivery System (EDS) is to improve the equality performance of the NHS and embed equality into mainstream business planning processes.

We have been using the national Equality Delivery System (EDS), a system designed to support our organisation in our commissioning role to deliver better outcomes for our local population and a better working environment for staff which are personal, fair and diverse.

All the NHS organisations in Leeds have worked in partnership to identify local interests and subsequently established the Leeds NHS Equality Advisory Panel and Assessment Panel. Our evidence and assessment for 2013 was presented at our annual Leeds NHS Assessment Panel event, attended by our partners and local interests where final grades will be agreed.

During 2014-15 we will be working towards our transition from EDS and EDS2, in addition to improving our performance and outcomes in relation to equality. Link to EDS page on the website

In 2013-2014:

- We worked, and are continuing to work, with other agencies across West Yorkshire, including local authorities, the police, and universities, to ensure that our services better meet the needs of transgender patients;
- We became members of the Leeds NHS Equality Forum, working with NHS organisations in Leeds to improve health inequalities for our communities in relation to the commissioning and provision of healthcare and to improve equality of opportunity in respect of our workforce. During 2013-14 we held two NHS Equality Advisory Panel events;
- We joined the Leeds Equality Network, which brings together statutory organisations across Leeds working collectively and collaboratively to ensure a fair and inclusive society for people in Leeds. The network has agreed to focus on the lesbian, gay, bisexual and transgender (LGBT) communities for 2014 and are working together to contribute to the LGBT Friendly City agenda; and
- We have established a regular monthly update, included in our staff newsletter, about forthcoming religious celebrations and national equality related events and awareness days.

We welcome the requirements of the Equality Act 2010 and recognise the many different characteristics that make up our diverse communities, both citywide and in our CCG’s geographical area.
2.16 Sustainability report

Clinical Commissioning Groups (CCGs) have a huge role to play in improving the NHS’s environmental performance. Upon authorisation, the Governing Body made a commitment to promote environmental and social sustainability within the organisation, and it is important that CCG employees and member practices work together in helping the organisation become more sustainable, leading the way for other CCGs and NHS organisations to follow. With this in mind, NHS Leeds South and East CCG has a real opportunity to impact and improve on the NHS’s environmental performance, carbon footprint and sustainability plan.

Our Sustainable Development Management Plan (SDMP) was developed as part of our authorisation and assurance process. Being a new organisation we were yet to establish our impact or how we benchmarked against other organisations – this made it difficult to set reduction targets and we needed a different type of structure to work against.

So we developed our SDMP following guidance from the Sustainable Development Unit (SDU), and integrated this with a ‘Green Ladder’ approach to sustainability: a concept that sets out a framework for continual improvement and achievement. Actions from our Green Ladder are shown in figure 2 below. Our focus for 2013-14 has been to complete level one actions. For 2014-15 we plan to focus on level two, and alongside this we will assess the baseline data that we have collated throughout the year and introduce reduction targets to stretch our green ambitions.

Figure 2: The ‘Green Ladder’ approach

We work closely with sustainability experts WRM-ltd to support the development and implementation of sustainable working practices. Through this partnership we utilise...
their expertise, while ensuring that we up-skill our staff in newer areas of sustainability.

**Our Impact**

Our priority objective for year one has been to develop a baseline of NHS Leeds South and East CCG’s resource impact and to establish clear reduction targets for our 2014-15 SDMP. Impact has been measured in the following way:

- Environmental Impact (CO₂ emissions related to CCG activity)
- Financial Impact (associated costs of activity e.g. resource and transport costs)

A breakdown of our resource use is shown in figure 2 below from 1 April 2013 – 31 March 2014.

<table>
<thead>
<tr>
<th>Resource</th>
<th>Quantity</th>
<th>CO₂ Emissions</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gas</td>
<td>83,824 kWh</td>
<td>15.4</td>
<td>£3,352*</td>
</tr>
<tr>
<td>Electricity</td>
<td>82,198 kWh</td>
<td>36.6</td>
<td>£10,000*</td>
</tr>
<tr>
<td>Business Miles Travelled</td>
<td>24,188 miles</td>
<td>5.6</td>
<td>£10,072.00</td>
</tr>
<tr>
<td>Public transport miles travelled</td>
<td>888 miles</td>
<td>0.1</td>
<td>£262.00</td>
</tr>
<tr>
<td>General Waste</td>
<td>3.4 tonnes</td>
<td>n/a</td>
<td>£468.00</td>
</tr>
<tr>
<td>Recycling</td>
<td>9 tonnes</td>
<td>n/a</td>
<td>£3,281.00</td>
</tr>
<tr>
<td>Water</td>
<td>780 m³</td>
<td>1.0</td>
<td>£1000*</td>
</tr>
</tbody>
</table>

Table 6: Resource use, and associated cost and CO₂ emissions from Leeds South and East CCG for 2013/14

*estimated costs as actuals are still being calculated by our landlord.

The charts below show a breakdown of our resource impact by both cost and CO₂ emissions. Looking at the data in this way helps us to highlight the areas that we should focus on next in 2014/15.
Work has begun to develop ways to quantify and monitor impact and emissions relating to the supply chain, primarily through procurement and commissioning. Programmes are currently being developed for the next financial year so a baseline of supply chain impact can be calculated (or at least a partial supply chain impact) and reported for 2014/15.

We are also researching methods to measure the associated social impact of our activity and aim to have a social impact baseline developed by March 2015. This
work is being mirrored at national level and is a core focus for the Sustainable Development Unit.

Progress against the SDMP

Gaining Authorisation
Systems and processes are in place to ensure we comply with environmental and social statutory duties and other requirements, and ongoing improvements are in place for continued assurance.

Measure and Monitor Resource Use
We developed an environmental impact monitoring and reporting system so we can collate data on resource use, evaluate this data, and then feed this back into our SDMP revisions for 2014/15. We have now developed a baseline for gas, electricity, water and paper consumption, waste disposal and business travel – all of which we monitor on a monthly schedule.

Staff behaviour change programme
We have developed a ‘Sustainability Champion Scheme’ which has recruited and inducted nine champions. Champions have been through an external training programme, and receive additional support from WRM to help them to:

- Collate and establish footprints,
- Deliver projects and campaigns and
- Evaluate results.

The ‘CCGreen Team’ of environment champions ran their first campaign in February 2014 to increase recycling rates and ensure adequate and well signposted facilities available throughout the premises.

Sustainable procurement opportunities
A sustainable commissioning research workshop was delivered in partnership with neighbouring CCGs to:

- Review commissioning and procurement opportunities
- Establish where our commissioning processes contain good working practices and
- Identify which areas of our commissioning cycle should be the focus for the 2014/15 SDMP.

GP Sustainability Healthcheck Programme Yr1
Supporting our GP members to be more sustainable is a crucial part of our programme. We have delivered:

- Three Sustainability Healthcheck reviews at member practices to identify cost and carbon saving and renewable energy opportunities.
- Supported practices to prioritise recommendations and agree to improvement action plans
- Provided implementation support to help carry out improvements and embed change
SDMP review for 2014/15

We believe that our SDMP should not be ‘bolted on’ to our business plans; sustainable development should be integrated into our delivery plans. As we create our draft SDMP for 2014/15 we will enter a process of consultation with key internal and external stakeholders to ensure that we align sustainable and operational working practices and embed them within the organisation and our member practices.

It is expected that the SDMP will develop into four objective areas:

- Internal operations including; focusing on reducing business and staff travel, working with our landlord to reduce our energy use, and continuing to drive up our recycling rates - while driving down our general waste disposals.
- Working in partnership and delivering work programmes with NHS Leeds North CCG, NHS Leeds West CCG and West, South Yorkshire and Bassetlaw Commissioning Support Unit.
- Sustainable commissioning and procurement, including: signing up to and delivering through the Procuring for Carbon Reduction Tool and working with and supporting commissioning managers to align and embed sustainable criteria into current practices.
- Developing a GP Sustainability Plan and further programme delivery. Further Health-checks are expected to run alongside a pilot project to support practices accommodated in shared services buildings, or those struggling to engage with landlord on sustainability issues.
2.17 Our plans for the future

We have produced a two year operational plan for 2014-15-16 that is underpinned by five key strategic aims. As described in the strategic aims and objectives section within this Report these aims and objectives were refined following review of the 2013-14 aims and objectives, following further feedback and engagement from member practices, the Governing Body, public engagement and collaboration with our partners.

When developing our priorities for the coming years we have considered key national policies, guidance and the rights and responsibilities placed upon staff and patients under the NHS Constitution. We have considered the impact of the revised budget allocations issued by NHS England, the NHS Operating Framework, the NHS Mandate and recommendations from key national inquiries such as the Francis Report.

We have not forgotten the important role that our patients, carers and the wider public will play in helping us to deliver and refine our plans based on their feedback and experience. Putting patients at the heart of what we do is a central to the future development of NHS service locally and nationally.

Our five strategic aims for 2014-15-16 are:

- To improve the health of the whole population and reduce inequalities in our communities;
- To secure continuous improvement in the quality and safety of all services commissioned for our population;
- To ensure that patient, public and carer voices are at the centre of our healthcare services from planning to delivery;
- To deliver continuous improvement in health and social care systems within available resources;
- To develop and maintain a healthy organisation to underpin the effective delivery of our strategy.

The 2014-15-16 Operational Plan will be delivered through the implementation of a corporate programme management structure and robust project planning.

You can find out more about each of our five strategic aims below.

To improve the health of the whole population and reduce inequalities in our communities

We will work with a range of partners including the Leeds South and East Health and Wellbeing Partnership Forum and Third Sector Leeds to work on initiatives that will tackle the health inequalities that mean some people in our poorer neighbourhoods die sooner than those living in more affluent areas.

We will work with colleagues at Leeds City Council to develop joint plans that will look at how local people can access and be signposted to a wide range of services that can have a positive impact on their health. This will include employment support.
and advice and schemes such as the affordable homes project. We will also work on joint awareness campaigns that are designed to encourage people to make healthy lifestyle choices such as the Leeds Let’s Change programme. Other areas that we will be looking at will be encouraging people to complete their bowel cancer test, supporting people to manage their drinking and encouraging uptakes of health checks.

We know that over the coming years the NHS will be faced with much greater financial pressures and one of the ways we can address this is by encouraging people, particularly those with long-term conditions, to take greater control over their own health. To do this we will look at developing initiatives and patient education programmes that encourage greater self-management of long-term conditions such as respiratory conditions, diabetes and cardiovascular conditions.

We are also going to be developing new care pathways to support patients and clinicians in a range of areas. These include mental health, dementia and stroke as well as supporting carers to access services such as respite care. We will be implementing improved maternity and neonatal to ensure the best start to life for babies. We will develop end of life care pathways that link in with feedback we have had from local people who have experienced their loved ones go through palliative care.

**To secure continuous improvement in the quality and safety of all services commissioned for our population**

We are committed to keeping our patients safe and as a result we will continue to monitor and respond to any areas of concern that could affect the delivery of quality and safe care. We will work with partner CCGs, community and voluntary sector organisations and HealthWatch Leeds as well as our providers of services to monitor and act upon patient experience information.

Our plans include supporting the continuing roll out of the national Friends and Family Test in line with directions provided by NHS England. We will also look at a range of data such as hospital deaths that could be attributed to problems experienced during a patient’s care, incident reports gathered through a range of sources and information on never events (events that should never be allowed to happen that could lead to fatal or catastrophic consequences).

We have a duty to safeguard the most vulnerable people in society and we will continue to develop plans and campaigns that support the work of both the Safeguarding Adults and Safeguarding Children Boards. In addition to this we will be looking to implement the key recommendations from a number of national inquiries and reports including the Francis report, the Berwick Report and the review into care provided at Winterbourne View.

We are working with Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust and Leeds and York Partnerships NHS Foundation Trust to reduce the number of healthcare associated infections (HCAIs) in line with national targets.
We will be working with our member practices to see how we can support them to gather patient experience information and prepare them for the roll out of the Friends and Family Test within primary care. In April 2014 we will be supporting the implementation of the staff Friends and Family Test for all providers. We will also support the early implementation of patient Friends and Family Test by October 2014 in mental health and community settings.

We have stated that our Quality Premium aim is to ‘improve the reporting of medication errors’ so that we can continue to learn from incidents. We will be helping prescribers to understand how they can report any such errors so that Leeds continues to be a leading city for reporting medication errors.

To ensure that patient, public and carer voices are at the centre of our healthcare services from planning to delivery

A successful healthcare system relies on developing patient-centred care responsive to individual and community needs. To do this we will be listening to the views of patients, carers, the wider public and clinicians. We will be implementing systems that encourage patients to take greater control of their own health and giving them the advice they need to have greater confidence in managing their own health to reduce the need for hospital admission.

We are going to establish structured patient education programmes to develop specific disease or condition-specific information and advice. This will look at a range of approaches using a mix of traditional resources and digital media to provide ongoing support to patients especially those with existing long-term conditions.

From April 2014 parents of children and adults with physical and mental health disabilities who are eligible for continuing healthcare will have the opportunity to set up personal health budgets. We will help patients and their carers to understand how they can set up personal health budgets and what they can buy with them.

In addition to this we have an action plan developed within our communications, engagement and equality and diversity strategy to help us develop closer working relationships with our patients, the wider public and patient representative bodies such as HealthWatch Leeds and Third Sector Leeds. The strategy also highlights how we will involve patients and the public in all elements of the commissioning cycle. It also pays consideration to meeting the needs of our diverse communities, ensuring their views are heard and embedding equality into mainstream business planning processes and commissioning responsibilities using the NHS Equality Delivery System

To deliver continuous improvement in health and social care systems within available resources

As we enter into a period where demand on services continues to grow rapidly, we have an ageing population and tighter finances we have a duty to drive improvements in the Leeds health economy so that we can work closely with Leeds City Council and make the ‘Leeds pound’ go further. We will be looking at how we
can effectively transfer budget into the Better Care Fund that is being set up to support the integration agenda.

We are pleased with the progress we have made on the Leeds integrated health and social care programme and we will continue to develop more joined-up care pathways. We will look to build on our status as one of only 14 Department of Health designated pioneer sites for integration and draw upon national expertise to help us align services.

There are a range of ways we can deliver improvements in services to make the best use of resources and this will include programmes designed to:

- Increase the proportion of older people living independently at home following discharge from hospital;
- Increase the proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services;
- Develop services and respite care for carers;
- Improve the use of the risk stratification tool to identify patients with long-term conditions who are at risk of hospital admission if not treated quickly enough in primary care or supported to self-manage their condition; and
- Work with the third sector to reduce social isolation of people.

We are committed to ensure people living in our communities can lead active, healthy and independent lives. We will establish new care pathways in maternity and children's services in an effort to tackle infant mortality and ensure children and young people in the city enjoy the best possible start in life. Patients (or their carers) requiring NHS Continuing Healthcare will be assessed quickly in line with the national framework and be informed about their right to a personal health budget. We know that people prefer being treated closer to home and we will be developing services that can meet this need as well as supporting patients to understand how they can access health and social care that can reduce the risk of them developing a condition that requires admission to hospital.

NHS England is looking at the way urgent and emergency care is delivered and is working to develop guidance on the delivery of seven day services which will include GP practices as well as other care providers. We will be working with our member practices, as well as other care providers, to review how services are currently offered and how they may be delivered in the future. This will be supported by a robust patient and public engagement programme at a citywide level.

We will continue to monitor performance against key national standards and look to make improvements to service provision where our providers fail to meet national standards. This will include looking at how they are meeting their responsibilities under the NHS Constitution and supporting the patient choice agenda.

To develop and maintain a healthy organisation to underpin the effective delivery of our strategy

We want to be an organisation recognised nationally and locally for excellence and for being open and transparent in the way we operate.
Over the coming two years we will be working on a programme called Investors in Excellence which is designed to provide an organisation-wide approach to delivering first-class systems and processes. We will actively involve staff in embedding these principles and openly invite their views on how we can develop as an organisation so that we can deliver on our ambitious targets.

As an organisation committed to being a leader in the field of health and care commissioning we will regularly provide tailored updates for the wide range of audiences we work with and ask for their views on how we are performing so that we can continuously improve and mature. This will include looking at feedback from the NHS staff survey and NHS England’s 360 stakeholder survey that every CCG is involved in.

We value our staff and will continue to offer professional development opportunities so that they can pick up the skills and knowledge they need to help us achieve our aims. We want to encourage innovative thinking and will look to share best practice internally and externally. We will identify any opportunities to take advantage of new approaches that can help improve the health and wellbeing of our local communities.

We are signed up to the NHS sustainable development programme so that we minimise our impact on the environment. We will continue to implement programmes and awareness campaigns that help us meet our objective of reducing our carbon footprint by 10%.
2.18 Declarations

The accounts for the year ending 31 March 2014 have been prepared as directed by NHS England in accordance with section 232 (Schedule 15, Paragraph 3) of the National Health Service Act 2006.

We certify that the clinical commissioning group has complied with the statutory duties laid down in the National Health Service Act 2006 (as amended).

The CCG has not changed in its statutory format since its inception and remains a single statutory entity operating from a single address and has no branches or affiliated entries in addition to it.

The CCG operates from a single location which it leases through NHS Property Services: and is located along with a number of local businesses within the Thorpe Park Business Park at 2180 Century Way, Thorpe Park, Leeds, LS15 8ZB.

Dr Andrew Harris
Clinical Chief Officer
29 May 2014
3.0 Members Report

This report is prepared by the Governing Body.

There are no important events since the end of the financial year affecting NHS Leeds South and East Clinical Commissioning Group to report.

3.1 Membership of the Clinical Commissioning Group

The following table details the member practices of NHS Leeds South and East Clinical Commissioning Group:

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Arthington Medical Centre</td>
<td>5 Moor Road, Hunslet, Leeds, LS10 2JJ</td>
</tr>
<tr>
<td>2 Ashfield Medical Centre</td>
<td>The Grange Medical Centre, 999 York Road, Leeds, LS14 6NX</td>
</tr>
<tr>
<td>3 Ashton View Medical Centre</td>
<td>7 Ashton View, Leeds, LS8 5BS</td>
</tr>
<tr>
<td>4 Austhorpe View Surgery</td>
<td>5 Austhorpe View, Leeds, LS15 8NN</td>
</tr>
<tr>
<td>5 Beeston Village Surgery</td>
<td>James Reed House, Leeds, LS11 8PN</td>
</tr>
<tr>
<td>6 Bellbrooke Surgery</td>
<td>Bellbrooke Avenue, Leeds, LS9 6AU</td>
</tr>
<tr>
<td>7 Church Street Surgery</td>
<td>57 Church Street, Leeds, LS10 2PE</td>
</tr>
<tr>
<td>8 City View Medical Practice</td>
<td>Beeston Hill Community Centre, 123 Cemetery Road, Leeds, LS11 8LH</td>
</tr>
<tr>
<td>9 Colton Mill Medical Centre</td>
<td>Stile Hill Way, Colton, Leeds, LS15 9JH</td>
</tr>
<tr>
<td>10 Conway Medical Centre</td>
<td>51-53 Conway Place, Leeds, LS8 5DE</td>
</tr>
<tr>
<td>11 Cottingley Surgery</td>
<td>115 Cottingley Approach, Leeds, LS11 0HJ</td>
</tr>
<tr>
<td>12 East Park Medical Centre</td>
<td>5-7 East Park Road, Leeds, LS9 9JD</td>
</tr>
<tr>
<td>13 Garforth Medical Centre</td>
<td>Church Lane, Garforth, Leeds, LS25 1HB</td>
</tr>
<tr>
<td>14 Gibson Lane Practice</td>
<td>Gibson Lane, Kippax, Leeds, LS25 7JN</td>
</tr>
<tr>
<td>15 Grange Medicare – Middleton Park</td>
<td>Middleton Park Surgery, Middleton Clinic, Middleton Park Avenue, Leeds, LS10 4HT</td>
</tr>
<tr>
<td>16 Grange Medicare – New Cross Surgery</td>
<td>Stone Brig Lane, Rothwell, Leeds, LS26 0UE</td>
</tr>
<tr>
<td>17 Grange Medicare – Swillington Health Practice</td>
<td>Hill Crest Close, Swillington, Leeds, LS26 8DZ</td>
</tr>
<tr>
<td>18 Harehills Corner Surgery</td>
<td>209 Roundhay Road, Leeds, LS8 4HQ</td>
</tr>
<tr>
<td>19 Hunslet Health Centre</td>
<td>24 Church Street, Leeds, LS10 2PE</td>
</tr>
<tr>
<td>20 Kippax Hall Surgery</td>
<td>54 High Street, Kippax, Leeds, LS25 7AB</td>
</tr>
<tr>
<td>21 Leeds City Medical Practice</td>
<td></td>
</tr>
<tr>
<td>22 Lincoln Green Medical Centre</td>
<td>Burmantofts Health Centre, Cromwell Mount, Leeds, LS9 7TA</td>
</tr>
<tr>
<td>23 Lingwell Croft Surgery</td>
<td>16 Sheldrake Drive, Middleton, Leeds, LS10 3NB</td>
</tr>
<tr>
<td>Practice Name</td>
<td>Address</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Lofthouse Surgery</td>
<td>2 Church Farm Close, Wakefield, WF3 3SA</td>
</tr>
<tr>
<td>Manston Surgery</td>
<td>72-76 Austhorpe Road, Cross Gates, Leeds, LS15 8DZ</td>
</tr>
<tr>
<td>Moorfield House Surgery</td>
<td>11 Wakefield Road, Garforth, Leeds, LS25 1AN</td>
</tr>
<tr>
<td>Nova Scotia Medical Centre</td>
<td>22a Leeds Road, Allerton Bywater, Castleford, WF10 2DP</td>
</tr>
<tr>
<td>Oakley Medical Practice</td>
<td>12 Oakley Terrace, Leeds, LS11 5HT</td>
</tr>
<tr>
<td>Oulton Medical Practice</td>
<td>Quarry Hill, Oulton, Leeds, LS26 8SZ</td>
</tr>
<tr>
<td>Park Edge Practice</td>
<td>Asket Drive, Leeds, LS14 1HX</td>
</tr>
<tr>
<td>Primary Health Care for the Homeless</td>
<td>68 York Street, Leeds, LS9 8AA</td>
</tr>
<tr>
<td>Radshan Medical Centre</td>
<td>33-35 Butt Hill, Kippax, Leeds, LS25 7JU</td>
</tr>
<tr>
<td>Shaftesbury Medical Centre</td>
<td>East Leeds Health Centre, 78 Osmondthorpe Lane, Leeds, LS9 9EF</td>
</tr>
<tr>
<td>Shafton Lane Medical Centre</td>
<td>20a Shafton Lane, Holbeck, Leeds, LS11 9RE</td>
</tr>
<tr>
<td>Shakespeare Medical Practice</td>
<td>Burmantofts Health Centre, Cromwell Mount, Leeds, LS9 7TA</td>
</tr>
<tr>
<td>The Garden Surgery</td>
<td>2nd Floor, East Leeds Health Centre, 78 Osmondthorpe Lane, Leeds, LS9 9EF</td>
</tr>
<tr>
<td>The Medical Centre</td>
<td>846 York Road, Leeds, LS14 6DX</td>
</tr>
<tr>
<td>The Richmond Medical Centre</td>
<td>15 Upper Accommodation Road, Leeds, LS9 8RZ</td>
</tr>
<tr>
<td>The Roundhay Road Surgery</td>
<td>173 Roundhay Road, Leeds, LS8 5AN</td>
</tr>
<tr>
<td>The Whitfield Practice</td>
<td>24 Church Street, Leeds, LS10 2PT</td>
</tr>
<tr>
<td>Whinmoor Surgery</td>
<td>White Laithe Approach, Whinmoor, Leeds, LS14 2EH</td>
</tr>
<tr>
<td>Windmill Health Centre</td>
<td>Mill Green View, Leeds, LS14 5JS</td>
</tr>
<tr>
<td>York Road Surgery</td>
<td>179 York Road, Leeds, LS9 7RD</td>
</tr>
</tbody>
</table>

Table 7: Member practices of NHS Leeds South and East CCG

3.2 Our Governing Body and committees

The CCG has established a Governing Body whose role is to:

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

Our Governing Body, which meets regularly in public, comprises a diverse range of skills and experience and brings together clinicians, lay representatives,
management staff and local partners. It is led by a Lay Chair, Philip Lewer, who works closely with the CCG’s Clinical Chief Officer, Dr Andrew Harris.

In addition to the Executive Directors, who are full time officers of the CCG, there are a number of Non-Executive members on the Governing Body also. These include the Lay Chair and a further two lay members (one leading on Audit and Governance and one leading on Patient and Public Involvement). During the year, the lay members have actively provided scrutiny and challenge to the way in which the CCG fulfils its functions, by their membership on the Governing Body and also by their involvement in sub-committees.

There are also four GP Non-Executive representatives who represent the voice of member practices, ensuring that these are integral to the CCG’s decision making process. A Secondary Care consultant is also a member of the Governing Body. Full details including names and profiles of the Governing Body members are included within the Remuneration Report.
3.3 Audit Committee

The CCG’s Audit Committee is a key part of our governance and assurance framework and supports the organisation to achieve its goals, objectives and responsibilities to its stakeholders. The Audit Committee was established to provide the Governing Body with an independent and objective review of its financial systems, financial information and compliance with laws, guidance and regulations governing the NHS. The committee is appointed by the Governing Body from its non-executive members and consists of not less than three members, with a quorum being two members. The Chief Finance Officer and representatives from internal and external audit, counter fraud and CCG management are also in attendance. During the financial year April 2013 to March 2014 four Audit Committee meetings were held. All meetings were recorded as fully quorate.

Our Audit Committee members are:-

Brian Roebuck, Audit Committee Chair, Lay Member – Audit and Governance
Gordon Tollefson, Lay Member – Patient and Public Involvement
Dr Ben Browning, GP Non-Executive representative.

Full details of the Governing Body and sub-committees is contained within the Annual Governance Statement. The Governing Body profiles section of the Remuneration Report includes details of declarations of interest.

3.4 Political or charitable donations

The CCG has made/received no political or charitable donations since its inception.

3.5 Future developments

The new governance arrangements for the CCG came into effect from 1 April 2014. It is anticipated that the changes will increase the effectiveness of the Governing Body in a number of ways: by enabling increased scrutiny and challenge of quality and performance; providing learning and development opportunities for non-executives and supporting them in developing their understanding of the work of the CCG; and by strengthening the assurance the Governing Body receives on the achievement of the CCG strategic aims and statutory duties.

The Governing Body has made a commitment to embed the principles of best practice through every area of our organisation and we will be using the Investors in Excellence standard to help us achieve our ambition of becoming a leading organisation of excellence. The Governing Body will be involved in further development and prioritisation of the range of organisational improvement programmes in 2014-15.

3.6 Research and innovation

The CCG has demonstrated its commitment to research, innovation and improvement through its involvement in the Leeds Institute for Quality Healthcare (LIQH). We believe that decisions made between professionals and patients/service...
users based on data will lead to better care, and that clinical professionals need senior management support to provide care that works across the hospital and home settings. Every patient is different and so we expect care to be varied based on need; but we also expect clinicians to explain any difference to their colleagues and learn from each other’s practice.

The LIQH will secure improvement in quality care by:

- Enabling clinicians to develop shared expertise in innovation and improvement
- Developing a rigorous approach to professional accountability using data to review variation and decision making

This focus will create a culture of best quality clinical care at the best value, with patients/service users as partners in decision making. We know that working and learning together about improving care is the fastest and most economical way to get the best we can for service users. Creating this focus through the LIQH will make room for what we need to do to make the biggest impact. We also know that involving service users in that work will add even more value, so that is a key part of our plan.

The LIQH is a partnership between all the NHS Trusts and commissioners in Leeds, the City Council and the University of Leeds. It has been established to provide a place to learn and improve together across health and social care; primary and secondary care; clinicians/social workers and patients/service users; front line and management. This is the first time there has been a focus on a whole place, and all the health professionals working in that place. So we are learning from work on tools and techniques, but doing it in a way that will last and be embedded into how we do things.

3.7 Statutory format

The CCG has not changed in its statutory format since its inception and remains a single statutory entity operating from a single address and has no branches or affiliated entries in addition to it.

3.8 Pension liabilities

Treatment of pension liabilities is detailed in the annual accounts (note 1.9) and in the Remuneration Report.

3.9 Sickness absence data

A table is included in the employee benefits note at 4.3 to the Financial Statements.

Line managers are committed to providing support to staff via the Managing Sickness Policy to provide excellent working conditions, balancing the health needs of staff against the needs of the organisation.
3.10 External Audit

Our External Auditors are KPMG LLP, St. James’s Square, Manchester, M26DS, UK. Payment for services in 2013/14 is £100,000. Within this fee the auditors will provide:

- An external audit plan;
- An interim audit report;
- ISA 260 Report to those charged with governance;
- An auditor’s report giving opinion on financial statements, Value for Money conclusion and Audit Certificate;
- An Opinion on the Whole of Government Accounts Return / NHS Summarisation Schedules; and
- The Annual Audit Letter.

3.11 Disclosure of serious untoward incidents

The Data Security section of the Annual Governance Statement confirms there were no serious incidents involving data loss or confidentiality breaches during 2013-14.

3.12 Cost Allocation and setting of charges for information

We certify that the clinical commissioning group has complied with HM Treasury’s guidance on cost allocation and the setting of charges for information.

3.13 Principles for remedy

NHS Leeds South and East CCG is committed to providing quality responses to queries and concerns in line with The Parliamentary and Health Service Ombudsman published Principles for Remedy and follows the good practice principles contained therein.

Complaints are taken seriously by the organisation because they are a genuine means of helping the improvement of services. They also help us to manage our performance and highlight any areas where closer monitoring may be needed.

Complaints procedures and our contact details are provided through leaflets and on our website.

In 2013-2014 we managed seven formal complaints on behalf of residents of the CCG. Four of these complaints related to services from the CCG’s providers. The remaining three related directly to the CCG.

All complaints are dealt with on an individual basis and our responses aim to address fully the specific concerns raised. We want to apologise where standards are not achieved, make the relevant improvement, or provide an acceptable explanation where this is not possible. All feedback is analysed and lessons learned from complaints are reviewed with a view to making changes in practice, systems and processes to improve the future experience for everybody.
3.14 Employee consultation

It is important to us for staff to feel included. We hold regular team briefs delivered by the Executive Management Team to communicate key messages to ensure staff have awareness and can be involved in the CCG’s development. The format of the team brief ensures that comments and feedback are captured.

We have also established a Leeds CCG wide Social Partnership Forum with management and recognised trade union representatives. The purpose of the forum is to inform, consult and sometimes negotiate with trade unions on key issues. In 2013-14 this included involvement of staff and the Social Partnership Forum in the development of the Pay Progression Policy to take effect from 1 April 2014.

We have also supported the National Staff Survey where the 2013 results were formally published in April 2014. The overall response rate for 2013 was 57% which is above the National average of 49%. Some highlights included 92% of staff knowing who senior managers were in the organisation and 96% of staff believing that the organisation provides equal opportunities for career progression or promotion.

3.15 Disabled employees

For further information of the CCG policy in relation to disabled employees please see the Our Staff section of the Strategic Report.

3.16 Emergency Preparedness, Resilience and Response

NHS Leeds South and East CCG has an important role to play in any serious incidents such as floods, bad weather, heat wave or chemical incident. Whilst the CCG hopes that events like this will not happen, the CCG does a lot of work behind the scenes to make sure we are ready to support any of these should they occur.

Responsibilities with the Civil Contingencies Act 2004

Within the Civil Contingencies Act 2004, all CCGs have a responsibility to ensure local arrangements are in place for civil protection should an emergency occur.

The CCG has plans in place to make sure your health services continue to function in a crisis and to support you if you are affected.

A major incident or emergency is usually defined as any event which causes a threat, results in death or injury or damage to property or the environment or disruption to the community where the impact cannot be handled within routine service arrangements.

The CCG has three key responsibilities during an incident or emergency:

- Mobilising health care for those affected by the incident, including psychological support, provision of prescription medicines to reception centres.
• Assisting hospital trusts to discharge patients from hospital.
• Our responsibilities are carried out in accordance with a variety of statutory requirements and legislation. Including the Civil Contingencies Act (2004).

We certify that the clinical commissioning group has incident response plans in place, which are fully compliant with the NHS Commissioning Board Emergency Preparedness Framework 2013. The clinical commissioning group regularly reviews and makes improvements to its major incident plan and has a programme for regularly testing this plan, the results of which are reported to the Governing Body.

3.17 Statement as to Disclosure to Auditors

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

• So far as the member is aware, that there is no relevant audit information of which the clinical commissioning group’s external auditor is unaware; and,
• That the member has taken all steps that they ought to have taken as a member in order to make them self-aware of any relevant audit information and to establish that the clinical commissioning group’s auditor is aware of that information.

Dr Andrew Harris
Clinical Chief Officer
29 May 2014
4.0 Remuneration Committee Report

4.1 Remuneration Committee (not subject to audit)

The Remuneration Committee is a formally appointed committee of the Governing Body and its terms of reference comply with the Secretary of State’s Code of Conduct and Accountability for NHS Boards. The Remuneration Committee’s role is to advise and make recommendations to the Governing Body about appropriate remuneration and terms of service for the Clinical Chief Officer and other senior managers / officers not on Agenda for Change national terms and conditions.

The Remuneration Committee is comprised of Philip Lewer as chair, Brian Roebuck, the Lay Member for Governance and Audit and Gordon Tollefson, the Lay Member for Patient and Public Engagement. Each member of the Remuneration Committee is also a member of the Governing Body.

The Remuneration Committee has met on three occasions.

<table>
<thead>
<tr>
<th>Remuneration Committee Members</th>
<th>Attendance (no. of meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Chair (Philip Lewer)</td>
<td>3</td>
</tr>
<tr>
<td>Lay Member PPI (Gordon Tollefson)</td>
<td>3</td>
</tr>
<tr>
<td>Lay Member Governance (Brian Roebuck)</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 8: Remuneration Committee meeting information

The Chief Finance Officer and Assistant Director of Workforce and Organisational development also attended the committee meetings as ‘standing attendees’.

The Assistant Director of Workforce and Organisational Development is an employee of the West and South Yorkshire and Bassetlaw Commissioning Support Unit. Their role is to provide the committee with senior expert HR advice and to ensure compliance with any relevant employment legislation. The post holder was appointed as part of a wider service level agreement with West and South Yorkshire and Bassetlaw Commissioning Support Unit. They were selected based on their level of seniority and expertise. The committee is assured the advice received was objective and independent as the individual is not directly employed by the organisation. The payment for this expert advice is an annual charge as part of a wider service level agreement with West and South Yorkshire and Bassetlaw Commissioning Support Unit.

4.2 Policy on remuneration of senior managers (not subject to audit)

All Executive Directors and Non-Executive Directors are appointed by the CCG through an open recruitment process.

The remuneration and terms of service for the Lay Chair, Clinical Chief Officer, Chief Finance Officer, Chief Operating Officer, Medical Director, Director of Primary Care Engagement and Lay Member for Governance and Audit and the Lay Member for Patient and Public Engagement are in line with the recommendations made by the Remuneration Committee.

65
The Governing Body has ensured the highest level of independence consistent with the principle that no member of the Committee shall be involved in recommending their own remuneration or terms of appointment. The standing Committee members shall be the Chair and the two lay members of the CCG Governing Body. In the event the Committee is considering the remuneration or other terms of appointment of the lay members, the Committee membership shall be the Chair and two other Non-Executive members of the Governing Body, appointed by the Governing Body. In the event the Committee is considering the remuneration or other terms of appointment of the Chair, the committee shall comprise the Chief Clinical Officer and the two Lay members of the CCG Governing Body.

In setting the remuneration of the Clinical Chief Officer, Chief Financial Officer and Chief Operating Officer the CCG adheres to the guiding principles of the Hutton Review of Fair Pay. Any increase in pay is in line with nationally agreed pay awards.

4.3 Senior managers performance related pay (not subject to audit)

Current contracts do not require any performance related elements which would impact on the remuneration packages.

All Executive and Non-Executive Directors are subject to individual performance reviews and their performance is assessed against personal and corporate objectives. Key performance objectives will be based on the targets of the NHS Leeds South and East CGG Operational Plan. This involves setting and agreeing objectives on an annual basis.

In delivering performance targets and personal objectives they will adhere to the standards of conduct as articulated in the ‘code of conduct for NHS Managers’.

4.4 Policy on senior managers contracts (not subject to audit)

The pay and conditions for other senior managers are determined nationally under the Agenda for Change initiative. Currently contracts for senior staff are permanent, with notice periods of three months. There is no additional compensation for early termination of contracts other than as per statute.
### 4.5 Senior Managers Service Contracts (not subject to audit)

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Status</th>
<th>Contract type</th>
<th>Start date</th>
<th>Hours</th>
<th>Tenure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philip Lewer</td>
<td>Lay Chair</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 days per week</td>
<td>3 years</td>
</tr>
<tr>
<td>Dr Andy Harris</td>
<td>Chief Clinical Officer</td>
<td>Office holder</td>
<td>VSM Contract</td>
<td>01.04.13</td>
<td>6 sessions / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Mark Bradley</td>
<td>Chief Finance Officer</td>
<td>Employee</td>
<td>VSM Contract</td>
<td>18.01.13</td>
<td>37.5 hours / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Matt Ward</td>
<td>Chief Operating Officer</td>
<td>Employee</td>
<td>VSM Contract</td>
<td>18.01.13</td>
<td>37.5 hours / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Eleanor Monkhouse</td>
<td>Director of Nursing &amp; Quality</td>
<td>Joint Appointment with NHS Leeds North CCG</td>
<td>8d – Agenda for Change Contract</td>
<td>03.01.13</td>
<td>37.5 hours / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Dr Dave Mitchell</td>
<td>GP Executive (Medical Director)</td>
<td>Office holder</td>
<td>VSM Contract</td>
<td>01.04.13</td>
<td>4 sessions / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Dr Jackie Campbell</td>
<td>GP Executive (Caldicott Guardian)</td>
<td>Office holder</td>
<td>VSM Contract</td>
<td>01.10.13</td>
<td>3 sessions / week</td>
<td>Permanent</td>
</tr>
<tr>
<td>Roderick Robertson</td>
<td>Secondary Care Consultant</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 sessions / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Brian Roebuck</td>
<td>Lay member - Governance</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.08.12</td>
<td>2.5 days / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Gordon Tollefson</td>
<td>Lay member - PPI</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.08.12</td>
<td>2.5 days / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Dr Alistair Walling</td>
<td>GP Non-Executive Director</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 sessions / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Dr Tom Gibbs</td>
<td>GP Non-Executive Director</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 sessions / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Dr Daniel Albert</td>
<td>GP Non-Executive Director</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 sessions / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Dr Ben Browning</td>
<td>GP Non-Executive Director</td>
<td>Office holder</td>
<td>Contract for service (payroll)</td>
<td>01.04.13</td>
<td>2 sessions / month</td>
<td>3 years</td>
</tr>
<tr>
<td>Victoria Eaton</td>
<td>Public Health Consultant</td>
<td>Leeds City Council Employee</td>
<td>Honorary Contract</td>
<td>01.04.13</td>
<td>37.5 hours / week</td>
<td>3 years</td>
</tr>
</tbody>
</table>

**Table 9: Service Managers Service Contracts**

There is no additional compensation for early termination of contracts other than as per statute.
4.6 Payments to Past Senior Managers (subject to audit)

The CCG did not make any Payments to Past Senior Managers in the Financial Year.

4.7 Payments for Loss of Office (subject to audit)

The CCG did not make any Payments for Loss of Office in the Financial Year.
4.8 Salary and Allowances Disclosure (subject to audit)

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Salary and Fees</th>
<th>Taxable Benefits Note 4</th>
<th>Annual Performance Related Bonuses</th>
<th>Long-term Performance Related Bonuses</th>
<th>Sub total Salaries and Other Remuneration</th>
<th>All Pension Related Benefits Note 5</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note (bands of £5,000)</td>
<td>(bands of £5,000)</td>
<td>(bands of £5,000)</td>
<td>(bands of £5,000)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phillip Lewer - Lay Chair</td>
<td>20 - 25</td>
<td>31</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Dr Andy Harris - Clinical Chief Officer</td>
<td>110 - 115</td>
<td>25 - 30</td>
<td>110 - 115</td>
<td>145 - 147.5</td>
<td>255 - 260</td>
<td>25 - 30</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Mark Bradley - Chief Finance Officer</td>
<td>100 - 105</td>
<td>4</td>
<td>100 - 105</td>
<td>72.5 - 75</td>
<td>175 - 180</td>
<td>25 - 30</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Matt Ward - Chief Operating Officer</td>
<td>95 - 100</td>
<td>7</td>
<td>95 - 100</td>
<td>42.5 - 45</td>
<td>140 - 145</td>
<td>25 - 30</td>
<td>25 - 30</td>
</tr>
<tr>
<td>Ellie Monkhouse - Director of Nursing and Quality</td>
<td>30 - 35</td>
<td>30 - 35</td>
<td>62.5 - 65</td>
<td>95 - 100</td>
<td>95 - 100</td>
<td>30 - 35</td>
<td>30 - 35</td>
</tr>
<tr>
<td>Dr Dave Mitchell – Medical Director</td>
<td>60 - 65</td>
<td>60 - 65</td>
<td>60 - 65</td>
<td>90 - 95</td>
<td>90 - 95</td>
<td>60 - 65</td>
<td>60 - 65</td>
</tr>
<tr>
<td>Dr Jackie Campbell – Director of Primary Care Engagement</td>
<td>45 - 50</td>
<td>45 - 50</td>
<td>45 - 50</td>
<td>45 - 47.5</td>
<td>90 - 95</td>
<td>45 - 50</td>
<td>45 - 50</td>
</tr>
<tr>
<td>Dr Rod Robertson – Secondary Care Consultant</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Brian Roebuck – Non Executive</td>
<td>5 - 10</td>
<td>8</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
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</tr>
<tr>
<td>Gordon Tollefson – Non Executive</td>
<td>5 - 10</td>
<td>4</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Dr Alistair Walling – GP Non Executive</td>
<td>5 - 10</td>
<td>5 - 10</td>
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<td>5 - 10</td>
<td>5 - 10</td>
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<td>5 - 10</td>
</tr>
<tr>
<td>Dr Tom Gibbs – GP Non Executive</td>
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</tr>
<tr>
<td>Dr Daniel Albert – GP Non Executive</td>
<td>5 - 10</td>
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<td>5 - 10</td>
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<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Dr Ben Browning – GP Non Executive</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
<td>5 - 10</td>
</tr>
<tr>
<td>Victoria Eaton – Public Health Consultant</td>
<td>3 -</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Table 10: Salaries and Allowances

Notes
The CCG became a statutory body on 1st April 2013, therefore comparable figures for 2012/13 are not available
1. Total NHS salary is in the band 65 - 70 and Pension related benefits in band 125 - 127.5 but only the element relating to NHS Leeds South & East CCG has been disclosed.
2. The salaries and fees disclosed reflect payments direct to GP Practices for replacement costs 1st April 2013 to 31st January 2014 and employment by the CCG from 1st February 2014 onwards.
3. Victoria Eaton is employed and remunerated by the Local Authority.
4. All pension related benefits - relates to the increase in Pension Entitlement calculated using the method set out in section 229 of Finance Act 2004.
5. Taxable Benefits relate to the element of taxable travel reimbursement.
4.9 Pay Multiples (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of the organisations workforce. The calculation is based on the annualised whole time equivalent of the CCG employees.

<table>
<thead>
<tr>
<th>Highest Paid Director 2013/14 Mid Point of £5,000 Salary Band</th>
<th>Median Remuneration 2013/14</th>
<th>Ratio 2013/14</th>
<th>Highest Paid Director 2012/13 Mid Point of £5,000 Salary Band</th>
<th>Median Remuneration 2012/13</th>
<th>Ratio 2012/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>£162,500</td>
<td>£34,530</td>
<td>4.7</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Table 11: Pay Multiples

Note
The CCG became a statutory body on 1st April 2013, therefore comparable figures for 2012/13 are not available

The banded remuneration of the highest paid member of the Governing Body in the clinical commissioning group in the financial year 2013-14 was £162,500. This was 4.7 times the median remuneration of the workforce, which was £34,530.

In 2013-14 no employees received remuneration in excess of the highest-paid member of the Governing Body.

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

Payments to agency staff are taken into account in the calculation of median remuneration.
### 4.10 Pensions Benefits (subject to audit)

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Note</th>
<th>Real Increase in pension at age 60 (bands of £2,500)</th>
<th>Real Increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2014 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2014 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2014</th>
<th>Cash Equivalent Transfer Value at 31 March 2013</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
<th>Employer's contribution to stakeholder pension</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Andy Harris - Clinical Chief Officer</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 7.5</td>
<td>15 - 20</td>
<td>45 - 50</td>
<td>325</td>
<td>121</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Matt Ward - Chief Operating Officer</td>
<td>2.5 - 5</td>
<td>10 - 12.5</td>
<td>10 - 15</td>
<td>40 - 45</td>
<td>150</td>
<td>103</td>
<td>45</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Bradley - Chief Finance Officer</td>
<td>5 - 7.5</td>
<td>17.5 - 20</td>
<td>25 - 30</td>
<td>75 - 80</td>
<td>364</td>
<td>263</td>
<td>96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ellie Monkhouse - Director of Nursing and Quality</td>
<td>7.5 - 10</td>
<td>25 - 30</td>
<td>10 - 15</td>
<td>35 - 40</td>
<td>175</td>
<td>39</td>
<td>136</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Jackie Campbell – Director of Primary Care Engagement</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>5 - 10</td>
<td>15 - 20</td>
<td>100</td>
<td>39</td>
<td>10</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Table 12: Pension Benefits

**Notes**

*The CCG became a statutory body on 1st April 2013, therefore comparable figures for 2012/13 are not available.*

*Only Governing Body Members for whom contributions are made to a Pension scheme are listed in the table.*

1. **Total pension details are shown for employment across 2 CCGs.**

**Cash Equivalent Transfer Values**

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member’s accrued benefits and any contingent spouse’s pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their membership of the pension scheme. This may be for more than just their service in a senior capacity to which disclosure applies (in which case this fact will be noted at the foot of the table). The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

**Real Increase in CETV**

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.
4.11 Off Payroll Engagements (not subject to audit)

Off-payroll engagements as of 31 March 2014, where payment is greater than £220 per day and that last longer than six months are as follows:

<table>
<thead>
<tr>
<th>Number</th>
<th>The number that have existed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• For less than one year at the time of reporting</td>
<td>3</td>
</tr>
<tr>
<td>• For between one and two years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>• For between two and three years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>• For between three and four years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>• For four or more years at the time of reporting</td>
<td>-</td>
</tr>
<tr>
<td>Total number of existing engagements as of 31 March 2014</td>
<td>3</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Number</th>
<th>Number of new engagements, or those that reached six months in duration, between 1 April 2013 and 31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Number</td>
<td>Number of the above which include contractual clauses giving the clinical commissioning group the right to request assurance in relation to Income Tax and National Insurance obligations</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Number</td>
<td>Number for whom assurance has been requested</td>
</tr>
<tr>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Of which, the number:</td>
<td></td>
</tr>
<tr>
<td>• For whom assurance has been received</td>
<td>3</td>
</tr>
<tr>
<td>• For whom assurance has not been received</td>
<td>-</td>
</tr>
<tr>
<td>• That have been terminated as a result of assurance not being received</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number</th>
<th>Number of off-payroll engagements of Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility, during the financial year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-</td>
</tr>
<tr>
<td>Number</td>
<td>Number of individuals that have been deemed “Membership Body and/or Governing Body members, and/or, senior officials with significant financial responsibility”, during the financial year (this figure includes both off-payroll and on-payroll engagements)</td>
</tr>
<tr>
<td></td>
<td>-</td>
</tr>
</tbody>
</table>

Table 13: Off-payroll Engagements
4.12 Governing Body Profiles

Our Governing Body members are:

Chair: Philip Lewer, Lay Chair
Philip has more than 40 years’ experience working across health and social care, including 25 years’ experience of managing large complex organisations and working with their governing bodies as a chief officer within a local authority. His career has seen him implement programmes in the Yorkshire and Humber region on behalf of the Department of Health as well as negotiating large scale contracts with independent providers at a national, regional and local level.

Philip has extensive experience of being a board member. This includes being chair of Mind the Gap (a theatre company for people with learning difficulties), a board member of the Dementia Collaborative, a Professional Executive Member at Calderdale PCT, board member of the National Involvement Project 2007-9, a co-opted member of the Government’s Standing Commission On Carers 2010-12 and a board member of Calico Housing Social Enterprise in Burnley.

Having started his career as a market trader, Philip has always been keen to deliver effective services based on the needs of people. It is this passion that has helped him deliver service improvements that benefit patients and the wider public. Philip is the chair of the CCG Governing Body and also chair of the Remuneration Committee.

Executive Directors

Clinical Chief Officer: Dr Andy Harris
Dr Andy Harris is a principle general practitioner with over 20 years’ experience of working in a large training practice in Leeds managing a population with diverse health and social care needs. In 2007 Andy was appointed as the Chairman of Leodis LLP which was a leading edge Practice Based Commissioning Consortia.

Leodis LLP has since evolved into NHS Leeds South and East Clinical Commissioning Group as part of legislative changes and has expanded to cover 43 local GP practices in the Leeds South and East area. Andy has led the organisational development of NHS Leeds South and East Clinical Commissioning Group and was formerly appointed to the position of Clinical Chief Officer in June 2012. Andy is also the Chair of the Leeds Health and Social Care Transformation Programme Board.
Chief Finance Officer: Mark Bradley
Mark qualified as an accountant in 1997 and has significant experience of working within senior finance positions in the NHS, including both commissioning and provider organisations. Mark is a member of the Chartered Institute of Management Accountants, holds an MBA (Dist) and has completed the NHS Strategic Financial Leadership Programme.

Mark is a member of the Healthcare Financial Management Association’s Commissioning Technical Group, enabling the sharing of best practice and innovation in commissioning finance.

Chief Operating Officer: Matthew Ward
Matt has worked in the NHS for more than 10 years, having left the private sector in 2003. Since then his roles have spanned across several health sectors including acute and community care, commissioning and strategic development. Throughout this time he has had significant success in delivering complex change programmes, managing large budgets and driving forward continuous improvements in clinical services. His experience to date has allowed him to understand the importance of commissioning in shaping the future of the health and social care system.

Matt studied economics at university before then undertaking a masters in healthcare leadership at Manchester business school. More recently he attended Oxford Said business school completing a leadership development programme, and believes strongly that organisational and individual development is key for success in the modern NHS.

Director of Nursing and Quality: Ellie Monkhouse
Ellie trained as a Registered General Nurse at Derby University and qualified in 1995. Since then Ellie has gained a wide range of experience, starting off her working life as a staff nurse in Trauma and Orthopedics. Ellie was able to gain experience working in other nursing specialties such as surgery and as a nutrition nurse specialist before moving into nursing management roles in Medical Education, Urgent Care, Emergency Assessment and Neonatal Medicine. In addition, Ellie was at NHS Sheffield where she was lead nurse for quality, infection control, audit and effectiveness before moving to back into a provider to work as a general manager in Elective Care.

Ellie has a strong interest and background in quality and patient safety, as well as having experience as both a nurse, and a manager. Ellie works full-time in the role, which is a joint appointment with NHS Leeds North Clinical Commissioning Group. This dual responsibility provides added value by promoting joint working with the two CCGs. Ellie works in partnership with Diane Hampshire who is the Director of Nursing and Quality for Leeds West CCG.

Consultant in Public Health: Victoria Eaton
Victoria has been a Consultant in Public Health in Leeds since 2007, and has worked in a range of public health roles in Leeds since 1997, following previous experience in the North West, West Midlands and Yorkshire and Humber regions. Victoria’s current role includes developing the public health agenda of NHS Leeds
South and East Clinical Commissioning Group, and supporting a joined-up approach with the new public health and wellbeing roles of Leeds City Council to improve health and reduce health inequalities in the South and East Leeds communities.

Throughout her career, Victoria has had a strong interest and commitment to addressing inequalities in health, which has consistently remained a theme in her work. This has included teaching in several academic programmes of public health and an active role in education and workforce development for public health. Victoria has a strong interest in translating policy into practice within communities and the use of evidence and innovation to address the challenges of the new public health agenda.

GP Executives

Dr Jackie Campbell Director of Primary Care Engagement (Caldicott Guardian)
Jackie qualified from Edinburgh University in 1984 and completed her GP training in 1988. Jackie has been a partner at Lingwell Croft Surgery in Middleton since 1988 and has been involved in commissioning of patient services through the various NHS changes for several years. She is the lead for practice engagement, education and training for Leeds South and East Clinical Commissioning Group.

Dr Dave Mitchell Medical Director and Prescribing Lead
Dave qualified at Leeds University in 1984 and has worked in the Leeds area ever since. He has been a GP partner at Leeds City and Parkside practice in Beeston since 1988. Dave became involved with Leodis LLP commissioning group in 2008 and has lead in prescribing and health & wellbeing, working with a medicines management team and local authority partners. Having worked in Leeds as a GP, since 1988, he has seen first-hand the effects that deprivation, poverty and social isolation can have on the health of individuals. As a board member of LSE CCG he feels we have a great opportunity to address the health inequalities in the city and make health services more responsive to local needs.

GP Non-Executive Directors:

Dr Daniel Albert
Daniel entered medicine late, after training in physics. He prides himself on having been a patient for a long time before being a doctor. He was a partner in the Whitfield Practice in South Leeds for 12 years, before taking on a broader portfolio. Since then, he had roles as chairman of South Leeds PCG and then PEC Chair of South Leeds PCT.

In recent years, he developed his interest in community emergency medicine, obtaining a post-graduate certificate in Urgent Care and becoming an associate fellow of the College of Emergency Medicine. He currently works as a GP with York Street Practice in Leeds, looking after homeless people and asylum seekers, and as a Hospital Practitioner in Emergency Medicine in Galloway Community Hospital. He is a trustee of a charity providing pre-hospital emergency care in West Yorkshire.

Daniel is the Chair of the Governance and Risk Committee and is a member of the Governing Body.
Dr Alistair Walling

Alistair qualified from Leeds University in 2003 and completed his GP training in Leeds in 2007. He has been a partner at Ashfield Medical Centre since 2007, after a short stint as a locum in and around Leeds. Alistair has been the practice commissioning lead since starting, and is looking forward to the challenges and opportunities the CCG will face in the future. He is interested in many aspects of primary care, especially the use of information technology to improve efficiency and quality.

Dr Tom Gibbs

Tom is a partner at Shaftesbury Medical Centre. He trained at Imperial College School of Medicine, qualifying in 2002. He moved to Leeds for his house jobs and then his GP training scheme. He finished this in 2007. He has worked at Shaftesbury Medical Centre since, first as a salaried GP and now as a partner. Prior to undertaking medicine, Tom gained a BSc in Medical Microbiology at Edinburgh University and a Masters in Public Health in Developing Countries from The London School of Hygiene and Tropical Medicine. During this period, he undertook research in London, Tanzania and Uganda. Tom is currently a GP trainer and his practice's lead for commissioning.

Tom is a member of the Governing Body meeting

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.

Ben has been a partner at Lofthouse Surgery for 16 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 is now working as a Non-executive Director on NHS Leeds South and East CCG board in addition to his full time G.P. role such that he can continue to move primary health care forwards. Ben 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. Ben is enthusiastic about the opportunity of working towards these ends representing the best interests of the patients in the NHS Leeds South and East CCG area.

Ben is a member of the Governing Body.
Secondary Care Consultant: Rod Robertson

Dr. Roderick (Rod) Robertson qualified in medicine at Edinburgh University in 1975. Rod was initially a medical officer in the Royal Navy, including 2 years as a submariner. During this time, he trained as a physician.

Upon leaving the Royal Navy, Rod trained as a radiologist, coming to Leeds in 1986. He became a Consultant Radiologist, involved predominantly in the investigation of chest diseases first at Killingbeck Hospital and the Leeds Chest clinic, followed by Leeds Teaching Hospitals NHS Trust as it evolved.

Rod’s other responsibilities have included training, having been Yorkshire Regional Adviser in Radiology. He was elected to the Council of the Royal College of Radiologists for four years, and in Leeds Teaching Hospital NHS Trust, Rod was the Divisional Medical Manager for Diagnostics and Therapeutics, retiring at the end of March 2013.

Rod was involved in setting up the trial of a self-referral Chest X-Ray service in Leeds, which started in areas of the Leeds South and East CCG locality. He wishes to continue to promote effective clinical collaboration across primary and secondary care to best meet the needs of the Leeds South and East CCG population.

Rod is a member of the Governing Body.

Lay member: Gordon Tollefson (Patient and Public Involvement)

Gordon has been involved in the NHS and patient services in particular for almost 40 years, initially as Chief Officer of the Pontefract & District Community Health Council and thereafter as a Patient Services Director for accident & emergency care with West Yorkshire Metropolitan Ambulance Service. Retiring from the ambulance service in 2006, Gordon joined the Board of Leodis Practice Based Commissioning Group in 2007 to lead the patient and public involvement agenda.

Within Leeds and the wider West Yorkshire area, Gordon holds a number of other positions, all of which involve close contact with the community.

Whilst recognising his corporate position as a member of the Governing Body of NHS Leeds South & East Clinical Commissioning Group, Gordon’s prime objective is to ensure that there is a robust and transparent structure in place for the voices of patients and the public to be heard at all stages within the commissioning process.

Gordon is the Chair of the Patient Advisory Group and is a member of the Governing Body, Governance and Risk Committee, Audit Committee and Remuneration Committee.
Lay Member: Brian Roebuck (Governance and Audit)

Brian qualified as a mathematician at Oxford University and as an engineer at Sheffield University, before qualifying with the Chartered Institute of Public Finance and Accountancy in 1977.

Brian has worked in a wide range of senior financial roles within the public, private and voluntary sectors. For the last 20 years, he has worked mostly in social housing (with Ridings Housing Association in Leeds and Futures Housing Group in Derbyshire) before retiring from full-time employment in 2011. During that time, he developed special interests in local authority housing stock transfers, treasury management and risk management.

Brian has a long association with mental health, having been a member of the Board of Community Links Limited since 1994. He is also a director of the Jephson Housing Association Group and Chair of that group’s Northern Board.

His primary aim as a member of the Governing Body of NHS Leeds South and East Clinical Commissioning Group is to ensure that there are sound governance arrangements in place, which will enable the organisation to operate with maximum effectiveness.

Formal meetings of the governing body take place on a bi-monthly basis and during the year six meetings were held. All meetings were recorded as fully quorate.

Brian is the chair of the Audit committee and a member of the Governing Body and Remuneration Committee.
**Declared interests and conflicts**

Governing Body members made the following declarations of interest:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/ Role</th>
<th>Details of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Philip Lewer</td>
<td>Lay Chair</td>
<td>Co-opted member on the Government’s Standing Commission of Carers</td>
</tr>
<tr>
<td>Dr Andy Harris</td>
<td>Clinical Chief Officer</td>
<td>GP Partner – Dr Darbyshire &amp; Partners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shareholder – Leodis Care Ltd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – Royal College of General Practitioners</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – Royal College of Surgeons (Edinburgh)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – Leodis LLP (shell company)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse – GP Partner at Oulton and Rothwell Medical Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Spouse - Clinical Lead for Integrated Health and Social Care</td>
</tr>
<tr>
<td>Matthew Ward</td>
<td>Chief Operating Officer</td>
<td>Spouse – Director of Health, The Campaign Company</td>
</tr>
<tr>
<td>Dr Dave Mitchell</td>
<td>Medical Director</td>
<td>GP Partner – Leeds City Medical Practice</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – Leodis LLP (shell company)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shareholder – Leodis Care Ltd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – British Medical Association</td>
</tr>
<tr>
<td>Dr Jacqueline Campbell</td>
<td>Director of Clinical Engagement</td>
<td>GP Partner – Lingwell Croft Surgery</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Member – Leodis LLP (shell company)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shareholder – Leodis Care Ltd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Shareholder &amp; Director Property owning Company – Lingwell Croft Ltd</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appraiser – NHS ABL</td>
</tr>
<tr>
<td>Name</td>
<td>Position</td>
<td>Experience</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Ellie Monkhouse    | Executive Nurse                   | Spouse Business – Ankle & Co  
Spouse Clinical Lead – Leeds Teaching Hospital Trust |
| Gordon Tollefson   | Lay Member – Patient & Public Involvement | Advisor on Standards & Conduct – Leeds City Council  
Magistrate – Leeds Magistrates Court  
Chairman of the Board – The Prince of Wales Hospice Pontefract  
Coordinator – West Yorkshire Medic Response Team  
Shareholder – Leodis Care Ltd  
Public Appointment of Deputy Lieutenant – West Yorkshire Lieutenancy |
| Brian Roebuck      | Lay Member – Governance & Audit   | Management Committee Member – Community Links (Northern) Ltd |
| Dr Tom Gibbs       | Non-Executive Director            | GP Partner – Dr Darbyshire & Partners  
Shareholder – Leodis Care Ltd  
Member – Royal College of General Practitioners  
Member – British Medical Association  
Spouse – Paediatric Registrar at Leeds Teaching Hospitals |
| Dr Alistair Walling| Non-Executive Director            | GP Partner – Ashfield Medical Centre & The Grange Medical Centre  
Member – Royal College of General Practitioners  
Member – British Medical Association  
Sessional Employee – Local Direct Care |
<table>
<thead>
<tr>
<th>Name</th>
<th>Position</th>
<th>Declarations of Interest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Benjamin Browning</td>
<td>Non-Executive Director</td>
<td>GP Partner – Lofthouse Surgery&lt;br&gt;Shareholder – Leodis Care Ltd&lt;br&gt;Spouse – GP Partner Lofthouse Surgery&lt;br&gt;Spouse – Clinical Lead Long Term Conditions and Elderly Care, NHS Leeds South and East CCG.</td>
</tr>
<tr>
<td>Dr Daniel Albert</td>
<td>Non-Executive Director</td>
<td>Employee – Leeds Community Healthcare Trust&lt;br&gt;Employee – Harrogate District NHS Trust&lt;br&gt;Employee – Leeds Teaching Hospitals NHS Trust&lt;br&gt;Employee – Dumfries and Galloway Health Board&lt;br&gt;Owner – Self Employed Locum Doctor/Out of Hours Doctor</td>
</tr>
<tr>
<td>Mark Bradley</td>
<td>Chief Finance Officer</td>
<td>Spouse – Community District Nurse, Mid Yorkshire Hospitals NHS Trust</td>
</tr>
<tr>
<td>Victoria Eaton</td>
<td>Consultant in Public Health</td>
<td>Leeds City Council Employee – transfer of employment from NHS – April 2013</td>
</tr>
</tbody>
</table>

Table 14: Governing Body Members and Declarations of Interest

Dr Andrew Harris  
Clinical Chief Officer  
29 May 2014
5.0 Annual Governance Statement

Governance Statement by the Clinical Chief Officer as the Accountable Officer of NHS Leeds South and East Clinical Commissioning Group.

5.1 Introduction and context

The clinical commissioning group was licenced from 1 April 2013 under provisions enacted in the Health & Social Care Act 2012, which amended the National Health Service Act 2006.

The clinical commissioning group operated in shadow form prior to 1 April 2013, to allow for the completion of the licencing process and the establishment of function, systems and processes prior to the clinical commission group taking on its full powers.

As at 1 April 2013, the clinical commissioning group was licensed with conditions as follows:

- The CCG must have a clear and credible integrated plan that meets authorisation requirements.
- The CCG must have a plan/s that clearly demonstrates where and how the CCG is working with other CCGs to meet QIPP, and can demonstrate stakeholder awareness and understanding of CCG priorities.

The conditions were subsequently removed on 22 July 2013 following review by NHS England.

5.2 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 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.

5.3 Compliance with the UK Corporate Governance Code

Whilst the detailed provisions of the UK Corporate Governance Code are not mandatory for public sector bodies, compliance is considered to be good practice. This Governance Statement is intended to demonstrate the clinical commissioning group’s compliance with the principles set out in Code.

For the financial year ended 31 March 2014, and up to the date of signing this statement, we complied with the provisions set out in the Code, and applied the principles of the Code.
5.4 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the clinical commissioning group, 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 has been in place in the clinical commissioning group for the year ended 31 March 2014 and up to the date of approval of the Annual Report & Accounts.

5.5 The Clinical Commissioning Group Governance Framework

The National Health Service Act 2006 (as amended), at paragraph 14L(2)(b) states: The main function of the governing body is to ensure that the group has made appropriate arrangements for ensuring that it complies with such generally accepted principles of good governance as are relevant to it.

NHS Leeds South and East Clinical Commissioning Group’s Constitution had been formally agreed by our member practices and sets out our arrangements for discharging our statutory responsibilities for commissioning care on behalf of our population. It describes our governing principles, rules and procedures that ensure probity and accountability in the day to day running of our clinical commissioning group, clarifying how decisions are made in an open and transparent way and in the interest of patients and the public.

More specifically, our Constitution includes:

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

Our Constitution is a living document and will be updated to reflect changes in national guidance and in our Membership and composition and submitted in line with NHS England guidance and following consultation and sign up by our Membership. We have ensured that our Constitution continues to correlate to our Detailed Financial Procedures. The CCG has been undertaking a review of its governance structure during 2013/14 and this is described in more detail in the Review of
Effectiveness section. Figure 4 highlights the 13/14 governance structure and also the revised structure implemented from April 2014 is shown in figure 5.

Figure 4: Governance Structure 1 April 2013 – 31 March 2014

Figure 5: Governance Structure from 1 April 2014

The Governing Body has overall responsibility for risk management and has several formal sub-committees to which it has delegated some of these responsibilities. These are described in the CCG constitution and consist of:

- Audit Committee
- Remuneration Committee
- Governance & Risk Committee
- Patient Advisory Group

The Membership Body is responsible for agreeing the Clinical Commissioning Group’s vision and values, determining the arrangements by which the members approve decisions that are reserved for the membership and consider and approve and applications to NHS England on any matter concerning changes to the group’s Constitution, terms of reference and membership of its committees and the scheme delegation.

The Governing Body has the responsibility of operationally managing the CCGs vision and structures as defined by the Membership.
Council of Members
The CCG’s Council of Members consists of representatives from each of the 43 member practices in LSE CCG and is led by the GP non-executive directors.

The Council of Members meeting is held twice a year as a minimum, although the non-executive directors are also available at drop in sessions following the bi-monthly members’ clinical commissioning meetings. In 2013/14 the meetings were held on 24th July 2013 with representation from 28 practices, and 26th March 2014 with representation from 39 practices. At both meetings members’ views have been sought on how the non-executive directors can best represent the members’ views, and any issues that need to be raised with the CCG on behalf of members.

Governing Body
The Governing Body meets in public regularly throughout the year. Additional meetings and workshops are also held on a regular basis.

The Governing Body has overall responsibility for ensuring that the group has appropriate arrangements in place to exercise its functions effectively, efficiently and economically and in accordance with the group’s principles of good governance.

The Governing Body has met on six occasions in public in 2013/14:

<table>
<thead>
<tr>
<th>Governing Body Members:</th>
<th>Attendance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Chair (Philip Lewer)</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Chief Officer (Andy Harris)</td>
<td>6</td>
</tr>
<tr>
<td>GP Non-Executive Director (Alistair Walling)</td>
<td>4</td>
</tr>
<tr>
<td>GP Non-Executive Director (Tom Gibbs)</td>
<td>6</td>
</tr>
<tr>
<td>GP Non-Executive Director (Daniel Albert)</td>
<td>6</td>
</tr>
<tr>
<td>GP Non-Executive Director (Ben Browning)</td>
<td>5</td>
</tr>
<tr>
<td>Lay Member - Governance (Brian Roebuck)</td>
<td>5</td>
</tr>
<tr>
<td>Lay Member – PPI (Gordon Tollefson)</td>
<td>6</td>
</tr>
<tr>
<td>Chief Finance Officer (Mark Bradley)</td>
<td>6</td>
</tr>
<tr>
<td>Chief Operating Officer (Matt Ward)</td>
<td>6</td>
</tr>
<tr>
<td>Medical Director (Dave Mitchell)</td>
<td>4</td>
</tr>
<tr>
<td>Director of Clinical Engagement (Jackie Campbell)</td>
<td>5</td>
</tr>
<tr>
<td>Director of Nursing (Ellie Monkhouse)</td>
<td>5</td>
</tr>
<tr>
<td>Lay Member - Secondary Care Consultant (Rod Robertson)</td>
<td>6</td>
</tr>
<tr>
<td>Public Health Consultant (Victoria Eaton)</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 15: Governing Body members meetings in public attendance record

The work of each CCG Committee is directed by the functions delegated to it by the Governing Body through their terms of reference.

A sub group of the governing body has met on three occasions to discuss issues affecting GPs as providers, for example Prescribing Incentive Scheme. This has involved the chair, secondary care consultant, public health representative, chief finance officer and chief operating officer. Under the new governance arrangement in 2014/15 the membership is to expand to become a formal sub-committee of all non GP governing body members.
Audit Committee
The Audit Committee provides the Board with an independent and objective view of the group’s financial systems, financial information and compliance with laws, regulations and directions governing the group in so far as they relate to finance.

The Audit Committee is chaired by the Lay Member for Audit & Governance and consists of one other lay member and a GP Non-Executive. Each member of the Audit Committee is also a member of the Board. In attendance at each meeting is the CCG Chief Finance Officer as well as representatives from internal audit, counter fraud and external audit.

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

The Audit Committee during 13/14 has met on four occasions.

<table>
<thead>
<tr>
<th>Audit Committee Members:</th>
<th>Attendance:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Member-Governance (Brian Roebuck)</td>
<td>4</td>
</tr>
<tr>
<td>Lay Member – PPI (Gordon Tollefson)</td>
<td>4</td>
</tr>
<tr>
<td>GP Non-Executive Director (Ben Browning) (*)</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 16: Audit Committee members attendance
(*) One meeting was held before Dr Browning joined the committee

In April 2014 the new Audit and Governance Committee met, with all three members present.

Remuneration Committee
The Remuneration Committee makes recommendations to the Board on determinations about the remuneration, fees and other allowances for employees and for people who provide services to the group and on determinations about allowances under any pension scheme that the group may establish as an alternative to the NHS pension scheme.

Members are the Chair and the two lay members of the CCG governing body. In appointing members of the Committee the Governing Body has ensured the highest level of independence consistent with the principle that no member of the Committee shall be involved in recommending their own remuneration or terms of appointment.

The Remuneration Committee has met on three occasions.

<table>
<thead>
<tr>
<th>Remuneration Committee Members</th>
<th>Attendance (no. of meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lay Chair (Philip Lewer)</td>
<td>3</td>
</tr>
<tr>
<td>Lay Member PPI (Gordon Tollefson)</td>
<td>3</td>
</tr>
<tr>
<td>Lay Member Governance (Brian Roebuck)</td>
<td>3</td>
</tr>
</tbody>
</table>

Table 17: Remuneration Committee member’s attendance
**Governance & Risk Committee**

The Governance & Risk Committee, which is accountable to the Governing Body, provides assurance that the CCG has effective systems of internal control in relation to risk management and governance and to ensure effective governance across all commissioned services.

The Governance & Risk Committee is chaired by a GP Non-Executive and consists of a lay member, Chief Clinical Officer, Chief Operating Officer, Chief Finance Officer, Director of Quality & Nursing and Representative of Director of Public Health.

The work of the committee has included monitoring of the risk management systems in the organisation with specific work around the development of the Board Assurance Framework and oversight of the risk register. The committee has oversight of the development of organisational policies relating to governance and risk and recommends adoption of the same by the board. The Committee receives and scrutinises performance data from its providers and has led the development of the performance reporting mechanisms.

The Governance & Risk Committee agenda is supported by four sub-committee’s that report into the Committee; The Health & Safety Sub-Committee, The Information Governance Sub-Committee, The Safeguarding Sub-Committee and The Leeds Quality Surveillance Group.

The Governance & Risk Committee has met on 5 occasions.

<table>
<thead>
<tr>
<th>Governance and Risk Committee Members:</th>
<th>Attendance (no. of meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GP Non-Executive Director (Daniel Albert)</td>
<td>5</td>
</tr>
<tr>
<td>Clinical Chief Officer (Andy Harris)</td>
<td>5</td>
</tr>
<tr>
<td>Lay Member PPI (Gordon Tollefson)</td>
<td>2</td>
</tr>
<tr>
<td>Director of Nursing (Ellie Monkhouse)</td>
<td>3</td>
</tr>
<tr>
<td>Chief Finance Officer (Mark Bradley)</td>
<td>5</td>
</tr>
<tr>
<td>Chief Operating Officer (Matt Ward)</td>
<td>2</td>
</tr>
<tr>
<td>Public Health Consultant (Victoria Eaton)</td>
<td>1</td>
</tr>
<tr>
<td>Head of Governance (Richard Gibson)</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 18: Governance and Risk Committee Members Attendance

From April 2014 The Governance and Risk Committee has ceased with its functions transferred where appropriate to the Audit and Governance, Quality and Finance, Activity and Performance Committees.

**Patient Advisory Group (PAG)**

The purpose of the PAG is to ensure that the engagement plans for commissioning cases for change are reviewed from a patient and public perceptive and to provide feedback, ideas and recommendations to the Governing Body.

The Chair of the PAG is the Lay Member of the Governing Body leading on patient and public engagement.

One voting patient representative is appointed from each of the council wards covered by the CCG and membership also includes a representative of the local HealthWatch.
The Patient Advisory Group has met on five occasions.

<table>
<thead>
<tr>
<th>Patient Advisory Group Members:</th>
<th>Attendance (no. of meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member – Barwick in Elmet (David Tompkins)</td>
<td>4</td>
</tr>
<tr>
<td>Member – Halton, Temple Newsam (Michelle Bates)</td>
<td>4</td>
</tr>
<tr>
<td>Member - Rothwell (Terry Hardy)</td>
<td>5</td>
</tr>
<tr>
<td>Member - Whinmoor/Cross Gates (Bill Butcher)</td>
<td>5</td>
</tr>
<tr>
<td>Member - Seacroft (Ed Walley)</td>
<td>5</td>
</tr>
<tr>
<td>Member - Beeston &amp; Holbeck (Dickson Acheampong)</td>
<td>3</td>
</tr>
<tr>
<td>Governing Body Lay Member – PPI (Gordon Tollefson)</td>
<td>5</td>
</tr>
<tr>
<td>Member - Gipton/Harehills (Jon Danks)</td>
<td>4</td>
</tr>
<tr>
<td>Member – Garforth &amp; Swillington (Kenneth Watson)</td>
<td>5</td>
</tr>
<tr>
<td>Chief Operating Officer (Matthew Ward)</td>
<td>2</td>
</tr>
<tr>
<td>Healthwatch (Phil Gleeson)</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 19: Patient Advisory Group Member Attendance

**Leeds Health and Wellbeing Board**

The primary purpose of the Leeds Health and Wellbeing Board is to provide overall strategic leadership to improve the health and wellbeing of residents in the city. Local authorities are required to establish Health and Wellbeing Boards under the Health and Social Care Act 2012. This board has responsibility for driving health improvements for residents and a much stronger role in shaping local services. Membership of the board includes the three Clinical Commissioning Groups in Leeds, Healthwatch and the third sector.

**Leeds Integrated Commissioning Executive (ICE)**

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

**Leeds CCG Network**

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

By working closely together the Directors and I lead the risk management process, to ensure an integrated and holistic approach to the CCG’s risk management activities. Throughout the reporting period there have been a number of Governing Body workshops that reviewed the effectiveness and development of a range of governance requirements.
Each of the Governing Body sub-Committees has an annual agenda item to carry out a review of Terms of Reference and the committee’s performance against these.

5.6 The Clinical Commissioning Group Risk Management Framework

The NHS Leeds South & East CCG Risk Management Strategy identifies the roles and responsibilities of directors, managers and staff in relation to the management of identified risk and was approved by the Governing Body in June 2013.

All identified risks have an executive director risk owner and a responsible manager documented against them to ensure appropriate accountability for the management of the risk. A web-based risk register system is in place across the CCG and all relevant staff has access to a standardised risk assessment form for the recording of risk. The Risk Management Strategy provides a standard risk scoring matrix for risk owners to use to score the level of each particular risk.

The Risk Management Strategy has documented set levels of risk score that determine the CCGs risk appetite, that is, which risks are managed at the operational level and those that are escalated to the Corporate Risk Register for review by the Governing Body.

The risks are reviewed and updated on a regular cycle with risk owners prior to Committee and Board meetings. Responsible managers will utilise various data streams to regularly assess the levels of risk they are managing and update the risk register to ensure that an accurate position is presented.

Risk management is embedded into the wider working of the CCG through the use of equality impact assessments of policies and service procurements. The CCG also operates an internal web-based incident reporting system to ensure that NHS Leeds South & East CCG is informed of any incidents reported by commissioning staff across the city as part of the Leeds CCG Network that may present as a risk to the organisation and require escalation to the risk register.

The CCG takes its responsibility for public involvement very seriously and is involved in a number of city-wide and CCG specific consultation and engagement activities. These give the public direct opportunity to directly engage with the CCG on various workstreams and raise risks they may identify. The CCG makes available a number of avenues for this to happen; via the website, on email or direct at specific public events.

The three levels of risk reporting in the organisation as described in the Risk Management Strategy are summarised below:

The Governing Body Assurance Framework (GBAF) 2013-2014

The Leeds South and East CCG Governing Body own and determines the content of its GBAF. The Governing Body identified potential strategic risks to delivery of its objectives and these are monitored throughout the year. Executive Directors manage and update progress on those risks and report back to both the Governing Body and the Governance and Risk Committee at each meeting on how these risks are
developing. The controls, assurances and gaps in controls and assurance are debated along with any actions required to work towards reducing the potential risk.

**The Corporate Risk Register**
The Leeds South and East CCG Governing Body/Executive Directors own the risks on the Corporate Risk Register. The corporate risks are the highest scoring operational risks that are managed by teams. Each corporate risk has an accountable director, senior manager and a workstream aligned to it. This may be a risk that is applicable across the city and the score will be considered by a Leeds South & East CCG Executive Director for acceptance onto the Leeds South & East CCG Corporate Risk Register.

The Executive Management team take a big role in overseeing the active risks that are recorded on the organisation’s risk management system and regularly review risks to understand the kind of risks that are been highlighted by staff at all levels/scores.

**The Operational Risk Registers**
The Datix Risk Management system is the tool used to enable staff to access and record risks. Initially a draft risk can be written on Datix and that can be followed by a manager review and approval prior to the risk being accepted as an active risk by NHS Leeds South and East CCG. A high scoring risk is escalated to the Corporate Risk Register.

It has taken a significant part of the first year of establishment to get systems, structures and staff in place to be confident that all areas of risk are captured and work continues to actively seek out areas of risk that are not adequately accounted for on the risk register. It has emerged that some risks would apply across the city but with different impacts to each CCG and other risks pertained only to a specific CCG. The process of identifying, recording and managing city wide and CCG specifics risks continues to be refined.

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

**5.7 The Clinical Commissioning Group Internal Control Framework**
A system of internal control is the set of processes and procedures in place in the clinical commissioning group to ensure it delivers its policies, aims and objectives. It is designed to identify and prioritise the risks, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control allows risk to be managed to a reasonable level rather than eliminating all risk; it can therefore only provide reasonable and not absolute assurance of effectiveness.
NHS Leeds South & East CCG has 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 have been undertaken to review the effectiveness of governance systems. The reports from these audits are submitted to the Audit Committee. All audit reports contain action plans of work required as a result of the review findings. All actions are assigned to a senior manager with responsibility to complete within the designated timescales. Managers are held to account by the audit committee for completion of all actions.

The Governing Body Assurance Framework and the Corporate Risk Register are standing agenda items on the Governing Body and Governance & Risk 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.

The CCG also seeks assurance from other areas about some of the services it receives. In January the CCG received a Service Auditor Report giving assurance relating to internal control at West and South Yorkshire and Bassetlaw Commissioning Support Unit (WSYBCSU). The Commissioning Support Unit supplies the CCG with key elements of function relating to Information Technology, Business Intelligence, elements of provider management, Information Governance, Health & Safety, Communications and Patient Engagement.

The CCG received on the 22nd May the Final Service Auditors Report on West and South Yorkshire and Bassetlaw CSU’s Internal Controls as undertaken by Deloitte’s LLP. The report comes in 2 sections - a Type 1 and Type 2 Service Auditor Report.

- Type 1 Testing which tests a control at a given point in time.
- Type 2 Testing which tests a control over a given period. (3 months)

The cohort of services which were chosen for Type 1 testing were as follows:
- Provider Management;
- IT; and
- Procurement.

The cohort of services which were chosen for Type 2 testing were as follows:
- Finance;
- Quality; and
- Payroll.

The CSU received exceptions in six of fifty one controls in relation to the Type 1 report. The CSU received two exceptions in relation to its Type 2 report that were relevant to the services commissioned by the CCG. These were in relation to the Human Resource Management (HR) team and link to payroll. Taking account of the issues identified in the service auditor reports, the CCG can be satisfied that there is reasonable assurance that there is a sound system of internal control at the CSU and this does not impact on the overall system of internal control for the CCG.
The most recent controls assurance report relating to the Payroll Service provided by Leeds Teaching Hospitals NHS Trust provided full assurance that there is a sound system of internal control.

5.8 Information Governance

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

The CCG takes its Information Governance responsibilities seriously, part of which involves data security. The CCG undertook an assessment of its IG arrangements through completion of the Information Governance Toolkit (IGT) which was submitted to the Health and Social Care Information Centre (HSCIC). The external assessment meant looking at evidence to support 28 separate IG related requirements and determined whether the CCG met the required standards. The CCG was judged to have reached the required level in all the requirements. This also led to the CCG being recognised as an Accredited Safe Haven (ASH). This means the CCG provides a safe environment for the processing of information containing NHS numbers. In addition to the above external assessment, the CCG internal auditors reviewed certain elements of the CCG IG Toolkit submission. This audit provided further assurance that the CCG has a suitable framework in place to process appropriate data and information.

The CCG has a set of Information Governance policies which are communicated to staff. The CCG has a board-level officer responsible for information security and the associated management processes, and this role is known as the Senior Information Risk Owner (SIRO). The CCG has a board-level clinician responsible for ensuring that all flows of patient information are justified and secure, and this role is known as the Caldicott Guardian. Information Governance (IG) training is mandatory for all staff, and the compliance has increased each month and by March 2014 has achieved over 90%.

There is an Information Governance Committee which reports to the Governance and Risk Committee. These are formal meetings with associated minutes and action tracking. The CCG buys an expert IG practitioner and advisory service from the Commissioning Support Unit. Any breaches of security are managed within the CCG risk management policy and reported using the Datix system.

5.9 Pension obligations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance
with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the regulations.

The most recent controls assurance report relating to the Payroll Service provided by Leeds Teaching Hospitals NHS Trust provided full assurance that there is a sound system of internal control.

5.10 Equality, diversity and human rights obligations

Control measures are in place to ensure that the clinical commissioning group complies with the required public sector equality duty set out in the Equality Act 2010.

NHS Leeds South & East CCG has an Equality and Diversity Manager who provides our organisation with the expertise advice, guidance and support required to ensure that we are compliant with the Equality Act 2010 Public Sector Equality Duty and continually improve our equality performance.

All CCG staff are required to complete an equality and diversity e-learning course, which is complemented with a two hour face to face training session specifically for staff directly involved in commissioning. This increases understanding of the Public Sector Equality Duty and how it relates to the NHS, considers practically the equality implications in relation to commissioning and increases understanding of the health inequalities experienced by the groups protected by the Equality Act 2010.

Equality requirements are embedded within our commissioning decisions, intentions and in the development of priorities in order to demonstrate that we have given due regard to the protected groups. In respect of this we have built the requirement to carry out Equality Analysis/ Equality Impact Assessments in our commissioning cycle to ensure all protected groups, seldom heard groups and other vulnerable groups are considered, in addition to policy and strategy development, business planning processes including service redesign and transformation, and decision making processes.

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 protected groups and other vulnerable groups are adopted. These policies are examined and approved by procurement teams prior to any contract award being made. We have just established performance reporting mechanisms for our provider trusts, in order to provide assurance to us that they are compliant with the Equality Act 2010 and continually improving performance in relation to equality.
5.11 Sustainable development obligations

The clinical commissioning group is required to report its progress in delivering against sustainable development indicators.

We are developing plans to assess risks, enhance our performance and reduce our impact, including against carbon reduction and climate change adaptation objectives. This includes establishing mechanisms to embed social and environmental sustainability across policy development, business planning and in commissioning. We will ensure the clinical commissioning group complies with its obligations under the Climate Change Act 2008, including the Adaptation Reporting power, and the Public Services (Social Value) Act 2012.

We are also setting out our commitments as a socially responsible employer. Sustainability is a key objective for NHS Leeds South & East CCG and one which is supported at every level within the organisation. Key sustainability achievements for 2013/14 have been:

- Developing a baseline for resource consumption
- Completing a review of the Sustainable Development Management Plan
- Establishing a team of green champions (CCGreen) to support behaviour change within the organisation
- Delivery of three GP Sustainability Health-checks identifying up to 30% savings on their current utility consumption.
5.12 Risk assessment in relation to Governance, Risk Management and Internal Control

Risk is assessed in accordance with the NHS Leeds South & East CCG Risk Management Strategy. This requires managers to identify risks through established reporting streams and assess the likelihood and consequences of the risk occurring. This is done using a measurement matrix included in the strategy. This ensures a consistent approach to risk assessment regardless of the individual performing it. The likelihood and consequence matrix reflects the organisation’s agreed risk levels and those at which escalation to senior managers and directors is required.

In preparation for the formal establishment of the CCG on 1st April 2013 the corporate risks from the former Leeds PCT were reviewed and the CCG received advice as to which risks may be relevant for the CCG. Those risks that were considered appropriate were adopted and formed the basis of the organisations risk register to ensure CCG directors and managers remained sighted on issues in the Leeds health economy during transition to the new commissioning structure.

The NHS Leeds South & East CCG Corporate Risks during 2013/14 are summarised below:

<table>
<thead>
<tr>
<th>Risk ID</th>
<th>Risk Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>338</td>
<td>Cancer 2 week wait under achievement</td>
</tr>
<tr>
<td>279</td>
<td>CCGs unable to use personal identifiable data</td>
</tr>
<tr>
<td>44</td>
<td>Risk of increasing patient morbidity or mortality from MRSA infection</td>
</tr>
<tr>
<td>306</td>
<td>Providers fail to achieve the NHS Constitution Standards on 18 weeks and the associated operational standards</td>
</tr>
<tr>
<td>226</td>
<td>Risk of increasing patient morbidity or mortality due to C Difficile Infection</td>
</tr>
</tbody>
</table>

Table 20: Summary of Corporate Risks during 2013/14
The NHS Leeds South & East CCG Governing Body Assurance Framework (GBAF) describes the CCG’s principal risks to its licence and being able to fulfil its strategic objectives.

<table>
<thead>
<tr>
<th>Risk Title</th>
<th>Responsible Committee</th>
<th>Assurances</th>
</tr>
</thead>
</table>
| CCG Culture and Approach           | Governing Body        | • Clear & Credible Plan  
• CCG Performance Report  
• National Assurance Framework |
| Sub-Optimal Quality                | Quality & Safety Cmtte | • Comprehensive quality report  
• Monitor CQC visits and action plans  
• Provider Management Groups in place |
| QIPP – Practice Engagement         | Executive Mgmt Team   | • Practice MOT and performance framework  
• QIPP Tracker |
| QIPP – Provider Squeeze and Grip   | Executive Mgmt Team   | • QIPP plans and analysis  
• Provider Management monitoring  
• NTDA support plan  
• FT pipeline |
| QIPP – Transformation              | Governing Body        | • Performance Report  
• Transformation Board programme |
| CSU Performance                    | Executive Mgmt Team   | • Action plan progress report  
• Issues log and performance rating  
• Service Auditor Report |
| Leeds Network Model                | Governing Body        | • Leeds Network  
• Contract Board meetings  
• Performance reports against plan |
| Public Health/Health Inequalities  | Governing Body        | • Monitoring of Public Health workplan |
| Finance                            | Governing Body        | • Governing Body finance report.  
• Risk sharing agreement in place. |

Table 21: Summary of CCG’s Principle Risks

Each GBAF risk has an identified accountable Director and Governing Committee for clarity of where the responsibility lies for managing and monitoring the risk. Directors are expected to ensure that adequate control measures against each element of risk and ensuring that the appropriate assurances are generated.
The identified Governing Committee is responsible for ensuring the agenda reflects the requirements of the assurance to maintain effective monitoring.

The Governing Body and the Governance & Risk Committee receive and review the CCG's strategic risks on a regular basis.

**5.13 Review of Economy, Efficiency and Effectiveness of the Use of Resources**

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

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

The CCG’s financial plan was developed for 2013/14, and budgets set within this plan, and signed off by the Governing Body prior to the start of the financial year. These budgets were communicated to managers and budget holders within the organisation. The Chief Finance Officer and his team have worked closely with managers to ensure robust annual budgets were prepared and delivered.

The 2013/2014 plan and budgets reflected QIPP schemes totalling £6.1m. These schemes have been delivered in full alongside the generation of a planned 2% surplus.

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

The CCG 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 are discussed in detail at meetings of the Audit Committee.

The CCG’s annual accounts are reviewed by the Audit Committee.

The financial austerity which lies ahead is recognised by the CCG and future plans reflect the anticipated lower levels of growth and transfer of resource to the Local Authority, as part of The Better Care Fund. The CCG is actively engaged in discussions in this regard to ensure resources are prioritised in line with its strategic direction.

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 which form part of future financial plans.
5.14 Review of the Effectiveness of Governance, Risk Management and Internal Control

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

Capacity to Handle Risk
The NHS Leeds South and East CCG takes the management of risk seriously and the Governing Body, Executive Directors, managers and staff work together to provide an integrated approach to the management of risk and in developing a culture of reporting risk, understanding and challenging risk and providing opportunities for the analysis of risk and discussions on risk across the whole organisation.

The NHS Leeds South & East CCG has appointed an executive Director lead for risk management who reports to the Governing Body on the risk management process. From September 2013 the Executive Director lead for the Governance portfolio was transferred from the Chief Operating Officer to the Chief Finance Officer with the SIRO responsibility following in November 2013.

Risk Management is a key task of both the Audit Committee and the Governance & Risk Committee, of which both are chaired by a non-executive Director.

The Governance Team is responsible for a training programme across the organisation to provide staff with support on the writing of risks, the culture of risk reporting, and an understanding of why risk is a key element of internal control for the organisation. The team also works with directors, senior managers and staff, both individually and collectively, to discuss, advise and facilitate progress on the risk management strategy.

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

The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage risks to the clinical commissioning group achieving its principles objectives have been reviewed.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Governing Body, and its sub committees and a plan to address weaknesses and ensure continuous improvement of the system is in place. There has been continuous improvement during 2013/14 and this will continue in to 2014/15.

The CCG is keen to ensure that we continually seek opportunities to develop our governance arrangements, in line with good practice, so that they remain as robust
and effective as possible. In March 2013 Internal Audit reviewed the Governance arrangements in the CCG and also how the governance structures and risk management function operated across the Leeds CCG network. Following a period of consolidation in the first two quarters the CCG began an internal review of the progress against the audit recommendations. As a consequence the Governing Body made a decision to revise its internal governance structure to take effect from the beginning of the new financial year. The changes have been designed to ensure quality of care is positioned at the centre of the CCGs business. The key features of the new structure are:-

- The Audit Committee will become the **Audit and Governance Committee** and will take on the oversight and assurance of integrated governance systems
- A new **Quality Committee** will report directly to the Governing Body and will ensure that improving the quality of care is at the heart of the CCGs commissioning activities and that lessons are learnt from clinical governance and other intelligence
- A new **Finance, Activity and Performance Committee** will ensure the CCG is achieving its financial and commissioning plans and ensure performance issues are addressed. There will be particular focus on QIPP.
- The **Governance and Risk Committee** will cease to exist
- A **GP Conflicts Committee** will be formally established to ensure issues affecting GPs as providers are managed by a sub-committee of the Governing Body excluding its GP members.
- The Patient Advisory Group will be renamed the **Patient Assurance Group** but its role will remain unchanged

The revised structure will deliver a range of benefits including:-

- A dedicated Quality Committee will allow a significantly increased level of scrutiny and assurance on quality matters which was a core recommendation from the external review
- Flatter structure, reduces the potential for bureaucracy and duplication of agendas between committees and sub-committees
- Finance, Activity and Performance committee will enable non-executive challenge and scrutiny of finance and performance issues
- The Finance, Activity and Performance and Quality Committees will meet alternately every other month to make most effective use of executive and non-executive time.
- Makes optimum use of the time of non-executive members and spreads the workload more equally between them
- Provides learning and development opportunities for non-executives and lay members and will assist their understanding of the key elements of the CCG’s work
- Will allow the Governing Body to delegate specific responsibilities to its sub-committees, including the scrutiny and approval of policies and oversight of delivery of the CCG’s statutory duties.
It is anticipated that these changes will significantly strengthen the CCGs governance framework, in particular the provision of assurance to the Governing Body.

A follow-up audit to review implementation has been commissioned as part of the Audit Plan for 2014/15 and is expected to report later in 2014. This will assess the effectiveness of the new governance arrangements and highlight any further work necessary to continually enhance the governance systems.

5.15 Head of Internal Audit Opinion

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

Based on the work undertaken in 2013/14, significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weaknesses were identified within specific elements of the CCG’s systems of internal control. These findings were identified as a result of our work undertaken during the year and the CCG needs to ensure these weaknesses are addressed through the agreed action plans in place.

Based on the work we have undertaken on the CCG’s system of internal control we do not consider that within these areas there are any issues that need to be flagged as significant internal control issues within the AGS.

During the year the Internal Audit issued the following audit reports with a conclusion of limited assurance:

- None

During the year the Internal Audit issued the following audit reports with a conclusion of no assurance:

- None
5.16 Data quality

Whilst a wide range of information is used to source Board reports, the main business critical data sources are subject to regular data quality assurance processes. These are deemed as appropriate by the relevant Information Asset Owners. The commissioned services from the Commissioning Support Unit (CSU) form a key part of this data quality assurance process. For example, any nationally collected data received from care providers is signed-off by the CSU in conjunction with the CCG. Anomalies have been identified and corrected using this quality assurance mechanism.

5.17 Business Critical Models

The CCG has appointed a Senior Information Risk Owner (SIRO) to ensure the Board that any potential information risks are identified and mitigated. To enable this, the SIRO has put in place an information governance management framework. This framework includes ensuring that business critical systems are identified and managed effectively. As part of the management framework Information Asset Owners (IAOs) have been appointed that cover the range of business systems used by the CCG. The IAOs have been trained. Their responsibility in relation to Business Critical systems involves the maintenance of an information asset register relevant to their organisational remit, the maintenance of service continuity plans and the continuity of key skills to operate such systems. For example, this would cover the operation and use of finance systems such as the Oracle financials.

5.18 Data security

We have submitted a satisfactory level of compliance with the information governance toolkit assessment.

The CCG has not reported any Serious Incidents in relation to data security breaches during 2013-14.

5.19 Discharge of statutory functions

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

In light of the Harris Review, the clinical commissioning group 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 clinical commissioning group is clear about the legislative requirements associated with each of the statutory functions for which it is responsible, including any restrictions on delegation of those functions.
Responsibility for each duty and power has been clearly allocated to a lead Director. Directorates have confirmed that their structures provide the necessary capability and capacity to undertake all of the clinical commissioning group’s statutory duties.

5.20 Conclusion

April 2013 marked the start-up of NHS Leeds South and East CCG. The CCG started with two conditions, which were quickly removed. The system of internal control has been developing and strengthening throughout our first year. The Governance Framework is clearly articulated within our constitution and implemented successfully along with our Information Governance and Risk Management Strategies detailing our approach to Information Governance as well as our appetite and management of risk.

The Head of Internal Audit Opinion states the CCG can take "significant assurance" from its system of internal control and that they do not consider there are any issues that need to be flagged as significant internal control issues.

The first year has been a journey of continuous improvement. During this time the CCG held a review of its governance arrangements, the culmination of which is the new structure for 2014/15. This aims to put quality even higher up the agenda of the CCG and is a sign of the continuous improvement the CCG is undertaking.

Dr Andrew Harris
Clinical Chief Officer
29 May 2014
6.0 Statement of Accountable Officer’s Responsibilities

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

The responsibilities of an Accountable Officer, including responsibilities for the propriety and regularity of the public finances for which the Accountable Officer is answerable, for keeping proper accounting records (which disclose with reasonable accuracy at any time the financial position of the Clinical Commissioning Group and enable them to ensure that the accounts comply with the requirements of the Accounts Direction) and for safeguarding the Clinical Commissioning Group’s assets (and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities), are set out in the Clinical Commissioning Group Accountable Officer Appointment Letter.

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

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

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my Clinical Commissioning Group Accountable Officer Appointment Letter.

Dr Andrew Harris
Clinical Chief Officer / Accountable Officer
29 May 2014
7.0 Annual Accounts 2013-14

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INDEPENDENT AUDITOR’S REPORT TO THE MEMBERS OF NHS LEEDS SOUTH AND EAST CCG

We have audited the financial statements of NHS Leeds South and East CCG for the year ended 31 March 2014, comprising the Statement of Comprehensive Net Expenditure, Statement of Financial Position, Statement of Changes in Taxpayers Equity, Statement of Cash Flows and related notes. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England. We have also audited the information in the Remuneration Report that is subject to audit.

This report is made solely to the Members of NHS Leeds South and East CCG, as a body, in accordance with Part II of the Audit Commission Act 1998. Our audit work has been undertaken so that we might state to the Members 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 CCG, as a body, for our audit work, for this report or for the opinions we have formed.

Respective responsibilities of the Accountable Officer and auditor

As explained more fully in the Statement of Accountable Officer’s Responsibilities, the Accountable Officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board’s Ethical Standards for Auditors.

Scope of the audit of the financial statements

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

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

Opinion on regularity

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

In our opinion the financial statements:

• give a true and fair view of the financial position of the CCG as at 31 March 2014 and of its net operating costs for the year then ended; and

• have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters prescribed by the Code of Audit Practice 2010 for local NHS bodies

In our opinion:

• the part of the Remuneration Report subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and

• the information given in the Strategic Report and Members’ Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Code of Audit Practice 2010 for local NHS bodies requires us to report to you if:

• in our opinion, the Governance Statement does not reflect compliance with NHS England’s Guidance;

• any referrals to the Secretary of State have been made under section 19 of the Audit Commission Act 1998; or

• any matters have been reported in the public interest under the Audit Commission Act 1998 in the course of, or at the end of the audit.

Conclusion on the CCG’s arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under Section 5 of the Audit Commission Act 1998 to satisfy ourselves that the CCG has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission requires us to report any matters that prevent us from being satisfied that the audited body has put in place such arrangements.

We have undertaken our audit in accordance with the Code of Audit Practice, having regard to the guidance issued by the Audit Commission in October 2013. We have considered the results of the following:
our review of the Governance Statement;

- the work of other relevant regulatory bodies or inspectorates, to the extent that the results of this work impact on our responsibilities at the CCG; and

- locally determined risk-based work.

As a result, we have concluded that there are no matters to report.

Certificate

We certify that we have completed the audit of the accounts of NHS Leeds South and East CCG in accordance with the requirements of the Audit Commission Act 1998 and the Code of Audit Practice 2010 for local NHS bodies issued by the Audit Commission.

Trevor Rees

for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
St James’ Square
Manchester
M2 6DS

4 June 2014
Statement of Comprehensive Net Expenditure for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>2013-14 (£000)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross employee benefits</td>
<td>4</td>
</tr>
<tr>
<td>Other costs</td>
<td>5</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>2</td>
</tr>
<tr>
<td>Net operating costs before financing</td>
<td></td>
</tr>
</tbody>
</table>

Financing

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Investment revenue</td>
<td>-</td>
</tr>
<tr>
<td>Other (gains)/losses</td>
<td>-</td>
</tr>
<tr>
<td>Finance costs</td>
<td>-</td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>340,907</td>
</tr>
</tbody>
</table>

Net (gain)/loss on transfers by absorption

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating costs for the financial year including absorption transfers</td>
<td>340,907</td>
</tr>
</tbody>
</table>

Of which:

Administration Costs

| Gross employee benefits | 4 | 3,129 |
| Other costs | 5 | 4,239 |
| Other operating revenue | 2 | (1,202) |
| Net administration costs before interest | | 6,166 |

Programme Expenditure

| Gross employee benefits | 4 | 1,829 |
| Other costs | 5 | 371,245 |
| Other operating revenue | 2 | (38,333) |
| Net programme expenditure before interest | | 334,741 |

Other Comprehensive Net Expenditure

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Impairments &amp; reversals</td>
<td>-</td>
</tr>
<tr>
<td>Net (gain)/loss on revaluation of property, plant &amp; equipment</td>
<td>-</td>
</tr>
<tr>
<td>Net (gain)/loss on revaluation of intangibles</td>
<td>-</td>
</tr>
<tr>
<td>Net (gain)/loss on revaluation of financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Movements in other reserves</td>
<td>-</td>
</tr>
<tr>
<td>Net (gain)/loss on available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Net (gain)/loss on assets held for sale</td>
<td>-</td>
</tr>
<tr>
<td>Net actuarial (gain)/loss on pension schemes</td>
<td>-</td>
</tr>
<tr>
<td>Share of (profit)/loss of associates &amp; joint ventures</td>
<td>-</td>
</tr>
</tbody>
</table>

Reclassification Adjustments

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>On disposal of available for sale financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Total comprehensive net expenditure for the financial year</td>
<td>340,907</td>
</tr>
</tbody>
</table>

The notes on pages 112 to 139 form part of this statement.
Statement of Financial Position as at 31 March 2014

<table>
<thead>
<tr>
<th>Note</th>
<th>31 March 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
</tr>
</tbody>
</table>

### Non-current assets
- Property, plant & equipment: -
- Intangible assets: -
- Investment property: -
- Trade & other receivables: -
- Other financial assets: -

Total non-current assets: -

### Current assets
- Inventories: -
- Trade and other receivables: 11 2,027
- Other financial assets: -
- Other current assets: -
- Cash & cash equivalents: 14 59

Total current assets: 2,086

### Non-current assets held for sale
- -

Total current assets: 2,086

Total assets: 2,086

### Current liabilities
- Trade & other payables: 17 (14,968)
- Other financial liabilities: -
- Other liabilities: -
- Borrowings: -
- Provisions: 24 (309)

Total current liabilities: (15,277)

Total Assets less Current Liabilities: (13,191)

### Non-current liabilities
- Trade & other payables: -
- Other financial liabilities: -
- Other liabilities: -
- Borrowings: -
- Provisions: 24 (618)

Total non-current liabilities: (618)

Total Assets Employed: (13,809)

### Financed by Taxpayers’ Equity
- General fund: (13,809)
- Revaluation reserve: -
- Other reserves: -
- Charitable Reserves: -

Total taxpayers’ equity: (13,809)

The notes on pages 112 to 139 form part of this statement.

The financial statements were approved by the Governing Body on 29 May 2014 and signed on its behalf by:

Dr Andy Harris
Clinical Chief Officer

Date: 29/05/14
### Statement of Changes In Taxpayers Equity for the year ended 31 March 2014

<table>
<thead>
<tr>
<th></th>
<th>General fund £000</th>
<th>Revaluation reserve £000</th>
<th>Other reserves £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer of assets &amp; liabilities from closed NHS Bodies as a result of the 1 April 2013 transition</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><strong>Adjusted balance at 1 April 2013</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Changes in taxpayers' equity for 2013-14</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Net operating costs for the financial year</td>
<td>(340,907)</td>
<td>-</td>
<td>-</td>
<td>(340,907)</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>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>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>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Transfer between reserves in respect of assets transferred under absorption</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Reserves eliminated on dissolution</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><strong>Net Recognised Expenditure for the Financial Year</strong></td>
<td>(340,907)</td>
<td>-</td>
<td>-</td>
<td>(340,907)</td>
</tr>
<tr>
<td>Net funding</td>
<td>327,098</td>
<td>-</td>
<td>-</td>
<td>327,098</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td>(13,809)</td>
<td>-</td>
<td>-</td>
<td>(13,809)</td>
</tr>
</tbody>
</table>
Statement of Cash Flows for the year ended 31 March 2014

<table>
<thead>
<tr>
<th>2013-14</th>
<th>£000</th>
</tr>
</thead>
</table>

**Cash Flows from Operating Activities**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net operating costs for the financial year</td>
<td>(340,907)</td>
</tr>
<tr>
<td>Depreciation and amortisation</td>
<td>-</td>
</tr>
<tr>
<td>Impairments and reversals</td>
<td>-</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>(Increase)/decrease in inventories</td>
<td>-</td>
</tr>
<tr>
<td>(Increase)/decrease in trade &amp; other receivables</td>
<td>(2,027)</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>14,968</td>
</tr>
<tr>
<td>Increase/(decrease) in other current liabilities</td>
<td>-</td>
</tr>
<tr>
<td>Provisions utilised</td>
<td>-</td>
</tr>
<tr>
<td>Increase/(decrease) in provisions</td>
<td>927</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Operating Activities</strong></td>
<td>(327,039)</td>
</tr>
</tbody>
</table>

**Cash Flows from Investing Activities**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest received</td>
<td>-</td>
</tr>
<tr>
<td>(Payments) for property, plant and equipment</td>
<td>-</td>
</tr>
<tr>
<td>(Payments) for intangible assets</td>
<td>-</td>
</tr>
<tr>
<td>(Payments) for investments with the Department of Health</td>
<td>-</td>
</tr>
<tr>
<td>(Payments) for other financial assets</td>
<td>-</td>
</tr>
<tr>
<td>(Payments) for financial assets (LIFT)</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale: property, plant and equipment</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from disposal of assets held for sale: intangible assets</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from disposal of investments with the Department of Health</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from disposal of other financial assets</td>
<td>-</td>
</tr>
<tr>
<td>Proceeds from disposal of financial assets (LIFT)</td>
<td>-</td>
</tr>
<tr>
<td>Loans made in respect of LIFT</td>
<td>-</td>
</tr>
<tr>
<td>Loans repaid in respect of LIFT</td>
<td>-</td>
</tr>
<tr>
<td>Rental revenue</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Investing Activities</strong></td>
<td>-</td>
</tr>
</tbody>
</table>

**Net Cash Inflow (Outflow) before Financing**

<table>
<thead>
<tr>
<th>£000</th>
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<tbody>
<tr>
<td>(327,039)</td>
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</tbody>
</table>

**Cash Flows from Financing Activities**

<table>
<thead>
<tr>
<th>Description</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Net parliamentary funding received</td>
<td>327,098</td>
</tr>
<tr>
<td>Other loans received</td>
<td>-</td>
</tr>
<tr>
<td>Other loans repaid</td>
<td>-</td>
</tr>
<tr>
<td>Capital element of payments in respect of finance leases and on Statement of Financial Position PFI and LIFT</td>
<td>-</td>
</tr>
<tr>
<td>Capital grants and other capital receipts</td>
<td>-</td>
</tr>
<tr>
<td>Capital receipts surrendered</td>
<td>-</td>
</tr>
<tr>
<td><strong>Net Cash Inflow (Outflow) from Financing Activities</strong></td>
<td>327,098</td>
</tr>
</tbody>
</table>

**Net Increase (Decrease) in Cash & Cash Equivalents**

<table>
<thead>
<tr>
<th>£000</th>
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<tbody>
<tr>
<td>59</td>
</tr>
</tbody>
</table>

**Cash & Cash Equivalents at the Beginning of the Financial Year**

<table>
<thead>
<tr>
<th>£000</th>
</tr>
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<tbody>
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<td>-</td>
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Effect of exchange rate changes on the balance of cash and cash equivalents held in foreign currencies

<table>
<thead>
<tr>
<th>£000</th>
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**Cash & Cash Equivalents (including bank overdrafts) at the End of the Financial Year**

<table>
<thead>
<tr>
<th>£000</th>
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<tbody>
<tr>
<td>59</td>
</tr>
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<table>
<thead>
<tr>
<th>£000</th>
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<tr>
<td>59</td>
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</table>

<table>
<thead>
<tr>
<th>£000</th>
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</thead>
<tbody>
<tr>
<td>111</td>
</tr>
</tbody>
</table>
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 Manual for Accounts issued by the Department of Health. Consequently, the following financial statements have been prepared in accordance with the Manual for Accounts 2013-14 issued by the Department of Health. The accounting policies contained in the Manual for Accounts follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to Clinical Commissioning Groups, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the Clinical Commissioning Group for the purpose of giving a true and fair view has been selected. The particular policies adopted by the Clinical Commissioning Group are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

In accordance with the Directions issued by NHS England comparative information is not provided in these Financial Statements.

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 Acquisitions & Discontinued Operations
Activities are considered to be ‘acquired’ only if they are taken on from outside the public sector. Activities are considered to be ‘discontinued’ only if they cease entirely. They are not considered to be ‘discontinued’ if they transfer from one public sector body to another.

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

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

For transfers of assets and liabilities from those NHS bodies that closed on 1 April 2013, HM Treasury has agreed that a modified absorption approach should be applied. For these transactions only, gains and losses are recognised in reserves rather than the Statement of Comprehensive Net Expenditure.
1.5 Balances Transferred from Predecessor Primary Care Trusts (PCTs)

The accounting arrangements for balances transferred from predecessor PCTs ("legacy" balances) are determined by the Accounts Direction issued by NHS England on 12 February 2014. The Accounts Directions state that the only legacy balances to be accounted for by the CCG are in respect of property, plant and equipment (and related liabilities) and inventories. All other legacy balances in respect of assets or liabilities arising from transactions or delivery of care prior to 31 March 2013 are accounted for by NHS England. There are no legacy balances accounted for by the CCG in these financial statements. The CCG's arrangements in respect of settling NHS Continuing Healthcare claims are disclosed in note 24 to these financial statements.

1.6 Charitable Funds

From 2013-14, the divergence from the Government Financial Reporting Manual that NHS Charitable Funds are not consolidated with bodies' own returns is removed. Under the provisions of IAS 27: Consolidated & Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entities' accounts.

1.7 Pooled Budgets

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

If the Clinical Commissioning Group is in a “jointly controlled operation”, the Clinical Commissioning Group recognises:
- The assets the Clinical Commissioning Group controls;
- The liabilities the Clinical Commissioning Group incurs;
- The expenses the Clinical Commissioning Group incurs; and,
- The Clinical Commissioning Group's share of the income from the pooled budget activities.

If the Clinical Commissioning Group is involved in a “jointly controlled assets” arrangement, in addition to the above, the Clinical Commissioning Group recognises:
- The Clinical Commissioning Group’s share of the jointly controlled assets (classified according to the nature of the assets);
- The Clinical Commissioning Group’s share of any liabilities incurred jointly; and,
- The Clinical Commissioning Group’s share of the expenses jointly incurred.

1.8 Critical Accounting Judgements & Key Sources of Estimation Uncertainty

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

1.8.1 Critical 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.

1.8.2 Key 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 note to the accounts.

1.9 Revenue

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

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

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

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

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

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

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

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

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

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

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

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

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different
from those that would be determined at the end of the reporting period. Fair values are determined as follows:
• Land and non-specialised buildings – market value for existing use; and,
• Specialised buildings – depreciated replacement cost.
Notes to the financial statements

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

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

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

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

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

1.13 Intangible Assets
1.13.1 Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Clinical Commissioning Group's business or which arise from contractual or other legal rights. They are recognised only:

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

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

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

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

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.
Notes to the financial statements

1.14 Depreciation, Amortisation & Impairments
Freehold land, properties under construction, and assets held for sale are not depreciated.
Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Clinical Commissioning Group expects to obtain economic benefits or service potential from the asset. This is specific to the Clinical Commissioning Group and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

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

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

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

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

1.17 Non-current Assets Held For Sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when:
- The sale is highly probable;
- The asset is available for immediate sale in its present condition; and,
- Management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification.

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

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

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

1.18 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.
Notes to the financial statements

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

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

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

1.18.2 The Clinical Commissioning Group as Lessor
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Clinical Commissioning Group’s net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the Clinical Commissioning Group’s net investment outstanding in respect of the leases.

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

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
- Payment for the fair value of services received;
- Payment for the PFI asset, including finance costs; and,
- Payment for the replacement of components of the asset during the contract ‘lifecycle replacement’.

1.19.1 Services Received
The fair value of services received in the year is recorded under the relevant expenditure headings within ‘operating expenses’.

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

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

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

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

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

1.19.4 Lifecycle Replacement
Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Clinical Commissioning Group’s criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

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

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

1.19.5 Assets Contributed by the Clinical Commissioning Group to the Operator For Use in the Scheme
Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Clinical Commissioning Group’s Statement of Financial Position.

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

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured at the present value of the minimum lease payments, discounted using the implicit interest rate. It is subsequently measured as a finance lease liability in accordance with IAS 17.

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

1.21 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.

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

- Timing of cash flows (0 to 5 years inclusive): Minus 1.90%
- Timing of cash flows (6 to 10 years inclusive): Minus 0.65%
- Timing of cash flows (over 10 years): Plus 2.20%
- All employee early departures: 1.80%
Notes to the financial statements

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.

1.23 Clinical Negligence Costs

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

1.24 Non-clinical Risk Pooling

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

1.25 Carbon Reduction Commitment Scheme

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

1.26 Contingencies

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

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

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

1.27 Financial Assets

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

Financial assets are classified into the following categories:

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

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

1.27.1 Financial Assets at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial assets at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in calculating the Clinical Commissioning Group’s surplus or deficit for the year. The net gain or loss incorporates any interest earned on the financial asset.

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

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

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

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

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

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

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

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

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

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

1.28.1 Financial Guarantee Contract Liabilities
Financial guarantee contract liabilities are subsequently measured at the higher of:

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

1.28.2 Financial Liabilities at Fair Value Through Profit and Loss
Embedded derivatives that have different risks and characteristics to their host contracts, and contracts with embedded derivatives whose separate value cannot be ascertained, are treated as financial liabilities at fair value through profit and loss. They are held at fair value, with any resultant gain or loss recognised in the Clinical Commissioning Group’s surplus/deficit. The net gain or loss incorporates any interest payable on the financial liability.

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

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

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

1.31 Third Party Assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Clinical Commissioning Group has no beneficial interest in them.

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

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

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

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

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

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

1.35 **Joint Ventures**
Material entities over which the Clinical Commissioning Group has joint control with one or more other parties so as to obtain economic or other benefits are classified as joint ventures. Joint ventures are accounted for using the equity method.

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

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

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

1.38 **Accounting Standards That Have Been Issued But Have Not Yet Been Adopted**
The Government Financial Reporting Manual does not require the following Standards and Interpretations to be applied in 2013-14, all of which are subject to consultation:

- IAS 27: Separate Financial Statements
- IAS 28: Investments in Associates & Joint Ventures
- IAS 32: Financial Instruments – Presentation (amendment)
- IFRS 9: Financial Instruments
- IFRS 10: Consolidated Financial Statements
- IFRS 11: Joint Arrangements
- IFRS 12: Disclosure of Interests in Other Entities
- IFRS 13: Fair Value Measurement

The application of the Standards as revised would not have a material impact on the accounts for 2013-14, were they applied in that year.
2 Other Operating Revenue

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14 Total £000</th>
<th>2013-14 Admin £000</th>
<th>2013-14 Programme £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Patient transport services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescription fees and charges</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Dental fees and charges</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Education, training and research</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: NHS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Charitable and other contributions to revenue expenditure: non-NHS</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receipt of donations for capital acquisitions: NHS Charity</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Receipt of Government grants for capital acquisitions</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>39,324</td>
<td>1,143</td>
<td>38,181</td>
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<tr>
<td>Income generation</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rental revenue from finance leases</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Rental revenue from operating leases</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other revenue</td>
<td>211</td>
<td>59</td>
<td>152</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39,535</strong></td>
<td><strong>1,202</strong></td>
<td><strong>38,333</strong></td>
</tr>
</tbody>
</table>

Admin revenue is revenue received that is not directly attributable to the provision of healthcare or healthcare services.

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

**Collaborative Arrangements**

There are three Clinical Commissioning Groups (CCGs) in Leeds: Leeds South and East (LSE), Leeds West (LW) and Leeds North (LN).

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

- LSE lead on continuing health care, community services and children's services
- LW lead on acute services
- LN lead on mental health, learning disabilities and urgent care

As lead commissioner for continuing health care, community services and children's services, LSE CCG accounts for a high volume and value of transactions and balances.

Included in the note above are recharges in relation to these collaborative arrangements which are classified as “Non-patient care services to other bodies”.

Subsequent notes contain figures detailing expenditure, trade payables and receivables which relate to these collaborative arrangements. Where this is the case, this detailed note is referred to.

**3 Revenue**

Revenue is totally from the supply of services. The Clinical Commissioning Group receives no revenue from the sale of goods.
4. Employee benefits & staff numbers

4.1.1 Employee benefits

<table>
<thead>
<tr>
<th>Employee Benefits Expenditure</th>
<th>2013-14</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</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>
<td>£000</td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>4,258</td>
<td>3,699</td>
<td>559</td>
<td>2,718</td>
<td>2,339</td>
<td>379</td>
<td>1,540</td>
<td>1,360</td>
<td>180</td>
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<tr>
<td>Social security costs</td>
<td>278</td>
<td>278</td>
<td>-</td>
<td>171</td>
<td>171</td>
<td>-</td>
<td>107</td>
<td>107</td>
<td>-</td>
<td></td>
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<tr>
<td>Employer Contributions to NHS Pension scheme</td>
<td>422</td>
<td>422</td>
<td>-</td>
<td>240</td>
<td>240</td>
<td>-</td>
<td>182</td>
<td>182</td>
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<tr>
<td>Other pension costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Other post-employment benefits</td>
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<td>-</td>
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<td>-</td>
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</tr>
<tr>
<td>Other employment benefits</td>
<td>-</td>
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<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Gross employee benefits expenditure</td>
<td>4,958</td>
<td>4,399</td>
<td>559</td>
<td>3,129</td>
<td>2,750</td>
<td>379</td>
<td>1,829</td>
<td>1,649</td>
<td>180</td>
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</tr>
</tbody>
</table>

Less recoveries in respect of employee benefits (note 4.1.2)

<table>
<thead>
<tr>
<th>2013-14</th>
<th>Total</th>
<th>Permanent</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td></td>
</tr>
<tr>
<td>Salaries and wages</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Social security costs</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Employer contributions to NHS Pension scheme</td>
<td>-</td>
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</tr>
<tr>
<td>Other pension costs</td>
<td>-</td>
<td>-</td>
<td>-</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>Total recoveries in respect of employee benefits</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Included in employee benefits and staff numbers are expenditure and staff numbers in relation to the Clinical Commissioning Groups' collaborative arrangements, described in detail in note 2.
4.2 Average number of people employed

<table>
<thead>
<tr>
<th>Total</th>
<th>Permanently employed</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Number</td>
</tr>
<tr>
<td></td>
<td>102</td>
<td>92</td>
</tr>
</tbody>
</table>

Of the above:
Number of whole time equivalent people engaged on capital projects:

4.3 Staff sickness absence and ill health retirements

<table>
<thead>
<tr>
<th>Total Days Lost</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>554</td>
</tr>
</tbody>
</table>

Total Staff Years

87

Average working Days Lost

6

The figures included above are provided by the Health and Social Information Centre on the Clinical Commissioning Group’s (CCG) behalf, collated annually on a calendar year basis (January - December).

As the CCG was not in existence for the first three months of the 2014 calendar year, the figures are for the 9 month period, April - December 2014.

4.4 Exit packages agreed in the financial year

There were no exit packages agreed in the financial year.
4.5 Pension costs

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

The Scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The Scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the Clinical Commissioning Group of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

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

4.5.1 Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the Scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme’s liabilities.

The last published actuarial valuation undertaken for the NHS Pension scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ended 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service provision due in 2015.

4.5.2 Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011 is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

The latest assessment of the liabilities of the Scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office.
4.5 Pension costs cont’d

4.5.3 Scheme Provisions

The NHS Pension Scheme provides defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service;

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HM Revenue & Customs rules. This new provision is known as "pension commutation";

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year;

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year’s pensionable pay for death in service, and five times their annual pension for death after retirement is payable;

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 the statement of comprehensive net expenditure at the time the Clinical Commissioning Group commits itself to the retirement, regardless of the method of payment; and,

Members can purchase additional service in the Scheme and contribute to money purchase AVC’s run by the Scheme’s approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.
## 5. Operating expenses

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total</td>
<td>Admin</td>
<td>Programme</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Gross employee benefits</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee benefits excluding governing body members</td>
<td>4,434</td>
<td>2,605</td>
<td>1,829</td>
</tr>
<tr>
<td>Executive governing body members</td>
<td>524</td>
<td>524</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total gross employee benefits</strong></td>
<td>4,958</td>
<td>3,129</td>
<td>1,829</td>
</tr>
<tr>
<td><strong>Other costs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services from other CCGs and NHS England</td>
<td>10,436</td>
<td>1,903</td>
<td>8,533</td>
</tr>
<tr>
<td>Services from foundation trusts</td>
<td>37,772</td>
<td>-</td>
<td>37,772</td>
</tr>
<tr>
<td>Services from other NHS trusts</td>
<td>199,781</td>
<td>10</td>
<td>199,771</td>
</tr>
<tr>
<td>Services from other NHS bodies</td>
<td>3</td>
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<td>3</td>
</tr>
<tr>
<td>Purchase of healthcare from non-NHS bodies</td>
<td>79,167</td>
<td>50</td>
<td>79,117</td>
</tr>
<tr>
<td>Chair and lay membership body and governing body members</td>
<td>83</td>
<td>83</td>
<td>-</td>
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<tr>
<td>Supplies and services – clinical</td>
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<td>-</td>
<td>-</td>
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<tr>
<td>Supplies and services – general</td>
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<td>96</td>
<td>408</td>
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<td>Consultancy services</td>
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<td>264</td>
<td>2</td>
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<tr>
<td>Establishment</td>
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<td>Transport</td>
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<td>Premises</td>
<td>847</td>
<td>843</td>
<td>4</td>
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<tr>
<td>Impairments and reversals of receivables</td>
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<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Inventories written down</td>
<td>-</td>
<td>-</td>
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</tr>
<tr>
<td>Depreciation</td>
<td>-</td>
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<td>Amortisation</td>
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<tr>
<td>Impairments and reversals of property, plant and equipment</td>
<td>-</td>
<td>-</td>
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<tr>
<td>Impairments and reversals of intangible assets</td>
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<tr>
<td>Impairments and reversals of financial assets</td>
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<td>-</td>
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</tr>
<tr>
<td>· Assets carried at amortised cost</td>
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<tr>
<td>· Assets carried at cost</td>
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<tr>
<td>· Available for sale financial assets</td>
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<td>Impairments and reversals of non-current assets held for sale</td>
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<td>Impairments and reversals of investment properties</td>
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<td>Audit fees</td>
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<td>Other auditor’s remuneration</td>
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<td>· Internal audit services</td>
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<td>-</td>
</tr>
<tr>
<td>· Other services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>General dental services and personal dental services</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Prescribing costs</td>
<td>42,954</td>
<td>103</td>
<td>42,851</td>
</tr>
<tr>
<td>Pharmaceutical costs</td>
<td>2</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Ophthalmic costs</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>GPMS/APMS and PCTMS</td>
<td>1,615</td>
<td>-</td>
<td>1,615</td>
</tr>
<tr>
<td>Other professional fees (excluding audit)</td>
<td>19</td>
<td>19</td>
<td>-</td>
</tr>
<tr>
<td>Grants to other public bodies</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Clinical negligence</td>
<td>7</td>
<td>7</td>
<td>-</td>
</tr>
<tr>
<td>Research and development (excluding staff costs)</td>
<td>136</td>
<td>135</td>
<td>1</td>
</tr>
<tr>
<td>Education and training</td>
<td>408</td>
<td>327</td>
<td>81</td>
</tr>
<tr>
<td>Change in discount rate</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Other expenditure</td>
<td>927</td>
<td>-</td>
<td>927</td>
</tr>
<tr>
<td><strong>Total other costs</strong></td>
<td>375,484</td>
<td>4,239</td>
<td>371,245</td>
</tr>
<tr>
<td><strong>Total operating expenses</strong></td>
<td>380,442</td>
<td>7,368</td>
<td>373,074</td>
</tr>
</tbody>
</table>

Admin expenditure is expenditure incurred that is not a direct payment for the provision of healthcare or healthcare services.

Included in gross employee benefits and other costs is expenditure in relation to the Clinical Commissioning Groups’ collaborative arrangements, described in detail in note 2.
6 Better Payment Practice Code

6.1 Measure of compliance

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000</td>
</tr>
<tr>
<td>Non-NHS Payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade</td>
<td>13,490</td>
<td>75,970</td>
</tr>
<tr>
<td>invoices paid in the Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Non-NHS Trade</td>
<td>13,191</td>
<td>75,132</td>
</tr>
<tr>
<td>Invoices paid within</td>
<td></td>
<td></td>
</tr>
<tr>
<td>target</td>
<td>97.78%</td>
<td>98.90%</td>
</tr>
<tr>
<td>NHS Payables</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices</td>
<td>1,838</td>
<td>247,324</td>
</tr>
<tr>
<td>Paid in the Year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total NHS Trade Invoices</td>
<td>1,759</td>
<td>247,239</td>
</tr>
<tr>
<td>Paid within target</td>
<td>95.70%</td>
<td>99.97%</td>
</tr>
</tbody>
</table>

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

Included in the note above are transactions in relation to the Clinical Commissioning Groups' collaborative arrangements, described in detail in note 2.

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

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
</tr>
<tr>
<td>Amounts included in</td>
<td>-</td>
</tr>
<tr>
<td>finance costs from claims</td>
<td></td>
</tr>
<tr>
<td>made under this legislation</td>
<td></td>
</tr>
<tr>
<td>Compensation paid to</td>
<td>-</td>
</tr>
<tr>
<td>cover debt recovery costs</td>
<td></td>
</tr>
<tr>
<td>under this legislation</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
</tr>
</tbody>
</table>

7 Income Generation Activities

The Clinical Commissioning Group does not undertake any income generation activities.
8. Operating Leases

8.1 As lessee

The Clinical Commissioning Group has operating leases in respect of photocopiers and leased cars for an agreed number of years, with no renewal terms, purchase options or escalation clauses.

### 8.1.1 Payments recognised as an Expense

<table>
<thead>
<tr>
<th>Payments recognised as an expense</th>
<th>2013-14</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum lease payments</td>
<td></td>
<td>-</td>
<td>745</td>
<td>(2)</td>
<td>743</td>
</tr>
<tr>
<td>Contingent rents</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sub-lease payments</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>-</td>
<td>745</td>
<td>(2)</td>
<td>743</td>
</tr>
</tbody>
</table>

### 8.1.2 Future minimum lease payments

<table>
<thead>
<tr>
<th>Payable:</th>
<th>2013-14</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>No later than one year</td>
<td></td>
<td>-</td>
<td>-</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Between one and five years</td>
<td></td>
<td>-</td>
<td>-</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>After five years</td>
<td></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td>-</td>
<td>-</td>
<td>58</td>
<td>58</td>
</tr>
</tbody>
</table>

The Clinical Commissioning Group occupies property leased and managed by NHS Property Services Ltd. For 2013-14, a transitional occupancy rent based on annual property cost allocation was agreed. This is reflected in Note 8.1.1.

While our arrangements with NHS Property Service Ltd fall within the definition of operating leases, the rental charge for future years has not been agreed. Consequently, this note does not include future minimum lease payments for these arrangements.
9 Investment property

The Clinical Commissioning Group had no investment property as at 31 March 2014.

10 Inventories

The Clinical Commissioning Group had no inventories as at 31 March 2014.

11 Trade and other receivables

<table>
<thead>
<tr>
<th>Description</th>
<th>Current 2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS receivables: Revenue</td>
<td>44</td>
</tr>
<tr>
<td>NHS receivables: Capital</td>
<td>-</td>
</tr>
<tr>
<td>NHS prepayments and accrued income</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS receivables: Revenue</td>
<td>1,719</td>
</tr>
<tr>
<td>Non-NHS receivables: Capital</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS prepayments and accrued income</td>
<td>99</td>
</tr>
<tr>
<td>Provision for the impairment of receivables</td>
<td>-</td>
</tr>
<tr>
<td>VAT</td>
<td>62</td>
</tr>
<tr>
<td>Private finance initiative and other public private partnership arrangement prepayments and accrued income</td>
<td>-</td>
</tr>
<tr>
<td>Interest receivables</td>
<td>-</td>
</tr>
<tr>
<td>Finance lease receivables</td>
<td>-</td>
</tr>
<tr>
<td>Operating lease receivables</td>
<td>-</td>
</tr>
<tr>
<td>Other receivables</td>
<td>42</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,027</strong></td>
</tr>
</tbody>
</table>

As at 31 March 2014 there were no non-current trade and other receivables.

There are no prepaid pension contributions included above.

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

Included in the note above are balances in relation to the Clinical Commissioning Groups' collaborative arrangements, described in detail in note 2.

11.1 Receivables past their due date but not impaired

<table>
<thead>
<tr>
<th>Duration</th>
<th>2013-14 £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>By up to three months</td>
<td>56</td>
</tr>
<tr>
<td>By three to six months</td>
<td>1</td>
</tr>
<tr>
<td>By more than six months</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>58</strong></td>
</tr>
</tbody>
</table>

£55,739 of the amount above has subsequently been recovered post the statement of financial position date.

The Clinical Commissioning Group did not hold any collateral against receivables outstanding at 31 March 2014.
12 Other financial assets
The Clinical Commissioning Group had no other financial assets as at 31 March 2014.

13 Other current assets
The Clinical Commissioning Group had no other current assets as at 31 March 2014.

14 Cash and cash equivalents

<table>
<thead>
<tr>
<th></th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance at 1 April 2013</td>
<td>-</td>
</tr>
<tr>
<td>Net change in year</td>
<td>59</td>
</tr>
<tr>
<td>Balance at 31 March 2014</td>
<td>59</td>
</tr>
</tbody>
</table>

Made up of:
- Cash with the Government Banking Service 59
- Cash with Commercial banks -
- Cash in hand -
- Current investments -
- Cash and cash equivalents as in statement of financial position 59

Bank overdraft: Government Banking Service -
Bank overdraft: Commercial banks -
Balance at 31 March 2014 59

15 Non-current assets held for sale
The Clinical Commissioning Group had no non-current assets held for sale as at 31 March 2014.

16 Analysis of impairments and reversals
The Clinical Commissioning Group had no impairments or reversals of impairments recognised in expenditure during 2013-14.
17 Trade and other payables

<table>
<thead>
<tr>
<th>Description</th>
<th>Current 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interest payable</td>
<td>-</td>
</tr>
<tr>
<td>NHS payables: Revenue</td>
<td>1,268</td>
</tr>
<tr>
<td>NHS payables: Capital</td>
<td>-</td>
</tr>
<tr>
<td>NHS accruals and deferred income</td>
<td>1,695</td>
</tr>
<tr>
<td>Non-NHS payables: Revenue</td>
<td>1,625</td>
</tr>
<tr>
<td>Non-NHS payables: Capital</td>
<td>-</td>
</tr>
<tr>
<td>Non-NHS accruals and deferred income</td>
<td>10,208</td>
</tr>
<tr>
<td>Social security costs</td>
<td>48</td>
</tr>
<tr>
<td>VAT</td>
<td>-</td>
</tr>
<tr>
<td>Tax</td>
<td>49</td>
</tr>
<tr>
<td>Payments received on account</td>
<td>-</td>
</tr>
<tr>
<td>Other payables</td>
<td>75</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>14,968</strong></td>
</tr>
</tbody>
</table>

As at 31 March 2014 there were no non-current trade and other payables.

Other payables include £69,629 outstanding pension contributions at 31 March 2014.

Included in the note above are balances in relation to the Clinical Commissioning Groups’ collaborative arrangements, described in detail in note 2.

18 Other financial liabilities

The Clinical Commissioning Group had no other financial liabilities as at 31 March 2014.

19 Other liabilities

The Clinical Commissioning Group had no other liabilities as at 31 March 2014.

20 Borrowings

The Clinical Commissioning Group had no borrowings as at 31 March 2014.

21 Private finance initiative, LIFT & other service concession arrangements

The Clinical Commissioning Group had no private finance initiative, LIFT or other service concession arrangements that were either excluded from or included in the Statement of Financial Position as at 31 March 2014.
22 Finance lease obligations

The Clinical Commissioning Group had no finance lease obligations as at 31 March 2014.

23 Finance lease receivables

The Clinical Commissioning Group had no finance lease receivables as at 31 March 2014.

24 Provisions

<table>
<thead>
<tr>
<th></th>
<th>Current 2013-14</th>
<th>Non-current 2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Pensions relating to former directors</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Pensions relating to other staff</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Restructuring</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Redundancy</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Agenda for change</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Equal pay</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Legal claims</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Continuing care</td>
<td>309</td>
<td>618</td>
</tr>
<tr>
<td>Other</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>309</strong></td>
<td><strong>618</strong></td>
</tr>
</tbody>
</table>

The continuing care provision relates to balances that have arisen during the year. Expected timing of cash flows are as follows:

<table>
<thead>
<tr>
<th>Continuing Care £000s</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Within one year</td>
<td>309</td>
</tr>
<tr>
<td>Between one and five years</td>
<td>618</td>
</tr>
<tr>
<td><strong>Balance at 31 March 2014</strong></td>
<td><strong>927</strong></td>
</tr>
</tbody>
</table>

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 establishment of the Clinical Commissioning Group (CCG). 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 2014 is £2,736,000.
25 Commitments

25.1 Capital commitments

The Clinical Commissioning Group had no contracted capital commitments not otherwise included in these financial statements as at 31 March 2014.

25.2 Other financial commitments

The Clinical Commissioning Group had no non-cancellable contracts (which were not leases, private finance initiative contracts or other services concession arrangements) as at 31 March 2014.

26 Financial instruments

26.1 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’s standing financial instructions and policies agreed by the Governing Body. Treasury activity is subject to review by the Clinical Commissioning Group’s internal auditors.

26.1.1 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.

26.1.2 Interest rate risk

The Clinical Commissioning Group is not permitted to borrow, therefore has low exposure to interest rate fluctuations.

26.1.3 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.

26.1.4 Liquidity risk

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

26.2 Financial assets

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>-</td>
<td>206</td>
<td>-</td>
<td>206</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total</strong></td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

26.3 Financial liabilities

<table>
<thead>
<tr>
<th>Description</th>
<th>2013-14</th>
<th>2013-14</th>
<th>2013-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td>-</td>
<td>14,796</td>
<td>14,796</td>
</tr>
</tbody>
</table>
27 Operating segments

The Clinical Commissioning Group considers that it has only one segment: commissioning of healthcare services.

28 Pooled budgets

The Clinical Commissioning Group was not party to any pooled budget arrangements during 2013-14.

29 NHS Lift investments

The Clinical Commissioning Group had no NHS LIFT investments as at 31 March 2014.

30 Intra-government and other balances

<table>
<thead>
<tr>
<th>Balances with:</th>
<th>Current Receivables £000</th>
<th>Current Payables £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Central Government bodies</td>
<td>62</td>
<td>171</td>
</tr>
<tr>
<td>Local Authorities</td>
<td>50</td>
<td>1,092</td>
</tr>
<tr>
<td>NHS bodies outside the Departmental Group</td>
<td>817</td>
<td>333</td>
</tr>
<tr>
<td>NHS Trusts and Foundation Trusts</td>
<td>946</td>
<td>2,631</td>
</tr>
<tr>
<td>Public corporations and trading funds</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Bodies external to Government</td>
<td>152</td>
<td>10,741</td>
</tr>
<tr>
<td><strong>Total at 31 March 2014</strong></td>
<td><strong>2,027</strong></td>
<td><strong>14,968</strong></td>
</tr>
</tbody>
</table>

As at 31 March 2014 there were no non-current receivables and payables.
31 Related party transactions

None of the Department of Health Ministers, or parties related to any of them, have undertaken any material transactions with the Clinical Commissioning Group during the year.

During the year the following Governing Body members, or parties related to any of them, were also members of medical practices with which the Clinical Commissioning Group had material transactions concerning the provision of medical services and the purchase of healthcare.

In addition, during the year members of the Governing Body held positions with organisations with which the Clinical Commissioning Group had transactions, in relation to the purchase of healthcare, that require disclosure.

Details of these related party transactions with individuals are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Payments to Related Party £000</th>
<th>Receipts from Related Party £000</th>
<th>Amounts owed to Related Party £000</th>
<th>Amounts due from Related Party £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Practices</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andy Harris - Oulton Medical Centre</td>
<td>116</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andy Harris - Shaftesbury Medical Centre</td>
<td>258</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Alistair Walling - Ashfield Medical Centre</td>
<td>50</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Benjamin Browning - Lofthouse Surgery</td>
<td>111</td>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Dave Mitchell - Leeds City Medical Practice</td>
<td>183</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Jacqueline Campbell - Lingwell Croft Surgery</td>
<td>172</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Tom Gibbs - Shaftesbury Medical Centre</td>
<td>258</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Daniel Albert - Yorks Street Health Practice</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Leodis Care Ltd - related party with the following individuals:</td>
<td>542</td>
<td>46</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Andy Harris</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Alistair Walling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dr Benjamin Browning</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Dr Dave Mitchell</td>
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<tr>
<td>Dr Jacqueline Campbell</td>
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<tr>
<td>Dr Tom Gibbs</td>
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<tr>
<td>Gordon Tollefson</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brian Roebuck - Community Links (Northern) Ltd</td>
<td>1,058</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

• NHS England
• NHS Leeds West Clinical Commissioning Group
• NHS Leeds North Clinical Commissioning Group
• NHS West Yorkshire Commissioning Support Unit
• Leeds Teaching Hospitals NHS Trust
• Leeds & York Partnership NHS Foundation Trust
• Leeds Community Healthcare NHS Trust
• Yorkshire Ambulance Service NHS Trust
• Mid Yorkshire Hospitals NHS Trust
• Harrogate and District NHS Foundation Trust

In addition, the Clinical Commissioning Group has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with Leeds City Council.
32 Events after the reporting period

There are no post balance sheet events which will have a material effect on the financial statements of the Clinical Commissioning Group.

33 Losses and special payments

The Clinical Commissioning Group had no losses and special payments cases during 2013-14.

34 Third party assets

The Clinical Commissioning Group held no third party assets as at 31 March 2014.

35 Financial performance duties

Clinical Commissioning Groups have a number of financial duties under the National Health Service Act 2006 (as amended).

The Clinical Commissioning Group’s performance against those duties was as follows:

<table>
<thead>
<tr>
<th>National Health Service Act Section</th>
<th>Duty</th>
<th>Maximum £000</th>
<th>2013-14 Performance £000</th>
<th>Duty Achieved?</th>
</tr>
</thead>
<tbody>
<tr>
<td>223H(1)</td>
<td>Expenditure not to exceed income</td>
<td>6,820</td>
<td>6,906</td>
<td>Yes</td>
</tr>
<tr>
<td>233I(2)</td>
<td>Capital resource use does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>233I(3)</td>
<td>Revenue resource use does not exceed the amount specified in Directions</td>
<td>347,813</td>
<td>340,907</td>
<td>Yes</td>
</tr>
<tr>
<td>223J(1)</td>
<td>Capital resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>-</td>
<td>-</td>
<td>N/A</td>
</tr>
<tr>
<td>223J(2)</td>
<td>Revenue programme resource use on specified matter(s) does not exceed the amount specified in Directions</td>
<td>341,623</td>
<td>334,741</td>
<td>Yes</td>
</tr>
<tr>
<td>223J(3)</td>
<td>Revenue administration resource use does not exceed the amount specified in Directions</td>
<td>6,190</td>
<td>6,166</td>
<td>Yes</td>
</tr>
</tbody>
</table>

36 Impact of IFRS

Accounting under IFRS had no impact on the results of the Clinical Commissioning Group during the 2013-14 financial year.