Leeds and York Partnership
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

1 April 2021
to
31 March 2022

Leeds and York Partnership NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7 paragraph 25 (4) (a) of the National Health Service Act 2006

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PART A
ANNUAL REPORT
2021/22

SECTION 1.1 – THE PERFORMANCE REPORT (Overview)

The purpose of the Overview Section is to provide a short summary setting out our purpose, key risks to the achievement of our objectives and how we have performed during the year.

1.1.1 A MESSAGE FROM OUR CHAIR

Once again, this last year has been a huge challenge for the NHS across the country. The impact of the various waves of the Covid-19 pandemic have been far-reaching, impacting on physical and mental health, economic wellbeing and our whole way of life. Its longer-term impact on us all is still largely to be determined, but it will be significant. Our staff have worked heroically to respond to the demands of the pandemic, continuing to provide the best care to services users of our mental health, learning disability and neurodiverse services. This has often required fast but thoughtful changes, resilience, creativity, adaptability, strong leadership and a positive 'can do' attitude from us all. Many staff have continued to work largely at home over the last year, but services have continued, and staff have found new ways to engage and support our service users and carers. As I write this foreword, Covid-19 case numbers are rising once more and the NHS and care services remain at the forefront of dealing with the human impact of the crisis.

Our services face many challenges. Not least, as with many other NHS organisations, we are working hard with partners to create solutions to address too many staffing vacancies. We published our 'People Plan' this year which sets out our commitment to be an excellent employer, enabling people to choose to work with us, develop their careers, and fulfil their potential so we can provide excellent services to those who need them. We want to challenge, tackle and eradicate discrimination, and embrace, nourish and celebrate diversity and inclusion across our Trust. The steps we have taken and how this will be accelerated are reflected in the Plan.

We remain grateful for the wonderful support of the public in Leeds and York, and for the sacrifices people have made in order to stay safe. As a Trust family, many staff and service users have been personally affected by Covid-19. Last winter, levels of Covid-19 related sickness were the highest we have ever experienced. Since last year, we have sadly lost some of our service users and at least one member of staff to this terrible virus. As we approach the National Day of Reflection, two years since the first lockdown, our thoughts and prayers are with their loved ones at this very sad time.

Despite the challenges of the pandemic, every day I continue to be humbled and inspired by so many of our staff, volunteers and service users. Their day-to-day commitment to the values underpinning the NHS are unwavering. I am privileged to see acts of kindness and compassion, along with professional knowledge, a willingness to share expertise and commitment to team working take place across our services. These are being severely tested by pressures in the system, and by the pandemic. A recent call to staff to donate toiletries and essentials for refugees from the war in Ukraine resulted in generosity on a massive scale from staff across all our sites. The humanity of our staff when faced with such urgent need, was beautiful and moving to witness. Our Trust values are Integrity, Simplicity and Caring and are, despite such difficulties, demonstrated in abundance. For this I am so very grateful.

The Board has continued to meet monthly mostly virtually, and we still start every Board meeting with an opportunity to hear about the experience of service users, carers or members of staff. This is more important than ever to remind us of the purpose of our organisation and of the reality of the day-to-day challenges we all face in trying to deliver services to the best of our ability within our financial limitations. We don't always get it right, and these sessions are challenging, but all the more important for that. Each story has been full of opportunities to learn, to improve and to strengthen our services for the better. I am hugely grateful for the candour, courage and willingness to share by all those who have participated in our virtual and latterly, face to face Board meetings.

Last year, as we started to learn more about the disproportionate impact of Covid-19 and other diseases on people from black, Asian and other ethnic communities, we started to have important, but sometimes challenging conversations in the Trust about these matters. Led by the Workforce Race Equality Network, we worked together to challenge and address inequalities in our Trust. This work has been complimented by a Reciprocal Mentoring Programme for staff from ethnic minorities and Board

members. It is an important start but only one part of our work across the Trust to eradicate racial inequalities.

This year we redesigned our community services and continued to work on a programme of 'Acute Care Excellence' to improve our acute care offer. In 2020, we introduced a new electronic patient record system, CareDirector, which is embedding how we document and record care, and already impacting how we record, interact with and manage care services. We are in the process of updating our Digital Strategy, which will be clearly influenced by the radical changes in how we use technology which have been accelerated in the last two years. We also published our Sustainability Strategy, setting out how we intend to reduce our carbon footprint, protect the environment, and be more energy efficient over the coming years.

Finally, we were delighted to open the brand new unit, Red Kite View, on the St Mary's Hospital site for the new specialist West Yorkshire Children and Young Peoples' Mental Health Inpatient Unit. We are delighted to welcome many new and experienced staff, who are working in partnership with young people to develop a new exciting service in this wonderful new building for young people from across West Yorkshire.

We continue to play an active role in partnerships with NHS, social care, third sector and others in Leeds and as part of the West Yorkshire Health and Care Partnership. We already work closely with many partners in delivering mental health and learning disability services to people in Leeds and York, and some specialist services more widely. We also work closely with colleagues in the Leeds Health and Care Academy, focusing on our role as employers, and the support and development of our workforce. I would like to take this opportunity to thank all of our partners within the NHS, local authorities, third sector and wider public sector. We look forward to continuing this work to deliver sustainable improvements in the coming year.

I am extremely grateful to the Council of Governors for its commitment and continued work in the Trust. Governors have continued to work closely with the Board and have participated in virtual service visits in addition to attending virtual meetings. Our Lead Governor, Peter Webster, stepped down this year. Peter has worked with the governors to help build their confidence in asking questions, participating in virtual service visits and Board meetings. We are so grateful for all his leadership during the last two years. Les France is the new lead governor and is already making a positive impact on the Council. Governors have such an important role in holding the non-executive directors to account, and in representing the views of the public, staff, service users and carers. I am very grateful for the contribution of all our governors.

I have to report some changes to the Board membership. I am extremely grateful for the commitment and professionalism of all Executive and Non-executive Directors. We said farewell to Claire Holmes, Director of Workforce and Organisational Development, and welcomed Darren Skinner as her interim replacement. Andrew Marran stepped down as a Non-executive Director last autumn as he left to take up a new role in Durham. Merran McRae joined us in January and is already making a valuable contribution. In April, two new Associate Non-executive Directors will join us, Kaneez Khan MBE and Dr Frances Healey. We look forward to working with them. Helen Grantham continues as my Deputy Chair and provides excellent support, and leadership in her capacity as Chair of the Workforce Committee.

As we look to the coming year, we will continue to plan and respond to the needs of people with mental illness, learning disabilities and to those affected by Covid-19 across Leeds and York. We will also plan for how we need to adapt further to respond to the potential longer-term effects on the mental health and wellbeing of our service users, staff and the wider community.

This last year has provided many tests and challenges. But, even after two years of the pressures associated with Covid-19, and the increasing mental health needs of people in the city, as a Trust, we have continued to provide good services, be a good partner, and live our values. We have worked hard to deliver safe, quality services. We have worked closely with our partners in the NHS, local government and the third sector to navigate our way through these difficult times. None of this would be possible without the wonderful dedication, compassion, professionalism, and flexibility of all of our staff, volunteers and service users. Thank you, I am proud to be your Chair.

Sue Proctor

Dr Sue Proctor
Chair of the Trust

1.1.2 A MESSAGE FROM OUR CHIEF EXECUTIVE

In a year once again dominated by the Covid-19 pandemic, our colleagues have continued to work tirelessly to provide high quality care and services to the people we serve. Many sacrifices have been made and as I have recommenced face to face service visits I have been truly humbled by the first-hand accounts of colleagues and of service users. I have been equally inspired and in awe of the progress that has continued in developing our services and implementing our plans for the future that will benefit our service users. The passion, commitment, and dedication of all at LYPFT is clear to see.

At the centre of everything we do is our workforce and I know how challenging it continues to be for everyone across the health and care sector. The pandemic has amplified staffing challenges and for many services demand is far greater than we are able to meet in the way that we would want to. This is going to take time but our leadership teams have been working hard in the latter part of the year to develop longer term plans for how we better meet the needs of those we serve in the coming years.

When the pressure has been greatest, we have unfortunately had to redeploy staff to other areas of work to ensure we keep everyone safe. This is never easy and I am immensely grateful to everyone who has been affected by this for being flexible and keeping our service users safe and cared for.

Acknowledging these challenges, it is therefore only right that we continue to place an ever-increasing focus on ensuring our people have access to the help and support they need, when they need it.

In March 2022 we launched our People Plan. This ambitious and exciting plan sets out our vision and commitments over the coming years. It builds on work that we have already been doing and is closely aligned to the NHS People Plan. It sets out what we will to do to continue to engage, retain and recruit colleagues. We want LYPFT to be a great place to work for everyone, where colleagues feel valued for the difference they make in the lives of others.

A major part of how we work now and going forwards will be collaborating with our partners across health and social care, local authorities, the third sector and many others. In Leeds, we are an active member of the place-based partnership (PBP), which will go live in June 2022. The PBP, which replaces the clinical commissioning group (CCG) will see us working across organisational boundaries more than ever before for the benefit of the people we serve. A lot of focus is currently around the capacity and demand challenges being faced by all partners and how, as a partnership, we can work together to provide services in new, innovative and sustainable ways.

On a regional level, we have seen the opening of West Yorkshire's new Children and Young Peoples' Mental Health Inpatient Unit, known as Red Kite View, on our St Mary's Hospital site. This fantastic new £20million (m) 22-bed facility is a significant improvement and replaces the previous eight bed unit at Little Woodhouse Hall. This has been years in the making and could not have happened without our dedicated teams and partners who have led this project to completion. Some of our most vulnerable young people now have access to expert therapy, treatment and facilities in a purpose-built environment close to home.

In other areas of the Trust, we've had several teams and colleagues recognised locally and as part of national schemes – this has been truly fantastic to see and is a testament to everyone in the organisation. It is impossible to highlight every one of these, but one of particular note was that in July we received our Veteran Aware accreditation in recognition of our commitment to improving NHS care for veterans, reservists, members of the armed forces and their families. In the coming year we will be doing much more to support our veterans, both as service users and as employees.

I'm sure you will all agree that the last year has been filled with many challenges and difficult times, but equally many opportunities and achievements we should be rightly proud of. As we learn to live with Covid-19 in the long-term, I know we will continue to work together, learn together and adapt together to whatever challenges we may face.

With my deepest thanks and appreciation to everyone of my colleagues at LYPFT and to all our partners – including our service users and carers who everyday go above and beyond.

Sara Munro

Dr Sara Munro
Chief Executive

1.1.3 ABOUT OUR TRUST – A BRIEF HISTORY AND STATUTORY BACKGROUND

As part of the NHS and Community Care Act (1990) the Leeds Community and Mental Health Services Teaching NHS Trust was formed on 1 February 1993. This was a self-governing trust providing community, mental health and learning disability services within the Leeds metropolitan area. In 2002 the community services previously provided by the NHS Trust transferred to the PCTs in Leeds, and the Trust was renamed the Leeds Mental Health Teaching NHS Trust; providing only mental health and learning disability services.

On 1 August 2007 NHS Improvement (formally Monitor) authorised us as a foundation trust, and we were formed as the Leeds Partnerships NHS Foundation Trust under the NHS Act 2006. As a foundation trust we provide mental health and learning disability services and have freedoms to act which NHS trusts don't.

A further development for our Trust was the acquisition of mental health, learning disability and substance misuse services from NHS North Yorkshire and York and NHS England on 1 February 2012. To reflect the new geographical area in which services were provided we became the Leeds and York Partnership NHS Foundation Trust. However, the services commissioned by NHS North Yorkshire and York transferred to Tees, Esk and Wear Valleys NHS Foundation Trust on 1 October 2015, although the Trust still provides specialist services commissioned by NHS England from its York bases to a regional population.

1.1.4 OUR STRATEGY

Our Trust Strategy *Improving health, improving lives*, describes what we want to achieve over the five years up until 2023 and how we plan to get there. The strategy is designed around the three key

elements of delivering great care; a rewarding and supportive workplace; and effective and sustainable services.

Our strategic intent is set out in our Trust Strategy (2018 to 2023). This has been fully aligned with the key themes within national and local strategies and the challenges and opportunities we see ahead over the next one to five years. We have continued to work alongside commissioners and providers, both locally and regionally, to develop integrated strategic objectives and plans.

In line with their statutory responsibility, our governors played a key role in shaping our strategy and through a series of meetings provided feedback to the Board of Directors on the views of the Council and members. These views were fed into the process of developing the strategy.

1.1.4.1 Our goals, strategic objectives and priorities

Through extensive staff, governor and member engagement the organisation developed and agreed its vision and ambition; three simple objectives that describe the outcomes we aspire to; and the values we will work to. Our objectives are the three things we believe will help us achieve our vision and which we are passionate about realising. We have deliberately kept them simple so all our staff can keep a clear focus on them every day and in everything they do.

For each objective we have a series of priorities for action for achievement by 2022/23. All our priorities are tracked through our governance framework to make sure we are on course to achieve them.

A headline summary of our strategy can be found below.

Table 1.1A – Our Trust strategy

Purpose	Improving health, Improving lives	
Vision	To provide outstanding mental health and learning disability services as an employer of choice	
Ambition	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health	
Our values		
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	**We keep it simple** We make it easy for the communities we serve and the people who work here to achieve their goals.	**We are caring** We always show empathy and support those in need.
Our strategic objectives		
1. We deliver great care that is high quality and improves lives.	2. We provide a rewarding and supportive place to work.	3. We use our resources to deliver effective and sustainable services.

1.1.4.2 Our strategic plans

To support the delivery of our overarching strategy our Board agreed five 3-year strategic plans. These are: the LYPFT People Plan; the Quality Strategic Plan; the Clinical Services Strategic Plan; the Strategic Health Informatics Plan; and the Strategic Estates Plan. These were signed off by our Board and priorities to support delivery of the plans are agreed by the Board each year. More information about the strategic plans can be found on our website www.leedsandyorkpft.nhs.uk .

1.1.5 OUR VALUES AND BEHAVIOURS

Our values and behaviours describe what attitudes and behaviours we believe are important in achieving our purpose. A key part of our strategy redevelopment has focused on the values and behaviours our staff are committed to deliver. Our charter of values is set out below.

Table 1.1B – Our values and behaviours

Our values	Behaviours that uphold our values
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	• We are committed to continuously improving what we do because we want the best for our service users. • We consider the feelings, needs and rights of others. • We give positive feedback as a norm and constructively challenge unacceptable behaviour. • We are open about the actions we take and the decisions we make, working transparently and as one team with service users, colleagues and relevant partner organisations.
We are caring We always show empathy and support those in need.	• We make sure people feel we have time for them when they need it. • We listen and act upon what people have to say. • We communicate with compassion and kindness.
We keep it simple We make it easy for the communities we serve and the people who work here to achieve their goals.	• We make processes as simple as possible. • We avoid jargon and make sure we are understood. • We are clear what our goals are and help others to achieve their goals.

1.1.6 STATEMENT OF PURPOSE AND ACTIVITIES OF THE TRUST

We are a provider of specialist mental health and learning disability services. As a teaching trust with strong links to local universities we have a reputation as a centre of excellence for teaching, research and development, partly attributable to the national profiles of a number of our clinicians.

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services. We have developed robust relationships with service users, carers and our partners in the NHS, Local Authorities and third sectors.

We provide services to approximately 798,786 individuals in the Leeds areas and specialist services and accept referrals from across the UK. We operate from 70 dispersed sites and employ approximately 3000 staff and nearly 500 bank staff.

Clinical services are currently delivered across nine service lines:

Acute services	Learning Disabilities services	Perinatal and Liaison services
Older People's Services	Children and Young Peoples' Mental Health Services (CYPMHS)	Regional Eating Disorders and Rehabilitation services
Forensic services	Community and Wellbeing services	Regional and specialist services

Our services are delivered across a range of settings in Yorkshire and the Humber and our Deaf Children and Young Peoples' Mental Health Service operates from Manchester and Newcastle. They are commissioned by a range of commissioners, including national specialised commissioning (NHS England), local CCGs, the Local Authority and Public Health. A number of our services are also delivered through formal partnerships with other agencies. The services we provide include:

- Community Mental Health Teams
- Care Home Team
- Memory Service
- Crisis Assessment Services
- Intensive Community Services including the Home-Based Treatment Team
- Younger People with Dementia Team
- Psychological and Psychotherapy Services
- Assertive Outreach Team
- Older People's Liaison Mental Health Service (based at St James's Hospital)
- Mental Health Inpatient Services
- Dementia Inpatient Service
- Rehabilitation and Recovery Services
- Healthy Living Service.
- Forensic Services
- Children and Young Peoples' Tier 4 Inpatient Mental Health Services
- Learning Disability Services
- Eating Disorders Services
- Gender Identity Services
- Liaison Psychiatry
- National Deaf Children and Families Service
- Northern School of Child and Adolescent Psychotherapy (NSCAP) Clinical Services
- Perinatal Services
- Personality Disorder Services
- Veterans Service
- Gambling Addiction Service.

1.1.7 PRINCIPAL RISKS AND OPPORTUNITIES FOR THE ORGANISATION

1.1.7.1 Risks

Key or principle risks for the organisation are those that have been identified as strategic risks on the strategic risk register which populate our Board Assurance Framework (BAF). Each of these risks has an identified executive director and management lead. The risks are managed through the risk management, risk register and operational planning processes. They are reported to the Executive Risk Management Group, Board sub-committees and the Board through the BAF. Behind each risk is a detailed risk assessment which sets out the controls and mitigations.

The Board has assessed its risk appetite which is 'open' to considering all potential options and solutions. It is classed as 'high' in relation to that openness, but the board would not take risks that either compromise the Trust's compliance with its duty of care to staff and patients or compromise compliance with the core regulatory and legislative frameworks within which it has a licence to operate.

These risks set the context in which the Board and its sub-committees carry out their roles. During the latter part of 2019/20 the Trust put in place a focused structure of governance to manage the risk to the delivery of services created by the Covid-19 pandemic. This has continued to operate through 2020/21 and 2021/22. Whilst a specific risk for Covid-19 was not entered on the Board Assurance Framework (BAF) the risk ratings of each of the risks listed below reflected the impact the pandemic was having on all areas of the Trust's business. As we move out of the pandemic our risks move to being focused on the strategic risks listed below.

The Board and its sub-committees continue to keep the risks under review at each meeting to gain assurances on the actions being taken and to understand the impact on performance and future plans.

In summary the key strategic risks are described as follows:

Table 1.1C – Our key strategic risks

Strategic risks	Linked to Strategic Objective:
SR1 - If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.	We deliver great care that is high quality and improves lives
SR2 - There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.	We deliver great care that is high quality and improves lives
SR3 - Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.	We provide a rewarding and supporting place to work
SR4 - A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.	We use our resources to deliver effective and sustainable services
SR5 - Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.	We use our resources to deliver effective and sustainable services
SR6 - As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.	We use our resources to deliver effective and sustainable services
SR7 - Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.	We deliver great care that is high quality and improves lives

1.1.7.2 Opportunities

The opportunities for the Trust focus on developing our services and partnerships.

The Clinical Services Strategic Plan sets out the priorities for our services. However, in 2020/21 and then in 2021/22 some of the priorities in the plan were paused to allow staff to focus on the management of the pandemic. One project that staff did complete was the completion of Red Kite View; our Children and Young Peoples' Mental Health Inpatient Unit which opened in January 2022.

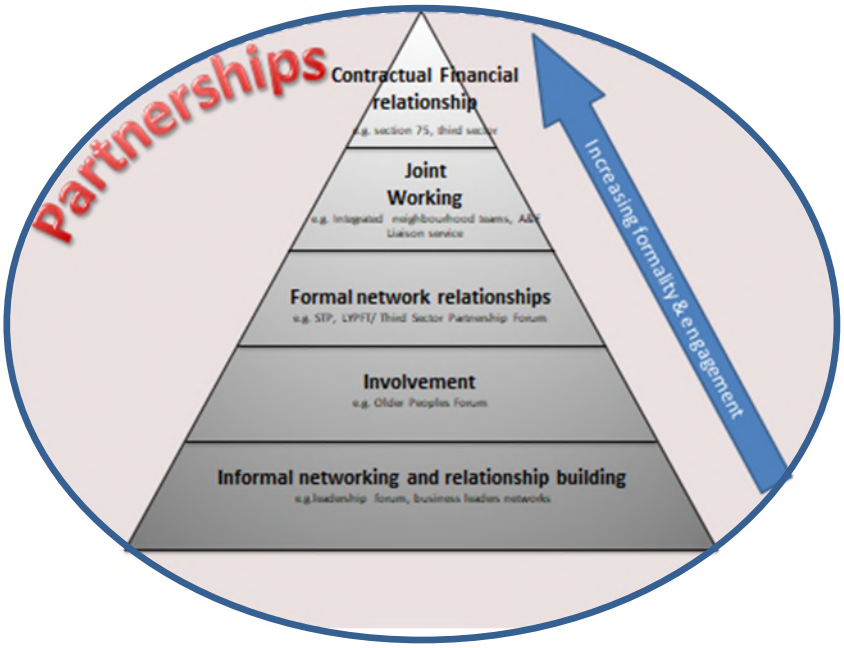
Working in partnership also provides us with an opportunity to work cohesively across geographical areas to ensure there is a seamless provision of care for our service users. During 2021/22 the Trust has focused on strengthening relationships with partners system-wide.

We have been involved in:

- work to establish and appoint to the West Yorkshire Integrated Care System (ICS) shadow Board
- the development of the constitution for the ICS
- the development of the operating model and governance arrangements for the Leeds Place Based Partnership (a committee of the ICS)

- meetings of the West Yorkshire Mental Health Learning Disability and Autism Committee in Common
- engagement with the Humber Coast and Vale ICS specific to the provider collaboratives for Forensic Services and Children and Young Peoples' Mental Health Services
- working with the Leeds Academic Health Partnership to look at reducing health inequalities, building an inclusive economy, tackling climate change and addressing the many pressures exacerbated by the pandemic have all come into sharper than ever focus over the last 18 months.

The Trust values working in partnership and recognises the positive impact this has on service users' experience and we will continue to develop partnerships through 2022/23 using the framework and approach illustrated below:



This framework clarifies our approach. We recognise the importance of third sector providers in supporting our service users and equally value working in partnership with them.

In 2021/22 the Covid-19 pandemic brought about some uncertainty about the way in which we delivered our services, however, our staff made a tremendous effort to put in place the necessary governance, structures, procedures and technologies to allow us to work in a different way and provide a continued safe and effective service. This different way of working presented an opportunity for delivering care differently using new technologies and we will look to build on that learning and take forward this new thinking.

1.1.8 CORONAVIRUS PANDEMIC

During the latter part of March 2020, the Government declared a Level 4 National Incident and took control of the response to the Covid-19 pandemic from the centre. The NHS has remained at Level 4 even when much of the nation has moved to a position of all restrictions being removed.

In line with the national and NHS incident requirements the Trust has in place a 'command and control' structure which allows us to interpret any guidance issued centrally to keep our service users and staff safe.

At the beginning of the pandemic Trust implemented its incident response structure of 'Gold', 'Silver' and 'Bronze' command working within our business continuity arrangements. Senior staff also linked into the structures that had been set up by partners locally and regionally to ensure we all worked together in the most effective way.

At the forefront of all these structures was the safety and protection of our service users and staff which was and continues to be paramount in all considerations of the national guidance. Our staff have worked tirelessly to ensure service delivery continued albeit in different ways.

To keep people safe we continue to hold the majority of our meetings virtually. We are also looking at implementing a hybrid way of working for those staff who can. This builds on the model of working from home for part of the time and bringing teams and people together where necessary. This will allow us to maximise the use of our estate and resources.

Whilst our patient facing staff will continue to provide services face to face we have in place infection prevention measures which will ensure the safety of our service users, staff and visitors as we move into living with Covid-19 and our new ways of delivering our services.

1.1.9 GOING CONCERN STATEMENT

After making enquiries, the directors have a reasonable expectation that the services provided by Leeds and York Partnership NHS Foundation Trust will continue to be provided for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.1.10 DISCLOSURE ON EQUALITY OF SERVICE DELIVERY TO DIFFERENT GROUPS

Our commitment to provide equitable mental health and learning disability services through the delivery of personalised care which promotes inclusion and addresses inequalities in access and experience is set out in our five-year strategy, Living our Values to Improve Health and Lives.

You can read our strategy using the link below:

https://www.leedsandyorkpft.nhs.uk/about-us/wp-content/uploads/sites/8/2017/04/Trust-strategy-2018-2023.pdf

During 2021/22 our focus once again was on our response to the Covid-19 pandemic and addressing the inequalities highlighted through the pandemic. We continued to work in partnership with our local communities, service users and health and social care partners to address inequalities in access and experience.

Reducing healthcare inequalities is of great importance to Leeds and York Partnership NHS Foundation Trust, with our Board of Directors agreeing three key health inequity priorities for delivery, including:

- The physical health of mental health service users (particularly those on the SMI register)
- Improving access – ensuring no one is accidentally excluded
- Equitable experience of all people receiving care, support and treatment.

We are taking a targeted approach to tackling the issues and during the pandemic employed a Clinical Inclusion Lead. This role has been focusing on our inclusion work plan, understanding the barriers and developing the actions required for our services. Over the last year all our service lines have developed a set of health inequalities objectives and actions for delivery over 2022/23 and are now a core component of their business plans.

During 2021/22 we introduced inclusion workers in our Crisis Services and Perinatal Services and we are looking to expand this role into our Eating Disorder Service during 2022/23. We are also looking to recruit a Head of Health Equity. This role will be vital in working across our care services to ensure high quality inclusive care is consistently delivered and enable particular attention to be given on individuals that fall behind in receiving the care they need because of background or their situation.

Building on the Core20PLUS5 focus areas, ensuring physical health checks are undertaken is of key importance to us. Reducing physical health inequalities is paramount to effective care planning and is a

key objective for our Forensic Inpatient Services, Adult and Older Adult Inpatient Services, Psychiatric Intensive Care Services and Community Complex Rehabilitation Services.

We also continue to be connected into the citywide and West Yorkshire ICS work and specifically around the actions pertaining to the recent report titled *'Tackling Health Inequalities for Ethnic Minority Communities and Colleagues'*. Furthermore, we are currently working through the impact the vaccination programme has had upon vulnerable groups both as a health provider and for our workforce.

We are continuing to take forward actions to respond to the needs of diverse ethnic groups within Mental Health Crisis Services, Perinatal Services and within our Community Services Transformation Programme, to achieve service level change and to measure and monitor impact.

We aim to meet the information and support needs of people accessing our services. This includes work on digital inclusion, producing information in easy read format and through the provision of, and monitoring access to, interpreting and translation services.

In 2021/22 the new Trustwide feedback measure 'Have Your Say' was introduced, to give service users and carers the opportunity to give their feedback at any point in their care pathway. Demographic analysis of online feedback received is taking place and will inform our service development during 2022/23.

1.1.11 THE ENVIRONMENT IN WHICH WE OPERATE

1.1.11.1 The national context

In January 2019, NHS England published the NHS Long Term Plan, setting out a ten-year vision for health services in England; showing how it will use the NHS long-term funding settlement that was agreed by the Government in July 2018. The Plan includes proposals that are relevant specifically to the Trust and for the partnerships we work in. The Plan guarantees investment in community services, promoting greater partnership working between primary and community care. The Plan continues the focus on the priorities within the Five Year Forward View for Mental Health and outlines further work on community mental health teams and other aspects of core services, including child and young peoples' mental health services. The Plan also sets out priorities for learning disability services, autism and neuro-developmental conditions, dementia and frailty and outlines work to support digital developments and the use of data, a focus on health inequalities and an emphasis on system working.

1.1.11.2 The regional context

The West Yorkshire and Harrogate Health and Care Partnership (WY&H ICS) is made up of NHS organisations, local councils and voluntary and community sector organisations working closely together to address shared challenges facing health and care services.

Together we support 2.4 million people, living in urban and rural areas. 770,000 are children and young people. 530,000 people live in areas ranked in the most deprived 10% of England. 20% of people are from minority ethnic communities. There are an estimated 400,000 unpaid carers, as many don't access support. Together we employ over 100,000 staff and work alongside thousands of volunteers.

We take a place-based approach across Bradford District and Craven; Calderdale, Kirklees, Leeds, and Wakefield that highlights the strengths, capacity, and knowledge of all those involved. This way of working is supported by West Yorkshire wide priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities, children and young people.

Our agreed memorandum of understanding will be replaced by a new Integrated Care Board (ICB) constitution in 2022. This new NHS West Yorkshire ICB will include independent non-executive members who will complement the role of the ICB's Independent Chair, Cathy Elliott.

Our way of working is supported by our politically led Partnership Board which brings partners together and is supported by the West Yorkshire Combined Authority and Local Resilience Forum. Our approach is supported by strong provider organisations, including West Yorkshire Association of Acute Trusts, the

Mental Health, Learning Disabilities and Autism Collaborative (MHLDA), and the current Joint Committee of Clinical Commissioning Groups.

Our strength provides greater opportunities to deliver our Five Year Plan ambitions, ensuring that all people are given the best start in life, are able to remain healthy and age well. You can see examples of the positive difference made together using the link below:

https://www.wypartnership.co.uk/our-priorities/difference-our-partnership-making

This collaborative approach has been central to handling the pandemic in maintaining personal protective equipment supply, coordinating testing, helping over 100,000 people shielding, rolling out the vaccine programme with volunteer support, and investing £12m in our social care sector to retain their valuable skills to deliver care in people's homes.

Another example can be seen in the establishment of the Partnership's health inequalities work. This identified a further 53,000 unpaid carers for early vaccine take up, delivering recommendations from our race review, investing £1m in warmer homes, as well as addressing the inequalities for people with learning disabilities.

We are committed to meaningful conversations with people, including colleagues to inform our work. Examples can be seen in the stroke reconfiguration of hyper acute units; assessment treatment units for people with complex learning disabilities; 'Looking out for our neighbours' – an award-winning campaign involving over 400 community organisations; the award winning staff check-in suicide prevention campaign; perinatal mental health work; our anti-racism movement; climate change; improving the uptake of cancer screening; and Let's DiaBEAT this.

As one of the country's leading integrated care systems (ICSs) we are now enhancing our work due to forthcoming legislative changes, subject to parliamentary approval. By July 2022, we will formalise on a statutory basis our successful health and care partnership of six years based on working together. We are very proud to have won the Health Service Journal Award for Integrated Care System of the year 2021.

SECTION 1.2 – THE PERFORMANCE REPORT (Performance Analysis)

1.2.1 MEASURING PERFORMANCE

1.2.1.1 Contractual and local targets

We have NHS England targets, NHS Standard contract requirements, and locally agreed performance and quality measures with our commissioners (referred to in this section as targets and measures).

Each month, we produce a Combined Quality and Performance Report (CQPR) that brings together performance, activity, quality, workforce and financial measures into one report for our Executive Team and Heads of Services. Each month this report accompanies the Chief Operating Officer Report which is presented to our Board of Directors for review. This includes the requirements for monitoring performance of national targets and standards as well as contractual and local metrics. Relevant sections of this report are shared with and discussed by our Board sub-committees to provide further challenge, insight and assurance. By bringing all these aspects of our organisation and care into one place, links can be made and risks identified which might impact on service user experience and our performance.

We have in place a quality, delivery and performance framework that delivers reporting for our team and service managers. Dashboards and reports are used to promote discussion and challenge in team and service quality, delivery and performance meetings and operational delivery groups. We also have a reporting schedule to submit performance and quality information to our commissioners.

As might be expected with a workforce dealing with and experiencing Covid-19, performance during 2021/22 has been varied. Whilst there appears to have been strong performance across all four quarters for some KPIs, monthly data has been variable throughout the year.

Analysis of the range of targets and standards for all of our services needs to be done through the lens of the significant challenges faced in 2021/22 from the impact of Covid-19. Our staff have worked flexibly to support our shared aim of continuing to care for our service users, providing care even when the usual face-to-face contact was not possible or service provision was temporarily scaled back to allow staff to be redeployed onto wards. All of our care and support services are vitally important to people and we have aimed, wherever possible, to deliver the care and support needed including redeploying staff where necessary. Undoubtedly, Covid-19 has had an impact on contractual and local targets.

Following the changes in how we deliver services in light of Covid-19 and the impact it has had on performance and, in particular, waiting times, we have undertaken modelling and analysis of the underlying data contributing to a number of our contractual measures, to help services better understand issues with flow, capacity and demand. We remain committed to delivering care in the most appropriate, individualised and clinically effective way within the constraints we have been faced with. In-year, improvement has been seen in services such as the Memory Assessment Service referrals assessed within 8 weeks, Community Learning Disability referrals assessed within 4 weeks and Cardio-Metabolic Assessments in inpatient services as well as Early Intervention in Psychosis services.

In 2021/22, we continued our approach in looking at expected levels of variation and more trend analysis. We have further expanded the range of available dashboards within CareDirector, our electronic patient record system, and explored interoperability opportunities in order to further expand reporting in the system, providing live analytics from within our Electronic Patient Record. Patient and team level reporting has been further developed, equipping clinical staff with trend-based outcomes information to assist in conversations about their patients, and the broader team with information that goes beyond the live position. The timely and accessible operational data CareDirector provides, alongside a more mature approach to data / performance analysis, is proving successful and providing the Trust with a solid platform to understand and improve performance and quality.

A programme of data quality audits was reinstated during 2021/22, which comprised mainly of performance KPIs as well as standard internal measures. The findings for these audits were presented back to operational management meetings and to individual services in order to provide oversight and

assurance of reporting. Planning for a further programme of audits in 2022/23 will begin during April and May 2022, which will again be made up of performance and standard internal indicators.

Month-on-month we continue to monitor and work to improve against our contractual and local targets. The table below sets out our performance during 2021/22.

Table 1.2A – Our contractual and local targets

Our contractual and local targets					
LEEDS CLINICAL COMMISSIONING GROUP					
	Target	**2021/22 Q1**	**2021/22 Q2**	**2021/22 Q3**	**2021/22 Q4**
Timely access to a MH assessment under S136 (target within 3 hours)	No target	13.7%	15.5%	14.8%	13.0%
Crisis and Intensive Support – Timely access to crisis assessment (ftf within 4 hours of referral)	90.0%	71.8%	75.5%	64.3%	53.0%
Crisis and Intensive Support – Length of stay on caseload (% less than 6 weeks)	70.0%	86.4%	81.3%	89.6%	90.2%
Crisis and Intensive Support – Frequency of contact (seen or visited 5 times in first week)	50.0%	58.1%	46.9%	52.7%	48.9%
Crisis and Intensive Support – Facilitated early discharge	No target	21.4%	21.4%	21.8%	18.9%
Timely commencement of a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)	90.0%	79.9%	78.1%	77.5%	65.6%
Timely access to a mental health assessment by the LYPFT liaison Psychiatry In-reach Service (24 hours)	90.0%	82.3%	80.2%	81.3%	77.8%
Bed Occupancy rates for Acute Adult Inpatient Services	94.0%	99.9%	96.6%	98.4%	96.1%
Percentage starting LADS assessment within 13 weeks	95.0%	62.6%	10.0%	54.3%	68.8%
Perinatal Community DNA Rate	No target	7.2%	7.0%	10.3%	6.7%
Perinatal Community – Timely access (less than 2 weeks) for routine referrals	85.0%	33.0%	32.2%	31.9%	69.5%
Perinatal Community – Timely access (less than 48hrs wait) for urgent referrals	No target	52.6%	10.0%	100.0%	100.0%
3 Day Follow Up – CCG Commissioned Services	80.0%	85.7%	84.3%	84.1%	84.5%
Waiting times Access to Memory Services; Referral to first face to face contact within 8 weeks	90.0%	41.1%	60.0%	73.4%	73.4%
Memory Services – Time from Referral to Diagnosis within 12 weeks	50.0%	51.9%	57.0%	56.1%	68.2%
Waiting times for Community Mental Health Teams first contact within 15 days	80.0%	80.4%	77.0%	81.5%	79.7%
Percentage of CLDT referrals seen within 4 weeks of receipt of referral	90.0%	66.7%	77.0%	79.8%	76.8%

Incidents Reported within 48 hrs from Incident identified as Serious	100.0%	100.0%	n/a	100.0%	n/a
Cardio Metabolic Assessment (current SMI inpatients)	90.0%	40.7%	72.0%	67.1%	64.7%
Cardio Metabolic Assessment (EIP Service)	90.0%	22.8%	35.0%	39.3%	37.9%
Percentage of people discharged to primary care (EIP Service)	No target	48.7%	54.1%	65.2%	62.6%
NHS ENGLAND					
	Target	**2021/22 Q1**	**2021/22 Q2**	**2021/22 Q3**	**2021/22 Q4**
Gender Identity Service – Waiting List	No target	2,757	3,104	3,227	3,513
Perinatal Community – Number of distinct women seen in rolling 12 months (LCCG only)	710 (by Q4)	475	565	620	712
CYPMHS Inpatients – Assessed within 7 days of admission (HoNOSCA / GBO)	100%	77.8%	50.0%	71.4%	26.7%
OTHER REPORTED INDICATORS					
	Target	**2021/22 Q1**	**2021/22 Q2**	**2021/22 Q3**	**2021/22 Q4**
Appraisals	85.0%	68.3%	66.2%	69.8%	67.3%
Clinical Supervision	85.0%	72.1%	69.8%	68.1%	65.5%
Sickness Absence Rate	4.9%	5.1%	5.3%	5.6%	5.8%
Staff Turnover	10.0%	8.1%	9.0%	9.5%	10.2%
Healthcare Associated Infections – C.difficile	0	0	0	0	0
Healthcare Associated Infections – MRSA	0	0	0	0	0
Delayed Transfers of Care	No target	8.8%	10.8%	10.5%	10.4%
Data Completeness – NHS Number	No target	99.3%	99.1%	99.1%	99.2%
Data Completeness – Ethnicity	No target	76.3%	76.9%	77.4%	77.1%
Data Completeness – Sexual Orientation	No target	21.6%	25.0%	29.6%	31.0%
SYSTEM OVERSIGHT FRAMEWORK AND STANDARD NHS CONTRACT					
	Target	**2021/22 Q1**	**2021/22 Q2**	**2021/22 Q3**	**2021/22 Q4**
3 Day Follow Up – Trust wide services	80%	84.7%	83.1%	84.2%	84.0%
Data Quality Maturity Index (MHSDS)	95%	90.0%	91.8%	91.2%	*
Early Intervention in Psychosis - % waiting less than 2wks for a NICE recommended package of care	60%	65.7%	63.8%	72.9%	58.2%
Never Events	0	0	0	0	0
Number of Incidents	No target	3,261	2,968	2,652	2,832
Inappropriate out-of-area placements for ad. ult mental health services (number of bed days)	1,093	773	1,015	1,282	1,312

*DQMI is published by NHS Digital three months in arrears, therefore, an updated Q4 position cannot be provided as the latest data available is for December 2021.

1.2.2 FINANCIAL PERFORMANCE

1.2.2.1 Overview

The financial year for 2021/22 was managed within the same framework as the previous year, which was put in place to support the response to the Covid-19 pandemic. This meant the ongoing suspension of normal contracting and planning arrangements. Most of the Trust's patient related income was received through block allocation arrangements including a significant non recurrent Covid-19 allocation to support the ongoing pressures generated by the pandemic.

During the year, the Trust maintained overall good financial governance in managing its finances whilst continuing to alleviate any undue burden on services and managers who were operationally focused on responding to the pandemic. There were some challenges and financial pressures, similar to that which we had experienced in the prior year. These related mainly to the availability of staffing and the availability of inpatient bed capacity.

In relation to staffing the focus was on ensuring sufficient safe staffing cover was maintained dealing with normal and Covid-19 related absence but also the general levels of vacancies within the Trust. These issues contributed to a significant increase in the use of agency in the year (see below operating expenses). The use of out of area placements (where service users cannot receive inpatient treatment locally, due to bed capacity) was broadly maintained at the same levels of the previous year for working age adults, but a growing financial pressure emerged in complex rehabilitation placements. This will be addressed through a significant service redesign project which is ongoing.

From 1 April 2021 the Trust took over service and financial responsibility for West Yorkshire Children and Young Peoples' inpatient services, from Leeds Community Healthcare Trust. This generated a significant increase in the Trust's turnover, with new income from NHS England associated with this service of £12.6 million. This change in contract responsibility included taking on operational management and responsibility for the existing inpatient service in Leeds centre (at Little Woodhouse Hall) and all the existing out of area placements. In January 2022 the Trust opened a new larger inpatient facility Red Kite View in Armley. Going forward this will reduce the use of out of area placements significantly for children and young people.

The overall good financial performance and management of the Trust's resources was maintained in 2021/22. A small surplus was delivered and whilst the Trust was not monitored against the usual financial metrics it maintained good financial standing. Key capital investment was also maintained during the year, although focused on core priorities due to the constraints of the pandemic.

1.2.2.2 The Statement of comprehensive income (year-on-year)

The statement of comprehensive income shows a surplus of £5.4 million for the year ended 31 March 2022 (compared to £0.25 million in the previous year). It is a very positive result for the Trust to be able to deliver a surplus despite the ongoing challenges of the pandemic. This reflects the fact that the Trust had all the available resources required and had some non- recurrent benefit due to unplanned income including that from commercial activities, some service development slippage, and a review of provisions and accruals held on the balance sheet of which some were released.

Operating income
Our income for the year increased to £225.7 million (£202.9 million in 2020/21). This is an overall increase of over 11%. The main change reflects impact of inflation, development funding reflecting the Mental Health Investment Standard and long-term plan investments. In addition, as noted the Trust took on the new contractual responsibility for Children and Young Peoples' services. All payments to NHS trusts for clinical services were paid on a block basis throughout the year, with additional income for Covid-19 related costs. Our Covid-19 specific allocation in the year was £9.0 million. There were some changes in other non-clinical income for commercial activities.

Operating expenses
The total operating expenses for the year was £216.5 million (£198.5 million in 2020/21), which is a net increase of 10%. Staff cost are our single largest operating expense, and this increased by 9%. Of this 3% is accounted for by pay awards, and there were also some small service development initiatives. There was a significant increase and pressure due to the level of agency expenditure which increased

by 27% in the year, rising from £7.3 million to £9.3 million. Whilst this partly represents the staffing pressures in response to Covid-19, it also reflects some workforce challenges in recruiting to key medical and nursing roles. Over 50% of the increase was in relation to medical locum expenditure which is a key challenge facing the Trust, alongside newly registered nursing. Recruitment and retention are high priority focus areas in our People Plan.

Other operating expenditure was broadly within the expected trend parameters, year on year of the ongoing pandemic. Following the annual revaluation exercise, the value of our estate resulted in an impairment charge in operating expenses. This impairment was a £0.17 million charge to our operating expenses.

Cost Savings/Efficiency
Due to the financial arrangements in place the requirements to make cost savings were also suspended in the year. However, the Trust continued to ensure the best use of resources, whilst recognising the need to respond to the pandemic. The requirement for savings will be reintroduced in 2022/23.

1.2.2.3 Capital expenditure

Capital expenditure planning continued to be affected by the pandemic, but there were no further significant changes to the way in which plans were agreed. All provider organisations work within a defined capital allocation, with additional funding allocated for specific purposes. Total capital investment for the year was £10.8 million (£16.9m in 2020/21). Of our total investment £6.8 million was spend on finalising the construction of the West Yorkshire Children and Young Peoples' Inpatient Unit, which opened in January 2022. A contribution from public dividend capital of £3.4 million partly funded this investment. We received a further £1.4 million public dividend capital towards our estates and digital critical infrastructure works. In addition to the major project of the new inpatient unit the balance of our expenditure was spent on other operational priorities, including some upgrading works at the Newsam and Becklin Centre sites. We scaled back on other strategic priorities due to the pandemic, as access to operationally live environments remained a challenge.

1.2.2.4 The statement of financial position

The summary of the Trust's overall value shows a net increase in taxpayers' equity of £11.7 million to £126.9 million as at 31 March 2022. This reflects the impact of the surplus generated in the year and the public dividend capital received in year. Working capital (current assets less current liabilities) has increased by £1.1 million, of which, the net cash increase was £9 million offset by an increase in payables, provisions and other liabilities. The surplus cash held at the end of the year was deposited with the Government Banking Service (GBS). It is our policy to deposit any temporary surpluses in cash in low-risk deposit accounts with either United Kingdom commercial clearing banks or the HM National Loans Fund, when interest rates are more beneficial than GBS.

1.2.2.5 Future financial outlook and risks

There is no doubt that the ongoing challenges and potential future consequences of the pandemic, will be significant for the way in which the NHS in total operates. Specifically for our services the impact on demand is beginning to be evident, but not yet fully quantified. We are expected to continue to manage our finances as part of an overall system, as the Integrated Care System evolves with the formation of the statutory Integrated Care Board. The Health and Social Care Act brings formally statutory obligations to Foundation Trusts which mean we will have to live within set overall revenue and capital limits. This will become increasingly challenging on an annual basis. In 2022/23 we have set a plan to meet these obligations, which is deliverable. The reintroduction of a national minimum efficiency requirement and also our inflationary cost pressures results in a savings target of around 3% for the Trust. Some of this we will only achieve non recurrently so we are focusing on developing medium term financial plans to ensure we live within our resources and the changes we need to make to meet the needs of our services on a financially sustainable basis. On a positive point we know the national commitment to continue to invest differentially in mental health services and the long-term plan funding commitments will support us. We remain challenged in terms of workforce, but this is also an opportunity to think about skills and roles, and we have a robust People Plan to underpin the work we need to do. Our capital investment priorities and requirements will become more challenging in the medium term, and we are looking ahead in this regard by developing a Strategic Outline Case for the longer term, as we are aware of the constraints on capital investment funding nationally.

The Trust is in a strong financial position and is fully cognisant of the risks and challenges it faces, which are not dissimilar to the scale of challenge facing the NHS overall. Our current robust standing will help us to move forward positively to meet these challenges.

1.2.2.6 Our exposure to financial risks

Price risk
We have a relatively low exposure to price risk, although this is becoming more unpredictable. Salaries continue to be the single biggest component of our costs and for 2022/23 our financial plans reflect the nationally assumed pay award. If a different amount is agreed this will be covered by additional central resource. With regard to non-pay our plans assume a level to the projected rate of increase in the consumer price index, and volatility beyond this can be managed in-year as the biggest component is fixed in terms of known PFI inflation agreed.

Income assumptions are set through the financial planning framework arrangements for the NHS, as mandated by the Department of Health and Social Care. The majority of income is received on a block contract' basis rather than 'pay as you go' and it is therefore highly unlikely that a significant part of our income will change quickly.

Credit risk
This is minimal as the majority of our customers are public sector organisations, in particular NHS organisations.

Liquidity risk
Liquidity risk is felt to be low. This is because operating costs are incurred primarily through legally-binding contracts for services provided to clinical commissioning groups and NHS England, which in turn are financed from money received from Parliament. Assumptions about future income have been revised to take into account the new market conditions.

Cash-flow risk
The main sources of income and expenditure are extremely predictable. The Trust is forecast to retain significant cash and other liquidity resources for the foreseeable future. Cash-flow risk is therefore felt to be low due to the adequate level of cash reserves; and the Trust not having sought a working capital loan facility because we have sufficient working capital. The Trust has modified its capital expenditure plans and has a robust approach to investment appraisal including risk issues.

1.2.3 CORPORATE SOCIAL RESPONSIBILITY

1.2.3.1 Human rights

Our Trust respects and abides by all human rights legislation. The human rights principles of fairness, respect, equality, dignity, and autonomy are detailed within our organisational values. They underpin our strategic objectives and our policies and procedures. Minimum standards are set out within our Equality, Diversity and Human Rights procedure and adherence to these standards and principles is monitored through our governance structure.

1.2.3.2 Sustainability report

1.2.3.2.1 Introduction

In October 2020, the NHS became the world's first health service to commit to reaching carbon net zero, in response to the profound and growing threat to health posed by climate change. This enhanced the previous target set for carbon reduction, and as an organisation we have risen to the new challenge.

The Trust has committed to driving sustainability through the organisation through the launch of its Green Plan in January 2022 and the development of a sustainability team that is currently being recruited to help develop, coordinate and drive change across all services.

Two clear and feasible targets are outlined in NHS England's *''Delivering a 'Net Zero' National Health Service''* report:

- The NHS Carbon Footprint: for the emissions we control directly, net zero by 2040
- The NHS Carbon Footprint Plus: for the emissions we can influence, net zero by 2045.

New national reporting structures are expected in 2022/23 which we will reflect in future annual reports.

1.2.3.2.2 The Trust's Green Plan

As part of the Greener NHS, all Trusts needed to have a Board approved Green Plan in place by January 2022 and with the Lead Integrated Care System by March 2022.

Our Green Plan sets out our action plan over the next five years, it identifies the benefits of embedding sustainable practices within the Trust's operations and describes the governance arrangements to keep the plan on track.

The Trust has previously implemented many successful sustainability initiatives, as detailed below, and it is the Trust's intention to continue to build on this considerable success. The Green Plan will be adapted over the period of the plan as we develop, learn from others and identify new technologies and working practices.

1.2.3.2.2.1 Our Green Plan Vision

The vision of the Trust is:

- we achieve Carbon-Zero ahead of schedule and are seen as an exemplar
- we collaborate between organisations to achieve our best potential
- all staff feel passionate about helping the Trust to become carbon neutral
- all staff and service users will feel involved and valued in the process
- we can embed environmental commitments as a thread throughout all our business
- we can become Carbon Neutral and generate our own energy and recycle waste in a sustainable manner
- we reach out to our local partners and work collaboratively together
- we can be at the forefront of supporting our communities to be prepared for the future ahead
- we adopt a collaborative approach throughout the organisation in supporting education and therapeutic involvement with our environment, creating informed networks.

1.2.3.2.2.2 Trust Priorities

The Trust, through staff engagement and subject matter experts, has identified the following areas as priorities for its Green Plan.

Leadership - The Board is fully behind the implementation of the Green Plan and has provided funding for new resources in the form of a Head of Sustainability role, and project support to lead and develop the plans over the coming period..

There is also an agreed governance route that will ensure the Board and other stakeholders receive assurance that we are meeting our targets and acting in an ethical way when delivering our services

Behaviour/Engagement - The Trust believes that engagement across all staff, service users and other stakeholders will be the key to the success of the plan, and we welcome feedback and input.

The Trust also recognises that for us to be a sustainable organisation, staff at all levels need to be trained and provided with ownership and accountability for carbon reduction.

Operational Practice - The way we operate may have changed forever following Covid-19, and we are all more open to new ways of working, buying goods and services, we are better at using technology and increasingly more concerned about our mental health than ever before.

These changes along with the NHS focus on the right care in the right place and preventative healthcare means we are continually looking to adapt working practice and how we operate our services and care for our service users.

All of these developments will need to consider their sustainability in the long term and their impact on the Trust's carbon footprint

Energy Use - The cost of energy continues to rise, and as an organisation this impacts on us being able to give funding directly to our front-line services, so the Trust is looking to firstly reduce the amount of energy used, ensure it is from a renewable source, and then move to look at self-generation of electricity and decarbonised heating.

The Trust already operates several solar arrays, but we want to expand this to include battery storage, and identify new technology to reduce our carbon.

The use of LED lighting and associated control, good insulation of buildings, the use of natural ventilation and building control systems will all feature significantly as part of the Green Plan.

Green IT - IT has made a significant impact on our ability to work from anywhere, to meet with colleagues and service users through various media, and to create new ways of working. Development of our IT credentials will form part of this plan, providing education, reducing travel through online meetings and contact with service users and clinical record keeping, but will also consider the impact of data storage, IT equipment and recycling and a reduction in carbon emitted from data centres.

Estates - Our estate comprises several owned, leased and privately funded buildings and facilities, and the estate and its operation contribute considerably to the Trust's carbon footprint.

We will be aiming for industry standard Building Research Establishment Environmental Assessment Method (BREEAM) outstanding status for all new buildings and will be undertaking sustainable assessments for all refurbishment projects, including the decarbonisation of heating and hot water to renewable sources such as solar, ground and air source heat pumps to reduce our reliance on gas.

Lighting, heating, ventilation, and the general management of our buildings will all be assessed as part of the plan.

Procurement - Procurement has a big impact on carbon reduction, so we will be seeking to implement best practice guidance as issued from the Department of Health and Social Care and NHS England and Improvement. We will review the structure and processes used by the Procurement Team to ensure sustainability of our suppliers and how we procure and deliver goods and services.

Reducing packaging, transport, waste, whole life costing of products, using local suppliers to keep money and jobs in the local area, and how we use SME organisations more effectively whilst still ensuring we meet the legislative aspects will be a focus for us throughout this plan.

Food & Beverage - The Trust recognises the importance of good nutrition and hydration and the impact on the physical and mental health of our service users, so we have been developing our offer over several months. A new Cook Fresh service has been introduced at our new Children and Young Peoples' Mental Health Service unit, which will then be rolled out across the organisation.

Using fresh local products reduces transportation and carbon footprint. Cooking fresh, adapting seasonal produce, and using meat free products also reduces food waste. It is our intention to start to grow our own produce and with the help of service users develop our own food supply whilst providing education.

Waste - Recycling has been part of the Trust for many years and will continue to be developed, however the focus has now turned towards reducing waste at source. The Trust will be looking at reusable items, reduced packaging (particularly concerning non-recyclable plastics), PPE, and the continued reduction in the use of paper.

Adaption - The issues brought about by climate change, such as extreme temperatures, increased flooding risk and biodiversity, will all impact on us as an organisation so we must consider these impacts on our staff and our service users to ensure our environments are adapted to ensure they remain fit for purpose.

Travel - Travel accounts for a significant amount of carbon generated by the Trust from staff coming into work, to service users attending appointments, suppliers delivering goods, and visitors coming to Trust premises.

Whilst we understand some of this is necessary travel, to enable us to provide the clinical services and care to our service users, we are looking where possible to reduce the number and frequency of journeys and ensure that where they need to be made, they are made in a way that reduces impact on carbon emissions, this could be electric vehicles, public transport, cycling or walking.

Transport - The diverse nature of our services means we operate from several premises, all of which require services and supplies to operate. Our internal Transport Team and Estates Team will be moving to a more sustainable fleet across the duration of the plan.

Hybrid Working - The Trust is introducing a new Hybrid Working Policy which will help staff to identify and make the right choice of a place and a time to undertake their roles in an effective and efficient manner, Covid-19 forced us to implement agile workplaces and technology has enabled us to work differently which has already seen an impact on our carbon footprint.

1.2.3.2.3 Our Performance

The Trust's performance has been affected by the Covid-19 pandemic over the last two years and continues to be impacted with PPE and staff working from home being the biggest impacts, so it is difficult to fully assess the impact of our sustainability improvements in the last two years.

1.2.3.2.3.1 Our Estate Footprint

There has been a slight increase in our estates footprint to provide additional capacity for PPE in the last reporting year and with the opening of Red Kite View, our new Children and Young Peoples' Mental Health Service unit, at the start of 2022.

Table 1.2B – Our Estate Footprint

	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Total gross internal floor space	105,692	59,632	59.632	58,902	58087	58087	58711

1.2.3.2.3.2 Energy Use

There is a continued reduction in energy use, although the data is significantly affected by home working.

Table 1.2C – Energy Use

Energy Use	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Electricity Consumed	5,605,299	5,179,717	5,000,289	4,768,420	4,682,312	2,542,756	2,386,728
Gas Consumed	13,135,153	12,179,328	11,919,676	11,312,409	9,193,186	8,213,442	8,599,741
Oil Consumed	0	0	0	0	0	0	0
Coal Consumed	0	0	0	0	0	0	0
Steam Consumed	1,143,587	0	0	0	0	0	0
Hot Water Consumed	0	0	0	0	0	0	0
Green electricity	0	0	0	0	0	1,471,037	2,099,993
Total	19,884,039	17,359,045	16,919,965	16,080,829	13,875,498	12,227,235	13,086,462

1.2.3.2.3.3 Waste

Waste volumes (tonnes) are reflective of the Covid-19 pandemic, increased PPE, and cleaning regimes, so it is difficult to compare with previous volumes, although our Green Plan will look at reducing waste at source in the coming years.

Table 1.2D – Waste Volumes

Waste Volumes	2017/18	2018/19	2019/20	2020/21	2021/22
Waste recycling weight	113	114	132.24	176.46	187.63
Other recovery weight	82	78	112.21	177.98	189.29
Incineration disposal weight	16	14	10.03	36.71	38.72
Landfill disposal weight	7	5	4.58	2.86	3.02
Total	218	211	259.06	394.01	418.66

1.2.3.2.3.4 C02 Emissions

Emissions from energy use continues to reduce. The Trust's owned and leased sites moved to green energy tariffs and it is expected that the Private Finance Initiative contract due for renewal in 2022/23 will also move to the green energy tariff.

Table 1.2E – C02 Emissions

CO2 EMISSIONS	2015/16	2016/17	2017/18	2018/19	2019/20	2020/21	2021/22
Electricity	3,223	2,677	2,229	1,682	1652	896.53	953
Gas	2,749	2,545	2,527	2,403	1556	1876	1575
Total	6,227	5,222	4,756	4,085	3,208	2,773	2,528

The Trust's CO2 emissions have also been affected by:

- waste volumes
- reduced travel to sites
- improved fleet and increased electric vehicles.

1.2.3.2.4 Our Sustainable Achievements

In addition to launching our Green Plan, and starting the recruitment of a dedicated Sustainability Team, the Trust has made good progress on our sustainable agenda.

1.2.3.2.4.1 Red Kite View

The new Children and Young Peoples' Mental Health Inpatient Unit located at St Marys Hospital has been constructed to a very high level, and we are awaiting confirmation that we have achieved BREEAM excellent standards with a score of 81, just below the 85 needed for outstanding.

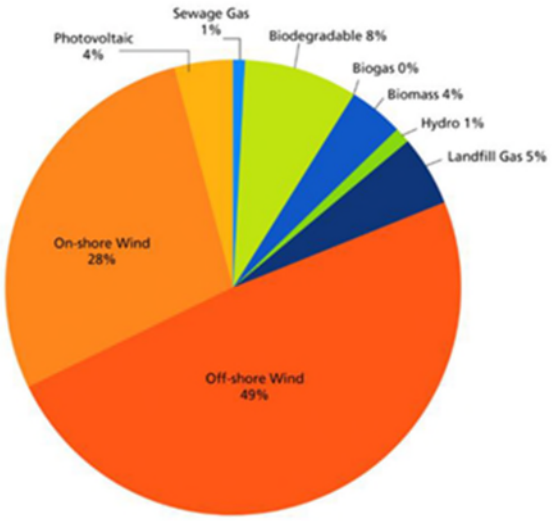
BREEAM is the world's leading sustainability assessment method for buildings. It recognises and reflects the value of high performing assets across the built environment.

This means BREEAM rated developments are more sustainable environments that enhance the wellbeing of the people who live and work in them, help protect natural resources and make for more attractive property investments.

1.2.3.2.4.2 Energy

The publication of NHS England's '*Estates Net Zero Carbon Delivery Plan'* has aided us in mapping out future improvements based around four key steps. We have continued to develop and plan our actions towards making every kWh of energy count, preparing our buildings for electricity-led heating, switching to non-fossil fuel heating, and increasing our on-site renewables.

All our owned sites and NHS Property Services sites now run on 100% clean renewable energy, which helps to support the renewable generation industry, encouraging growth and more competitive pricing to enable others to make the switch. In the coming year we aim to ensure all PFI sites and the remaining leased sites also make this transition. The chart below shows how our renewable electricity is now generated.



EDF supplied Leeds & York Partnership Nhs Foundation Trust with 1,132 Megawatt Hours (MWh) of renewable (REGO backed) energy during the period 1st April 2020 to 31st March 2021.

We have continued to progress LED lighting upgrades across our owned and PFI estate, and the installation of solar panels at Red Kite View means that the Trust has now doubled its solar energy generating capacity.

1.2.3.2.4.3 Waste

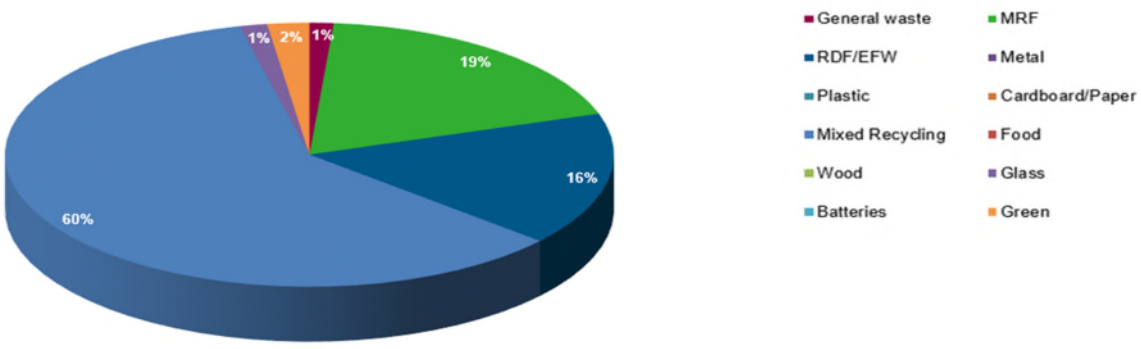


Illustration shows breakdown of municipal waste from LYPFT by weight form 01/04/2020 - 31/03/2021

Our plan is to continually increase resource productivity with the aim of eliminating waste by turning all waste into a resource. A newly formed Waste Management Group has been tasked with identifying opportunities. To date 100% recycled paper is now procured for all office general functions and the Trust has signed up to the NHS single-use plastics reduction pledge to reduce our reliance on, and disposal of single use plastic products. Energy generated from waste processing now accounts for 16% of municipal waste and up to 80% of clinical waste. 70% of the Trust's municipal waste is now recycled, with landfill waste accounting for less than 1%.

1.2.3.2.4.4 Travel

We are now well on target to meet and exceed the NHS Long Term Plan commitment for 90% of NHS fleet to use low, ultra-low and zero-emission vehicles by 2028, and to go beyond this with the entire owned fleet of the NHS eventually reaching net zero emissions. The Trust has now purchased fifteen fully electric vehicles to replace diesel vehicles in the Estates and Logistics Departments. This means the estates fleet is currently 78% zero emissions and the logistics fleet 74% zero emissions.

We have continued our commitment to support and promote alternative forms of travel, as of September 2021 our Cycle to Work scheme price limit was increased to allow staff to purchase electric bicycles and a wider range of higher end cycles. A promotional campaign to encourage uptake is currently being rolled out. We are also installing digital bus timetables at sites to inform staff and visitors of public transport options.

1.2.3.2.4.5 Procurement

The Trust has signed up to the West Yorkshire Association of Acute Trusts Sustainable Procurement Policy and is now engaged in monitoring, recording, and influencing its supply chain to eliminate emissions from the goods and services we buy, through a range of shared objectives.

1.2.3.2.4.6 Adaptation

In increasing our resilience to climate related severe weather events, we have developed local protocols for mitigating the effects of heatwaves and cold weather spells and produced local flood plans. Climate change and its impacts has also been included as a category on the Trust's risk register.

1.2.4 ANTI-BRIBERY CULTURE

We have a zero-tolerance approach to bribery and the Board has in place an Anti-Bribery and Fraud Policy which is available to staff on Staffnet. Staff are reminded of their responsibilities under the procedure and how to access this on a regular basis. Counter-fraud services are provided by NHS Audit Yorkshire who carry out proactive and, where necessary, reactive work in relation to bribery. They will

make a report to each meeting of the Audit Committee to provide on progress with their work. In 2021/22 there were no instances of bribery identified within the Trust.

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Performance Report is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed Date: 16 June 2022

Dr Sara Munro
Chief Executive

SECTION 2.1 – THE ACCOUNTABILITY REPORT (Directors' Report)

The directors are responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and enable them to ensure that the accounts comply with the requirements outlined in the direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors consider that to the best of their knowledge and belief they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for service users, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

2.1.1 MEMBERS OF THE BOARD OF DIRECTORS

At the end of 2021/22 the Board of Directors was made up of seven non-executive directors (including the Chair of the Trust) and six executive directors (including the Chief Executive). The table below lists members of the Board of Directors on 31 March 2022. It shows the name of the Chair of the Trust and Deputy Chair; the Senior Independent Director; the Chief Executive and the Deputy Chief Executive.

Table 2.1A – Members of the Board of Directors on 31 March 2022

NON-EXECUTIVE TEAM	
Dr Sue Proctor	Chair of the Trust
Prof John Baker	Non-executive Director
Helen Grantham	Non-executive Director (Deputy Chair of the Trust)
Cleveland Henry	Non-executive Director
Merran McRae*	Non-executive Director
Sue White	Non-executive Director
Martin Wright	Non-executive Director (Senior Independent Director)
EXECUTIVE TEAM	
Dr Sara Munro	Chief Executive
Joanna Forster Adams	Chief Operating Officer
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)
Darren Skinner**	Director of People and Organisational Development
Dr Chris Hosker	Medical Director
Cathy Woffendin	Director of Nursing, Professions and Quality

*Merran McRae was appointed as a non-executive director on the 1 January 2022.

**Darren Skinner was appointed as Interim Director of People and Organisational Development on 10 May 2021. In May 2022, following a robust recruitment process, Darren was appointed substantively to this role. More detailed information about our executive directors is set out in the Remuneration Report in Part A section 2.2 of this Annual Report.

Non-executive directors (NEDs), including the Chair of the Trust, are appointed by the Council of Governors. Where there is a vacancy this would be filled through a full open advertisement process. Where there is an incumbent NED who is eligible for re-appointment by virtue of the number of years they have served and where they wish to be considered for re-appointment, this would be done based on a satisfactory appraisal and approval by the Council of Governors. Should it be necessary to remove either the Chair of the Trust or any of the other non-executive directors this would be done by the Council of Governors. A decision to remove the Chair of the Trust or another non-executive director must be done in accordance with our constitution and only if three quarters of the total number of governors appointed or elected at the time, vote to remove the individual.

The Board of Directors considers that it is balanced, complete and appropriate and this can be seen in the biographical details of Board members as set out in Part A section 3.3 of this Annual Report. All the

non-executive directors are considered to be independent in both judgement and character, and the Board has confirmed there are no relationships or circumstances which are likely to affect, or could appear to affect, judgment in this respect.

It is also reported that Dr Sue Proctor, the Chair of the Trust, had no other significant commitments during the year 2021/22 which affected her ability to carry out her duties to the full, and she has been able to allow sufficient time to undertake these duties.

Further information about the Board of Directors can be found in Part A sections 2.2 and 3 of this Annual Report.

2.1.2 REGISTER OF DIRECTORS' INTERESTS

Under the provisions of the constitution, we are required to have a register of interests to formally record any declarations of interests of members of the Board of Directors. The register includes details of all directorships and other relevant material interests, which both executive and non-executive directors have declared.

On appointment and annually thereafter, members of the Board of Directors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interests and those arising from their membership of the Board of Directors. None of the interests declared conflict with their role as a director.

Members of the Board of Directors are also required to declare any conflict or pecuniary interests that arise in the course of conducting Trust business. An opportunity to do this is provided at every internal meeting they attend.

The register of interests is maintained by the Associate Director for Corporate Governance and is available for inspection on the Trust's website. The Associate Director for Corporate Governance can be contacted by email chill29@nhs.net.

2.1.3 DISCLOSURE FOR THE PAYMENT OF CREDITORS

We adopt the Better Payment Practice Code, which requires payment of all our undisputed invoices by the due date or within 30 days of receipt of goods. Further information can be found in note 9 of the Annual Accounts in Part B of this Annual Report. There has also been no interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.

2.1.4 INCOME DISCLOSURE

The Trust is required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to ensure that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement in 2021/22. The Board of Directors, therefore, declares that there has been no material income other than from the provision of goods and services for the purposes of the health service in England. Any benefit is re-invested in the provision of those services.

2.1.5 COST ALLOCATION AND CHARGING

The Trust has complied with the cost allocation and charging requirements set out in the HM Treasury and the Office of Public Sector Information guidance.

2.1.6 POLITICAL AND CHARITABLE DONATIONS

The Board reports that it has not made any political or charitable donations and that it is not the policy of the Leeds and York Partnership NHS Foundation Trust to make any such payments.

2.1.7 NHS IMPROVEMENT'S WELL-LED FRAMEWORK

The Board is required to carry out an independent review of governance against the well-led framework every three years. In 2021/22 Deloitte LLP carried out a Well-led Governance and Leadership Review which built on their findings and recommendations from the 2017 review.

Their approach was as follows:

- undertaking a desktop review of relevant Trust documentation which included Board and sub-committee papers
- distributing and analysing a board survey that was completed by all Board members and the Associate Director for Corporate Governance which focussed on the effectiveness of the Board
- undertaking virtual non-attributable interviews with each member of the Board and the Associate Director for Corporate Governance
- undertaking observations of Board and sub-committee meetings
- undertaking four virtual staff and service line leadership focus groups to obtain the views of both clinical and non-clinical staff from throughout the organisation
- undertaking virtual focus group with members of the Council of Governors to obtain their views on the current governance and leadership arrangements at the Trust
- obtaining the views of external stakeholders via telephone interviews.

They then assessed this information against the key findings and recommendations from the 2017 review and undertook benchmarking activity against the newly revised CQC Well-led Framework. The detailed outcome of the review was presented to the Board of Directors in January and March 2022.

The report concluded that since the independent review of governance arrangements undertaken in May and October 2017 the Trust had made good progress against many of those recommendations. It noted that this progress had been made within the context of a move towards Integrated Care Systems and also the Covid-19 pandemic, which inevitably had impacted on the Trust's ability to make progress against some of those recommendations.

In regard to the benchmarking against the revised CQC Well-led Framework there were nine further recommendations. Progress against these were presented to the March private Board meeting and will continue to be monitored through the Board's governance arrangements.

The Board can report that there are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement and the information within the Annual Report. It can also be reported that the Trust was rated overall 'good' in the last CQC inspection with the well-led domain also being rated as 'good'.

More information on the arrangements in place to ensure services are 'well-led' can be found in the Annual Governance Statement in Section 2.7 of the Annual Report.

The Trust is registered with the CQC and is fully compliant with the registration requirements. Compliance with the CQC essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of non-compliance with CQC registration the Director of Nursing, Quality and Professions has established a process for monitoring progress against the CQC action plan which will identify any risks that require immediate action. During the Covid-19 pandemic this has involved one-to-one meetings with action leads to monitor progress. Actions from the CQC inspection are to be included in the Trust's Quality and Safety Peer Review process to ensure that all actions are embedded and sustained.

Following a CQC inspection we will take a Trustwide view of the themes and have a holistic approach to resolving any issues and reducing the risk of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a process for carrying out Quality and Safety Peer Reviews to improve, share and embed best practice around the Trust. This process was stood down during the Covid-19 pandemic but has been relaunched in 2022. The aim of the Quality and Safety Peer Reviews is to improve care for the people we serve by ensuring our services are as safe as possible, improving the quality and effectiveness of care, improving the patient and carer experience and providing development and learning for all involved. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we will identify areas for improvement, risks to service delivery and areas of good practice.

SECTION 2.2 – ACCOUNTABILITY REPORT (Remuneration Report)

2.2.1 INTRODUCTION

In company law, senior managers are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the foundation trust'. For the purpose of this Remuneration Report, the description 'senior managers' refers to the executive and non-executive directors holding positions on the Board of Directors.

This Remuneration Report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2021/22) as required by NHS Improvement's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager during 2021/22.

It should be noted that in 2021/22 the Council of Governors agreed to appoint two Associate Non-executive Directors. Other than making reference to these appointments in relation to the work of the governors' Appointments and Remuneration Committee, these roles are not classed as senior managers for the purpose of the Remuneration Report because they are not members of the Board and have no authority or responsibility for directing or controlling major activities of the Trust.

The information in sections 2.2.2 to 2.2.5 below is not subject to audit by our external auditors, KPMG; however, they will read the narrative to ensure it is consistent with their knowledge of our Trust.

2.2.2 ANNUAL STATEMENT ON REMUNERATION

The information provided in Sections 2.2.2 to 2.2.4 forms the annual report from the chair of the committees that are responsible for the remuneration of the executive and non-executive directors. The Chair of these committees is the Chair of the Trust.

Remuneration for senior managers is determined by two committees: the Remuneration Committee (a sub-committee of the Board of Directors made up of all the non-executive directors), which is responsible for the remuneration for the executive directors; and the Appointments and Remuneration Committee (a sub-committee of the Council of Governors made up of a majority of governors), which is responsible for the remuneration for the non-executive directors.

The policy of the two committees is that salaries for executive directors and the remuneration for non-executive directors will be benchmarked periodically or when there is a fundamental change in the level of payment. Where any level is set over and above the Civil Service Threshold of £150,000 per annum consideration will be made to ensure this is set at a reasonable level. This will include taking account of any guidance received from NHS England and Improvement in relation to Very Senior Managers (VSM) salaries including any recommendations on pay uplift; the level of complexity in relation to the role/s and the landscape in which the Trust is operating; any additional responsibility outside the organisation for example leading at a regional or national level; and any effect of market forces that might be pertinent to the role/s.

2.2.2.1 Remuneration Committee – executive directors' remuneration

With regard to executive directors, the overarching policy of the Remuneration Committee is set out in the Trust's VSM pay policy. In applying the policy the committee will: use benchmarked figures to ensure they are in line with other similar organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference to NHS England and Improvement guidance on Very Senior Managers (VSM) salaries. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports to ensure the overall level of responsibility for executive directors is recognised. When awarding percentage pay uplifts ('cost of living awards') the committee is always mindful of the guidance from NHS England and Improvement which will be used as a benchmark. There is no performance-related pay in any director's current contract of employment. Where a salary requires

review, a benchmarking exercise may be requested to make comparison against other similar NHS organisations and similar posts.

Further information about the work of the Remuneration Committee during 2021/22 can be found in section 2.4.4.2 below.

2.2.2.2 Appointments and Remuneration Committee – non-executive directors' remuneration

The overarching policy for the remuneration of the non-executive directors (NEDs) is to award levels in line with other comparable NHS foundation trusts, using benchmarked figures and taking account of any guidance issued by NHS England / Improvement. When awarding annual percentage uplifts ('cost of living' awards) to non-executive directors the committee will be mindful of the amount awarded to executive directors and to staff on Agenda for Change (AfC) pay bandings.

Further information about the work of the Appointments and Remuneration Committee during 2021/22 can be found in section 2.2.4.3 below.

2.2.3 SENIOR MANAGERS' REMUNERATION POLICY

2.2.3.1 Future policy tables

This section describes the policy narrative relating to the components of the remuneration packages for executive and non-executive directors. Each of the components detailed in these tables supports the Trust's Strategic Objective 2: we provide a rewarding and supportive place to work (putting in place a benchmarked remuneration package to fairly remunerate our Board members; recognising the liability and responsibility they carry; attracting an appropriately skilled and qualified senior team to lead the organisation).

The future policy tables 2.2A and 2.2B refer to the reporting and performance period 1 April 2021 to 31 March 2022.

Table 2.2A – Remuneration policy for executive directors

Element	Policy
Salary	The overarching policy of the Remuneration Committee is to: use benchmarked figures to ensure they are in line with other similar organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference to the Department of Health guidance on VSM salaries. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports. There are no annual increments associated with executive directors' salaries. A time-limited additional payment of up to 10% of salary may be payable for undertaking the Senior Responsible Officer role within the Integrated Care System.
Taxable benefits	In the main this will be any mileage rates paid which are over and above the HMRC threshold or any other benefit in kind applicable at the time of remuneration.
Annual performance related bonuses	The Trust does not pay any annual performance-related bonuses to executive directors. (Section 2.2.3.2 below sets out the process for performance appraisals (not linked to pay)).
Long-term performance-related benefits	The Trust does not pay long-term performance related bonuses to executive directors. (Section 2.2.3.2 below sets out the process for performance appraisals (not linked to pay)).
Pension-related benefits	Pension rights for executive directors are determined by the NHS Pension Scheme, and the maximum payable (by the employee and the employer) is determined by the NHS Pension Scheme.

Element	Policy
Percentage uplift (cost of living increase)	The Remuneration Committee will decide if the executive directors are to be awarded a percentage uplift ('cost of living' increase) for each financial year and what level this will be. In doing this the committee is mindful of the national advisory rate for VSM issued by NHS England / Improvement.
Other remuneration (e.g. relocation expenses)	Any other expenses paid to executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to executive directors. Relocation expenses are available to new executive directors under the Trust's Relocation Procedure

It should be noted that the executive directors' contract allows the Trust to recover any monies owed at any time via deductions from salary.

Table 2.2B – Remuneration policy for non-executive directors

Element	Policy
Fee payable	The overarching policy for the remuneration of the non-executive directors (NEDs) is to award levels in line with other comparable NHS foundation trusts using benchmarked figures. The Council of Governors will also keep under review any guidance issued by NHS England and Improvement and take this into consideration when setting levels of remuneration. The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors. There are no annual increments associated with non-executive directors' remuneration.
Additional fees for any other duties	The remuneration for the Chair of the Trust recognises the specialist role and extra time commitment over and above that of the other NEDs. The Chair of the Audit Committee is also remunerated differently in recognition of the specific skills and responsibility this role requires. All other NEDs are remunerated equally; however, for those NEDs who chair a Board sub-committee (excluding the Audit Committee, which attracts a separate level of remuneration) there is an honorarium of £1,000 per annum (paid pro-rata). This honorarium is in recognition of the added workload and responsibility that comes with chairing a Board sub-committee The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors.
Percentage uplift (cost of living increase)	The Appointments and Remuneration Committee will decide if the NEDs will be awarded a percentage uplift ('cost of living' increase) and what level this will be. In doing this the committee is mindful of the uplift awarded to staff on AfC pay bandings and any percentage uplifts awarded to the executive directors.
Travel	Travel costs will be reimbursed through the payroll and will be submitted on a completed travel claim form supported by receipts. Costs incurred will be reimbursed on a like-for-like basis with mileage being paid at a fixed pence per mile.
Pension contributions	No pension deductions are made from non-executive directors' remuneration and no contribution is made to a pension fund in respect of any non-executive director.
Other remuneration	Any other expenses paid to non-executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to non-executive directors.

There have been no new components of the remuneration package for either the executive directors or non-executive directors since the last remuneration report.

It should be noted that employees of the Trust are paid on AfC bandings with an incremental scale; executive and non-executive directors are paid on a fixed salary which has no element of incremental scale. The level of salary paid to those on AfC is determined nationally, whereas the remuneration of the executive and non-executive directors are determined by the Remuneration Committee and the

Appointments and Remuneration Committee respectively, informed by appropriate policy and benchmarking data.

The Trust has not consulted with staff when setting directors' or VSM remuneration policy with the exception of the policy for non-executive directors where staff governors have been involved in determining their remuneration.

2.2.3.2 Performance and appraisals

2.2.3.2.1 Overview

Performance and appraisals are not linked to remuneration and there is no element of performance related pay in senior managers' salaries or remuneration packages.

The Board of Directors is committed to continuous improvement and it undertakes an evaluation on a regular basis. We also have in place an evaluation process for members of the Board with information from this being fed into the appraisals of individual members.

The appraisal of individual Board members identifies strengths and good performance, and also areas for development. The appraisal looks at an individual's development needs, which informs tailored development plans and objectives.

All executive and non-executive directors undertake compulsory training. Furthermore, regular Board of Directors' workshop sessions take place with some being used specifically for Board development. In addition to any internal development or training sessions non-executive directors and executive directors will also attend external training and development courses as required.

The processes described in section 2.2.3.2.2 and 2.2.3.2.3 below refer to the performance and appraisals of the executive and non-executive directors for the period 1 April 2021 to 31 March 2022.

2.2.3.2.2 Executive Directors

Objectives are set for each executive director in conjunction with the Chief Executive (the Chief Executive's objectives are set in discussion with the Chair of the Trust). These objectives are monitored through the appraisal process. The Chair of the Trust carries out the appraisal of the Chief Executive against agreed objectives, and appraisals for the other executive directors are carried out by the Chief Executive against their agreed objectives. The Chair of the Trust and the non-executive directors will contribute to the appraisal of each executive director in regard to their performance as a member of the unitary Board. This will be fed back to the Chief Executive for inclusion in their overall appraisal.

The Remuneration Committee has been assured that a process is in place and has been completed for each executive director including the Chief Executive. Any areas of concern about the performance of any of the executive directors will be reported to the committee with an assurance on the proposed remedial action.

2.2.3.2.3 Non-executive Directors

Objectives are set for each of the NEDs in conjunction with the Chair of the Trust (the Chair's objectives are set in discussion with the Senior Independent Director and Lead Governor). Performance against these is monitored through one-to-one meetings and annual appraisals.

The NEDs have their objectives agreed with the Chair; the Chair agrees their objectives in conjunction with the Lead Governor. Annual appraisals of the non-executive directors are carried out by the Chair of the Trust with the Lead Governor in attendance. The Senior Independent Director conducts the annual appraisal of the Chair of the Trust again in conjunction with the Lead Governor. Governors and members of the Board are invited to provide feedback on each of the NEDs and the Chair which informs the appraisal discussion. The Council of Governors has received assurance that a process is in place and has been completed effectively.

Any areas of concern about the performance of any non-executive director will be reported to the Appointments and Remuneration Committee along with an assurance on the proposed remedial action and a summary report would be made to the Council of Governors.

2.2.3.3 Policy on payment for loss of office and notice periods

All contracts for executive directors are permanent and therefore open-ended. The period of notice for each executive director is set out in their contract and is normally three months. Non-executive directors do not have a contract of employment; they have a letter of appointment. Non-executive directors are not subject to employment law or regulations and as such do not have a formal period of notice.

The executive directors' contract contains details of the grounds on which a director's contract may be terminated. The contract also contains information about the circumstances under which PILON (payment in lieu of notice) may be paid.

Payment for loss of office or in lieu of notice does not apply to non-executive directors as they are appointed not employed.

2.2.3.4 Policy on diversity and inclusion

The Trust believes in fairness and equality and above all values diversity and inclusion in all aspects of work, this includes within our Board. The Nominations Committee, which appoints the executive directors and the Appointments and Remuneration Committee, which appoints our non-executive directors will, with each new appointment to the Board of Directors, consider matters of diversity and equity. The committees will act within the requirements of the Trust's diversity and inclusion policies in order to meet the Trust's overall aim of providing outstanding mental health and learning disability services as an employer of choice. Whilst maintaining the diversity of the Board is one of our main considerations in any appointment, ensuring that the right person is in post is important so the Board continues to be fit for purpose.

More information on the Trust's policy on diversity and inclusion can be found in Section 2.3.20.

2.2.4 ANNUAL REPORT ON REMUNERATION

This section includes a description of the work of the committees that are involved in the appointment of both the executive and non-executive directors, and which determines their respective salaries and remuneration. These are:

- The Remuneration Committee (a sub-committee of the Board of Directors) which is made up of all the non-executive directors and is chaired by the Chair of the Trust
- The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) which is made up of a majority of governors and is chaired by the Chair of the Trust (unless the Chair is conflicted in any agenda item in which case the committee would be chaired by the Deputy Chair of the Trust or Lead Governor as appropriate)
- The Nominations Committee (a sub-committee of the Board of Directors) which is made up of a mix of executive and non-executive directors (NEDs) and is chaired by the Chair of the Trust.

2.2.4.1 Executive directors' period of employment as Board members

Details of the start date for the Chief Executive and other members of the Executive Team who have served on the Board during 2021/22 are set out in the table below.

Table 2.2C – Executive directors who have served during 2021/22

Name	Title	Date appointment effective from	Date left the Board position
Dr Sara Munro	Chief Executive	5 September 2016	N/A
Joanna Forster Adams	Chief Operating Officer	3 July 2017	N/A
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)	1 August 2012	N/A
Claire Holmes *	Director of OD and Workforce	1 October 2018	9 May 2021 *
Dr Chris Hosker	Medical Director	1 August 2020	N/A
Darren Skinner *	Interim Director of People and OD	10 May 2021	N/A
Cathy Woffendin	Director of Nursing, Professions and Quality	1 March 2018	N/A

*In March 2021 it was announced that Claire Holmes (Director of OD and Workforce) would be leaving the Trust and on the 9 May 2021 she stepped down as a member of the Board. On the 10 May 2021 Darren Skinner joined the Trust as the Interim Director of Human Resources. In May 2022 following a competitive interview process Darren was appointed to this role substantively.

Details of the non-executive directors who have served during 2021/22 are shown in the table below along with details of their terms of appointment.

Table 2.2D – Non-executive directors that have served during 2021/22

Name	Date appointment effective from	Term	Date appointment ends or ended	Number of the term of office
Dr Sue Proctor (Chair of the Trust)	1 April 2020	3 years	1 April 2023	Second
Prof John Baker	1 September 2019	3 years	31 August 2022	Second
Helen Grantham	15 November 2020	3 years	14 November 2023	Second
Cleveland Henry	1 April 2020	3 years	31 March 2023	First
Andrew Marran *	17 February 2019	3 years	30 September 2021	First
Merran McRae *	1 January 2022	3 years	31 December 2025	First
Sue White	7 November 2019	3 years	31 October 2022	Second
Martin Wright	20 January 2021	3 years	19 January 2024	Second

* As a result of other work commitments, Andrew Marran took the decision to step down as a NED with effect from 31 September 2021. To fill his vacancy the Council of Governors agreed a competitive recruitment process, through which Merran McRae was appointed as a NED with effect from 1 January 2022.

2.2.4.2 The Remuneration Committee (a sub-committee of the Board of Directors)

The Remuneration Committee is a sub-committee of the Board of Directors. It has been established in accordance with the NHS Act 2006 and operates in accordance with the principles in NHS Improvement's Code of Governance for Foundation Trusts. It is chaired by the Chair of the Trust and is made up of all the non-executive directors. A copy of the Terms of Reference for this committee is available on our website.

The committee has a key role in providing the Board with assurance that: executive directors are rewarded appropriately; appropriate contractual arrangements are in place; that there is a process for assessing the performance of individual executive directors against their agreed objectives, and that plans are in place to address any areas of development.

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2021/22 the committee took advice from the following officers of the Trust: Dr Sara Munro, Chief Executive who provided information in regard to the remuneration for executive directors; Darren Skinner, the Interim Director for People and OD; and Cath Hill, the Associate Director for Corporate Governance, who provided secretariat support and advice on matters of governance. In taking this advice the committee was mindful of any potential conflicts of interest and has dealt with these appropriately as evidenced in the minutes.

The Remuneration Committee has a key role regarding the recruitment and retention of appropriately qualified and experienced executive directors. It does this by agreeing appropriate reward packages. It exercises scrutiny of the remuneration of executive directors in regard to both salary and other areas of reward and has a core responsibility to ensure compliance with all legal obligations and regulations in respect of the employment and remuneration of executive directors.

During 2021/22 the committee met on two occasions with membership being made up of the Chair of the Trust and six non-executive directors. Its main areas of business were:

- Receiving assurance on the outcome of the Chief Executive and the executive directors' annual appraisals
- Agreeing a 2% cost of Living increase for the executive directors for the period commencing 1 April 2021
- Finalising the Trust's VSM pay policy.

The membership of the Remuneration Committee is all the NEDs plus the Chair of the Trust. The table below shows the Remuneration Committee meetings that each member attended.

Table 2.2E – The Remuneration Committee

Name	9 December 2021	31 March 2022
Dr Sue Proctor (chair of the committee)	✓	✓
Prof John Baker	✓	-
Helen Grantham	✓	✓
Cleveland Henry	✓	✓
Merran McRae		✓
Sue White	✓	✓
Martin Wright	✓	✓

2.2.4.3 The Appointments and Remuneration Committee (a sub-committee of the Council of Governors)

The term non-executive director used in this section refers to all non-executives, including the Chair of the Trust.

The Appointments and Remuneration Committee is a sub-committee of the Council of Governors. It has been established in accordance with the NHS Act 2006 and operates in accordance with the principles of NHS Improvement's Code of Governance for Foundation Trusts. It sets the remuneration and terms of service for the non-executive directors and it also plays a role in the appointment of non-executive directors, particularly in respect of the interview panels which are normally made up of members of the committee.

The committee meets as required and is made up of governors chosen by ballot by members of the Council to represent them. It is chaired by the Chair of the Trust and is supported by the Interim Director of People and OD and the Associate Director for Corporate Governance. If the Chair of the Trust is conflicted in any agenda item the committee will be chaired by the Deputy Chair of the Trust or the Lead Governor as appropriate. At the end of 2021/22 its membership was Steven Howarth, Niccola Swan, Les France, Ivan Nip and Peter Webster; all of whom are elected governors.

During 2021/22 the Council of Governors held a ballot that was open to all governors, this was to choose two new members to replace Steven Howarth and Niccola Swan, both of whom will come to the end of their terms of office in July 2022 and as such will not be eligible to be on the committee. As a result of the ballot, Caroline Bentham and Ian Andrews were elected to join the Appointments and Remuneration Committee when Steven and Niccola step down.

In 2021/22 there were two formal meeting of the Appointments and Remuneration Committee. The table below shows the attendance of members at the meetings.

Table 2.2F – The Appointments and Remuneration Committee

Name	26 August 2021	20 January 2022
Dr Sue Proctor (chair of the committee)	✓	-
Helen Grantham (standing in for Sue Proctor)		✓
Les France	✓	✓
Steve Howarth	✓	✓
Ivan Nip	✓	✓
Niccola Swan	✓	✓
Peter Webster (Lead Governor)	-	✓

In 2021/22 the main areas of work for the committee were:

- agreeing the process for the recruitment of one non-executive director and two associate non-executive directors
- agreeing the role description, transition process and remuneration for the Associate Non-executive Directors
- agreeing the timetable and process for the appointment of a new Chair of the Trust. This process will be followed in order to replace Dr Proctor when she comes to the end of her term of office.

It should be noted that any decisions taken by the committee must be ratified by the Council of Governors.

The process of appointment and re-appointment for non-executive directors

Where there is a non-executive director vacancy the appointment is normally carried out through a competitive interview process. However, where there is an incumbent NED and they are eligible by virtue of the number of years they have served in the Trust as a NED, and where they wish to be considered for re-appointment, the Council of Governors can agree to re-appoint the individual for a second term of office of up to three years subject to a satisfactory appraisal.

Competitive interview process

The first step in any appointment process is for the Nominations Committee (a sub-committee of the Board of Directors) to define the skills and experience required on the Board and to agree a role profile and person specification. The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) receives the agreed role profile and person specification, against which appointments are made. It is also the responsibility of the committee to agree the process and timetable for any appointment process. The process and timetable will then be ratified by the Council of Governors.

Candidates can be sought using external search companies, local networks and through the NHS Jobs website. A panel consisting of a majority of governors led by the Chair of the Trust will draw up a shortlist of candidates from the applicants. Where the role being recruited to is for the Chair of the Trust, the shortlisting panel will be led by the Senior Independent Director.

An interview panel will be formed from the membership of the Appointments and Remuneration Committee with a majority of governors (where possible four governors), the Chair of the Trust and an independent assessor. The panel will then conduct the interviews and choose the preferred candidate based on merit. Once the panel has made its choice, a recommendation is made to the Council of Governors and it is for the Council to ratify the recommended appointment at a general meeting.

Re-appointment process

In regard to the re-appointment process, the Chair of the Trust will meet with the non-executive director concerned to discuss their performance and preference in relation to re-appointment. Where the process is for the re-appointment of the Chair of the Trust, the Chair will meet with the Senior Independent Director and the Lead Governor.

The most recent appraisal will be used to inform the meeting and the Lead Governor will have been present as part of that appraisal. A report will be made to the Council of Governors by the Chair who will advise if the appraisal has been satisfactory and if the non-executive director wishes to be considered for re-appointment. The Council of Governors will then be asked to ratify their re-appointment. If the Council has evidence that this it is not appropriate to re-appoint the individual then a competitive interview process will be carried out and the individual's appointment as a NED will come to an end.

Appointment / re-appointment of non-executive directors in 2021/22

In 2021/22 there were no non-executive director re-appointments.

However, in 2021/22 a competitive interview process was undertaken to fill the vacancy left by Andrew Marran who stepped down on 30 September 2021. As a result of that interview process, Merran McRae was appointed as a non-executive director. Merran commenced her role on 1 January 2022.

Also in 2021/22 the Appointments and Remuneration Committee agreed to appoint two Associate Non-executive Directors (ANEDs). This is the first time the Trust has adopted such roles and they have been reated to strengthen succession planning in relation to outgoing NEDs. Whilst the role allows the ANEDs to shadow specific substantive NEDs and for there to be a period of handover, the expectation around time commitment is the same as for a substantive NED. On that basis the Appointments and Remuneration Committee agreed to remunerate ANEDs at the same level as a substantive NED.

Following a successful recruitment process Kaneez Khan MBE and Dr Frances Healey were appointed as ANEDs and will commence in post on 1 April 2022 and 2 April 2022 respectively. Kaneez will be shadowing Sue White and Frances Healey will be shadowing Prof John Baker. Sue and John will be leaving the organisation later in 2022, at which point the Council will follow a process to consider the transition of Kaneez and Frances from being ANEDs to being substantive NEDs.

2.2.4.4 The Nominations Committee (a sub-committee of the Board of Directors)

The Nominations Committee is a sub-committee of the Board of Directors. It has been established in accordance with the NHS Act 2006 and NHS Improvement's Code of Governance for Foundation Trusts.

Its role is to: regularly review the structure, size and composition of the Board of Directors and make recommendations for changes where appropriate; identify the skills, knowledge and experience required for vacant director posts (for both executive and non-executive directors); and ensure there are arrangements in place for succession planning within the Board.

Where the vacant post is for a non-executive director, the Nominations Committee will provide the Council of Governors' Appointments and Remuneration Committee with details of the agreed skills and experience required. Where the vacant post is for an executive director a panel, constituted in accordance with the NHS Act 2006, made up of a majority of non-executive directors, will lead on the appointment process to appoint to the skill set by a process agreed by the Nominations Committee

The Nominations Committee meets as required. It is chaired by the Chair of the Trust and its membership is made up of the Chief Executive, the Director of People and OD and two non-executive directors. The choice of which NED will be at any given meeting will depend on them not having a conflict of interest in any matter under discussion at that meeting. The committee is supported by the Associate Director for Corporate Governance who provides secretariat support and advice on governance matters.

During 2021/22 the committee met on two occasions.

Table 2.2G – The Nominations Committee

Name	29 July 2021	31 March 2022
Prof Sue Proctor (chair of the committee)	✓	✓
Helen Grantham (NED)	✓	✓
Merran McRae (NED)		✓
Sara Munro (Chief Executive)	✓	✓
Darren Skinner (Interim Director for People and OD)	✓	✓
Martin Wright (NED)	✓	-

In 2021/22 the main areas of work for the committee were:

- Agreeing the specific skills required for three non-executive director vacancies that had occurred due to Andrew Marran leaving the Trust on 30 September 2021, or that would be created when John Baker and Sue White leave the Trust in August and October 2022.
- Agreeing the role description for the Chair of the Trust, taking account of the extended duties relating to the ICS and Place-based governance arrangements
- Reviewing and agreeing the role description for the Director of People and OD and also agreeing the recruitment process for the role.

Appointment of executive directors in 2021/22

In 2021/22 there were no executive director appointments, although Darren Skinner commenced in post following an appointment process in 2020/21.

Information in sections 2.2.5 to 2.2.7 is subject to audit by our external auditors, KPMG.

2.2.5 DIRECTORS AND GOVERNORS' EXPENSES

The following table sets out the total paid to directors (executive and non-executive) and governors for out-of-pocket expenses during 2021/22.

Table 2.2H – Directors and governors' expenses

	2021/22			2020/21
	Number in office throughout the reporting period	Number receiving expenses in the reporting period	The aggregate sum paid in the reporting period £'00	The aggregate sum paid in the reporting period £'00
Executive directors	7	2	13	1
Non-executive directors	8	0	0	1
Governors *[1]	25	2	1	1

*[1] Appointed governors have not been included in this figure as their organisations pay the cost of travel

Expenses relating to executive and non-executive directors are shown in more detail in the expenses payments column in table 2.4J below.

2.2.6 SENIOR EMPLOYEES PENSION ENTITLEMENTS, REMUNERATION AND BENEFITS IN KIND

Accounting policies for pensions and other retirement benefits are set out in the notes to the annual accounts; see Part B of this Annual Report. The disclosure on senior employees' remuneration and pension entitlements is subject to audit by our external auditors, KPMG.

Information about pension entitlements, remuneration and benefits in kind are set out in table 2.2I and 2.2J below.

Table 2.2l – Pension entitlement for senior employees (executive directors)

Name and title	Real increase in pension at pension age (Bands of £2500) £'000	Real increase in pension lump sum at pension age (Bands of £2500) £'000	Total accrued pension at 31 March 2022 (Bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2022 (Bands of £5000) £'000	Cash equivalent transfer value at 31 March 2021 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31 March 2022 £'000	Employer's contribution to stakeholder pension To nearest £100
Dr Sara Munro (Chief Executive)	2.5 - 5	0 - 2.5	50 - 55	95 - 100	738	22	786	0
Joanna Forster Adams (Chief Operating Officer)	0 - 2.5	0 - 2.5	55 - 60	120 - 125	1,058	33	1,111	0
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	0 - 0	0 - 2.5	0 - 5	0 - 5	0	0	0	0
Claire Holmes (Director of OD and Workforce)	0 - 2.5	0 - 2.5	30 - 35	0 - 0	270	4	347	0
Dr Chris Hosker (Medical Director from 1 August 2020)	0 - 2.5	0 - 2.5	35 - 40	60 - 65	495	21	533	0
Darren Skinner (Interim Director of People and OD)	7.5 - 10	12.5 - 15	5 - 10	15 - 20	0	123	156	0
Cathy Woffendin (Director of Nursing and Professions)	0 - 2.5	0 - 2.5	45 - 50	95 - 100	898	31	947	0

Cash Equivalent Transfer Value (CETV) - The CETV is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. 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.

The benefits and CETV's do not include any adjustment for the potential future legal remedy arising from the McCloud judgement on age discrimination in relation to the implementation of the 2015 public sector pension schemes.

Non-executive directors do not receive pensionable remuneration and consequently there are no entries for them in this report.

The Chief Financial Officer has not contributed to pension schemes this financial year.

Claire Holmes left the post of Director of Workforce Development on 9th May 2021.

Darren Skinner started in post as Interim Director of People and Organisational Development on 10th May 2021.

Table 2.2J – Remuneration and benefits in kind for senior staff

Name and title	2021/22							2020/21						
	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000
Dr Sara Munro (Chief Executive)	185 - 190	0	0	0	45 - 47.5	0	230 - 235	185 - 190	0	0	0	75.0 - 77.5	0	260 - 265
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	150 - 155	0	0	0	0 - 0	0	150 - 155	150 - 155	100	0	0	0	0	150 - 155
Joanna Forster Adams (Chief Operating Officer)	130 - 135	0	0	0	25 - 27.5	0	160 - 165	130 - 135	0	0	0	112.5 - 115.0	0	245 - 250
Cathy Woffendin (Director of Nursing and Professions)	120 - 125	0	0	0	25 - 27.5	0	145 - 150	120 - 125	0	0	0	110.0 - 112.5	0	230 - 235
Dr Chris Hosker (Medical Director)	165 - 170	0	0	0	27.5 - 30	0	195 - 200	105 - 110	0	0	0	707.5 - 710.0	0	815 - 820
Claire Holmes (Director of OD and Workforce)	130 - 135	0	0	0	142.5 - 145	5 - 10	280 - 285	115 - 120	0	0	0	67.5 - 70.0	0	185 - 190
Darren Skinner (Director of People and Organisational Development)	105 - 110	0	0	0	170 - 172.5	0	280 - 285	0	0	0	0	0	0	0
Dr Sue Proctor (Chair of the Trust)	45 - 50	0	0	0	0	0	45 - 50	45 - 50	100	0	0	0	0	45 - 50
Helen Grantham (Non-execute Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15
Andrew Marran (Non-executive Director)	5 - 10	0	0	0	0	0	5 - 10	10 - 15	0	0	0	0	0	10 - 15
Martin Wright (Non-executive Director)	15 - 20	0	0	0	0	0	15 - 20	15 - 20	0	0	0	0	0	15 - 20
Prof John Baker (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15
Sue White (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15
Merran McRae (Non-executive Director)	0 - 5	0	0	0	0	0	0 - 5	0	0	0	0	0	0	0
Cleveland Henry (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15

Claire Holmes left the post of Director of Workforce Development on 9th May 2021.

Darren Skinner started in post as interim Director of People and Organisational Development on 10th May 2021.

2.2.7 FAIR PAY MULTIPLE

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median, 25th percentile and 75th percentile remuneration of the organisation's workforce.

Table 2.2K – Fair pay disclosure

	25th Percentile Pay Ratio	Median Pay Ratio	75th Percentile Pay Ratio
2021/22	8.25:1	5.95:1	4.46:1
2020/21	8.39:1	6.1:1	4.62:1

The banded remuneration of the highest-paid director in the Trust in the financial year was £187,994 (2020/21, £187,994), a percentage change of 0.00%. The average salary and allowance for all employees in the financial year was £43,701 (2020/21, £42,238), a percentage change of 3.46%.

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

- The ratio was 8.25 times (2020/21, 8.39 times) the 25th percentile remuneration of the workforce, which was £22,777 (2020/21, £22,420).
- The ratio was 5.95 times (2020-21, 6.10 times) the median remuneration of the workforce, which was £31,607 (2020-21, £30,820).
- The ratio was 4.46 times (2020-21, 4.62 times) the 75th percentile remuneration of the workforce, which was £42,121 (2020-21, £40,682).

The ratios have decreased partly due to the highest paid director this year, having the same basic salary as the previous year.

In 2021/22, no substantive employees received remuneration in excess of the highest-paid director (1 in 2020/21).

The remuneration range for employees receiving remuneration in excess of the highest-paid director is not applicable this year (2020/21, the remuneration was £221,269).

For employees of the Trust as a whole, the range of remuneration in 2021-22 was from £10 to £187,994 (2020-21 £10 to £221,269)

The median, 25th percentile and 75th percentile salaries are calculated based on data that is generated from our payroll system. All staff that were employed by the Trust on 31 March 2022 are included in the calculation.

2.2.8 ACCOUNTING POLICIES

Accounting policies for pensions and other retirement benefits are set out in note 1.5 of the annual accounts in Part B of this Annual Report. Details of senior employees' remuneration can be found in this Remuneration Report (senior employees for the purpose of the Remuneration Report are our executive and non-executive Board members).

SECTION 2.3 – ACCOUNTABILITY REPORT (Staff Report)

2.3.1 EQUALITY REPORTING

We believe in fairness and equality and above all value diversity and inclusion in all aspects of our work. This is demonstrated by our commitment to improving health and improving lives for our service users and staff.

Everyone who comes into contact with our organisation can expect to be treated with respect and dignity. We are committed to eliminating discrimination and to the fair treatment of everyone, taking into account all 'protected characteristics' under the Equality Act 2010 and the Human Rights Act 1998. If unfair discrimination occurs it will be taken seriously and it may result in formal action being taken against individual members of staff, including disciplinary action.

Over the last year we have developed and launched our People Plan, informed by staff feedback from various sources. This sets out our workforce equality commitments for 2021 to 2024 and a clear road map detailing how we will achieve these.

You can read our People Plan using the link below:

https://www.leedsandyorkpft.nhs.uk/about-us/wpcontent/uploads/sites/8/2022/03/LYPFT_People_Plan_@_14Feb2022.pdf

2.3.2 DISABILITY AND EMPLOYMENT

Our recruitment and selection procedures take full account of the requirements of the Equality Act 2010 and the associated public sector equality duties. This includes giving full and fair consideration to applicants with a disability or long-term health condition. We have developed our new People Plan which details current and future actions and initiatives to respond to the immediate and longer- term response needs of colleagues and to further develop our Trust as a healthy workplace in respect of both physical and psychological wellbeing. We are also a Disability Confident employer at level two. This demonstrates we are positive about people with disabilities and support them to successfully attain and retain employment within our Trust.

We have supportive employment practices in place not only for those that we employ who have a disability, but for those who may become disabled whilst working for us. These include a support package within our Wellbeing and Managing Attendance Procedure; a process for the management of work-related stress; an Employee Assistance programme providing counselling and other support to staff; flexible working arrangements; and a bespoke Occupational Health Service. Our attendance procedures also take account of individual needs related to disability and provides for disability leave as a reasonable adjustment, to support people to remain in work.

Our Wellbeing Assessment process provides a holistic and supportive approach through a recorded supportive discussion between a staff member and their manager, to identify actions or reasonable adjustments required. We have made reasonable adjustments to working environments including home working and redeployment and through the purchase of specialised equipment. In addition, a career conversation process has been incorporated within the assessment to identify and action career development support and training needs. These procedures and services support the employment, retention and experience of disabled employees and the implementation of reasonable adjustments to take account of individual needs.

Our diversity training package aims to raise awareness of a wide range of diversity issues, including disability in order to minimise discrimination in all aspects of employment. Diversity training is compulsory for all staff and is required to be undertaken every three years. This ensures that our workforce is aware of current legislative and organisational requirements and best practice.

2.3.3 VALUING OUR WORKFORCE

Our workforce is our most valuable asset and we recognise this by making a commitment to ensure they are well trained, well informed and are given every opportunity to contribute not only to the delivery of services but also to the development of these and other new services. The demands on NHS colleagues during the past year have been unprecedented and supporting our colleagues to keep well and continuing to ensure they feel valued has been central to our approach.

2.3.3.1 Volunteers

Volunteering improves self-esteem, provides a wealth of experience, and can increase employment opportunities. By becoming a volunteer, a person can provide additional support to clinical teams which in turn enables them to provide the best possible care to our patients their families and their carers. Volunteers support us to think differently and using fresh eyes add value to services in a variety of ways.

2021/22 has seen us continue to actively support our Trust with volunteers who are in Covid-19 related roles such as vaccination hub volunteers and shopping volunteers who are helping in roles that we would normally not have support in.

It is fantastic that we are retaining such a high percentage of volunteers throughout these difficult times with this continuing epidemic, this shows that our volunteers are proud of the work they do and are made to feel valued, and it reflects the quality of working relationships between our staff and volunteers.

Our Volunteers are offered the same care as our workforce, this includes access to do the same training opportunities, with a specific focus on mandatory training. The Trust continues to offer every volunteer support in their role with designated supervision. We continue to grow the Volunteer Service enduring that we attract a more diverse range of people who are both reflective and representative of the communities we serve.

More information on the Trust's Volunteer Service can be found on the Trust website using the link below:

https://www.leedsandyorkpft.nhs.uk/get-involved/volunteering/

2.3.3.2 Staffside – working with the trade unions that represent our staff

Staffside is the elected body of the representative trade unions in our Trust. Our Joint Negotiation and Consultation Committee (JNCC) meets at least monthly to discuss and question, on behalf of the wider union membership, any issues raised by the individual trade unions or by the Trust. This committee enables our trade union colleagues to negotiate with one voice. The JNCC is the place where all issues raised at Staffside meetings are brought to the attention of management.

Staffside has many years of successful partnership working with the Trust. We have achieved this through the nationally recognised *In Partnership*s agreement. Our Staffside Lead (partnership) works closely with the People and OD agenda and is a member of various governance groups where initiatives and challenges are discussed to ensure effective partnership working in the decision making of the organisation.

During the past year Staffside has contributed to the strategic agenda by contributing to the Trust's response to Covid-19 particularly in relation to workforce issues and redeployment of our workforce. Staffside colleagues have helped to develop the Trust's approach to agile working and continue to be involved in service redesign and management restructuring, and communication and engagement with staff. In 2021/22 Staffside has:

- actively encouraged staff to complete the annual staff survey which has enabled colleagues to have their voices heard

- continued involvement in the development of our People Plan and in a range of workforce issues particularly in response to Covid-19 through regular dialogue with the Director of People and OD and senior operational managers
- successfully worked in partnership with the People and OD Directorate and its managers to support staff going through significant change and workforce transformation
- contributed to the job evaluation process under Agenda for Change to ensure fairness and equity in pay banding
- continued to support staff who are redeployed to minimise any redundancies
- contributed to feedback and action planning for teams to improve employee relations and learn lessons
- contributed to the review and development of employment procedures namely the development of our new Disciplinary Policy, adopting a just and learning culture.

Staffside also provides information and advice to colleagues through the development of an internal intranet page on Staffnet. They can also be contacted by emailing staffside.lypft@nhs.net.

The following tables show the Trade Union Facility Time which is required to be reported under the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Table 2.3A – The number of employees who were relevant union officials employed during 2021/22

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
6	5.67

Table 2.3B – Percentage of time spent on facility time – The number of employees who were relevant union officials employed during 2021/22 and the percentage time of their working hours spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	6
51-99%	0
100%	0

Table 2.3C – Percentage of pay bill spent on facility time during 2021/22

Total cost of facility time	£40,921.63
Total pay bill	£146,238,176
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	2.80%

Table 2.3D – Paid trade union activities during 2021/22

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	2.79%

2.3.4 STAFF ENGAGEMENT

Engaging with colleagues and their representatives, to ensure they have the opportunity to share their views and receive regular information on decisions that may affect their interests is aligned with our Trust's value of integrity. The ways in which we have engaged with colleagues in previous years have adapted through 2021/22 to align to the new ways of working brought on by the Covid-19 pandemic. By altering our approach, we have ensured meaningful engagement work can still take place. Our aim continues to be that we are open about actions taken and decisions made, to work as transparently as possible.

2.3.4.1 Communications

Communications with our colleagues in 2021/22 was again dominated by the Covid-19 pandemic response.

We continued to support the Gold Command, Silver Command and the workforce specific groups which met regularly. The Communications Team was mainly responsible for developing regular colleague briefings, communications materials and curating content on our digital channels related to the pandemic.

Our key Covid-19 related messages focused on encouraging vaccination take up, infection prevention and control guidance, testing, and promoting colleague health and wellbeing.

We continued to support the Chief Executive with monthly all staff Zoom calls, collating content, arranging guest speakers and promoting the live involvement opportunity. We also restarted the Chief Executive's monthly leadership blog in 2021.

We maintained a high level of dedicated resource and a high level of outputs to support colleague health and wellbeing, including the monthly Wellbeing Wednesday newsletter and a mini z card with our wellbeing offer which was posted to all colleagues. We also provided a lot of dedicated support to recruitment and resourcing activity, and to equality and inclusion.

Other key areas of focus for 2021/22 were as follows:

- Red Kite View – the development and launch of West Yorkshire's new Children and Young Peoples' Mental Health Inpatient Unit which went live in January 2022
- recruitment and resourcing activity e.g., refreshing our career's website, campaigns targeting health support workers, service specific campaigns (e.g. Specialised Supported Living Service), harder to fill roles etc.
- developing the LYPFT People Plan, planning communications and engagement priorities for year one, and launching the plan into the organisation in March 2022
- supporting the hybrid working programme
- supporting the Community Mental Health Transformation programme in Leeds – including securing dedicated agency support and recruiting a comms and engagement lead
- a high level of support to our Perinatal Mental Health Team, including a regional perinatal mental health campaign
- a high level of support to the equality, diversity and inclusion agenda – including sharing stories from our diverse communities and a regional anti racism campaign
- supporting our organisational commitment to veterans and reservists e.g., achieving Veteran Aware status, communications support to the Veteran's High Intensity Service etc.
- providing communications support and consultancy to the Leeds Recovery College
- improving our communications channels – this included a content audit of our intranet Staffnet, driving forward plans to improve the accessibility and usability of Staffnet, and developing a new approach to managing social media engagement.

2.3.4.2 Improving Culture: Improving Lives

Since autumn 2020 we have continued a staff engagement approach to developing our culture together and have worked with colleagues to listen to their feedback and drive changes. Taking regular feedback from our colleagues to develop and steer our approach to key strategic challenges

and change has continued to be a key feature of our approach during the Covid-19 pandemic. This has shaped our approach to supporting the health and wellbeing of our colleagues and we have continued to support the development of our Trust staff networks, of which there are three: the Workforce Race Equality Network; the Workforce Disability and Wellbeing Network; and the Rainbow Alliance. Following colleague feedback, we have launched the Menopause Support Group which meets monthly. We regularly co-ordinate colleague consultation forums where issues are raised, for example, Vaccination as a Condition of Deployment and menopause support. A bank forum was established in 2020 and this has continued to be a useful forum to consult with and receive feedback from our bank workers.

During 2021/22 the Trust developed and approved a new 3 year People Plan, the plan was developed, in partnership with our expert People and Organisational Development colleagues and teams and also with colleagues and leaders across the wider Trust. A dedicated communications and engagement campaign to socialise the plan across the Trust and with our external partners started in March 2021.

We know that leaders play a key role in developing our culture to create positive and healthy working environments for our people. Work to develop our leaders to lead collectively and inclusively, in line with our Trust values has been ongoing during 2021/22.

2.3.5 OUR STAFF SURVEY

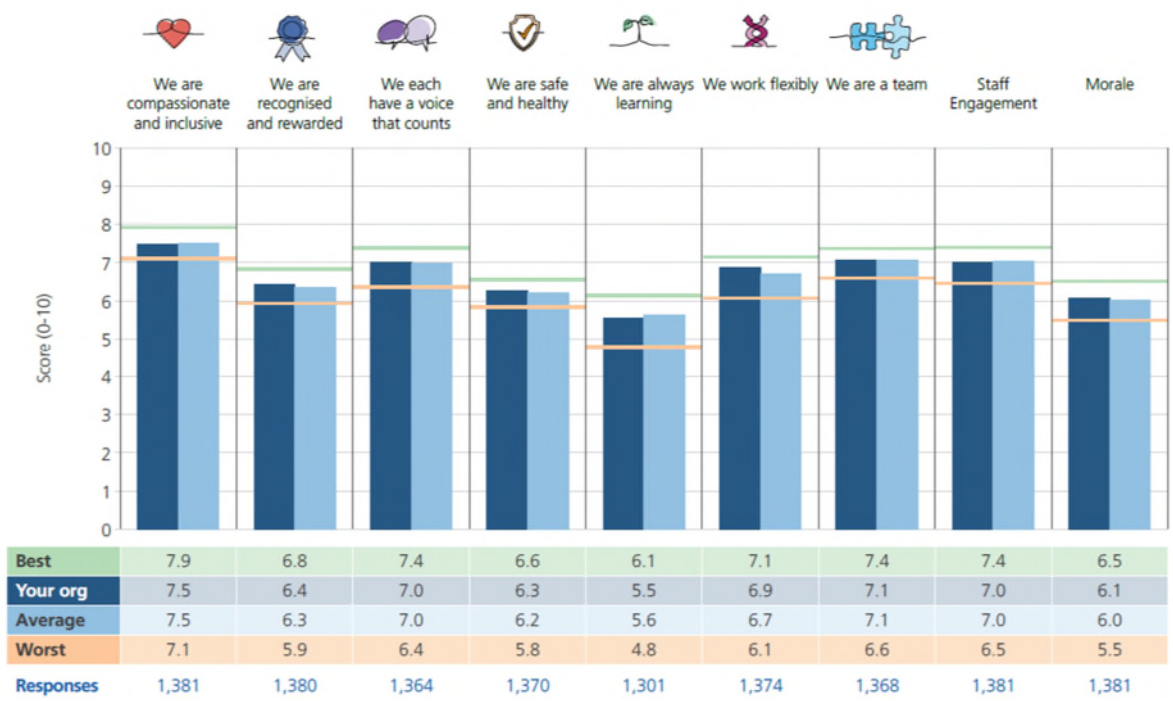
The NHS Staff Survey is conducted annually. From 2021 the questions have been changed to align to the People Promise, which sets out, in the words of NHS Staff, the things that would most improve their working experience. With the addition of 32 new questions and the implementation of the seven People Promises as opposed to the ten Key Themes, there is less comparable year on year data than in previous years.

The 2021/22 Staff Survey response rate for Trust staff was 47% (2020/21: 47%, 2019/20: 54.5%, 2018/19: 58.1 %). The overall response rate for our survey benchmarking group (Mental Health and Learning Disability Trusts) was 52%. Scores for each People Promise together with that of the survey benchmarking group are presented below.

Table 2.3E – People Promise scores for the staff survey

	2021/22 Survey	
People Promise	**Trust**	**Benchmark**
We are compassionate and inclusive	7.5	7.5
We are recognised and rewarded	6.4	6.3
We each have a voice that counts	7.0	7.0
We are safe and healthy	6.3	6.2
We are always learning	5.5	5.6
We work flexibly	6.9	6.7
We are a team	7.1	7.1
Staff Engagement	7.0	7.0
Morale	6.1	6.0

The following chart displays the Trust's theme scores for 2021/22 against the benchmark and includes the best and worst scores from the group.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.9	6.8	7.4	6.6	6.1	7.1	7.4	7.4	6.5
Your org	7.5	6.4	7.0	6.3	5.5	6.9	7.1	7.0	6.1
Average	7.5	6.3	7.0	6.2	5.6	6.7	7.1	7.0	6.0
Worst	7.1	5.9	6.4	5.8	4.8	6.1	6.6	6.5	5.5
Responses	1,381	1,380	1,364	1,370	1,301	1,374	1,368	1,381	1,381

Prior to the changes made to the Staff Survey for 2021/22, the survey consisted of 10 Key Themes. For 2019-2020, our scores were:

Table 2.3F – Key Theme Metrics for the 2019 and 2020 Staff Survey

	2020/21 Survey		2019/20 Survey	
Theme	**Trust**	**Benchmark**	**Trust**	**Benchmark**
Equality, Diversity and Inclusion	9.1	9.1	9.1	9.0
Health & Wellbeing	6.5	6.4	6.4	6.0
Immediate Managers	7.6	7.3	7.6	7.3
Morale	6.5	6.4	6.5	6.3
Quality of Appraisals	Removed for 2020		5.9	5.8
Quality of Care	7.3	7.5	7.3	7.4
Safe Environment - Bullying and Harassment	8.4	8.3	8.3	8.0
Safe Environment - Violence	9.3	9.5	9.3	9.3
Safety Culture	6.9	6.9	6.8	6.8
Staff Engagement	7.2	7.2	7.1	7.0
Team Working	6.9	7.0	7.0	7.0

For 2021, we are therefore performing better than the national average for mental health and learning disability trusts in England across three of the seven People Promises, and one of the two themes. We are equal to the benchmark group for two People Promises and one theme.

This year 73% of our surveys were sent to colleagues to complete electronically. Paper surveys continued to be provided to those teams where accessing the online survey would present a barrier to them participating. Everyone receiving a paper copy also had the opportunity to complete their survey

online instead. 14% of responses received were completed via a paper survey and therefore this option will remain available to colleagues.

This year our overall response rate remained the same as in 2020 at 47%. As the survey took place during the second year of the Covid-19 pandemic, we knew this may continue have an impact on our completion rate and therefore, this score did not come as a surprise. We regularly communicated with line managers on their team level response rates to enable local encouragement where this was appropriate. Therefore, we still consider 47% response rate a positive achievement.

Local action planning was stood down again in March 2021 so as not to add to the operational pressures being experienced across the Trust. However, work continued to focus on improving colleague experience across the Trust as the results were considered by a number of working groups including the Health and Wellbeing Steering Group, the Equality Steering Group and the People and Organisational Development Group. Discussions at these groups led to some important implementations across the Trust to boost colleague experience, including:

- appointing a Head of Wellbeing as a brand-new role to provide a dedicated resource to improving Health and Wellbeing in the Trust
- commencing an audit of Trust sites to implement dedicated Wellbeing rooms across the organisation for colleagues to use as a safe space to unwind and relax
- developing a new working group to develop an improved agile / hybrid working policy which will continue to develop flexible working patterns and take the best ways of working away from our pandemic response
- our staff networks (the Workforce Race Equality Network, the Disability and Wellbeing Network and the Rainbow Alliance) have continued to work hard to engage with all our colleagues and break down barriers and stigma around race, disability, sexuality, and gender. A new staff Menopause Support Group has also been set up for discussions dedicated to how we manage and support it in the workplace.

2.3.5.1 Future priorities and targets

An analysis of our Staff Survey results provides us with a basis for determining the main areas to focus on when developing our key areas for action in 2022/23.

This year we are encouraging teams to complete local Intention Planning, using the results of their Staff Survey as a guide. By engaging with service managers throughout April, the Engagement Team will support them to work with their teams and choose at least one area of focus to work on that will make a different to their working lives.

2.3.6 HOW WE INVOLVE OUR STAFF IN UNDERSTANDING PERFORMANCE

Our performance information is shared with our Board, our Council of Governors and performance dashboards have been created at team and service line level, in order that we can share performance information with our staff.

2.3.6.1 Financial Performance

Our performance information is shared with our Council of Governors and performance dashboards have been created at team, service and care group level, in order that we can share performance information with our staff.

2.3.6.2 Contractual and regulatory performance

Further work has been done to expand the range of timely and accessible operational dashboards for service managers, during the second year with our electronic patient record system, CareDirector. These dashboards provide teams with the tools to manage patient care pathway activity and to

monitor data integrity. Additionally, we continue to promote and add to, the Quality, Delivery and Performance Report which was developed in 2020/21 to present the Key Performance Indicator data that services need in order to better manage the performance and quality of their services. Whilst the Covid-19 pandemic has impacted on the bi-monthly Quality, Delivery and Performance meetings with services we have been pro-active in engaging with staff in each area (including service managers and clinical leads) to promote the use of new dashboards to enable discussion of performance across a range of topics including improved service delivery and quality improvement plans.

Following a workshop in Quarter 3 that initiated the Trust's reset and recovery work, the Informatics Team has worked closely with services to help with understanding their data around backlogs created by the pandemic, whilst receiving new referrals and the likely effects on waiting times. This has been well received by services, and the expertise provided by the Team has brought clarity to the data analysis work when formulating recovery plans.

Overall performance against our contracts is monitored by the Finance and Performance Committee, which has tracked the impact of Covid-19 on performance, data quality and risk.

We have a series of Quality Reviews, whereby staff visit services and assess them using the Key Lines of Enquiry template used by the CQC. During 2021/22 these have been scaled back and a more focused approach has been taken. The emphasis of the Quality Reviews is on highlighting good practice and high-quality care as well as recognising areas for improvement. As part of the reviews, ongoing progress and compliance against the CQC standards for that specific area is also reviewed.

The main aim of our approach is to engage all staff in the quality agenda and build up a body of knowledge through the organisation on what good quality looks like.

2.3.7 SICKNESS ABSENCE

Details of the Trust's sickness absence data can be found on the NHS Digital website using the link below:

http://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

The overall average sickness absence rate between April 2021 to March 2022 is 5.84% which is an increase when compared with the previous years' absence which was 5%. Whilst the data at the end of March 2022 shows a positive downward trajectory, sickness absence in the previous 12 months was high, particularly from November 2021 through to February 2022 when the Covid-19 pandemic was at a peak.

The latest figures available from the NHS Digital at November 2021 show that the overall sickness absence rate for England was 5.6% which is slightly lower than the Trust's position of 5.84% for 2021/22. This is significantly higher than November 2020 (4.9%). When compared to other mental health and learning disability trusts we are slightly higher on average for sickness absence, comparing the November 2021 absence rate of 6.45% to that of the benchmark group which was 6.14% on average.

The Trust has been supporting individuals through periods of absence, recognising that absence has been significantly affected by the Covid-19 pandemic and the impact and pressure individuals have faced during this time. The long term sickness absence rate was 4% on average with short term absence increasing slightly to 2% on average of overall absence.

The top three service areas with the highest overall absence rate in 2021/22 were the Older Peoples Services at 8.67%, the Eating Disorders, Rehabilitation and Gender Services at 7.70%, and the Adult Acute Services at 7.27%. The People and OD Team is actively working with service areas to address those teams with a high prevalence of sickness absence i.e. understanding whether long term absence is the issue and working with those services to enable individuals to return more quickly to the workplace. The Absence Improvement subgroup was stood down for a period of 2021/22 due to the Trust's business continuity measures however is being stood back up in April 2022 where effective management of absence will be the focus.

The professional group with the highest sickness absence in the previous 12 months when compared to the size of the professional group was Additional Clinical Services at 8.48% of overall sickness absence. This group includes our non-qualified clinical workforce, and is a similar position to the previous year which was 8.05%. Those in admin and clerical roles have seen an increase in their overall sickness absence increasing to 4.14% on average when compared to the previous year which was 2.74%.

Our top reason for sickness absence continues to be mental health related absences (Stress and Anxiety) at 36.4% of overall absence which is a decrease when compared to the previous year which was 42.5% of overall absence. This is consistent position compared the rest of the NHS who report Anxiety/stress/depression/other psychiatric illnesses is consistently the most reported reason for sickness absence. The second top reason for absence in 2021/22 was Covid-19 related and the third was Musculoskeletal (MSK) related absence. These are the areas where we are focusing our efforts to support colleagues and improve attendance overall.

The tables below show our sickness absence rate during 2021/22 and also present some statistics around the number of days lost due to sickness absence.

Table 2.3G – Sickness absence (percentage for 2021/22)

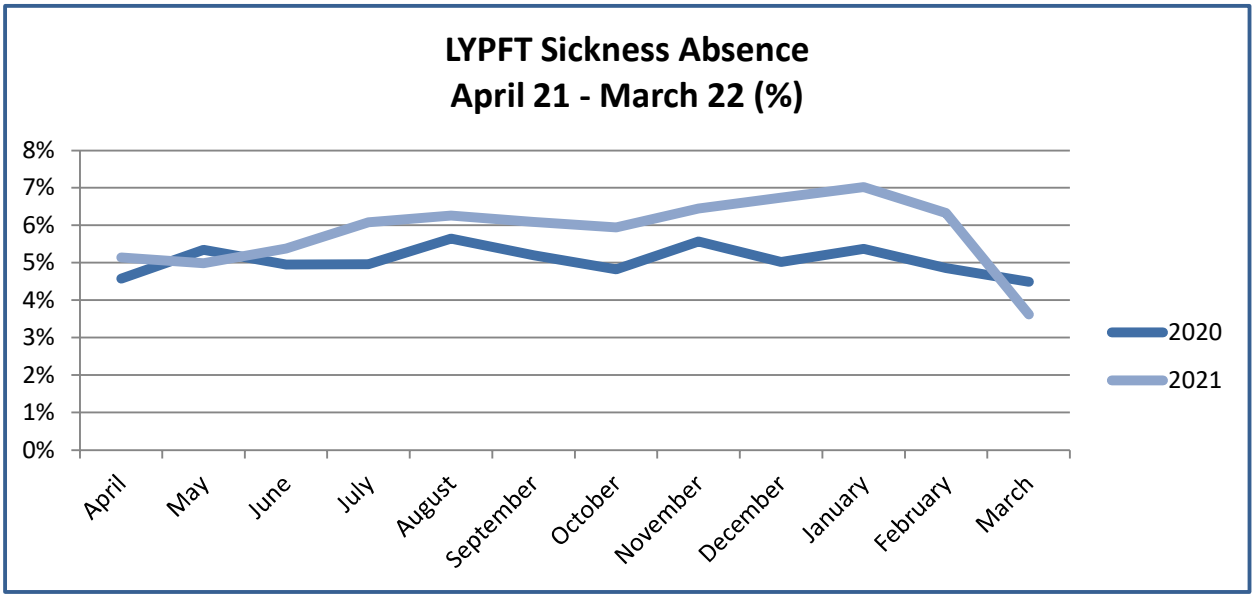


Table 2.3H – Sickness absence (percentage for 2021/22)

%	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Current year	5.14	4.99	5.38	6.08	6.26	6.09	5.95	6.45	6.74	7.02	6.33	3.62
Previous year	4.57	5.34	4.95	4.96	5.64	5.19	4.82	5.57	5.02	5.37	4.86	4.49

Table 2.3I - Long Term Sickness Absence (percentage for 2021/22)

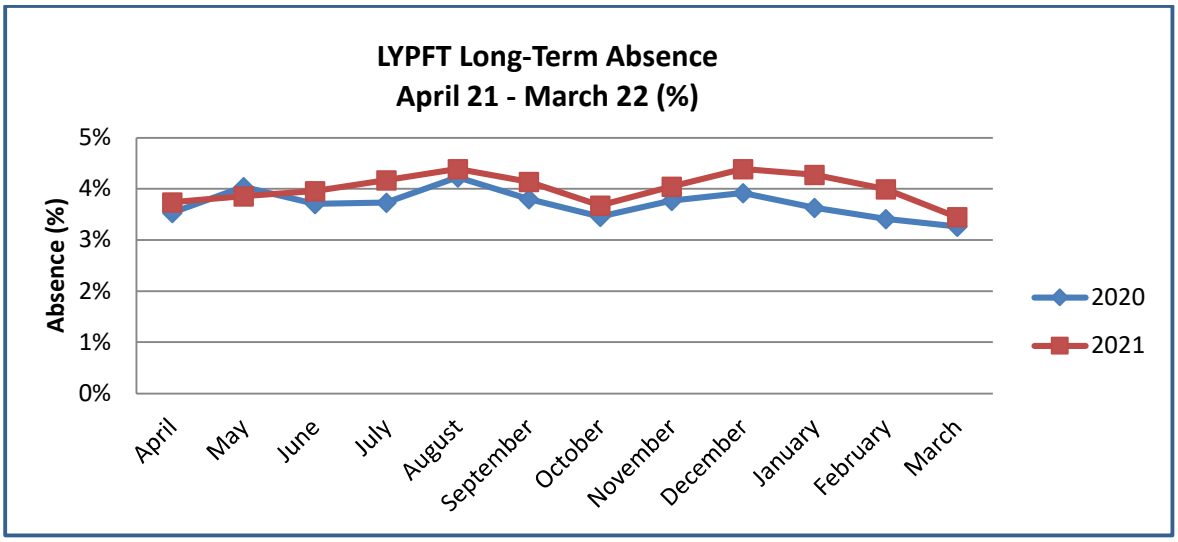


Table 2.3J - Short Term Sickness Absence (percentage for 2021/22)

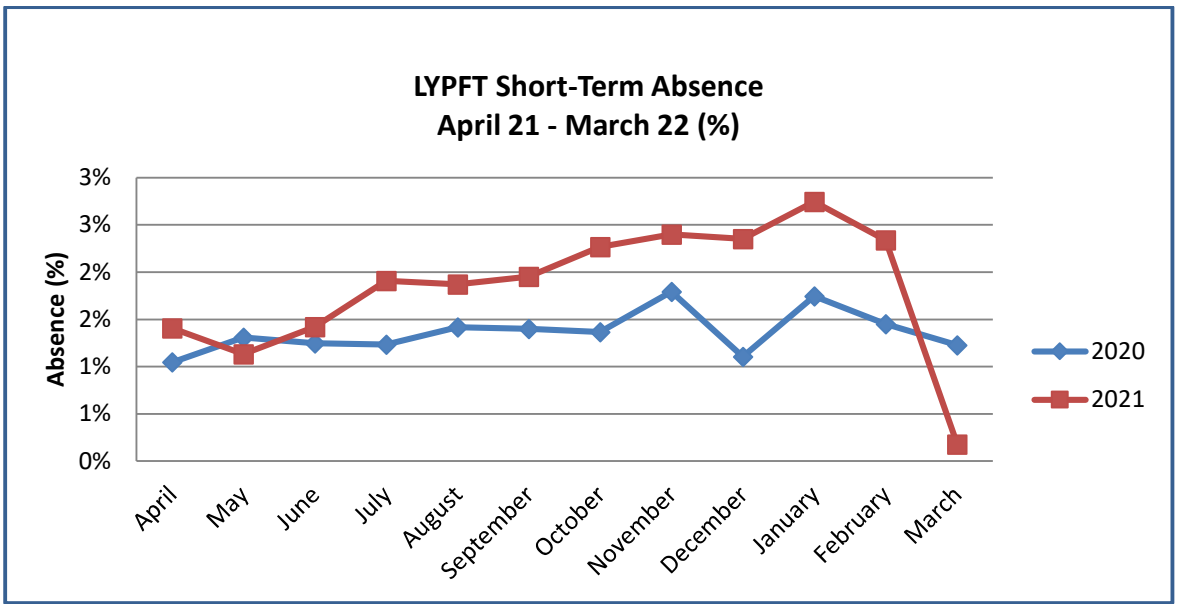


Table 2.3K – Sickness absence as reported in the FTCs

Figures Converted by DH to Best Estimates of Required Data Items		Statistics Produced by NHS Digital from ESR Data Warehouse		
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	FTE-Days Available	FTE-Days Lost to Sickness Absence	Average Sick Days per FTE
2879.67	38064.45	1051079.04	61749.00	10.49

All absence data is recorded internally using the functionality of the Health Roster system and absence data is regularly reported through our Electronic Staff Record and shared with the People and Organisational Development (OD) Team and service lines to identify hotspots and particular trends.

Our strategic approach to the health and wellbeing of our workforce, and ultimately a reduction in colleagues being absent from work, is led by the Trust's Health and Wellbeing Steering Group. The group implements and monitors the Health and Wellbeing agenda and aligns to the Looking After Our People ambition as set out in the Trust's People Plan. There is both clinical and corporate representation within this group to ensure all colleagues are considered when implementing wellbeing support. Our People Plan will continue to embed the support services that are available and will have a focus on prevention and early intervention, with areas of focus for the next three years, such as specialised support groups for certain staff groups e.g. Menopause.

We continue to have fast track access to Occupational Health Services to effectively support the management of ill health at work, with consistent return to work and reporting processes. Three absence management support pathways were introduced in the latter months of 2021/22 to help manage absence more effectively, recognising that one size does not fit all in the management of ill health and absence. The pathways include support for mental health related conditions, cancer and long Covid-19. These pathways provide additional and bespoke support for managers and colleagues who are experiencing these conditions and the support which is in place.

We continue to provide a 24/7 Employee Assistance Programme (EAP) through Health Assured to support colleagues both from a work and personal perspective which includes counselling support. This service is well used with a total of 627 calls logged between 1 March 2021 and 28 February 2022. Anxiety was the most common reason for EAP usage.

Our EAP Service supports our colleagues to return back to work effectively, we know 38% of individuals who had completed the course of counselling who were not in work at the start of therapy, had returned to work.

Annual wellbeing conversations which were introduced since the start of the Covid-19 pandemic are a mandatory requirement with the Trust currently reporting 81% compliance across the organisation. The wellbeing conversations template is a helpful tool to support individual conversations between the line manager and colleague regarding their health and wellbeing. This can include support for working in an agile way and at home, both physical and emotional support to maintain colleagues in the workplace.

Our Physiotherapy Service is well established and provides a proactive support to those who have different physical challenges in the workplace and as such experience MSK related problems. We support virtual physiotherapy sessions and continue to provide education and advice to prevent injury and absence where possible.

We offer a telemedicine model to triage symptoms and offer first line advice and support. We offer physical health checks for blood pressure, blood sugar, cholesterol, and body composition along with a lifestyle questionnaire with advice being offered and onward referral to GPs where appropriate. These appointments are available at a monthly clinic drop-in session at St. Mary's Hospital with an Occupational Health colleague and colleagues can book in with them directly.

We enable colleagues to access Salary Finance, a company that provides financial wellbeing solutions including flexible options of loans with repayments directly from salary and access to an educational site and helpline. This scheme was supported in response to the evidence-based links between mental health and financial wellbeing.

2.3.8 OCCUPATIONAL HEALTH SERVICE

We continue to share our Occupational Health Service with South West Yorkshire Partnership NHS Foundation Trust. It remains a nurse-led service created to meet the specific needs of colleagues in mental health, learning disability and community services. The team now provides an overall

occupational health service for 20,000 employees in the region and continues to operate service level agreements for external contracts. During 2021/22 our Occupational Health Service has evolved with its support and guidance on Covid-19 and contributed leadership support for the development of our health and wellbeing strategy within our People Plan. The service now provides a general advice line for managers and colleagues Monday to Friday, having recently recruited a clinic nurse who supports our vaccination programme, Occupational Therapists, and a Mental Health Nurse. The increased provision of more specialist roles provided by this service demonstrates the wide variety of need and usage by our workforce.

2.3.9 HEALTH AND SAFETY

In 2021/22 health and safety continued to be proactively managed throughout the pandemic. The Trust has ensured that all audits and inspections are up to date with a review of any incidents completed. Whilst this has been a difficult period, active management of health and safety has ensured that the Trust is Covid-secure with robust procedures, continued monitoring and assurance in line with the Health and Safety Executive's guidance and Government guidance.

The focus of the Health and Safety Team for 2021/22 has been the implementation of the NHS Workplace Health and Safety Standards. This set criteria focusses on key health, safety and wellbeing subjects and documents to implement/review. The workplace standards has around 500 actions associated with it and at the time of writing the Trust is at 54% completion. Another focus has been restarting internal audits, the Trust now has a three year audit plan which is being delivered by the Health and Safety Team.

Following a review of more serious incidents in the Trust, it has been identified that violence accounts for the majority of the injuries/incidents. We are currently involved with a wider piece of work led by the Associate Director of People Experience specifically looking at the risk assessment for violence and aggression.

2.3.10 COUNTER-FRAUD

During 2021/22 the Local Counter Fraud Specialist Service (LCFS) was provided by NHS Audit Yorkshire. Audit Yorkshire specialises in all aspects of internal audit and counter fraud work, primarily across the NHS but also the public, corporate and not for profit sectors. Audit Yorkshire has a team of accredited and experienced LCFS personnel.

In January 2021 the NHS Counter Fraud Authority (NHSCFA) issued the NHS Requirements which provided detailed information on how the Government Functional Standard 013 Counter Fraud must be applied across the NHS. The requirements outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action.

For 2021/22 the LCFS produced an Annual Counter Fraud Plan aligned to the standards.

There are 12 components within the Functional Standard which are sub divided as:

- governance which outline how the organisation supports and directs counter fraud, bribery and corruption work undertaken to create a strategic organisation wide response when combatting fraud bribery and corruption
- counter Fraud Bribery and Corruption Practices, which outline the organisations operational counter fraud activities undertaken during the year when detecting and combatting fraud.

The Trust's Audit Committee reviews and approves the Annual Counter Fraud Plan identifying the actions to be undertaken to promote an anti-fraud culture, prevent and deter fraud and investigate suspicions of fraud. The LCFS also produces an annual report for the Trust and regular progress reports for the review and consideration of the Chief Financial Officer and the Audit Committee.

The Chief Finance Officer for the Trust is proactively and demonstrably responsible for tackling fraud, bribery and corruption and the LCFS regularly attends the Audit Committee. The Trust has also appointed an officer at the Trust as a Counter Fraud Champion to support the work of the LCFS.

The Trust's counter fraud arrangements are currently in compliance with the NHS Requirements published by the NHSCFA. These arrangements are underpinned by the appointment of the LCFSs, the Counter Fraud, Bribery and Corruption Policy and the nomination of the Chief Financial Officer as the executive lead for counter fraud.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's standards, which is reviewed and approved by the Chief Financial Officer and Audit Committee Chair prior to submission to the NHSCFA. The 2020/21 assessment for the Trust was completed with reference to the NHS Requirements. The assessment was submitted in May 2021 with an overall rating of Amber. This rating was largely determined by the NHS Requirements being published in late January 2021, with key publications and guidance being unavailable prior to the end of the 2020/21 financial year. The self-assessment was reviewed by the Chief Financial Officer and the Audit Committee Chair and was submitted prior to the NHSCFA deadline of the 31st of May 2021. The return was also shared with Audit Committee members within the 2020/21 Annual Counter Fraud Report.

The LCFS will be providing a response to the Counter Fraud Functional Standard Return on behalf of the Trust in April/May 2022. This will look at the Trust's compliance to the NHS Requirements within the 2021/22 financial year, and will be reviewed by the Chief Financial Officer and the Audit Committee Chair prior to submission.

The Trust participates in the National Fraud Initiative (NFI). The NFI is a sophisticated data matching exercise, which matches electronic data within and between participating bodies to prevent and detect fraudulent and erroneous payments from the public purse. This includes NHS bodies, local authorities, government departments and other agencies and a number of private sector bodies.

During 2021/22 the LCFS has received allegations regarding possible fraudulent behaviour and has investigated the matters accordingly whilst working in conjunction with the relevant departments throughout the Trust where appropriate. As a result of the investigations the LCFS undertook, no criminal action was taken in any of the reported matters.

2.3.11 AVERAGE STAFF NUMBERS

Table 2.3L – Average staff numbers for 2021/22

Average number of employees (Whole Time Equivalent basis)	Permanent (Number)	Other (Number)	Total Number (2021/22)	Total Number (2020/21)
Medical and dental	191	25	216	204
Administration and estates	687	48	735	679
Healthcare assistants and other support staff	664	271	935	879
Nursing, midwifery and health visiting staff	793	53	846	811
Scientific, therapeutic and technical staff	394	2	396	344
Social care staff	28	0	28	23
Total average numbers	**2,757**	**399**	**3,156**	**2,940**
Of which: Number of employees (WTE) engaged on capital projects	0	0	0	0

2.3.12 GENDER PROFILE OF OUR TRUST

Table 2.3M - The gender profile for the Trust as at end March 2022

Group	Number male	Number female	Total
Directors	5	8	13
Senior managers (Band 8 and above)	92	222	314
Employees	741	1975	2716

2.3.13 GENDER PAY GAP INFORMATION

The gender pay gap shows the differences in average pay between men and women. The gender breakdown of our workforce is 73% female and 27% male. The national median gender pay gap for large employers according to the 2021 Office for National Statistics Annual Survey of Hours and Earnings was 15.4% in favour of men. In 2021 the Trust's median pay gap figure was substantially below this figure at 5.3%.

We continue to undertake actions to address the gender pay gap through promoting opportunities for flexible working, shared parental leave, career progression, promotion, and leadership development opportunities.

Details of the Trust's gender pay gap data can be found on the Cabinet Office website using the following link: https://gender-pay-gap.service.gov.uk/

2.3.14 ANALYSIS OF STAFF COSTS

Table 2.3N – Analysis of staff costs for 2021/22

Average number of employees (Whole Time Equivalent basis)	**Permanent (£000)**	**Other (£000)**	**Total £000 (2021/22)**
Salaries and wages	100,210	11,777	111,987
Social security costs	10,734	0	10,734
Employer's contributions to NHS pensions	13,774	0	13,774
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	6,020	0	6,020
Apprenticeship Levy	538	0	538
Agency staff	0	9,261	9,261
Employee benefits expense	**131,276**	**21,038**	**152,314**
Of which: Charged to capital			0
Recharged to income			(270)
Total employee costs			152,044

2.3.15 OFF-PAYROLL ENGAGEMENTS

The Trust's policy in relation to off payroll engagements includes:

Off-payroll arrangements are those where individuals, either self-employed or acting through a personal service company, are paid gross. While off-payroll arrangements may sometimes be appropriate for those engaged on a genuinely interim basis, they are not appropriate for those in management positions or those working for a significant period with the same employer.

The Trust acknowledges that off payroll engagements may sometimes be appropriate and beneficial. It is therefore important that these engagements are transparent and are open to scrutiny in the event of challenge.

Off payroll engagements should only be made via the Procurement Team, with an authorised requisition and purchase order in place. Under no circumstances should Trust employees engage with any agency or individual (Personal Service Company) directly without consultation with the Procurement Team.

In all circumstances appropriate contracts and/or framework agreements should be in place between the Trust and either the individual, agency or personal service company. All contracts and/or framework agreements should include a clause giving the Trust the right to seek assurance in relation to income tax and national insurance.

In addition, the appointing manager is required to undertake a risk assessment as to whether or not assurance needs to be sought that the individual is paying the right amount of tax and national insurance. This applies to all circumstances and a proforma for this is included in the policy.

The following table sets out all highly-paid off-payroll worker engagements as at 31 March 2022, earning £245 per day or greater

Table 2.3O

Number of existing engagements as of 31 March 2022	22
Of which:	
The number that have existed for less than one year at the time of reporting	20
The number that have existed for between one and two years at time of reporting.	6
The number that have existed for between two and three years at time of reporting.	3
The number that have existed for between three and four years at time of reporting.	1

The following table relates to all highly-paid off-payroll workers engaged at any point during the year ended 31 March 2022, earning £245 per day or greater.

Table 2.3P

Number of off-payroll workers engaged during the year ended 31 March 2022	35
Of which:	
Not subject to off payroll legislation	35
Subject to off-payroll legislation and determined as within the scope of IR35	0
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

All of the above were sourced through employment agencies.

The following table shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2021 and 31 March 2022.

Table 2.3Q

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

2.3.16 STAFF EXIT PACKAGES

These reporting requirements cover the total costs of exit packages agreed in the year. They include payments under the Civil Service Compensation Scheme (CSCS), payments under any other compensation schemes where applicable, e.g. other Non-departmental Public Bodies (NDPBs) and any other payments made.

Exit packages for Board members are included above with further detail in the Directors' Remuneration Report. There was no exit package agreed relating to a Board member in 2021/22 (one in 2020/21).

The Remuneration Report provides specific details of exit payments payable to individuals named in that report.

Table 2.3R

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	1 (0)	7 (9)	8 (9)
£10,001 - £25,000	1 (0)	2 (3)	3 (3)
£25,001 - £50,000	1 (0)	0 (0)	1 (0)
£50,001 - £100,000	0 (0)	0 (0)	0 (0)
£100,001 - £150,000	0 (0)	0 (1)	0 (1)
£150,001 - £200,000	0 (0)	0 (0)	0 (0)
Greater then £200,000	0 (0)	0 (0)	0 (0)
Total number of exit packages by type	**3 (0)**	**9 (13)**	**13 (13)**
Total resource cost (£000)	**53 (0)**	**65 (175)**	**118 (175)**
Note: Figures in brackets relate to 2020/21			

2.3.17 NON-COMPULSORY / OTHER DEPARTURES AGREED

Table 2.3S

	Agreements (number)	Total value of agreements (£000)
Voluntary redundancies including early retirement contractual costs	0 (1)	0 (30)
Mutually agreed resignations (MARS) contractual costs	0 (0)	0 (0)
Early retirements in the efficiency of the service - contractual costs	0 (0)	0 (0)
Contractual payments in lieu of notice	9 (13)	65 (145)
Exit payments following Employment Tribunals or court orders	0 (0)	0 (0)
Non-contractual payments requiring HMT approval	0 (0)	0 (0)
Total	**9 (14)**	**65 (175)**
Of which: Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0 (0)	0 (0)
		Figures in brackets relate to 2020/21

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above may not necessarily match the total numbers in Table 2.3N (staff exit packages), which will be the number of individuals.

Non-contractual payments requiring HMT approval includes any non-contractual severance payment made following judicial mediation and any non-contractual payments in lieu of notice.

The Remuneration Report provides specific details of exit payments payable to individuals named in that report.

2.3.18 EXPENDITURE ON CONSULTANCY

Details of our expenditure on consultancy can be found in Note 5 of the Annual Accounts in Part B of Annual Report.

2.3.19 MENTAL HALTH ACT MANAGERS

2.3.19.1 The role and remit of the Mental Health Act Managers

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)
- Discharge those service users who no longer meet the criteria to be detained or are subject to a CTO.

The Board has a Mental Health Legislation Committee as a sub-committee of the Board. During 2021/22 this committee was chaired by a non-executive director. Andrew Marran chaired the committee until he stepped down in September 2021 and then Sue White became chair. The committee met four times during 2021/22. Meetings have been attended by members of the committee supported by members of the Mental Health Legislation Team. All meetings held during the reporting period were held remotely via Zoom.

Providing assurance to the committee is the Mental Health Act Manger's Forum. The forum is chaired by a non-executive director and/or the lead Mental Health Act Manager to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice. This seeks to provide a forum for communication between the committee, the Mental Health Act Managers and the officers of the Trust. It provides a mechanism for assurance on, the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983.

The Mental Health Act Managers Forum was chaired jointly by Andrew Marran, Non-executive Director, Sue White, Non-executive Director, and Marilyn Bryan, lead Mental Health Act Manager and Deputy Chair of the Forum. In 2021/22 the Forum met twice on 12 May 2021 and 19 August 2021. All meeting were held remotely via Zoom.

2.3.19.2 Mental Health Act Managers who have served in 2021/22

We currently have 31 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2021/22.

Table 2.3T - Mental Health Act Managers during 2021/ 22

Mental Health Act Managers during the period 1 April 2021 to 31 March 2022		
Bernadette Addyman	Nasar Ahmed	Marilyn Bryan
Rebecca Casson	Aqila Choudhry	Judith Devine
John Devine	Michael Hartlebury	Ian Hughes
Peter Jones	Trevor Jones	Andrea Kirkbride
Harold Kolawole	Susan Mosley	Graham Martin
Claire Morris	Ismail Patel	Gillian Nelson
Shamaila Qureshi	Andrea Robinson	Debra Pearlman
Susan Smith	Niccola Swan	Alex Sangster
Claire Turvill	Viv Uttley	Jeffrey Tee
Janice Wilson	Tom White	Michael Yates
Paul Yeomans		

Table 2.3U - Non-executive directors acting as Mental Health Act Managers during 2021/22

Non-executive directors also acting as Mental Health Act Managers during the period 1 April 2021 to 31 March 2022		
	Andrew Marran	

We are appreciative of the time and commitment that Mental Health Act Managers and non-executive directors acting as Mental Health Act Managers have given this year. Once again we wish to thank our Mental Health Act Managers for their dedication and the skill they apply when undertaking this vital role.

2.3.20 DIVERSITY AND INCLUSION POLICIES

Our commitment to establishing a positive culture which promotes diversity and inclusion through narrowing inequality gaps, openly addressing discrimination and ensuring that all our people have a voice, is set out in our People Plan 2021 to 2024, which can be found on the Trust website using the following link:

https://www.leedsandyorkpft.nhs.uk/news/articles/lypft-launches-its-dynamic-new-people-plan/

In 2021/22 we have continued to build upon work to develop an inclusive and compassionate leadership community through the development of a collaborative leadership programme for our senior leaders.

We have also completed a twelve-month Reciprocal Mentoring Programme between colleagues from diverse ethnic backgrounds and our Board in order to increase inclusive leadership learning and challenge thinking through personal insight and personal growth. We aim to roll this out more widely across the organisation.

To address disparities in our recruitment and employer relations processes, the Trust has introduced the Cultural Inclusion Ambassadors (CIA's) programme in partnership with the Royal College of Nursing. We have appointed nine CIA's who are colleagues from across our workforce. Their focus is to support, advise and constructively challenge on employee relations and recruitment processes to bring about real cultural change.

We have process mapped recruitment against three stages; attraction, selection and retention to further understand current approaches to identify gaps and to make improvements to our recruitment processes, particularly for our black and minority ethnic and disabled applicants and staff. We will continue to work in partnership with the West Yorkshire ICS to collectively share and take forward ideas and learning.

Our staff networks play a key role in influencing and driving our equality and inclusion strategic direction and plans. We have strengthened the role of our staff networks to increase their contribution to decision making processes and to provide a collective voice to inform and support organisational learning and cultural change. Celebrating awareness days and months, such as Disability History Month, Black History Month and LGBT+ History Month with programmes of activities and events aimed at increasing visibility and understanding.

Although our strategy and approaches are further developed, our current workforce disability and ethnicity data and experiential feedback identify marked differences in experience and outcomes. There will be a continued focus on the development of collective and inclusive leadership cultures, with clear focus on improvement and advancing equality of opportunity, to drive change.

2.3.21 STAFF TURNOVER

Details of the Trust's staff turnover data can be found on the NHS Digital website using the following link:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/december-2020#resources

SECTION 2.4 – ACCOUNTABILITY REPORT (Disclosures required in the Annual Report)

2.4.1 COMPLIANCE WITH THE CODE OF GOVERNANCE

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The NHS Foundation Trust Code of Governance (the Code) is published by NHS Improvement (previously Monitor). The purpose of the Code is to assist foundation trust boards with ensuring good governance and to bring together best practice from public and private sector corporate governance.

2.4.1.1 Comply or explain

The Code is issued as best practice, but also contains a number of main principles, supporting principles and code provisions on a 'comply or explain' basis. The Leeds and York NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

A full review of compliance with the Code is submitted to the Audit Committee on an annual basis to support this statement. A copy of the full report to the Audit Committee is available on request from the Associate Director for Corporate Governance. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Audit Committee for approval and to support this statement that the Trust continues to comply with the principles of the Code with the exceptions as listed in the table below.

Table 2.4A – Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust. The current best practice is for a three- to five-year period of appointment.	The Trust's auditors are normally appointed for a period of three years with an option to extend for a further two – subject to the Council of Governors' approval. **EXPLAIN** The Trust's external auditors were appointed by the Council of Governors in 2017 for a period of three years and this appointment was then extended for a further two years. In February 2022, the Council of Governors approved the extension of the current arrangements by exception for both 2022/23 and 2023/24. This was due to significant risks in the External Audit market. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust. Individuals within the External Audit Team are regularly refreshed to ensure independence.

Code provision	Requirement	Explanation
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if asked. The Remuneration Committee has agreed that the pension rights for executive directors will be determined by the NHS Pension Scheme. **EXPLAIN** The staff on the next level down are paid under the NHS Agenda for Change pay structure and are therefore not within the remit of the Remuneration Committee. However, the only time the salaries of staff on agenda for change would be taken account of by the Remuneration Committee would be in ensuring this is sufficient differential between those on VSM and their direct reports.

2.4.2 DISCLOSURE STATEMENTS TO BE MADE IN THE ANNUAL REPORT

The Code contains a number of disclosure statements that the Board is required to include in the Annual Report. The disclosure statements contained in the Annual Report are based on the 2014 version of the Code of Governance, and the table below shows how the Board has complied with those disclosures that it is required to include in this Annual Report.

The table below also includes a small number of specific additional requirements as set out in the NHS Foundation Trust Annual Reporting Manual, which directly relate to, or enhance the annual reporting requirements as set out in the NHS Foundation Trust Code of Governance.

Table 2.4B – How we have complied with the disclosures we are required to report on in the Annual Report

Code provision	Requirement	Section in Annual Report
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	Section 3.1 (Board of Directors) Section 4.4 (Council of Governors)
A.1.2	The Annual Report should identify the: • Chairperson and the deputy chairperson (where there is one) • Chief Executive • Senior Independent Director • Chairperson and members of the Nominations Committee and the number of meetings and attendance by directors • Chairperson and members of the Audit Committee and the number of the meeting and attendance by directors • Chairperson and members of the Remuneration Committee and the number of the meeting and attendance by directors • Number of meetings of the Board and individual attendance by directors.	Section 2.1.1 Section 2.1.1 Section 2.1.1 Section 2.2.4.4 Section 3.6 Section 2.2.4.2 Section 3.4

Code provision	Requirement	Section in Annual Report
A.5.3	The Annual Report should identify: • The members of the Council of Governors • A description of the constituency or organisation that governors represent, whether they were elected or appointed, and the duration of their appointments • The nominated lead governor.	Tables 4B and 4C in Section 4.1 Table 4B and 4C in Section 4.1 Section 4.1
Annual Reporting Manual additional disclosure	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	Table 4H in Section 4.3 and table 4I in Section 4.5
B.1.1	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent, with reasons if necessary.	Section 2.1.1
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	Section 3.3 Section 2.1.1
Annual Reporting Manual additional disclosure	The Annual Report should include a brief description of the length of appointments of the non-executive directors, and how they might be terminated.	Section 2.1.1
B.2.8	The Annual Report should describe the process followed by the Council of Governors in relation to appointments of the chairperson and non-executive directors.	Section 2.2.4.3
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	Section 2.2.4.3 (Appointments and Remuneration Committee) Section 2.2.4.4 (Nominations Committee)
Annual Reporting Manual additional disclosure	The disclosure on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of the chair or non-executive director.	Not applicable, open advertising and external search companies are used in NED recruitment campaigns.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	Section 2.1.1 and 3.3

Code provision	Requirement	Section in Annual Report
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	Section 1.1.4.1
Annual Reporting Manual additional disclosure	If during the financial year the governors have exercised their power under paragraph 10c of Schedule 7 of the NHS Act 2006 then information on this must be included in the Annual Report (power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).	This power has not been exercised during the course of the financial year
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the • Board • Board committees • Directors including the chairperson, has been conducted.	Section 2.2.3.2 Section 3.5.2 Section 2.2.3.2
B.6.2	Where there has been external evaluation of the board and or governance of the Trust, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the trust.	Section 2.1.7
C.1.1	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and accounts, and state that they consider the Annual Report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	Section 2.1
C.1.1	Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	Section 2.7
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	Section 2.7(Annual Governance Statement)
C.2.2	The trust should disclose in the Annual Report if it has an internal audit function, how the function is structured and what role it performs.	Section 6.2
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, re-appointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable

Code provision	Requirement	Section in Annual Report
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	Section 3.6
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the Annual Report.	For governors, section 5.5 For directors section 3.3
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	Section 4.5
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	Sections 5.3 and 5.4
Annual Reporting Manual additional disclosure	The Annual Report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • Information on the number of members and the number of members in each constituency • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	Section 5.1 Section 5.2 Section 5.3 and 5.4
Annual Reporting Manual additional disclosure	The Annual Report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	Governors = Section 4.7 Directors = Section 2.1.2

2.4.3 DISCLOSURES AS PER SCHEDULE 7 OF THE LARGE AND MEDIUM SIZED COMPANIES AND GROUPS REGULATIONS 2008

This section sets out those disclosures required as per Schedule 7 of the Large and Medium Sized Companies and Groups Regulations 2008 and where these have been reported.

Table 2.4C – Disclosures and where they are reported in the Annual Report

Disclosure requirement	Statutory reference	Section in which reported
Any important events since the end of the financial year affecting the NHS foundation trust	7(1) (a) Schedule 7	There have been no significant events after the year end
An indication of likely future developments	7(1) (b) Schedule 7	Section 1.1.7.2
An indication of any significant activities in the field of research and development	7(1) (c) Schedule 7	See the Trust's Quality Report
An indication of the existence of branches outside the UK	7(1) (d) Schedule 7	Not applicable, no disclosure required
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities	10(3) (a) Schedule 7	Section 2.3.2
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period	10(3) (b) Schedule 7	Section 2.3.2
Policies applied during the financial year for the training career development and promotion of disabled employees	10(3) (c) Schedule 7	Section 2.3.2
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	11(3) (a) Schedule 7	Section 2.3.4 Section 2.3.6
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	11(3) (b) Schedule 7	Section 2.3.4
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	11(3) (c) Schedule 7	Section 2.3.4 and 2.3.6
Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust	11(3) (d) Schedule 7	Section 2.3.6
In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash-flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	6 Schedule 7	Section 1.2.2

SECTION 2.5 – ACCOUNTABILITY REPORT (NHS Oversight Framework)

2.5.1 NHS OVERSIGHT FRAMEWORK

NHS England and NHS Improvement's System Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care, access and outcomes
- Finance and use of resources
- People
- Preventing ill health and reducing inequalities
- Leadership and capability.

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers with serious and complex issues, and '1' reflects providers who are consistently high performing across the 5 areas above. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

2.5.2 SEGMENTATION

Segmentation enables NHS England and Improvement to take an overview of the level and nature of support required across the provider sector, and to target its support capacity as effectively as possible. During 2021/22 the focus was on trusts that met the criteria for segments 3 and 4. The default position being segment 2. NHS England and Improvement has assessed Leeds and York NHS Foundation Trust as segment 2.

There are no enforcement actions placed upon the Trust by NHS Improvement and no actions are being taken or proposed by the organisation. This segmentation information is the Trust's position as of 31 March 2022.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website with benchmarking available via the Model Health System, a data-driven improvement tool that supports health and care systems to improve patient outcomes and population health.

2.5.3 FINANCE AND USE OF RESOURCES

The Finance and Use of Resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Table 2.5A

Area	Metric	2021/22				2020/21			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	2	3	3	2	3	2	3	3
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin	1	2	2	1	2	1	3	3
Financial controls	Distance from financial plan	1	1	2	1	1	1	2	2
	Agency spend	2	3	1	1	3	3	3	2
Overall scoring		1	2	2	1	2	2	2	2

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Accountability Report (made up of sections 2.1 to 2.5 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed: Date: 16 June 2022

Dr Sara Munro
Chief Executive

SECTION 2.6 – STATEMENTS

2.6.1 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of [name] NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care's Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signed

Date: 16 June 2022

Dr Sara Munro
Chief Executive

SECTION 2.7 – ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2021 to 31 March 2022.

2.7.1 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2.7.2 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 Leeds and York Partnership NHS Foundation Trust, 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 Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2022 and up to the date of approval of the Annual Report and Accounts.

2.7.3 CAPACITY TO HANDLE RISK

The Board of Directors has overall responsibility for the governance of the Trust. It provides high-level leadership for risk management. The directors (both executive and non-executive) have appropriate skills and experience to carry out this function effectively and each member of the Board of Directors has corporate and joint responsibility for the management of risk across the organisation.

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The cycle of Board meetings continues to ensure that it devotes sufficient time to setting and monitoring strategy and having oversight of the key risks to achieving the strategic objectives. The Board also monitors performance against key targets and measures and considers any risks to achieving these.

A Board sub-committee structure is in place and includes the: Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, Workforce Committee; and an Audit Committee. Each has delegated responsibility for monitoring risk within their areas of responsibility, including receiving the Board Assurance Framework in accordance with their terms of reference.

The Director of Nursing, Quality and Professions has overall lead responsibility for the development and implementation of a framework of organisational risk management, they also have responsibility for the management of risk of infection prevention and control and their portfolio incorporates the role of the Director for Infection Prevention and Control (DIPC). However, all executive directors have a duty to effectively manage risk within their own area of responsibility. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk (including oversight for counter-fraud). Within their portfolio, the CFO also has the role of Senior Information Risk Officer (SIRO); and the Medical Director is the Caldicott Guardian and the Deputy Medical Director is the Responsible Officer. The responsibility for risk management is communicated to all staff through their job descriptions and a compulsory training module.

2.7.3.1 Staff training

The organisation provides compulsory training for all staff to complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place. We have a process for monitoring the uptake of compulsory training through a system called iLearn. The Interim Director of People and Organisational Development oversees performance, and assurance reports are made to the Workforce Committee on performance against our target measures.

Risk management training and awareness is included in the compulsory health and safety training and is supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust. The role of individual staff in managing risk is supported by a framework of policies and procedures that promotes learning from experiences and sharing good practice.

The Board also receives training on risk through bespoke training sessions which address their legal and statutory responsibilities as a Board member.

2.7.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards. It uses all such reports as an opportunity to learn and improve. All reported incidents are reviewed by an assigned manager who reviews, completes and approves the incident, any required additional support is offered to the relevant teams and any learning is identified including good practice.

The Learning from Incidents and Mortality Meeting (LIMM) reviews all level 4 (serious harm) and level 5 (death) incidents reported via Datix. Any deaths are coded in accordance with the Mazar tool. The LIMM membership agrees the required level of investigation, progress of which is monitored through that group or other appropriate forums within the Trust's governance structure. The work of LIMM identifies themes and trends and where appropriate will provide links to the mortality review process (Structured Judgement Reviews).

LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly. TIRG has responsibility for reviewing in detail all serious incident reports, with the aim of agreeing that the recommendations and actions from the relevant reviews are appropriate.

The Trust also seeks additional learning opportunities through the identification and sharing of good practice, both internal and external to the Trust, including: benchmarking; clinical supervision; reflective practice; individual and peer reviews; continuing professional development programmes; clinical audit; the application of evidence-based practice; and the application of robust Health and Safety processes. Points of learning from any of these sources and potential changes in clinical practice are reviewed as necessary by the Trustwide Clinical Governance Group with assurances being made to the Board through the Quality Committee.

Whilst in business continuity in January and February 2022, noting the pressures on clinically based colleagues we made temporary changes to the LIMM and Serious Incident processes. These changes provided continued organisational oversight of any deaths reported within the Trust and ensured that appropriate action was taken to review and learn from these thereby maintaining the Trust's commitment to patient safety.

2.7.3.3 NHS Litigation Authority risk management standards

The Trust is committed to the effective and timely investigation of any claims and subsequent response to any claim. The Trust is a member of NHS Resolution (previously NHS Litigation Authority) a claims management scheme. As a member, it respects the requirements and notes the recommendations of the Department of Health and Social Care and of NHS Resolution and its claim handling schemes. The components of the scheme are set out below:

- Clinical negligence claims against the Trust are covered by NHS Resolution's Clinical Negligence Scheme for Trusts (CNST). The Trust is the legal defendant, however, the NHSR takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by NHS Resolution's Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims, from straightforward slips and trips in the workplace to serious manual handling, bullying and stress claims. In addition LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act
- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by NHS Resolution's RPST Property Expenses Scheme (PES).

2.7.3.4 Work performed to assess Well-led

The Board is required to carry out an independent review of governance against the well-led framework every three years. In 2021/22 Deloitte LLP carried out a Well-led Governance and Leadership Review which built on their findings and recommendations from the 2017 review.

Their approach was as follows:

- Undertaking a desktop review of relevant Trust documentation which included Board and sub-committee papers
- Distributing and analysing a Board survey which was completed by all Board members and the Associate Director for Corporate Governance. This focused on the effectiveness of the Board
- Undertaking virtual non-attributable interviews with each member of the Board and the Associate Director for Corporate Governance
- Observing Board and sub-committee meetings
- Undertaking four virtual staff and service line leadership focus groups to obtain the views of both clinical and non-clinical staff from the organisation
- Undertaking a virtual focus group with members of the Council of Governors to obtain their views on the current governance and leadership arrangements at the Trust.
- Obtaining the views of external stakeholders via telephone interviews.

Deloitte then assessed this information against the key findings and recommendations from the 2017 review and undertook benchmarking activity against the newly revised CQC Well-led Framework. The detailed outcome of the review was presented to the Board of Directors in January and March 2022.

The report concluded that since the independent review of governance arrangements undertaken in May and October 2017 the Trust had made good progress against many of those recommendations although it outlined some areas where further work was required. It noted this progress had been made within the context of a move towards Integrated Care Systems and also the COVID-19 pandemic, which inevitably had impacted on the Trust's ability to make progress against some of those recommendations.

In regard to the benchmarking against the revised CQC Well-led Framework there were 9 further recommendations. Progress against these were presented to the March private Board meeting and will continue to be monitored through the Board's governance arrangements.

The Board can report there are no material inconsistencies between the Annual Governance Statement, the Corporate Governance Statement and the information within the Annual Report. It can also be reported that the Trust was rated overall 'good' in the last CQC inspection with the well-led domain also being rated as 'good'.

2.7.4 THE RISK AND CONTROL FRAMEWORK

The Trust has in place a comprehensive Risk Management Policy which is published on Staffnet and available to all staff. The purpose of this policy is to ensure the Trust manages risks in all areas using a systematic and consistent approach. It provides the framework for a robust risk management process throughout the Trust. The document describes the Trust's overall risk management process and the Trust's risk identification, evaluation and control system.

All risks are assessed using an electronic system (DATIX) for recording and managing risk assessments, which can be accessed through Staffnet. This system is used by staff to assess and record risk assessments, scoring risks using a 5 x 5 assessment of likelihood and impact. Risks are then captured on the appropriate risk register which could be local, service line, corporate or strategic. We have in place an Executive Risk Management Group which is chaired by the Chief Executive. This monitors risks, in particular those scoring 15+.

Local and service line level risks are discussed and reviewed within the appropriate operational or clinical governance meetings to ensure that appropriate and timely mitigation is in place. Where actions require escalation there should be a discussion within the operational or clinical governance meeting to identify the appropriate forum in which to raise issues and seek further support.

Clinical risk management is based on a structured clinical assessment model and supported by decision-making aids.

2.7.4.1 The Board Assurance Framework

The Board Assurance Framework (BAF) is one of the key risk assurance tools for the Board. It contains the principal risks to the achievement of the organisation's strategic objectives, which are taken from the strategic risk register. It also sets out the Board's risk appetite in relation to those risks. The BAF enables the Board, primarily through its Board sub-committee structure, to monitor the effectiveness of the controls required to minimise the principal risks to the achievement of the Trust's objectives and therefore provides evidence to support this Annual Governance Statement.

The BAF is regularly reviewed by the Board and the Audit Committee. The relevant sections of the BAF are also reviewed by the Board sub-committees for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with 'significant assurance' being given to its governance process.

During the pandemic the scores for the strategic risks on the BAF were increased to reflect the risk posed by Covid-19 on the potential to achieve our strategic objectives. A decision was taken not to add a specific risk relating to the pandemic, but to manage any day-to-day risks through the incident command governance structure, specifically Gold Command.

2.7.4.2 Quality governance arrangements

The Trust has established a Governance, Accountability, Assurance and Performance Framework which sets out the organisation's overarching principles and approach to delivering a quality service in a high performing organisation. The framework aims to ensure the Trust successfully delivers national standards for governance and performance through clear lines of accountability.

The framework describes how the Trust will use improved information management, alongside clear governance and accountability in order to deliver better performance. This will be achieved through the introduction of a tiered performance management process which demonstrates rigour, support, challenge, timely escalation and a consistent approach to clinical governance and performance management at all levels of the organisation. It uses the approach set out in the System Oversight Framework from NHS Improvement.

The underpinning principles of the framework are also aligned with the Trust's strategy, values and behaviours and the Care Quality Commission's Key Lines of Enquiry (KLoE).

The Trust is registered with the CQC and is fully compliant with the registration requirements. Compliance with the CQC essential standards of quality and safety are one of the elements of the organisation's risk management process.

To manage any risk of non-compliance with CQC registration the Director of Nursing, Quality and Professions has established a process for monitoring progress against the CQC action plan which will identify any risks that require immediate action. During the Covid-19 pandemic this has involved one-to-one meetings with action leads to monitor progress. Actions from the CQC inspection are to be included in the Trusts Quality and Safety Peer Review process to ensure that all actions are embedded and sustained.

Following a CQC inspection we will take a Trustwide view of the themes and have a holistic approach to resolving any issues and reducing the risk of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a process for carrying out Quality and Safety Peer Reviews to improve, share and embed best practice around the Trust. This process was stood down during the Covid-19 pandemic but has been relaunched in 2022. The aim of the Quality and Safety Peer Review's is to improve care for the people we serve by ensuring our services are as safe as possible, improving the quality and effectiveness of care, improving the patient and carer experience and providing development and learning for all involved. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we will identify areas for improvement, risks to service delivery and areas of good practice.

2.7.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist (LCFS) in accordance with the standards set out in the provider contracts.

Our LCFS has conducted work across all generic areas of counter-fraud activity, placing emphasis on the continued anti-fraud culture within our Trust and the prevention of fraud. Presentations at staff induction sessions and to selected groups of staff have been undertaken. The LCFS has continued to be proactive in their work and our staff have continued to be alerted to potential and real fraud risks.

2.7.4.4 Principal risks to compliance with licence Condition 4.2 of FT4 (FT Governance)

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services.

Our arrangements include a governance structure with four locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Performance Committee, the Mental Health Legislation Committee and the Workforce Committee). This ensures that members of the Board (particularly non-executive directors) are assured of the governance of the organisation and are assured on the quality of services (clinical and non-clinical). There is also a comprehensive governance and management structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios and support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and its sub-committees have agreed terms of reference setting out the accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including a constitution,

a scheme of delegation and matters reserved to the Board. The Trust also has a Corporate Governance Strategy which describes the framework for corporate governance and which references all the documents that sit within that framework. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a signed memorandum of understanding between the Chair and Chief Executive, setting out their respective responsibilities. All Board members have been deemed to be Fit and Proper in accordance with the CQC standard.

In accordance with its cycle of business the Board receives reports from executive directors that details compliance with, and achievement of, regulatory, contractual and local targets. The Board and its sub-committees receive timely and accurate information at each of their meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised. Performance is also reported to the Council of Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

2.7.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2021/22 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the Audit Committee for assurance about the process. The Board received the Corporate Governance Statement and agreed how it would declare against the standards.

2.7.4.6 Stakeholders and partners

The Trust involves stakeholders and partners in identifying and managing risks to its strategic objectives in a number of ways. These include:

- Working in partnership to develop system-wide plans with stakeholders across Leeds and West Yorkshire through the Integrated Care System (ICS) and Leeds Place-based Partnership processes.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Learning Disability and Autism Collaborative and its Committees in Common)
- Working with partners in health and social care services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change
- Active engagement with governors on strategic, service, and quality risks and changes including the setting of strategic priorities.

2.7.4.7 NHS Pension Scheme control measures

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's regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments to 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.

2.7.4.8 Equality, diversity and human rights control measures

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. The Board has arrangements in place to ensure that the Trust complies with the Equality Act 2010. It has approved equality objectives and an annual equality progress assessment is undertaken using the Equality Delivery System framework. These arrangements go beyond those required in statute, and provide a comprehensive system of support,

understanding, participation and scrutiny in relation to equality and diversity; including a dedicated resourced Equality and Inclusion Team.

The Chair of the Trust is the non-executive director champion for equality, diversity and inclusion. She has oversight of this from the Board's perspective and will ensure that Board agendas adequately reflect the discussions that need to be taken at a strategic and Board level in relation to equality, diversity and inclusion.

As national data on those affected by Covid-19 started to emerge, the disproportionate impact on people of colour was made clear. We are committed to addressing matters of racial discrimination, injustice and prejudice. We started to have important, but sometimes challenging conversations in the Trust about these matters. Led by the Workforce Race Equality Network (WREN), we worked together to challenge and address inequalities in our Trust. This work has been complimented by a Reciprocal Mentoring programme bringing together staff from ethnic minority communities and Board members. Our equality and diversity agenda is supported by the Trust's participation in the national programme called the Synergi Collaborative which is gathering information and developing ideas to address this challenge.

We have in place systems for monitoring equality progress and compliance against our People Plan 2021 - 2024 through the Workforce Committee, which also includes reporting to the Board on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report. We have invested in our WREN Network to ensure people have a place where they can participate in discussion, ensuring equality of access within the workforce and that we meet the Workforce Race Equality Standards.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Equality analysis screening is required for all papers presented to governance meetings and for all new and revised procedural documents.

Alongside the arrangements we have in place for ensuring equity and diversity in the workforce, the Quality Committee receives assurance on how we are improving outcomes for service users from ethnic minorities, learning disability service users as well as those from disadvantaged groups. The committee has also discussed equality of access to our services by diverse communities and how we and can make our services both more accessible and ensure the needs of service users from ethnic minorities are met whilst an inpatient. Our Mental Health Legislation Committee receives reports on understanding why there are a disproportionate number of service users from ethnic minorities within our crisis service and detained under the Mental Health Act. Assurance on the matters discussed at the committee meetings is provided to the Board through Committee Chair's reports with any matters of concern being escalated to the Board through those reports.

2.7.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. There is an executive lead with oversight of the sustainability agenda and we also have a non-executive director champion in place to provide a further level of assurance to the Board. In 2021/22 we published our Green plan which will help us support the achievement of a 'Net Zero' NHS.

2.7.4.10 Workforce

Our People Plan 2021/2024 sets out our longer-term vision and ambitions as well as the annual priorities and deliverables. We have undertaken an active role in the NHS Improvement Retention cohort with the objective of reducing our turnover, and improving our recruitment processes, career pathways and career development for nurses and Allied Health Professionals. We have also revised a number of our practices to improve access to substantive opportunities including implementing a guaranteed job scheme for our student nurses, a more flexible Retire and Return policy, and implementation of a fast-track bank to substantive recruitment process. Part of our People Plan is to increase the quality and grow our internal bank to reduce reliance on agency staff. Our workforce requirements and performance are effectively managed through the workforce governance structure

made up of a range of focused operational groups which identify short and long term workforce requirements, solutions to meet immediate needs, and undertake long term job planning in relation to the development of new roles. The performance against workforce metrics is scrutinised by the Workforce Committee, the chair of which makes a report to the Board of Directors.

We recognise that some of our wider workforce challenges are best met by working in partnership. We are already working collaboratively within both Leeds and in the West Yorkshire ICS on shared leadership and development programmes; workforce planning; coaching and mediation services; and promotional recruitment materials to promote working in the NHS. We are also active partners in the development and leadership as part of the West Yorkshire Mental Health Workforce Collaborative.

In 2021/22 the Medical Strategy was supported by the Workforce Committee it also supported the Psychological Professions Strategy. These strategies set out plans for the leadership and development of the workforce within the Trust for the next three years.

We have also appointed a Wellbeing Guardian. This role is fulfilled through Helen Grantham our Non-executive Directors and the Workforce Committee (which she chairs). On behalf of the Board the Wellbeing Guardian holds the executives to account for matters relating to staff wellbeing. The Wellbeing Guardian aligns with nine principles outlined by NHS England / Improvement. Wellbeing is a standing agenda item at each of the Workforce Committee meetings.

2.7.4.11 Non-executive Director Champions

In December 2021, NHSE&I released a guidance document titled *'Enhancing board oversight: a new approach to NED champion roles'*. This recommends that the named individual should be the chair of the relevant Board sub-committee with the requirements of the role being discharged through that committee. In March 2022 it was agreed how the Trust would meet these requirements:

NED champion role	Legal basis	NED / Sub-committee to oversee the NED Champion role	How assurance will be received
Maternity board safety champion	Recommended to all trusts providing maternity services. Please note - while LYPFT does not provide maternity services, it was agreed by the Board in January 2021 that the Quality Committee would carry out the NED Champion role for the Perinatal Service.	• Named champion to be the chair of the Quality Committee. • Requirements of the role to be discharged through the Quality Committee.	• Annual Quality Report from the Perinatal Service. • Assurance and escalation from governance groups.
Wellbeing guardian	Recommended to all trusts.	• Named champion to be the chair of the Workforce Committee. • Requirements of the role to be discharged through the Workforce Committee.	• Wellbeing guardian report presented at every meeting. • Escalations and assurance from governance groups. • Data within the Workforce Performance Report.
Freedom to speak up	Recommended to all trusts.	• Named champion to be the Senior Independent Director. • Requirements of the role to be discharged through the Board of Directors.	• Freedom to Speak Up Guardian update report. • Freedom to Speak Up Guardian Annual Report.

NED champion role	Legal basis	NED / Sub-committee to oversee the NED Champion role	How assurance will be received
Doctors disciplinary	Statutory for all trusts (advisory for foundation trusts).	• Named champion to be the chair of the Quality Committee. • Requirements of the role to be discharged through the Quality Committee.	• Six monthly updates on professional regulatory cases. • Bi-annual employee relations, disciplinary investigations and litigation claims report.
Security management	Statutory for all trusts, excluding foundation trusts.	N/A – applicable to all trusts, excluding foundation trusts.	
Hip fracture, falls and dementia	Recommended to all trusts.	• Requirements of the role to be discharged through the Quality Committee.	• Data within the CQPR • Annual Quality Report from the Older Peoples Services. • Escalations and assurance from governance groups.
Learning from deaths	Recommended to all trusts.	• Requirements of the role to be discharged through the Quality Committee.	• Quarterly Learning from Deaths Report. • Annual Learning from Deaths Report.
Safety and risk	Recommended to all trusts.	• Requirements of the role to be discharged through the Audit Committee.	• Risk Management Annual Report. • Board Assurance Framework.
Palliative and end of life care	Recommended to all trusts but not applicable to LYPFT.	• Requirements of the role to be discharged through the Quality Committee.	• Reports to the Quality Committee.
Health and safety	Recommended to all trusts.	• Requirements of the role to be discharged through the Audit Committee.	• Health and Safety Annual Report. • Health and safety updates to each meeting.
Children and young people	Recommended to all trusts.	• Requirements of the role to be discharged through the Quality Committee.	• Annual Quality Report from the CYPMHS. • Escalations and assurance from governance groups.
Resuscitation	Recommended to all trusts.	• Requirements of the role to be discharged through the Quality Committee.	• Escalations and assurance from governance groups.
Cybersecurity	Recommended to all trusts.	• Requirements of the role to be discharged through the Finance and Performance Committee.	• Quarterly Cyber Security Dashboard.
Emergency preparedness	Recommended to all trusts.	• Requirements of the role to be discharged through the Finance and Performance Committee.	• Emergency Preparedness, Resilience and Response Assurance Standard.

NED champion role	Legal basis	NED / Sub-committee to oversee the NED Champion role	How assurance will be received
			• Emergency Preparedness, Resilience and Response Annual Report.
Safeguarding	Recommended to all trusts.	• Named champion to be Sue Proctor. • Requirements of the role to be discharged through the Quality Committee.	• Safeguarding Annual Report. • Assurance and escalations from Trustwide Safeguarding Group.
Counter fraud	No longer a statutory requirement to designate a NED champion for counter fraud.	N/A The 2004 Counter Fraud Directions included a requirement for NHS trusts to designate a NED Champion for counter fraud. However, these were revoked by the 2017 Directions on Counter Fraud, so there is no longer a statutory requirement to designate a NED champion for counter fraud. It should be noted that the Trust's Local Counter Fraud Specialist attends and submits information to each Audit Committee meeting.	
Procurement	Recommended to all trusts.	• Requirements of the role to be discharged through the Finance and Performance Committee.	• Procurement Plan updates. • NOE CPC update report.
Security management – violence and aggression	Recommended to all trusts.	• Requirements of the role to be discharged through the Workforce Committee.	• Wellbeing guardian report presented at every meeting. • Escalations and assurance from governance groups. • Data within the Workforce Performance Report.

2.7.4.12 Registers of Interests

The Trust has published on its website an up-to-date register of interests including gifts and hospitality for the decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS guidance.

2.7.5 KEY RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks, held on the strategic risk register. These are also set out in our Board Assurance Framework (BAF). Each of these risks has an identified executive director and management lead. These are managed through the risk management, risk register and operational planning processes. They are reported to the Executive Risk Management Group, Board sub-committees and the Board through the BAF. Behind each risk is a detailed risk assessment which sets out the controls and mitigations.

In summary the risks are described as follows:

- SR1 - If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.
- SR2 - There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.

- SR3 - Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.
- SR4 - A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.
- SR5 - Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.
- SR6 - As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.
- SR7 - Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.

During the latter part of 2019/20 the Trust put in place a focused structure of governance to manage the risk to the delivery of services created by the Covid-19 pandemic. This has continued to operate through 2020/21 and 2021/22. Whilst a specific risk for Covid-19 was not entered on the Board Assurance Framework (BAF) the risk ratings of each of the risks listed above reflected the impact the pandemic was having on all areas of the Trust's business. The Board and its sub-committees continue to keep the risks under review at each of their /meetings in order to gain assurances on the actions being taken.

2.7.5.1 Covid-19 Pandemic

During the latter part of March 2020, the Government declared a Level 4 National Incident and took control of the response to the Coronavirus pandemic from the centre. The NHS has remained at Level 4 even when much of the nation has moved to a position of all restrictions being removed.

In line with the national and NHS incident requirements the Trust has in place a 'command and control' structure which allows us to interpret any guidance issued centrally to keep our service users and staff safe.

At the beginning of the pandemic Trust implemented its incident response structure of 'Gold', 'Silver' and 'Bronze' command working within our business continuity arrangements. Senior staff also linked into the structures that had been set up by partners locally and regionally to ensure we all worked together in the most effective way.

At the forefront of all these structures was the safety and protection of our service users and staff which was and continues to be paramount in all considerations of the national guidance. Our staff have worked tirelessly to ensure service delivery continued albeit in different ways.

To keep people safe we continue to hold the majority of our meetings virtually. We are also looking at implementing a hybrid way of working for those staff who can. This builds on the model of working from home for part of the time and bringing teams and people together where necessary. This will allow us to maximise the use of our estate and resources.

Whilst our patient facing staff will continue to provide services face to face we have in place infection prevention measures which will ensure the safety of our service users, staff and visitors as we move into living with COVID and our new ways of delivering our services.

2.7.6 REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

We published our refreshed Trust Strategy for the period 2018 to 2023 in November 2017. This set out our ambitions and plans over five years. Our strategy is relevant and fully aligned with those key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. It is also aligned to the NHS Five Year Forward View and the Mental Health Five Year Forward View. All these plans have been translated into local actions through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

Our Strategy describes what we want to achieve over the five years to 2023 and how we plan to get there. It is designed around three key elements: delivering great care; having a rewarding and supportive workplace; and providing effective and sustainable services.

To enable the delivery of our strategy we have developed a set of strategic plans. These are our delivery plans which provide detailed information about how we will achieve our ambitions and include our plans for: clinical services; estates; health informatics; workforce and organisational development; and quality. Each year we have set out our annual actions for achievement as part of our planning and priorities and in 2021/22 the Board agreed its main areas of focus were workforce, estates and clinical services reset. It has received refreshed plans setting out the priorities and has also received updates on progress.

When operating under the normal financial regime we have a financial strategy. This shows, on a projected basis, what the expected financial performance for the coming year is to be. This is written within a comprehensive process for developing the plan with sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives regular updates through the Finance and Performance Committee.

The Financial Planning Group has been set up to provide routine assurance and oversight related to the quality and financial impact of existing cost improvement schemes. This group normally meets on a bi-monthly basis and is chaired by the Chief Financial Officer. The ongoing process of assessing the actual impact on quality and delivery is routinely undertaken by each responsible directorate management team meetings and escalated through to the Financial Planning Group. All accepted cost improvement plans are presented to a joint meeting of the Quality, Finance and Performance and Workforce Committees where assurance is provided on the rigour of the quality and delivery impact assessment process.

The Trust operates within a well-defined corporate governance framework, with financial governance being set out through a number of documents including the Corporate Governance Policy, Standing Financial Instructions, financial procedures, the Scheme of Delegation and Matters Reserved to the Board of Directors. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets
- Delegation of authority for committing resources
- Performance management
- Achieving value for money.

The Trust receives its core accounting systems and processes from third parties. The main accounting functions are provided by NHS Shared Business Services Ltd. Assurance is provided to the Trust through the Statement of Auditing Standards (SAS) No. 70, prepared by NHS Shared Business Services independent auditors. This internationally-recognised auditing standard signifies that a service organisation has had its control objectives and control activities examined by an independent accounting and auditing firm.

The payroll service is provided by the Leeds Teaching Hospitals NHS Trust (LTHT). Assurance is received from LTHT and its internal auditors regarding both the performance and controls associated with the Electronic Staff Record (ESR) system, which concludes that the payroll function is operational within an environment of effective control.

The structures that have been applied in maintaining and reviewing economy, efficiency and effective use of resources include:

- **The Board of Directors** which receives reports on any significant events or matters that affect the Trust. The Board also receives a Chief Operating Officers' Report at each meeting which reports on performance against the Trust's regulatory, contractual and internal targets and standards; financial reports from the CFO; the Board Assurance Framework; and reports from the Chairs of its sub-committees including the Audit Committee.

- **Internal Audit** (NHS Audit Yorkshire) provides an independent and objective opinion on the degree to which risk management, controls and governance support the achievement of the Trust's objectives. The audit plan is derived from an assessment of risk areas within the Trust and includes all areas where Internal Audit is named in the Board Assurance Framework as a provider of assurance on the effectiveness of key controls.

  In 2021/22 the Internal Audit reports issued in the year have generated an overall opinion of 'Significant Assurance' as detailed in the Head of Internal Audit Opinion. It should also be noted that within 2021/22 there were four reports issued with a 'limited assurance' opinion

    - LY03/2022 Physical Health Monitoring – The objective of the audit was to provide assurance on the compliance with physical health monitoring requirements across the Trust and the arrangements in place for recording, monitoring and reporting on the level of compliance.
    - LY04/2022 Disciplinary and Grievance Procedures – The objective of the audit was to provide assurance on the consistent and timely application of the Disciplinary and Grievance procedures.
    - LY12/2022 Service Users' Money – The objective of the audit was to provide assurance on the effective implementation of the revised 'Service Users' Property Income and Allowances' procedure notes
    - LY16/2022 Care planning and Risk Assessments – The objective of the audit was to assess whether the policies and procedures in place are fit for purpose and to ensure that the clinical risk assessment template and care plan template are being fully completed to the required standards on a timely basis.

  The recommendations made by Internal Audit have been accepted by management and action plans put in place.

- **External Audit** (KPMG) provides audit scrutiny of the annual financial statements, and looks at the Trust's economy, efficiency and effectiveness in its use of resources. External audit also provides assurance through the review of systems and processes as part of the annual audit plan

  The audit team will carry out the audit of the 2021/22 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors. It reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's systems of internal control, including risk management, health and safety and for overseeing the activities of internal audit, external audit and the local counter-fraud services.

  The committee executes this role by approving the annual plans for internal and external audit and counter-fraud; receiving reports and updates against those plans; reviewing risks through the Board Assurance Framework; carrying out deep-dives into any area where further assurance is required on an area of risk

- **Board sub-committee structure** is made up of four locally determined committees; the Quality Committee, the Mental Health Legislation Committee, Workforce Committee and the Finance and Performance Committee; each of which has responsibility for assurance in areas of clinical and financial performance and compliance. The Board also has two further statutory committees: the Nominations Committee and the Remuneration Committee. Each of the Board sub-committees is chaired by a non-executive director, with the Remuneration Committee being made up wholly of non-executive directors.

  The Board sub-committee structure has strong interconnectivity with cross-membership and sharing of information. The committees, through the Chairs' reports, make suggestions as to what issues other committees should receive assurance on which are within their role and remit. Non-executive Directors use information from other sources such as service visits and

sharing stories sessions at Board meetings, to inform their knowledge and understanding of the organisation which informs their questions at meetings or the areas on which sub-committees should receive assurance on.

2.7.7 INFORMATION GOVERNANCE

2.7.7.1 Incidents Relating to Information Governance

The Trust has an obligation to assess information governance / data protection incidents against the NHS Digital methodology and report serious incidents to the Information Commissioner's Office and, for the most serious or large-scale incidents, to the Department of Health & Social Care. Aligned to the Data Protection Act (2018) & UK-GDPR, the NHS Digital incident grading methodology employs a 5 x 5 likelihood versus impact approach, assessing both the likelihood and severity of harm caused.

Since May 2018, incidents are graded as follows:

- Non-Reportable
- ICO Reportable
- ICO Reportable and DHSC Notified

Below is an analysis of our information governance incident reporting records for 2021/22. This shows that no incidents met the reporting threshold in the financial year.

Table 2.7A – Summary of Reportable Incidents involving personal data as reported to the ICO / DHSC in 2021/22

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
N/A	N/A	N/A	N/A	N/A
Further action taken	We will continue to monitor and assess information governance / data protection breaches. When weaknesses in systems or processes are identified, interventions will be undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. A 6-monthly report is made to our Trustwide Clinical Governance Group, highlighting themes, trends, or 'hot spot' teams emerging through our analysis of incident reporting so that lessons can be learned & cascaded through service management structures. We will continue to support information governance training via the national e-learning tool. All staff undertake annual refresher training as a reminder of their information governance obligations and to raise cyber-security awareness. The IG team continues to deliver an induction IG briefing presentation to new starters as part of Trust induction.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from Information Governance (IG), Information, Communication and Technology (ICT), networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of the Information Governance Group. The Group makes assurance reports to the Finance and Performance Committee, thereby maintaining a reporting line to the Board as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Trustwide Clinical Governance Group on a 6 monthly basis.

2.7.7.2 Data security

The Trust recognises that our approach to information security requires both a technical and organisational approach as described in Data Protection Principle (f).

The Trust has a highly developed and mature approach to information governance, which includes high compliance with staff IG training and a comprehensive suite of IG-related procedural documents, giving instruction and regulation to our staff. The Trust deploys the mandatory public sector safeguards

recommended by the HM Government Cabinet Office “Data Handling Procedures in Government”, including the operation of secure network storage, port control and the provision of encrypted digital media, and the encryption of high-risk portable computing resources.

The Trust continues to use NHSmail, facilitating secure digital communications with other NHS partners and the wider public sector and to local partner organisations operating email services with Transport Level Security. NHSmail [SECURE] also gives us secure communication channels to otherwise unsecure e-mail endpoints.

Senior managers in ICT receive the NHS Digital CareCERT broadcasts, to maintain an awareness of current information security threats so that timely and appropriate action can be taken where necessary. We have embedded the use of a CareCERT action tracking solution, with all CareCERT-reported threats recorded, assessed for exposure and potential impact, with solutions tracked, implemented and reported monthly to the IG Group.

The Trust continues to use the national NHS IG Training offering, *Data Security Awareness Level 1*, which contains regularly refreshed content on IG in a healthcare context which has been aligned to UK-GDPR / DPA-2018 and entirely new content on the user aspects of information / cyber security.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership of developing BC/DR plans for their services. Work is continuing to align ICT BC/DR with clinical service system criticality. Our plans are tested using National Cyber Security Centre table-top exercises, with themes chosen as highly relevant to the current threat landscape.

The Trust made an initial self-assessment against the NHS Digital Data Security and Protection Toolkit of ‘Approaching Standards’ at 30 June 2021, as COVID pressures affected the staffing of an external contractor who was essential to our Toolkit compliance. The work was subsequently completed in late 2021. This was supported by an internal audit appraisal of a sample of 13 of the compulsory Assertions – aligned to the new national DSP Toolkit Audit Framework, with an outcome of “Moderate Risk / High Assurance” at audit.

The Trust is currently working towards the submission of the 2021/22 Toolkit, to be finalised with an end date of 30 June 2022, and will once again undertake a round of audit scrutiny, with standards assessed in alignment with the now compulsory national DSP Toolkit Audit Framework.

2.7.8 DATA QUALITY AND GOVERNANCE

The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the System Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed Director of Nursing, Quality and Professions with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to understand challenges within the service lines.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete.

To manage the risk of there being incorrect data, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into patient records’ systems. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in the Quality Report is both accurate and reliable. A data quality warehouse is used to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity.

In March 2020 the Trust transitioned from the PARIS patient information system, to CareDirector. This provided wider functionality in terms of clinical staff recording and accessing patient information. In 2021/22 there was an audit carried out of *Care Director: IT Security & Housekeeping and Data Quality***.** This audit was assessed as having 'Significant Assurance'. However, the executive summary noted that the Trust recognises there was still work to do to embed a culture whereby clinicians and local teams take more responsibility for the quality of data. Further assurances on this are being taken through the Board sub-committee structure to look at progress in respect of this.

2.7.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust 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. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Quality Committee, the Finance and Performance Committee, the Workforce Committee and the Mental Health Legislation Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

2.7.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place. The systems of internal control are designed to ensure delivery of the Trust's goals and strategic objectives and to manage and minimise exposure to risks and no significant internal control issues have been identified.

I am satisfied that the process for identifying and managing risks is robust and dynamic as evidenced above. I am also satisfied that the Trust is doing all it can to mitigate the risks that have been identified and has in place a sufficient system of internal control to manage the strategic and other organisational risks.

Signed

Date: 16 June 2022

Dr Sara Munro
Chief Executive

SECTION 3 – THE BOARD OF DIRECTORS (further information)

3.1 INTRODUCTION

The Board of Directors is the body legally responsible for the day-to-day management of the organisation and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of our strategy. It has a duty to ensure the provision of safe and effective services for our service users. It does this by having in place effective governance structures and by:

- Establishing and upholding our values and culture
- Setting the strategic direction
- Ensuring we provide high quality, safe, effective and service user focused services
- Promoting effective dialogue with our local communities and partners
- Monitoring performance against our objectives, targets, measures and standards
- Providing effective financial stewardship
- Ensuring high standards of governance are applied across the organisation.

The Chair of the Trust is responsible for ensuring that the Board of Directors focuses on the strategic development of our organisation and that robust governance and accountability arrangements are in place. The Chair of the Trust chairs both the Board of Directors and the Council of Governors and ensures there is effective communication between the two bodies and that, where necessary, the views of the governors are taken into account by the Board.

Whilst the executive directors individually are accountable to the Chief Executive for the day-to-day operational management of the organisation they, along with the non-executive directors, are part of the unitary Board. They all share corporate responsibility and liability for ensuring that our Trust operates safely, effectively and economically They do this by making objective decisions in the best interests of the Trust. The non-executive directors will assure themselves of performance by holding the executive directors to account for the achievement of the agreed goals, objectives, targets and measures.

The Board sets out the Trust's vision, values and standards of conduct, whilst ensuring that its obligations to our members and the public are understood, clearly communicated and met. This is achieved by ensuring that the Board is made up of individuals who have the appropriate balance of skills, experience, independence and knowledge to enable the Board to discharge its duties and responsibilities effectively. The Board provides entrepreneurial leadership in a transparent manner and supports Trust staff in accordance with the Trust's values and accepted standards of behaviour in public life, including the Nolan Principles of:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership.

The Board will reserve certain matters to itself and will delegate others to specific committees and executive directors. Details of this are set out in a document called *Reservation of Powers to the Board of Directors and Council of Governors and Schedule of Decisions/Duties Delegated by the Board of Directors*.

Copies of this document are available on our website using the link below:

www.leedsandyorkpft.nhs.uk

3.2 COMPOSITION OF THE BOARD OF DIRECTORS

3.2.1 Non-executive directors

Our non-executive director (NED) team is made up of seven non-executive directors including a non-executive Chair. More detailed information about our non-executive directors is set out in the Remuneration Report in Part A section 2.2 of this Annual Report.

3.2.2 Executive directors

The executive director team is made up of six executives, including the Chief Executive. The team is made up as follows:

Chief Executive	Medical Director
Chief Financial Officer and Deputy Chief Executive	Director of Nursing, Professions and Quality
Chief Operating Officer	Director of People and Organisational Development

More detailed information about our executive directors is set out in the Remuneration Report in Part A section 2.2 of this Annual Report.

3.2.3 Associate non-executive directors

In 2021/22 the Appointments and Remuneration Committee agreed to appoint two Associate Non-executive Directors (ANEDs). This is the first time the Trust has adopted such roles and they have been created to strengthen succession planning in relation to outgoing NEDs. Whilst the role allows the ANEDs to shadow specific substantive NEDs and for there to be a period of handover, the expectation around time commitment is the same as for a substantive NED.

Following a successful recruitment process Kaneez Khan MBE and Dr Frances Healey were appointed as ANEDs and will commence in post on 1 April 2022 and 2 April 2022 respectively. Kaneez will be shadowing Sue White and Frances will be shadowing John Baker. Sue and Johns' terms of office will conclude later in 2022, at which point the Council of Governors will follow a process to consider the transition of Kaneez and Frances from being ANEDs to being substantive NEDs.

3.2.4 Members of the Board of Directors

Information about who our members of our Board of Directors were on 31 March 2021 can be found in Part A section 2.1.1 of this Annual Report.

3.3 PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS

Dr Sue Proctor, Chair of the Trust

Sue is the Chair of the Trust Board. As Chair, along with the non-executive directors, her role is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. Sue chairs the Board of Directors, the Council of Governors, the Remuneration Committee, the Nominations Committee and the governors' Appointments and Remuneration Committee. She is the Board lead for equality and diversity, and for safeguarding.

Sue has expertise in leadership development, corporate and clinical governance, safeguarding, strategic planning and delivery. She has a passion for improving services for service users and carers by working in partnership with them.

Sue has almost 40 years of experience in health care; qualifying as a nurse in 1987 and a midwife in 1990. She has an MSc in Nursing and a PhD in Health Services Research, both from the University of Bradford. She is also a Visiting Professor at Leeds Beckett University. In 2021, she was awarded an Honorary Doctorate in Health for services to the NHS from the University of Bradford. She has

extensive leadership experience in the NHS, including seven years as an executive director, and four years as a non-executive director. From 2010 to 2013 she was Chief Officer at the Diocese of Ripon and Leeds.

Currently, Sue is also Independent Chair of the North Yorkshire Safeguarding Adults Board, a member of the Lord Chancellor's Advisory Committee for North & West Yorkshire, and Chair of charity Day One Trauma Support.

Professor John Baker, Non-executive Director (Chair of the Quality Committee)

John's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. He is also the Chair of the Quality Committee.

By holding the executive directors to account he is able to be assured that services are provided in the most effective and efficient way. As Chair of the Quality Committee he can be assured that we provide high quality services. He can also be assured that we make the best use of research and evidence based practice to benefit the development of our services.

John has a passion for ensuring that quality is at the heart of what we do and for ensuring that the voice of our service users and carers is heard and able to influence the way in which we provide our services.

John is a registered mental health nurse and nurse teacher with the Nursing and Midwifery Council. He has 20 years clinical and academic experience. He also has a strong international reputation as a leading mental health nurse, researcher and clinical academic and is a Professor of Mental Health Nursing at the University of Leeds.

Helen Grantham, Non-executive Director (Chair of the Workforce Committee and Deputy Chair of the Trust)

Helen's role on the Board is to provide support and challenge in ensuring that the Trust is well led and delivering on its aims and objectives now and into the future. She acts as Deputy Chair as well as Chairing the Workforce Committee and is a member of the Quality Committee and the Audit Committee.

She contributes to improving the experience of staff and service users and carers by having a particular focus on workforce related matters including being the NED champion for Health and Safety.

She brings 30 years of leadership experience, with the last 17 years having been in Local Government. Until October 2017, she was the Assistant Chief Executive at Wakefield Council with responsibility for HR, ICT, Communications, Customer Services, Policy and Performance.

Cleveland Henry, Non-executive Director

Cleveland's role as a non-executive director is to hold the Chief Executive and the executive team to account for the delivery of the organisation's strategic aims and objectives. He is a member of the Finance and Performance Committee, the Workforce Committee and the Audit Committee.

Cleveland has 30 years of delivery experience in several industries, with a primary expertise in technology. He currently holds a substantial role as a Delivery Director for a Health Technology organisation, responsible for a large team charged with delivery of the company's products and services into Health and Care organisation.

Prior to this, Cleveland was a Senior Director for the Health division of a Cloud Technology organisation and previous to that at NHS Digital where he led, as Programme Director, a number of National Programmes including NHS Choices and NHSmail in addition to leading NHS Digital's horizon scanning on market innovation nationally and internationally.

Cleveland is also a Trustee for the Leeds Community Foundation, a grant-making charitable foundation which supports thousands of charities and voluntary groups across the city, addressing inequalities and working together to help create opportunities for those that most need help.

Merran McRae, Non-executive Director (Date of commencement 1 January 2022)

Merran's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is a member of the Workforce Committee and the Mental Health Legislation Committee.

By holding the executive directors to account she is able to be assured that our services are provided in the most effective and efficient way. Merran is passionate about person-centred services run by a workforce that is valued and well supported.

Merran has over 30 years of experience in Local Government, leading services across housing, social care, culture and community development. Previously, she has been a statutory Director of Adult Social Care and Chief Executive at both Calderdale and Wakefield Councils. She has a professional qualification in housing, an MBA and is also a qualified executive coach. She is a trustee of the Hollybank Trust, which provides services for children and adults with profound and multiple disabilities. She is also a trustee of two arts organisations: The Hepworth Wakefield; and The Yorkshire Sculpture Park.

Sue White, Non-executive Director (Chair of the Finance and Performance Committee and Chair of the Mental Health Legislation Committee)

Sue's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is the Chair of the Finance and Performance Committee, Chair of the Mental Health Legislation Committee and the NED champion for environmental sustainability.

By holding the executive directors to account Sue is able to be assured that services are provided in the most effective and efficient way. As Chair of the Finance and Performance Committee she makes sure that we are in a strong position to use the money we receive in the best way we can to benefit our service users and their carers, and that we take opportunities to build a sustainable organisation able to continue to provide high quality services. As Chair of the Mental Health Legislation Committee, Sue seeks assurance that we are appropriately administering the legislation relating to mental health for our service users, in terms of both the practice and spirit of the law. Sue has a passion for ensuring that the services we provide are of a high quality, that service users are at the heart of everything we do and that we strive to ensure that the way we work is more environmentally friendly

Previously Sue was the Chief Executive and Company Secretary for Voluntary Action Sheffield (VAS) where she had responsibility for strategic and operational leadership and for the leadership and representation of the voluntary and community sector in the city. Before this she worked for Sheffield Teaching Hospitals NHS Trust as the Business Development and External Affairs Director and also worked for the Department of Health as Head of Social Enterprise Unit. Sue brings to the Board experience of working in the complex environment of health and social care and in building partnerships at local, regional, national and international level.

Martin Wright, Non-executive Director (Chair of the Audit Committee and Senior Independent Director)

Martin's role as a non-executive director is to hold the Chief Executive and the executive team to account for the delivery of the organisation's strategic aims and objectives. He is the Chair of the Audit Committee and a member of the Finance and Performance Committee.

He has also been appointed by the Board as the Senior Independent Director. This role means that he is available to members of the Trust and to governors in instances where they have concerns which have been raised through the usual channels of Chair, Chief Executive, Chief Financial Officer or Trust Board Secretary and these have failed to resolve the issue. He is also available where it

would be inappropriate to use such channels. He is also the NED champion for speaking up and whistleblowing.

Part of his role is to make sure that services are being provided in the most effective and efficient way and as the Chair of the Audit Committee he ensures that the committee looks closely at the Trust's budgets and spending; making sure that the Trust is getting best value from the money it spends and is using its resources wisely to offer the highest quality services possible.

He was the Deputy Chief Financial Officer for DLA Piper International, one of the largest global law firms, where he was responsible for all aspects of financial reporting and control, including treasury, taxation and financial planning. He managed an international team of finance staff which provided support for more than 4,000 lawyers operating in more than 30 countries around the world.

Dr Sara Munro, Chief Executive

Sara leads the team of executive directors who, along with the chair and the non-executive directors, make up our Board of Directors. The Board is responsible for setting the strategic direction for the organisation. Sara is also a senior leader within a wider group of chief executives and chief officers that come together to look at health and social care provision across Leeds and across West Yorkshire. She has also been appointed as the Senior Responsible Officer for Mental Health, Learning Disabilities and Autism within the West Yorkshire and Harrogate ICS and is the executive lead on Workforce for the health and care partners in Leeds. Sara is a Trustee of The Workforce Development Trust.

Sara's passion is to improve the experience of service users and carers by ensuring we set the right objectives for our organisation which reflect the needs of our service users, carers and local communities. She will then make sure we provide the right support, including resources, for our staff to deliver the best possible mental health and learning disability services for the people we serve; that we monitor how well we are doing; and that we include service users, carers, communities and our staff in the decisions we make about our services.

Sara was appointed to the post of Chief Executive on 5 September 2016. She started her career in the NHS as a student nurse and agency nursing assistant. She is a registered mental health nurse and her clinical work was spent in inpatient mental health settings and has worked across a range of NHS mental health providers in the North West of England.

Sara has a PhD which looked at attitudes of acute mental health nurses and their impact on service users' experience of care. Prior to working at our Trust she was the Director of Quality and Nursing / Deputy CEO in Cumbria. Nationally, she is a board member of the Positive Practice Collaborative.

Joanna Forster Adams, Chief Operating Officer

As Chief Operating Officer Joanna works with Trust staff, leaders and managers, together with partners and stakeholders across the north east and Yorkshire, to deliver care across all of our services. She leads on service development and integration, ensuring that we respond to changes in the needs of the people we serve, working alongside health and care statutory and voluntary colleagues. Joanna is also responsible for major service change and supporting people to encourage and enable improvement on an ongoing basis. At a West Yorkshire level, Joanna leads the Children and Young Peoples' Service provider collaborative and plays an active role in the broader Mental Health, Learning Disability and Autism Programme.

With statutory responsibility for making sure we plan for and respond to an emergency or crisis; Joanna leads our response to the Covid-19 pandemic. Joanna led our Covid-19 vaccination programme from January 2020 to January 2021. She is the Executive Lead in our work which aims to achieve health equity for the people who access our services or need our support.

Joanna contributes to improving the experience of service users and carers by managing and leading on the delivery of high-quality care and services. She reports on what we are doing well and where we do not meet the standards of care, access or delivery which provides high quality care for our service users. She ensures that an 'at a glance dashboard' is available to make the information easier

to understand. She, and her team, pay particular attention to the problems that directly affect service users and their carers and look for ways to improve the quality of what we do.

Joanna joined the Trust in July 2017. She was previously Executive Director of Operations for Mental Health and Community Services in the North West of England. She has worked in the NHS since 1984 and has experience of clinical and corporate services in hospitals, community and mental health organisations in the North East of England. She gained a Master's in Business Administration from Durham University and is a graduate of the NHS Leadership Academy Nye Bevan programme.

Her motivation is drawn from the passion and determination shown by staff, stakeholders, service users and carers to drive improvement in mental health and learning disability care. With over 20 years as a senior NHS manager and leader, she aims to support staff to be the best they can be by prioritising their development, supporting their wellbeing, creating a culture of inclusion, and enabling people to do the right thing for the people who need our help.

Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

Dawn leads a number of departments which include finance and contracting, information management and technology, estates and facilities, and procurement (including mHabitat and the North of England Commercial Procurement Collaborative).

The functions she oversees make a significant contribution to the work of our Trust's frontline staff, in order to support them to focus on working directly with service users and carers. These functions contribute by:

- Looking after the finances and advising on what we can spend our resources on, including how to buy goods and services within the limits which we are set
- Dealing with our commissioners to get the best possible income settlement to provide the services we deliver
- Maintaining the estate to the best possible standard for delivering safe care and providing a good environment for staff
- Maintaining and continuously improving the technology, tools and infrastructure which support our work on a daily basis.

Dawn was appointed to this post on 1 August 2012, having previously worked at our Trust as the Deputy Director of Finance between 2003 and 2007. Her previous role was as Director of Finance and Information at Barnsley Hospital NHS Foundation Trust. She started her career in the NHS as a financial management trainee and has worked across a number of NHS organisations, mainly on the provider side but also briefly in commissioning and at the Department of Health. She has a wide range of experience mostly in finance but more recently managing estate and information.

Her first degree is in Theology and Religious Studies and she qualified as an accountant with the Chartered Institute of Public Finance Accountancy (CIPFA) in 1990.

Dr Chris Hosker, Medical Director

Chris was appointed as our Medical Director on 1 August 2020 and is responsible for applying the best medical practice and the highest quality of care for our service users. He works closely with Cathy Woffendin, our Director of Nursing, Professions and Quality, to oversee the current quality and delivery of our services and shape these to best meet future needs. Improving patient safety and overall patient experience is a key part of Chris' role.

Chris studied medicine at Nottingham University and qualified in 2000 before moving to Leeds in 2001 to commence specialist training in psychiatry. During his psychiatric training he worked in a range of services across the region, also training briefly in a Crisis Service in Melbourne, Australia. While training he became a Member of the Royal College of Psychiatry, completed a Masters in Clinical Psychiatry and gained a Post Graduate Diploma in Mental Health Law.

He commenced his first consultant post in 2008, which was in the Leeds Liaison Psychiatry Service and developed a special interest in palliative care psychiatry, multi-disciplinary approaches to persistent physical symptoms and the psychological aspects of liver transplantation. He worked closely with the British Psycho-Oncology Society and has been the Academic Secretary for the Regional Division of the Royal College of Psychiatry.

In addition to his clinical interests, Chris also developed a particular focus on clinical leadership and the conditions for organisational improvement. He has held a variety of leadership positions within the Trust, including Associate Medical Director for Mental Health Legislation, Clinical Lead for Liaison Psychiatry and Lead Psychiatrist and has been supported to enhance his leadership experience through the NHS Leadership Academy where he has completed the Shadow Board and Aspiring Medical Director Programmes as well as a Masters in Health Care Leadership. The latter culminated in a research dissertation on psychological safety in LYPFT. More recently Chris has taken on the Clinical Chair position for the Mental Health Care Delivery Board in Leeds and is enhancing his knowledge of Population Health Management approaches via the King's Fund.

Darren Skinner, Interim Director of People and Organisational Development

Darren was appointed as our Interim Director for People and Organisational Development (OD) on 10 May 2021 and is responsible for leading our Workforce and OD Team to ensure they have the right support and structures in place, helping our workforce through Covid-19 recovery and overseeing the delivery of the Trust's People Plan in which staff wellbeing and equality and inclusion continue to be key priorities.

Darren started his career as a nurse, working in adult intensive care and later neonatal and paediatric intensive care at Birmingham Children's Hospital. He was an active and experienced local Royal College of Nursing (RCN) representative and went on to work for the RCN as a Regional Officer, covering healthcare across North London before embarking on his HR career.

As a senior human resources practitioner he has worked at Guy's and St Thomas' NHS Foundation Trust leading an employment relations team before going on to work for the City of London Police, ultimately as HR Director, followed by the British Transport Police.

He worked with the Government of Jersey as an Interim HR Director for the Health and Community Services department, supporting a significant change programme and the development of the 'Jersey Care Model', as well as advising the Minister for Health and Social Services on workforce and HR policy related issues. Darren's most recent assignment was a significant staff engagement project with NHS Blood and Transplant before taking the role at LYPFT. He is also a Director for Skinner Consulting Ltd.

Cathy Woffendin, Director of Nursing, Quality and Professions

Cathy leads on the professional development and standards of staff within the Trust which covers Nursing, Allied Health Professionals and Psychology. Her particular focus is to ensure that quality is of a high standard across the organisation, and she works closely with Chris Hosker, our Medical Director, to oversee the current quality and delivery of our services and shapes these to best meet future needs. In addition, Cathy is our Director of Infection, Prevention and Control and has played a key role in keeping our service users and staff safe and free from the spread of infection over the years, but this has required a more intensive focus and oversight during the last two years due to the Covid-19 pandemic

Cathy is passionate about improving the experience of service users and carers and, by working together through co-production with service users, carers and staff, has developed a Patient Experience and Involvement Strategy which sets out the improvements which need to be made over the next three years and how these will be achieved. Cathy leads a team which works directly with service users to gather and share their insight and feedback about their experience whilst in our care. In addition, service users are members of the Trust's Patient Experience and Involvement Steering Group which monitors the progress of all areas of this work. This feedback is a vital tool for us as it

shows us where we're getting things right and where there is still work to be done to improve our services.

Cathy has a strong interest in ensuring our workforce is highly skilled and that our services are safely staffed and has developed strong links with our surrounding universities to ensure the students we train want to come and work with us when they qualify. In addition, through Cathy's leadership the organisation has become part of an overseas initiative and looks forward to welcoming qualified overseas nurses to work in our services for the first time in 2022/23.

Cathy is a qualified nurse and has worked in a variety of organisations in the NHS and private sector for over 30 years. She did some further training and gained a degree in Public Health Nursing and then worked as a health visitor developing a child health and safeguarding specialism. She moved into management in 2005 and has undertaken further study at Master's level in Management and leadership. Cathy has worked in a mental health and learning disability setting for the last 12 years and was appointed as our Director of Nursing, Quality and Professions, Director of Infection, Prevention and Control on 1 March 2018.

Anyone wanting to contact our directors can find their contact details on our website using the link below:
www.leedsandyorkpft.nhs.uk.

3.4 MEETINGS OF THE BOARD OF DIRECTORS

Our Board meets every other month with the exclusion of August and December. All meetings are held in public but items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session. Since March 2020 in order to comply with Government directions, which were included in the UK Coronavirus Act 2020, whereby public meetings of more than two people were deemed unlawful, Board meetings have been held more frequently and have been held virtually. Members of the public were not invited to attend the meetings but were invited to submit questions. Video recordings of the meetings were published on the Trust's website within one week of the meeting.

In 2021/22 the Board of Directors met on eight occasions. The table below shows directors' attendance at those meetings. Attendance at Board meetings is also reported to the Council of Governors at each of its meetings.

Table 3A – Attendance at Board of Directors' meetings during 2021/22

Name	Meetings eligible to attend	29 April 2021 (Extraordinary)	20 May 2021	10 June 2021 (Extraordinary)	29 July 2021	30 September 2021	25 November 2021	27 January 2022	31 March 2022
Non-executive directors									
Prof Sue Proctor (Chair)	8	✓	✓	✓	✓	✓	✓	✓	✓
John Baker	8	✓	✓	✓	✓	✓	✓	✓	-
Helen Grantham	8	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Marran	5	✓	✓	✓	✓	✓			
Merran McRae	2							✓	✓
Cleveland Henry	8	✓	✓	✓	✓	✓	✓	✓	✓
Sue White	8	✓	✓	✓	✓	✓	✓	✓	✓

Name	Meetings eligible to attend	29 April 2021 (Extraordinary)	20 May 2021	10 June 2021 (Extraordinary)	29 July 2021	30 September 2021	25 November 2021	27 January 2022	31 March 2022
Martin Wright	8	✓	✓	✓	✓	✓	✓	✓	✓
Executive directors									
Sara Munro	8	✓	✓	✓	✓	✓	✓	✓	✓
Joanna Forster Adams	7	✓	✓	✓	-	✓	✓	✓	✓
Dawn Hanwell	8	✓	✓	✓	✓	✓	✓	✓	-
Claire Holmes	1	✓							
Chris Hosker	8	✓	✓	✓	✓	✓	✓	✓	✓
Darren Skinner	7		✓	✓	✓	✓	✓	✓	✓
Cathy Woffendin	8	-	✓	✓	✓	✓	✓	✓	✓

✓ Shows attendance
- Indicates those Board members who sent apologies during 2021/22
Indicates when a Board member was not eligible to attend the meeting.

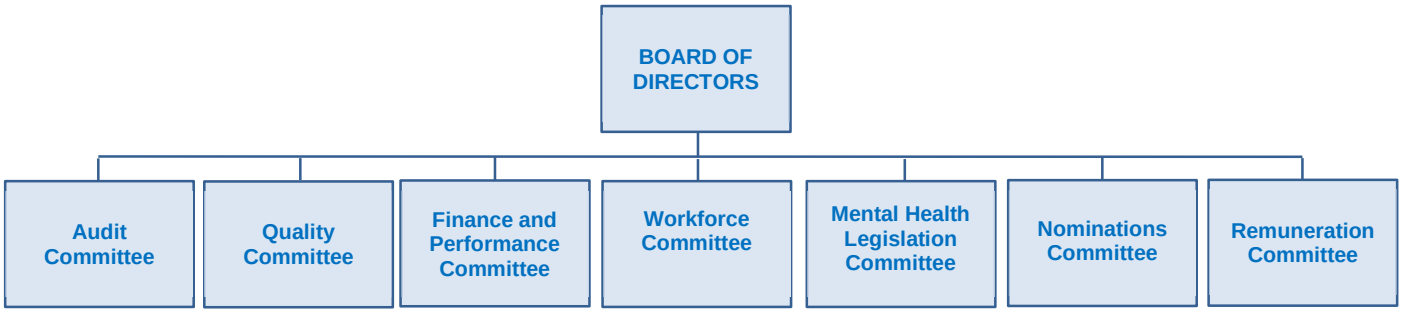
3.5 EVALUATION OF THE BOARD OF DIRECTORS

3.5.1 The Board of Directors and members of the Board

Details relating to the evaluation of the members of the Board of Directors can be found in Part A section 2.2.3.2 of this Annual Report.

3.5.2 Board sub-committees

The Board's sub-committee structure is made up of the: Audit Committee, Quality Committee, Finance and Performance Committee, Workforce Committee, Mental Health Legislation Committee, Remuneration Committee, and Nominations Committee. Each of these committees receives secretariat support from the Corporate Governance Team. Since March 2020 in order to comply with Government directions, which were included in the UK Coronavirus Act 2020, whereby public meetings of more than two people were deemed unlawful, all of the Board sub-committee meetings have been held virtually.



Evaluation of the Board sub-committees is carried out using an internal evaluation questionnaire. The Audit Committee is also evaluated using the HFMA (Healthcare Financial Management Association's) NHS Audit Committee Effectiveness Checklist. The outcome is reviewed by the committee and a

report on any proposed changes that may be required is made to the Board of Directors by the chair of the committee. If required the Terms of Reference would be changed and ratified by the Board.

3.6 THE AUDIT COMMITTEE

The Audit Committee is the primary governance and assurance committee for the Trust. It is a formal sub-committee of the Board of Directors.

The Audit Committee seeks high-level assurance and provides an independent and objective review on the effectiveness of our governance (corporate and clinical), health and safety and risk management processes and it assures the Board of Directors in respect of internal controls. It receives assurance from executive directors and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit and External Audit, again through reports and attendance by key personnel at its meetings to present papers on specific matters. Assurance is also gained through the knowledge that non-executive directors bring from other areas of their work, not least their own specialist areas of expertise, visiting services, and talking to staff and governors.

The Audit Committee has responsibility for ensuring that, should our auditors (KPMG) carry out any non-audit work, their independence is maintained. The committee will do this by reviewing and approving the scope of the work and the fees charged prior to the work being undertaken.

The substantive membership of the Audit Committee is made up at any one time of three non-executive directors. During 2021/22, the following members served on the committee as substantive members: Martin Wright, who was the chair of the committee, Helen Grantham and Cleveland Henry. The other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it is appropriate.

In regular attendance at committee meetings are the Chief Financial Officer, and the Associate Director for Corporate Governance. There is also representation from our external auditors KPMG and NHS Audit Yorkshire for audit and counter-fraud services.

The table below shows the number of Audit Committee meetings in 2021/22 and attendance by each non-executive director member.

Table 3B – Attendance at Audit Committee meetings in 2021/22

Name	Tuesday 20 April 2021	Tuesday 8 June 2021	Tuesday 20 July 2021	Tuesday 19 October 2021	Tuesday 18 January 2022
Substantive non-executive director members					
Martin Wright (chair of the committee)	✓	✓	✓	✓	✓
Helen Grantham	✓	-	✓	✓	✓
Cleveland Henry	✓	✓	✓	✓	✓

✓ Shows attendance
\- Indicates those members who sent apologies during 2021/22
Indicates when a member was not eligible to attend the meeting.

During 2021/22 the Audit Committee fulfilled the role of the primary governance and assurance committee and carried out its role primarily through:

- The approval of the work plans (annual and strategic) for internal audit and counter fraud
- The approval of the work plan for the annual audit of the Annual Accounts and the Annual Report
- Regular progress reports and annual reports from internal audit and counter fraud
- Regular updates from the external auditors on current sector developments and their audit findings
- ISA 260 report on the outcome of the annual audit of annual accounts
- Assessing the effectiveness of external and internal audit by reviewing periodic reports from the auditors and monitoring the pre-agreed key performance indicators.

At its June 2021 meeting the committee reviewed the Annual Report, Annual Accounts, the Annual Governance Statement and the Head of Internal Audit Statement for 2020/21. It was assured in relation to each of these documents and recommended to the Board that they should be adopted.

A separate annual report for the Audit Committee is produced and submitted to the Board of Directors for assurance and is also submitted to the Council of Governors for information. This can be found on our website using the link below:

www.leedsandyorkpft.nhs.uk

Further information about the sufficiency of our internal control processes can be found in the Annual Governance Statement in Part A section 2.7 of this Annual Report.

SECTION 4 – THE COUNCIL OF GOVERNORS

4.1 COMPOSITION OF THE COUNCIL OF GOVERNORS

The Council of Governors is the body that gives the public a voice in helping to shape and influence the future of mental health and learning disability services provided by our Trust. It is made up of people who have been elected from and by our membership and who are representative of our constituencies. It also includes people appointed from a range of partner organisations. The Council of Governors is chaired by the Chair of the Trust, who ensures a link between the Council and the Board of Directors; the Deputy Chair of the Trust is also the Deputy Chair of the Council of Governors.

NHS Improvement requires each foundation trust to have a Lead Governor. Peter Webster carried out the role of Lead Governor from 9 May 2019 to 1 November 2021. At its November 2021 meeting the Council ratified the appointment of Les France as Lead Governor for a period of two years commencing from 2 November 2021. The main duties of the Lead Governor are to: be a point of contact for governors; make a presentation at the Annual Members' Meeting accounting for the work of the Council over the past year; and to be involved in the appraisal of the Chair of the Trust (with the Senior Independent Director) and the other non-executive directors (with the Chair of the Trust).

During 2021/22 no amendments were made to the composition of seats within our Council of Governors. The composition ensures the Council is representative of our members and the public. Table 4A shows the composition of seats within our Council of Governors.

Table 4A – Composition of our Council of Governors

	Constituency name	Number of seats
ELECTED	Public: Leeds	6
	Public: York and North Yorkshire	1
	Public: Rest of England and Wales	1
	Service User: Leeds	4
	Service User: York and North Yorkshire	1
	Carer: Leeds	3
	Carer: York and North Yorkshire	1
	Service User and Carer: Rest of the UK	1
	Clinical Staff: Leeds and York & North Yorkshire	4
	Non-Clinical Staff: Leeds and York & North Yorkshire	2
APPOINTED	Director for Children and Families Programme, West Yorkshire and Harrogate ICS	1
	Volition Leeds – mental health representative	1
	Volition Leeds – learning disability representative	1
	York Council for Voluntary Services	1
	Leeds City Council	1
	City of York Council	1
	TOTAL	**30**

Governors are either elected or appointed to seats on the Council of Governors for a period of up to three years. Elected governors consist of public, service user, carer, and staff (clinical and non-clinical) governors. Appointed governors are nominated individuals from partner organisations. Elected governors can stand to be re-elected for three terms of office holding a seat for up to a maximum of nine years. Elections are carried out in accordance with the election rules in Annex 5 of our Constitution. Further details about the elections we have held during 2021/22 can be found below in section 4.2.1.

Appointed governors can also be on our Council for a maximum of nine years. This period is made up of three terms each of up to three years. Tables 4B and 4C list those governors that have been members on the Council of Governors during 2021/22.

Table 4B – Elected governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of terms served
Ian Andrews**	Staff: Non-clinical	3 years	06.05.21	06.05.24	1st
Sophia Bellas*	Service User: York and North Yorkshire	3 years	09.10.20	09.10.23	1st
Caroline Bentham	Carer: Leeds	3 years	09.10.20	09.10.23	1st
Mark Clayton	Carer: Leeds	3 years	20.03.20	19.03.23	1st
Rita Dawson	Service User: Leeds	3 years	09.10.20	09.10.23	1st
Les France	Public: Leeds	3 years	22.08.16	23.07.22	2nd
Rachel Gibala**	Service User: Leeds	3 years	06.05.21	06.05.24	1st
Ruth Grant	Staff: Non-clinical	3 years	24.07.19	23.07.22	2nd
Hazel Griffiths**	Carer: York and North Yorkshire	3 years	06.05.21	06.05.24	1st
Oliver Hanson**	Staff: Clinical	3 years	06.05.21	06.05.24	1st
Gail Harrison**	Staff: Clinical	3 years	06.05.21	06.05.24	1st
Peter Holmes	Service User: Leeds	3 years	20.03.20	19.03.23	1st
Steve Howarth	Public: Leeds	3 years	17.08.13	23.07.22	3rd
Andrew Johnson	Staff: Clinical	3 years	09.04.13	20.03.23	3rd
Mussarat Khan	Public: Leeds	3 years	24.07.19	23.07.22	1st
Sarah Layton	Staff: Non-clinical	3 years	30.04.18	29.04.21	1st
Kirsty Lee	Public: Leeds	3 years	25.09.17	09.10.23	2nd
Ivan Nip**	Public: Leeds	3 years	06.05.21	06.05.24	2nd
David O'Brien	Public: York and North Yorkshire	3 years	09.10.20	09.10.23	1st
Sally Rawcliffe-Foo	Staff: Clinical	3 years	25.09.17	09.10.23	2nd
Joseph Riach**	Service User: Leeds	3 years	06.05.21	06.05.24	1st
Bryan Ronoh**	Carer: Leeds	3 years	06.05.21	06.05.24	1st
Ann Shuter	Service User: Leeds	3 years	12.04.12	29.04.21	3rd
Niccola Swan	Public: Rest of England and Wales	3 years	17.08.13	23.07.22	3rd
Peter Webster	Public Leeds	3 years	22.08.16	24.07.22	2nd

* Indicates those governors who stepped down early during 2021/22, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2021/22

Table 4C – Appointed governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of Terms served
Councillor Fiona Venner**	Leeds City Council	3 years	14.06.21	13.06.24	1st
Helen Kemp	Volition - Leeds (mental health representative)	3 years	08.11.17	07.11.23	2nd
Councillor Anna Perrett	City of York Council	3 years	23.05.19	22.05.22	1st
Sue Rumbold*	Director for Children and Families Programme, West Yorkshire and Harrogate ICS	3 years	22.02.21	28.02.22	1st
Tina Turnbull	Volition - Leeds (learning disabilities representative)	3 years	02.06.20	02.06.23	1st

* Indicates those governors who stepped down early during 2021/22, before the end of their term of office
** Indicates those governors who were re-appointed or newly appointed part-way through 2021/22

4.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2021/22 there were a number of changes to the individuals holding the position of governor on our Council of Governors. The Board of Directors would like to thank all those who either stepped down early from office or came to the end of their term of office and note the valuable contribution they made to the work of the Council. These are: Sophia Bellas, Sarah Layton, Sue Rumbold and Ann Shuter.

4.2.1 Elected governors

Elections are carried out in accordance with the election rules as set out in Annex 5 of the Trust's Constitution (elected governors are in the constituencies set out in Table 4A). To be eligible to stand for election you must be a member of our Trust. Where a vacancy occurs in a constituency and the Trust agrees to hold an election, members in that constituency are invited to nominate themselves, and where more people stand for election than there are seats available it will be necessary to hold a ballot which is held on a first-past-the-post system of voting. In 2021/22 we held one round of elections in spring 2021.

4.2.1.1 Elections held in spring 2021

During spring 2021 an election was held to the Council of Governors. This was due to there being a number of vacant seats already on the Council caused either by governors stepping down early or because the seats had been vacant for some time. The following seats were included in the election:

Table 4D – Seats included in the spring 2021 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	1
Carer	Leeds	1
Carer	York and North Yorkshire	1
Service user	Leeds	2
Service user and carer	Rest of UK	1
Staff non-clinical	Leeds and York & North Yorkshire	1
Staff clinical	Leeds and York & North Yorkshire	2

This round of elections commenced on the 16 February 2021 and concluded on the 6 May 2021. We were successful in filling seats as follows:

Table 4E – Elected unopposed

Name	Constituency elected to:
Rachel Gibala	Service user: Leeds
Hazel Griffiths	Carer: York and North Yorkshire
Joseph Riach	Service user: Leeds
Bryan Ronoh	Carer: Leeds

For the Public: Leeds, Staff Non-Clinical: Leeds and York & North Yorkshire and Staff Clinical: Leeds and York & North Yorkshire constituencies we had more people stand than seats available and so we had to hold a ballot. The following governors were elected by ballot and turnout was 4.8% for Public: Leeds, 16.8% for Staff Non-Clinical and 12.9% for Staff Clinical.

Table 4F – Elected by ballot

Name	Constituency elected to:
Ian Andrews	Staff non-clinical
Oliver Hanson	Staff clinical
Gail Harrison	Staff clinical
Ivan Nip	Public: Leeds

At the end of the election, we still had a vacancy in the constituency of Service user and Carer: Rest of UK (one seat).

4.2.2 Appointed governors

Appointed governors are nominated by those organisations we have identified as our partner organisations, for the purpose of the Council of Governors, and are set out in table 4A.

During 2021/22 there were two changes to our appointed governors. Sue Rumbold (Director for Children and Families Programme, West Yorkshire and Harrogate Integrated Care System) stepped down during her first term of office. Cllr Fiona Venner commenced her first term of office as an appointed governor on the Council of Governors.

The Board of Directors would like to thank all the appointed governors it has worked with through the year for their hard work, supporting the development of the services we provide, and we would like to welcome those newly appointed to our Council.

4.3 MEETINGS OF THE COUNCIL OF GOVERNORS

During 2021/22 the Council of Governors had four formal business meetings. The four business meetings of the Council of Governors were held virtually in order to comply with Government Covid-19 guidance. Members of the public were not invited to attend the meetings but were invited to submit questions. Video recordings of the meetings were published on the Trust's website within one week of the meeting.

Notice of public Council of Governors' meetings along with the agenda and papers are published on our website. You can access our website using the link below:

https://www.leedsandyorkpft.nhs.uk/get-involved/governors/council-of-governors/governor-meetings/

The governors also hold an Annual Members' Meeting. This was held in July 2021 and was held virtually in order to comply with Government Covid-19 guidance. This is a public meeting and members are encouraged to attend to hear more about the work of the Trust and the Council of Governors.

Table 4H below details the number of meetings attended by each governor during 2021/22, including the Annual Members' Meeting. This is shown out of a maximum of five meetings. If a governor has either resigned from or joined the Council of Governors part-way through the financial year, the number of meetings they were eligible to attend has been amended to reflect this (those meeting dates which have been blanked out in the table indicate that a governor was not eligible to attend the meeting).

Table 4H – Number of meetings attended by each governor

				COUNCIL BUSINESS MEETINGS ATTENDED			ATTENDANCE AT THE ANNUAL MEMBERS MEETING
Name	**Appointed (A) or elected (E)**	Number of business meetings eligible to attend	**4 May 2021**	**6 July 2021**	**2 November 2021**	**1 February 2022**	**28 July 2021**
Ian Andrews**	E	3		✓	✓	✓	✓
Sophia Bellas*	E	1	-				
Caroline Bentham	E	4	✓	-	✓	✓	✓
Mark Clayton	E	4	✓	-	-	✓	✓
Rita Dawson	E	4	✓	✓	-	✓	-
Les France	E	4	✓	✓	✓	✓	✓
Rachel Gibala**	E	3		✓	✓	-	✓
Ruth Grant	E	4	-	✓	✓	-	✓
Hazel Griffiths**	E	3		✓	✓	-	-
Oliver Hanson**	E	3		✓	-	-	✓
Gail Harrison**	E	3		✓	✓	✓	✓
Peter Holmes	E	4	✓	-	✓	✓	✓
Steve Howarth	E	4	✓	✓	-	✓	✓
Andrew Johnson	E	4	✓	✓	✓	✓	✓
Helen Kemp	A	4	✓	✓	✓	-	✓
Mussarat Khan	E	4	-	-	-	-	✓
Sarah Layton	E	0					
Kirsty Lee	E	4	✓	✓	-	✓	-
Ivan Nip**	E	4	✓	✓	✓	✓	✓
David O'Brien	E	4	✓	✓	✓	-	-
Councillor Anna Perrett	A	4	-	-	-	-	-
Sally Rawcliffe-Foo	E	4	-	✓	✓	✓	✓
Joseph Riach**	E	3		✓	✓	-	-
Bryan Ronoh**	E	3		✓	-	✓	-
Sue Rumbold*	A	4	✓	✓	✓	✓	-
Ann Shuter	E	0					
Niccola Swan	E	4	✓	✓	✓	-	✓
Tina Turnbull	A	4	-	-	✓	-	✓
Fiona Venner**	A	3		✓	✓	-	✓
Peter Webster	E	4	✓	-	✓	✓	✓

✓ Shows attendance
\- Indicates those governors who sent apologies during 2021/22
* Indicates those governors who stepped down during 2021/22, before the end of their term of office and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)
** Indicates those governors who were newly elected or appointed during 2021/22 and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)

4.4 DUTIES OF THE COUNCIL OF GOVERNORS

The overarching role of the Council of Governors is to make our Trust publicly accountable for the services it provides. It does this by representing the interests of members as a whole and those of the public. It informs our forward plans and holds the non-executive directors (NEDs) to account, individually and collectively, for the performance of the Board. Governors are not directors and the duty of holding the NEDs to account does not mean governors are responsible for the decisions taken by the Board of Directors (members of the Board of Directors (both executive and non-executive directors collectively) share corporate responsibility and liability for those decisions).

Further information about the work of the Board of Directors can be found in Part A section 3 of this Annual Report.

In addition, there are a number of other key statutory tasks the Council of Governors must also carry out. These include:

- Appointing (and if necessary, removing) the Chair of the Trust and non-executive directors
- Approving the appointment of the Chief Executive
- Appointing (and if necessary, removing) the external auditor
- Receiving the Annual Report and Accounts, and the auditor's report on these
- Approving amendments to the constitution
- Taking decisions on significant transactions and on any changes to non-NHS income.

If during the course of the Board of Directors and the Council of Governors carrying out their respective duties, it becomes apparent that there is a dispute between the Council and the Board there is a formal dispute resolution process which is set out in the Constitution at Annex 7 paragraph 10.

To help governors carry out their role, the Board of Directors also has a number of statutory duties placed on it including: sending a copy of the agenda of Board meetings to governors before each meeting and copies of minutes of meetings as soon as practicable after the meeting; and ensuring that governors have the skills and knowledge they require to undertake their role.

4.5 WORKING TOGETHER

The work of the Board of Directors and of the Council of Governors is closely aligned. The Chair of the Trust, supported by the Associate Director for Corporate Governance, provides a formal link between the two bodies and it is the Chair's responsibility to ensure an appropriate flow of information.

The Council of Governors has a primary relationship with the non-executive directors (NEDs) who are encouraged wherever possible to attend Council meetings to get to know the governors better and to hear first-hand their views and those of members. One way in which this is further supported is through the annual Board to Council meeting. This private meeting includes a number of the Trust's key strategic areas of focus on the agenda. This meeting further enhances the relationship between the Council and the NEDs and provides an opportunity for the governors to work more closely with NEDs and other members of the Board. Governors are also invited to observe a number of the Board sub-committee meetings and are encouraged to observe at least one public Board of Directors' meeting each year. This provides further opportunity for the governors to witness the NEDs holding the executive directors to account for the performance of the Board.

The following table shows those Council meetings in 2021/22 that were attended by non-executive directors.

Table 4I – Attendance by non-executive directors at Council of Governors' meetings

Name	4 May 2021	6 July 2021	2 November 2021	1 February 2022
Prof Sue Proctor	✓	✓	✓	✓
Prof John Baker	✓	✓	✓	✓
Helen Grantham	✓	✓	✓	✓
Cleveland Henry	✓	✓	✓	✓
Andrew Marran	✓	✓		
Merran McRae				-
Sue White	✓	✓	✓	✓
Martin Wright	✓	-	✓	✓

4.6 SUB-COMMITTEES OF THE COUNCIL OF GOVERNORS

The Council of Governors may not delegate any of its responsibilities; however, it can choose to carry out its duties either through individual governors or through groups and committees. In light of this, the Council of Governors has formed the Appointments and Remuneration Committee (a committee required in statute). This committee reports formally to the Council of Governors.

- **The Appointments and Remuneration Committee** – this committee reviews and makes recommendations to the Council of Governors regarding the appointments process for vacant posts within the non-executive director team and also sets the level of remuneration for NEDs. Further information about the work of this committee during 2021/22 can be found in the Remuneration Report in Part A section 2.2 of this Annual Report.

4.7 THE REGISTER OF GOVERNORS' INTERESTS

Under the provisions of the Constitution and as described in the provider license, we are required to have a register of interests to formally record declarations of interests of members of the Council of Governors. The register will include details of all directorships and other relevant material interests which have been declared. It also asks governors to declare that they are of sound character and background to hold a position in public office.

On appointment and annually thereafter, members of the Council of Governors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interest and those arising from their membership of the Council of Governors. Members of the Council of Governors are also required to declare any conflict or pecuniary interests that arise in the course of conducting business at each meeting. Each year governors will complete a new declaration of interest form to ensure the most up-to-date position is declared. These annual declarations are also reported to the Council of Governors.

The Register of Interests is maintained by the Associate Director for Corporate Governance and is available for inspection on the Trust's website. The Associate Director for Corporate Governance can be contacted by telephone on 0113 8555930 or by email at chill29@nhs.net.

SECTION 5 – MEMBERSHIP

5.1 OUR CONSTITUENCIES AND ELIGIBILITY TO JOIN

As at 31 March 2022 the membership was 14,515. This has been steadily maintained throughout the year. The tables below illustrate the breakdown, by constituency, of the total number of members.

We have three membership constituencies: public; service user and carer; and staff. A breakdown of these is shown at table 5A.

There are three public constituencies: Leeds; York and North Yorkshire and Rest of England and Wales. These constituencies are made up of a number of local government electoral areas. This is in accordance with the NHS Act 2006. If a person wants to join a public constituency the relevant one will be determined by the address at which they live.

The Service User and Carer Constituency is divided into five constituencies for the geographical areas of: Leeds; York and North Yorkshire and the rest of England and Wales. Again these constituencies follow the local government electoral boundaries. Anyone who has used our services in the last 10 years or cares for someone who has used our services can join the Service User and Carer Constituency. An individual's home address will determine which constituency they join.

The Staff Constituency is divided into two categories: Staff: Clinical and Staff: Non-clinical. Any individual who is employed by the Trust under a contract of employment will automatically become a member unless they opt out. In addition to those individuals directly employed by the Trust, people who exercise a function for the Trust may also choose to be a member of the Staff Constituency. Whether a person joins the clinical or the non-clinical class will be determined by national occupation codes.

Table 5A – Membership constituencies

Public constituency	Service User and Carer constituency	Staff constituency
Public: Leeds Public: York and North Yorkshire Public: Rest of England and Wales	Service User: Leeds Service User: York and North Yorkshire Carer: Leeds Carer: York and North Yorkshire Service User and Carer: Rest of UK	Clinical Staff: Leeds and York & North Yorkshire Non-clinical Staff: Leeds and York & North Yorkshire

5.2 NUMBER OF MEMBERS

Table 5B – Total membership by constituency as at 31 March 2022

Public constituency	Number of members
Public: Leeds	7186
Public: York and North Yorkshire	1358
Public: Rest of England and Wales	1901
Total public members (including 55 members outside England and Wales)	**10,500**

Service User and Carer constituency	Number of members
Service user: Leeds	486
Service user: York and North Yorkshire	79
Carer: Leeds	302
Carer: York and North Yorkshire	38
Service User and Carer: Rest of UK	89
Total service user and carer members	**994**

Staff constituency	Number of members
Clinical staff: Leeds and York & North Yorkshire	2246
Non-clinical staff: Leeds and York & North Yorkshire	775
Total staff members	**3,021**

Membership has maintained steady at 14,515 as at 31 March 2022. These tables illustrate the breakdown, by constituency, of the total number of members.

5.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

Members of the public, staff, service users, their families and carers can join our Trust as a member. We are responsible for ensuring that our membership is representative of the people that the Trust could provide services to. The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, with no significant deficits.

A review of membership has been undertaken by the Trust and results from this confirmed that membership numbers remain high and representative. The Trust has reached a strong solid membership number; now the focus will be on developing a programme of engagement for members. Due to Covid-19, NHS Improvement and NHS England advised that membership engagement should be limited to Covid-19 purposes. As a result, the Trust has paused its membership development work and engagement with members will be reviewed in 2022/23.

5.4 MEMBERSHIP RECRUITMENT AND ENGAGEMENT

We value the contribution of our membership and our focus will be on qualitative rather than quantitative membership levels and engagement. The Council of Governors support planned development work of the membership database alongside the creation of an ongoing engagement programme. Due to Covid-19, NHS Improvement and NHS England advised that membership engagement should be limited to Covid-19 purposes. As a result, the Trust has paused its membership development work and engagement with members will be reviewed in 2022/23.

We have a varied approach to facilitating engagement between governors, members and the wider public. In particular, each year we hold our Annual Members Meeting. This not only incorporates the statutory annual meeting where the Council accounts for how it has carried out its duties on behalf of members, it also has an opportunity for a 'Big Conversation'. This is where members and the public can talk about their experience of our services both good and not so good which informs their role on the Council. Governors get the opportunity to meet with, talk to and hear from their constituents and the wider public. The Trust's Annual Members' Meeting was held virtually in July 2021. In 2022/23 we will continue to ensure that our governors are central to this event which allows them to engage with a diverse group of people.

5.5 THE MEMBERSHIP OFFICE

The Membership Office is the initial point of contact for members to speak to someone within our Trust or with our governors. The office can be contacted by telephone on (0113) 8555900 or by email at ftmembership.lypft@nhs.net.

SECTION 6 – OUR AUDITORS

6.1 EXTERNAL AUDIT SERVICES

Our external audit service is provided by KPMG. They were appointed by our Council of Governors with effect from 1 October 2017 following a full tender process. Their tenure was initially for three years. This was extended by the Council for a further year until May 2021. It was extended again for a further year until May 2022. Then in January 2022, the Council agreed to extend their tenure for a further two years until June 2024.

All members of the KPMG audit team are independent of the Board of Directors and of staff members. Each year the audit team provides a statement in support of the requirements for their objectivity and independence to the Audit Committee. The auditors provide audit services in accordance with the Code of Audit Practice. This covers the opinion on the annual accounts and work to be satisfied whether the Trust has proper arrangements to secure value for money.

The cost of independent audits during 2021/22 is detailed in the table below:

Table 6A – Cost of statutory audits

Statutory audit (accounts and value for money responsibilities)	£72,000
TOTAL KPMG FEES	**£72,000**

6.2 INTERNAL AUDIT SERVICES

Our internal audit and counter fraud services are provided by Audit Yorkshire. This is a specialist NHS provider of internal audit and counter fraud services to the NHS.

On 1 June 2019 the Trust became a formal member of NHS Audit Yorkshire. This provides a direct cost benefit, in terms of a reduced day rate. It also has the benefit of 'buy-in' and ownership with the ability to shape coverage and direction of the service, and will contribute to the consolidation of back office functions which is in line with the Lord Carter and NHS Improvement recommendations.

The Internal Audit Team is led by Helen Higgs. Helen is the Managing Director and Head of Internal Audit and replaced Helen Kemp Taylor in January 2022 following the latter's retirement. She is supported by Sharron Blackburn (CPFA) as Client Manager. Sharron is the Deputy Head of Internal Audit. The remaining team of auditors and specialists is drawn from across Audit Yorkshire.

The scope of the work of internal audit is to review and evaluate the risk management, control and governance arrangements that we have in place, focusing in particular on how these arrangements help us to achieve our objectives. The audit opinion may be used by the Accounting Officer to support the Annual Governance Statement. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee. Internal Audit is only one source of assurance and it works closely with other assurance providers, such as external audit and Local Counter-fraud Services, to ensure that duplication is minimised and a suitable breadth of assurance obtained.

Audit Yorkshire provides services in line with the Public Sector Internal Audit Standards (April 2017). This was confirmed in the mandated external quality assessment in February 2020 where an outcome of 'Fully Conforms' was achieved. The external assessment is required every five years and was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA).

The impact of the pandemic has continued to be felt during 2021/22 and the internal audit plan has been kept under constant review as a result of this. All changes to the plan have been overseen by the Audit Committee. Audit Yorkshire has been able to complete the audit plan as largely intended in 2021/22 which has formed the basis for the Head of Internal Audit Opinion.

PART B
ANNUAL ACCOUNTS
2021/22

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Leeds and York Partnership NHS Foundation Trust ("the Trust") for the year ended 31 March 2022 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2021/22.

Basis for opinion

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

Going concern

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

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve control totals delegated to the Trust by NHS Improvement
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, and the risk that management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals that reversed income in the final period of the year.
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Testing of accruals in order to assess the existence and accuracy of accruals recorded in the financial statements.

Identifying and responding to risks of material misstatement related to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards), and discussed with the directors the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the National Health Service Act 2006 and financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information.
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.
- in our opinion that report has been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2021/22. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2021/22.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 80, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2022 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

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

22 June 2022

FOREWORD TO THE ACCOUNTS

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2022, have been prepared by Leeds and York Partnership NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:  (Chief Executive)

Name: Dr Sara Munro

Date: 16 June 2022

STATEMENT OF COMPREHENSIVE INCOME AS AT 31 March 2022	note	**Year ended 31 March 2022** £000	Year ended 31 March 2021 £000
Operating income	2, 3 & 4	225,735	202,911
Operating expenses	2 & 5	(216,534)	(198,516)
OPERATING SURPLUS		**9,201**	**4,395**
FINANCE COSTS			
Finance income	10	113	
Finance expense - financial liabilities	12	(3,943)	(4,022)
Finance expense - unwinding of discount on provisions	25	15	8
PDC dividend payable		(16)	
Share of profit/(loss) of associates/ joint ventures			
NET FINANCE COSTS		**(3,831)**	**(4,014)**
Gains (losses) on disposal of assets	11	**1**	(131)
Surplus from operations		5,371	250
SURPLUS FOR THE YEAR		**5,371**	**250**
Other comprehensive income			
Items that will not be reclassified to income or expenditure:			
Revaluation gains and (impairment losses) on intangible assets		67	38
Revaluation gains and (impairment losses) on property, plant and equipment		1,424	(1,304)
Other comprehensive income for the year		**1,491**	**(1,266)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**6,862**	**(1,016)**

The notes on pages 6 to 35 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2022	note	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Non-current assets			
Intangible assets	13	589	600
Property, plant and equipment	14	61,675	54,159
Trade and other receivables	17	6,186	5,664
Total non-current assets		**68,450**	**60,423**
Current assets			
Inventories	16	47	20
Trade and other receivables	17	6,939	5,859
Non-current assets for sale	19		
Cash and cash equivalents	18	120,754	111,695
Total current assets		**127,740**	**117,574**
Current liabilities			
Trade and other payables	20	(35,408)	(28,152)
Borrowings	21	(2,392)	(2,208)
Provisions	25	(4,268)	(3,810)
Other liabilities	22	(8,970)	(7,766)
Total current liabilities		**(51,038)**	**(41,936)**
Total assets less current liabilities		**145,152**	**136,061**
Non-current liabilities			
Borrowings	21	(12,897)	(15,289)
Provisions	25	(5,363)	(5,543)
Total non-current liabilities		**(18,260)**	**(20,832)**
Total assets employed		**126,892**	**115,229**
Financed by (taxpayers' equity)			
Public dividend capital		35,733	30,932
Revaluation reserve		5,549	4,271
Other reserves		(651)	(651)
Income and expenditure reserve		86,261	80,677
Total taxpayers' equity		**126,892**	**115,229**

The notes on pages 6 to 35 form part of this account.

The accounts on pages 1 to 35 were approved by the Board on 16 June 2022 and signed on its behalf by:

Signed:  (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2021	30,932	4,271	(651)	80,677	115,229
Surplus for the year				5,371	5,371
Revaluation gains and impairment losses on intangible assets		67			67
Revaluation gains and impairment losses property, plant and equipment		1,424			1,424
Public dividend capital received	4,801				4,801
Transfers to the income and expenditure account in respect of assets disposed of		(1)		1	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(212)		212	
Movement in year subtotal	**4,801**	**1,278**		**5,584**	**11,663**
Taxpayers' equity at 31 March 2022	35,733	5,549	(651)	86,261	126,892

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Expenditure Reserve £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2020	19,732	5,799	(651)	80,165	105,045
Surplus for the year				250	250
Revaluation gains and impairment losses on intangible assets		38			38
Revaluation gains and impairment losses property, plant and equipment		(1,304)			(1,304)
Public dividend capital received	11,200				11,200
Transfers to the income and expenditure account in respect of assets disposed of		(3)		3	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(259)		259	
Movement in year subtotal	**11,200**	**(1,528)**		**512**	**10,184**
Taxpayers' equity at 31 March 2021	30,932	4,271	(651)	80,677	115,229

Description of Reserves:

a) Public dividend capital represents in substance, the Secretary of State for Health's 'equity' investment in the Trust. When the Trust's predecessor NHS Trust was established, the amount of PDC provided to it equated to the initial net assets of the Trust. The PDC balance is usually a constant amount but can change occasionally where the Trust receives additional PDC (usually to fund capital investment) or is asked to repay an element to the Secretary of State.

b) The revaluation reserve is used to record revaluation gains/losses and impairment reversals on property, plant and equipment that are recognised in other comprehensive income. An annual transfer is made from the reserve to retained earnings of amounts representing the excess of current cost depreciation over historic cost depreciation for each item of PPE. When an asset is sold or otherwise disposed of, any remaining revaluation reserve balance for the asset is transferred to Retained Earnings. The balance in the reserve is wholly in respect of property, plant and equipment.

c) Other reserves relates to the write off of an asset which was included in the original NHS Trust's asset base at inception.

d) The Trust's surplus or deficit for the year is recognised in the Income and Expenditure Reserve, together with any other gain or loss for the financial year that is not recognised in any other reserve.

The notes on pages 6 to 35 form part of this account.

STATEMENT OF CASH FLOWS AS AT 31 March 2022	note	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Cash flows from operating activities			
Operating surplus from continuing operations		9,201	4,395
Operating surplus		**9,201**	**4,395**
Non-cash income and expense:			
Depreciation and amortisation	5	4,554	4,520
Impairments and reversals	14	174	620
(Increase)/decrease in trade and other receivables	17	(1,463)	1,145
(Increase)/decrease in inventories	16	(27)	(15)
Increase/(decrease) in trade and other payables	20	9,050	10,514
Increase/(decrease) in other liabilities	22	1,204	4,344
Increase/(decrease) in provisions	25	293	2,677
NET CASH GENERATED FROM OPERATIONS		**22,986**	**28,200**
Cash flows from investing activities			
Interest received	10	58	21
Purchase of intangible assets	13		(9)
Purchase of property, plant and equipment	14	(12,586)	(13,974)
Sales of property, plant and equipment		43	
Net cash used in investing activities		**(12,485)**	**(13,962)**
Adjustment for net assets de-recognised on merger			
Cash flows from financing activities			
Public dividend capital received		4,801	11,200
Capital element of private finance initiative obligations	21	(2,193)	(2,024)
Interest element of private finance initiative obligations	12	(3,950)	(4,023)
PDC dividend (paid)/refunded		(100)	4
Cash flows from (used in) other financing activities			
Net cash used in financing activities		**(1,442)**	**5,157**
Increase/(decrease) in cash and cash equivalents		9,059	19,395
Cash and Cash equivalents at 1 April		111,695	92,300
Cash and Cash equivalents at 31 March		**120,754**	**111,695**

Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	2021/22 £000s	2020/21 £000s
(Increase)/decrease in receivables as per SOFP	(1,602)	1,170
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		
- Financing transactions	139	(25)
(Increase)/decrease in receivables adjusted for non-I&E items	(1,463)	1,145
Increase/(decrease) in payables per SOFP	7,256	13,454
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	1,802	(2,927)
- Financing transactions	(8)	(13)
Increase/(decrease) in payables adjusted for non-I&E items	9,050	10,514
Increase/(decrease) in Other Liabilities per SOFP	1,204	4,344
Adjustments for Other Liabilities movements not related to I&E:		
Increase/(decrease) in Other Liabilities adjusted for non-I&E items	1,204	4,344
Increase/(decrease) in provisions per SOFP	278	2,669
Adjustments for provisions movements:		
- Unwinding of discount on provisions	15	8
Increase/(decrease) in provisions for non I&E items	293	2,677
Opening capital payables	(4,163)	(1,236)
Closing capital payables	(2,361)	(4,163)
Change in capital payables in-year	**(1,802)**	**2,927**

The notes on pages 6 to 35 form part of this account.

Notes to the accounts

The principal activity of the Trust is to provide excellent quality mental health and learning disability care that supports people to achieve the very best that they can for their health and wellbeing. The Trust's registered address is 2150 Century Way, Thorpe Park, Leeds LS15 8ZB.

1 Accounting policies

NHS Improvement (NHSI), in exercise of the powers conferred has directed that the accounts of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2021/22 GAM issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), in accordance with EU endorsed IFRS and IFRIC, and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently, other than where new policies have been adopted, in dealing with items considered material in relation to the accounts.

In accordance with IAS1, the accounts are prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

After making enquiries, the directors have a reasonable expectation that the services provided by Leeds and York Partnership NHS Foundation Trust will continue to be provided for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

1.1 Accounting convention

The accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets. For specialised operational property the modern equivalent asset valuation method has been used.

1.2 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors.

1.3 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment related payments such as social security and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry-forward leave into the following year.

1.4 Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) 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 payable by employers and employees.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have laid Scheme Regulations confirming an increase to the employer contribution rate to 20.68% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Employers and employee contribution rates may be varied from time to time, as above, to reflect changes in the scheme's liabilities. In 2017/18 employee contributions are tiered depending on salary and range from 5% to 14.5%. Employer contributions for 2021/22 were 20.68%, including the administration levy (20.68% in 2020/21).

Notes to the accounts - 1. Accounting policies (continued)

1.4 Pension costs (continued)

b) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as at 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

In 2021/22 the NHS pension scheme provided defined benefits, which are summarised below. The 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:

Annual Pensions

The annual pension under the 1995 section of the scheme is based on 1/80th of the best of the last three years pensionable pay for each year of service and for the 2008 section it is based on 1/60th of reckonable pay per year of membership. Further changes to the scheme came into effect from 1 April 2015, which mean that the scheme is now based on average salary rather than final salary, with an accrual rate of 1/54th.

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 HMRC rules. This is known as pension commutation.

Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and from 2011/12, are based on changes in consumer prices (CPI) in the twelve months ending 30 September in the previous calendar year.

Ill-health retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Death benefits

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.

Additional voluntary contributions (AVCs)

Members can purchase additional service in the NHS pension scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other free standing additional voluntary contribution (FSAVC) providers.

Transfer between funds

Scheme members have the option to transfer their pension between the NHS pension scheme and another scheme when they move into or out of NHS employment.

Preserved benefits

Where a scheme member ceases NHS employment with more than two years service, they can preserve their accrued NHS pension for payment when they reach retirement age.

1.4.1 Alternative pension scheme

From 1 August 2013 (deferred to 1 October 2013), Leeds and York Partnership NHS Foundation Trust offers an alternative pension scheme to all employees who are not eligible to be members of the NHS pension scheme at the Trust. This includes employees who are members of the NHS pension scheme through another role outside of the Trust and those that are not eligible to join the NHS pension scheme.

Every three years all eligible employees are auto-enroled in either the NHS or alternative pension scheme. The auto-enrolment exercise was carried out in October 2019 and following this process, all employees who meet the criteria for the alternative pension scheme are enroled each month on a continuous basis, unless they specifically opt out.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined minimum of 8% (with a minimum 3% being contributed by the Trust).

1.4.2 Civil Service Pension Scheme

One employee is a member of the Civil Service Pension Scheme, which is a defined benefit pension scheme administered by the Cabinet Office. Employee and employer contribution rates are based on employee salary band. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.civilservicepensionscheme.org.uk

Notes to the accounts - 1. Accounting policies (continued)

1.5 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for Leeds and York Partnership NHS Foundation Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Where income is received for a specific activity, which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations, which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability

1.5.2 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

The Trusts main healthcare contracts are agreed on a block contract basis.

1.5.3 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

1.5.4 Provider sustainability fund (PSF) and Financial recovery fund (FRF)

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

1.5.5 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5.6 **Other income**

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6.1 Property, plant and equipment

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 Leeds and York Partnership NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;

and if any of the following apply:

- the item has cost of at least £5,000;
- 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.

The finance costs of bringing property, plant and equipment into use are not capitalised.

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.

1.6.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs 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.

Land and buildings used for the Trust's purposes are stated in the Statement of Financial Position at their revalued amounts being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. In accordance with IFRS and NHS policy, a full revaluation is performed at least every five years, with an interim revaluation in the third year after the full revaluation. An impairment review is undertaken in all other years. The Trust believes that this is sufficiently regular 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;
- Specialised buildings – depreciated replacement cost based on providing a modern equivalent asset;
- Non-operational land and buildings – fair value based on alternative use.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation manual. A valuation was last undertaken as at 31 March 2022 and the assets were reviewed for impairment using the Modern Equivalent Asset (MEA) and alternative site methods as appropriate. From 31 March 2018 PFI assets are valued excluding VAT.

Plant and equipment assets were last indexed using the latest available Consumer Price Indices (CPI), being for February 2021, as issued by the Office for National Statistics.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 14.

1.6.3 Subsequent expenditure

Expenditure after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits or service potential expected to be obtained from the use of an item of property, plant and equipment, and where the cost can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement. The carrying amount of the part replaced is de-recognised.

1.6.4 Depreciation

Items of property, plant and equipment are depreciated, using the straight line method, over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an indefinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as 'held for sale' ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The useful economic lives of property, plant and equipment are estimated by Leeds and York Partnership NHS Foundation Trust as follows:

Plant and machinery	
• Short life engineering plant and equipment	5 years
• Medium life engineering plant and equipment	10 years
• Long life engineering plant and equipment	15 years
• Short life medical and other equipment	5 years
• Medium life medical equipment	10 years
• Long life medical equipment	15 years
Transport	
• Vehicles	7 years
Furniture and fittings	
• Furniture	10 years
Information technology	
• Office and IT equipment	2 years
• Mainframe type IT installations	10 years

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional independent valuers. The assessed lives of the individual building elements may vary. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

1.6.4 **Depreciation (continued)**

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from it. This period is specific to the foundation trust and may be shorter than the physical life of the asset itself.

Assets held under finance leases (including leased land) are depreciated over the shorter of their estimated useful economic lives or the lease period. Where the Trust will, or is reasonably certain to, acquire ownership of the asset at the end of the lease, the asset is depreciated over its useful economic life.

Estimated useful lives and residual values are reviewed each year end, with the effects of any changes recognised on a prospective basis.

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.

At the end of each reporting period, a transfer is made from the revaluation reserve to the income and expenditure reserve, in respect of the difference between the depreciation expense on the revalued asset and the depreciation expense based on the assets historic cost carrying value.

1.6.5 **Revaluation and Impairment**

Increases in asset values arising from revaluations are taken to the revaluation reserve except where, and to the extent they, reverse an impairment for the same asset previously recognised in operating expenses. In this case they are recognised in operating income.

Impairments, that arise from a loss of economic benefit or service potential, are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the income and expenditure reserve for the amount of the impairment (or the remaining balance in the revaluation reserve relating to the asset if this is a lower amount).

Decreases in asset values and all other impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter, are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of “other comprehensive income”.

At each reporting period end, the Trust checks whether there is any indication that any of its property, plant or equipment has suffered an impairment loss. If there is an 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.

1.6.6 **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.

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met.

- the asset is available for immediate sale in its present condition subject only to terms, which are usual and customary for such sales;

- the sale must be highly probable, i.e. management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Fair value is open market value including alternative uses. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount.

Assets are de-recognised when all material sale contract conditions have been met. The non-current assets held for sale are identified in note 19.

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 Income. On disposal, the balance for the asset in the revaluation reserve is transferred to the income and expenditure reserve.

Property, plant and equipment, which is to be scrapped or demolished, does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with HM Treasury's FReM.

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

a) Payment for the fair value of services received (including lifecycle costs);
b) Payment for the PFI asset, comprising finance costs and the repayment of the liability; and
c) Operating lease for the land.

a) Services received

The fair value of service received in the year is recorded under the relevant expenditure heading within operating expenses.

Leeds and York Partnership NHS Foundation Trust has adopted the approach that we incur the lifecycle costs evenly over the contract period as part of the unitary payment. This is due to the nature of the costs involved.

b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to 'fair value' by the District Valuer in accordance with the principles of HM Treasury's FReM. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. From 31 March 2018, PFI assets are valued excluding VAT.

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 Income. Contingent rent due to inflationary increases in the unitary payment is also included in the finance cost.

The minimum lease payments of the finance lease component are split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each year is then calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in 'finance costs' in the Statement of Comprehensive Income.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with HM Treasury's FReM, 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 part of the PFI Operating Expenses in the Statement of Comprehensive Income.

c) Operating lease for the land

The land, which the PFI building is built on, is classified as an operating lease in accordance with HM Treasury's FReM.

Assets contributed by the Trust 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 Trusts Statement of Financial Position.

Other assets contributed by the Trust to the operator

Assets contributed, eg cash payments and surplus property, by the Trust 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, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Leeds and York Partnership NHS Foundation Trust did make an initial 'bullet' payment of cash upfront of £5.4m. This was off set against the initial liability (based on the fair value cost of the building less the £5.4m).

1.8 Intangible Assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. The Trust holds software licences as intangible assets. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 2 and 5 years depending on the software licence.

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an internally generated intangible asset for sale or use;
• the Trust intends to complete the asset and sell or use it;
• the Trust has the ability to sell or use the asset;
• how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
• the Trust can measure reliably the expenses attributable to the asset during development.

1.8.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequent intangible assets are measured at fair value. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment, see notes 1.6.2 and 1.6.5.

1.8.4 Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is recognised in the Statement of Comprehensive Income.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first in - first out cost formula. Inventories are identified in note 16. The Trust's inventories do not include drugs, but comprise stationery, oil and other work stores.

1.10 Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, balances with banks and investments. Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Leeds and York Partnership NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Interest earned on bank accounts is recorded as "interest receivable" in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Provisions

Leeds and York Partnership NHS Foundation Trust provides for present legal or constructive obligations that are of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate in real terms. The discount rate for early retirement and injury benefit provisions (both use the HM Treasury's pension discount rate) is -1.30% (-0.95% in 2020/21) in real terms. The discount rate for other provisions varies depending on the timing of the liability from 0.47% (up to 5 years), 0.7% (5 - 10 years) and 0.95% over 10 years (in 2020/21 the discount rates were -0.02%, 0.18% and 1.99% respectively).

1.11 Provisions (continued)

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 recorded as an asset, if it is virtually certain that reimbursement will be received and the amount of the receivable can be measured reliably.

Clinical negligence costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the Trust.

The NHSLA operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Leeds and York Partnership NHS Foundation Trust does not include any amounts in its accounts relating to these cases. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

Non-clinical risk pooling

Leeds and York Partnership NHS Foundation Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA 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 when the liability arises; these are the only amounts included in the accounts of the Leeds and York Partnership NHS Foundation Trust.

1.12 Contingencies

Contingent assets, ie assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is possible. Otherwise, they are not recognised, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Value added tax (VAT)

Most of the activities of Leeds and York Partnership NHS Foundation Trust 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.

1.14 Corporation tax

Leeds and York Partnership NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities, which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disapplied, the foundation trust has no corporation tax liability.

1.15 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Transactions that are denominated in a foreign currency are converted into sterling at the exchange rate ruling on the date of each transaction. Gains and losses that result are taken to the Statement of Comprehensive Income.

1.16 Third party assets

Assets belonging to third parties, in which the Leeds and York Partnership NHS Foundation Trust has no beneficial interest, (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts, note 30, in accordance with the requirements of the HM Treasury FReM.

1.17 Leases

Finance leases

Where substantially all the risks and rewards of ownership of a leased asset are borne by Leeds and York Partnership NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is also recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted by the interest rate implicit in the lease. The implicit rate is that which discounts the minimum lease payments and any unguaranteed residual interest to the fair value of the asset at the inception of the lease.

The asset and liability are recognised as property, plant and equipment at the inception of the lease and de-recognised when the liability is discharged, cancelled or expires.

The annual rental is split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each financial year is calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in the Statement of Comprehensive Income.

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

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land, in the PFI, is treated as an operating lease.

1.18 Public dividend capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by Leeds and York Partnership NHS Foundation Trust, is paid over as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and the average daily balance of cash held with the Government Banking Service, the National Loans Fund and PDC receivable/payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

In accordance with the requirements laid down by the Secretary of State (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the accounts. The dividend is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

1.19 Losses and 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 each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis. Note 31 is compiled directly from the losses and special payments register which is prepared, as per the DHSC GAM, on an accruals basis (with the exception of provisions for future losses).

1.20 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase and sale of non-financial items (such as goods or services), which are entered into in accordance with Leeds and York Partnership NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policies for leases.

All other financial assets and financial liabilities are recognised when Leeds and York Partnership NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

Derecognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or Leeds and York Partnership NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'loans and receivables' and financial liabilities are classified as ‘other financial liabilities’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments, which are not quoted in an active market, and are included in current assets.

Leeds and York Partnership NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, Leeds and York Partnership NHS Foundation Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only 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 the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

Notes to the accounts - 1. Accounting policies (continued)

1.21 Accounting standards that have been issued but have not yet been adopted

a) IASB standard and IFRIC interpretations

Under paragraph 30 of IAS 8, entities need to disclose any new IFRSs that are issued but not yet effective and that are likely to impact the entity.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases and IFRIC 4 Determining whether an arrangement contains a lease, as well as other interpretations, and is applicable in the public sector from 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022, this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets. Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

Based on the forecast figures for 2022/23, the Trust expects the transition to this standard to increase Right of Use Assests by £5.2m, Right of Use Liabilities by a similar amount and to reduce revenue by £90k.

b) Government Financial Reporting Manual (FReM) changes

In preparing the DH GAM, the Department of Health and Social Care must take account of the requirements of the Government FReM issued by HM Treasury. In some cases, where there is a compelling reason, HM Treasury may grant permission not to adopt a change to the FReM in the DH GAM.

c) Other changes

From 2013/14 the exemption applicable to NHS FTs from consolidating NHS charitable funds that they control has been removed. The effect on Leeds and York Partnership NHS Foundation Trust is the need to consider whether charitable fund income, expenditure, assets, liabilities and reserves should be consolidated within the Trusts main accounts. Income and expenditure between the Trust and the charitable fund would be eliminated on consolidation. Further details are included in note 1.25 - Charitable Funds.

1.22 Accounting standards issued that have been adopted early by Leeds and York Partnership NHS Foundation Trust

No new accounting standards or revisions to existing standards have been adopted early in 2021/22

1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust'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. These 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 as the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.24 Private patient income cap

Previously, NHS Foundation Trusts were required to disclose private patient income where this exceeded the amount specified. This disclosure is no longer required.

1.25 Charitable funds

Under IAS 27 (revised) Leeds and York Partnership NHS Foundation Trust is required to consolidate any Charitable Funds that meet the definition of a subsidiary contained in the standard. HM Treasury has previously granted dispensation to NHS FT organisations in this respect, however this dispensation ended in 2013/14. Leeds and York Partnership NHS Foundation Trust has therefore considered the need to consolidate Charitable Funds within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Fund is not material and will not therefore be consolidated within the Trusts main accounts.

IAS 27 (revised) also requires specific disclosures to be included in the accounts. The dispensation previously granted did not include the requirement for appropriate disclosure and consequently note 33 - Charitable funds, continues to be included in the Trusts accounts in compliance with these disclosure requirements.

1.26 Transfer of services

Where the Trust transfers a function to, or receives a function from another entity within the Whole of Government Accounts boundary this represents a “machinery of government change” regardless of the mechanism used to effect the combination, eg, statutory merger or purchase of the business.

The Trust will normally account for a machinery of government change as a transfer by absorption. This includes all transfers of functions involving other bodies within the Department of Health and Social care’s Resource Accounting Boundary and transfers of functions involving local government bodies.

1.27 Investment in associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust’s financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust’s share of the entity’s profit or loss or other gains and losses (eg revaluation gains on the entity’s property, plant and equipment) following acquisition. It is also reduced when any distribution of gainshare is received by the Trust.

Associates which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Leeds and York Partnership NHS Foundation Trust is a 25% partner in the Collaborative Procurement Partnership LLP (CPP LLP), with 3 other NHS foundation trusts. The partnership was registered at Companies House on 18 January 2017 and began implementation on 8 November 2017, following a successful tender process to deliver services to the Department of Health and Social Care from 8 May 2018. For the year ended 31 March 2022 the CPP LLP is transacting based on a reimbursement of cost model and a gainshare on savings achieved.

Notes to the accounts

2 Operating segments

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services across the city of Leeds. Specialist services, eg, Forensics, Eating Disorders, CAHMS, Liaison and Perinatal, commissioned by NHS England are also provided by LYPFT in Leeds, York and North Yorkshire.

The majority of Trust income (by value) is on a block basis. The Trust contracted with Leeds Clinical Commissioning Groups (CCGs) for 53% of its income (55% in 2020/21). The Trust also had contracts with NHS England, Health Education England and Local Authorities for the provision of clinical services and education training services.

Two operating segments are reported below. The operating segments are care services and hosted services. The hosted services segment includes the Commercial Procurement Collaborative (CPC), Research & Development, and the Northern School of Child & Adolescent Psychotherapy. The figures have been calculated using full absorption costing.

The reportable segments are those used by the Trust's Board and management (the 'Chief Operating Decision Maker' as defined in IFRS 8, Operating Segments) to run the business . Segment information is presented on the same basis as that used for internal reporting purposes. The surplus or deficit for each segment is used to inform the Board of Directors on performance and to assist in negotiations with commissioners on the cost and resources needed to maintain services at a level consistent with the need of the population.

Further detail of each directorate can be found in the Annual Report of the Trust.

	Care Services		**Hosted Services**		**Total**	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2022
	£000	£000	**£000**	£000	**£000**	£000
Income by segment						
Income from activities	**201,562**	173,283			**201,562**	173,283
Other operating income	**12,932**	19,025	**11,241**	10,603	**24,173**	29,628
TOTAL INCOME	**214,494**	192,308	**11,241**	10,603	**225,735**	202,911
TOTAL EXPENDITURE	**(205,571)**	(188,167)	**(10,963)**	(10,349)	**(216,534)**	(198,516)
Operating surplus	**8,923**	4,141	**278**	254	**9,201**	4,395
Non Operating Income and Expenditure Total	**(3,830)**	(4,145)			**(3,830)**	(4,145)
Surplus/(Deficit) from continuing operations	**5,093**	(4)	**278**	254	**5,371**	250

a) Income includes £199m (£178m in 2020/21) from NHS organisations (primarily £119m from Leeds CCG and £40m from NHS England).

b) Expenditure includes employee expenses £152,045k (£140,798k in 2020/21), premises £7,010k (£5,942k in 2020/21), depreciation and amortisation £4,553k (£4,520k in 2020/21) and establishment £2,036k (£1,749k in 2020/21).

3 Revenue from patient care activities

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Clinical Commissioning Groups and NHS England	**181,891**	162,309
Foundation Trusts	**8,218**	234
Local Authorities	**101**	43
NHS other	**1,973**	1,201
Non-NHS:		
Income for social care clients	**9,293**	9,393
Other	**86**	103
Total revenue from patient care activities	**201,562**	173,283

All income from patient care activities is classed as commissioner requested services (CRS).

4	**Other operating revenue**	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
	Research and development	**1,654**	2,110
	Education and training	**5,663**	4,651
	Non-patient care services to other bodies	**1,337**	1,327
	Provider sustainability fund		
	Reimbursement and Top Up Funding	**370**	6,218
	Contributions to expenditure donated from DHSC bodies for COVID	**253**	2,944
	Other income:		
	Inter NHS Foundation Trust	**554**	1,005
	Inter NHS Trust	**333**	1,033
	Inter RAB	**3,743**	3,423
	Inter Other WGA bodies	**842**	230
	Other (outside WGA)	**8,286**	5,625
	Income in respect of staff costs where accounted on gross basis	**1,138**	1,062
	Total Other Operating Revenue	**24,173**	29,628

5	**Operating expenses**	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
	Purchase of healthcare from NHS and DHSC bodies	**229**	262
	Purchase of healthcare from non-NHS and non-DHSC bodies	**12,775**	11,774
	MH collaboratives (lead provider) - purchase of healthcare from NHS bodies	**807**	
	MH collaboratives (lead provider) - purchase of healthcare from non-NHS bodies	**3,785**	
	Purchase of social care	**841**	638
	Staff and executive directors costs	**152,044**	140,798
	Non-executive directors	**213**	208
	Supplies and services – clinical (excluding drugs costs)	**1,399**	2,128
	Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**253**	2,928
	Supplies and services - general	**3,158**	2,146
	Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold		16
	Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**1,850**	1,742
	Consultancy	**348**	
	Establishment	**2,036**	1,749
	Premises - business rates collected by local authorities	**1,066**	1,030
	Premises - other	**6,551**	5,686
	Transport (business travel only)	**460**	256
	Transport - other (including patient travel)	**745**	883
	Depreciation	**4,329**	4,255
	Amortisation	**225**	265
	Impairments net of (reversals)	**174**	620
	Increase/(decrease) in impairment of receivables	**(6)**	64
	Provisions arising / released in year	**468**	2,789
	Change in provisions discount rate	**33**	47
	Audit services - statutory audit	**86**	68
	Internal audit - non-staff	**159**	110
	Clinical negligence - amounts payable to NHS Resolution (premium)	**486**	372
	Legal fees	**176**	651
	Insurance	**169**	159
	Research and development - non staff	**1,773**	2,375
	Education and training - non staff	**1,200**	882
	Education and training - notional expenditure funded from apprenticeship fund	**380**	191
	Operating lease expenditure (net)	**1,424**	1,458
	Early retirements - non staff	**14**	10
	Redundancy costs - non staff	**77**	
	Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis	**8,024**	7,840
	Car parking and security	**187**	183
	Other losses and special payments - non staff	**46**	340
	Other	**8,550**	3,593
	Total operating expenditure	**216,534**	198,516

Details of provisions arising in year are included in note 25.

Details of the Directors' remuneration can be found in Section 2.2 of the annual report.

Notes to the accounts - 5. Operating expenses (continued)

5.1 Auditors remuneration

The Board of Governors appointed KPMG as external auditors of the Foundation Trust for 2021/22. The statutory audit fee will be £72k for 2021/22 excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by NHSi as updated in December 2014.

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Financial Audit	**72**	57
Total	**72**	57

6 Operating leases

6.1 As lessee

The leases are for buildings, vehicles and other equipment. Building leases include the lease on Trust headquarters at Thorpe Park, which has been extended by three years to June 2022 and other non specialised properties used for clinical purposes. Vehicle leases are for cars supplied to qualifying staff under a vehicle lease scheme. Other equipment leases are mainly for photocopy equipment in the various Trust properties.

Payments recognised as an expense	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Minimum lease payments	**1,424**	1,458
Sub-lease payments		
	1,424	1,458

Total future minimum lease payments	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Not later than one year	**1,109**	1,256
Between one and five years	**2,948**	771
After 5 years	**1,236**	
Total	**5,293**	2,027

Notes to the accounts

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2022			Year Ended 31 March 2021		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**111,987**	**100,210**	**11,777**	104,981	93,700	11,281
Social security costs	**10,734**	**10,734**		9,835	9,835	
Employer contributions to NHS pension scheme	**13,774**	**13,774**		12,819	12,819	
Agency staff	**9,261**		**9,261**	7,346		7,346
Employee benefits expense	**145,756**	**124,718**	**21,038**	134,981	116,354	18,627

There were no employee benefits paid in the year ended 2021/22 (£nil in 2020/21)

In addition to the above:		
Charged to capital		
Employer contributions to NHS pension scheme paid by NHSE	**6,020**	5,593
Apprentice Levy	**538**	493
Recharged income	**(270)**	(269)
Total employee costs	**152,044**	140,798

Full details of the Directors' remuneration can be found in section 2.2 of the Annual Report, of which a summarised version is given below.

The disclosures required under the Hutton report can also be found in section 2.2 of the Annual Report.

	Year Ended 31 March 2022	Year Ended 31 March 2021
Directors' remuneration	**£000**	£000
Aggregate emoluments to Executive Directors	**812**	841
Remuneration of Non-Executive Directors	**214**	207
Pension cost	**95**	99
Additional Pension cost covered by NHS E	**42**	43
	1,163	1,190

Remuneration of Non-Executives include MH Act Managers £71k (£64k in 2020/21).

7.2 Monthly average number of people employed (wte)

	Year Ended 31 March 2022			Year Ended 31 March 2021		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**212**	**187**	**25**	204	185	19
Administration and estates	**730**	**682**	**48**	679	636	43
Healthcare assistants and other support staff	**917**	**647**	**271**	879	611	268
Nursing, midwifery and health visiting staff	**828**	**775**	**53**	811	763	48
Scientific, therapeutic and technical staff	**381**	**379**	**2**	344	341	3
Social care staff	**28**	**28**		23	23	
Total	**3,097**	**2,698**	**399**	2,940	2,559	381

8 Retirements due to ill-health

During 2021/22 there were 4 (3 in 2020/21) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £178k (£294k in 2020/21). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

9 Better Payment Practice Code

	Year Ended 31 March 2022		Year Ended 31 March 2021	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**19,840**	**73,262**	22,911	69,178
Total Non-NHS trade invoices paid within target	**18,603**	**69,809**	22,266	66,307
Percentage of Non-NHS trade invoices paid within target	**94%**	**95%**	97%	96%
Total NHS trade invoices paid in the year	**414**	**7,216**	535	7,589
Total NHS trade invoices paid within target	**370**	**6,646**	481	6,424
Percentage of NHS trade invoices paid within target	**89%**	**92%**	90%	85%

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

Notes to the accounts

10 Finance Income

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Bank accounts	**113**	
Total	**113**	

This figure includes accrued interest of £55k (2020/21 £0).

11 Other gains and losses

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Gain on disposal of property, plant and equipment	**17**	
Loss on disposal of property, plant and equipment	**(16)**	(85)
Loss on disposal of intangible assets		(46)
Total	**1**	(131)

12 Finance costs

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Interest on obligations under finance leases		
Interest on obligations under PFI contracts:		
- main finance cost	**1,327**	1,497
- contingent finance cost	**2,616**	2,525
Total	**3,943**	4,022

13 Intangible assets

2021/22:	Computer software - purchased £000	2020/21:	Computer software - purchased £000
Gross valuation at 1 April 2021	943	Gross valuation at 1 April 2020	1,138
Additions purchased	167	Additions purchased	
Additions work in progress		Additions work in progress	9
Disposals other than by sale	(14)	Disposals other than by sale	(186)
Impairments	(3)	Impairments	
Reclassifications		Reclassifications	
Revaluation/indexation	(491)	Revaluation/indexation	(18)
Gross valuation at 31 March 2022	**602**	**Gross valuation at 31 March 2021**	**943**
Accumulated amortisation at 1 April 2021	343	Accumulated amortisation at 1 April 2020	274
Disposals other than by sale	(14)	Disposals other than by sale	(140)
Revaluation	(561)	Revaluation	(56)
Impairments	20	Impairments	
Charged during the year	225	Charged during the year	265
Accumulated amortisation at 31 March 2022	**13**	**Accumulated amortisation at 31 March 2021**	**343**
Net book value		**Net book value**	
Purchased	589	Purchased	600
Total at 31 March 2022	**589**	**Total at 31 March 2021**	**600**

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5k is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 2 and 5 years depending on the software licence. The remaining economic life is assessed each year.

Quotations were sought in 2021/22 for the software licences and this led to an impairment charge to operating expenses of £20k (impairment charge of £0k in 2020/21).

Notes to the accounts

14. Property, plant and equipment

2021/22:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2021	1,850	31,138	15,873	993	521	9,811	1,111	61,297
Additions purchased			8,475	18	279	1,782	63	10,617
Additions donated								
Reclassifications		23,203	(23,935)	7		89	636	
Reclassified as held for sale								
Disposals		(118)			(139)		(19)	(276)
Revaluation/indexation (losses)/gains	53	(1,586)		17	90		176	(1,250)
Impairments		(101)	(63)					(164)
Reversal of Impairments	27							27
At 31 March 2022	**1,930**	**52,536**	**350**	**1,035**	**751**	**11,682**	**1,967**	**70,251**
Accumulated depreciation at 1 April 2021		292		855	273	5,134	584	7,138
Disposals		(118)			(111)		(5)	(234)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(2,884)		15	29		65	(2,775)
Impairments		591						591
Reversal of Impairments		(473)						(473)
Charged during the year		2,921		41	52	1,231	84	4,329
Accumulated depreciation at 31 March 2022		**329**		**911**	**243**	**6,365**	**728**	**8,576**
Net book value								
Total at 31 March 2022	**1,930**	**52,207**	**350**	**124**	**508**	**5,317**	**1,239**	**61,675**
Asset financing								
Owned	1,930	43,349	350	124	508	5,317	1,239	**52,817**
PFI		8,848						**8,848**
Donated		10						**10**
Total at 31 March 2022	**1,930**	**52,207**	**350**	**124**	**508**	**5,317**	**1,239**	**61,675**

The latest revaluation of land and buildings was carried out by the Valuation Office with an effective date of 31 March 2022.

Specialist land and buildings in operational use are valued at Depreciated Replacement Cost (DRC), using a Modern Equivalent Asset basis (MEA). The MEA basis includes consideration of modern building techniques, occupancy rates, service delivery output and alternative site as required.

Non specialist land and buildings in operational use are valued at open market value, assuming existing use.

The Foundation Trust's property, plant and equipment are held for service delivery, rather than for cash generating purposes. Consequently, in accordance with the DH GAM, the "value in use" is assumed to be at least equal to the cost of replacing the service potential provided by the asset unless there has been a reduction in service potential. When measuring impairments, the recoverable amount for operational properties is considered to be the value in use rather than the "fair value less costs to sell".

There are no restrictions imposed on the use of donated assets.

14.1 Property, plant and equipment - prior year

2020/21:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	1,878	33,939	2,077	961	321	10,524	1,042	50,742
Additions purchased			15,820	46	180	794	61	16,901
Additions donated								
Reclassifications		1,940	(2,011)			71		
Reclassified as held for sale								
Disposals						(1,578)		(1,578)
Revaluation/indexation (losses)/gains	(28)	(4,741)		(13)	20		7	(4,755)
Impairments			(13)	(1)				(14)
Reversal of Impairments							1	1
At 31 March 2021	**1,850**	**31,138**	**15,873**	**993**	**521**	**9,811**	**1,111**	**61,297**
Accumulated depreciation at 1 April 2020		275		834	240	5,368	503	7,220
Disposals						(1,493)		(1,493)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(3,454)		(12)	11		4	(3,451)
Impairments		607						607
Reversal of Impairments								
Charged during the year		2,864		33	22	1,259	77	4,255
Accumulated depreciation at 31 March 2021		**292**		**855**	**273**	**5,134**	**584**	**7,138**
Net book value								
Total at 31 March 2021	**1,850**	**30,846**	**15,873**	**138**	**248**	**4,677**	**527**	**54,159**
Asset financing								
Owned	1,850	20,861	15,873	138	248	4,677	527	**44,174**
PFI		9,974						**9,974**
Donated		11						**11**
Total at 31 March 2021	**1,850**	**30,846**	**15,873**	**138**	**248**	**4,677**	**527**	**54,159**

Notes to the accounts - 14. Property, plant and equipment (continued)

14.2 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Loss or damage from normal operations		
Abandonment of assets in course of construction	**63**	14
Over specification of assets		
Changes in Market Place	**591**	607
Reversals of impairments	**(500)**	(1)
At 31 March	**154**	620

15 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Property, plant and equipment	**136**	3,020
Total	**136**	3,020

This includes a new building for Child & Adolescent Mental Health Services at St Mary's Hospital £0k (£2,996k 2020/21).

16 Inventories

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Energy, consumables and work in progress	**47**	20
Total	**47**	20
Of which held at net realisable value:	**47**	20

16.1 Inventories recognised in expenses

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Inventories recognised as an expense in the year	**20**	23
Total	**20**	23

17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Trade Receivables				
Contract receivables	**2,967**	2,970		
Accrued Income	**2,129**	1,516		
Allowance for impaired contract receivables	**(774)**	(780)		
Prepayments	**1,410**	1,315	**5,771**	5,393
Interest Receivable	**55**			
PDC Receivable	**84**			
VAT	**714**	497		
Other receivables	**354**	341	**415**	271
Total	**6,939**	5,859	**6,186**	5,664

The majority of trade is with Clinical Commissioning Groups (CCGs), as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Credit scoring is not applied to other receivables

17.1 Receivables past their due date but not impaired

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
By up to three months	**1,734**	508
By three to six months	**3**	10
Over six months	**(7)**	(207)
Total	**1,730**	311

The Trust does not consider the above debtors, past their due date, to be impaired, based on previous trends and experience.

17.2 Allowances for credit losses

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Balance at 1 April	**780**	716
Amount written off during the year		
Increase/(decrease) in receivables impaired	**(6)**	64
Balance at 31 March	**774**	780

The provision for impairment of receivables for the year ended 31 March 2022 has increased/decreased after taking all factors into consideration regarding the potential for recovery.

18 Cash and cash equivalents

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Balance at 1 April	**111,695**	92,300
Net change in year	**9,059**	19,395
Balance at 31 March	**120,754**	111,695
Made up of		
Cash with Government Banking Service	**120,563**	111,570
Commercial banks and cash in hand	**191**	125
Cash and cash equivalents as in statement of financial position	**120,754**	111,695
Cash and cash equivalents as in statement of cash flows	**120,754**	111,695

Notes to the accounts

19 Non-current assets held for sale

At 31 March 2022 there are no assets held for sale (Nil in 2020/21).

20 Trade and other payables

	Current	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Trade payables	**11,202**	7,254
Amounts due to other related parties		
Non NHS trade payables - capital	**2,361**	4,163
Accruals	**21,295**	12,191
Other	**550**	4,544
Total	**35,408**	28,152

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
PFI liabilities	**2,392**	2,208	**12,897**	15,289
Total	**2,392**	2,208	**12,897**	15,289

22 Other liabilities

	Current	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Deferred Income	**8,970**	7,766
Total	**8,970**	7,766

23 Finance lease obligations

There are no current finance leases in operation.

Notes to the accounts

24 Private Finance Initiative (PFI) contracts

PFI schemes on-Statement of Financial Position

The PFI contract is for the provision of seven mental health units, providing a comprehensive range of mental health services. The estimated capital value of the PFI scheme is £43,778k. The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028. The Trust has the right to purchase the units at market value at the end of the contract.

More detail is provided in the PFI accounting policy in note 1.7

Minimum amounts payable under the contract:

Asset financing component	**Gross Payments**		**Present value of payments**	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Not later than one year	**6,151**	6,060	**5,922**	5,834
Later than one year, not later than five years	**24,605**	24,241	**19,913**	19,619
Later than five years	**2,050**	8,080	**1,419**	5,401
Sub total	**32,806**	38,381	**27,254**	30,854
Less: finance cost attributable to future periods	**(17,517)**	(20,884)	**(11,965)**	(13,357)
Total	**15,289**	17,497	**15,289**	17,497

Services component	**Gross Payments**	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Not later than one year	**6,914**	6,812
Later than one year, not later than five years	**27,658**	27,249
Later than five years	**2,305**	9,083
Total	**36,877**	43,144

The future services amounts due as at 31 March 2022 reflect an adjustment for the RPI indexation of the unitary payment applied during 2021/22.

The amount charged to operating expenses during the year in respect of services was £6,909k (2020/21 £6,754k).

24.1 Analysis of amounts payable to service concession operator

	Gross Payments	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Unitary payment	**14,553**	14,332
Consisting of:		
- Interest charge	**1,327**	1,497
- Repayment of finance lease liability	**2,208**	2,038
- Service element and other charges to operating expenses	**7,271**	7,108
- Capital lifecycle maintenance		
- Revenue lifecycle maintenance	**753**	732
- Contingent rent	**2,616**	2,525
- Addition to lifecycle prepayment	**378**	422
Total	**14,553**	14,322

The addition to lifecycle prepayment relates to a rent free period at the end of the contract £378k (£422k 2020/21). Service element and other charges to operating expenses includes the operating lease payments for the land element of the properties £433k (£424k 2020/21).

25 Provisions

	Current		Non-current	
	Year ended 31 March 2022	Year ended 31 March 2021	**Year ended 31 March 2022**	Year ended 31 March 2021
	£000	£000	**£000**	£000
Pensions relating to other staff	**145**	147	**1,369**	1,464
Legal claims	**71**	79		
Redundancy	**2,552**	2,668		
Other	**1,500**	916	**3,994**	4,079
Total	**4,268**	3,810	**5,363**	5,543

	Pensions relating to other staff	**Legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2020	1,627	100	3,171	1,786	6,684
Arising during the year	97	59	131	3,301	3,588
Change in discount rate	47				47
Used during the year	(147)	(52)			(199)
Reversed unused	(5)	(28)	(634)	(92)	(759)
Unwinding of discount	(8)				(8)
At 31 March 2021	1,611	79	2,668	4,995	9,353
At 1 April 2021	1,611	79	2,668	4,995	9,353
Arising during the year	48	43	355	4,230	4,676
Change in discount rate	33				33
Used during the year	(147)	(37)	(140)	(28)	(352)
Reversed unused	(16)	(14)	(331)	(3,703)	(4,064)
Unwinding of discount	(15)				(15)
At 31 March 2022	**1,514**	**71**	**2,552**	**5,494**	**9,631**
Expected timing of cash flows:					
Between 1 April 2022 and 31 March 2023	145	71	2,552	1,500	4,268
Between 1 April 2023 and 31 March 2027	581			2,540	3,121
Thereafter	788			1,454	2,242
TOTAL	**1,514**	**71**	**2,552**	**5,494**	**9,631**

The pensions provision is in respect of employees who have taken early retirement through injury or prior to 1995. These provisions are calculated using current year payments and GAD tables as issued by the Office for National Statistics. The GAD tables provide an estimate of remaining lives, which the provision is based on. Payments made against the pensions provisions are quarterly to the NHS Business Services Authority Pensions Division. Due to the nature of the other provisions, there is no certainty regarding the timing of payments.

The legal claims provision is in respect of excess payments to NHS Litigation Authority for employers' and public liability claims. NHS Litigation Authority provides estimates of the likely outcome of the case and damages/costs to be paid. The provision is calculated based on these estimates.

Other provisions comprise the commitment placed on the Trust in ensuring it meets its obligations in respect of dilapidation costs £768k (£645k 2020/21), IT software contracted out services vat £381k (£435k 2020/21), Pension Final Pay Controls £0k (£336k 2020/21), Pension Annual Allowance (as per national guidance) £415k (£271k 2020/21), leases £92k (£109k 2020/21) and in relation to one of the Trust's PFI assets £3,837k (£3,200k 2020/21).

The unwinding of discount on the provisions appears as a finance cost on the face of the Statement of Comprehensive Income.

Leeds and York Partnership NHS Foundation Trust has no expected reimbursements for any class of provision made.

£17,822k is included in the provisions of the NHS Litigation Authority at 31 March 2022 in respect of the clinical negligence liabilities of the Trust (31 March 2021 £9,856k).

26 Contingent liabilities

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Other	**38**	51
Total	**38**	51

Contingent liabilities represent excess payments not provided for on legal cases being dealt with by NHSLA, on the Trust's behalf, (primarily in respect of employer's liability - £38k in 2021/22 and £51k in 2020/21). Due to the nature of the amounts and timing of the cash flows it would be impractical to estimate the value and timings of the amounts and cash flows.

27 Financial Instruments

Leeds and York Partnership NHS Foundation Trust's financial assets are classified either as "loans and receivables" financial assets. All the Trust's financial liabilities are classified as "other liabilities".

Leeds and York Partnership NHS Foundation Trust undertakes active financial risk management to manage its exposure to risk, particularly credit risk and treasury risk. Similar to general risk management, financial risk management requires identifying its sources, measuring it and implementing plans to address them.

27.1 Financial assets - carrying amount

	Loans and receivables £000
Receivables	4,318
Cash at bank and in hand	111,695
Total at 31 March 2021	116,013
Receivables	**4,731**
Cash at bank and in hand	**120,754**
Total at 31 March 2022	**125,485**

Ageing of over due receivables included in Financial Assets

Receivables overdue by:	
1-30 days	**206**
31-60 days	**199**
61-90 days	**20**
91-180 days	**36**
Greater than 180 days	**34**
	495

27.2 Financial liabilities - carrying amount

	£000
Embedded derivatives	
Payables	25,354
PFI and finance lease obligations	17,497
Provisions under contract	8,647
Total at 31 March 2021	51,498
Embedded derivatives	
Payables	**35,408**
PFI and finance lease obligations	**15,289**
Provisions under contract	**9,250**
Total at 31 March 2022	**59,947**

27.3 Fair values of loans and receivables and other financial liabilities

The fair value of current loans and receivables are considered to be equal to their carrying amounts. There are no non-current loans and receivables.

The fair values of current financial liabilities are considered to be equal to their carrying amounts.

27.4 Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Leeds and York Partnership NHS Foundation Trust's activities are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Consequently the Trust's financial risks are relatively small in comparison with commercial entities. The Trust does not use financial instruments to alter or hedge its risk and therefore their importance to the Trust's finances are similarly relatively low.

Credit risk

This is the risk that other parties may not pay amounts that are due from them to Leeds and York Partnership NHS Foundation Trust. The majority of the Trust's income comes from contracts with other public sector bodies, however, and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in the Trade and other receivables note.

Leeds and York Partnership NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investors. Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

Leeds and York Partnership NHS Foundation Trust's net operating costs are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Leeds and York Partnership NHS Foundation Trust also largely finances its capital expenditure from funds generated through operating surpluses. Consequently, the Trust is not considered to be exposed to significant liquidity risks (the inability of paying financial liabilities).

Leeds and York Partnership NHS Foundation Trust's main long term liability is its PFI obligation, with the contract ending in 2028. Further information on the commitments under this contract are provided in note 24.

Market risk

Market risk comprises three elements: foreign currency risk, interest rate risk and price risk.

Foreign currency risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure. Consequently, exposure to currency risk is not significant.

Interest rate risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities, e.g. borrowing and financial assets. However, a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds and York Partnership NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Price risk

As explained in note 24, Leeds and York Partnership NHS Foundation Trusts' annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard. The annual adjustments are reflected in finance costs (contingent rent), operating expenses and property, plant and equipment additions respectively.

For 2021/22 the percentage increase in the unitary payment was 1.50%, equalling a monetary increase of £30k (2.61%, £182k in 2020/21).

The table below shows a sensitivity analysis of the impact on cash payments and on the surplus/deficit for the year if the uplift had been between 3.7% and 5.5%.

2021/22 Uplift in unitary payment	**Actual uplift at 1.5%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	(79)	54	163
Recognised in operating expenses	109	268	399
Recognised in surplus/deficit	30	322	562
	30	322	562
Net impact of sensitivities on surplus/(deficit)		**(292)**	**(532)**

2020/21 Uplift in unitary payment	**Actual uplift at 2.61%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	(3)	62	168
Recognised in operating expenses	185	261	388
Recognised in surplus/deficit	182	323	556
	182	323	556
Net impact of sensitivities on surplus/(deficit)		**(141)**	**(374)**

28 Related party transactions

Leeds and York Partnership NHS Foundation Trust is a public benefit corporation, which was established by the granting of authorisation by the independent Regulator for NHS Foundation Trusts, NHS Improvement.

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year the Trust has had a significant number of material transactions with other NHS Bodies. In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central and local Government bodies.

During the year 2021/22, Leeds and York Partnership NHS Foundation Trust had significant transactions with Leeds University, where 1 Non Executive Director of the Trust's Board holds a position of employment with the university.

28.1 Related party transactions - members of the Board of Directors

During the year Leeds and York Partnership NHS Foundation Trust had the following material transactions with entities, which are considered related parties to members of the Board of Directors of the Trust:

	Payments to Related Parties	Receipts from Related Parties	Amounts owed to Related Parties	Amounts due from Related Parties
	£000	**£000**	**£000**	**£000**
University of Leeds (2021/22)	**415**	**89**	**3**	**7**
University of Leeds (2020/21)	240	78	22	46

In 2021/22, the Trust had £6k of related party transactions with its charitable fund (2020/21 £4k).

28.2 Related party transactions - commitments (year ending 31/3/2023)

		Income £000
Leeds Clinical Commissioning Groups	£	119,033
NHS England	£	35,236
	£	**154,269**

These commitments are material transactions relating to NHS bodies. The figures are draft, and block contract values.

The Trust has no expenditure commitments with related parties for the year ending 31 March 2023.

28.3 Related party transactions - UK Government ultimate parent

	Income		Expenditure	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Department of Health and Social Care	**1,304**	1,934		
Other DHSC Group bodies	**199,007**	176,559	**10,076**	7,577
Other	**1,310**	586	**33,931**	29,424
Total	**201,621**	179,079	**44,007**	37,001

	Receivables		Payables	
	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000	**Year ended 31 March 2022 £000**	Year ended 31 March 2021 £000
Department of Health and Social Care	**254**	444		
Other DHSC Group bodies	**2,243**	2,006	**4,862**	2,461
Other	**714**	497	**2,702**	2,798
Total	**3,211**	2,947	**7,564**	5,259

29 Intra-Government and other balances

	Current receivables £000	**Non-current receivables £000**	**Current payables £000**	**Non-current payables £000**
Balances with other Central Government bodies	714			
Balances with Local Authorities			2,702	
Balances with NHS bodies	2,497		4,862	
Intra Government balances	**3,211**		**7,564**	
Balances with bodies external to Government	3,728	6,186	27,844	
At 31 March 2022	**6,939**	**6,186**	**35,408**	
Balances with other Central Government bodies	497		2,798	
Balances with Local Authorities				
Balances with NHS bodies	2,449		2,460	
Intra Government balances	**2,946**		**5,258**	
Balances with bodies external to Government	2,913	5,664	22,894	
At 31 March 2021	**5,859**	**5,664**	**28,152**	

Notes to the accounts

30 Third party assets

The Trust held £343k cash and cash equivalents at 31 March 2022 (£327k 2020/21), which relates to monies held on behalf of service users. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 Losses and special payments

There were 2 cases of losses totalling £0k (0 in 2020/21 totalling £0k) and 32 special payments totalling £46k (27 in 2020/21 totalling £340k) during the year. The prior year includes nationally funded overtime corrective payments of £312k. These amounts are reported on an accruals basis, excluding provisions for future losses.

	Number	Value £000
Losses		
Cash - other	2 (0)	0 (0)
Bad debts - other	0 (0)	0 (0)
Total	**2 (0)**	**0 (0)**
Special payments		
Ex-gratia - loss of personal effects	25 (20)	9 (4)
Ex-gratia - personal injury with advice	7 (5)	37 (24)
Ex-gratia - overtime corrective payments (nationally funded)	0 (1)	0 (312)
Total	**32 (26)**	**46 (340)**

Figures in brackets relate to 2020/21.

32 Events after the reporting period

There were no events after the reporting period that had an impact on the Trust's 2021/22 accounts (2020/21: none).

33 Charitable Fund

	Year ended 31 March 2022 £000	Year ended 31 March 2021 £000
Income	**73**	112
Expenditure	**(14)**	(27)
Net movement in funds	**59**	85
Current assets	**216**	162
Current liabilities	**(6)**	(1)
Total Charitable Funds	**210**	161

The Charitable fund is not consolidated within these accounts but is disclosed in line with IAS 27 (revised).

CONTACT INFORMATION

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Dr Sara Munro

Tel: 0113 85 55913
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Patient Advice and Liaison Services (PALS)
If you need any help or advice about our services, please contact:
PALS Team

Tel: 0800 0525 790 (Freephone)
Email: pals.lypft@nhs.net

Membership
If you are interested in becoming a member of Leeds and York Partnership NHS Foundation Trust, please contact:
The Membership Office

Tel: 0113 85 55900
Email: ftmembership.lypft@nhs.net
Web: www.leedsandyorkpft.nhs.uk/membership

Communications
If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:
The Communications Team

Tel: 0113 85 55989
Email: communications.lypft@nhs.net

Members of the Board of Directors and Council of Governors
Can be contacted by email at the addresses shown on our website at:

www.leedsandyorkpft.nhs.uk