Leeds and York Partnership
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

1 April 2019
to
31 March 2020

Leeds and York Partnership NHS Foundation Trust

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PART A
ANNUAL REPORT
2019/20

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

The last few weeks of this financial year are some of the toughest ever for the NHS as we work together to respond to the Coronavirus. It has had an impact on all of our services, requiring fast but thoughtful changes, strong leadership and a positive 'can do' attitude from us all. Lockdown has ensured that much of our normal way of life at home, at work and as a Board has completely changed. As I write this foreword, the UK remains in lockdown and the NHS and Care services remain at the forefront of dealing with the human impact of the crisis. We are grateful for the wonderful support of the public in Leeds and York, and for the sacrifices being made to stay safe. As a Trust we have lost some of our service users and at least one member of staff to this terrible virus. Our thoughts and prayers are with their loved ones at this very sad time.

Every day I continue to be humbled and inspired by so many of our staff, volunteers and service users by their day-to-day commitment to the values underpinning the NHS. I am privileged to see acts of kindness and compassion, along with professional knowledge, sharing 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. Our Trust values are Integrity, Simplicity and Caring, and are despite such difficulties, demonstrated in abundance. For this I am so very grateful.

We start every Board meeting with an opportunity to hear about the experience of service users, carers or members of staff. This discussion reminds 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.

Some of these accounts are very moving and are eloquent descriptions of how it feels to live with a mental illness and be served by an imperfect system. Others have been more positive accounts of the life changing impact of our services on individuals and their families. 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 come along to our Board meetings.

This year the Board started a process to update our strategic vision and refresh the detailed underpinning plans. The plans cover workforce, estates, information technology, clinical services and quality. They represent a huge amount of work, detailed planning and a creative ambition for the future provision of services for people with mental illness and learning disabilities in Leeds and York.

There have been a number of major developments in our services. We welcomed the extension of the new services for Veterans in the armed services, now located on three sites in Leeds, Salford and Sunderland. New services were also established for those who experience gambling addiction. Both these services were developed with partner agencies (Combat Stress, and GamCare respectively) and we look forward to their continued development over the coming year. We were also delighted to see the expansion of our new model of care for eating disorders. This has been recognised as an excellent service and has secured national commendation.

This year we redesigned our community services and are currently working on a programme of 'Acute Care Excellence' to improve our acute care offer. In March, we introduced a new electronic patient record system, 'Care Director' which is already improving how we record, interact and manage care services. We also developed a new system for improving the engagement and involvement of service users and carers right across the Trust. Finally, we were delighted to see the start of new building work on the St Mary's Hospital site for the new specialist CAMHS unit. We know this will make a major difference to the mental health and well being of some of our most vulnerable children and young people in the city.

Last August we had our latest inspection visit from CQC. I was delighted that we were rated as 'Good' overall. As ever, there are many areas where we can improve further, but it was a welcome recognition

of the hard work of our teams since the previous inspection, and the positive improvements that have taken place across all our services. Our Staff Survey also demonstrated some significant improvements and real progress in the embedding of our values and the levels of engagement of our staff.

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 and Harrogate Integrated Care System. We already work closely with many partners in delivering mental health and learning disability services to people in Leeds and York. 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 their commitment and continued work in the Trust. This year has seen a number of changes in welcoming new governors and saying goodbye and thanks to a number of long-serving governors too. Our new lead governor Peter Webster, has been a great support in the role. He has worked with the governors to help build their confidence in asking questions, participating in service visits and observing Board meetings. Governors have such an important role in holding the non-executives to account, and in representing the views of the public, staff, service users and carers. We have done some important work to strengthen their contribution and to enable them to carry out their roles effectively.

The Board membership has been relatively stable this year. I am grateful for the commitment and professionalism of all Board members. We welcomed one new non-executive director Cleveland Henry. I would like to take the opportunity of thanking his predecessor, Margaret Sentamu, for her dedication, passion and support to the Trust over the last six years.

As we look to next year, we will plan, manage and respond to the challenges presented by Coronavirus in the here and now. 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.

We will no doubt continue to face pressures across our services, but we have strong foundations in place, and are proud to have staff who live and demonstrate our values every day. We are focused on continuing to improve and to develop our services to ensure excellence for all our service users and their families.

Prof Sue Proctor
Chair of the Trust

1.1.2 A MESSAGE FROM OUR CHIEF EXECUTIVE

As I write my introduction for this year's Annual Report, I do so at a time like no other. NHS organisations like ours have never before faced a challenge like the current Coronavirus pandemic and I'd like to take this opportunity to pay tribute to the work undertaken by our staff and the values they've shown during this unprecedented time. But first of all, it's important to reflect on some of our progress and achievements from over the past year before our lives, personally and professionally, changed before our eyes.

Making improvements

There's been a range of service developments over the past year, both within the Trust and with our partners. In September, we opened our first Northern Gambling Clinic in Leeds, followed shortly by more in Manchester and Sunderland. This is such a crucial service and I'm pleased we're able to support the growing number of people struggling with gambling addiction across the North.

Much has also been achieved to help people across the city access immediate support for their mental health. For example, the Leeds Recovery College, which opened in September, offers courses to people living and working in Leeds to help them live mentally and physically well. The Leeds Mental Wellbeing Service is a partnership involving our Trust that offers psychological therapies, both face to face and online. It's another way we're supporting local people to overcome common mental health problems.

We received an early Christmas present when planning was approved for the new regional CAMHS unit on our St Mary's Hospital site. The West Yorkshire and Harrogate collaborative have been working closely together to develop a better way of providing care for young people with complex mental health issues across the region, and planning approval marks an important milestone in our efforts. I'm pleased to say that as I write this, work has already begun onsite.

In March, we switched to a new patient record system, CareDirector, an event that was two years in the making. It was a challenging time for staff to move to something so new and different but their resilience and determination shone through and I'm happy to say it was a safe and secure launch. CareDirector has been an important tool in our fight against Coronavirus, and its flexibility means it can be developed to suit our needs now and in the future.

Listening and responding

I'm so pleased we were able to include our bank staff in this year's Staff Survey– this reflects the crucial role they play in our teams. Our Trustwide results have improved or stayed the same in most areas, with significant improvements in how we rate our line managers and staff morale.

We've made extra efforts to listen to our staff this year, in the form of 'culture conversations'. There are some fantastic examples of positive culture across the organisation, and there's also ways we can improve how we work together, which in turn shapes our quality of care and performance. Both online and face to face conversations have taken place to understand how our staff feel about coming to work for us every day, and we're now analysing those conversations to give us a focus for improvement. I'm really invested in this piece of work, and I'm excited to see it come to fruition over the next year.

Listening and having conversations is just as important outside our organisation, with our members, service users, carers and the public – after all, these are the people we serve. I'm pleased that we have recently launched our co-produced Patient and Carer Experience Strategy, which sets out how we will better involve people in the development of our services and improve their experience with us. We also carried out surveys and focus groups to evaluate our redesigned Community Mental Health Services, to ensure our service users and carers remain at the heart of our decision making.

Celebrating our achievements

In November came our annual Trust Awards, a glittering event and one of my favourite nights of the year, where I help to present awards and celebrate with our staff and volunteers. Beyond our internal celebrations, some of our teams and individuals have gone on to be nominated for and even win national awards. There are too many amazing people to mention here, but what I will say is how proud I am of all their achievements and I'm so pleased that they are recognised by their peers externally too.

On the night I was also very pleased to see the launch of our Trust choir who provided us with an uplifting start to the event. They continue to come together and provide inspiration to us all.

The Trust as a whole received its own accolade in December, when we received a rating of “Good” by the Care Quality Commission. All of us remember the feeling of waiting for exam results, hoping your efforts have paid off. For me, those feelings returned while we’re awaiting our CQC report, and I am delighted that the hard work undertaken by everyone at the Trust has been recognised. The CQC’s report says we really are fulfilling our purpose of improving the health and lives of people with mental health problems, learning disabilities and autism. And after all, that’s why we all come to work every day.

Unprecedented times

The Coronavirus pandemic has proved to be the biggest healthcare crisis in a generation. As events began to unfold, the future felt daunting for many of us. But in such challenging times I found strength in our staff, and their courage and determination to continuing caring for our service users.

The crisis has affected all of us, personally and professionally. We’ve had to change how we support our service users, how we work together and how we balance our work and lives.

Throughout all this change and uncertainty, I’m incredibly proud of our staff and I can’t thank them enough for what they do. They’ve lived our values in the most difficult of situations – we have integrity, we keep it simple, we are caring – and they’ve shown many more too, like determination, bravery, flexibility, resilience, and compassion. They’ve supported each other through overwhelming circumstances and remained committed to our service users despite having their own families and loves ones to care for. I consider myself lucky to lead an organisation that is full of such heroic individuals.

As we look to the year ahead, I hope for peace and stability for our staff and service users. It’s likely that current events will further highlight the importance of mental health services, and as a Trust we’re committed to continuing to develop and improve our mental health and learning disability services for the people who need us.

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 for: Workforce and Organisational Development; Quality; Clinical Services; Health Informatics; and Estates. 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 781,000 adults in the Leeds areas and specialist services and accept referrals from across the UK. We operate from 123 dispersed sites and employ approximately 2,500 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 People's services	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 CAMHS 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
- CAMHS Tier 4 Inpatient 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 THE ENVIRONMENT IN WHICH WE OPERATE

1.1.7.1 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 adolescent 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.

1.1.7.2 The regional context

The West Yorkshire and Harrogate Integrated Care System (WY&H ICS) is made up of NHS organisations, local councils and voluntary sector organisations working closely together to plan services and address the challenges facing health and care services across the areas.

The WY&H ICS plans are built from six local area place-based plans, including Leeds, and builds on our strong history of partnership working. The neighbourhood will be the primary unit for both commissioning and delivery of services. Only when improved outcomes and greater efficiency can be achieved will services be planned and delivered at the whole place or, for the most specialist services, at West Yorkshire and Harrogate level.

The WY&H ICS has agreed a Memorandum of Understanding to formalise working arrangements and support the next stage of development of the partnership. The Trust is working with the three other mental health providers (Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership NHS Foundation Trust) in a mental health services collaborative. We are working together on the following areas:

- **Acute Mental Health Pathway (Adults):** We are working as a partnership to ensure that care is provided in the least restrictive environment with more care delivered closer to home. This will also address the significant number of people who have to go out of their local area for inpatient care. We will ensure that people are treated in the community wherever possible but if they do need to go into hospital, they can access care locally and if not, they will be cared for in West Yorkshire.

- **Complex Care/Rehabilitation Services:** The partnership currently has a large number of service users who are placed away from home in a rehabilitation unit, often in ‘locked’ units. As a partnership we will work to understand the clinical needs and plan to repatriate patients, prevent 14 future out of area placements and minimise lengths of stay and have bid successfully for national capital funding.

- **Adult Medium and Low Secure Services:** In response to NHS England’s review of adult secure mental health services, the partnership is completing a business case for a future service model.

- **Child and Adolescent Mental Health Services (CAMHS):** The partnership is a new model of care pilot for tertiary mental health services (CAMHS Tier 4). The focus is on preventing unnecessary admissions, reducing out of area placements, with effective management of children and young people in the community.

- **Children and Young People’s Autism:** Take forward system work on autism and Attention Deficit Hyperactivity Disorder in children and young people. This is prioritised because of the increasing volume of assessments being requested year on year and the challenges faced by organisations trying to meet this demand.

- **Learning Disabilities - Assessment & Treatment Units:** Providers and commissioners are collaborating to develop a standard future model for inpatient care. This will operate as a networked service working to the same standards.

1.1.8 PRINCIPAL RISKS AND OPPORTUNITIES FOR THE ORGANISATION

1.1.8.1 Risks

Key risks for the organisation are those that have been identified as strategic risks on the strategic risk register which are also set out in our Board Assurance Framework (BAF). Each of these risks has an identified executive director and management lead. These risks will 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 COVID19 pandemic. Whilst a specific risk for this was not entered on the Board Assurance Framework (BAF) at the end of March 2020 the risk ratings of each of the risks listed above were amended to reflect impact the pandemic was having on all areas of the Trust's business.

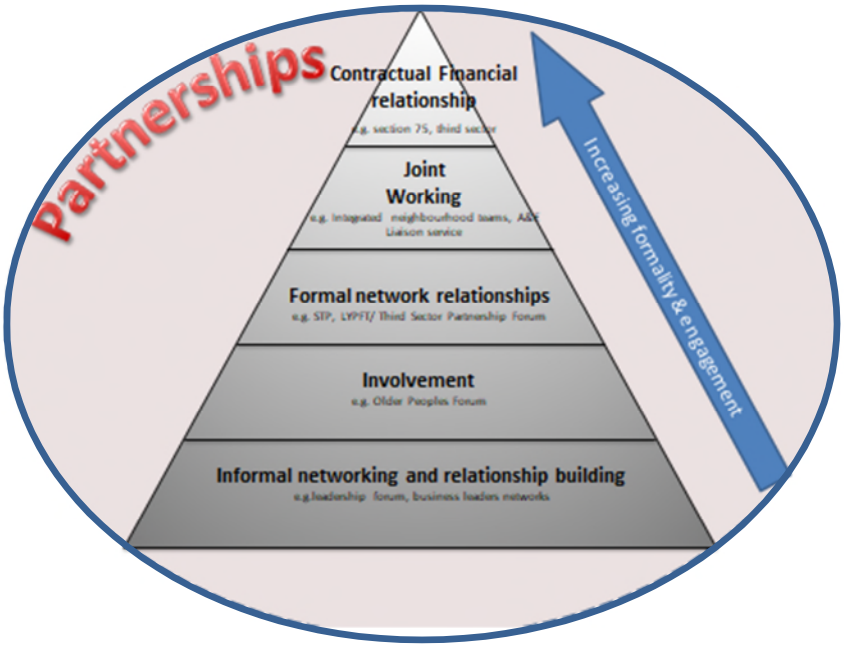
There is a specific COVID-19 operational risk register which informs the meetings of the 'Gold Command' and it sits behind the Board Assurance Framework.

1.1.8.2 Opportunities

The Trust's opportunities are to continue to develop our services. The Clinical Services Strategic Plan sets out the priorities and in 2019/20 we achieved much of what we set out to do. However, there is more that can be done and we would look to co-produce that with our service users.

Working in partnership also provides us with an opportunity to work cohesively across geographical areas to ensure there is a seamless provision of care. During 2019/20 the Trust has focused on strengthening relationships and delivering system-wide improvements to services with a range of partners. The Trust values working in partnership and recognises the positive impact this has on service users' experience of clinical services. Consequently we have seen an increase in the number of partners with which we engage and collaborate.

We have strengthened our approach through the development of a framework and approach to partnership working which is illustrated below:



This framework has clarified the approach taken and is leading to improvements to the contractual arrangements in place with our partners. We recognise the importance of third sector providers in supporting our service users and equally value working in partnership with them. We have instigated a forum to bring together third sector partners on a quarterly basis to undertake in-depth reviews into different service areas to improve the care provided across all providers.

In addition to the partnership working at a service level, the Trust has formal partnership arrangements with other NHS organisations in Leeds and the wider West Yorkshire and Harrogate Integrated Care System footprint.

The Coronavirus pandemic has brought about much uncertainty as to the future for the safety of our staff and service users and it has changed the way we deliver our services. Our staff have made a tremendous effort to put in place the necessary governance, structures, procedures and technologies to allow us all to work in a different way and provide a continuing safe and effective service. This different way of working also presents an opportunity for delivering care differently using new technologies and we will look to build on that learning and take forward this new thinking.

1.1.9 PERFORMANCE SUMMARY

1.1.9.1 Contractual and local targets

We have NHS Improvement targets, NHS Standard contract requirements, national and local Commissioning for Quality and Innovation (CQUIN) measures 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. Bi-monthly, this report is given 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 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 regular dialogue

with our commissioners and have a reporting schedule to submit performance and quality information to them. We meet on a regular basis (bi-monthly and quarterly) and have a set agenda which addresses all aspects of performance and quality.

Performance during 2019/20 has been varied. There have been some areas of strong performance, for example the Memory Services referral to diagnosis target consistently being exceeded throughout the year and maintaining the standard for length of stay on caseload in our Crisis and Intensive Support Services.

Analysis of the range of targets and standards for our community services needs to be done through the lens of the significant service redesign at the end of March 2019. 2019/20 has been a year of embedding these new models and continuous improvement with some significant improvements in performance seen within our Crisis and Intensive Support services given the level of change and staffing available through the year.

In-year improvement has been seen in services such as the Leeds Autism Diagnostic Service referral to assessment starting within 13 weeks and the national CQUIN for data quality maturity being met.

During the year, performance assessment has moved from a focus on month versus month analysis and reacting to small changes to taking a step back and looking at expected levels of variation and more trend analysis. The introduction of a new electronic patient record (CareDirector) at the end of 2019/20 will have an impact on data quality in the initial part of the year but the improvement in operational data it will provide alongside a more mature approach to data / performance analysis should set the Trust on a solid platform to understand and improve performance during the coming year.

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 2019/20.

Table 1.1C – Our contractual and local targets

Our contractual and local targets					
LEEDS CLINICAL COMMISSIONING GROUP					
	Target	**2019/20 Q1**	**2019/20 Q2**	**2019/20 Q3**	**2019/20 Q4**
Timely access to a MH assessment under S136 (target within 3 hours)	No target	26.4%	26.4%	21.9%	18.4%
Crisis and Intensive Support – Timely access to crisis assessment (ftf within 4 hours of referral)	90%	40.4%	52%	77.5%	73.6%
Crisis and Intensive Support – Length of stay on caseload (% less than 6 weeks)	70%	94.9%	85.9%	90.5%	90.4%
Crisis and Intensive Support – Frequency of contact (seen or visited 5 times in first week)	50%	30.5%	41.7%	41.4%	48.5%
Timely commencement of a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)	90%	81.5%	84.8%	85.9%	85%
Timely access to a mental health assessment by the LYPFT liaison Psychiatry In-reach Service (24 hours)	90%	84.8%	82.7%	86.8%	86.9%
Bed Occupancy rates for Acute Adult Inpatient Services	94-98%	100.2%	99.3%	99.3%	97.7%
Proportion of In Scope patients assigned to a Cluster	90%	88.6%	85.6%	85.1%	84.2%
Percentage starting LADS assessment within 13 weeks	95%	83.2%	82%	89.2%	94%

Perinatal Community – Timely access (less than 2 weeks) for routine referrals	85% (Q2) 90% (Q3) 95% (Q4)	75.8%	72.6%	65.3%	74%
Perinatal Community – Timely access (less than 48hrs wait) for urgent referrals	95% (Q2/3) 97% (Q4)	-	67%	100%	100%
Waiting times Access to Memory Services; Referral to first face to face contact within 8 weeks	90%	81.2%	85.3%	81.9%	82%
Memory Services – Time from Referral to Diagnosis within 12 weeks	50%	68.6%	66.7%	70.4%	61.4%
Waiting times for Community Mental Health Teams first contact within 15 days	80% (Q1/2) 85% (Q3/4)	75.2%	82.4%	81.6%	85.6%
Percentage of CLDT referrals seen within 4 weeks of receipt of referral	95%	82.7%	89%	88%	75.3%
Percentage of CLDT Care Plans reviewed within last 12 months	90%	-	60.4%	65.3%	59.7%
Incidents Reported within 48 hrs from Incident identified as Serious	100.0%	100.0%	100.0%	100.0%	100.0%
Cardio Metabolic Assessment (SMI community caseload)	80%	51%	47.8%	33.9%	31.2%
Cardio Metabolic Assessment (current SMI inpatients)	90%	78.2%	74.7%	84.3%	76.7%
Cardio Metabolic Assessment (EIP Service)	90%	62.8%	62%	67.8%	74.8%
NHS ENGLAND					
	Target	**2019/20 Q1**	**2019/20 Q2**	**2019/20 Q3**	**2019/20 Q4**
HCR20 within 3 months of Admission	95.0%	100%	100.0%	100.0%	91.7%
HCR20 & HoNOS Secure (service users with LOS > 9 months)	95.0%	94.1%	92.3%	88.9%	97.3%
CAMHS use on Admission of HoNOSca and CGAS as effective tools for improving outcomes	95%	100.0%	66.7%	100.0%	90.9%
CAMHS use on Discharge of HoNOSca and CGAS as effective tools for improving outcomes	95%	100.0%	77.8%	100.0%	64.3%
Gender Identity Service – Median wait (weeks) for those on the waiting list	No target	42	48	54	61
Gender Identity Service – Waiting List	No target	1,614	1,795	1,979	2,093
Perinatal Community – Number of new women supported (LCCG only)	567 (by Q4)	65	61	74	75
Perinatal Community – Number of women supported (LCCG only)	No target	155	167	184	212
OTHER REPORTED INDICATORS					
	Target	**2019/20 Q1**	**2019/20 Q2**	**2019/20 Q3**	**2019/20 Q4**
Appraisals	85%	82.9%	82.7%	78.7%	72.8%
Clinical Supervision	85%	80.7%	74.7%	77.9%	69.5%
Sickness Absence Rate	4.88%	5.21%	5.10%	5.14%	5.17%

Staff Turnover	10%	10.4%	10.5%	9.4%	9.2%
Healthcare Associated Infections – C.difficile	0	0	0	0	0
Healthcare Associated Infections – MRSA	0	0	0	0	0
Delayed Transfers of Care	7.5%	12.0%	13.4%	12.2%	14.9%
3 Day Follow Up	80%	75.4%	76.9%	74.1%	81.2%
Percentage of CPA Formal Reviews within 12 months	95%	86.7%	85.6%	85%	83.3%
SINGLE OVERSIGHT FRAMEWORK AND STANDARD NHS CONTRACT					
	Target	**2019/20 Q1**	**2019/20 Q2**	**2019/20 Q3**	**2019/20 Q4**
7 Day Follow Up	95%	92.7%	91.4%	91.2%	92.9%
Data Quality Maturity Index (MHSDS)	90-95% by Q4	81.5%	81.1%	90.1%	n/a
Data Completeness - NHS Number	99%	99.6%	99.3%	98.9%	99.3%
Percentage of service users in Employment	No target	15.9%	15.6%	15.7%	16.1%
Percentage of service users in Settled Accommodation	No target	76.8%	74.6%	73.2%	72.5%
Number of Incidents	No target	3,014	2,932	2,767	2,889
Communication with GPs within 7 days (CPA care plans)	80%	29.0%	42.2%	40.0%	43.9%
Communication with GPs, percentage of inpatients discharge summaries notified within 24hours	80%	0%	0.3%	0.6%	0%
Early Intervention in Psychosis - % waiting less than 2wks for a NICE recommended package of care	56%	56%	69%	68.8%	76.1%
Never Events	0	0	0	0	0
Inappropriate out-of-area placements for adult mental health services (number of bed days)	3,636	1,901	1,489	1,089	1,356

1.1.9.2 Financial performance

1.1.9.2.1 Overview

The Trust's overall financial performance in 2019/20 remained very strong, and the Trust continued its good track record of delivering all its financial targets, as set within the national NHS financial framework. The underlying performance of the Trust remained stable with a range of challenges and pressures experienced which were not dissimilar to those being experienced across the NHS and within the mental health sector, namely on going workforce challenges and inpatient bed occupancy linked to patient flow between hospital and community settings. These issues continue into the new financial year, with a range of actions and measures in place to improve.

The Trust's plan and actual performance is highlighted in the table below, showing the key areas against which we measure and assess our overall financial performance. The table demonstrates overall a very solid financial performance by the Trust, building on good performances in previous years helping to maintain an underlying stable position.

Table 1.1D

Plan		Outturn	
Income and expenditure surplus	£1.3m	Income and expenditure surplus	£4.4m
Capital expenditure	£8.3m	Capital expenditure	£7.2m
Cost improvement / efficiency	£3.0m	Cost improvement / efficiency	£3.0m
Agency ceiling	£5.0m	Agency ceiling	£5.6m
Use of resources score	2	Use of resources score	1

The use of resources score is the overall assessment used by NHS Improvement, our regulator. It is based on five key financial metrics which are shown in the table below;

Table 1.1E – Use of Resources Metric

Year ending 31 March 2020	Score	Risk rating category	Weighted Score
Capital service capacity	1.97	2	0.4
Liquidity	159 days	1	0.2
Income and expenditure margin	1.49%	1	0.2
Variance in income and expenditure margin	0.7%	1	0.2
Agency spend	11.8%	2	0.4
Use of resource metric score		**1**	**1.4**

An overall score ranging from 1 (highest performance / lowest risk) to 4 (lowest performance / highest risk) is calculated based on these five metrics.

Capital service capacity

This metric measures our ability to service long-term debt. This is important for the Trust to manage as we have high levels of debt linked to our Private Finance Initiative (PFI) assets.

Liquidity

This measures the number of days the Trust can operate and pay day-to-day expenses, after accounting for all outstanding current liabilities. The Trust remained in a strong position with this metric ending the year at 159 days (the prior year was 184 days). The lower number of days does not indicate a material deterioration but is just a function of the balance of working capital receivables and payables at the year end.

Income and expenditure margin

This measures the overall surplus as a percentage of operating income. A good minimum surplus is around 1-2% in order to generate cash for reinvestment. The Trust's overall level of income and expenditure surplus was £4.377 m. This level of surplus was mainly achieved as a consequence of additional non-recurrent income linked to Provider Sustainability Funding (PSF). PSF is part of the national financial framework arrangements and is allocated to Trusts for delivering their planned financial performance. In addition there was a technical adjustment based on the revaluation of our assets, which also increased the year end surplus position. The table below shows a breakdown of the component parts of our income and expenditure position against our intended plan for the year.

Table 1.1F

Year ending 31 March 2020	Plan £m	Actual £m	Variance £m
Surplus / (Deficit) - pre PSF	(0.043)	0.596	0.639
Provider Sustainability Fund	1.305	3.056	1.751
Surplus (pre impairments)	**1.262**	**3.652**	**2.390**
Revaluation Gain	0	0.725	0.725
Reported surplus	**1.262**	**4.377**	**3.115**

Income and expenditure variance
This measures the gap between the planned margin and the actual margin. The Trust over-achieved on the plan so this equates to a good performance.

Agency ceiling
This metric was introduced in 2017/18 to provide a focus on reducing the excessive cost burden of spending on agency staff nationally. The Trust increased spending on agency from £5.1m (2018/19) to £5.6 million in 2019/20. The Trust exceeded the maximum ceiling (target maximum spend) of £5 million. The biggest area of pressure attributable to this increase was on medical agency. This reflects the national context and ongoing pressure due to shortages in medical staffing in some psychiatric specialties.

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

The statement of comprehensive income shows a surplus of £4.4 million for the year ended 31 March 2020 (compared to £32.4 million in the previous year). The exceptionally high surplus in the previous year was a consequence of non- recurrent asset disposals and PFI refinancing income which enabled the Trust to access much higher levels of PSF (total £21.9 million).

Operating income
Our income for the year decreased to £183.7 million (£186.1 million in 2018/19), which reflects movements in tariff inflation and the impact of recurrent and non-recurrent funding changes across the years. Income received in respect of service user care activities is predominantly received on a fixed block basis.

Operating expenses
The total operating expenses for the year was £175.8 million (£158.4 million in 2018/19), which is a net increase of 11%. Staff costs are our single largest operating expense and this increased by 12% in the year reflecting pay awards and a technical adjustment relating to employer contributions paid to the NHS pension scheme by NHS England (NHSE). Expenditure on the purchase of healthcare from non-NHS bodies increased to £9.1 million during the year (£8.2 million in 2018/19) mainly as a consequence of additional voluntary sector sub-contracting arrangements. Following a full revaluation exercise, the value of our estate increased, resulting in a reversal of impairment in operating expenses. The reversed impairment was £0.7 million but this benefit is excluded from the financial performance assessment for the purposes of control total targets and sustainability funding. This valuation was subject to material uncertainty due to the COVID-19 pandemic.

Cost Improvement Plans (CIPs)
Each year we are required to meet a level of efficiency savings through the cost improvement programme. This enables us to demonstrate on going value for money as we manage the requirement to continually deliver services in the most cost efficient way. A combined £3 million cost savings plan was delivered (around 1.6% of operating expenses less PFI costs) in the year, of which £1.8 million were delivered on a recurrent basis.

1.1.9.2.3 Capital expenditure

The Trust originally planned to spend £13.4 million on capital improvements in 2019/20. However, the original plan was scaled back through the planning cycle to £10 million with a further re-forecast to £8.3 million at month 5 as it became clear that the initial plans would not be fully delivered in year. This was mainly due to slippage on plans linked to the West Yorkshire CAMHS Tier 4 Unit and the St James' development, the decision not to convert the Becklin Centre management suite to a ward and changes to the proposed timing of lifecycle upgrade work on the PFI estate. Overall we delivered a level of investment of £7.2 million, which was significantly higher than 2018/19 (£4.4 million) and 2017/18 (£1.7 million). The key strategic investments included the enabling works for the West Yorkshire CAMHS Tier 4 Unit, the refurbishment of Willow House, Linden House and Poplar House at St Mary's Hospital, investment in the IT network infrastructure and the continued phased implementation of our new Electronic Patient Record system.

1.1.9.2.4 The statement of financial position

The summary of the Trust's overall value shows a net increase in taxpayers' equity of £6.6 million to £105.0 million as at 31 March 2020. This reflects the impact of the surplus generated in the year and the net impact of asset disposals and revaluations. Working capital (current assets less current liabilities) has decreased by £1.8 million, of which, the net cash increase was £22.9 million offset by a decrease in other receivables. 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 the GBS. .

1.1.9.2.5 Future financial outlook and risks

The Trust completed a draft operational financial plan for 2020/21 on 5 March 2020, to support the delivery of the objectives for the year. Due to the significant financial pressure that the NHS provider sector, in aggregate, remains under, individual organisations had again been asked by the regulatory bodies to deliver specific financial positions in the context of their underlying positions. This Trust was set a £0.5 million surplus position at that point. This plan would have required an overall cost improvement plan of around 1.8% (£3.3 million).

However at the time of writing this annual report the COVID-19 national crisis is the dominant issue within healthcare and has impacted on all operational and financial planning. All usual planning and contracting has been suspended and an interim financial regime is in place. The Trust is working within this framework and maintaining solid financial governance arrangements. The Trust remains in a strong and stable underlying financial position and remains well placed to move forward as we emerge through the current national emergency. Our plans are well progressed in terms of delivering against the long term plan for Mental Health and we have good alignment with the commissioners in regard to the growth in investment required to support this, as well as on going work to re design services models as appropriate.

1.1.9.2.6 Our exposure to financial risks

Price risk
We have a relatively low exposure to price risk. This is for three main reasons. Firstly, salary costs are the single biggest component of our costs and for 2019/20 our financial plans reflect the nationally agreed pay award. With regard to non-pay our plans assume a similar level to the projected rate of increase in the consumer price index.

Secondly, income assumptions are set out each year through the business and planning arrangements for the NHS, as mandated by the Department of Health and Social Care. Assumptions made regarding inflationary / deflationary changes have been assumed to be extremely challenging in the future. Finally, most income is received on a block contract' basis rather than 'pay as you go' and it is unlikely for the significant part of our income that this 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.

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.

1.1.9.2.7 Financial Performance

Financial plans are set in the context of an annual planning process. We are required to complete a one year Operational Plan produced in the context of our overarching strategy. Key assumptions to be used are discussed by the Executive Team and the Board of Directors to ensure there is an understanding of the key assumptions being made and the impact on our use of resources rating.

Finance managers are integrated within the Care Groups, forming part of the leadership teams at this level. This ensures consistency and understanding across the Trust on service and financial objectives. In the context of the annual planning cycle, the agreement of the budgets for each year are discussed and agreed with the relevant lines of management in the organisation. Individual budget holders have an opportunity to discuss pressures (as well as efficiencies), which are considered for funding as part of the budgetary process.

The Board of Directors and the Council of Governors receive regular information regarding financial performance within the Combined Quality and Performance Report. The performance report highlights financial performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives a report on performance (including financial performance) which allows the Council to hold the non-executive directors to account for the performance of the Board (including financial performance) and to understand how they have challenged the executive directors in respect of any areas of poor performance or risks to performance.

At each meeting of the Joint National Consultative Committee (JNCC), Staffside representatives are informed of the current and forecast financial position, together with future prospects.

1.1.10 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 Coronavirus pandemic from the centre. In line with these requirements the Trust put in place a ‘command and control’ structure which allowed us to interpret the guidance issued centrally to effect the changes needed to keep our service users and staff safe.

This saw the Trust quickly develop an incident response structure of ‘Gold’, ‘Silver’ and ‘Bronze’ command within the Trust 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 paramount in all considerations of the national guidance. Our staff worked tirelessly to ensure service delivery continued albeit in very different ways and whilst some services had to be reduced or paused we continued to provide the majority of our mental health and learning disability services to our service users.

We also found it necessary to pause some of our governance and development work so we could free up the time of staff to focus on managing the pandemic. This work will be stepped back up during 2020/21 in a phased way as we return to some level of normality.

The effect of the pandemic will be felt throughout 2020/21 and possibly beyond by not only this Trust but the NHS more widely. It will inevitably change the way in which we provide our services. As we contemplate how we will return to the ‘new normal’ we will be looking at the positive changes we have made to service delivery, such as adopting new technology and engaging with services users and staff in different ways. We will work with our service users to look at how we can build on the progress we have made and move forward, and co-produce the changes.

1.1.11 GOING CONCERN STATEMENT

After making enquiries, the directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason they continue to adopt a going concern basis in preparing the accounts.

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 2020

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 2019/20 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 2020. 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 2020

NON-EXECUTIVE TEAM	
Prof Sue Proctor	Chair of the Trust
Prof John Baker	Non-executive Director
Helen Grantham	Non-executive Director
Andrew Marran	Non-executive Director
Margaret Sentamu *	Non-executive Director
Sue White	Non-executive Director (Deputy Chair of the Trust)
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)
Claire Holmes	Director for OD and Workforce
Dr Claire Kenwood	Medical Director
Cathy Woffendin	Director of Nursing, Professions and Quality

*It should be noted that Margaret Sentamu came to the end of her term of office on 31 March 2020 and was not eligible for re-appointment, having completed six full years on the Board.

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.

We are pleased that during 2019/20 the Council of Governors approved the re-appointment of our Chair, Prof Sue Proctor. She will take up her second term of office on 1 April 2020 and will continue to lead the Board of Directors and Council of Governors for a further three years.

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 Prof Sue Proctor, the Chair of the Trust, had no other significant commitments during the year 2019/20 that 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 telephone 0113 8555930 or 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 2019/20. 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

In January 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the NHS Improvement well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice and the requirements of the well-led framework.

The first phase of the review looked at sub-Board level structures and processes i.e. structures and processes at executive director (corporate) through to directorate (care service) level. Phase 2 of the review looked at Board and committee effectiveness.

This review against the well-led framework strengthened our existing internal governance arrangements and our systems of internal control. It made clear to staff where decisions are taken and where risks or issues are escalated to; where accountability sits and what assurance looks like. It provided us with a comprehensive system of monitoring, evaluating and reporting on performance. The changes also ensured that we are clear about the performance measures we need to report against and where these are reported to. We reviewed and refreshed the Board Assurance Framework and strengthened our quality governance reporting.

The key arrangements that are in place to ensure we are well-led are:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board and Senior Leadership Team has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understood them in relation to their daily roles
- The newly developed trust strategy is directly linked to the vision and values of the trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery the strategy.
- Senior leaders visit all parts of the trust and feed back to the board to inform the discuss in relation to the challenges staff and the services face
- We are actively engaged in and leading on collaborative work with external partners including NHS partners, primary care, Local Authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that included data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators (KPIs) and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation.

In line with NHS Improvements requirement for Board to carry out a governance review every three years, in 2020/21 we will invite an external review of the Trust's compliance with the Well-led Framework and will report to outcome of the review to the Board of Directors.

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 its recent 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.

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 2019/20) 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 2019/20.

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, which 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 Improvement in relation to Very Senior Managers (VSM) salaries including any recommendations on pay uplift; the level of complexity in relation to the role 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.

2.2.2.1 Remuneration Committee – executive directors' remuneration

With regard to executive directors, 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 NHS 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 percentage awarded to staff and the national advisory for VSM salaries, 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 20/19/20 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. When awarding annual percentage uplifts ('cost of living' awards) to non-executive directors the committee will be mindful of the amount awarded to staff on Agenda for Change pay bandings and any percentage uplift awarded to the executive directors.

In 2019/20 the Appointments and Remuneration Committee considered the NHS Improvement / NHS England guidance on non-executive remuneration ("structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts" issued in September 2019) and agreed that the levels of remuneration that were current at the time of the meeting would be paid to our Chair and the other non-executive directors. The reasons for this were that governors believed that they had set the levels of remuneration in line with robust procedures using benchmarking information available to it at the time. Having made its decision the committee agreed to keep the guidance under review in relation to future considerations of remuneration. The decisions of the committee were endorsed by the Council of Governors at its meeting in February 2020.

Further information about the work of the Appointments and Remuneration Committee during 2019/20 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; recognising the liability and responsibility they carry; attracting an appropriately skilled and qualified senior team to lead the organisation).

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 organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference the Department of Health 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. 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	This will, in the main, 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.
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 and the uplift awarded to staff on Agenda for Change pay bandings.
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 paragraph 7.2 of 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 the guidance issued by NHS Improvement / NHS England "Structure to align remuneration for chairs and non-executive directors of NHS trusts and NHS foundation trusts". 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 non-executive directors 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 non-executive directors 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 Agenda for Change pay bandings and any percentage uplifts awarded to the executive directors.
Travel	Travel costs will be reimbursed through the payroll and will be supported by a completed travel claim form and 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. An honorarium of £1000 per annum is paid to chairs of Board sub-committees (excluding the Chair of the Audit Committee).

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 Agenda for Change (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 of its performance as part of its meetings. 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.

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.

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 will be 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.

The NEDs have their objectives agreed with the Chair; the Chair agrees their objectives in conjunction with the Lead Governor. 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 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 will receive assurance that the 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 with an assurance on the proposed remedial action.

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 to ensure the Board is fit for purpose.

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 Lead Governor)
- 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 Directors' contracts

Details of the contract start date for the Chief Executive and other members of the Executive Team who have served during 2019/20 are set out in the table below.

Table 2.2C – Executive directors who have served during 2019/20

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	N/A
Dr Claire Kenwood	Medical Director	1 March 2017	N/A
Cathy Woffendin	Director of Nursing, Professions and Quality	1 March 2018	N/A

Details of the non-executive directors who have served during 2019/20 are shown in the table below along with details of their terms of appointment.

Table 2.2D – Non-executive directors that have served during 2019/20

Name	Date appointment effective from	Term	Date appointment ends or ended	Number of the term of office
Prof 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 2017	3 years	14 November 2020	First
Andrew Marran	17 February 2019	3 years	16 February 2022	First
Margaret Sentamu	31 July 2017	3 years	30 July 2020 *	Second
Sue White	7 November 2019	3 years	6 November 2022	Second
Martin Wright	20 January 2018	3 years	19 January 2021	First

Margaret Sentamu's term of office was due to end on 30 July 2020; however, due to other commitments she advised the Trust that she would step down on 31 March 2020. The Board would like to thank her for all her hard work and commitment to the work of the Trust over her six years of appointment and wish her all the very best in the future.

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 for their contribution; 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 2019/20 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; Claire Holmes, the Director for OD and Workforce; 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 2019/20 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 discussions in regard to:

- The outcome of the appraisal of the Chief Executive
- Reviewing and agreeing the Trust's Very Senior Manager (VSM) policy
- 1.7% cost of Living increase for the executive directors for the period commencing 1 April 2019.
- The annual review of the VSM benchmarking report.

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. The shaded boxes relate to those meetings that individuals were not eligible to attend due to their appointment date.

Table 2.2E – The Remuneration Committee

Name	25 July 2019	26 September 2019
Prof Sue Proctor (chair of the committee)	✓	✓
Prof John Baker	✓	✓
Helen Grantham	✓	✓
Andrew Marran	✓	✓
Margaret Sentamu	✓	-
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 is 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 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 Director of OD and Workforce 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 Lead Governor. At the end of 2019/20 its membership was Steven Howarth, Niccola Swan, Les France, Ivan Nip and Peter Webster; all of whom are elected governors.

In 2019/20 there were three formal meetings 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	10 September 2019	17 October 2019	18 January 2020
Prof Sue Proctor (chair of the committee)	✓	-	-
Les France	✓	✓	✓
Steve Howarth (Lead Governor)	✓	✓	-
Ivan Nip	✓	✓	✓
Niccola Swan	-	✓	✓
Peter Webster	✓	✓*	✓*

* For the meetings held in October 2019 and January 2020 the Chair (Sue Proctor) was conflicted in relation to the agenda items, therefore Peter Webster (Lead Governor) chaired those meetings.

In 2019/20 the main areas of work for the committee were:

- Considering the recommendation to reappoint Prof Sue Proctor as Chair of the Trust for a second term of office commencing on 1 April 2020, this recommendation was subsequently ratified by the Council of Governors
- Forming an interview panel for a non-executive director appointment and making a recommendation to the Council of Governors to appoint Cleveland Henry for a period of three years commencing 1 April 2020
- Agreeing a 'cost of living' uplift of 1.7% for the non-executive directors with effect from 1 April 2019. This level of uplift was recommended to the Council of Governors for ratification
- Agreeing the appointment of the Deputy Chair of the Trust prior to making a recommendation to the Council of Governors
- Considering the NHS Improvement and NHS England guidance on remuneration for Chairs and non-executive directors and the appraisals and competency framework for chairs.

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

Where there is a vacancy for non-executive directors, 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 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 headed by the Chair of the Trust will draw up a shortlist of candidates from the applicants. 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.

Re-appointment process

Where there is a re-appointment process carried out, the Chair will meet with the non-executive director concerned to discuss their performance and preferences in relation to re-appointment. 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 2019/20

In 2019/20 there was one appointment made by the Council of Governors. This was in respect of Cleveland Henry who was appointed for a period of three years with effect from 1 April 2020. This

appointment was through a competitive interview process. Cleveland was appointed to fill a vacancy that will occur on 31 March 220 when Margaret Sentamu comes to the end of her term of office.

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 is 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 agreed 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 OD and Workforce 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 2019/20 the committee met on two occasions. The table below shows the number of meetings each member took part in.

Table 2.2G – The Nominations Committee

Name	3 September 2019	8 January 2020
Prof Sue Proctor (Chair of the Committee)	✓	✓
Helen Grantham (Non-executive Director)	✓	✓
Claire Holmes (Director of OD and Workforce)	✓	✓
Dr Sara Munro (Chief Executive)	✓	✓
Margaret Sentamu (Non-executive Director)	✓	✓
Sue White (Non-executive Director)	✓	✓

During the year its main areas of work were:

- Agreeing the role description for a vacant non-executive director position, which was determined to be: experience of strategic digital management
- Agreeing the role description and appointment process for the substantive post of the Medical Director.

Appointment of executive directors in 2019/20

In 2019/20 there was a process undertaken to appoint to the upcoming Medical Director role. In March 2020 Dr Chris Hosker was appointed and he will take up this position on the retirement of Dr Claire Kenwood who will be retiring at some point during 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 2019/20.

Table 2.2H – Directors and governors' expenses

	2019/20			2018/18
	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	6	2	2	9
Non-executive directors	7	3	3	18
Governors *[1]	19	2	4	2

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

Please note that 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 2.2I – 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 2020 (Bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2020 (Bands of £5000) £'000	Cash equivalent transfer value at 31 March 2019 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31 March 2020 £'000	Employer's contribution to stakeholder pension To nearest £100
Dr Sara Munro (Chief Executive)	5.0 - 7.5	5.0 - 7.5	40 - 45	90 - 95	554	53	644	0
Joanna Forster Adams (Chief Operating Officer)	0.0 - 2.5	0	45 - 50	105 - 110	841	27	906	0
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	0	0	0	0	0	0	0	0
Claire Holmes (Director of OD and Workforce)	17.5 - 20.0	0	15 - 20	0	8	192	214	0
Dr Claire Kenwood (Medical Director)	0.0 - 2.5	5.0 - 7.5	55 - 60	165 - 170	1,163	56	1,265	0
Cathy Woffendin (Director of Nursing and Professions)	0.0 - 2.5	0	35 - 40	85 - 90	695	27	754	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.

In August 2019 the Government amended the methodology for calculating the CETV. CETV values at 31 March 2019 and 31 March 2020 have therefore been calculated using different methodologies and this may have impacted on the real increase in CETV figure.

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

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

Name and title	2019/20							2018/19						
	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)	160 - 165	100	0	0	82.5 – 85.0	0	245 - 250	150 - 155	300	0	0	25 – 27.5	0	175 – 180
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	135 - 140	100	0	0	0	0	135 - 140	130 - 135	100	0	0	415 – 417.5	0	550 - 555
Joanna Forster Adams (Chief Operating Officer)	115 - 120	0	0	0	22.5 – 25.0	0	140 - 145	115 - 120	100	0	0	35 – 37.5	0	150 - 155
Cathy Woffendin (Director of Nursing and Professions)	105 - 110	0	0	0	22.5 – 25.0	0	130 - 135	105 - 110	0	0	0	160 – 162.5	0	265 - 270
Dr Claire Kenwood (Medical Director)	150 - 155	0	0	0	27.5 – 30.0	0	175 - 180	150 - 155	200	0	0	22.5 - 25	0	175 - 180
Claire Holmes (Director of OD and Workforce)	110 - 115	0	0	0	360.0 – 362.5	0	470 - 475	45 - 50	100	0	0	0 – 2.5	0	45 - 50
Prof Sue Proctor (Chair of the Trust)	45 - 50	100	0	0	0	0	45 - 50	45 - 50	100	0	0	0	0	45- 50
Helen Grantham (Non-execute Director)	10 - 15	100	0	0	0	0	10 - 15	10 - 15	300	0	0	0	0	10 - 15
Andrew Marran (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	0 - 5	0	0	0	0	0	0 - 5
Margaret Sentamu (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	100	0	0	0	0	10 - 15
Martin Wright (Non-executive Director)	15 - 20	100	0	0	0	0	15 - 20	10 - 15	400	0	0	0	0	15 - 20
Prof John Baker (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	300	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

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 remuneration of the organisation's workforce.

Below is a table showing the median remuneration (the Hutton Disclosure) of all staff compared with the remuneration of the highest paid employee and the comparison ratio between the two.

Table 2.2K – Median remuneration

	2019/20	2018/19
Band of highest paid directors' total remuneration (£'000)	**160 – 165**	150 – 155
Median Salary (£)	**29,869**	29,334
Ratio	**5.52**	5.20

The banded remuneration of the highest-paid director in the Trust in the financial year was £164,898 (2018/19, £150,847). 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 5.52 times (2018/19, 5.20 times) the median remuneration of the workforce, which was £29,868 (2018/19, £29,334). The ratio has increased partly due to the highest paid director this year being paid higher than the previous year's highest paid director and partly due to there being less lower paid staff (administrators and support workers) than last year.

In 2019/20, 2 substantive employees (2018/19, 3) received remuneration in excess of the highest-paid director. Remuneration for these employees ranged from £173,709 to £199,485 (2018/19, £152,909 to £207,194).

The median salary is calculated based on data that is generated from our payroll system. All staff that were employed by the Trust on 31 March 2020 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).

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Remuneration Report (made up of sections 2.2.1 to 2.2.8 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 2020

Dr Sara Munro
Chief Executive

SECTION 2.3 – ACCOUNTABILITY REPORT (Staff Report)

2.3.1 EQUALITY REPORTING

We believe in fairness and equality and above all value diversity 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. 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.

We undertake an annual assessment to review equality progress across the organisation using the NHS Equality Delivery System framework and identify priority areas for action through this process. Progress is monitored through our Equality and Inclusion Group and membership includes staff, and service users to ensure there are wide ranging contributions to the development and implementation of the strategic equalities agenda.

The work of our Rainbow Alliance Network has further developed, aimed at increasing the inclusivity of our services and processes for people who are LGBT+ (lesbian, gay, bisexual or transgender). Membership of our WREN (Workforce Race Equality Network) has increased to over 90 members of staff, which aims to strengthen access to development and support opportunities for staff from Black and Minority Ethnic communities.

We also aim to ensure that we employ and develop a workforce that is diverse, non-discriminatory and appropriate to deliver modern healthcare. Valuing the differences of each team member is fundamental. It enables staff to create respectful work environments so we are able to deliver high quality care and services whilst giving service users the opportunity to reach their full potential.

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 committed to the Mindful Employer Charter and through our annual health and wellbeing action plan we implement activities to further develop our Trust as a healthy workplace in respect of mental health. We are also a Disability Confident employer at Level 2. 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 the Employee Wellbeing and Managing Attendance Procedure; a process for the management of work-related stress including a stress pathway tool-kit; an Employee Assistance programme (EAP) providing counselling and other support to staff; flexible working arrangements; and a bespoke Occupational Health Service. These procedures and services support the employment and retention of disabled employees and the implementation of reasonable adjustments to take account of individual needs.

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. We have made reasonable adjustments to working environments through the purchase of specialised equipment and have made necessary alterations to premises in respect of access to buildings.

In addition to this, 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. We have developed an annual programme of development sessions to provide our staff with the knowledge and expertise they require when working with our service users and staff from diverse communities.

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.

2.3.3.1 Volunteers

As a Trust we value the contributions that our volunteers make to the experience of people accessing our services. Our volunteers have a variety of skills and experiences, including volunteers with personal lived experience. This is invaluable to providing inclusive, recovery-focused activities for our service users.

Our Voluntary Services department continues to provide a high quality service across our sites; working in partnership with volunteers, staff, service users and external voluntary organisations. We have achieved the Leeds Volunteering kite mark recognition by Leeds City Council and Voluntary Action Leeds that the Trust manages a volunteering programme where volunteers receive a high quality, positive volunteering experience.

We actively support our volunteers to build on their skills and confidence and volunteering with our Trust continues to be a route into paid employment or full-time / part-time education. During the last year we developed new areas of volunteering whilst continuing to support existing schemes and their volunteers. This included the development of gardening activities within our younger people's mental health services.

We continue to maintain and raise the profile of the value of volunteers both within our Trust and the communities we serve. We are extremely grateful for all the good work undertaken by volunteers and the feedback they provide as well as the difference they make to the lives of our service users, carers and staff.

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. Staffside 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 the trade unions to negotiate with one voice. The JNCC (Joint Negotiation and Consultation Committee) is the place where all issues raised at Staffside meetings are brought to the attention of management.

Staffside has many years of experience of successful partnership working with the Trust. We have achieved this through the nationally recognised *In Partnerships* agreement.

During the past year Staffside has contributed to the strategic agenda by continuing to have involvement in service redesign and management restructuring, and also in communication and engagement with staff. Staffside has:

- Actively encouraged staff to complete the annual staff survey which has resulted in an increased response rate
- Continued involvement in the development of our strategy and in workforce issues through regular dialogue with the Director of Workforce Development and senior operational managers
- Successfully worked in partnership with the Workforce Development Directorate and its managers to support staff going through significant change
- 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 in order 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.

Staffside also provides information and advice to staff 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 – Relevant union officials – The total number of employees who were relevant union officials during 2019/20

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
8	8.0

Table 2.3B – Percentage of time spent on facility time – The number of employees who were relevant union officials employed during 2019/20 and the percentage time of their working hours spent on facility time

Percentage of time	Number of employees
0%	2
1-50%	6
51%-99%	0
100%	0

Table 2.3C – Percentage of pay bill spent on facility time during 2019/20

Total cost of facility time	£30,664.63
Total pay bill	£127,221,000
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.024%

Table 2.3D – Paid trade union activities during 2019/20

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	11.135%

2.3.4 STAFF ENGAGEMENT

Engaging with staff 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 aim is to be open about actions taken and decisions made, to work as transparently as possible.

2.3.4.1 Internal communications

Our main corporate communications with staff consist of:

- A twice weekly e-bulletin called Trustwide
- A staff intranet called Staffnet

We relaunched Staffnet in July 2019. The new system is designed to be much more end user friendly and enable them to find what they need quickly using the search function, rather than navigating the menus.

We undertook significant work to improve key document libraries such as policies and procedures, mental health legislation and clinical guidance. We also undertook a massive purge of out of date content and a training programme for new and existing content editors. The launch went well and we have received positive feedback via staff and from a CQC inspection that took place just after the launch.

We have continued to improve our Trustwide bulletin in terms of content, tone and relevance. We conducted some surveys with staff to understand their needs during 2019 and we had planned to implement a new version of Trustwide which has been delayed due to Coronavirus response.

2.3.4.2 Chief Executive Blogs

Our Chief Executive shares a blog every two months which is aimed at staff and external stakeholders. This tends to focus on activity from the previous two months.

We launched a new internal briefing from the Chief Executive in January 2020 which is more of a look forward and aims to share more of our strategic narrative, calling out key projects that are starting or due to get underway.

2.3.4.3 Improving Culture: Improving Lives

One of the focal points of our staff engagement work during 2019/20 has been the Culture Collaborative. This key initiative launched following three significant reports which all talked about staff culture; an ACAS review on alleged bullying and harassment, the results from the 2018 Staff Survey and an assessment by the Institute for Healthcare Improvement (IHI) on our current quality culture and learning system.

While these showed some great examples of positive culture across the organisation, and anecdotally we are aware of plenty more, they also included feedback and concerns raised by staff. Therefore, the Culture Collaborative was created as a small, open group of staff who will take an active role in listening, engaging and recommending ways in which to make our culture better.

Throughout October, November and December 2019 we conducted two online conversations in a campaign called Improving Culture: Improving Lives around our culture via our crowdsourcing platform; Your Voice Counts. All staff (including Bank Staff) were invited to take part in these conversations. We reached a 21% participation rate and we consider this a real achievement.

Face to face events with our Chief Executive were scheduled to invite staff directly who are often underrepresented in conversations like this, namely Bands 2-5. The first of these took place in February 2020 with 17 attendees and some great conversations and very positive feedback around the culture work.

2.3.5 OUR STAFF SURVEY

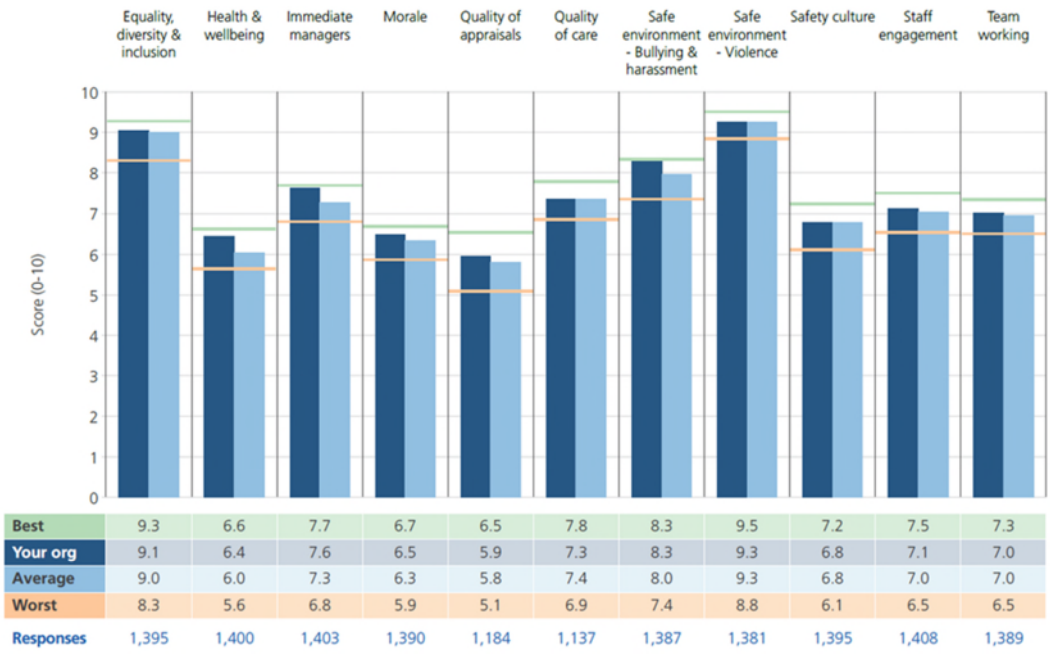
The NHS staff survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The response rate to the 2019/20 survey among trust staff was 54.5% (2018/19: 58.1 %). Scores for each indicator together with that of the survey benchmarking group (Mental Health and Learning Disability Trusts) are presented below.

Table 2.3E – Response rate for the staff survey

	2019/20 Survey		2018/19 Survey		2017/18 Survey	
Theme	**Trust**	**Benchmark**	**Trust**	**Benchmark**	**Trust**	**Benchmark**
Equality, Diversity and Inclusion	9.1	9.0	9.0	8.8	9.1	9.0
Health & Wellbeing	6.4	6.0	6.4	6.1	6.4	6.2
Immediate Managers	7.6	7.3	7.4	7.2	7.3	7.2
Morale	6.5	6.3	6.4	6.2	New theme for 2018	
Quality of Appraisals	5.9	5.8	5.8	5.7	5.4	5.5
Quality of Care	7.3	7.4	7.3	7.3	7.2	7.3
Safe Environment - Bullying and Harassment	8.3	8.0	8.2	7.9	8.2	8.0
Safe Environment - Violence	9.3	9.3	9.2	9.3	9.1	9.2
Safety Culture	6.8	6.8	6.7	6.7	6.5	6.7
Staff Engagement	7.1	7.0	7.1	7.0	6.9	7.0
Team Working (new for 2019)	7.0	7.0	6.8	6.9	6.7	6.9

The following chart displays our theme scores for 2019/20 against the benchmark but also includes the best and worse scores from the group too:



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.3	6.6	7.7	6.7	6.5	7.8	8.3	9.5	7.2	7.5	7.3
Your org	9.1	6.4	7.6	6.5	5.9	7.3	8.3	9.3	6.8	7.1	7.0
Average	9.0	6.0	7.3	6.3	5.8	7.4	8.0	9.3	6.8	7.0	7.0
Worst	8.3	5.6	6.8	5.9	5.1	6.9	7.4	8.8	6.1	6.5	6.5
Responses	1,395	1,400	1,403	1,390	1,184	1,137	1,387	1,381	1,395	1,408	1,389

We are therefore performing better than the national average for mental health and learning disability trusts in England across seven of the 11 Key Themes, with three of the remaining four themes being equal to the benchmark group average. The theme where we were below the benchmark average was Quality of Care. Our score of 7.3 was 0.1 less than the 7.4 average.

This year 69% of our surveys were sent to staff to complete electronically. Paper surveys continued to be provided to those teams where accessing the online survey would present a barrier to them participating.

Of the completed surveys, 1005 were completed online compared to 403 paper copies. This equates to an online completion rate of 55.6% and a paper completion rate of 49.6%.

This year we saw our overall response rate decline by 3.6%. We knew when launching our Culture Collaborative discussions as mentioned above that the timeline may have an impact on Staff Survey due to potential survey fatigue from our staff and therefore, this slight decline did not come as a surprise. The Trust still considers a 54.5% response rate a great achievement.

We also maintained the approach taken in previous years to increase participation, which included a collation of dedicated staff, managers and Staffside representatives, who came together to steer delivery of the survey and encourage participation by staff at a local level. This year's response rate of 54.5% is 1.2% above the national average for all mental health and learning disability trusts in England.

Following the results of the survey in 2018 we commenced specific programmes of work to address some of the key themes and areas for improvement, and the 2019 results show that staff are reporting improvements in these areas. Some of the ways in which we have addressed staff concerns are set out below.

- The Culture Collaborative as discussed above was launched in October 2019 based on the Staff Survey 2018 feedback alongside data gathered from other Trust staff engagement activity involving ACAS (Advisory, Conciliation and Arbitration Service) and IHI (Institute for Health Improvement). The purpose of this group going forward is to work on staff feedback around our culture to improve the way our staff feel about coming to work at our Trust. The collaborative allows staff who want to be involved in taking this work forward, the opportunity to do so.

- Our staff networks continued to meet regularly throughout the year with a focus on enabling social inclusion and challenging stigma by providing an inclusive and fair working environment for all our staff. These include the Workforce Race Equality Network (WREN), Disability and Wellbeing Network (DaWN) and the Rainbow Alliance (our LGBT Wellbeing Partnership) which all work to support equality and promote inclusive cultures.

- We ran an engagement campaign for staff around our new Community Services which were redesigned and launched in March 2019. The campaign used our crowdsourcing platform where our members of staff who were impacted by the redesign could take the opportunity to give their feedback and suggestions. This was then followed by a series of face to face events across the Trust to which all staff impacted were again invited to give their views. A 10-weekly meeting also continues to take place which brings all the managers of our Community Services teams together to discuss how they can continuously improve their multi-disciplinary team working across the service. We believe the support managers have been able to provide their staff throughout the redesign of the Community Services has played a large part in our increased score in the Immediate Managers theme.

- The Affina OD programme has been launched as a team development across the Trust. This initially began as a development for the teams involved in the redesign of our Community Services but has now been extended across the Trust. We have 12 Affina team coaches trained to guide team leaders through the programme which focuses on creating high performing teams by looking at areas such as team objectives, constructive debate and inter-team working

The tables below show a comparison between our scores and that of the sector average; specifically the top five and bottom five ranking scores where we compare most and least favourably with other mental health and learning disability Trusts in England. The questions in italics indicate where a lower percentage score is more favourable and therefore a negative percentage difference for these questions is also more favourable.

Table 2.3F – Response rate for the staff survey – Top five ranking scores

	Trust Score 2019	National Average* 2019	Positive difference against national average*
My manager supported me to receive this training, learning or development	69%	60%	9%
On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	*53%*	*62%*	*-8%*
Does your organisation take positive action on health and well-being?	36%	28%	7%
I am involved in deciding on changes introduced that affect my work area / team / department	62%	55%	7%
Senior managers here try to involve staff in important decisions	44%	37%	7%

*****national average for all mental health and learning disability trusts in England.*

Table 2.3G – Bottom five ranking scores

	Trust Score 2019	National Average* 2019	Negative difference against national average*
I have unrealistic time pressures	*31%*	*23%*	*8%*
I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams).	53%	60%	-7%
Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)	87%	94%	-7%
On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	30%	25%	5%
It [my appraisal] left me feeling that my work is valued by my organisation.	31%	35%	-4%

**national average for all mental health and learning disability trusts in England.*

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 2020. The Trust will continue to use the *Your Voice Counts* Crowdsourcing platform, as well as face-to-face listening events to engage with staff on strategic issues from the national staff survey key findings.

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

Financial plans are set in the context of an annual planning process. We are required to complete an Operational Plan, produced in the context of our overarching strategy. Key assumptions to be used are discussed by the Executive Management Team and the Board of Directors to ensure there is an understanding of the key assumptions being made and the impact on our use of resources rating.

Finance managers are integrated within the Service Lines, forming part of the leadership teams at this level. This ensures consistency and understanding across the Trust on service and financial objectives. In the context of the annual planning cycle, the agreement of the budgets for each year are discussed and agreed with the relevant lines of management in the organisation. Individual budget holders have an opportunity to discuss pressures (as well as efficiencies), which are considered for funding as part of the budgetary process.

The Board of Directors and the Council of Governors receive regular information regarding financial performance within the Combined Quality and Performance Report. The performance report highlights financial performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives a report on performance (including financial performance) which allows the Council to hold the non-executive directors to account for the performance of the Board and to understand how they have challenged the executive directors in respect of any areas of poor performance or risks to performance.

2.3.6.2 Contractual and regulatory performance

There has been a great deal of work again this year to further develop existing and create new dashboards for service managers to access. These dashboards provide the Key Performance Indicator (KPI) data that services need in order to better manage the performance of their services. The bi-monthly Quality, Delivery and Performance Meetings with each service line also give an opportunity for a range of staff in each area (including service managers and clinical leads) to discuss performance across a range of topics including improved service delivery and quality improvement plans.

Overall performance against our contracts is monitored by the Finance and Performance Committee and it has been assured of performance against contracts and any risks that have been identified.

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. The emphasis 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 this 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. The visiting team will be made up of clinicians from other teams supported by staff from corporate services such as safeguarding, mental health act legislation and medicines management.

2.3.7 SICKNESS ABSENCE

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

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

2.3.8 OCCUPATIONAL HEALTH SERVICE

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

occupational health service for 13,000 employees in the region and continues to operate service level agreements for external contracts.

2.3.9 HEALTH AND SAFETY

In 2017 the Health and Safety Executive carried out a review of the most common health and safety issues that had been reflected in their own statistics across all the NHS Trusts and concluded that musculoskeletal disorders and violence / aggression incidents were at the top of their list. In the middle part of 2018 the Health and Safety Executive carried out audits of many NHS Trusts across the country of which Leeds and York Partnership Foundation Trust was one of the first to be audited.

The auditors found that there was no material breaches of health and safety within the Trust however there were areas of improvement for the Trust to pursue. These were largely around the current policies, procedures and risk assessments. In 2019 an external review was commissioned and a number of recommendations were provided to the Trust, including a review of the policies, procedures, risk assessments and the Trust governance arrangements.

The outcomes of the audits resulted in the production of an action plan. The plan was reviewed by the Executive Risk Management Group to confirm director level engagement and ownership and that plan has been returned to the Health and Safety Executive.

Following the production of the action plan, stakeholders within the Trust have been working collaboratively to help introduce a new health and safety management system which also fulfils the requirements of the improvements.

2.3.10 COUNTER-FRAUD

During 2019/20 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.

Our LCFS has conducted work across all areas of counter-fraud activity, placing emphasis on the continued development of fraud awareness within the Trust and the prevention of fraud. The LCFS regularly attends the 'Trust Welcome Event' to meet with staff to raise fraud awareness and to advise them on how to report fraud. Furthermore the LCFS has delivered presentations with selected groups of staff, particularly with departments where the risk of fraud is greater. The service has continued to be proactive in its work and has liaised with staff regarding potential fraud risks and has provided advice accordingly.

The LCFS regularly attends the Employment Procedures Group and has provided advice from a counter fraud perspective on policies and procedures where necessary. They have liaised with the NHS Counter Fraud Authority and disseminated all relevant prevention guidance, intelligence bulletins and alerts issued by them, following any relevant instructions provided.

The Trust participates in the National Fraud Initiivatie (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 2019/20 all data matches were reviewed for the Trust and any anomalies were passed to the LCFS for further investigation.

During 2019/20 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 2.3H – Average staff numbers for 2019/20

Average number of employees (Whole Time Equivalent basis)	Permanent (Number)	Other (Number)	Total Number (2019/20)	Total Number (201819)
Medical and dental	186	17	203	193
Administration and estates	593	38	632	626
Healthcare assistants and other support staff	571	243	813	812
Nursing, midwifery and health visiting staff	730	46	776	738
Scientific, therapeutic and technical staff	323	4	328	327
Social care staff	14	0	14	6
Total average numbers	**2,417**	**349**	**2,766**	**2,702**
Of which: Number of employees (WTE) engaged on capital projects	0	0	0	0

2.3.12 GENDER PROFILE OF OUR TRUST

Table 2.3I - The gender profile for the Trust as at end March 2020

Group	Number male	Number female
Directors	3	10
Senior managers (Band 8 and above)	86	166
Employees	670	1824

2.3.13 GENDER PAY GAP INFORMATION

Due to the Coronavirus outbreak, the Government Equalities Office (GEO) and the Equality and Human Rights Commission took the decision on 24 March 2020, to suspend enforcement of the gender pay gap deadlines for 2019/20. However, the most up to date information can be found on the following government website:

https://data.gov.uk/dataset/54219db1-dd98-49d9-a383-a5978bb0aeb9/gender-pay-gap

Information in section 2.3.14 is subject to audit by our external auditors, KPMG LLP.

2.3.14 ANALYSIS OF STAFF COSTS

Table 2.3J – Analysis of staff costs for 2019/20

Average number of employees (Whole Time Equivalent basis)	Permanent (£000)	Other (£000)	Total £000 (2019/20)
Salaries and wages	85,264	10,974	96,238
Social security costs	8,836	0	8,836
Employer's contributions to NHS pensions	11,848	0	11,848
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	5,172	0	5,172
Apprenticeship Levy	453	0	453
Agency staff	0	5,600	5,600
Employee benefits expense	**111,573**	**16,574**	**128,147**
Of which: Charged to capital			(617)
Recharged to income			(528)
Total employee costs			127,002

2.3.15 OFF-PAYROLL ENGAGEMENTS

The Trust's policy in relation to off-payroll engagements is as follows:

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 pro-forma for this is included in the policy.

The following table sets out all off-payroll engagements as at 31 March 2020 where the individual is paid more than £245 per day and where the engagement lasts for longer than six months.

Table 2.3K

Number of existing engagements as of 31 March 2020	7
Of which:	
The number that have existed for less than one year at the time of reporting	2
The number that have existed for between one and two years at time of reporting.	4
The number that have existed for between two and three years at time of reporting.	1

The following table relates to all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, where the individual was paid more than £245 per day and where the engagement lasted for longer than six months.

Table 2.3L

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	5
Of which:	
Number assessed as within the scope of IR35	5
Number assessed as not within the scope of IR35	0
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 2019 and 31 March 2020.

Table 2.3M

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 were no exit packages relating to Board members in 2019/20 (0 in 2018/19).

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

Table 2.3N

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)	11 (4)	12 (4)
£10,001 - £25,000	2 (0)	4 (2)	6 (2)
£25,001 - £50,000	2 (1)	3 (0)	5 (1)
£50,001 - £100,000	0 (0)	1 (0)	1 (0)
£100,001 - £150,000	0 (0)	0 (0)	0 (0)
£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	**5 (1)**	**19 (6)**	**24 (7)**
Total resource cost (£000)	96 (27)	296 (52)	392 (79)
Note: Figures in brackets relate to 2018/19			

2.3.17 NON-COMPULSORY / OTHER DEPARTURES AGREED

Table 2.3O

	Agreements (Number)	Total value of agreements (£000)
Voluntary redundancies including early retirement contractual costs	0 (0)	0 (0)
Mutually agreed resignations (MARS) contractual costs	10 (1)	249 (18)
Early retirements in the efficiency of the service - contractual costs	0 (0)	0 (0)
Contractual payments in lieu of notice	9 (5)	47 (34)
Exit payments following Employment Tribunals or court orders	0 (0)	0 (0)
Non-contractual payments requiring HMT approval	0 (0)	0 (0)
Total	**19 (6)**	**296 (52)**
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 2018/19		

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 2.3S (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 HEALTH 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 Community Treatment Order.

The Trust Board has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2019/20 this committee was chaired by a non-executive director (Margaret Sentamu) and it met four times during 2019/20.

Providing assurance to the committee is the Mental Health Act Manger's Forum. The forum is chaired by a non-executive director 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 Margaret Sentamu, a Non-Executive Director, and Marilyn Bryan, lead Mental Health Act Manager and Deputy Chair of the Forum. In 2019/20 the Forum met 4 times on 21 May 2019, 7 August 2019, 11 November 2019 and 20 February 2020.

2.3.19.2 Mental Health Act Managers who have served in 2019/20

We currently have 32 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2019/20.

Table 2.3P

Mental Health Act Managers during the period 1 April 2019 to 31 March 2020		
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	Andrew Marran	Graham Martin
Claire Morris	Susan Mosley	Gillian Nelson
Lynsey Nicholson*	Ismail Patel	Debra Pearlman
Shamaila Qureshi	Andrea Robinson	Alex Sangster
Susan Smith	Niccola Swan	Jeffrey Tee
Claire Turvill	Viv Uttley	Tom White
Janice Wilson	Michael Yates	Paul Yeomans
Jennifer Taylor*	Nicolle Levine*	Lorna James*
Deborah Byatt*		

* retried during 2019/20

Non-executive directors also acting as Mental Health Act Managers during 2019/2020
Andrew Marran Margaret Sentamu

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.

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 issued in 2012, most recently revised in July 2014. This is based on the principles of the UK Corporate Governance Code.

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
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 required to do so. The Remuneration Committee has agreed that the pension rights for executive directors are determined by the NHS pension scheme not by the committee itself. Senior management are paid under the NHS Agenda for Change pay structure and are therefore not within the remit of the Remuneration Committee

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 / explanatory statement
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
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 4G in Section 4.3 and table 4H 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

Code provision	Requirement	Section in Annual Report / explanatory statement
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 new NED recruitment campaign.
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
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 2.1.8
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

Code provision	Requirement	Section in Annual Report / explanatory statement
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 there was no appointment of the auditors made during 2019/20
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

Code provision	Requirement	Section in Annual Report / explanatory statement
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	1.1.10
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

Disclosure requirement	Statutory reference	Section in which reported
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	• Not applicable for 2019/20 reporting requirements

SECTION 2.5 – ACCOUNTABILITY REPORT (NHS Oversight Framework)

2.5.1 NHS OVERSIGHT FRAMEWORK

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

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. 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

NHS Improvement has assessed Leeds and York NHS Foundation Trust as segment 2: targeted support.

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 at 31 March 2020.

Current segmentation information for NHS Trusts and foundation Trusts is published on the NHS Improvement website.

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	2019/20				2018/19			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	**Capital service capacity**	2	2	2	2	1	1	1	3
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	**I&E Margin**	1	1	2	3	1	1	1	1
Financial controls	**Distance from financial plan**	1	1	1	1	1	1	1	1
	Agency spend	2	2	2	2	2	2	2	1
Overall scoring		1	1	2	2	1	1	1	1

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 2020

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 Leeds and York Partnership 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 Leeds and York Partnership 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 2020

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 2019 to 31 March 2020.

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 the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2020 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 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 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, Professions and Quality has overall lead responsibility for the development and implementation of organisational risk management. 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 Responsible Officer. The responsibility for risk management is communicated to all staff through their job descriptions and the 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 Director of OD and Workforce oversees performance, and assurance reports are made to the Workforce Committee and to the Board of Directors 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 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.

Incidents of severity 3 and above are now being reviewed on a weekly basis, with support offered to the relevant teams and any learning established including good practice.

The Learning from Incidents and Mortality Meeting (LIMM) reviews all deaths and codes them in accordance with the Mazar tool. The group decides the required level of investigation and monitors its progress through the relevant forums in the Trust's governance structure.

The work of LIMM identifies themes and trends and where appropriate will provide more depth to the mortality review process and reduce variation in reviews. LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly.

The Trust Incident Review Group (TIRG) has responsibility for reviewing in detail all incidents reported as serious, for agreeing that the recommendations and actions are appropriate.

The Trust also seeks to learn from good practice (both internal and external to the Trust) through a range of mechanisms including: benchmarking; clinical supervision and 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.

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) 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.

- Clinical negligence claims are covered by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. 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 the NHS Resolution 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 the NHS Resolution RPST Property Expenses Scheme (PES).

2.7.3.4 Work performed to assess Well-led

In January 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice. This looked at both Board and sub-Board level structures and processes i.e. ward to Board structures and processes.

This review made a number of recommendations as to how the governance structures and arrangements could be strengthened. These were accepted by the Board and then implemented. To ensure the organisation is 'well-led' the following key arrangements are in place:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understand them in relation to their daily roles
- The Trust strategy is directly linked to the vision and values of the Trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery of the strategy.
- Senior leaders visit all parts of the Trust and feed back to the Board to inform the discussion in relation to the challenges staff and the services face
- The Board has a sharing stories session at the beginning of each public meeting which allows service users to come and share their experience of our services
- We are actively engaged in collaborative work with external partners including NHS partners, primary care, local authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that include data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation
- We monitor the quality of our services at all levels of our organisation with our governance structure providing clear lines of accountability and ward to Board reporting.

2.7.4 THE RISK AND CONTROL FRAMEWORK

The Trust has in place a comprehensive Risk Management Policy which is available to all staff on Staffnet. The purpose of this policy is to ensure that 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 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, directorate, corporate or strategic. We have in place an Executive Risk Management Group which is chaired by the Chief Executive. This monitors risk, in particular those scoring 15+.

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

Business, financial and service delivery risks are derived from organisational objectives through the business planning process. Clinical and non-clinical risks are identified through a well-defined process of assessment and reporting.

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 formally reviewed by the Board and the Audit Committee at least twice a year. 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.

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 Single Oversight Framework from NHS Improvement (November 2017).

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 Care Quality Commission (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 the CQC registration the Trust has established a CQC Project Group which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of 'good' or 'outstanding'. There are also monthly discussions between the Nursing Leadership Team and the CQC link officers and a quarterly meeting between the Director of Nursing, Professions and Quality and the CQC officers linked with the Trust.

We will take a Trustwide view of the themes from our CQC inspections and take a holistic approach to resolving these issues and reducing risks 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 bespoke electronic activity tracker which is a tool to monitor deadlines, record evidence of actions and evidences in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group who then make assurance reports to the Quality Committee and in turn the Board.

The Trust has a programme of Peer Reviews throughout the year to improve, share and embed best practice around the Trust. 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 identify risks to service delivery and use the evidence to make processes and procedures easier to comply with.

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 more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios to 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 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.

At each meeting the Board receives a Combined Quality and Performance Report that details compliance with, and achievement of, all regulatory, contractual and local targets and also provides financial information. The Board and its sub-committees receive timely and accurate information to the 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 2019/20 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance or risks to 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.

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) process.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Learning Disability and Autism Collaborative and the Committees in Common)
- Working with partners in health and social 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 Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2018 to 2020 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.

We have in place systems for monitoring equality progress and compliance against our objectives through the Workforce Committee, which also includes reporting to the Board of Directors on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report. We have invested in our Workforce Race Equality Network (WREN) 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 as detailed in the Trust's Procedure for the Development and Management of 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 BAME service users, learning disability service users and well as those from disadvantaged groups. Our Mental Health Legislation Committee receives reports on understanding why there are a disproportionate number of BAME service users within our crisis service and detained under the Mental Health Act. This work 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.

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.

2.7.4.10 Workforce

Our Workforce and OD Strategic Plan 2018-2021 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 Workforce and OD Strategic Plan is to increase the quality and grow our internal bank to reduce reliance on agency staff. In 2019/20 we have achieved a growth rate of 20%. Our workforce requirements and performance are effectively managed through the Workforce governance structure made up of a range of focused operational groups including our safer staffing and workforce planning 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 of workforce is held to account through the Workforce Committee and specific performance indicators monitored through the CQPR 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 and Harrogate ICS on shared leadership and development programmes; workforce planning; coaching and mediation services; and promotional recruitment materials to promote working in the NHS and in shortage occupations. We are also active partners in the development and leadership of the new Health and Social care Academy in Leeds and are part of the West Yorkshire Mental Health Workforce Collaborative.

2.7.4.11 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 on the strategic risk register which are also set out in our Board Assurance Framework (BAF). Each of these risks has an identified executive director and management lead. These risks will 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 COVID19 pandemic. Whilst a specific risk for this was not entered on the Board Assurance Framework (BAF) at the end of March 2020 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 related to the pandemic under review at each of its meetings and to gain assurances on the actions being taken.

Each of the strategic risks has an identified executive director and management lead. These risks will be managed through the risk management and risk register processes and reported to the Executive Risk Management Group, the Board and the relevant Board sub-committee through the Board Assurance Framework.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is reviewed by the Executive Risk Management Group via the Board Assurance Framework.

2.7.5.1 COVID19 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. In line with requirements the Trust put in place a command and control structure which saw a change in the way our staff worked in all areas of service delivery.

In response the Trust quickly developed an Incident Response Gold, Silver and Bronze command structure within the Trust 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 paramount in all considerations of the national guidance. Our staff worked tirelessly to ensure service delivery continued albeit in very different ways and whilst some work had to be paused in the initial weeks of response we continued to provide mental health and learning disability services to our service users and worked to look at how we could resume some aspects of business as usual.

The effect on the delivery of services, our systems of internal control and our risk register is kept under constant review by our Board, its sub-committees, the executive team and the Business Continuity structures that have been put in place.

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

We published our refreshed Trust Strategy for 2018 to 2023 in November 2017. This sets out our ambitions and plans for the next five years. In refreshing our strategy we wanted to make sure it is relevant and fully aligned with the key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. Of particular note is 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 next five years (to 2023) and how we plan to get there. The strategy is designed around three key elements: delivering great care; rewarding and supportive workplace; and 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 development; and quality. Each year we set out our annual actions for achievement as part of our planning and priorities.

The financial strategy shows on a projected basis what the expected financial performance for the coming year is to be. There is in place 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.

As part of the annual planning process we are required to identify our Cost Improvement Plans (CIPs). All our CIPs have been through the standard quality and delivery impact assessment process, with a CIP pro-forma being completed for each individual scheme. Each scheme has been scored and electronically signed off by both the Medical Director and the Director of Nursing, Professions and Quality and is monitored through the Programme Management Office.

The Financial Planning Group is set up to provide routine assurance and oversight related to the quality and financial impact of existing cost improvement schemes. This group 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 plans are presented to a join meeting of the Quality Committee and the Finance and Performance Committee 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** receives reports on any significant events or matters that affect the Trust. The Board also receives the Combined Quality and Performance Report at each meeting which reports on performance against the Trust's regulatory, contractual and internal targets and standards both non-financial and financial; the Board Assurance Framework; and reports from the Chairs of its sub-committees including the Audit Committee

- **Internal Audit** (Audit Yorkshire) provides an independent and objective opinion on the degree to which risk management, control 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 2019/20 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.

  Whist an overall opinion of 'significant assurance' has been provided; attention is drawn to the fact that there have been four reports issued in 2019/20 with a 'limited assurance' opinion which are detailed below.

  - **LY03/2020 Liaison Psychiatry**

    In response to a serious incident the Trust worked with its partner, Leeds Teaching Hospitals Trust (LTHT), to review the Liaison Psychiatry Hospital Mental Health Team Local Operating Policy. Internal Audit was requested to provide assurance on the robustness and effective implementation of the revised policy.

    Whilst an overall opinion of Limited Assurance was provided the audit did identify that improvements had taken place in arrangements to maintain patient safety. However, an overall opinion of Limited Assurance was provided as the local operating policy was not robust in fulfilling its role to evidence that all the incident recommendations had been addressed. Policy statements about communication between the Trusts' clinical staff, clinical accountability, service user and carer involvement, training, the governance structure and a definition of the integrated approach to managing patients with coexisting medical and mental health conditions were not included. In addition, in relation to specific responsibilities for LTHT to manage we found that the Liaison Psychiatry policies were not commonly used as an information resource by LTHT staff and not easily accessible on the LTHT intranet. The joint governance structure required a full and comprehensive review to ensure that it functioned effectively.

    An action plan was agreed with LYPFT that is being addressed in partnership with LTHT. Progress has been made on the recommendations with the updated policy and related documentation awaiting approval. Work is also underway to review the joint governance arrangements for oversight of the policy. A further audit of this area has been reflected in the audit plan for 2020/21.

  - **LY05/2020 Contract Management**

    The Board of Directors requested assurance on the arrangements in place at the Trust for the management of contracts and requested that this be included in the 2019/20 Internal Audit plan. The audit identified weaknesses in relation to both the design and consistent operation of the controls in place for the management of contracts.

    Whilst the audit identified that some good practice was taking place, this was in the absence of a clearly documented framework setting out roles and responsibilities and

expected practice. There is a need for further clarity in relation to roles and responsibilities in Procurement and between Procurement and other departments. Evidence was identified of post contract award management and review meetings taking place. However, this was not governed by reference to defined risk criteria and was inconsistent. It was not always clear who was responsible for this part of the process and also who held a copy of the relevant contract.

Management agreed to all the recommendations in the report and an action plan was put in place. A further audit of this area has been reflected in the audit plan for 2020/21.

- **LY06/2020 Service Users Money and Property**

An overall opinion of Limited Assurance was provided for the administration of service users' money and property. The focus of the audit was a sample of in-patient wards.

Whilst the Service Users (SUs) Property Income and Allowances Procedure Notes and the FM-0003 Financial Procedures outline the processes for the safekeeping of service user property and money inconsistencies between the two documents were identified and aspects of the system were not covered in either document.

Property and valuables are managed at ward level and cash and benefit payments are managed by the Patient Affairs Team. Testing undertaken throughout the audit identified a lack of compliance with the Trust's procedures for administering service users' money and property at ward level. This was in relation to procedures on admission, those during a SUs stay and on discharge or death of a SU. However, testing did confirm that arrangements had been made for the Trust to receive benefits payments for the SUs in the testing sample and that the payments had been correctly credited to their accounts.

An action plan has been agreed with management with the majority of recommendations agreed for implementation by 31 March 2020. Management has advised that a full review of the procedures and associated documentation has been completed and is management review prior to formal approval and issue. A further audit of this area has been reflected in the audit plan for 2020/21.

- **LY14/2020 Management of the Capital Programme**

An opinion of Limited Assurance has been provided on the basis that the existing arrangements for the management of capital projects at the Trust require formalising and the oversight and accountability strengthening.

The Trust does not have documented policy or procedure for management of the capital programme. A framework setting out the objectives, roles and responsibilities and information flows needs to be produced. An Estates Process Map has been produced, which was in draft at the time of the audit.

It is acknowledged that until now the Trust has not managed any major projects in house and the five year capital programme is a new area for the Trust. The projects tested during the audit were managed in house and there was a lack of supporting documentation in respect of agreed specifications, project status reports, post project evaluations and financial reporting of individual capital projects.

There is currently no central repository for project documents. Documents for the projects tested had to be requested from various sources as they are not currently stored in one central location on a shared drive.

An action plan has been agreed with management. A further audit of this area has been reflected in the audit plan for 2020/21.

- **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

  Our audit team will carry out the audit of the 2019/20 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 internal controls, including risk management, 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.

2.7.7 INFORMATION GOVERNANCE

2.7.7.1 Incidents Relating to Information Governance

Aligned to the Data Protection Act (2018), as derived from the EU General Data Protection Regulation (GDPR), NHS Digital revised the Information Governance incident grading methodology. This method of grading took a different approach to previous iterations, employing a 5 x 5 likelihood vs impact methodology, assessing both the likelihood and severity of harm caused. Serious incidents are still escalated to the Information Commissioners' Office (ICO), but only the most serious or large-scale are further escalated to the Department for Health and Social Care (DHSC). This new approach to incident grading came into effect on 25 May 2018, so as such 2019-2020 is the first full reporting year to be graded entirely in this way.

Incidents are now graded as follows:-

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

Below is an analysis of our information governance incident reporting records for 2019/2020. This shows that ZERO 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 2019/2020

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 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. 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. 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 of Directors 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 bi-annual 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 the 6th Data Protection Principle (DPA-2018).

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 e-mail services with Transport Level Security.

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 GDPR / DPA-2018 and entirely new content on the user aspects of information / cyber security. Course content was refreshed again in December 2019.

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, and a joint ICT / Clinical Team table top exercise was undertaken in 2019. Review cycles of current plans are undertaken in response to any actual or near-miss BC/DR events.

The Trust made a self-assessment against the NHS Digital Data Security and Protection Toolkit of 'Standards Met' at 31 March 2020, meeting the required evidential standard for all compulsory Assertions. This was supported by an internal audit appraisal of a sample of 29 of the 40 compulsory Assertions, with an outcome of "Significant Assurance" at audit. Requirements were included from across all ten of the National Data Guardian's core data security standards.*

**Note: At the time of writing, the Trust's final DSP Toolkit outcome has not been published. Due to the COVID19 crisis, NHS Digital extended the deadline for the Toolkit to 30th September 2020. Aligned to this and the suspension of normal Trust committee activity to focus on COVID19-related issues, the usual route to publication via ratification at the Finance & Performance Committee and then Board of Directors will be delayed until the resumption of normal working after the COVID19 crisis.*

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 Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Project Group with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to supportively challenge performance within directorates.

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.

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 Act Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their opinion; the Head of Internal Audit Opinion other audit reports. I have been advised on the effectiveness of the systems of internal controls by: the Board of Directors; the Audit Committee; the Quality Committee; the Workforce Committee; the Finance and Performance Committee; the Mental Health Legislation Committee; the Board Assurance Framework; and internal audit reports. I have also been advised by leadership from the executive directors with regard to risk reporting (clinical and non-clinical), implementing learning, and plans to address weaknesses and ensure continuous improvement of the systems in place.

2.7.10 CONCLUSION

In summary, the Trust has a sound system of internal control in place and no significant control issues have been identified. 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 that 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 2020

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 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 OD and Workforce

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 Members of the Board of Directors

Information about who our members of our Board of Directors were on 31 March 2020 can be found in Part A section 2.1.1 of this Annual Report.

3.3 PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS

Prof Sue Proctor, Chair of the Trust

Prof Sue Proctor 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.

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 over 35 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 also 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.

She currently runs a management consultancy working with charity and faith-based organisations. She has strong links with higher education as a former member of the University of Leeds Council and a Visiting Professor at Leeds Beckett University. Currently, she is Chair of the Strategic Safeguarding Group for the Diocese of York, Independent Chair of the North Yorkshire Safeguarding Adults Board, a member of the Lord Chancellors Advisory Committee for North & West Yorkshire, and a lay member of the Veterinary Nursing Council at the Royal College of Veterinary Surgeons.

In the last few years, she has led a number of extensive and complicated investigations into allegations of historical sexual abuse. From 2013 to 2014, she chaired the independent investigation into matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust and then led the national NHS Savile Legacy Unit overseeing 16 subsequent Savile-related NHS investigations.

From August 2013 to March 2017 Sue was Vice Chair of Harrogate and District NHS Foundation Trust; she was a member of their Audit Committee and the Quality Committee, as well as being the non-executive lead for research and development within the Trust.

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

Prof Baker'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, Midwifery Council. He has with 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

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 is a member of the Quality Committee and the Audit Committee and Chairs the newly formed Workforce 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 champion NED for Health and Safety and the nominated lead for Emergency Preparedness, Resilience and Response (EPRR).

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.

She has recently become freelance as director / owner of Entwyne Ltd, providing HR and Organisational Development consultancy and is currently the Interim Director of HR and OD at Manchester City Council.

Andrew Marran, Non-executive Director

Andrew'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 and the Quality Committee.

An Institute of Directors qualified director, Andrew's skills and expertise lie in leading sustainable growth in organisations, helping to develop long-term, sustainable partnerships and commercial relationships with other organisations; in particular establishing high quality , successful growth opportunities in the healthcare sector.

Andrew is a Mental Health Act Manager and non-executive board Director on a range of university spin-out and subsidiary companies at Leeds Beckett University. He manages a team of Business Development Managers who support the transfer of university ideas and research into tackling real world problems and innovations. He has 12 years' experience as a corporate management consultant and is currently the Chairman of Leeds Student Residences; a charity established to help students in accommodation hardship.

Margaret Sentamu, Non-executive Director (Chair of the Mental Health Legislation Committee)

Margaret'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 Audit Committee and the Chair of the Mental Health Legislation Committee. She also actively carries out the role of Mental Health Act Manager.

By holding the executive directors to account Margaret is able to be assured that services are provided in the most effective and efficient way. As a member of the Audit Committee she can be assured that the Trust is well governed and that we have effective processes and procedures in place. As the Chair of the Mental Health Legislation Committee and a practising Mental Health Act Manager she can make sure that we correctly apply the mental health legislation and ensure that we correctly 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), and discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

Margaret's background is in recruitment and selection in the private, public and the third sectors. More recently she has focused on helping organisations to embed diversity practices in the workplace by challenging unconscious bias in the areas of recruitment, retention and people development.

Her portfolio career includes regulating solicitors who breach the code of conduct for the Solicitors Regulatory Authority; and accountants, who are members of the Chartered Institute of Public Finance and Accountancy (CIPFA) who breach the by-laws. Margaret is a trustee and patron of a number of charities in the areas of health, education and poverty and is keen to strengthen partnerships between the mental health sector and the third sector and help fight stigma and discrimination.

Sue White, Non-executive Director (Chair of the Finance and Performance Committee and Deputy Chair of the Trust)

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, a member of the Mental Health Legislation Committee and the NED champion for 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 is able to make 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. Sue has a passion for ensuring that the services our Trust provides are of a high quality and that service users are at the heart of everything we do.

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 Finance 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

Dr Sara Munro 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 carte partners in Leeds.

Sara contributes 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.

Dr Munro 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 the Trust's managers, clinical leads and staff to lead and support all our care services. She focuses on developing and improving service delivery, often working alongside our health and social care partners. Joanna is also responsible for major service change and supporting people to make these changes positively, and is responsible for making sure we can respond to an emergency or crisis situation and provide continuity for our service users and support for the wider public as needed.

Joanna contributes to improving the experience of service users and carers by reporting on what we're doing well and where we don't meet the standards of care, access or delivery which provides high quality care for our service users. She ensures that at a glance 'dashboard' is available to make the information easier to understand. She, and her team, will 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. 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 care. During her 20 years as a senior NHS manager she has been keen to help staff be the best that they can be through personal and professional development.

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 many years ago 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.

Claire Holmes, Director of OD and Workforce

Claire Holmes is the Director for Organisational Development & Workforce and was appointed on 1 October 2018. She leads the Human Resources (HR), Organisational Development (OD) and Communications teams. Her role is to ensure we provide a positive working environment where our staff are, and feel valued, developed, and engaged.

Part of her role is to listen to staff and service user feedback and use it to influence the direction of the HR & OD strategy. Her aim is to make sure we give people development opportunities at work to help create a skilled workforce which is able to deliver quality specialist mental health and LD services.

Claire is a Fellow of the Chartered Institute of Personnel and Development. She was formerly the Group HR Director of the NPS Group, a national multi-disciplinary property design and consultancy company wholly owned by Norfolk County Council. She has worked across a variety of sectors including professional services, financial services, retail and the NHS.

From University, she joined Aviva (then Norwich Union Insurance) on its fast track HR graduate programme based in Norwich. Then having gained a master's in Strategic HR Management, she took a permanent role delivering major change programmes nationally for Aviva and a host of its subsidiary companies including the RAC, Auto Windscreens and car checking service HPI.

She then left Aviva to become Strategic HR Business Partner for Cambridgeshire and Peterborough Mental Health Trust and was part of a team that supported its successful journey to Foundation Trust status.

Dr Claire Kenwood, Medical Director

Dr Claire Kenwood was appointed as our Medical Director on 1 March 2017 and is responsible for applying the best medical practice and the highest quality of care for our service users.

Claire studied medicine at Birmingham University and qualified in 1988. She began her career in mental health in 1989 and completed her training in a variety of placements and specialties in Birmingham and Southampton, becoming consultant in assertive outreach in 1999.

After a period of work in Trafford as a consultant in assertive outreach and rehabilitation she moved to Scotland and spent 10 years working in Livingston, initially as a consultant and then as Clinical Director. Here she developed an interest in clinical leadership, initially completing a post graduate certificate in front line leadership and management and becoming a member of the chartered institute of managers. After this she completed a master's degree in clinical leadership at Glasgow University and then a master's degree in advanced leadership practice with Edinburgh Napier and Harvard Executive Education. The focus of these studies was on clinical, quality and safety and in particular research interests in relationships and leadership required for good service user outcomes.

In 2014 Claire took up a post in Cumbria Partnership NHS Foundation Trust as Associate Medical Director for Quality, also clinically supporting and leading the development of a new inpatient rehabilitation service for men. During this time she was successful in becoming part of the first cohort of the Q initiative and also a non-executive director of the Quality Improvement Organisation AQuA.

Cathy Woffendin, Director of Nursing, Professions and Quality

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 Claire Kenwood our Medical Director, to oversee the current quality and delivery of our services and shape these to best meet future needs.

Cathy contributes to improving the experience of service users and carers in many ways but in particular by leading a team which works directly with service users to gather and share their insight and feedback about their experience whilst in our care. 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 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 eight years and was appointed as our Director of Nursing, Professions and Quality on 1 March 2018.

Anyone wanting to contact our directors can find their contact details on our website 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. In 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, it was agreed that the March Board meeting would be held by teleconference. Members of the public were not invited to attend the

meeting, but were invited to submit questions. The draft minutes of the meeting were published on the Trust's website within one week of the meeting.

In 2019/20 the Board of Directors met on 7 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 2019/20

Name	Meetings eligible to attend	25 April 2019	23 May 2019	25 June 2019	26 September 2019	29 November 2019	30 January 2020	26 March 2020
Non-executive directors								
Prof Sue Proctor (Chair)	7	✓	✓	✓	✓	✓	✓	✓
John Baker	7	-	✓	✓	✓	✓	✓	✓
Helen Grantham	7	✓	✓	✓	✓	✓	✓	✓
Andrew Marran	7	✓	✓	✓	✓	✓	-	✓
Margaret Sentamu	7	✓	✓	✓	-	✓	✓	✓
Sue White	7	✓	✓	✓	✓	✓	✓	✓
Martin Wright	7	✓	✓	✓	✓	✓	✓	✓
Executive directors								
Sara Munro	7	✓	✓	✓	✓	✓	✓	✓
Joanna Forster Adams	7	✓	✓	✓	✓	✓	✓	✓
Dawn Hanwell	7	✓	-	✓	✓	✓	✓	✓
Claire Holmes	7	✓	✓	✓	✓	✓	-	✓
Claire Kenwood	7	✓	✓	✓	-	✓	✓	✓
Cathy Woffendin	7	✓	✓	✓	-	✓	✓	-

3.5 EVALUATION OF THE BOARD OF DIRECTORS

3.5.1 The Board of Directors and members of the Board

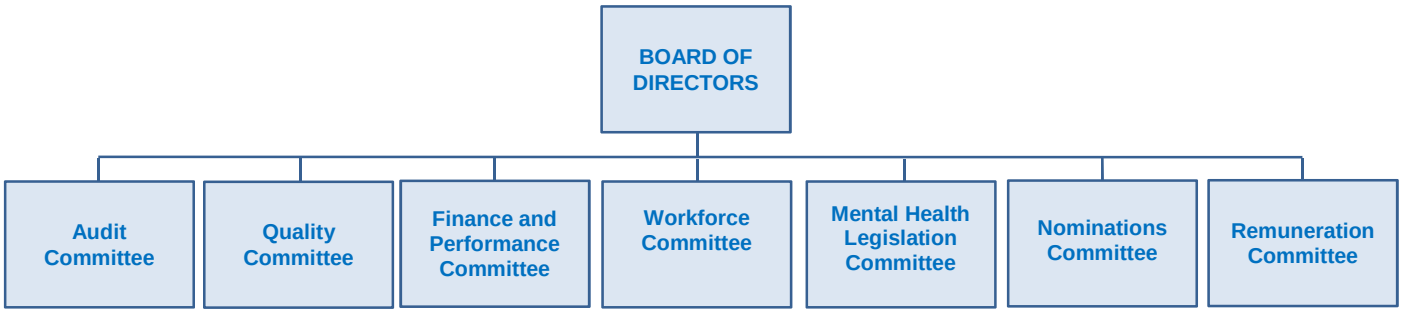
Details relating to the evaluation of the members of the Board of Directors can be found in Part A section 2.2.3.2 of this Annual Report.

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, except in the case of the Mental Health Legislation Committee which is supported by the Mental Health Legislation Team.

In 2019/20 the Board made a decision to establish a Workforce Board sub-committee. This was in view of the challenges and risks the Trust faces (along with all other NHS organisations) in relation to workforce recruitment and retention. This committee like all other Board sub-committees looks at

various aspects of strategic workforce issues in more detail than can be carried out at Board and makes assurances to the Board through committee chair's reports.



Evaluation of the Board sub-committees is carried out using an internal evaluation questionnaire. 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) 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 brought to the committee through the knowledge that non-executive directors gain 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 2019/20 the following members served on the committee as substantive members: Martin Wright, who was the chair of the committee, Helen Grantham and Margaret Sentamu. The other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it is appropriate, with the Chair of the Trust and the Chief Executive being invited to attend the Audit Committee on an annual basis; in 2019/20 Prof Sue Proctor attended the meeting in October 2019 and Sara Munro attended the meeting in May 2019.

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 2019/20 and attendance by each non-executive director member.

Table 3B – Attendance at Audit Committee meetings in 2019/20

Name	16 April 2019	20 May 2019	18 July 2019	24 October 2019	23 January 2020
Substantive non-executive director members					
Martin Wright (chair of the committee)	✓	✓	✓	✓	✓
Helen Grantham	✓	✓	✓	✓	✓
Margaret Sentamu	✓	✓	✓	✓	-

During 2019/20 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, the Annual Report and the Quality 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 May 2019 meeting the committee reviewed the Annual Report, Annual Accounts, the Quality Report, the Annual Governance Statement and the Head of Internal Audit Statement for 2018/19. 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 at 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 has carried out the role of Lead Governor since April 2019. 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 the 2019/20 there was no change 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	Equitix Ltd (our PFI partner)	1
	Volition (third sector mental health network)	1
	Tenfold (third sector learning disabilities network)	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 2019/20 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 2019/20.

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
Marc Pierre Anderson	Service User: Leeds	3 years	25.09.17	24.09.20	1st
Peter Chapman**	Service User: Leeds	3 years	20.03.20	19.03.23	1st
Mark Clayton**	Carer: Leeds	3 years	20.03.20	19.03.23	1st
Les France**	Public: Leeds	3 years	22.08.16	23.07.22	2nd
Gill Galea	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Ruth Grant**	Staff: Non-clinical	3 years	24.07.19	23.07.22	2nd
Steve Howarth**	Public: Leeds	3 years	17.08.13	23.07.22	3rd
Peter Holmes**	Service User: Leeds	3 years	20.03.20	19.03.23	1st
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	24.09.20	1st
Edo Nannelli*	Service User: Leeds	3 years	24.07.19	10.09.19	1st
Ivan Nip	Public: Leeds	3 years	30.04.18	29.04.21	1st
Sally Rawcliffe-Foo	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Adam Seymour**	Staff: Clinical	3 years	20.03.20	19.03.23	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 2019/20, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2019/20

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 Anna Perrett**	City of York Council	3 years	23.05.19	22.05.22	1st
Councillor Jenny Brooks*	City of York Council	3 years	23.08.17	02.05.19	1st
Helen Kemp	Volition	3 years	08.11.17	07.11.20	1st
Councillor Keith Wakefield *	Leeds City Council	3 years	25.07.18	06.05.19	1st
Councillor Rebecca Charlwood**	Leeds City Council	3 years	03.02.20	02.02.23	1st

* Indicates those governors who stepped down early during 2019/20, before the end of their term of office
** Indicates those governors who were re-appointed or newly appointed part-way through 2019/20

4.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2019/20 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: Edo Nannelli, Councillor Jenny Brooks and Councillor Keith Wakefield.

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 there are more people standing 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 2019/20 we held two rounds of elections: one in summer 2019 and one in spring 2020.

4.2.1.1 Elections held in summer 2019

During summer 2019 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 summer 2019 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	4
Public	York and North Yorkshire	1
Public	Rest of England and Wales	1
Carer	Leeds	3
Carer	York and North Yorkshire	1
Service user	Leeds	2
Service user	York and North Yorkshire	1
Service user and Carer	Rest of UK	1
Staff non-clinical	Leeds and York & North Yorkshire	1
Staff non-clinical	Leeds and York & North Yorkshire	1

This round of elections commenced 7 May and concluded on 24 July 2019. We were successful in filling seats as follows:

Table 4E – Elected unopposed

Name	Constituency elected to:
Ruth Grant	Staff: Non-clinical
Steve Howarth	Public: Leeds
Mussarat Khan	Public: Leeds
Edo Nannelli	Service User: Leeds
Peter Webster	Public Leeds
Les France	Public: Leeds

For the Public: Rest of England and Wales constituency we had more people stand than seats available and so we had to hold a ballot. The following governor was elected by ballot and turnout was 2.5%.

Table 4F – Elected by ballot

Name	Constituency elected to:
Niccola Swan	Public: Rest of England and Wales

At the end of the election we still had vacancies in the constituencies of Service user: Leeds (two seats), Carer: Leeds (three seats), Carer: York and North Yorkshire (one seat), Service user: York and North Yorkshire (one seat) and Public: York and North Yorkshire (one seat). These will go into the next round of elections in spring 2020.

4.2.1.2 Elections held in spring 2020

During spring 2020 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 4G – Seats included in the spring 2020 election

Constituency	Name of constituency	Number of seats included in the election
Public	York and North Yorkshire	1
Carer	Leeds	3
Carer	York and North Yorkshire	1
Service user	Leeds	2
Service user	York and North Yorkshire	1
Service user and Carer	Rest of UK	1
Staff Clinical	Leeds and York & North Yorkshire	2

This round of elections commenced 6 January and concluded on 20 March 2020. We were successful in filling seats as follows:

Table 4H – Elected unopposed

Name	Constituency elected to:
Mark Clayton	Carer: Leeds
Andrew Johnson	Staff: Clinical
Adam Seymour	Staff: Clinical

For the Service User: Leeds constituency we had more people stand than seats available and so we had to hold a ballot. The following governor was elected by ballot and turnout was 6%.

Table 4I – Elected by ballot

Name	Constituency elected to:
Peter Chapman**	Service User: Leeds
Peter Holmes**	Service User: Leeds

At the end of the election we still had vacancies in the constituencies of Carer: Leeds (two seats), Carer: York and North Yorkshire (one seat), Service user: York and North Yorkshire (one seat) and Public: York and North Yorkshire (one seat). These will go into the next round of elections.

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 2019/20 there were four changes to our appointed governors. Councillor Jenny Brooks (City of York Council) and Councillor Keith Wakefield (Leeds City Council) both stepped down during their first term of office. Councillor Rebecca Charlwood (Leeds City Council) and Councillor Anna Perrett (City of York Council) commenced their first term of office as appointed governors 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 all 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 2019/20 the Council of Governors had four business meetings. All general Council meetings are held in public, although 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. The table below shows attendance at those four meetings.

Notice of public Council of Governors' meetings along with the agenda and papers are published on our website www.leedsandyorkpft.nhs.uk.

The governors also hold an Annual Members' Meeting. This was held in July 2019. 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 below shows those governors who attended the Annual Members' Meeting.

Table 4G details the number of meetings attended by each governor during 2019/20. This is shown out of a maximum of four 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 to the meeting).

Table 4J – 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**	**9 May 2019**	**16 July 2019**	**7 November 2019**	**4 February 2020**	**30 July 2019**
Marc Pierre Anderson	E	4	✓	-	-	-	✓
Councillor Jenny Brooks*	A	0	-				
Peter Chapman**	E	0					
Councillor Rebecca Charlwood**	A					-	
Mark Clayton**	E	0					
Les France**	E	4	-	✓	-	✓	✓
Gill Galea	E	4	✓	✓	✓	✓	✓
Ruth Grant**	E	2			✓	✓	✓
Steve Howarth**	E	4	✓	✓	-	✓	✓
Peter Holmes**	E	0					
Andrew Johnson**	E	4	✓	✓	✓	✓	✓
Helen Kemp	A	4	✓	-	✓	✓	✓
Mussarat Khan**	E	2			-	✓	✓
Sarah Layton	E	4	✓	✓	✓	✓	✓
Kirsty Lee	E	4	✓		✓	✓	✓
Edo Nannelli*	E	0					-
Ivan Nip	E	4	✓	✓	✓	✓	✓
Councillor Anna Perrett**	E	3		✓	-	-	✓
Sally Rawcliffe-Foo	E	4	✓	✓	✓	✓	✓
Adam Seymour**	E	0					
Ann Shuter	E	4	-	✓	-	✓	✓
Niccola Swan**	E	4	✓	✓	✓	✓	✓
Councillor Keith Wakefield *	A	0					
Peter Webster**	E	4	✓	✓	✓	-	✓

\- Indicates those governors who sent apologies during 2019/20

* Indicates those governors who stepped down during 2019/20, 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 2019/20 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 publically 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 also 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 a number of the Board sub-committee meetings and are encouraged to attend 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 Trust.

The following table shows those Council meetings that were attended by members of the Board.

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

Name	9 May 2019	16 July 2019	7 November 2019	4 February 2020
Non-executive directors				
Prof Sue Proctor	✓	✓	✓	-
Prof John Baker	✓	✓	✓	✓
Helen Grantham	-	✓	✓	✓
Margaret Sentamu	✓	✓	✓	✓
Andrew Marran	✓	-	✓	✓
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 2019/20 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 2020 the membership was 14,471. 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 2020

Public constituency	Number of members
Public: Leeds	7412
Public: York and North Yorkshire	1401
Public: Rest of England and Wales	1944
Total public members (including 64 members outside England and Wales)	10821

Service User and Carer constituency	Number of members
Service user: Leeds	497
Service user: York and North Yorkshire	87
Carer: Leeds	309
Carer: York and North Yorkshire	37
Service User and Carer: Rest of UK	89
Total service user and carer members (including 1 member unspecified)	1020

Staff constituency	Number of members
Clinical staff: Leeds and York & North Yorkshire	1889
Non-clinical staff: Leeds and York & North Yorkshire	643
Total staff members (including 98 unspecified)	2630

Membership has maintained steady at 14,471 as at 31 March 2020. 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. It was felt that further work should be undertaken to develop meaningful engagement with members whilst maintaining the total number. Work has taken place to review what meaningful engagement could look like for our members. It was decided the basis of this would include:

- Improving member engagement
- Communicating better with members
- Maintaining a representative membership.

Work has also been underway to create a clear branding for membership that is consistent with the Trust's brand and its wider strategy. The Trust has reached a strong solid membership number; now the focus will be on developing a programme of engagement for members.

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. Work to develop these areas of work is on-going.

A focused approach to membership engagement and recruitment is supported by the development of the membership database. This allows for recruitment and engagement campaigns to maintain a representative membership. Engagement with members is enhanced through improved communication tools using the database, and a structured membership engagement plan that is supported by the Trust's Communications Team.

We have a varied approach to facilitating engagement between governor, 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. In 2020/21 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 and this was extended by the Council for a further year until May 2021.

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, financial aspects of corporate governance, the use of resources, the Annual Report and the Quality Report.

The cost of independent audits during 2019/20 is detailed in the table below:

Table 6A – Cost of statutory audits

The Annual Accounts	£47,000
The Quality Report	£8,100
Total	£55,100

6.2 INTERNAL AUDIT SERVICES

Our internal audit and counter fraud services are provided by Audit Yorkshire. This is a specialist provider of internal audit services to the NHS. Audit Yorkshire was formed on 1 July 2016 from a merger of West Yorkshire Audit Consortium (WYAC) and North Yorkshire Audit Services (NYAS).

The Internal Audit Team is led by Helen Kemp-Taylor who is the Managing Director and Head of Internal Audit. 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 it 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.

In 2018/19 the Trust took the decision to become a formal member of Audit Yorkshire rather than a client. 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 membership of Audit Yorkshire commenced on 1 June 2019.

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. The external assessment is required every five years and was undertaken by the Chartered Institute of Public Finance and Accountancy (CIPFA).

PART B
ANNUAL ACCOUNTS
2019/20

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

1. Our opinion is unmodified

We have audited the financial statements of Leeds and York Partnership NHS Foundation Trust ("the Trust") for the year ended 31 March 2020 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2020 and of its income and expenditure for the year then ended; and

— the Trust's financial statements 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, the NHS Foundation Trust Annual Reporting Manual 2019/20 and the Department of Health and Social Care Group Accounting Manual 2019/20.

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.

Overview	
Materiality: financial statements as a whole	£3m (2018/19:£2.9m) 1.76% (2018/19: 1.63%) of total revenue

Risks of material misstatement		vs 2018/19
Recurring risks	Valuation of land and buildings	▲
	Fraudulent revenue recognition	◄►
	Fraudulent expenditure recognition	◄►

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
Valuation of land and buildings (£35.5 million; 2018/19: £33.3 million) *Refer to Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, note 1.6.2 (accounting policy) and note 14 (financial disclosures)*	**Subjective Valuation:** Land and buildings are initially recognised at cost. Non specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets (such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). A review is carried out each year to test assets for potential impairment or revaluation. Trusts are responsible for ensuring their land and buildings are fairly valued. Guidance from NHSI has suggested that Trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation (usually every three years) and a full valuation (usually in five yearly intervals). The asset valuation and impairment review processes are both estimates and therefore present a significant risk to the audit. There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole. **Disclosure Quality:** There is a risk that uncertainties expressed by the Trust's valuers around the impact of the Covid-19 pandemic on the values of land and buildings will be inappropriately disclosed.	Our procedures included: — **Assessing valuer's credentials:** We assessed the competence, capability, objectivity and independence of the Trust's external valuer and considered the terms of engagement of, and the instructions issued to, the valuer to confirm consistency with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20; — **Test of detail:** We considered whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records. This included paying particular attention to one of the Trust's assets (St Mary's) where redevelopment work had taken place resulting in changes to floor areas; — **Test of details:** We critically assessed the Trust's formal consideration of indications of impairment within its estate, including the process undertaken and the adequacy of the judgements made by management in determining whether assets are impaired or surplus to requirements; — **Test of details:** We agreed movements in asset valuation per the Trust's Fixed Asset Register to the reports provided by the valuer; — **Test of details:** We undertook work to understand the basis upon which movements in the valuation of land and buildings as per the Fixed Asset Register have been identified and treated in the financial statements and determined whether they have complied with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20; — **Test of details:** We tested a sample of the 2019/20 capital expenditure additions to confirm that the additions were appropriately valued in the financial statements; — **Benchmarking assumptions:** We corroborated significant assumptions and key data elements, used by the external valuer, to supporting evidence; — **Assessing Transparency:** We considered the adequacy of the disclosures made around the uncertainty caused by Covid-19 pandemic on market data used to underpin the valuer's assumptions, and management's consideration of these factors when arriving at the year-end valuation figures; and — **Assessing Transparency:** We ensured that the disclosures made were in line with the requirements of the Department of Health and Social Care Group Accounting Manual 2019/20, supplemented by additional guidance issued by NHS Improvement in April 2020.

2. Key audit matters: our assessment of risks of material misstatement (continued)

	The risk	Our response
Fraudulent revenue recognition Income from patient care activities (£157.3 million; 2018/19: £140.3 million) *Refer to Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, note 1.5.2 (accounting policy) and note 3 (financial disclosures)*	**Effect of irregularities:** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS Commissioners. There is a significant risk of material misstatements in respect of this income recognition, since this includes a number of significant estimates. The Trust participates in the national Agreement of Balances (AoB) exercise, which is mandated by the Department of Health and Social Care covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health and Social Care's resource account. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its counterparties at the balance sheet date. Mismatches can occur for a number of reasons, but the most significant arise where: - the Trust and Commissioners record different accruals for completed periods of healthcare which have not yet been invoices; or - income relating to partially completed period of healthcare is apportioned across the financial year and the Commissioners and the Trust make different apportionment assumptions. Where there is a lack of agreement, mismatches can also be classified as formal disputes and referred to NHS England Area Teams for resolution. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial targets rather than financial incentives related to remuneration. Whilst the risk of error is low, due to the nature of the income, there is a risk of fraudulent income recognition due to the pressure on management to deliver the agreed control total.	Our procedures included: — **Test of details:** We compared the actual income for the Trust's most significant commissioners against the block contracts agreed at the start of the year and checked the validity of any significant variations between the actual income and the contract via the agreement to appropriate third party confirmations; — **Test of details:** We inspected confirmations of balances provided by he Department of Health and Social Care as part of the AoB exercise and compared the relevant income recorded in the Trust's financial statements to the expenditure balances recorded within the accounts of the Commissioners. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising income from Commissioners. We confirmed that none of the variances had been escalated to formal disputes; and — **Test of details:** We agreed a sample of income received in March and April 2020 to supporting evidence to assess whether income has been accounted for in the correct financial year.

2. Key audit matters: our assessment of risks of material misstatement (continued)

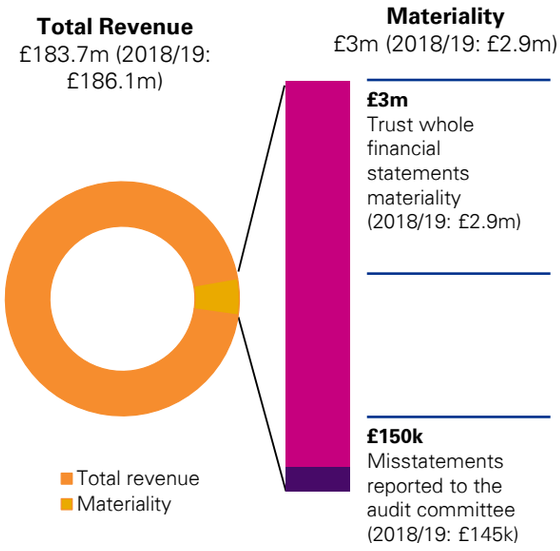
	The risk	Our response
Fraudulent expenditure recognition Operating expenses (£175.8 million; 2018/19: £158.4 million) Trade and other payables (£14.7 million; 2018/19: £18.3 million) *Refer to Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, note 1.6 (accounting policy) and note 5 (financial disclosures).*	Effect of irregularities: In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk of material misstatements due to fraud related to revenue recognition and so the auditor has regard to this when planning and performing audit procedures. This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions	Our procedures included: — **Control design and operation:** We assessed the design and implementation, and the operating effectiveness of the application of appropriate segregation of duties between those responsible for monitoring budgets and those preparing the financial statements to confirm that appropriate anti-fraud controls, such as segregation of duties were designed, implemented and operating effectively; — **Control design and operation:** We assessed the design and implementation, and the operating effectiveness of the application of the three way match control, which matches the purchase order to the goods received note and valid invoice, prior to making a payment to the supplier; — **Test of detail:** We tested a sample of expenditure in March and April 2020 and confirmed that these items had been accounted for in the correct period, with reference to when the service was delivered, through inspection of relevant source documentation such as invoices; — **Test of detail:** We inspected confirmations of balances provided by the Department of Health and Social Care as part of the AoB exercise and compared the relevant expenditure and payables recorded in the Trust's financial statements to the income receivables balances recorded within the accounts of other providers and other bodies within the AoB boundaries. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure and payables with other providers and other bodies within the AoB boundaries; and — **Test of detail:** We tested a sample of accruals in the year to test they were calculated on a reasonable basis and related to the 2019/20 financial year.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £3 million (2018/19: £2.9 million), determined with reference to a benchmark of total revenue (of which it represents approximately 1.7%) {2018/19: 1.6%). We consider total revenue to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £150k (2018/19:£145k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed remotely.



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the 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 their 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").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's 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. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1.1.11 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the 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

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2019/20.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2019/20, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

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6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 67, 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

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

— any matters have been reported in the public interest under Schedule 10(3) 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.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the 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 the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), 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 the 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 the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability:	**Financial sustainability (including delivery of the Cost Improvement Programmes (CIPs)** As part of our responsibilities in relation to reaching our use of resources conclusion we are required to perform any work that we regard as necessary to allow us to conclude on whether the Trust has effectively, efficiently and economically exercised its functions. Due to the significant financial challenge in the sector we have undertaken a detailed consideration of the financial position and financial sustainability.	Our work included: **Financial Sustainability:** We assessed the Trust's financial sustainability. This considered whether the financial results included significant non-recurrent items of income within the reported headline result. We also considered the Trust's management of its cash position and delivery of CIPs through the year. **Future forecasts:** We assessed the core assumptions in the Trust's draft 2020/21 Annual Plan submission. **Our findings:** For 2019/20 total CIP savings of £2.969m were achieved in year and of these £1.817m were recurrent. Management were in the process of compiling their 2020/21 annual plans in March 2020 when the Covid-19 pandemic hit and all planning arrangements were put on hold nationally for the interim period. The financial plan for 2020/21 was completed with planned efficiencies of £2.393m, of which £1.840m was recurrent but £350k of this remained unidentified. £553k of non-recurrent savings also remained unidentified. Whilst the impact of the Covid-19 pandemic is still ongoing the Trust is being funded on a break even basis. This is planned to continue until October 2020 with a possibility of continuing further into the 2020/21 year. Despite planning arrangements being put on hold nationally, we noted arrangements were being developed along similar timelines to previous years for CIPs. While the Trust had not identified all the required savings for 2020/21, this was in line with previous years and we note the Trust has a good track record of delivering CIP savings. We also note the strong level of reserves the Trust holds. Our work has confirmed that the Trust has adequate arrangements to deliver financial sustainability. No issues were identified as a result of our testing that impacts on our value for money conclusion.

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 2020 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rashpal Khangura for and on behalf of KPMG LLP

Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

22 June 2020

KPMG

Leeds and York Partnership NHS Foundation Trust

Annual Accounts
for the year ended
31 March 2020

FOREWORD TO THE ACCOUNTS

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2020, 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 2020

STATEMENT OF COMPREHENSIVE INCOME AS AT 31 March 2020	note	**Year ended 31 March 2020** £000	Year ended 31 March 2019 £000
Operating income	2, 3 & 4	183,733	186,143
Operating expenses	2 & 5	(175,829)	(158,402)
OPERATING SURPLUS		**7,904**	**27,741**
FINANCE COSTS			
Finance income	10	544	6,868
Finance expense - financial liabilities	12	(4,025)	(4,033)
Finance expense - unwinding of discount on provisions	25	(5)	(2)
PDC dividend payable		(37)	(301)
Share of profit/(loss) of associates/ joint ventures			70
NET FINANCE COSTS		**(3,523)**	**2,602**
Gains (losses) on disposal of assets	11	**(4)**	2,060
Surplus from operations		4,377	32,403
SURPLUS FOR THE YEAR		**4,377**	**32,403**
Other comprehensive income			
Items that will not be reclassified to income or expenditure:			
Revaluation gains and (impairment losses) on intangible assets		42	8
Revaluation gains and (impairment losses) on property, plant and equipment		2,076	(1,353)
Other comprehensive income for the year		**2,118**	**(1,345)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**6,495**	**31,058**

The notes on pages 7 to 36 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2020	note	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Non-current assets			
Intangible assets	13	864	435
Property, plant and equipment	14	43,522	37,863
Trade and other receivables	17	5,201	4,577
Total non-current assets		**49,587**	**42,875**
Current assets			
Inventories	16	5	27
Trade and other receivables	17	7,492	31,613
Non-current assets for sale	19		
Cash and cash equivalents	18	92,300	69,424
Total current assets		**99,797**	**101,064**
Current liabilities			
Trade and other payables	20	(14,698)	(18,343)
Borrowings	21	(2,038)	(1,881)
Provisions	25	(4,447)	(2,371)
Other liabilities	22	(3,422)	(1,447)
Total current liabilities		**(24,605)**	**(24,042)**
Total assets less current liabilities		**124,779**	**119,897**
Non-current liabilities			
Borrowings	21	(17,497)	(19,535)
Provisions	25	(2,237)	(1,963)
Total non-current liabilities		**(19,734)**	**(21,498)**
Total assets employed		**105,045**	**98,399**
Financed by (taxpayers' equity)			
Public dividend capital		19,732	19,581
Revaluation reserve		5,799	3,832
Other reserves		(651)	(651)
Income and expenditure reserve		80,165	75,637
Total taxpayers' equity		**105,045**	**98,399**

The notes on pages 7 to 36 form part of this account.

The accounts on pages 2 to 36 were approved by the Board on 16 June 2020 and signed on its behalf by:

Signed: Sara Munro (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 2019	19,581	3,832	(651)	75,637	98,399
Surplus for the year				4,377	4,377
Revaluation gains and impairment losses on intangible assets		42			42
Revaluation gains and impairment losses property, plant and equipment		2,076			2,076
Public dividend capital received	151				151
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		(150)		150	
Movement in year subtotal	**151**	**1,967**		**4,528**	**6,646**
Taxpayers' equity at 31 March 2020	19,732	5,799	(651)	80,165	105,045

Annual Accounts 2018/19

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 2018	19,569	5,784	(651)	42,627	67,329
Surplus for the year				32,403	32,403
Revaluation gains and impairment losses on intangible assets		8			8
Revaluation gains and impairment losses property, plant and equipment		(1,353)			(1,353)
Public dividend capital received	12				12
Transfers to the income and expenditure account in respect of assets disposed of		(341)		341	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(266)		266	
Movement in year subtotal	**12**	**(1,952)**		**33,010**	**31,070**
Taxpayers' equity at 31 March 2019	19,581	3,832	(651)	75,637	98,399

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 7 to 36 form part of this account.

STATEMENT OF CASH FLOWS AS AT 31 March 2020	note	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Cash flows from operating activities			
Operating surplus from continuing operations		7,904	27,741
Operating surplus		**7,904**	**27,741**
Non-cash income and expense:			
Depreciation and amortisation	5	3,971	4,094
Impairments and reversals	14	(725)	1,915
(Increase)/decrease in trade and other receivables	17	23,333	(25,029)
(Increase)/decrease in inventories	16	22	37
Increase/(decrease) in trade and other payables	20	(4,269)	8,108
Increase/(decrease) in other liabilities	22	1,975	221
Increase/(decrease) in provisions	25	2,345	279
NET CASH GENERATED FROM OPERATIONS		**34,556**	**17,366**
Cash flows from investing activities			
Interest received	10	563	6,847
Purchase of intangible assets	13	(644)	(227)
Purchase of property, plant and equipment	14	(5,976)	(4,270)
Sales of property, plant and equipment		12	3,353
Net cash used in investing activities		**(6,045)**	**5,703**
Adjustment for net assets de-recognised on merger			
Cash flows from financing activities			
Public dividend capital received		151	12
Capital element of private finance initiative obligations	21	(1,868)	(1,724)
Interest element of private finance initiative obligations	12	(4,026)	(4,027)
PDC dividend (paid)/refunded		108	(400)
Cash flows from (used in) other financing activities			70
Net cash used in financing activities		**(5,635)**	**(6,069)**
Increase/(decrease) in cash and cash equivalents		22,876	17,000
Cash and Cash equivalents at 1 April		69,424	52,424
Cash and Cash equivalents at 31 March		**92,300**	**69,424**

Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	2019/20 £000s	2018/19 £000s
(Increase)/decrease in receivables as per SOFP	23,497	(25,149)
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		
- Financing transactions	(164)	120
(Increase)/decrease in receivables adjusted for non-I&E items	23,333	(25,029)
Increase/(decrease) in payables per SOFP	(3,645)	8,065
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	(612)	61
- Financing transactions	(12)	(18)
Increase/(decrease) in payables adjusted for non-I&E items	(4,269)	8,108
Increase/(decrease) in Other Liabilities per SOFP	1,975	221
Adjustments for Other Liabilities movements not related to I&E:		
Increase/(decrease) in Other Liabilities adjusted for non-I&E items	1,975	221
Increase/(decrease) in provisions per SOFP	2,350	281
Adjustments for provisions movements:		
- Unwinding of discount on provisions	(5)	(2)
Increase/(decrease) in provisions for non I&E items	2,345	279
Opening capital payables	(624)	(685)
Capital payable written off		
Closing capital payables	(1,236)	(624)
Change in capital payables in-year	**612**	**(61)**

The notes on pages 7 to 36 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 2019/20 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.

Where management are aware of material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the NHS foundation trust, these have been disclosed.

1.1 a

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.

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 2019/20 were 20.68%, including the administration levy (14.38% in 2018/19).

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 are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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 2019/20 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 5% (with a minimum 2% being contributed by the Trust) and from October 2018 the combined contribution rate will be 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 2020 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 2020, 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.

As a result of the global pandemic, the valuation at 31 March 2020, is reported on the basis of material valuation uncertainty and therefore a higher degree of caution needs to be taken in this respect. The valuation of the Trust's assets is normally carried out annually but will be frequently monitored throughout 2020-21 to determine any material impact.

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.

Notes to the accounts - 1. Accounting policies (continued)

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.

Notes to the accounts - 1. Accounting policies (continued)

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

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 -0.5% (0.29% in 2018/19) in real terms. The discount rate for other provisions varies depending on the timing of the liability from 0.51% (up to 5 years), 0.55% (5 - 10 years) and 1.99% over 10 years (in 2018/19 the discount rates were 0.76%, 1.14% 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.

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2019-20. These standards, IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2021. 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 2021, 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. Currently this rate is 1.27% but this may change between now and adoption of the standard. 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 2021 for existing finance leases.

For leases commencing in 2021/22, 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 2020/21, the Trust does not expect the transition to this standard to have a material impact on non-current assets, liabilities and deprieciation.

IFRS 17 Insurance contracts

Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

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 2019/20

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’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 2020 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 58% of its income (53% in 2018/19). 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. Operating segments are reported on the basis of full cost absorption.

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 2020	Year ended 31 March 2019	**Year ended 31 March 2020**	Year ended 31 March 2019	**Year ended 31 March 2020**	Year ended 31 March 2019
	£000	£000	**£000**	£000	**£000**	£000
Income by segment						
Income from activities	**157,294**	140,302			**157,294**	140,302
Other operating income	**15,755**	35,158	**10,684**	10,683	**26,439**	45,841
TOTAL INCOME	**173,049**	175,460	**10,684**	10,683	**183,733**	186,143
TOTAL EXPENDITURE	**(165,562)**	(148,119)	**(10,267)**	(10,283)	**(175,829)**	(158,402)
Operating surplus	**7,487**	27,341	**417**	400	**7,904**	27,741
Non Operating Income and Expenditure Total	**(3,527)**	4,634		27	**(3,527)**	4,661
Surplus/(Deficit) from continuing operations	**3,960**	31,975	**417**	427	**4,377**	32,403

a) Income includes £162m (£168m in 2018/19) from NHS organisations (primarily £111m from Leeds CCG and £33m from NHS England).

b) Expenditure includes employee expenses £127,002k (£113,468k in 2018/19), premises £5,715k (£6,009k in 2018/19), depreciation and amortisation £3,971k (£4,094k in 2018/19) and establishment £2,392k (£2,334k in 2018/19).

3 Revenue from patient care activities

	Year ended 31 March 2020	Year ended 31 March 2019
	£000	£000
Clinical Commissioning Groups and NHS England	**146,993**	129,137
Foundation Trusts	**197**	193
Local Authorities	**50**	346
NHS other	**445**	1,561
Non-NHS:		
Income for social care clients	**9,061**	8,719
Other	**548**	346
Total revenue from patient care activities	**157,294**	140,302

All income from patient care activities is classed as commissioner requested services (CRS).

Notes to the accounts

4 Other operating revenue	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Research and development	**1,983**	1,692
Education and training	**4,248**	4,187
Non-patient care services to other bodies	**1,359**	1,427
Provider sustainability fund	**2,241**	21,957
Other income:		
Inter NHS Foundation Trust	**1,966**	1,666
Inter NHS Trust	**941**	1,319
Inter RAB	**7,917**	4,425
Inter Other WGA bodies	**179**	146
Other (outside WGA)	**4,391**	7,750
Income in respect of staff costs where accounted on gross basis	**1,214**	1,272
Total Other Operating Revenue	**26,439**	45,841

5 Operating expenses	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Purchase of healthcare from NHS and DHSC bodies	**1,983**	51
Purchase of healthcare from non-NHS and non-DHSC bodies	**9,067**	8,161
Purchase of social care	**525**	535
Staff and executive directors costs	**127,002**	113,468
Non-executive directors	**219**	216
Supplies and services – clinical (excluding drugs costs)	**1,273**	1,200
Supplies and services - general	**1,628**	1,405
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**1,861**	2,103
Consultancy	**61**	106
Establishment	**2,392**	2,334
Premises - business rates collected by local authorities	**988**	1,013
Premises - other	**4,727**	4,996
Transport (business travel only)	**1,095**	1,002
Transport - other (including patient travel)	**713**	674
Depreciation	**3,757**	3,879
Amortisation	**214**	215
Impairments net of (reversals)	**(725)**	1,915
Increase/(decrease) in impairment of receivables	**226**	(41)
Provisions arising / released in year	**2,432**	399
Change in provisions discount rate	**83**	(20)
Audit services - statutory audit	**56**	56
Other auditor remuneration (payable to external auditor only)	**1**	10
Internal audit - non-staff	**86**	84
Clinical negligence - amounts payable to NHS Resolution (premium)	**299**	258
Legal fees	**376**	311
Insurance	**116**	171
Research and development - non staff	**2,106**	1,831
Education and training - non staff	**993**	1,062
Education and training - notional expenditure funded from apprenticeship fund	**177**	88
Operating lease expenditure (net)	**1,372**	1,182
Early retirements - non staff	**11**	11
Redundancy costs - non staff	**20**	
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis	**7,708**	7,268
Car parking and security	**141**	227
Other losses and special payments - non staff	**18**	25
Other	**2,828**	2,207
Total operating expenditure	**175,829**	158,402

£9,067k of expenditure categorised as purchase of healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£8,161k in 2018/19).

Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis £7,708k (£7,268k in 2018/19) includes premises cost £486k, operating leases £414k and supplies and services - general £6,808k, previously included under separate headings (2018/19: £397k, £401k and £6,470k respectively).

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 the three year period commencing 1 June 2017, with an option to extend for a further year. The statutory audit fee will be £47k for 2019/20 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. Other audit remuneration was for audit related assurance services relating to the Quality Report £1k (£8k in 2018/19).

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Financial Audit	**47**	47
Other audit remuneration - audit related assurance services (Quality report)	**1**	8
Total	**48**	55

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 2020 £000**	Year ended 31 March 2019 £000
Minimum lease payments	**1,372**	1,182
Sub-lease payments		
	1,372	1,182

Total future minimum lease payments	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
Not later than one year	**1,247**	1,118
Between one and five years	**745**	829
After 5 years		
Total	**1,992**	1,947

Notes to the accounts

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2020			Year Ended 31 March 2019		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**96,238**	**85,264**	**10,974**	89,440	79,446	9,994
Social security costs	**8,836**	**8,836**		8,158	8,158	
Employer contributions to NHS pension scheme	**11,848**	**11,848**		11,069	11,069	
Agency staff	**5,600**		**5,600**	5,138		5,138
Employee benefits expense	**122,522**	**105,948**	**16,574**	113,805	99,093	15,132

There were no employee benefits paid in the year ended 2019/20 (£nil in 2018/19)

In addition to the above:		
Charged to capital	**(617)**	(194)
Employer contributions to NHS pension scheme paid by NHSE	**5,172**	
Apprentice Levy	**453**	420
Recharged income	**(528)**	(563)
Total employee costs	**127,002**	113,468

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 2020	Year ended 31 March 2019
Directors' remuneration	**£000**	£000
Aggregate emoluments to Executive Directors	**760**	711
Remuneration of Non-Executive Directors	**219**	216
Pension cost	**90**	102
Additional Pension cost covered by NHS E	**39**	
	1,108	1,029

Remuneration of Non-Executives include MH Act Managers £75k (£75k in 2018/19).

7.2 Monthly average number of people employed (wte)

	Year Ended 31 March 2020			Year Ended 31 March 2019		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**203**	**186**	**17**	193	182	11
Administration and estates	**631**	**593**	**38**	626	573	53
Healthcare assistants and other support staff	**815**	**571**	**244**	812	565	247
Nursing, midwifery and health visiting staff	**776**	**730**	**46**	738	695	43
Scientific, therapeutic and technical staff	**327**	**323**	**4**	327	322	5
Social care staff	**14**	**14**		6	6	
Total	**2,766**	**2,417**	**349**	2,702	2,343	359

8 Retirements due to ill-health

During 2019/20 there were 0 (2 in 2018/19) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £0k (£140k in 2018/19). 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 2020		Year Ended 31 March 2019	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**22,335**	**56,344**	22,816	49,406
Total Non-NHS trade invoices paid within target	**21,546**	**53,892**	21,980	47,277
Percentage of Non-NHS trade invoices paid within target	**96%**	**96%**	96%	96%
Total NHS trade invoices paid in the year	**1,174**	**8,860**	998	6,069
Total NHS trade invoices paid within target	**1,089**	**8,278**	929	5,686
Percentage of NHS trade invoices paid within target	**93%**	**93%**	93%	94%

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.

10 Finance Income

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Bank accounts	**544**	359
PFI Re-financing		6,509
Total	**544**	6,868

This figure includes accrued interest of £21k (2018/19 £40k).

11 Other gains and losses

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Gain on disposal of property, plant and equipment	**1**	2,095
Loss on disposal of property, plant and equipment	**(1)**	(18)
Loss on disposal of intangible assets	**(4)**	(17)
Total	**(4)**	2,060

12 Finance costs

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Interest on obligations under finance leases		
Interest on obligations under PFI contracts:		
- main finance cost	**1,654**	1,799
- contingent finance cost	**2,371**	2,234
Total	**4,025**	4,033

13 Intangible assets

2019/20:	**Computer software - purchased £000**	**2018/19:**	**Computer software - purchased £000**
Gross valuation at 1 April 2019	578	Gross valuation at 1 April 2018	726
Additions purchased	632	Additions purchased	21
Disposals other than by sale	(9)	Disposals other than by sale	(56)
Impairments		Impairments	
Reclassifications		Reclassifications	
Revaluation/indexation	(63)	Revaluation/indexation	(113)
Gross valuation at 31 March 2020	**1,138**	**Gross valuation at 31 March 2019**	**578**
Accumulated amortisation at 1 April 2019	143	Accumulated amortisation at 1 April 2018	79
Disposals other than by sale	(5)	Disposals other than by sale	(39)
Revaluation	(105)	Revaluation	(121)
Impairments	27	Impairments	9
Charged during the year	214	Charged during the year	215
Accumulated amortisation at 31 March 2020	**274**	**Accumulated amortisation at 31 March 2019**	**143**
Net book value		**Net book value**	
Purchased	864	Purchased	435
Total at 31 March 2020	**864**	**Total at 31 March 2019**	**435**

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 2019/20 for the software licences and this led to an impairment charge to operating expenses of £27k (impairment charge of £9k in 2018/19).

Notes to the accounts

14. Property, plant and equipment

2019/20:	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 2019	1,830	31,718	1,652	972	309	6,537	894	43,912
Additions purchased			4,988	7	29	1,425	151	6,600
Additions donated								
Reclassifications		1,999	(4,561)			2,562		
Reclassified as held for sale								
Disposals				(40)	(18)			(58)
Revaluation/indexation (losses)/gains	48	222		22	1		(2)	291
Impairments			(2)				(1)	(3)
Reversal of Impairments								
At 31 March 2020	**1,878**	**33,939**	**2,077**	**961**	**321**	**10,524**	**1,042**	**50,742**
Accumulated depreciation at 1 April 2019		266		808	240	4,294	441	6,049
Disposals				(28)	(18)			(46)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(1,804)		19	1		(1)	(1,785)
Impairments								
Reversal of Impairments		(755)						(755)
Charged during the year		2,568		35	17	1,074	63	3,757
Accumulated depreciation at 31 March 2020		**275**		**834**	**240**	**5,368**	**503**	**7,220**
Net book value								
Total at 31 March 2020	**1,878**	**33,664**	**2,077**	**127**	**81**	**5,156**	**539**	**43,522**
Asset financing								
Owned	1,878	21,949	2,077	127	81	5,156	539	**31,807**
PFI		11,702						**11,702**
Donated		13						**13**
Total at 31 March 2020	**1,878**	**33,664**	**2,077**	**127**	**81**	**5,156**	**539**	**43,522**

The latest revaluation of land and buildings was carried out by the Valuation Office with an effective date of 31 March 2020.

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.

Notes to the accounts - 14.1 Property, plant and equipment (continued)

14.1 Property, plant and equipment - prior year

2018/19:	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 2018	2,175	36,126	555	882	335	7,098	863	48,034
Additions purchased			3,308	107		739	261	4,415
Additions donated								
Reclassifications		2,124	(2,204)			80		
Reclassified as held for sale								
Disposals	(355)	(470)		(31)	(36)	(1,380)	(231)	(2,503)
Revaluation/indexation (losses)/gains	10	(4,675)	(7)	14	10		1	(4,647)
Impairments		(1,387)						(1,387)
Reversal of Impairments								
At 31 March 2019	**1,830**	**31,718**	**1,652**	**972**	**309**	**6,537**	**894**	**43,912**
Accumulated depreciation at 1 April 2018		253		794	244	4,690	631	6,612
Disposals		(10)		(27)	(32)	(1,367)	(231)	(1,667)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(4,695)	(7)	12	8		1	(4,681)
Impairments		1,900	7					1,907
Reversal of Impairments		(1)						(1)
Charged during the year		2,819		29	20	971	40	3,879
Accumulated depreciation at 31 March 2019		**266**		**808**	**240**	**4,294**	**441**	**6,049**
Net book value								
Total at 31 March 2019	**1,830**	**31,452**	**1,652**	**164**	**69**	**2,243**	**453**	**37,863**
Asset financing								
Owned	1,830	18,970	1,652	164	69	2,243	453	**25,381**
PFI		12,468						**12,468**
Donated		14						**14**
Total at 31 March 2019	**1,830**	**31,452**	**1,652**	**164**	**69**	**2,243**	**453**	**37,863**

14.2 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Abandonment of assets in course of construction	**2**	7
Changes in Market Place	**29**	1,909
Reversals of impairments	**(756)**	(1)
At 31 March	**(725)**	1,915

15 Capital commitments

Contracted capital commitments at 31 March not otherwise included in these accounts:

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Property, plant and equipment	**15,819**	1,382
Total	**15,819**	1,382

This includes a new building for Child & Adolescent Mental Health Services at St Mary's Hospital £15,541k.

16 Inventories

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Energy, consumables and work in progress	**5**	27
Total	**5**	27
Of which held at net realisable value:	**5**	27

16.1 Inventories recognised in expenses

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Inventories recognised as an expense in the year	**39**	57
Total	**39**	57

Notes to the accounts

17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
Trade Receivables				
Contract receivables	**2,371**	6,885		
Accrued Income	**4,195**	22,739		
Allowance for impaired contract receivables	**(716)**	(497)		
Prepayments	**945**	1,819	**4,970**	4,577
PDC Receivable	**4**			
VAT	**420**	212		
Other receivables	**273**	455	**231**	
Total	**7,492**	31,613	**5,201**	4,577

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 2020 £000	Year ended 31 March 2019 £000
By up to three months	**455**	384
By three to six months	**47**	166
Over six months	**215**	241
Total	**717**	791

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 2020 £000	Year ended 31 March 2019 £000
Balance at 1 April	**497**	548
Amount written off during the year	**(7)**	(10)
Increase/(decrease) in receivables impaired	**226**	(41)
Balance at 31 March	**716**	497

The provision for impairment of receivables for the year ended 31 March 2020 has increased/decreased after taking all factors into consideration regarding the potential for recovery.

18 Cash and cash equivalents

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Balance at 1 April	**69,424**	52,424
Net change in year	**22,876**	17,000
Balance at 31 March	**92,300**	69,424
Made up of		
Cash with Government Banking Service	**92,140**	69,294
Commercial banks and cash in hand	**160**	130
Cash and cash equivalents as in statement of financial position	**92,300**	69,424
Cash and cash equivalents as in statement of cash flows	**92,300**	69,424

Notes to the accounts

19 Non-current assets held for sale

	Property, Plant and Equipment £000
Balance brought forward 1 April 2019	
Plus assets classified as available for sale in the year	
Less Impairment of assets held for sale	
Less assets sold in the year	
Balance carried forward 31 March 2020	

At 31 March 2020 there are no buildings held for sale (Nil in 2018/19).

20 Trade and other payables

	Current	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Trade payables	**4,476**	6,452
Amounts due to other related parties		
Non NHS trade payables - capital	**1,236**	624
Accruals	**8,958**	7,395
Other	**28**	3,872
Total	**14,698**	18,343

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
PFI liabilities	**2,038**	1,881	**17,497**	19,535
Total	**2,038**	1,881	**17,497**	19,535

22 Other liabilities

	Current	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Deferred Income	**3,422**	1,447
Total	**3,422**	1,447

Notes to the accounts

23 Finance lease obligations

There are no current finance leases in operation.

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 2020 £000	Year ended 31 March 2019 £000	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
Not later than one year	**5,906**	5,769	**5,685**	5,554
Later than one year, not later than five years	**23,623**	23,076	**19,119**	18,676
Later than five years	**13,780**	19,230	**8,898**	12,000
Sub total	**43,309**	48,075	**33,702**	36,230
Less: finance cost attributable to future periods	**(23,774)**	(26,659)	**(14,167)**	(14,814)
Total	**19,535**	21,416	**19,535**	21,416

Services component	**Gross Payments**	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Not later than one year	**6,639**	6,485
Later than one year, not later than five years	**26,555**	25,940
Later than five years	**15,490**	21,616
Total	**48,684**	54,041

The future services amounts due as at 31 March 2020 reflect an adjustment for the RPI indexation of the unitary payment applied during 2019/20.

The amount charged to operating expenses during the year in respect of services was £6,606k (2018/19 £6,201k).

24.1 Analysis of amounts payable to service concession operator

	Gross Payments	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Unitary payment	**14,007**	13,290
Consisting of:		
- Interest charge	**1,654**	1,799
- Repayment of finance lease liability	**1,881**	1,736
- Service element and other charges to operating expenses	**6,950**	6,602
- Capital lifecycle maintenance		
- Revenue lifecycle maintenance	**758**	666
- Contingent rent	**2,371**	2,234
- Addition to lifecycle prepayment	**393**	253
Total	**14,007**	13,290

The addition to lifecycle prepayment relates to a rent free period at the end of the contract £393k (£253k 2018/19). Service element and other charges to operating expenses includes the operating lease payments for the land element of the properties £414k (£401k 2018/19).

25 Provisions

	Current		Non-current	
	Year ended 31 March 2020	Year ended 31 March 2019	**Year ended 31 March 2020**	Year ended 31 March 2019
	£000	£000	**£000**	£000
Pensions relating to other staff	**146**	142	**1,481**	1,439
Legal claims	**100**	113		
Redundancy	**3,171**	1,711		
Other	**1,030**	405	**756**	524
Total	**4,447**	2,371	**2,237**	1,963

	Pensions relating to other staff	**Legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
At 1 April 2018	1,622	140	1,499	791	4,052
Arising during the year	119	61	1,031	153	1,364
Change in discount rate	(20)				(20)
Used during the year	(142)	(54)			(196)
Reversed unused		(34)	(819)	(15)	(868)
Unwinding of discount	2				2
At 31 March 2019	1,581	113	1,711	929	4,334
At 1 April 2019	1,581	113	1,711	929	4,334
Arising during the year	112	26	2,163	857	3,158
Change in discount rate	83				83
Used during the year	(145)	(28)	(324)		(497)
Reversed unused	(9)	(11)	(379)		(399)
Unwinding of discount	5				5
At 31 March 2020	**1,627**	**100**	**3,171**	**1,786**	**6,684**
Expected timing of cash flows:					
Between 1 April 2020 and 31 March 2021	146	100	3,171	1,030	4,447
Between 1 April 2021 and 31 March 2025	581			525	1,106
Thereafter	900			231	1,131
TOTAL	**1,627**	**100**	**3,171**	**1,786**	**6,684**

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. There is also a provision relating to employment tribunals £29k (£46k 2018/19).

Other provisions comprise the commitment placed on the Trust in ensuring it meets its obligations in respect of dilapidation costs £645k (£561k 2018/19), IT software contracted out services vat £466k (£368k 2018/19) and new provisions for Pension Final Pay Controls £336k, Pension Annual Allowance (as per national guidance) £231k and leases £109k.

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.

£8,438k is included in the provisions of the NHS Litigation Authority at 31 March 2020 in respect of the clinical negligence liabilities of the Trust (31 March 2019 £818k).

26 Contingent liabilities

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Other	**40**	23
Total	**40**	23

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 - £40k in 2019/20 and £23k in 2018/19). 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	29,433
Cash at bank and in hand	69,424
Total at 31 March 2019	98,857
Receivables	**6,354**
Cash at bank and in hand	**92,300**
Total at 31 March 2020	**98,654**

Ageing of over due receivables included in Financial Assets

Receivables overdue by:	
1-30 days	**417**
31-60 days	**259**
61-90 days	**22**
91-180 days	**12**
Greater than 180 days	**(15)**
	695

27.2 Financial liabilities - carrying amount

	£000
Embedded derivatives	
Payables	16,141
PFI and finance lease obligations	21,416
Provisions under contract	3,966
Total at 31 March 2019	41,523
Embedded derivatives	
Payables	**14,698**
PFI and finance lease obligations	**19,535**
Provisions under contract	**5,987**
Total at 31 March 2020	**40,220**

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 2020 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 2019/20 the percentage increase in the unitary payment was 2.37%, equalling a monetary increase of £155k (3.82%, £155k in 2018/19 which was partially offset by a rebate of £116k).

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%.

2019/20 Uplift in unitary payment	**Actual uplift at 2.37%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	(8)	69	173
Recognised in operating expenses	163	255	379
Recognised in surplus/deficit	155	324	552
	155	324	552
Net impact of sensitivities on surplus/(deficit)		**(169)**	**(397)**

2018/19 Uplift in unitary payment	**Actual uplift at 3.82%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	79	72	172
Recognised in operating expenses	76	62	277
Recognised in surplus/deficit	155	134	449
	155	134	449
Net impact of sensitivities on surplus/(deficit)		**21**	**(294)**

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 2019/20, 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 (2019/20)	**273**	**58**	**10**	**51**
University of Leeds (2018/19)	190	61	54	3

In 2019/20, the Trust had £4k of related party transactions with its charitable fund (2018/19 £5k).

28.2 Related party transactions - commitments (year ended 31/3/2021)

	Income £000
Leeds Clinical Commissioning Groups	110,585
NHS England	30,445
	141,030

These commitments are material transactions relating to NHS bodies.

The Trust has no expenditure commitments with related parties for the year ending 31 March 2021.

28.3 Related party transactions - UK Government ultimate parent

	Income		Expenditure	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
Department of Health and Social Care	**1,850**	2,950	**22**	
Other DHSC Group bodies	**162,000**	165,374	**10,383**	7,833
Other	**361**	492	**26,964**	20,331
Total	**164,211**	168,816	**37,369**	28,164

	Receivables		Payables	
	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000	**Year ended 31 March 2020 £000**	Year ended 31 March 2019 £000
Department of Health and Social Care	**209**	156	**3**	
Other DHSC Group bodies	**3,818**	25,624	**2,300**	2,762
Other	**420**	212	**182**	2,293
Total	**4,447**	25,992	**2,485**	5,055

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	420			
Balances with Local Authorities			182	
Balances with NHS bodies	4,026		2,303	
Intra Government balances	**4,446**		**2,485**	
Balances with bodies external to Government	3,046	5,201	12,213	
At 31 March 2020	**7,492**	**5,201**	**14,698**	
Balances with other Central Government bodies	212		2,238	
Balances with Local Authorities			55	
Balances with NHS bodies	25,780		2,762	
Intra Government balances	**25,992**		**5,055**	
Balances with bodies external to Government	5,621	4,577	13,288	
At 31 March 2019	**31,613**	**4,577**	**18,343**	

Notes to the accounts

30 Third party assets

The Trust held £323k cash and cash equivalents at 31 March 2020 (£292k 2018/19), 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 21 cases of losses totalling £7k (3 in 2018/19 totalling £10k) and 13 special payments totalling £11k (24 in 2018/19 totalling £32k) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

Losses	**Number**	**Value £000**
Cash - other	2 (1)	0 (0)
Bad debts - other	19 (2)	7 (10)
Total	**21 (3)**	**7 (10)**
Special payments		
Ex-gratia - loss of personal effects	9 (20)	1 (2)
Ex-gratia - personal injury with advice	4 (4)	10 (30)
Ex-gratia - other	0 (0)	0 (0)
Special severance payments	0 (0)	0 (0)
Total	**13 (24)**	**11 (32)**

Figures in brackets relate to 2018/19.

32 Events after the reporting period

There were no events after the reporting period that had an impact on the Trust's 2019/20 accounts (2018/19: none).

33 Charitable Fund

	Year ended 31 March 2020 £000	Year ended 31 March 2019 £000
Income	**4**	5
Expenditure	**(20)**	(10)
Net movement in funds	**(16)**	(5)
Current assets	**114**	114
Current liabilities	**(34)**	(14)
Total Charitable Funds	**80**	100

The Charitable fund is not consolidated within these accounts but is disclosed in line with IAS 27 (revised).

CONTACT INFORMATION

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Chief Executive
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:
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 55977
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Members of the Board of Directors and Council of Governors
Can be contacted by email at the addresses shown on our website at
Web: www.leedsandyorkpft.nhs.uk
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