Leeds and York Partnership
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS

1 April 2020
to
31 March 2021

Leeds and York Partnership NHS Foundation Trust

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

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PART A
ANNUAL REPORT
2020/21

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

This year has been one of the most challenging for the NHS in living memory. The impact of the Coronavirus pandemic has been far-reaching, and we are only now beginning to understand its longer term impact on our way of life, our economy, and our mental and physical health. Responding to the demands of the pandemic has been a priority for all our services, requiring fast but thoughtful changes, resilience, creativity, adaptability, strong leadership and a positive 'can do' attitude from us all. Many staff have worked largely at home over the last year, but services have continued and staff have found new ways to engage and support our service users and carers. As I write this foreword, we remain 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 family, many staff and service users have been personally affected by Covid-19. Further, we have sadly 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.

Despite the challenges of the pandemic, every day I continue to be humbled and inspired by so many of our staff, volunteers and service users 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.

The Board has continued to meet monthly albeit via Zoom, and we still start every Board meeting with an opportunity to hear about the experience of service users, carers or members of staff. This is more important than ever to remind us of the purpose of our organisation and of the reality of the day-to-day challenges we all face in trying to deliver services to the best of our ability within our financial limitations. Each story has been full of opportunities to learn, to improve and to strengthen our services for the better. I am hugely grateful for the candour, courage and willingness to share by all those who have participated in our 'virtual' Board meetings.

Last summer, as national data on those affected by Covid-19 started to emerge, the disproportionate impact on people of colour was made clear. In addition, we were shocked and saddened by the killing of George Floyd in America. It brought to a head the need to address matters of racial discrimination, injustice and prejudice. We started to have important, but sometimes challenging conversations in the Trust about these matters. Led by the Workforce Race Equality Network, we worked together to challenge and address inequalities in our Trust. This work has been complimented by a Reciprocal Mentoring Programme for staff from ethnic minorities and Board members. It is an important start in our work across the Trust to eradicate racial inequalities.

This year we redesigned our community services and continue to work on a programme of 'Acute Care Excellence' to improve our acute care offer. Last spring, we introduced a new electronic patient record system, 'Care Director' which is already improving how we record, interact with 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 West Yorkshire Children and Young Peoples' Mental Health unit. We are delighted to welcome the Leeds CYPMHS in-patient team to our Trust and together, to develop a new exciting services for young people across West Yorkshire.

Our Staff Survey has demonstrated some significant improvements and real progress in the embedding of our values and the levels of engagement of our staff, including our Bank 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, and some specialist services more widely. We also work closely with colleagues in the Leeds Health and Care Academy, focusing on our role as employers, and the support and development of our workforce. I would like to take this opportunity to thank all of our partners within the NHS, local authorities, third sector and wider public sector. We look forward to continuing this work to deliver sustainable improvements in the coming year.

I am extremely grateful to the Council of Governors for its commitment and continued work in the Trust. Governors have continued to work closely with the Board and have participated in virtual service visits in addition to attending virtual meetings. Our lead governor, Peter Webster, has been a great support in the role. He has worked with the governors to help build their confidence in asking questions, participating in virtual service visits and Board meetings. Governors have such an important role in holding the non-executive directors to account, and in representing the views of the public, staff, service users and carers. We have done some important work to strengthen their contribution and to enable them to carry out their roles effectively.

Board membership has been relatively stable this year. I am grateful for the commitment and professionalism of all Board members. We said 'au revoir' to our Medical Director, Dr Claire Kenwood, and welcomed her successor, Dr Chris Hosker. Sue White ended her term as Deputy Chair, but will stay with us as a Board member. I am very grateful to Sue for her commitment and dedication to this role over the last two years. Helen Grantham will now take on the Deputy role and I wish her well in this new endeavour.

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

This last year has been like no other. But, together, we have survived. As a Trust we have worked hard to deliver safe, quality services. We have worked closely with our partners in the NHS, local government and the third sector to navigate our way through these difficult times. None of this would be possible without the wonderful dedication, compassion, professionalism and flexibility of all of our staff. Thank you, each and every one.

Prof Sue Proctor
Chair of the Trust

1.1.2 A MESSAGE FROM OUR CHIEF EXECUTIVE

The NHS has faced an exceptional challenge in its response to the Coronavirus pandemic. Our amazing colleagues have worked heroically throughout - adapting quickly to demands, developing new ways of working and they have done it all with a high degree of flexibility and resilience.

The Trust's Annual Report gives us an opportunity to share some of the important work we have done over the year and celebrate our achievements. I am immensely proud to say that we have continued to deliver on our core ambition to support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives.

Great care that is high quality and improves lives

In our inpatient wards, the crisis assessment unit and supported living settings, we have worked incredibly hard to keep people safe - implementing national measures and testing and cohorting people to help minimise the spread of infection. At the Becklin Centre, one of our main inpatient sites, we rapidly set up a separate annexe to provide a more therapeutic environment for people with acute mental health needs who had Coronavirus. In line with government guidance we introduced restrictions on leave and visiting, but supported service users to keep in touch with loved ones with digital technology. On occasions we paused admissions to manage outbreaks swiftly and effectively while working with partner organisations to maintain capacity for people needing care.

Our community mental health and learning disability services, along with our specialist and regional services, have continued to support people in their recovery remotely by providing: video consultations; live social media sessions; and virtual support groups. Our Leeds Recovery College courses have also successfully moved online. We have been mindful of the health inequalities that have been emphasised by this pandemic. Some service users do not have access to technology or have been at heightened risk of poor health, so we have continued to offer face-to-face contact where it has been most needed.

I have felt so heartened by the sustained compassion of staff for service users, during the highs and lows of 2020/21. The creativity and imagination of colleagues across all of our services with initiatives such as the Ward Olympics, Letters to Loved Ones and 'wobble' rooms have helped morale, inspired us all and will have made a huge difference to people getting through some very tough times.

We have continued to develop and expand our specialist services, helping more people receive the treatment they require. In November 2020, the new Veterans' Mental Health High Intensity Service was launched to provide care and treatment for veterans experiencing a mental health crisis. The Northern Gambling Service expanded in 2020, launching clinics in Manchester and Sunderland, and marked its one year anniversary in September with the news that it has supported over 400 clients.

In September 2020 we announced that the Young People's Mental Health Inpatient Service at Little Woodhouse Hall in Leeds would be managed by our Trust from 1 April 2021. This is part of our shared ambition to ensure we deliver the right care, at the right time, and in the right place for young people who require highly specialist mental health support. Young people will benefit from our new £20million purpose-built unit, known as Red Kite View, which will open in December 2021 providing a spacious, safe and modern facility for young people with significant mental health needs.

Engagement with our service users, carers and the public on their experience of our services is at the heart of all we do, enabling us to improve the care we provide. In April 2020 we launched 'Together' our new three year Experience and Involvement Strategy. Our newly established Patient Experience Team will play an important role alongside our service users and carers in making sure we take a joined up approach and put co-production at the centre of our work.

A rewarding and supportive place to work

A key priority for us is supporting the health and wellbeing of our staff. People who work in health and care are often slow to put up their hand for help for themselves and so we have launched individual wellbeing assessments to understand the issues facing our staff and how best we can support them to feel safe and well at work. Taking our lead from the NHS People Plan, we are continuing to foster a culture of compassion, inclusion and belonging.

Our new staff Facebook group 'LYPFT Together', our popular staff engagement platform 'Your Voice Counts' and the annual NHS Staff Survey along with regular forums have given staff a variety of opportunities to talk and provide feedback about their experiences and also to be directly engaged in improving our workplaces. I am delighted that in the middle of a difficult year so many of our staff have taken the time to make their voice count and share their views.

I would also like to give a special mention about the excellent work to confront racism and improve diversity and equality within the Trust led by our Workforce Race Equality Network which has done much to improve the culture of our organisation in becoming more inclusive.

Using our resources to deliver effective and sustainable services

NHS mental health trusts like ours have had to plan for an increase in the prevalence of mental ill health as a consequence of Coronavirus. Responding to increased demand and acuity, often with pressures on staffing levels, we have had to move some teams into different locations, pause some services and redeploy some staff to support our acute and crisis care settings.

Key members of our management team have been heavily involved with working groups both within the Trust and across the local health and care system. We have consulted with experts from our clinical, operational and corporate services, enabling us to develop innovative ways of working and cut through some of the usual red tape. This kind of agile joined-up working has really helped us get through this crisis effectively and efficiently together.

The work of our often unsung support services has played a huge part in ensuring the continuity of our frontline clinical services – colleagues in infection prevention, IT support, communications, human resources, logistics, procurement, estates and finance have kept us all going safely and efficiently whether working remotely or on site.

Despite the pandemic, the construction of the new Young People's Mental Health Inpatient unit has progressed to schedule and is on track for an 'excellent' BREEAM rating in sustainability. In November 2020 we made another application to Leeds City Council to modify the layout of the new unit. These modifications will allow for enhanced infection prevention controls and social distancing within the building and is based on our learning from the impact of Covid-19 ensuring that the building is fit for purpose now and in the future.

We took the decision to continue with the launch of our new electronic patient record system, CareDirector, although making the system live in the midst of a global pandemic was challenging. I remain immensely grateful to every one of our staff for how they have adapted and responded. We're taking every opportunity we can to learn and to work together to further develop this system.

LYPFT Together

I look back on the last 12 months as a time of hugely inspiring collective effort. From the start of the pandemic we have all faced a huge amount of anxiety, change and uncertainty - responding to ever-changing guidance. We have worked hard to translate this into simple, actionable measures and processes.

The roll out of vaccine trials and the vaccination programme has taken place at pace across our region with many colleagues, and indeed former colleagues, stepping up to play a part in this essential work – taking part in local Novavax trials, vaccinating inpatients, working in our own vaccination hub through to working on a community vaccination bus and even going into people's own homes.

As has been seen with the massive outpouring of affection for key workers and the NHS in particular, there is an immense sense of gratitude due to everyone who has come forward to help keep our communities safe in the drive to get back to some normality. I am incredibly proud of our staff, managers, team leaders and volunteers and I can't thank them enough for what they do. So much has been achieved by teams working together and this, for me, really embodies the Trust values – we have integrity, we keep it simple, we are caring.

Our teams have supported each other magnificently as we've tackled some difficult times especially with

the loss of colleagues and service users to Covid-19. They have remained committed to doing excellent work while dealing with their own personal challenges. This really has been no mean feat.

As I write this the pandemic is still with us, and the physical, emotional and economic impact of the virus, will shape how we provide services in the future. Every day seems to bring more challenges, new problems to solve and barriers to overcome. Yet, again and again we see amazing efforts, a real desire to do the best we can for colleagues, services users, their families and partners. There are many challenges ahead, of course, but there is also a lot of hope that we will soon move towards a better, healthier and brighter future, together.

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 Peoples' Mental Health Services (CYPMHS)	Regional Eating Disorders and Rehabilitation services
Forensic services	Community and Wellbeing services	Regional and specialist services

Our services are delivered across a range of settings in Yorkshire and the Humber and our Deaf CYPMHS 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
- CYPMHS 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 young peoples' mental health services. The Plan also sets out priorities for learning disability services, autism and neuro-developmental conditions, dementia and frailty and outlines work to support digital developments and the use of data, a focus on health inequalities and an emphasis on system working.

1.1.7.2 The regional context

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

The WY&H ICS plans are informed by local area place-based plans, including Leeds, and builds on our strong history of partnership working. The neighbourhood is 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. However, by working in partnership across the WY&H system we are also better able to share good practice and reduce inequality

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, learning disability & autism services collaborative. We are working together on the following areas:

Delivering priorities agreed before the Covid-19 pandemic:

- **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, including for Psychiatric Intensive Care; reducing the 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 by expanding community services in partnership with primary care and VCSE partners 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 now understand their clinical needs and plan to repatriate patients, by providing both intensive community support and inpatient provision, thereby preventing out of area placements and minimising lengths of stay.

- **Adult Medium and Low Secure Services:** Taking on responsibility for commissioning and providing new models of care within secure services.

- **Children and Young Peoples' Mental Health Services (**CYPMHS**):** preventing unnecessary admissions, reducing out of area placements, with effective management of children and young people in the community. This includes ensuring effective relationships between the development of the new CYPMHS unit at Red Kite View and all community CYPMHS teams, social care teams and other place-based providers of care across West Yorkshire,

- **Autism:** Better understanding the needs for people with autism and neurodiversity, including barriers to accessing services and support, and developing networks and service offers to improve this support.

- **Learning Disabilities - Assessment & Treatment Units:** Providers and commissioners have collaborated to develop a standard future model for inpatient care as part of a single 'centre of excellence' model, with reduced reliance on inpatient beds and a move towards a new care model approach that reinvests in community provision.

- **Improving determinants of health** – by investing both locally and across the system in suicide prevention, better understanding barriers to access for different ethnic groups with regard to Perinatal Mental Health services and sharing good practice in improving the physical health of people with mental illness or a learning disability.

Delivering support during the Covid-19 pandemic:

- **Regular mutual aid arrangements** – working as a collaborative on crisis pathways, cohorting arrangements and wider mutual aid possibilities to ensure that we learn together and support one another as organisations

- **Population support schemes** – helping keep people with neurodiversity connected during the pandemic so they can access support and developing a Grief and Loss helpline for people who need to talk to someone or require signposting onto other services

Delivering new priorities identified as a result of the Covid-19 pandemic:

- **Improving collaboration** – working together as a collaborative to agree a common methodology for Prevention and Management of Violence and Aggression, and undertaking of restraint, and developing a collaborative bank

- **Staff wellbeing** – operationalising the WY&H Mental Wellbeing Hub for staff across all NHS, local authority and VCSE partners; providing access to specialist psychology support, approved advice and guidance, and training teams in how to have the right conversations to support one another and help people who are struggling.

In December 2020 NHS England and NHS Improvement carried out a consultation '*Integrating Care – Next steps to building a strong, integrated care system across England'.* This sought views on the proposed changes in the governance framework for the ICS. We anticipate that in 2021/22 we will play an important role as part of a statutory ICS to support care delivery and transformation both at place and system levels. We will look at how our own governance structures need to fit with this.

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 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:

Table 1.1C – Our key strategic risks

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

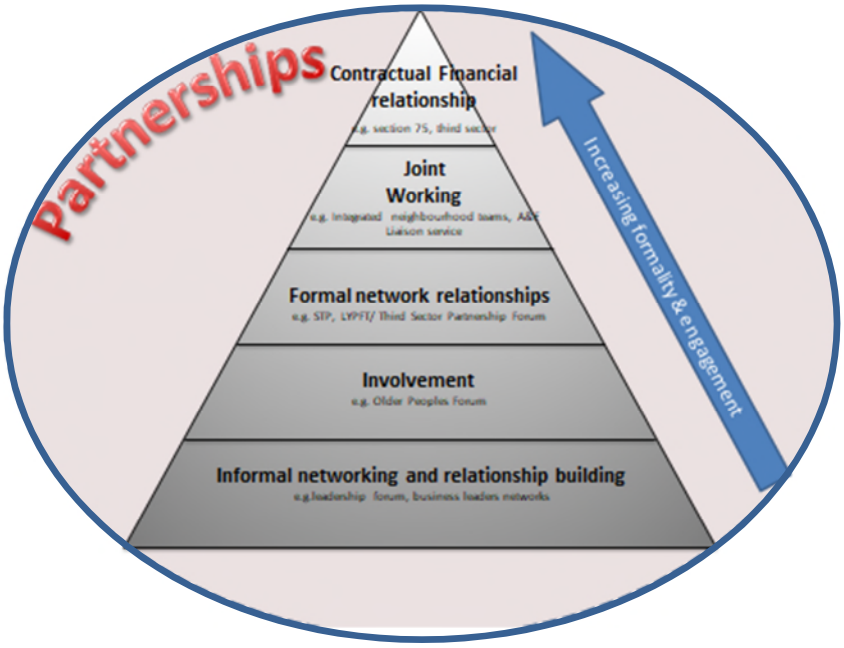
During the latter part of 2019/20 the Trust put in place a focused structure of governance to manage the risk to the delivery of services created by the Covid-19 pandemic. This has continued to operate through 2020/21. Whilst a specific risk for Covid-19 was not entered on the Board Assurance Framework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

1.1.8.2 Opportunities

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

The Clinical Services Strategic Plan sets out the priorities for our services. However, in 2020/21 some of the priorities in the plan were paused to allow staff to focus on the management of the pandemic. One project that staff did complete was the transfer of the Tier 4 Child and Young Peoples' Mental Health Service which transferred on 1 April 2021 from Leeds Community Healthcare NHS Trust to our Trust. In 2021/22 we will continue to work to support the transfer of the service and its staff into the Trust and to complete the new build to house the inpatient service, Red Kite View, which is expected to open later in the year.

Working in partnership also provides us with an opportunity to work cohesively across geographical areas to ensure there is a seamless provision of care for our service users. During 2020/21 the Trust has focused on strengthening relationships with partners system-wide. The Trust values working in partnership and recognises the positive impact this has on service users' experience and we will continue to develop partnerships through 2021/22 using the framework and approach illustrated below:



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

In 2020/21 the Covid-19 pandemic brought about some uncertainty about the way in which we delivered our services, however, our staff made a tremendous effort to put in place the necessary governance, structures, procedures and technologies to allow us to work in a different way and provide a continuing safe and effective service. This different way of working 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 England and NHS Improvement targets, NHS Standard contract requirements, and locally agreed performance and quality measures with our commissioners (referred to in this section as targets and measures).

Each month, we produce a Combined Quality and Performance Report (CQPR) that brings together performance, activity, quality, workforce and financial measures into one report for our Executive Team and Heads of Services. 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 quality, delivery and performance framework that delivers reporting for our team and service managers. Dashboards and reports are used to promote discussion and challenge in team and service quality, delivery and performance meetings and operational delivery groups. We also have regular dialogue with our commissioners and have a reporting schedule to submit performance and quality information to them.

Performance during 2020/21 has been varied. There have been some areas of strong performance, for example maintaining the standard for length of stay on caseload in our Crisis and Intensive Support Services and the percentage of people starting treatment within two weeks of referral to Early Intervention in Psychosis or At Risk Mental State services.

Analysis of the range of targets and standards for all of our services needs to be done through the lens of the significant challenges faced in 2020/21 from the impact of Covid-19 and the replacement of our main electronic patient record system. Our staff have worked flexibly to support our shared aim of continuing to care for our service users, providing care even when the usual face-to-face contact was not possible or service provision was temporarily scaled back to allow staff to be redeployed onto wards. All of our care and support services are vitally important to people and we have aimed, wherever possible, to deliver the care and support needed including redeploying staff where necessary. Undoubtedly, Covid-19 has had an impact on contractual and local targets.

Following the changes in how we deliver services in light of Covid-19, we have reviewed how our standards and measures can better reflect our new ways of working. We have undertaken analysis of the underlying data contributing to a number of our contractual measures, with alternative measures developed, for example in services where video or telephone contacts have been blended with face-to-face contact. We remain committed to delivering care in the most appropriate, individualised and clinically effective way within the constraints we have been faced with. In-year improvement has been seen in services such as the Acute Liaison Psychiatry Service referrals responded to within one hour and the percentage of inpatients followed up within three days of discharge from services.

In 2020/21, we continued our approach in looking at expected levels of variation and more trend analysis. The introduction of a new electronic patient record system (CareDirector) at the end of 2019/20 impacted on data quality in the initial part of the year. However, the improvement in the timely and accessible operational data it provides, alongside a more mature approach to data / performance analysis, is proving successful and providing the Trust with a solid platform to understand and improve performance and quality 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 2020/21.

Table 1.1D – Our contractual and local targets

Our contractual and local targets					
LEEDS CLINICAL COMMISSIONING GROUP					
	Target	**2020/21 Q1**	**2020/21 Q2**	**2020/21 Q3**	**2020/21 Q4**
Timely access to a MH assessment under S136 (target within 3 hours)	No target	19.5%	12%	17.1%	10.3%
Crisis and Intensive Support – Timely access to crisis assessment (ftf within 4 hours of referral)	75% (Q1) 80% (Q2) 85% (Q3) 90% (Q4)	33.3%	50%	69.2%	80.6%
Crisis and Intensive Support – Length of stay on caseload (% less than 6 weeks)	70%	95.2%	90.4%	91.4%	88.6%
Crisis and Intensive Support – Frequency of contact (seen or visited 5 times in first week)	50%	14.5%	26.1%	26.2%	32.4%
Crisis and Intensive Support – Facilitated early discharge	No target	21.9%	21.6%	22%	25.7%
Timely commencement of a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)	90%	22.2%	35.2%	57.4%	65.1%
Timely access to a mental health assessment by the LYPFT liaison Psychiatry In-reach Service (24 hours)	90%	70.9%	70.7%	72%	78.5%

Bed Occupancy rates for Acute Adult Inpatient Services	94-98%	89.1%	98.4%	93%	88.4%
Percentage starting LADS assessment within 13 weeks	95%	28.3%	63.6%	63.6%	20.6%
Perinatal Community DNA Rate	No target	5.3%	3.7%	3.4%	5.3%
Perinatal Community – Timely access (less than 2 weeks) for routine referrals	85%	33.3%	35.4%	29.5%	29.7%
Perinatal Community – Timely access (less than 48hrs wait) for urgent referrals	No target	50.0%	0%	100%	57.1%
3 Day Follow Up – CCG Commissioned Services	80%	80.5%%	82.2%	86.2%	88.2%
Waiting times Access to Memory Services; Referral to first face to face contact within 8 weeks	90%	57.7%	59.4%	60.2%	40.1%
Memory Services – Time from Referral to Diagnosis within 12 weeks	50%	29.4%	19.4%	48.4%	46.2%
Waiting times for Community Mental Health Teams first contact within 15 days	80%	74.7%	73.1%	74.3%	76.8%
Percentage of CLDT referrals seen within 4 weeks of receipt of referral	90%	87.2%	83.3%	77.5%	72.2%
Incidents Reported within 48 hrs from Incident identified as Serious	100.0%	100%	100%	100%	100%
Cardio Metabolic Assessment (current SMI inpatients)	90%	50.9%	33.5%	23.6%	18.3%
Cardio Metabolic Assessment (EIP Service)	90%	61.0%	41.7%	24.6%	12.1%
Percentage of people discharged to primary care (EIP Service)	No target	46.9%	50.0%	54.2%	54.5%
NHS ENGLAND					
	Target	**2020/21 Q1**	**2020/21 Q2**	**2020/21 Q3**	**2020/21 Q4**
Gender Identity Service – Waiting List	No target	2,295	2,530	2,742	2,847
Perinatal Community – Number of distinct women seen in rolling 12 months (LCCG only)	547 (by Q4)	330	361	402	382
CYPMHS Inpatients – Assessed within 7 days of admission (HoNOSCA / GBO)	100%	n/a	n/a	85.7%	57.1%
OTHER REPORTED INDICATORS					
	Target	**2020/21 Q1**	**2020/21 Q2**	**2020/21 Q3**	**2020/21 Q4**
Appraisals	85%	56.8%	58.2%	53.8%	58.6%
Clinical Supervision	85%	68.2%	65.3%	58.8%	63.8%
Sickness Absence Rate	4.9%	5.1%	5.2%	5.1%	5%
Staff Turnover	10%	8.6%	8.3%	9%	7.9%
Healthcare Associated Infections – C.difficile	0	0	0	0	0
Healthcare Associated Infections – MRSA	0	0	0	0	0
Delayed Transfers of Care	No target	9.3%	8.9%	10.7%	8%
Data Completeness – NHS Number	No target	n/a	99.3%	99.3%	99.3%
Data Completeness – Ethnicity	No	n/a	80%	77.4%	75.1%

	target				
Data Completeness – Sexual Orientation	No target	n/a	22.2%	21.7%	21.3%
SINGLE OVERSIGHT FRAMEWORK AND STANDARD NHS CONTRACT					
	Target	**2020/21 Q1**	**2020/21 Q2**	**2020/21 Q3**	**2020/21 Q4**
3 Day Follow Up – Trust wide services	80%	76.7%	80.1%	81.5%	87%
Data Quality Maturity Index (MHSDS)	95%	81.9%	87.6%	89.9%	n/a
Early Intervention in Psychosis - % waiting less than 2wks for a NICE recommended package of care	60%	37.8%%	52.1%	75.4%	75%
Never Events	0	0	0	0	0
Number of Incidents	No Target	2,400	2,854	2,630	2,717
Inappropriate out-of-area placements for adult mental health services (number of bed days)	1,609	1,610	1,729	1,077	965

1.1.9.2 Financial performance

1.1.9.2.1 Overview

The Trusts financial performance during 2020/21 was managed in the context of the interim financial framework put in place as a response to the Covid-19 pandemic. The key approach in this framework was the immediate suspension of normal contracting arrangements from 1 April 2020, which were replaced by a series of block contract payments and other allocations. The arrangements were initially put in place for the first half of the financial year, with all organisations at that point being retrospectively allocated additional resources to meet their ongoing needs in response to managing the financial consequences of the pandemic. This was known as a “top up” arrangement to ensure all organisations had a balanced income and expenditure position. In the second half of the year fixed resource allocations were distributed at an ICS level, largely replicating the revenue resources used in the first half of the year. Each organisation produced a financial plan to manage within their share of this allocation, with the aim of the overall ICS delivering a balanced plan.

In this context it is difficult to make meaningful year-on-year comparisons of underlying financial performance. Working in the interim financial regime the Trust amended its financial governance arrangements to ensure sound financial management discipline was maintained whilst also alleviating any undue burden on services and managers. Efficiency planning requirements were also suspended and whilst there was some expectation that these were reintroduced during the second half of the year, this was not a high priority focus in the context of the pressures the Trust was dealing with. There was very little service development activity during the year as resources were inevitably targeted at maintaining safe services throughout the period. The two most material financial pressures that the Trust experienced during the year were both linked to our inpatient settings and managing the risks and challenges that Covid-19 presented. The first consequence was the need for substantially more staff, including cover arrangements for staff absence. The second was linked to the unpredictable use of out of area inpatient bed placements. Due to environmental constraints, managing Covid-19 outbreaks safely in ward areas impacted on bed capacity, resulting in higher demand for alternative provision at peak times.

Alongside the suspension of normal planning and contracting arrangements the Trust was not monitored against the usual financial metrics as in previous years. However the underlying financial standing of the organisation has not deteriorated during the year. Overall the Trust delivered a small surplus of £0.25 million in the second half of the year (the first half being balanced), and maintained good working capital/liquidity. Key capital investment was also maintained during the year, although focused on core priorities and schemes already in progress.

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

The statement of comprehensive income shows a surplus of £0.25 million for the year ended 31 March 2021 (compared to £4.4 million in the previous year).

Operating income
Our income for the year increased to £202.9 million (£183.7 million in 2019/20). This is an overall increase of over 10%. All payments to NHS trusts for clinical services were paid on a block basis throughout the year, with additional income for Covid-19 related costs. Our Covid-19 specific allocation in the year was £9.993 million. There were minor changes in other non-clinical income for commercial activities.

Operating expenses
The total operating expenses for the year was £198.5 million (£175.8 million in 2019/20), which is a net increase of 13%. Staff cost are our single largest operating expense and this increased by 10%, which reflects our staffing pressure in response to Covid-19. Agency costs increased 30% in the year as part of this response. Following a full revaluation exercise, the value of our estate decreased, resulting in an impairment charge in operating expenses. The impairment was £0.62 million charge to our operating expenses.

1.1.9.2.3 Capital expenditure

Capital expenditure planning was also affected by the pandemic, but there were no further significant changes to the way in which plans were agreed. All provider organisations work within a defined capital allocation, with additional funding allocated for specific purposes. During 2020/21 the Trust received a small amount of specific additional funding (£0.7 million) for Covid-19 related expenditure which included ward adaptations. We also received and utilised £9.2 million public dividend capital towards the construction of the West Yorkshire Children and Young Peoples' Mental Health Service Inpatient Unit, and a further £0.5 million towards digital and critical infrastructure works. The balance of our expenditure £6.5 million was spent on other operational priorities but also included £4 million further towards the CYPMHS unit. We scaled back on a number of strategic priorities due to the pandemic. Overall we delivered a level of investment of £16.9 million, which was significantly higher than 2019/20 (£7.2 million) even in the midst of the pandemic.

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 £10.2 million to £115.2 million as at 31 March 2021. This reflects the impact of the surplus generated in the year and the public dividend capital received in year. Working capital (current assets less current liabilities) has increased by £0.4 million, of which, the net cash increase was £19.4 million offset by an increase in payables and other liabilities. The surplus cash held at the end of the year was deposited with the Government Banking Service (GBS). It is our policy to deposit any temporary surpluses in cash in low-risk deposit accounts with either United Kingdom commercial clearing banks or the HM National Loans Fund, when interest rates are more beneficial the GBS.

1.1.9.2.5 Future financial outlook and risks

As the impact and consequences of the pandemic are ongoing, with overall medium/long term impact for healthcare unquantified, the financial regime for 2021/22 has continued in the same framework as introduced last year. We have set a plan for the first six months based on the allocations which are nationally mandated. We continue with an ICS system approach, with the aim of delivering a balanced income and expenditure position. Within these allocations there is a renewed expectation on efficiency, and we are working through this based on our learning from Covid-19 and what changes we need to make to our operating delivery models across all services. As a specialist provider of mental health services we have specifically been tasked to reset our ambitions for delivering the long term plan for mental health and have significant additional investment to support this, as the national commitment for increasing mental health spending continues. During the year we also expect to transition more specialist services (Children and Young Peoples' Mental Health Service and Adult Forensic Services) into a Provider Collaborative model. This way of working gives full financial management responsibilities to groups of providers, which whilst bringing a potential degree of financial risk, is a good opportunity to improve services and deliver efficiency.

The Trust is in a strong financial position and remains well placed to move forward. Our focus is on stabilising our expenditure patterns as we emerge from the pandemic and on developing our service plans aligned to the investment pathway for mental health services.

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 2020/21 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.

1.1.10 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.

In order to comply with Government directions which were included in the UK Coronavirus Act 2020, whereby public meetings of more than two people were deemed unlawful, Board of Directors' and

Council of Governors' meetings have been held virtually throughout 2020/21. The Trust's Annual Members' Meeting was also held virtually.

In January 2021 the Trust opened its Covid-19 Vaccination Hub at The Mount in central Leeds. In March 2021, the Trust was involved in a citywide project to launch a vaccination hub on wheels in a bid to make it as easy as possible for residents to receive their Covid-19 vaccine.

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.

1.1.11 GOING CONCERN STATEMENT

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

1.1.12 DISCLOSURE ON EQUALITY OF SERVICE DELIVERY TO DIFFERENT GROUPS

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

You can read our strategy using the link below:
https://www.leedsandyorkpft.nhs.uk/about-us/wp-content/uploads/sites/8/2017/04/Trust-strategy-2018-2023.pdf

We are working in partnership with our local communities, service users and health and social care partners to tackle ethnic inequalities for those diagnosed with a severe mental illness. We have reviewed our crisis pathway and we are developing integrated approaches, so that we can respond to the needs of diverse ethnic groups and to develop services in culturally responsive ways. In August 2020 we committed to a national ethnic equality pledge and we are taking forward actions to achieve service level change and to measure and monitor impact. This includes the establishment of safe haven accommodation in Leeds to provide an alternative to hospital admission in situations where social support rather than medical care is required.

Further details can be found using the link below:
https://www.leedsandyorkpft.nhs.uk/news/articles/senior-leaders-pledge-reduce-ethnic-inequalities-mental-health-care/

We aim to meet the information and communication support needs of people accessing our services. This includes producing information in easy read through our 'Easy on the I' service and through the provision and monitoring access of interpreting and translation services. We are implementing the Accessible Information Standard and monitoring the recording of communication support needs of service users with a disability, impairment or sensory loss.

During 2020 service users supported by our trust were given the opportunity to give their feedback by completing the Acute Inpatients Survey and the Community Mental Health survey. In both these surveys, service users were asked to give details of their gender, age, ethnic group, religion, and in the case of the Community Mental Health survey – details of their sexual orientation which gave us an insight into who was completing the feedback. In addition our service user feedback structures at service and Trust level, such as our Service User Network (SUN), continued to gain and act upon real time feedback in response to the pandemic situation.

For most of 2020, the Friends and Family Test was stepped down due to the Covid-19 pandemic. In March 2021 the new Friends and Family Test question was included as the first question on the new Trust wide feedback measure which is being rolled out. Service users have a variety of ways in which they can complete the feedback tool, by completing a postcard with a pre-paid return address, by

completing an online survey, by giving their feedback to a PALS advisor or by emailing their feedback to a designated email address. Where service users complete their feedback via the online survey, they are asked to give details of their protected characteristics including their gender, age and ethnicity.

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: 10 June 2021

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 2020/21 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 2021. 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 (Deputy Chair of the Trust)
Cleveland Henry	Non-executive Director
Andrew Marran	Non-executive Director
Sue White	Non-executive Director
Martin Wright	Non-executive Director (Senior Independent Director)
EXECUTIVE TEAM	
Dr Sara Munro	Chief Executive
Joanna Forster Adams	Chief Operating Officer
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)
Claire Holmes	Director for OD and Workforce
Dr Chris Hosker*	Medical Director
Cathy Woffendin	Director of Nursing, Professions and Quality

*Dr Chris Hosker was appointed as the Trust's Medical Director on the 1 August 2020 and Dr Claire Kenwood was the Medical Director until then. More detailed information about our executive directors is set out in the Remuneration Report in Part A section 2.2 of this Annual Report.

In March 2021 it was announced that Claire Holmes, Director of Organisational Development and Workforce, would be leaving the Trust and on 9 May 2021 she stepped down as a member of the Board. On 10 May 2021 Darren Skinner joined the Trust as the Interim Director of Human Resources. The Board of Directors would like to thank Claire for her hard work and dedication during her time on the Board and wish her all the very best in the future.

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 2020/21 the Council of Governors approved the re-appointment of two of our Non-executive Directors, Helen Grantham and Martin Wright. Helen began her second term of office on 15 November 2020 and Martin began his second term of office on 20 January 2021. Both Helen and Martin will continue to be a NED for a further three years. The Council of Governors also appointed Helen Grantham as the Deputy Chair of the Trust for a two-year period from the 1 February 2021. Sue White was the Deputy Chair of the Trust until the 1 February 2021.

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 2020/21 which affected her ability to carry out her duties to the full, and she has been able to allow sufficient time to undertake these duties.

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

2.1.2 REGISTER OF DIRECTORS' INTERESTS

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

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

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

The register of interests is maintained by the Associate Director for Corporate Governance and is available for inspection on the Trust's website. The Associate Director for Corporate Governance can be contacted by 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 2020/21. The Board of Directors, therefore, declares that there has been no material income other than from the provision of goods and services for the purposes of the health service in England. Any benefit is re-invested in the provision of those services.

2.1.5 COST ALLOCATION AND CHARGING

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

2.1.6 POLITICAL AND CHARITABLE DONATIONS

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

2.1.7 NHS IMPROVEMENT'S WELL-LED FRAMEWORK

The Board is required to carry out an independent review of governance against the well-led framework every three years. Due to the Covid-19 pandemic the scheduled review was postponed.

Previous to this an independent review of our governance arrangements against the NHS Improvement well-led framework well-led review was carried out in 2017/18 by Deloitte LLP.

Part 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.

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 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 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 (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.

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

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

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 2020/21) 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 2020/21.

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

Further information about the work of the Remuneration Committee during 2020/21 can be found in section 2.4.4.2 below.

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

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

Further information about the work of the Appointments and Remuneration Committee during 2020/21 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).

The future policy tables 2.2A and 2.2B refer to the reporting and performance period 1 April 2020 to 31 March 2021.

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 to 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	In the main this will be any mileage rates paid which are over and above the HMRC threshold or any other benefit in kind applicable at the time of remuneration.
Annual performance related bonuses	The Trust does not pay any annual performance-related bonuses to executive directors. (Section 2.2.3.2 below sets out the process for performance appraisals (not linked to pay)).
Long-term performance-related benefits	The Trust does not pay long-term performance related bonuses to executive directors. (Section 2.2.3.2 below sets out the process for performance appraisals (not linked to pay)).
Pension-related benefits	Pension rights for executive directors are determined by the NHS Pension Scheme, and the maximum payable (by the employee and the employer) is determined by the NHS Pension Scheme.
Percentage uplift (cost of living increase)	The Remuneration Committee will decide if the executive directors are to be awarded a percentage uplift ('cost of living' increase) for each financial year and what level this will be. In doing this the committee is mindful of the national advisory rate for VSM issued by NHS Improvement.

Element	Policy
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 any guidance issued by NHS Improvement / NHS England and take this into consideration when setting levels of remuneration. The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors. There are no annual increments associated with non-executive directors' remuneration.
Additional fees for any other duties	The remuneration for the Chair of the Trust recognises the specialist role and extra time commitment over and above that of the other NEDs. The Chair of the Audit Committee is also remunerated differently in recognition of the specific skills and responsibility this role requires. All other 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 submitted on a completed travel claim form supported by receipts. Costs incurred will be reimbursed on a like-for-like basis with mileage being paid at a fixed pence per mile.
Pension contributions	No pension deductions are made from non-executive directors' remuneration and no contribution is made to a pension fund in respect of any non-executive director.
Other remuneration	Any other expenses paid to non-executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to non-executive directors.

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

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

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

2.2.3.2 Performance and appraisals

2.2.3.2.1 Overview

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

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

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

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

The processes described in section 2.2.3.2.2 and 2.2.3.2.3 below refer to the performance and appraisals of the executive and non-executive directors for the period 1 April 2020 to 31 March 2021.

2.2.3.2.2 Executive Directors

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

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

2.2.3.2.3 Non-executive Directors

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

The NEDs have their objectives agreed with the Chair; the Chair agrees their objectives in conjunction with the Lead Governor. 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 has received assurance that a process is in place and has been completed effectively.

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

2.2.3.3 Policy on payment for loss of office and notice periods

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

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

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

2.2.3.4 Policy on diversity and inclusion

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

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

2.2.4 ANNUAL REPORT ON REMUNERATION

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

- The Remuneration Committee (a sub-committee of the Board of Directors) which is made up of all the non-executive directors and is chaired by the Chair of the Trust
- The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) which is made up of a majority of governors and is chaired by the Chair of the Trust (unless the Chair is conflicted in any agenda item in which case the committee would be chaired by the 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 Executive directors' period of employment as Board members

Details of the start date for the Chief Executive and other members of the Executive Team who have served on the Board during 2020/21 are set out in the table below.

Table 2.2C – Executive directors who have served during 2020/21

Name	Title	Date appointment effective from	Date left the Board position
Dr Sara Munro	Chief Executive	5 September 2016	N/A
Joanna Forster Adams	Chief Operating Officer	3 July 2017	N/A
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)	1 August 2012	N/A
Claire Holmes	Director of OD and Workforce	1 October 2018	9 May 2021 *
Dr Chris Hosker	Medical Director	1 August 2020	N/A
Dr Claire Kenwood	Medical Director	1 March 2017	31 July 2020
Cathy Woffendin	Director of Nursing, Professions and Quality	1 March 2018	N/A

*In March 2021 it was announced that Claire Holmes (Director of OD and Workforce) would be leaving the Trust and on the 9 May 2021 she stepped down as a member of the Board and on the 10 May 2021 Darren Skinner joined the Trust as the Interim Director of Human Resources. Darren will remain with the Trust until a substantive appointment is made.

Details of the non-executive directors who have served during 2020/21 are shown in the table below along with details of their terms of appointment.

Table 2.2D – Non-executive directors that have served during 2020/21

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 2020	3 years	14 November 2023	Second
Cleveland Henry	1 April 2020	3 years	31 March 2023	First
Andrew Marran	17 February 2019	3 years	16 February 2022	First
Sue White	7 November 2019	3 years	6 November 2022	Second
Martin Wright	20 January 2021	3 years	19 January 2024	Second

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

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

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

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2020/21 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 2020/21 the committee met on three 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:

- Agreeing the salary for the incoming Medical Director
- Reviewing the salaries of the Chief Executive and the other Executive Directors
- Agreeing a 1.03% cost of Living increase for the executive directors for the period commencing 1 April 2020.

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

Table 2.2E – The Remuneration Committee

Name	25 June 2020	29 October 2020	14 January 2021
Prof Sue Proctor (chair of the committee)	✓	✓	✓
Prof John Baker	✓	✓	✓
Helen Grantham	✓	✓	✓
Cleveland Henry	✓	✓	✓
Andrew Marran	✓	✓	✓
Sue White	✓	✓	✓
Martin Wright	✓	✓	✓

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

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

The Appointments and Remuneration Committee is a sub-committee of the Council of Governors. It has been established in accordance with the NHS Act 2006 and operates in accordance with the principles of NHS Improvement's Code of Governance for Foundation Trusts. It sets the remuneration and terms of service for the non-executive directors and it also plays a role in the appointment of non-executive directors, particularly in respect of the interview panels which are 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 2020/21 its membership was Steven Howarth, Niccola Swan, Les France, Ivan Nip and Peter Webster; all of whom are elected governors.

In 2020/21 there was one formal meeting of the Appointments and Remuneration Committee. The table below shows the attendance of members at the meetings.

Table 2.2F – The Appointments and Remuneration Committee

Name	20 October 2020
Prof Sue Proctor (chair of the committee)	✓
Les France	✓
Steve Howarth	✓
Ivan Nip	✓
Niccola Swan	-
Peter Webster (Lead Governor)	✓

In 2020/21 the main areas of work for the committee were:

- Consideration of the outcome of the non-executive director appraisals
- The re-appointment of Helen Grantham and Martin Wright as non-executive directors for a second term of office of three years commencing 15 November 2020 and 20 January 2021 respectively
- The appointment of Helen Grantham as Deputy Chair of the Trust with effect from 1 February 2021.

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

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

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

Competitive interview process

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

Candidates can be sought using external search companies, local networks and through the NHS Jobs website. A panel consisting of a majority of governors led by the Chair of the Trust will draw up a shortlist of candidates from the applicants. An interview panel will be formed from the membership of the Appointments and Remuneration Committee with a majority of governors (where possible four governors), the Chair of the Trust and an independent assessor. The panel will then conduct the interviews and choose the preferred candidate based on merit. Once the panel has made its choice, a recommendation is made to the Council of Governors and it is for the Council to ratify the recommended appointment at a general meeting.

Re-appointment process

In regard to the re-appointment process, the Chair of the Trust will meet with the non-executive director concerned to discuss their performance and preference in relation to re-appointment. 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 2020/21

In 2020/21 there were no non-executive director appointments. However, in 2019/20 there was one appointment made by the Council of Governors in respect of Cleveland Henry who was appointed for a period of three years and who took up his appointment on 1 April 2020.

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

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

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

Where the vacant post is for a non-executive director, the Nominations Committee will provide the Council of Governors' Appointments and Remuneration Committee with details of the agreed skills and experience required. Where the vacant post is for an executive director a panel, constituted in accordance with the NHS Act 2006, made up of a majority of non-executive directors, will lead on the appointment process to appoint to the 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 2020/21 the committee had no cause to meet.

Appointment of executive directors in 2020/21

In 2020/21 there were no executive director appointments. However, in 2019/20 there was a process undertaken to appoint a new Medical Director and in March 2020 Dr Chris Hosker was appointed. He took up his appointment on 1 August 2020 and replaced Dr Claire Kenwood who stepped down as Medical Director on 31 July 2020.

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 2020/21.

Table 2.2G – Directors and governors' expenses

	2020/21			2019/20
	Number in office throughout the reporting period	Number receiving expenses in the reporting period	The aggregate sum paid in the reporting period £'00	The aggregate sum paid in the reporting period £'00
Executive directors	7	1	1	2
Non-executive directors	7	1	1	3
Governors *[1]	22	1	1	4

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

It should be noted that the reduction in the amount of expenses paid in 2020/21 in comparison to 2019/20 is due to people working from home and not attending face-to-face meetings due to the pandemic, other than in exceptional circumstances. Additionally, any expenses relating to executive and non-executive directors are shown in more detail in the expenses payments column in table 2.4I 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 2.2H and 2.2I below.

Table 2.2H – 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 2021 (Bands of £5000) £'000	Lump sum at pension age related to accrued pension at 31 March 2021 (Bands of £5000) £'000	Cash equivalent transfer value at 31 March 2020 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31 March 2021 £'000	Employer's contribution to stakeholder pension To nearest £100
Dr Sara Munro (Chief Executive)	2.5 - 5.0	2.5 - 5.0	45 - 50	95 - 100	655	52	734	0
Joanna Forster Adams (Chief Operating Officer)	5.0 - 7.5	10.0 - 12.5	50 - 55	120 - 125	922	112	1,053	0
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	0	0	0	0	0	0	0	0
Claire Holmes (Director of OD and Workforce)	2.5 - 5.0	0	20 - 25	0	218	32	268	0
Dr Chris Hosker (Medical Director from 1 August 2020)	20.0 - 22.5	40.0 - 42.5	30 - 35	60 - 65	0	316	493	0
Dr Claire Kenwood (Medical Director until 31 July 2020)	0	0	55 - 60	170 - 175	1,286	0	173	0
Cathy Woffendin (Director of Nursing and Professions)	5.0 - 7.5	10.0 - 12.5	40 - 45	95 - 100	766	110	893	0

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

Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

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

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

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

Name and title	2020/21							2019/20						
	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)	180 - 185	0	0	0	75.0 - 77.5	0	255 - 260	160 - 165	100	0	0	82.5 – 85.0	0	245 - 250
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	145 - 150	100	0	0	0	0	145 - 150	135 - 140	100	0	0	0	0	135 - 140
Joanna Forster Adams (Chief Operating Officer)	130 - 135	0	0	0	112.5 - 115.0	0	245 - 250	115 - 120	0	0	0	22.5 – 25.0	0	140 - 145
Cathy Woffendin (Director of Nursing and Professions)	120 - 125	0	0	0	110.0 - 112.5	0	230 - 235	105 - 110	0	0	0	22.5 – 25.0	0	130 - 135
Dr Claire Kenwood (Medical Director)	45 - 50	0	0	0	0	0	45 - 50	150 - 155	0	0	0	27.5 – 30.0	0	175 - 180
Dr Chris Hosker (Medical Director)	105 - 110	0	0	0	707.5 - 710.0	0	815 - 820	0	0	0	0	0	0	0
Claire Holmes (Director of OD and Workforce)	115 - 120	0	0	0	67.5 - 70.0	0	185 - 190	110 - 115	0	0	0	360.0 – 362.5	0	470 - 475
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	0	0	0	0	0	10 - 15	10 - 15	100	0	0	0	0	10 - 15
Andrew Marran (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15
Martin Wright (Non-executive Director)	15 - 20	0	0	0	0	0	15 - 20	15 - 20	100	0	0	0	0	15 - 20
Prof John Baker (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15
Sue White (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15

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 2.2J – Median remuneration

	2020/21	2019/20
Band of highest paid directors' total remuneration (£'000)	**180 - 185**	160 – 165
Median Salary (£)	**30,820**	29,869
Ratio	**5.90**	5.52

The banded remuneration of the highest-paid director in the Trust in the financial year was £181,715 (2019/20, £164,898). 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 5.90 times (2019/20, 5.52 times) the median remuneration of the workforce, which was £30,820 (2019/20, £29,869). The ratio has increased partly due to the highest paid director this year being paid higher than the previous year's highest paid director..

In 2020/21, two substantive employees received remuneration in excess of the highest-paid director (2 in 2019/20). Remuneration for these employees ranged from £185,738 to £221,269 (2019/20, £173,709 to £199,485).

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 2021 are included in the calculation.

2.2.8 ACCOUNTING POLICIES

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

SECTION 2.3 – ACCOUNTABILITY REPORT (Staff Report)

2.3.1 EQUALITY REPORTING

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

Everyone who comes into contact with our organisation can expect to be treated with respect and dignity. We are committed to eliminating discrimination and to the fair treatment of everyone, taking into account all 'protected characteristics' under the Equality Act 2010 and the Human Rights Act. 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 have developed our equality objectives for 2018 to 2021 using the NHS Equality Delivery System (2) framework and undertake an annual assessment with stakeholders and partners to review equality progress across the organisation and to identify priority areas for action through this process. Our equality and inclusion strategic plans are further developed and driven through our internal governance structures and groups, such as the Equality Group, the Patient Experience and Involvement Strategic Group. During 2020/21 we have reviewed our governance arrangements to ensure that our plans are implemented robustly and at speed. The Chair of the Trust now holds the non-executive lead for the equality and inclusion agenda and progress is reported to the Board on a quarterly basis.

Our equality ambitions are as follows;

1. To deliver better health outcomes for all
2. To improve the quality and consistency of service user access and experience
3. To ensure our workforce has a positive experience at work, is offered opportunities to meet their full potential and live our values
4. To ensure our workforce is representative of the communities we serve at all grades and within all roles
5. To ensure visible commitment and leadership to creating an environment that promotes equality, diversity and inclusion in all that we do.

Annual analysis of workforce race and disability equality and gender pay gap data is analysed and submitted in line with the Workforce Race Equality and Workforce Disability Equality Standard requirements and annual data and action plans are published on the Trust website.

Further details can be accessed using the link below:
https://www.leedsandyorkpft.nhs.uk/about-us/equality-and-diversity/

Work to develop our people priorities has continued through 2020/21 and has been further informed by individual staff feedback received from various sources. Our Trust Strategic People Plan will continue to be developed as we emerge from Covid-19 response and into recovery in 2021/22 as part of the wider work being undertaken by the Board on Strategic Planning.

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 and our Covid-19 emergency response plans we have implemented actions and initiatives to respond to the immediate and longer term response needs of colleagues during the pandemic and to further develop our Trust as a healthy workplace in respect of mental health. We are also a Disability Confident employer at

level two. This demonstrates we are positive about people with disabilities and support them to successfully attain and retain employment within our Trust.

We have supportive employment practices in place not only for those that we employ who have a disability, but for those who may become disabled whilst working for us. These include a support package within 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. 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.

In 2020/21 we introduced the Wellbeing Assessment process for all staff; a holistic and supportive risk assessment process through a recorded supportive discussion between a staff member and their manager, to identify actions or reasonable adjustments required. We have made reasonable adjustments to working environments including home working and redeployment and through the purchase of specialised equipment. In addition a career conversation process has been incorporated within the assessment to identify and action career development support and training needs. These procedures and services support the employment, retention and experience of disabled employees and the implementation of reasonable adjustments to take account of individual needs.

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.

2.3.3 VALUING OUR WORKFORCE

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

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 in providing inclusive, recovery-focused activities for our service users.

Our Voluntary Services department continues to grow and provide a high quality service across our sites; working in partnership with volunteers, staff, service users and external voluntary organisations.

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 have extended our volunteer training programme to include an appropriate level of practical clinical holding training to our volunteers working in our acute wards to keep themselves and our service users safe. We have been directly working alongside the Leeds Recovery College to provide feedback on their Mental Health and Stress course, with the aim of providing the opportunity for all our volunteers to attend when they begin their role with us to improve their knowledge and understanding of issues such as stress, anxiety and depression, and to meet people who have lived experience of mental health issues. We have also developed a new online database which compiles all of our volunteer information confidentially in one place, providing the Trust with easy access to data.

Covid-19 and Our Volunteers

The contributions our volunteers have made during the Covid-19 pandemic to support the Trust has been extraordinary. Our volunteers have shown great commitment and dedication and provided invaluable support to services users and staff. Throughout the Covid-19 response, Trust volunteers have been actively supporting in new roles as Volunteer Healthcare Assistants, specifically supporting the allocation and use of personal protective equipment (PPE), the Trust vaccination programme and supporting our service users with shopping.

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

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

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

Staffside is the elected body of the representative trade unions in our Trust. 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 contributing to the Trust's response to Covid-19 particularly in relation to workforce issues, helping to develop the Trust's approach to agile working and continuing to have involvement in service redesign and management restructuring, and communication and engagement with staff. In 2020/21 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 a range of workforce issues particularly in response to Covid-19 through regular dialogue with the Director of OD and Workforce and senior operational managers
- Successfully worked in partnership with the Workforce and Organisational 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 2020/21

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
11	11

Table 2.3B – Percentage of time spent on facility time – The number of employees who were relevant union officials employed during 2020/21 and the percentage time of their working hours spent on facility time

Percentage of time	Number of employees
0%	4
1-50%	4
51%-99%	2
100%	1

Table 2.3C – Percentage of pay bill spent on facility time during 2020/21

Total cost of facility time	£29,112
Total pay bill	£141,005,430
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.021%

Table 2.3D – Paid trade union activities during 2020/21

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	13.06%

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 ways in which we have engaged with staff in previous years have adapted through 2020/21 to align to the new ways of working, brought on by the Covid-19 pandemic. By altering our approach we have ensured meaningful engagement work can still take place. Our aim continues to be that we are open about actions taken and decisions made, to work as transparently as possible.

2.3.4.1 Communications

The focus of our communications with our staff in 2020/21 was dominated by the Covid-19 pandemic response. Alongside this, communications support to major projects continued, including launching the new electronic patient record system CareDirector, leading the communications and engagement work stream for the Children and Young Peoples' Mental Health Service inpatient unit and delivering the annual flu campaign.

Throughout 2020/21, the Trust published over 160 'All Staff Briefings', providing our staff with timely information and updates on all aspects of the Coronavirus response. We developed a dedicated section of the Trust website for staff to be able to access important guidance and resources. We also used the Trust website to develop our staff Health and Wellbeing Hub which became a cornerstone of our strategy to support staff across the Trust with resources and opportunities to maintain their mental and physical health. With staff working remotely and with restrictions on meeting in person, we set up regular video conference webinars with the Chief Executive via the video conferencing app Zoom. These gave staff the opportunity to dial in and listen to a summary of the latest developments and how the Trust was responding to them, as well as sharing her reasons to be proud.

2.3.4.2 Improving Culture: Improving Lives

Since autumn 2019 we have adopted a staff engagement approach to developing our culture together and have worked with staff to listen to their feedback and drive changes. Online conversations have taken place on our crowdsourcing platform 'Your Voice Counts' and we have continued to conduct the annual Staff Survey as full census of all bank and substantive staff.

The invaluable feedback gathered from these conversations has helped shape how our work to improve the culture of our Trust will continue. Notably in the summer of 2020 we held an online conversation via the Your Voice Counts platform to ask staff about their experience of the changes made as part of the Trust's response to Covid-19.

16% of staff took part in the online conversation to share their thoughts, feedback and suggestions on how we can continue to work together across the Trust to improve our culture. This conversation gave us valuable quantitative and qualitative data, particularly around what support staff have found beneficial during the pandemic and what more we could be doing moving forward.

All staff were invited to a zoom presentation to share the results of the online conversation and senior leaders from across the Trust shared the improvements that were being made in their areas to improve staff experience. The presentation detailed the Trust's immediate and longer term priorities based on what staff had shared.

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 key themes. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. For the 2020/21 Staff Survey, the key theme 'quality of appraisals' was removed after appraisals were stood down for the majority of the year. The other key themes remained the same as previous years.

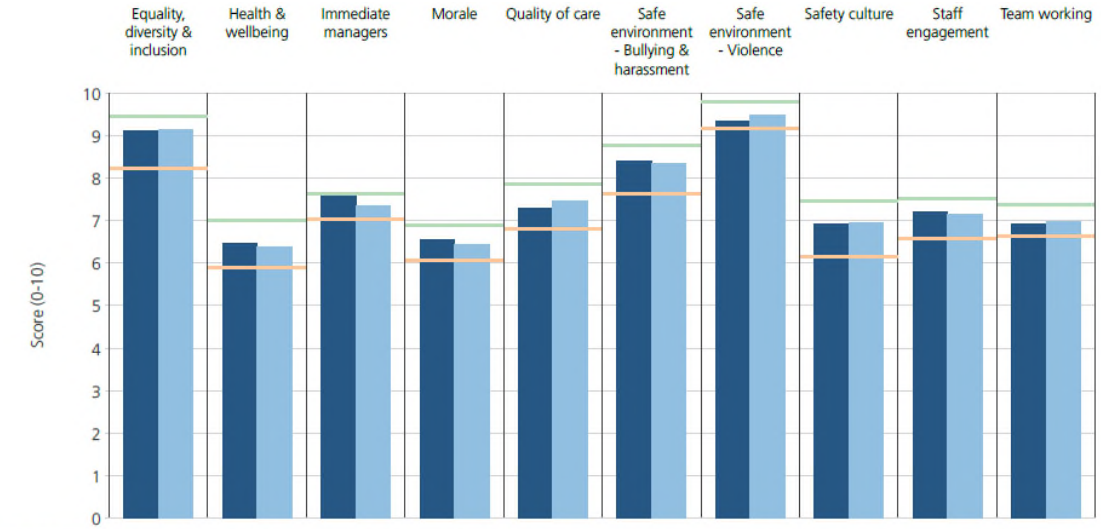
The 2020/21 Staff Survey response rate for Trust staff was 47% (2019/20: 54.5%, 2018/19: 58.1 %). Scores for each indicator together with that of the survey benchmarking group (Mental Health and Learning Disability Trusts) are presented below.

Table 2.3E – Response rate for the staff survey

	2020/21 Survey		2019/20 Survey		2018/19 Survey		2017/18 Survey	
Theme	**Trust**	**Benchmark**	**Trust**	**Benchmark**	**Trust**	**Benchmark**	**Trust**	**Benchmark**
Equality, Diversity and Inclusion	9.1	9.1	9.1	9.0	9.0	8.8	9.1	9.0
Health & Wellbeing	6.5	6.4	6.4	6.0	6.4	6.1	6.4	6.2
Immediate Managers	7.6	7.3	7.6	7.3	7.4	7.2	7.3	7.2
Morale	6.5	6.4	6.5	6.3	6.4	6.2	New theme for 2018	
Quality of Appraisals	Removed for 2020		5.9	5.8	5.8	5.7	5.4	5.5
Quality of Care	7.3	7.5	7.3	7.4	7.3	7.3	7.2	7.3
Safe Environment - Bullying and Harassment	8.4	8.3	8.3	8.0	8.2	7.9	8.2	8.0

Safe Environment - Violence	9.3	9.5	9.3	9.3	9.2	9.3	9.1	9.2
Safety Culture	6.9	6.9	6.8	6.8	6.7	6.7	6.5	6.7
Staff Engagement	7.2	7.2	7.1	7.0	7.1	7.0	6.9	7.0
Team Working	6.9	7.0	7.0	7.0	6.8	6.9	6.7	6.9

The following chart displays the Trust's theme scores for 2020/21 against the benchmark and includes the best and worst scores from the group.



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement	Team working
Best	9.5	7.0	7.6	6.9	7.9	8.8	9.8	7.5	7.5	7.4
Your org	9.1	6.5	7.6	6.5	7.3	8.4	9.3	6.9	7.2	6.9
Average	9.1	6.4	7.3	6.4	7.5	8.3	9.5	6.9	7.2	7.0
Worst	8.2	5.9	7.0	6.1	6.8	7.6	9.1	6.1	6.6	6.6
Responses	1,302	1,306	1,303	1,299	983	1,290	1,293	1,306	1,307	1,290

We are therefore performing better than the national average for mental health and learning disability trusts in England across four of the 10 key themes. We are equal to the benchmark group average for three themes and below the benchmark average for three key themes: quality of care; safe environment – violence; and team working.

This year 64% 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. For the first time this year, staff receiving a paper copy of the survey had the option to complete the survey online instead. However, 16% of responses were still via the paper survey and therefore it is important going forward that we keep this option open to staff.

This year we saw our overall response rate decline by 7.5%. As the survey took place during the Covid-19 pandemic, we knew this may have an impact on our completion rate and therefore, this decline did not come as a surprise. We regularly communicated with line managers on their team level response rates to enable local encouragement where this was appropriate. Therefore, we still consider 47% response rate a positive achievement.

In March 2020 a decision was taken to stand down mandated local action planning due to operational pressures. However, the continued focus on improving the staff experience of working at our Trust during the pandemic was picked up by a number of working parties including the Health and Wellbeing Steering Group, the Equality Steering Group and the Workforce and Communications Group. Discussions at these groups led to some important implementations across the Trust to boost staff experience:

- Wellbeing assessments were introduced for all staff to support regular conversations with their line manager about their health and wellbeing. The conversations are designed to consider staff members' feelings regarding safety and mental health and wellbeing

- The Trust's Freedom to Speak Up Guardian has now been joined by five Freedom to Speak Up Ambassadors who contribute to creating a culture of speaking up where all staff feel safe and confident to raise concerns. They work alongside the Freedom to Speak Up Guardian, to promote, listen, support and provide an impartial view to staff when speaking up

- Discussions in the Workforce Race Equality Network (WREN) and our Workforce Race Equality Standard highlighted that staff members from ethnic minorities specifically feel they experience limited training opportunities and opportunities to progress in their careers. This prompted the review of the Trust appraisal process and introduction of career conversations for all staff members from ethnic minorities with line managers to ensure staffs' full potential can be further developed. There is also now a representative for staff from ethnic minorities on the recruitment panel for all jobs band 8C and above

- 11 members of our Workforce Race Equality Network and Board members have committed to a Reciprocal Mentoring journey together. The mentoring journey started in November 2020 and will take place over 12 months. The pairs will offer insight through their personal lens to promote organisational learning and personal growth

- 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). This required all members and network chairs to quickly adapt to ensure the networks could still come together remotely. For our WREN in particular, the meetings increased to take place more frequently to support staff, particularly following the murder of George Floyd and the Black Lives Matter movement, and as statistics came to light around the disproportionate impact of Covid-19 on people from ethnic minorities. All networks continued their work to support equality and promote inclusive cultures

- All staff working from home during the Covid-19 pandemic have been issued with the relevant equipment needed to safely and effectively do their job from home. To support this, the Trust introduced an Agile Working Guidance Policy which details all of the support available to employees.

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 2020	National Average* 2020	Positive difference against national average*
[How satisfied are you with] The opportunities for flexible working patterns	73%	67%	6%
The last time you experienced harassment, bullying or abuse at work, did you or a colleague report it?	66%	61%	5%
My immediate manager asks for my opinion before making decisions that affect my work	69%	64%	5%
My immediate manager can be counted on to help me with a difficult task at work.	82%	77%	5%

My immediate manager encourages me at work	81%	77%	4%

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

Table 2.3G – Bottom five ranking scores

	Trust Score 2020	National Average* 2020	Positive difference against national average*
Experienced physical violence at work from patients/service users, their relatives or other members of the public in the last 12 months.	19%	14%	5%
I am satisfied with the quality of care I give to patients/service users.	78%	83%	-5%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	67%	72%	-5%
I am able to deliver the care I aspire to	65%	70%	5%
On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	28%	24%	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 2021/22. Teams are encouraged to discuss the results of their surveys at local level and use the feedback as part of their post-Covid-19 recovery work. The Trust will continue to use the Your Voice Counts Crowdsourcing platform, as well as other 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 receive regular information regarding financial performance within the Chief Financial Officer's 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 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

Following the implementation of our new electronic patient record system, Care Director, there has been a great deal of work to develop timely and accessible operational dashboards for service managers. These dashboards provide teams with the tools to manage patient care pathway activity and to monitor data integrity. Additionally a new Quality, Delivery and Performance Report was developed in 2020/21 to present the Key Performance Indicator (KPI) data that services need in order to better manage the performance and quality of their services. Whilst the Covid-19 pandemic has impacted on the bi-monthly Quality, Delivery and Performance meetings with services we have been pro-active in engaging with staff in each area (including service managers and clinical leads) to promote the use of new dashboards to enable discussion of performance across a range of topics including improved service delivery and quality improvement plans. Data has played a crucial role in our understanding the impact of Covid-19 and service reset work.

Overall performance against our contracts is monitored by the Finance and Performance Committee, which have tracked the impact of Covid-19 and our new electronic patient record system, Care Director, over the last year on performance, data quality and risk.

We have a series of Quality Reviews, whereby staff visit services and assess them using the Key Lines of Enquiry template used by the CQC. 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 link below:

http://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. 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. During 2020/21 our Occupational Health Service has provided invaluable advice on Covid-19 particularly in relation to supporting staff with Covid-19 or who have had to self-isolate, clinically extremely vulnerable staff, shielding and the vaccine. This advice has informed the Trust's approach to the welfare of our staff during the pandemic which has been very well received.

2.3.9 HEALTH AND SAFETY

In 2020/21 health and safety has been proactively managed throughout the pandemic. The Trust has ensured that all audits and inspections are up to date with a review of any incidents completed. Whilst this has been a difficult period, active management of health and safety has ensured that the Trust is

covid secure with robust procedures, continued monitoring and assurance in line with the Health and Safety Executive's guidance and Government guidance.

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 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. Throughout 2020/21 the Executive Risk Management Group monitored the progress made with the action plan.

2.3.10 COUNTER-FRAUD

During 2020/21 the Local Counter Fraud Specialist Service (LCFS) was provided by NHS Audit Yorkshire. Audit Yorkshire specialises in all aspects of internal audit and counter fraud work, primarily across the NHS but also the public, corporate and not for profit sectors. Audit Yorkshire has a team of accredited and experienced LCFS personnel.

In January 2020 the NHS Counter Fraud Authority (NHSCFA) issued Standards for commissioners – fraud, bribery and corruption to LCFSs and Chief Finance Officers. The standards outlined an organisation's corporate responsibilities regarding counter fraud and the key principles for action. In May 2020 the LCFS produced an annual counter fraud plan aligned to these standards.

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

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

The Trust's counter fraud arrangements are currently in compliance with NHSCFA's Standards for Providers: fraud, bribery and corruption. These arrangements are underpinned by the appointment of the LCFSs, a Trust-wide Counter Fraud and Corruption policy and the nomination of the Chief Finance Officer as the executive lead for counter fraud. However, it should be noted that these standards have subsequently been superseded by the Government Functional Standard GovS 013: Counter Fraud (Functional Standard), which was formally introduced in February 2021.

The LCFS completes an annual self-assessment of compliance against the NHSCFA's Standards for Providers: fraud, bribery and corruption, which is reviewed and approved by the Chief Finance Officer and Audit Committee Chair prior to submission to the NHSCFA. This self-assessment process will be undertaken on behalf of the Trust in May 2021 against the new Functional Standard.

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

During 2020/21 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 2020/21

Average number of employees (Whole Time Equivalent basis)	Permanent (Number)	Other (Number)	Total Number (2020/21)	Total Number (2019/20)
Medical and dental	185	19	204	203
Administration and estates	636	43	679	632
Healthcare assistants and other support staff	611	268	879	813
Nursing, midwifery and health visiting staff	763	48	811	776
Scientific, therapeutic and technical staff	341	3	344	328
Social care staff	23	0	23	14
Total average numbers	**2,559**	**381**	**2,940**	**2,766**
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 2021

Group	Number male	Number female
Directors	5	8
Senior managers (Band 8 and above)	92	187
Employees	694	1910

2.3.13 GENDER PAY GAP INFORMATION

The gender pay gap shows the differences in average pay between men and women. The gender breakdown of our workforce is 73% female and 27% male. In May 2019 the Nuffield Trust published their analysis of median pay across NHS organisations and concluded that the estimated median basic full-time pay gap for NHS staff was 8.6% in favour of men. In 2020 the Trust's median pay gap figure was below this figure at 5.9%.

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

Details of the Trust's gender pay gap data can be found on the Trust website and the Cabinet Office website using the following links:

https://www.leedsandyorkpft.nhs.uk/about-us/equality-and-diversity/

https://gender-pay-gap.service.gov.uk/

2.3.14 ANALYSIS OF STAFF COSTS

Table 2.3J – Analysis of staff costs for 2020/21

Average number of employees (Whole Time Equivalent basis)	Permanent (£000)	Other (£000)	Total £000 (2019/20)
Salaries and wages	93,700	11,281	104,981
Social security costs	9,835	0	9,835
Employer's contributions to NHS pensions	12,819	0	12,819
Pension cost - employer contributions paid by NHSE on provider's behalf (6.3%)	5,593	0	5,593
Apprenticeship Levy	493	0	493
Agency staff	0	7,346	7,346
Employee benefits expense	**122,440**	**18,627**	**141,067**
Of which: Charged to capital			0
Recharged to income			(269)
Total employee costs			140,798

2.3.15 OFF-PAYROLL ENGAGEMENTS

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

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

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

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

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

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

The following table sets out all highly-paid off-payroll worker engagements as at 31 March 2021, earning £245 per day or greater

Table 2.3K

Number of existing engagements as of 31 March 2021	21
Of which:	
The number that have existed for less than one year at the time of reporting	16
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 highly-paid off-payroll workers engaged at any point during the year ended 31 March 2021, earning £245 per day or greater.

Table 2.3L

Number of off-payroll workers engaged during the year ended 31 March 2021	39
Of which:	
Not subject to off payroll legislation	37
Subject to off-payroll legislation and determined as within the scope of IR35	2
Subject to off-payroll legislation and determined as out-of-scope of IR35	0
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

All of the above were sourced through employment agencies.

The following table shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2020 and 31 March 2021.

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.	14

2.3.16 STAFF EXIT PACKAGES

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

Exit packages for Board members are included above with further detail in the Directors' Remuneration Report. There was one exit package agreed relating to a Board member in 2020/21 (nil in 2019/20).

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	0 (1)	9 (11)	9 (12)
£10,001 - £25,000	0 (2)	3 (4)	3 (6)
£25,001 - £50,000	0 (2)	0 (3)	0 (5)
£50,001 - £100,000	0 (0)	0 (1)	0 (1)
£100,001 - £150,000	0 (0)	1 (0)	1 (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	**0 (5)**	**13 (19)**	**13 (24)**
Total resource cost (£000)	0 (96)	175 (296)	175 (392)
Note: Figures in brackets relate to 2019/20			

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	1 (0)	30 (0)
Mutually agreed resignations (MARS) contractual costs	0 (10)	0 (249)
Early retirements in the efficiency of the service - contractual costs	13 (9)	145 (47)
Contractual payments in lieu of notice	0 (9)	0 (47)
Exit payments following Employment Tribunals or court orders	0 (0)	0 (0)
Non-contractual payments requiring HMT approval	0 (0)	0 (0)
Total	**14 (19)**	**175 (296)**
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 2019/20		

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

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

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

2.3.18 EXPENDITURE ON CONSULTANCY

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

2.3.19 MENTAL 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 CTO.

The Board has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2020/21 this committee was chaired by a non-executive director (Andrew Marran) and it met four times during 2020/21. Meetings normally include members of the Committee and members of the Mental Health Legislation Team. Due to Covid-19 a decision was made to hold smaller meetings to allow focus to remain on responding to the pandemic. All hearings held during the reporting period have been held remotely via Zoom.

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

The Mental Health Act Managers Forum was chaired jointly by Andrew Marran, a Non-Executive Director, and Marilyn Bryan, lead Mental Health Act Manager and Deputy Chair of the Forum. In 2020/21 the Forum met three times on 14 August 2020, 9 November 2020 and 16 February 2021, all meeting have been held remotely via Zoom.

2.3.19.2 Mental Health Act Managers who have served in 2020/21

We currently have 31 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2020/21.

Table 2.3P

Mental Health Act Managers during the period 1 April 2020 to 31 March 2021		
Bernadette Addyman	Nasar Ahmed	Marilyn Bryan
Rebecca Casson	Aqila Choudhry	Judith Devine
John Devine	Michael Hartlebury	Ian Hughes
Peter Jones	Trevor Jones	Andrea Kirkbride
Harold Kolawole	Susan Mosley	Graham Martin
Claire Morris	Ismail Patel	Gillian Nelson
Shamaila Qureshi	Andrea Robinson	Debra Pearlman
Susan Smith	Niccola Swan	Alex Sangster
Claire Turvill	Viv Uttley	Jeffrey Tee
Janice Wilson	Tom White	Michael Yates
Paul Yeomans		

Non-executive directors also acting as Mental Health Act Managers during 2020/21
Andrew Marran

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

2.3.20 DIVERSITY AND INCLUSION POLICIES

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

https://www.leedsandyorkpft.nhs.uk/about-us/wp-content/uploads/sites/8/2018/07/Workforce-and-Organisational-Development-Strategic-Plan-2018.pdf

We have continued to build upon work to develop an inclusive and compassionate leadership community through the delivery of a Culturally Intelligent and Inclusive Leaders programme for our senior leaders. We have also commenced a twelve month Reciprocal Mentoring Programme between colleagues from diverse ethnic backgrounds and our Board to increase inclusive leadership learning and challenge thinking through personal insight and personal growth.

We have established representative recruitment panels for senior roles to increase culturally inclusive decision making. We have also developed an inclusive recruitment training module for appointing managers incorporating cultural intelligence approaches and experiential narrative from staff with protected characteristics on recruitment and promotion challenges and barriers.

Our staff networks play a key role in influencing and driving our equality and inclusion strategic direction and plans. We have strengthened the role of our staff networks to increase their contribution to decision making processes to inform and support organisational learning and cultural change.

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

Further granular workforce data analysis and actions will be undertaken to further inform the diversity representation of our workforce by profession and to ensure that our workforce leadership is representative as detailed within the NHS Model Employer goals. Further information on the Model Employer can be found using the following link:

https://www.england.nhs.uk/publication/a-model-employer/

In addition a culture dashboard is under development, which will utilise both hard and soft intelligence data from a variety of sources to provide real time feedback on the culture of our organisation by team, service and at Trust level.

2.3.21 STAFF TURNOVER

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

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

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

2.4.1 COMPLIANCE WITH THE CODE OF GOVERNANCE

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

2.4.1.1 Comply or explain

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

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

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

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

2.4.2 DISCLOSURE STATEMENTS TO BE MADE IN THE ANNUAL REPORT

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

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

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

Code provision	Requirement	Section in Annual Report / 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 4H in Section 4.3 and table 4I in Section 4.5
B.1.1	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent, with reasons if necessary.	• Section 2.1.1
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	• Section 3.3 • Section 2.1.1
Annual Reporting Manual additional disclosure	The Annual Report should include a brief description of the length of appointments of the non-executive directors, and how they might be terminated.	• Section 2.1.1

Code provision	Requirement	Section in Annual Report / explanatory statement
B.2.8	The Annual Report should describe the process followed by the Council of Governors in relation to appointments of the chairperson and non-executive directors.	• Section.2.2.4.3
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	• Section 2.2.4.3 (Appointments and Remuneration Committee) • Section 2.2.4.4 (Nominations Committee)
Annual Reporting Manual additional disclosure	The disclosure on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of the chair or non-executive director.	Not applicable, open advertising and external search companies are used in NED recruitment campaigns.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	• Section 2.1.1 and 3.3
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.	Not applicable, no external evaluation carried out during the course of the financial year
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

Code provision	Requirement	Section in Annual Report / explanatory statement
C.1.1	Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	• Section 2.7
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	• Section 2.7(Annual Governance Statement)
C.2.2	The trust should disclose in the Annual Report if it has an internal audit function, how the function is structured and what role it performs.	• Section 6.2
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, re-appointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable
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	Section 1.1.9.2

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

Segmentation enables NHS Improvement to take an overview of the level and nature of support required across the provider sector, and to target its support capacity as effectively as possible. 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 2021.

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

2.5.3 FINANCE AND USE OF RESOURCES

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

Table 2.5A

Area	Metric	2020/21				2019/20			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	3	2	3	3	2	2	2	2
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E Margin	2	1	3	3	1	1	2	3
Financial controls	Distance from financial plan	1	1	2	2	1	1	1	1
	Agency spend	3	3	3	2	2	2	2	2
Overall scoring		2	2	2	2	1	1	2	2

CONFIRMATION FROM THE CHIEF EXECUTIVE

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

Signed

Date: 10 June 2021

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: 10 June 2021

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 2020 to 31 March 2021.

2.7.1 SCOPE OF RESPONSIBILITY

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

2.7.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2021 and up to the date of approval of the Annual Report and Accounts.

2.7.3 CAPACITY TO HANDLE RISK

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

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

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

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

2.7.3.1 Staff training

The organisation provides compulsory training for all staff to complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place. We have a process for monitoring the uptake of compulsory training through a system called iLearn. The Interim Director of Human Resources 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. All reported incidents are reviewed by an assigned manager who reviews, completes and approves the incident, any required additional support is offered to the relevant teams and any learning is identified including good practice.

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

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

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

During the Covid-19 pandemic a number of temporary changes were made to the LIMM and Serious Incident processes. These changes allowed organisational oversight of any deaths reported within the Trust and ensured that appropriate action was taken to review and learn from these thereby maintaining the Trust's commitment to patient safety. By the end of the year all processes had returned to pre-Covid-19 arrangements, with the exception of meetings which are currently held remotely rather than face-to-face.

2.7.3.3 NHS Litigation Authority risk management standards

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

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

2.7.3.4 Work performed to assess Well-led

The Board is required to carry out an independent review of governance against the well-led framework every three years. Due to the Covid-19 pandemic and the delay in the CQC releasing new standards the scheduled review due to take place in 2020 was postponed.

Previous to this an independent review of our governance arrangements against the NHS Improvement well-led framework was carried out in 2017/18 by Deloitte LLP.

Part 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.

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 were 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 were clear about the performance measures we need to report against and where these were 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 the Senior Leadership Team have set out a clear vision and values that are at the heart of all the work within the organisation. We ensure staff at all levels understand them in relation to their daily roles.
- The Trust's 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 discussion in relation to the challenges staff and the services face.
- We co-create how our services are run.
- 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 the mitigating actions through the Board Assurance Framework.
- Robust governance arrangements are in place to ensure we discharge our safeguarding responsibilities appropriately. The Director of Nursing, Quality and Professions has executive responsibility for safeguarding at Board level and chairs the internal safeguarding committee which provides assurance to the Quality Committee. The Trust's Safeguarding Committee has oversight of all serious case reviews, domestic homicide reviews, lessons learnt reviews and safeguarding adult reviews. It fosters an environment to share lessons learnt and share good

practice. In addition the Director of Nursing, Quality and Professions attends the Safeguarding Children's and Adult Boards to ensure learning is reflected both internal and external to the organisation.

- Appropriate governance arrangements are in place in relation to the administration of and compliance with the Mental Health Act.
- We have a structured and systematic approach to staff engagement.
- The Board reviews performance reports which included data about the services. We also have an Executive Performance Overview Group which allows executive directors, 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.

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

2.7.4 THE RISK AND CONTROL FRAMEWORK

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

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

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

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

2.7.4.2 Quality governance arrangements

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

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

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

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

To manage any risk of non-compliance with CQC registration the Director of Nursing, Quality and Professions has established a process for monitoring progress against the CQC action plan which will identify any risks that require immediate action. During the Covid-19 pandemic this has involved one-to-one meetings with action leads to monitor progress.

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

The Trust has a bespoke electronic activity tracker which is a tool used to monitor deadlines and record evidence of actions. It also shows in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group which then makes an assurance report to the Quality Committee and in turn the Board.

The Trust has a process for carrying out Peer Reviews 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 will 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 assured of the governance of the organisation and are assured on the quality of services (clinical and non-clinical). There is also a comprehensive governance and management structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios and support the Chief Executive in carrying out their duties as Accounting Officer.

The Board of Directors and its sub-committees have agreed terms of reference setting out the accountabilities and the delegated authority they have been given by the Board to carry out work on its behalf. The Trust has in place all the necessary statutory documentation including a constitution, a scheme of delegation and matters reserved to the Board. The Trust also has a Corporate Governance Strategy which describes the framework for corporate governance and which references all the documents that sit within that framework. All members of the Board have role descriptions, clearly setting out their duties and areas of accountability and there is a signed memorandum of understanding between the Chair and Chief Executive, setting out their respective responsibilities. All Board members have been deemed to be Fit and Proper in accordance with the CQC standard.

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

2.7.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2020/21 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the Audit Committee for assurance about the process. The Board received the Corporate Governance Statement and agreed how it would declare against the standards.

2.7.4.6 Stakeholders and partners

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

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

- Active engagement with governors on strategic, service, and quality risks and changes including the setting of strategic priorities.

2.7.4.7 NHS Pension Scheme control measures

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

2.7.4.8 Equality, diversity and human rights control measures

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

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

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

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

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

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

2.7.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. There is an executive lead with oversight of the sustainability agenda and we also have a non-executive director champion in place to provide a further level of assurance to the Board.

2.7.4.10 Workforce

Our Workforce and Organisational Development (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. Our workforce requirements and performance are effectively managed through the workforce governance structure made up of a range of focused operational groups which identify short and long term workforce requirements, solutions to meet immediate needs, and undertake long term job planning in relation to the development of new roles. The performance against workforce metrics is seen by 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. We are also active partners in the development and leadership of the 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, held on the strategic risk register. These are also set out in our Board Assurance Framework (BAF). Each of these risks has an identified executive director and management lead. These are managed through the risk management, risk register and operational planning processes. They are reported to the Executive Risk Management Group, Board sub-committees and the Board through the BAF. Behind each risk is a detailed risk assessment which sets out the controls and mitigations.

In summary the risks are described as follows:

- SR1 - If there is a breakdown of quality and safety assurance processes we risk not being able to maintain compliance with regulatory requirements.
- SR2 - There is a risk that we fail to make the improvements outlined in the quality strategic plan and that this has an adverse impact on the care of those who use our services.
- SR3 - Due to an inability to recruit and retain sufficient numbers of staff with the appropriate skills experience and behaviours, there is a risk that we are unable to deliver high quality, evidence based, person centred care to meet new models of care now and in the future.
- SR4 - A lack of financial sustainability results in a destabilisation of the organisation and an inability to deliver services.

- SR5 - Due to inadequate, inflexible or poorly managed estates we compromise the safe environment which places staff, service users and visitors at risk.
- SR6 - As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.
- SR7 - Changes in the roles of commissioners and providers and the move to system-level working will require changes in the role and function NHS Trust boards and new governance arrangements There is a risk we do not have appropriate governance arrangements in place nor the capacity and capability to fulfil all our statutory functions.

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

2.7.5.1 Covid-19 Pandemic

During the latter part of March 2020 the Government declared a Level 4 National Incident and took control of the response to the Covid-19 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. These structures have remained in operation through 2020/21.

At the forefront of 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 the majority of 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.

At the forefront of keeping people safe were the infection prevention precautions and procedures which were enhanced in response to the management of the Covid-19 pandemic. The Director of Nursing, Quality and Professions has executive responsibility and oversight for infection prevention within the organisation and is the designated Director of Infection Prevention and Control (DIPC) and as such attends the regional DIPC meetings held by NHS England. The Board received oversight and assurance through the organisation's completed Infection Prevention and Control (IPC) BAF and Covid-19 framework along with regular updates to the Quality Committee.

In addition IPC processes were pivotal to discussions as part of our Emergency Planning Resilience and Response (EPRR) arrangements and there was a dedicated work stream at Bronze, Silver and Gold command levels. Additional standard operating procedures were produced over the last 12 months to reflect changes to national and regional guidance regular IPC audits were undertaken to advise on compliance to these changes which were discussed at the two-weekly IPC/Physical Health Group. In addition our IPC team now works seven days per week covering 12 hours each day offering advice and support and to undertake swabbing on all new admissions on day one, three, five and seven; more recently providing weekly testing on all service users who are asymptomatic. This approach has proved to be successful in reducing the number of outbreaks across the organisation.

Some of our day-to-day governance was paused during 2020/21 to ensure staff had sufficient capacity to manage the impact of the pandemic. We had a command structure of Gold, Silver and Bronze meetings so that strategic and tactical decisions could be made at the right level. Some governance groups still continued to operate, albeit covering a reduced agenda. This allowed some functions that could be more effectively carried out by those specific groups rather than dealt with

within the incident command structure were. Gold command had oversight of which groups were still in operation to ensure matters were dealt with in appropriate forums and that reports were linked into the appropriated levels of governance.

Our Board was advised of the current position relating to Covid-19 through reports from the Chief Executive and the executive directors. Our Board sub-committees continued to have oversight of governance issues through their meetings, albeit on a reduced and more focused agenda.

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

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

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

To enable the delivery of our strategy we have developed a set of strategic plans. These are our delivery plans which provide detailed information about how we will achieve our ambitions and include our plans for: clinical services; estates; health informatics; workforce and organisational development; and quality. Each year we have set out our annual actions for achievement as part of our planning and priorities.

When operating under the normal financial regime we have a financial strategy. This shows, on a projected basis, what the expected financial performance for the coming year is to be. This is written within a comprehensive process for developing the plan with sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives regular updates through the Finance and Performance Committee. However during 2020/21 the normal financial planning process was paused due to the pandemic and contracts were rolled forward with specific Covid-19 funding available to cover any Covid-19 related expenditure.

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

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

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

- Setting and monitoring financial budgets

- Delegation of authority for committing resources
- Performance management
- Achieving value for money.

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

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

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

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

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

  In 2020/21 the Internal Audit reports issued in the year have generated an overall opinion of 'Significant assurance' as detailed in the Head of Internal Audit Opinion. It should also be noted that within 2020/21 there were no reports issued with a 'limited assurance' opinion

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

  The audit team will carry out the audit of the 2020/21 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors. It reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's systems of internal control, including risk management, 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 versus 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).

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 2020/21. This shows that no incidents met the reporting threshold in the financial year.

Table 2.7A – Summary of Reportable Incidents involving personal data as reported to the ICO / DHSC in 2020/21

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. A 6-monthly report is made to our Trustwide Clinical Governance Group, highlighting themes, trends, or 'hot spot' teams emerging through our analysis of incident reporting so that lessons can be learned & cascaded through service management structures. We will continue to support information governance training via the national e-learning tool. All staff undertake annual refresher training as a reminder of their information governance obligations. The IG team continues to deliver an induction IG briefing presentation to new starters as part of Trust induction.			

The Trust has a robust Information Governance function and framework that utilises subject matter expertise from Information Governance (IG), Information, Communication and Technology (ICT), networks, informatics, health records and systems administration. The Trust's Senior Information Risk Owner (SIRO) (Chief Financial Officer) and Caldicott Guardian (Medical Director) are members of the Information Governance Group. The Group makes assurance reports to the Finance and Performance Committee, thereby maintaining a reporting line to the Board as required by regulation. It maintains effective links with the Trust's clinical teams by the escalation of incidents to the Trustwide Clinical Governance Group on a 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 email 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 2020.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership for 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 30 September 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 all ten of the National Data Guardian's core data security standards. The September submission date was revised from the usual 31 March submission in acknowledgement of Covid-19 pressures severely impacting health and care organisations throughout 2020/21.

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

2.7.10 CONCLUSION

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

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

Signed

Date: 10 June 2021

Dr Sara Munro
Chief Executive

SECTION 3 – THE BOARD OF DIRECTORS (further information)

3.1 INTRODUCTION

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

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

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

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

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

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

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

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

www.leedsandyorkpft.nhs.uk

3.2 COMPOSITION OF THE BOARD OF DIRECTORS

3.2.1 Non-executive directors

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

3.2.2 Executive directors

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

Chief Executive	Medical Director
Chief Financial Officer and Deputy Chief Executive	Director of Nursing, Professions and Quality
Chief Operating Officer	Director of 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 2021 can be found in Part A section 2.1.1 of this Annual Report.

3.3 PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS

Sue Proctor, Chair of the Trust

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

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

Currently, Sue is also 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 Chair of a new charity in Leeds, Day One Trauma Support.

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

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

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

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

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

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

Helen's role on the Board is to provide support and challenge in ensuring that the Trust is well led and delivering on its aims and objectives now and into the future. She is a member of the Quality Committee and the Audit Committee and Chairs the 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 NED champion 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.

Helen is the sole owner and director of Entwyne Ltd, providing HR and Organisational Development consultancy.

Cleveland Henry, Non-executive Director

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

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

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

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

Andrew Marran, Non-executive Director (Chair of the Mental Health Legislation Committee)

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, the Workforce Committee and Chairs the Mental Health Legislation 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.

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

Sue's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is the Chair of the Finance and Performance Committee, 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 Financial Officer for DLA Piper International, one of the largest global law firms, where he was responsible for all aspects of financial reporting and control, including treasury, taxation and financial planning. He managed an international team of finance staff which provided support for more than 4,000 lawyers operating in more than 30 countries around the world.

Sara Munro, Chief Executive

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

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

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

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

Joanna Forster Adams, Chief Operating Officer

As Chief Operating Officer Joanna works with Trust staff, leaders and managers, together with partners and stakeholders, to deliver care across all of our services. She leads on service development, ensuring that we respond to changes in the needs of the people we serve, working alongside health and care statutory and voluntary colleagues. Joanna is also responsible for major service change and supporting people to encourage and enable improvement on an ongoing basis. Joanna has lead and statutory responsibility for making sure we respond to an emergency or crisis situation, such as the Covid-19 pandemic. More recently Joanna has taken a lead on the Covid-19 vaccination programme and has started to develop further our health inequalities work, particularly in relation to our care services.

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 an '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. With over 20 years as a senior NHS manager, she has been keen to help staff be confident and supported to do the right thing and 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 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 (stepped down as a member of the Board on 9 May 2021)

Claire Holmes, the Director for Organisational Development & Workforce 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 learning disability 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.

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.

Chris Hosker, Medical Director (from 1 August 2020)

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

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

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

In addition to his clinical interests, Chris also developed a particular interest in clinical leadership. He has held a variety of leadership positions within the Trust, including Associate Medical Director for Mental Health Legislation, Clinical Lead for Liaison Psychiatry and more recently, Lead Psychiatrist. Chris has been supported to enhance his leadership experience through resources such as the NHS Leadership Academy where he completed the Shadow Board and Aspiring Medical Director Programmes, while also continuing to complete a Masters in Health Care Leadership.

Cathy Woffendin, Director of Nursing, Quality and Professions

Cathy leads on the professional development and standards of staff within the Trust which covers Nursing, Allied Health Professionals and Psychology. Her particular focus is to ensure that quality is of a high standard across the organisation and she works closely with Chris Hosker our Medical Director, to oversee the current quality and delivery of our services and 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, Quality and Professions on 1 March 2018.

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

3.4 MEETINGS OF THE BOARD OF DIRECTORS

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

In 2020/21 the Board of Directors met on ten 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 2020/21

Name	Meetings eligible to attend	Thursday 30 April 2020	Thursday 21 May 2020	Tuesday 16 June 2020 (ExtraO)	Thursday 25 June 2020	Thursday 30 July 2020	Thursday 24 September 2020	Thursday 29 October 2020	Thursday 26 November 2020	Thursday 28 January 2021	Thursday 25 March 2021
Non-executive directors											
Prof Sue Proctor (Chair)	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Baker	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Grantham	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Marran	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cleveland Henry	10	✓	✓	✓	✓	-	✓	✓	✓	✓	✓
Sue White	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Wright	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive directors											
Sara Munro	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joanna Forster Adams	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Dawn Hanwell	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Holmes	10	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Hosker	5						✓	✓	✓	✓	✓
Claire Kenwood	5	✓	✓	✓	✓	-					
Cathy Woffendin	10	✓	✓	-	✓	✓	-	✓	✓	✓	✓

✓ Shows attendance
\- Indicates those Board members who sent apologies during 2020/21
Indicates when a Board member was not eligible to attend the meeting.

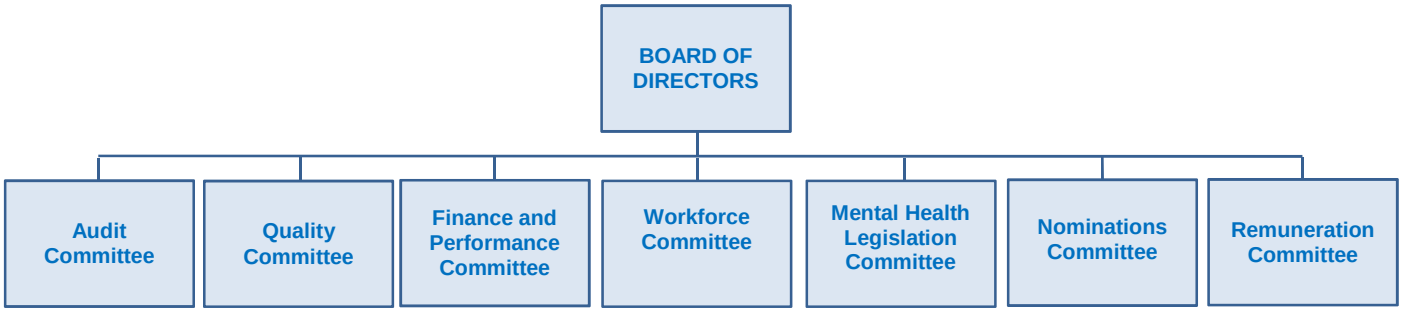
3.5 EVALUATION OF THE BOARD OF DIRECTORS

3.5.1 The Board of Directors and members of the Board

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

3.5.2 Board sub-committees

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



Evaluation of the Board sub-committees is carried out using an internal evaluation questionnaire. The Audit Committee is also evaluated using the HFMA (Healthcare Financial Management Association's) NHS Audit Committee Effectiveness Checklist. The outcome is reviewed by the committee and a report on any proposed changes that may be required is made to the Board of Directors by the chair of the committee. If required the Terms of Reference would be changed and ratified by the Board.

3.6 THE AUDIT COMMITTEE

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

The Audit Committee seeks high-level assurance and provides an independent and objective review on the effectiveness of our governance (corporate and clinical), health and safety and risk management processes and it assures the Board of Directors in respect of internal controls. It receives assurance from executive directors and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit and External Audit, again through reports and attendance by key personnel at its meetings to present papers on specific matters. Assurance is also 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 2020/21 the following members served on the committee as substantive members: Martin Wright, who was the chair of the committee, Helen Grantham and Cleveland Henry.

The other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it is appropriate, with the Chair of the Trust and the Chief Executive being invited to attend the Audit Committee on an annual basis; in 2020/21 Prof Sue Proctor attended the meeting in October 2020 and Dr Sara Munro attended the meeting in June 2020.

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 2020/21 and attendance by each non-executive director member.

Table 3B – Attendance at Audit Committee meetings in 2020/21

Name	Tuesday 21 April 2020	Monday 15 June 2020	Tuesday 21 July 2020	Tuesday 20 October 2020	Tuesday 19 January 2021
Substantive non-executive director members					
Martin Wright (chair of the committee)	✓	✓	✓	✓	✓
Helen Grantham	✓	✓	✓	✓	✓
Cleveland Henry	✓	✓	✓	✓	-

During 2020/21 the Audit Committee fulfilled the role of the primary governance and assurance committee and carried out its role primarily through:

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

At its June 2020 meeting the committee reviewed the Annual Report, Annual Accounts, the Annual Governance Statement and the Head of Internal Audit Statement for 2019/20. It was assured in relation to each of these documents and recommended to the Board that they should be adopted.

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

www.leedsandyorkpft.nhs.uk

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

SECTION 4 – THE COUNCIL OF GOVERNORS

4.1 COMPOSITION OF THE COUNCIL OF GOVERNORS

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

NHS Improvement requires each foundation trust to have a Lead Governor. Peter Webster 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 2020/21 two amendments were made to the composition of seats within our Council of Governors. Both amendments were in respect of the Appointed Governors that sit on the Council of Governors. The first amendment made was to the constituency names of two of our partner organisations. In 2019/20, Tenfold and PSI-Volition merged to become a single charity, Volition Leeds. The Trust now has two appointed governors from Volition Leeds. This amendment was approved by the Council of Governors in November 2020. The second amendment made was the removal of the appointed governor seat left vacant by Equitix Ltd (our PFI partner). In February 2021, the Council of Governors agreed that the Equitix seat should be replaced by a seat for the Director for Children and Families Programme within the West Yorkshire and Harrogate ICS. The rationale for this was to further enhance the partnership working arrangements between the Trust and the West Yorkshire and Harrogate ICS and to bring to the Council knowledge and expertise in the area of children at a point where the Trust was about to take over the Tier 4 inpatient CYPMHS services in Leeds and establish a new CYPMHS unit on the St Mary's Hospital site.

The composition ensures the Council is representative of our members and the public. Table 4A shows the composition of seats within our Council of Governors.

Table 4A – Composition of our Council of Governors

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

Governors are either elected or appointed to seats on the Council of Governors for a period of up to three years. Elected governors consist of public, service user, carer, and staff (clinical and non-clinical) governors. Appointed governors are nominated individuals from partner organisations. Elected governors can stand to be re-elected for three terms of office holding a seat for up to a maximum of nine-years. Elections are carried out in accordance with the election rules in Annex 5 of our Constitution. Further details about the elections we have held during 2020/21 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 2020/21.

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
Sophia Bellas**	Service User: Leeds	3 years	09.10.20	09.10.23	1st
Caroline Bentham**	Carer: Leeds	3 years	09.10.20	09.10.23	1st
Peter Chapman*	Service User: Leeds	3 years	20.03.20	02.02.21	1st
Mark Clayton	Carer: Leeds	3 years	20.03.20	19.03.23	1st
Rita Dawson**	Service User: Leeds	3 years	09.10.20	09.10.23	1st
Les France	Public: Leeds	3 years	22.08.16	23.07.22	2nd
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	09.10.23	2nd
Ivan Nip	Public: Leeds	3 years	30.04.18	29.04.21	1st
David O'Brien**	Public: York and North Yorkshire	3 years	09.10.20	09.10.23	1st
Sally Rawcliffe-Foo**	Staff: Clinical	3 years	25.09.17	09.10.23	2nd
Adam Seymour*	Staff: Clinical	3 years	20.03.20	18.02.21	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 2020/21, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2020/21

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 Rebecca Charlwood*	Leeds City Council	3 years	03.02.20	01.02.21	1st
Helen Kemp**	Volition - Leeds (mental health representative)	3 years	08.11.17	07.11.23	2nd
Councillor Anna Perrett	City of York Council	3 years	23.05.19	22.05.22	1st

Sue Rumbold**	Director for Children and Families Programme, West Yorkshire and Harrogate ICS**	3 years	22.02.21	22.02.24	1st
Tina Turnbull**	Volition - Leeds (learning disabilities representative)	3 years	02.06.20	02.06.23	1st

* Indicates those governors who stepped down early during 2020/21, before the end of their term of office
** Indicates those governors who were re-appointed or newly appointed part-way through 2020/21

4.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2020/21 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: Peter Chapman, Cllr Rebecca Charlwood, Gill Galea and Adam Seymour.

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 2020/21 we held one round of elections in autumn 2020.

4.2.1.1 Elections held in autumn 2020

During autumn 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 4D – Seats included in the autumn 2020 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	1
Public	York and North Yorkshire	1
Carer	Leeds	2
Carer	York and North Yorkshire	1
Service user	Leeds	1
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 on 24 July 2020 and concluded on 9 October 2020. We were successful in filling seats as follows:

Table 4E – Elected unopposed

Name	Constituency elected to:
Sophia Bellas	Service User: York and North Yorkshire
Caroline Bentham	Carer: Leeds
David O'Brien	Public: York and North Yorkshire
Sally Rawcliffe-Foo	Staff: Clinical

For the Service User: Leeds and Public: Leeds constituencies we had more people stand than seats available and so we had to hold a ballot. The following governors were elected by ballot and turnout was 4% for Public: Leeds and 7% for Service User: Leeds.

Table 4F – Elected by ballot

Name	Constituency elected to:
Rita Dawson	Service User: Leeds
Kirsty Lee	Public: Leeds

At the end of the election we still had vacancies in the constituencies of Carer: Leeds (one seat), Carer: York and North Yorkshire (one seat), Service user and Carer: Rest of UK (one seat) and Staff: clinical.

4.2.1.2 Elections held in spring 2021

In spring 2021 an election to the Council of Governors began. 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 2021 election

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

This round of elections commenced on the 16 February 2021 and will conclude on the 6 May 2021. The results of the election will be included in the 2021/22 Annual Report.

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 2020/21 there were three changes to our appointed governors. Councillor Rebecca Charlwood (Leeds City Council) stepped down during her first term of office. Tina Turnbull and Sue Rumbold both 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 2020/21 the Council of Governors had three formal business meetings. The Council of Governors' meeting in May 2020 was cancelled due to the coronavirus pandemic. Governors were invited to two informal meetings in May 2020 and June 2020 and were invited to submit questions for these informal meetings. Governors have received regular communications throughout the pandemic. The three business meetings of the Council of Governors were held virtually 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. Members of the public were not invited to attend the meetings but were invited to submit questions. Video recordings of the meetings were published on the Trust's website within one week of the meeting.

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

www.leedsandyorkpft.nhs.uk

The governors also hold an Annual Members' Meeting. This was held in November 2020 and was held virtually 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. This is a public meeting and members are encouraged to attend to hear more about the work of the Trust and the Council of Governors.

Table 4H below details the number of meetings attended by each governor during 2020/21, including the Annual Members' Meeting.. 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 4H – Number of meetings attended by each governor

			COUNCIL BUSINESS MEETINGS ATTENDED			ATTENDANCE AT THE ANNUAL MEMBERS MEETING
Name	**Appointed (A) or elected (E)**	Number of business meetings eligible to attend	**7 July 2020**	**5 November 2020**	**2 February 2021**	**5 November 2020**
Marc Pierre Anderson	E	1	-			
Sophia Bellas**	E	2		✓	-	✓
Caroline Bentham**	E	2		✓	✓	✓
Peter Chapman*	E	2	✓	✓		✓
Councillor Rebecca Charlwood*	A	2	-	-		-
Mark Clayton	E	3	✓	-	✓	✓
Rita Dawson**	E	2		✓	✓	✓
Les France	E	3	-	✓	✓	✓
Gill Galea	E	1	✓			
Ruth Grant	E	3	✓	✓	✓	✓
Steve Howarth	E	3	✓	✓	✓	-
Peter Holmes	E	3	-	✓	✓	✓
Andrew Johnson	E	3	✓	✓	✓	✓
Helen Kemp**	A	3	✓	✓	✓	✓
Mussarat Khan	E	3	-	✓	-	✓
Sarah Layton	E	3	-	✓	-	✓
Kirsty Lee**	E	3	✓	-	-	✓
Ivan Nip	E	3	-	✓	✓	✓
David O'Brien**	E	2		-	✓	-
Councillor Anna Perrett	A	3	✓	✓	✓	✓
Sally Rawcliffe-Foo**	E	3	✓	-	✓	✓
Sue Rumbold**	A	0				
Adam Seymour*	E	3	-	-	-	✓
Ann Shuter	E	3	✓	✓	-	✓
Niccola Swan	E	3	✓	✓	✓	✓
Tina Turnbull**	A	3	-	-	-	-
Peter Webster	E	3	✓	✓	✓	✓

✓ Shows attendance
\- Indicates those governors who sent apologies during 2020/21
* Indicates those governors who stepped down during 2020/21, 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 2020/21 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 observe a number of the Board sub-committee meetings and are encouraged to observe at least one public Board of Directors' meeting each year. This provides further opportunity for the governors to witness the NEDs holding the executive directors to account for the performance of the Trust.

The following table shows those Council meetings in 2020/21 that were attended by non-executive directors.

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

Name	7 July 2020	5 November 2020	2 February 2021
Prof Sue Proctor	✓	✓	✓
Prof John Baker	✓	✓	✓
Helen Grantham	✓	✓	✓
Cleveland Henry	✓	✓	-
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 2020/21 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 2021 the membership was 14,964. 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 2021

Public constituency	Number of members
Public: Leeds	7256
Public: York and North Yorkshire	1374
Public: Rest of England and Wales	1910
Total public members (including 57 members outside England and Wales)	**10597**

Service User and Carer constituency	Number of members
Service user: Leeds	496
Service user: York and North Yorkshire	80
Carer: Leeds	301
Carer: York and North Yorkshire	38
Service User and Carer: Rest of UK	89
Total service user and carer members (including 1 member unspecified)	**1005**

Staff constituency	Number of members
Clinical staff: Leeds and York & North Yorkshire	2550
Non-clinical staff: Leeds and York & North Yorkshire	812
Total staff members (including 0 unspecified)	**3362**

Membership has maintained steady at 14,964 as at 31 March 2021. These tables illustrate the breakdown, by constituency, of the total number of members.

5.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

Members of the public, staff, service users, their families and carers can join our Trust as a member. We are responsible for ensuring that our membership is representative of the people that the Trust could provide services to. The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, with no significant deficits.

A review of membership has been undertaken by the Trust and results from this confirmed that membership numbers remain high and representative. The Trust has reached a strong solid membership number; now the focus will be on developing a programme of engagement for members. Due to Covid-19, NHS Improvement and NHS England advised that membership engagement should be limited to Covid-19 purposes. As a result, the Trust has paused its membership development work and engagement with members will be reviewed in 2021/22.

5.4 MEMBERSHIP RECRUITMENT AND ENGAGEMENT

We value the contribution of our membership and our focus will be on qualitative rather than quantitative membership levels and engagement. The Council of Governors support planned development work of the membership database alongside the creation of an ongoing engagement programme. Due to Covid-19, NHS Improvement and NHS England advised that membership engagement should be limited to Covid-19 purposes. As a result, the Trust has paused its membership development work and engagement with members will be reviewed in 2021/22.

We have a varied approach to facilitating engagement between governors, members and the wider public. In particular, each year we hold our Annual Members Meeting. This not only incorporates the statutory annual meeting where the Council accounts for how it has carried out its duties on behalf of members, it also has an opportunity for a 'Big Conversation'. This is where members and the public can talk about their experience of our services both good and not so good which informs their role on the Council. Governors get the opportunity to meet with, talk to and hear from their constituents and the wider public. The Trust's Annual Members' Meeting was held virtually in 2020. In 2021/22 we will continue to ensure that our governors are central to this event which allows them to engage with a diverse group of people.

5.5 THE MEMBERSHIP OFFICE

The Membership Office is the initial point of contact for members to speak to someone within our Trust or with our governors. The office can be contacted by telephone on (0113) 8555900 or by email at ftmembership.lypft@nhs.net.

SECTION 6 – OUR AUDITORS

6.1 EXTERNAL AUDIT SERVICES

Our external audit service is provided by KPMG. They were appointed by our Council of Governors with effect from 1 October 2017 following a full tender process. Their tenure was initially for three years, this was extended by the Council for a further year until May 2021 and it was extended again for a further year until May 2022.

All members of the KPMG audit team are independent of the Board of Directors and of staff members. Each year the audit team provides a statement in support of the requirements for their objectivity and independence to the Audit Committee. The auditors provide audit services in accordance with the Code of Audit Practice. This covers the opinion on the annual accounts and work to be satisfied whether the Trust has proper arrangements to secure value for money.

The cost of independent audits during 2020/21 is detailed in the table below:

Table 6A – Cost of statutory audits

The Annual Accounts	£47,000
Value for Money	£10,000 *
TOTAL KPMG FEES	£57,000

* As a result of changes in the NAO Audit Code of Practice an additional fee of £10,000 has been added to reflect the additional responsibilities that KPMG are required to discharge in forming their value for money risk assessment and preparing the public commentary on the Trust's value for money arrangements.

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).

On 1 June 2019 the Trust became a formal member of Audit Yorkshire. This provides a direct cost benefit, in terms of a reduced day rate. It also has the benefit of 'buy-in' and ownership with the ability to shape coverage and direction of the service, and will contribute to the consolidation of back office functions which is in line with the Lord Carter and NHS Improvement recommendations.

The Internal Audit Team is led by Helen 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.

Audit Yorkshire provides services in line with the Public Sector Internal Audit Standards (April 2017). This was confirmed in the mandated external quality assessment in February 2020 where an outcome

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

During 2020/21 the internal audit plan has been kept under constant review as a result of the impact of the Covid-19 pandemic. All changes to the plan have been overseen by the Audit Committee and ‘Must Do’ audits for the purpose of the annual Head of Internal Audit Opinion were agreed. During 2020/21 some of the available audit days were used to support the Trust by completing advisory and benchmarking work. The key pieces of work were: Completion of Estates Issues Escalation Advisory Review; Health and Safety Benchmarking; Workforce Committee Benchmarking; and Clinical Supervision Data Analysis.

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

Opinion

We have audited the financial statements of Leeds and York NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006 and the Department of Health and Social Care Group Accounting Manual 2020/21.

Basis for opinion

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

Going concern

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

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance as a result of the need to achieve control totals delegated to the Trust by NHS Improvement.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition and the risk that Trust management may be in a position to make inappropriate accounting entries.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals.

We did not identify any additional fraud risks.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals posted by the Chief Financial Officer and Deputy and unusual cash journals
- Assessing significant estimates for bias.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements.
- Reviewing the completeness of information provided by the Trust as part of the 'NHS Agreement of Balances' exercise to ensure consistency with the information in the accounts.
- Sample testing expenditure transactions around the period end (including accruals), vouching to supporting external documentation to corroborate whether those items were recorded in the correct accounting period.

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors (as required by auditing standards), and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

Other information in the Annual Report

The Directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 71, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.

- any matters have been reported in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006 and the terms of our engagement by the Trust. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report, and the further matters we are required to state to them in accordance with the terms agreed with the Trust, and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.

Rashpal Khangura
for and on behalf of KPMG LLP
Chartered Accountants
Leeds

17 June 2021

FOREWORD TO THE ACCOUNTS

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2021, 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: 10 June 2021

STATEMENT OF COMPREHENSIVE INCOME AS AT 31 March 2021	note	**Year ended 31 March 2021** £000	Year ended 31 March 2020 £000
Operating income	2, 3 & 4	202,911	183,733
Operating expenses	2 & 5	(198,516)	(175,829)
OPERATING SURPLUS		**4,395**	**7,904**
FINANCE COSTS			
Finance income	10		544
Finance expense - financial liabilities	12	(4,022)	(4,025)
Finance expense - unwinding of discount on provisions	25	8	(5)
PDC dividend payable			(37)
Share of profit/(loss) of associates/ joint ventures			
NET FINANCE COSTS		**(4,014)**	**(3,523)**
Gains (losses) on disposal of assets	11	**(131)**	(4)
Surplus from operations		250	4,377
SURPLUS FOR THE YEAR		**250**	**4,377**
Other comprehensive income			
Items that will not be reclassified to income or expenditure:			
Revaluation gains and (impairment losses) on intangible assets		38	42
Revaluation gains and (impairment losses) on property, plant and equipment		(1,304)	2,076
Other comprehensive income for the year		**(1,266)**	**2,118**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**(1,016)**	**6,495**

The notes on pages 6 to 35 form part of this account.

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2021	note	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Non-current assets			
Intangible assets	13	600	864
Property, plant and equipment	14	54,159	43,522
Trade and other receivables	17	5,664	5,201
Total non-current assets		**60,423**	**49,587**
Current assets			
Inventories	16	20	5
Trade and other receivables	17	5,859	7,492
Non-current assets for sale	19		
Cash and cash equivalents	18	111,695	92,300
Total current assets		**117,574**	**99,797**
Current liabilities			
Trade and other payables	20	(28,152)	(14,698)
Borrowings	21	(2,208)	(2,038)
Provisions	25	(3,810)	(4,447)
Other liabilities	22	(7,766)	(3,422)
Total current liabilities		**(41,936)**	**(24,605)**
Total assets less current liabilities		**136,061**	**124,779**
Non-current liabilities			
Borrowings	21	(15,289)	(17,497)
Provisions	25	(5,543)	(2,237)
Total non-current liabilities		**(20,832)**	**(19,734)**
Total assets employed		**115,229**	**105,045**
Financed by (taxpayers' equity)			
Public dividend capital		30,932	19,732
Revaluation reserve		4,271	5,799
Other reserves		(651)	(651)
Income and expenditure reserve		80,677	80,165
Total taxpayers' equity		**115,229**	**105,045**

The notes on pages 6 to 35 form part of this account.

The accounts on pages 1 to 35 were approved by the Board on 10 June 2021 and signed on its behalf by:

Signed:  (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2020	19,732	5,799	(651)	80,165	105,045
Surplus for the year				250	250
Revaluation gains and impairment losses on intangible assets		38			38
Revaluation gains and impairment losses property, plant and equipment		(1,304)			(1,304)
Public dividend capital received	11,200				11,200
Transfers to the income and expenditure account in respect of assets disposed of		(3)		3	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(259)		259	
Movement in year subtotal	**11,200**	**(1,528)**		**512**	**10,184**
Taxpayers' equity at 31 March 2021	30,932	4,271	(651)	80,677	115,229

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 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

Description of Reserves:

a) Public dividend capital represents in substance, the Secretary of State for Health's 'equity' investment in the Trust. When the Trust's predecessor NHS Trust was established, the amount of PDC provided to it equated to the initial net assets of the Trust. The PDC balance is usually a constant amount but can change occasionally where the Trust receives additional PDC (usually to fund capital investment) or is asked to repay an element to the Secretary of State.

b) The revaluation reserve is used to record revaluation gains/losses and impairment reversals on property, plant and equipment that are recognised in other comprehensive income. An annual transfer is made from the reserve to retained earnings of amounts representing the excess of current cost depreciation over historic cost depreciation for each item of PPE. When an asset is sold or otherwise disposed of, any remaining revaluation reserve balance for the asset is transferred to Retained Earnings. The balance in the reserve is wholly in respect of property, plant and equipment.

c) Other reserves relates to the write off of an asset which was included in the original NHS Trust's asset base at inception.

d) The Trust's surplus or deficit for the year is recognised in the Income and Expenditure Reserve, together with any other gain or loss for the financial year that is not recognised in any other reserve.

The notes on pages 6 to 35 form part of this account.

STATEMENT OF CASH FLOWS AS AT 31 March 2021	note	Year ended 31 March 2021 £000	Year ended 31 March 20120 £000
Cash flows from operating activities			
Operating surplus from continuing operations		4,395	7,904
Operating surplus		**4,395**	**7,904**
Non-cash income and expense:			
Depreciation and amortisation	5	4,520	3,971
Impairments and reversals	14	620	(725)
(Increase)/decrease in trade and other receivables	17	1,145	23,333
(Increase)/decrease in inventories	16	(15)	22
Increase/(decrease) in trade and other payables	20	10,514	(4,269)
Increase/(decrease) in other liabilities	22	4,344	1,975
Increase/(decrease) in provisions	25	2,677	2,345
NET CASH GENERATED FROM OPERATIONS		**28,200**	**34,556**
Cash flows from investing activities			
Interest received	10	21	563
Purchase of intangible assets	13	(9)	(644)
Purchase of property, plant and equipment	14	(13,974)	(5,976)
Sales of property, plant and equipment			12
Net cash used in investing activities		**(13,962)**	**(6,045)**
Adjustment for net assets de-recognised on merger			
Cash flows from financing activities			
Public dividend capital received		11,200	151
Capital element of private finance initiative obligations	21	(2,024)	(1,868)
Interest element of private finance initiative obligations	12	(4,023)	(4,026)
PDC dividend (paid)/refunded		4	108
Cash flows from (used in) other financing activities			
Net cash used in financing activities		**5,157**	**(5,635)**
Increase/(decrease) in cash and cash equivalents		19,395	22,876
Cash and Cash equivalents at 1 April		92,300	69,424
Cash and Cash equivalents at 31 March		**111,695**	**92,300**

Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	2020/21 £000s	2019/20 £000s
(Increase)/decrease in receivables as per SOFP	1,170	23,497
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		
- Financing transactions	(25)	(164)
(Increase)/decrease in receivables adjusted for non-I&E items	1,145	23,333
Increase/(decrease) in payables per SOFP	13,454	(3,645)
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	(2,927)	(612)
- Financing transactions	(13)	(12)
Increase/(decrease) in payables adjusted for non-I&E items	10,514	(4,269)
Increase/(decrease) in Other Liabilities per SOFP	4,344	1,975
Adjustments for Other Liabilities movements not related to I&E:		
Increase/(decrease) in Other Liabilities adjusted for non-I&E items	4,344	1,975
Increase/(decrease) in provisions per SOFP	2,669	2,350
Adjustments for provisions movements:		
- Unwinding of discount on provisions	8	(5)
Increase/(decrease) in provisions for non I&E items	2,677	2,345
Opening capital payables	(1,236)	(624)
Closing capital payables	(4,163)	(1,236)
Change in capital payables in-year	**2,927**	**612**

The notes on pages 6 to 35 form part of this account.

Notes to the accounts

The principal activity of the Trust is to provide excellent quality mental health and learning disability care that supports people to achieve the very best that they can for their health and wellbeing. The Trust's registered address is 2150 Century Way, Thorpe Park, Leeds LS15 8ZB.

1 Accounting policies

NHS Improvement (NHSI), in exercise of the powers conferred has directed that the accounts of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2020/21 GAM issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), in accordance with EU endorsed IFRS and IFRIC, and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently, other than where new policies have been adopted, in dealing with items considered material in relation to the accounts.

In accordance with IAS1, the accounts are prepared on a going concern basis unless management either intends to apply to the Secretary of State for the dissolution of the NHS foundation trust without the transfer of the services to another entity, or has no realistic alternative but to do so.

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

1.1 Accounting convention

The accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment and intangible assets. For specialised operational property the modern equivalent asset valuation method has been used.

1.2 Segmental reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Board of Directors.

1.3 Expenditure on employee benefits

Short term employee benefits

Salaries, wages and employment related payments such as social security and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry-forward leave into the following year.

1.4 Pension costs

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

Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates payable by employers and employees.
The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have laid Scheme Regulations confirming an increase to the employer contribution rate to 20.68% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Employers and employee contribution rates may be varied from time to time, as above, to reflect changes in the scheme's liabilities. In 2017/18 employee contributions are tiered depending on salary and range from 5% to 14.5%. Employer contributions for 2020/21 were 20.68%, including the administration levy (20.68% in 2019/20).

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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 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 2020/21 the NHS pension scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

Annual Pensions

The annual pension under the 1995 section of the scheme is based on 1/80th of the best of the last three years pensionable pay for each year of service and for the 2008 section it is based on 1/60th of reckonable pay per year of membership. Further changes to the scheme came into effect from 1 April 2015, which mean that the scheme is now based on average salary rather than final salary, with an accrual rate of 1/54th.

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

Members who are practitioners as defined by the scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and from 2011/12, are based on changes in consumer prices (CPI) in the twelve months ending 30 September in the previous calendar year.

Ill-health retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity.

Death benefits

A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional voluntary contributions (AVCs)

Members can purchase additional service in the NHS pension scheme and contribute to money purchase AVC's run by the scheme's approved providers or by other free standing additional voluntary contribution (FSAVC) providers.

Transfer between funds

Scheme members have the option to transfer their pension between the NHS pension scheme and another scheme when they move into or out of NHS employment.

Preserved benefits

Where a scheme member ceases NHS employment with more than two years service, they can preserve their accrued NHS pension for payment when they reach retirement age.

1.4.1 Alternative pension scheme

From 1 August 2013 (deferred to 1 October 2013), Leeds and York Partnership NHS Foundation Trust offers an alternative pension scheme to all employees who are not eligible to be members of the NHS pension scheme at the Trust. This includes employees who are members of the NHS pension scheme through another role outside of the Trust and those that are not eligible to join the NHS pension scheme.

Every three years all eligible employees are auto-enroled in either the NHS or alternative pension scheme. The auto-enrolment exercise was carried out in October 2019 and following this process, all employees who meet the criteria for the alternative pension scheme are enroled each month on a continuous basis, unless they specifically opt out.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined minimum of 8% (with a minimum 3% being contributed by the Trust).

1.4.2 Civil Service Pension Scheme

One employee is a member of the Civil Service Pension Scheme, which is a defined benefit pension scheme administered by the Cabinet Office. Employee and employer contribution rates are based on employee salary band. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.civilservicepensionscheme.org.uk

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 2021 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.

Although there was valuation uncertainty due to Coronavirus at 31st March 2020, by 31st March 2021 this had lifted and there is no material uncertainty at this date.

1.6.3 Subsequent expenditure

Expenditure after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits or service potential expected to be obtained from the use of an item of property, plant and equipment, and where the cost can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement. The carrying amount of the part replaced is de-recognised.

1.6.4 Depreciation

Items of property, plant and equipment are depreciated, using the straight line method, over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is considered to have an indefinite life and is not depreciated.

Property, plant and equipment, which has been reclassified as 'held for sale' ceases to be depreciated upon reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

The useful economic lives of property, plant and equipment are estimated by Leeds and York Partnership NHS Foundation Trust as follows:

Plant and machinery	
• Short life engineering plant and equipment	5 years
• Medium life engineering plant and equipment	10 years
• Long life engineering plant and equipment	15 years
• Short life medical and other equipment	5 years
• Medium life medical equipment	10 years
• Long life medical equipment	15 years
Transport	
• Vehicles	7 years
Furniture and fittings	
• Furniture	10 years
Information technology	
• Office and IT equipment	2 years
• Mainframe type IT installations	10 years

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the Trust's professional independent valuers. The assessed lives of the individual building elements may vary. Leaseholds are depreciated over the primary lease term.

Equipment is depreciated on current cost evenly over the estimated life of the asset.

1.6.4 Depreciation (continued)
The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from it. This period is specific to the foundation trust and may be shorter than the physical life of the asset itself.

Assets held under finance leases (including leased land) are depreciated over the shorter of their estimated useful economic lives or the lease period. Where the Trust will, or is reasonably certain to, acquire ownership of the asset at the end of the lease, the asset is depreciated over its useful economic life.

Estimated useful lives and residual values are reviewed each year end, with the effects of any changes recognised on a prospective basis.

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

At the end of each reporting period, a transfer is made from the revaluation reserve to the income and expenditure reserve, in respect of the difference between the depreciation expense on the revalued asset and the depreciation expense based on the assets historic cost carrying value.

1.6.5 Revaluation and Impairment
Increases in asset values arising from revaluations are taken to the revaluation reserve except where, and to the extent they, reverse an impairment for the same asset previously recognised in operating expenses. In this case they are recognised in operating income.

Impairments, that arise from a loss of economic benefit or service potential, are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the income and expenditure reserve for the amount of the impairment (or the remaining balance in the revaluation reserve relating to the asset if this is a lower amount).

Decreases in asset values and all other impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter, are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of “other comprehensive income”.

At each reporting period end, the Trust checks whether there is any indication that any of its property, plant or equipment has suffered an impairment loss. If there is an indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

1.6.6 Non-current assets held for sale
Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use.

Assets intended for disposal are reclassified as ‘held for sale’ once all of the following criteria are met.

- the asset is available for immediate sale in its present condition subject only to terms, which are usual and customary for such sales;

- the sale must be highly probable, i.e. management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as ‘held for sale’; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Fair value is open market value including alternative uses. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount.

Assets are de-recognised when all material sale contract conditions have been met. The non-current assets held for sale are identified in note 19.

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

Property, plant and equipment, which is to be scrapped or demolished, does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with HM Treasury's FReM.

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

a) Payment for the fair value of services received (including lifecycle costs);
b) Payment for the PFI asset, comprising finance costs and the repayment of the liability; and
c) Operating lease for the land.

a) Services received

The fair value of service received in the year is recorded under the relevant expenditure heading within operating expenses.

Leeds and York Partnership NHS Foundation Trust has adopted the approach that we incur the lifecycle costs evenly over the contract period as part of the unitary payment. This is due to the nature of the costs involved.

b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to 'fair value' by the District Valuer in accordance with the principles of HM Treasury's FReM. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16. From 31 March 2018, PFI assets are

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 -0.95% (-0.5% in 2019/20) in real terms. The discount rate for other provisions varies depending on the timing of the liability from -0.02% (up to 5 years), 0.18% (5 - 10 years) and 1.99% over 10 years (in 2019/20 the discount rates were 0.51%, 0.55% 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.

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 2020-21. 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 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. 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 2022 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 and Social care’s Resource Accounting Boundary and transfers of functions involving local government bodies.

1.27 Investment in associates

Associate entities are those over which the Trust has the power to exercise a significant influence. Associate entities are recognised in the Trust’s financial statements using the equity method of accounting. The investment is initially recognised at cost. It is increased or decreased subsequently to reflect the Trust’s share of the entity’s profit or loss or other gains and losses (eg revaluation gains on the entity’s property, plant and equipment) following acquisition. It is also reduced when any distribution of gainshare is received by the Trust.

Associates which are classified as held for sale are measured at the lower of their carrying amount and fair value less costs to sell.

Leeds and York Partnership NHS Foundation Trust is a 25% partner in the Collaborative Procurement Partnership LLP (CPP LLP), with 3 other NHS foundation trusts. The partnership was registered at Companies House on 18 January 2017 and began implementation on 8 November 2017, following a successful tender process to deliver services to the Department of Health and Social Care from 8 May 2018. For the year ended 31 March 2021 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 Group (CCG) for 55% of its income (58% in 2019/20). 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 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000	**£000**	£000
Income by segment						
Income from activities	**173,283**	157,294			**173,283**	157,294
Other operating income	**19,025**	15,755	**10,603**	10,684	**29,628**	26,439
TOTAL INCOME	**192,308**	173,049	**10,603**	10,684	**202,911**	183,733
TOTAL EXPENDITURE	**(188,167)**	(165,562)	**(10,349)**	(10,267)	**(198,516)**	(175,829)
Operating surplus	**4,141**	7,487	**254**	417	**4,395**	7,904
Non Operating Income and Expenditure Total	**(4,145)**	(3,527)			**(4,145)**	(3,527)
Surplus/(Deficit) from continuing operations	**(4)**	3,960	**254**	417	**250**	4,377

a) Income includes £178m (£162m in 2019/20) from NHS organisations (primarily £112m from Leeds CCG and £42m from NHS England).

b) Expenditure includes employee expenses £140,798k (£127,002k in 2019/20), premises £6,716k (£5,715k in 2019/20), depreciation and amortisation £4,520k (£3,971k in 2019/20) and establishment £1,749k (£2,392k in 2019/20).

3 Revenue from patient care activities

	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Clinical Commissioning Groups and NHS England	**162,309**	146,993
Foundation Trusts	**234**	197
Local Authorities	**43**	50
NHS other	**1,201**	445
Non-NHS:		
Income for social care clients	**9,393**	9,061
Other	**103**	548
Total revenue from patient care activities	**173,283**	157,294

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 2021 £000	Year ended 31 March 2020 £000
Research and development	**2,110**	1,983
Education and training	**4,651**	4,248
Non-patient care services to other bodies	**1,327**	1,359
Provider sustainability fund		2,241
Reimbursement and Top Up Funding	**6,218**	
Contributions to expenditure donated from DHSC bodies for COVID	**2,944**	
Other income:		
Inter NHS Foundation Trust	**1,005**	1,966
Inter NHS Trust	**1,033**	941
Inter RAB	**3,423**	7,917
Inter Other WGA bodies	**230**	179
Other (outside WGA)	**5,625**	4,391
Income in respect of staff costs where accounted on gross basis	**1,062**	1,214
Total Other Operating Revenue	**29,628**	26,439

5 Operating expenses	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Purchase of healthcare from NHS and DHSC bodies	**262**	1,983
Purchase of healthcare from non-NHS and non-DHSC bodies	**11,774**	9,067
Purchase of social care	**638**	525
Staff and executive directors costs	**140,798**	127,002
Non-executive directors	**208**	219
Supplies and services – clinical (excluding drugs costs)	**2,128**	1,273
Supplies and services – clinical: utilisation of consumables donated from DHSC group bodies for COVID response	**2,928**	
Supplies and services - general	**2,146**	1,628
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold	**16**	
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**1,742**	1,861
Consultancy		61
Establishment	**1,749**	2,392
Premises - business rates collected by local authorities	**1,030**	988
Premises - other	**5,686**	4,727
Transport (business travel only)	**256**	1,095
Transport - other (including patient travel)	**883**	713
Depreciation	**4,255**	3,757
Amortisation	**265**	214
Impairments net of (reversals)	**620**	(725)
Increase/(decrease) in impairment of receivables	**64**	226
Provisions arising / released in year	**2,789**	2,432
Change in provisions discount rate	**47**	83
Audit services - statutory audit	**68**	56
Other auditor remuneration (payable to external auditor only)		1
Internal audit - non-staff	**110**	86
Clinical negligence - amounts payable to NHS Resolution (premium)	**372**	299
Legal fees	**651**	376
Insurance	**159**	116
Research and development - non staff	**2,375**	2,106
Education and training - non staff	**882**	993
Education and training - notional expenditure funded from apprenticeship fund	**191**	177
Operating lease expenditure (net)	**1,458**	1,372
Early retirements - non staff	**10**	11
Redundancy costs - non staff		20
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis	**7,840**	7,708
Car parking and security	**183**	141
Other losses and special payments - non staff	**77**	18
Other	**3,856**	2,828
Total operating expenditure	**198,516**	175,829

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 £57k for 2020/21 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 assurance services relating to the Quality Report £0k (£1k in 2019/20).

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Financial Audit	**57**	47
Other audit remuneration - audit related assurance services (Quality report)		1
Total	**57**	48

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 2021 £000**	Year ended 31 March 2020 £000
Minimum lease payments	**1,458**	1,372
Sub-lease payments		
	1,458	1,372

Total future minimum lease payments	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Not later than one year	**1,256**	1,247
Between one and five years	**771**	745
After 5 years		
Total	**2,027**	1,992

Notes to the accounts

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2021			Year Ended 31 March 2020		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**104,981**	**93,700**	**11,281**	96,238	85,264	10,974
Social security costs	**9,835**	**9,835**		8,836	8,836	
Employer contributions to NHS pension scheme	**12,819**	**12,819**		11,848	11,848	
Agency staff	**7,346**		**7,346**	5,600		5,600
Employee benefits expense	**134,981**	**116,354**	**18,627**	122,522	105,948	16,574

There were no employee benefits paid in the year ended 2020/21 (£nil in 2019/20)

In addition to the above:		
Charged to capital		(617)
Employer contributions to NHS pension scheme paid by NHSE	**5,593**	5,172
Apprentice Levy	**493**	453
Recharged income	**(269)**	(528)
Total employee costs	**140,798**	127,002

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 2021	Year Ended 31 March 2020
Directors' remuneration	**£000**	£000
Aggregate emoluments to Executive Directors	**841**	760
Remuneration of Non-Executive Directors	**207**	219
Pension cost	**99**	90
Additional Pension cost covered by NHS E	**43**	39
	1,190	1,108

Remuneration of Non-Executives include MH Act Managers £64k (£75k in 2019/20).

7.2 Monthly average number of people employed (wte)

	Year Ended 31 March 2021			Year Ended 31 March 2020		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**204**	**185**	**19**	203	186	17
Administration and estates	**679**	**636**	**43**	631	593	38
Healthcare assistants and other support staff	**879**	**611**	**268**	815	571	244
Nursing, midwifery and health visiting staff	**811**	**763**	**48**	776	730	46
Scientific, therapeutic and technical staff	**344**	**341**	**3**	327	323	4
Social care staff	**23**	**23**		14	14	
Total	**2,940**	**2,559**	**381**	2,766	2,417	349

8 Retirements due to ill-health

During 2020/21 there were 3 (0 in 2019/20) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £294k (£0 in 2019/20). 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 2021		Year Ended 31 March 2020	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**22,911**	**69,178**	22,335	56,344
Total Non-NHS trade invoices paid within target	**22,266**	**66,307**	21,546	53,892
Percentage of Non-NHS trade invoices paid within target	**97%**	**96%**	96%	96%
Total NHS trade invoices paid in the year	**535**	**7,589**	1,174	8,860
Total NHS trade invoices paid within target	**481**	**6,424**	1,089	8,278
Percentage of NHS trade invoices paid within target	**90%**	**85%**	93%	93%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Notes to the accounts

10 Finance Income

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Bank accounts		544
Total		544

This figure includes accrued interest of £0k (2019/20 £21k).

11 Other gains and losses

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Gain on disposal of property, plant and equipment		1
Loss on disposal of property, plant and equipment	**(85)**	(1)
Loss on disposal of intangible assets	**(46)**	(4)
Total	**(131)**	(4)

12 Finance costs

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Interest on obligations under finance leases		
Interest on obligations under PFI contracts:		
- main finance cost	**1,497**	1,654
- contingent finance cost	**2,525**	2,371
Total	**4,022**	4,025

13 Intangible assets

2020/21:	Computer software - purchased £000	2019/20:	Computer software - purchased £000
Gross valuation at 1 April 2020	1,138	Gross valuation at 1 April 2019	578
Additions purchased		Additions purchased	632
Additions work in progress	9	Additions work in progress	
Disposals other than by sale	(186)	Disposals other than by sale	(9)
Impairments		Impairments	
Reclassifications		Reclassifications	
Revaluation/indexation	(18)	Revaluation/indexation	(63)
Gross valuation at 31 March 2021	**943**	**Gross valuation at 31 March 2020**	**1,138**
Accumulated amortisation at 1 April 2020	274	Accumulated amortisation at 1 April 2019	143
Disposals other than by sale	(140)	Disposals other than by sale	(5)
Revaluation	(56)	Revaluation	(105)
Impairments		Impairments	27
Charged during the year	265	Charged during the year	214
Accumulated amortisation at 31 March 2021	**343**	**Accumulated amortisation at 31 March 2020**	**274**
Net book value		**Net book value**	
Purchased	600	Purchased	864
Total at 31 March 2021	**600**	**Total at 31 March 2020**	**864**

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 2020/21 for the software licences and this led to an impairment charge to operating expenses of £0k (impairment charge of £27k in 2019/20).

Notes to the accounts

14. Property, plant and equipment

2020/21:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2020	1,878	33,939	2,077	961	321	10,524	1,042	50,742
Additions purchased			15,820	46	180	794	61	16,901
Additions donated								
Reclassifications		1,940	(2,011)			71		
Reclassified as held for sale								
Disposals						(1,578)		(1,578)
Revaluation/indexation (losses)/gains	(28)	(4,741)		(13)	20		7	(4,755)
Impairments			(13)	(1)				(14)
Reversal of Impairments							1	1
At 31 March 2021	**1,850**	**31,138**	**15,873**	**993**	**521**	**9,811**	**1,111**	**61,297**
Accumulated depreciation at 1 April 2020		275		834	240	5,368	503	7,220
Disposals						(1,493)		(1,493)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(3,454)		(12)	11		4	(3,451)
Impairments		607						607
Reversal of Impairments								
Charged during the year		2,864		33	22	1,259	77	4,255
Accumulated depreciation at 31 March 2021		**292**		**855**	**273**	**5,134**	**584**	**7,138**
Net book value								
Total at 31 March 2021	**1,850**	**30,846**	**15,873**	**138**	**248**	**4,677**	**527**	**54,159**
Asset financing								
Owned	1,850	20,861	15,873	138	248	4,677	527	**44,174**
PFI		9,974						**9,974**
Donated		11						**11**
Total at 31 March 2021	**1,850**	**30,846**	**15,873**	**138**	**248**	**4,677**	**527**	**54,159**

The latest revaluation of land and buildings was carried out by the Valuation Office with an effective date of 31 March 2021.

Specialist land and buildings in operational use are valued at Depreciated Replacement Cost (DRC), using a Modern Equivalent Asset basis (MEA). The MEA basis includes consideration of modern building techniques, occupancy rates, service delivery output and alternative site as required.

Non specialist land and buildings in operational use are valued at open market value, assuming existing use.

The Foundation Trust's property, plant and equipment are held for service delivery, rather than for cash generating purposes. Consequently, in accordance with the DH GAM, the "value in use" is assumed to be at least equal to the cost of replacing the service potential provided by the asset unless there has been a reduction in service potential. When measuring impairments, the recoverable amount for operational properties is considered to be the value in use rather than the "fair value less costs to sell".

There are no restrictions imposed on the use of donated assets.

14.1 Property, plant and equipment - prior year

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**

Notes to the accounts - 14. Property, plant and equipment (continued)

14.2 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Loss or damage from normal operations		
Abandonment of assets in course of construction	**13**	2
Over specification of assets		
Changes in Market Place	**608**	29
Reversals of impairments	**(1)**	(756)
At 31 March	**620**	(725)

15 Capital commitments

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

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Property, plant and equipment	**3,020**	15,819
Total	**3,020**	15,819

This includes a new building for Child & Adolescent Mental Health Services at St Mary's Hospital £2,996k (£15,541k 2019/20).

16 Inventories

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Energy, consumables and work in progress	**20**	5
Total	**20**	5
Of which held at net realisable value:	**20**	5

16.1 Inventories recognised in expenses

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Inventories recognised as an expense in the year	**23**	39
Total	**23**	39

Notes to the accounts

17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Trade Receivables				
Contract receivables	**2,970**	2,371		
Accrued Income	**1,516**	4,195		
Allowance for impaired contract receivables	**(780)**	(716)		
Prepayments	**1,315**	945	**5,393**	4,970
PDC Receivable		4		
VAT	**497**	420		
Other receivables	**341**	273	**271**	231
Total	**5,859**	7,492	**5,664**	5,201

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 2021 £000	Year ended 31 March 2020 £000
By up to three months	**508**	455
By three to six months	**10**	47
Over six months	**(207)**	215
Total	**311**	717

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 2021 £000	Year ended 31 March 2020 £000
Balance at 1 April	**716**	497
Amount written off during the year		(7)
Increase/(decrease) in receivables impaired	**64**	226
Balance at 31 March	**780**	716

The provision for impairment of receivables for the year ended 31 March 2021 has increased/decreased after taking all factors into consideration regarding the potential for recovery.

18 Cash and cash equivalents

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Balance at 1 April	**92,300**	69,424
Net change in year	**19,395**	22,876
Balance at 31 March	**111,695**	92,300
Made up of		
Cash with Government Banking Service	**111,570**	92,140
Commercial banks and cash in hand	**125**	160
Cash and cash equivalents as in statement of financial position	**111,695**	92,300
Cash and cash equivalents as in statement of cash flows	**111,695**	92,300

Notes to the accounts

19 Non-current assets held for sale

At 31 March 2021 there are no assets held for sale (Nil in 2019/20).

20 Trade and other payables

	Current	
	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Trade payables	**7,254**	4,476
Amounts due to other related parties		
Non NHS trade payables - capital	**4,163**	1,236
Accruals	**12,191**	8,958
Other	**4,544**	28
Total	**28,152**	14,698

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
PFI liabilities	**2,208**	2,038	**15,289**	17,497
Total	**2,208**	2,038	**15,289**	17,497

22 Other liabilities

	Current	
	Year ended 31 March 2021	Year ended 31 March 2020
	£000	£000
Deferred Income	**7,766**	3,422
Total	**7,766**	3,422

23 Finance lease obligations

There are no current finance leases in operation.

Notes to the accounts

24 Private Finance Initiative (PFI) contracts

PFI schemes on-Statement of Financial Position

The PFI contract is for the provision of seven mental health units, providing a comprehensive range of mental health services. The estimated capital value of the PFI scheme is £43,778k. The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028. The Trust has the right to purchase the units at market value at the end of the contract.

More detail is provided in the PFI accounting policy in note 1.7

Minimum amounts payable under the contract:

Asset financing component	**Gross Payments**		**Present value of payments**	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Not later than one year	**6,060**	5,906	**5,834**	5,685
Later than one year, not later than five years	**24,241**	23,623	**19,619**	19,119
Later than five years	**8,080**	13,780	**5,401**	8,898
Sub total	**38,381**	43,309	**30,854**	33,702
Less: finance cost attributable to future periods	**(20,884)**	(23,774)	**(13,357)**	(14,167)
Total	**17,497**	19,535	**17,497**	19,535

Services component	**Gross Payments**	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Not later than one year	**6,812**	6,639
Later than one year, not later than five years	**27,249**	26,555
Later than five years	**9,083**	15,490
Total	**43,144**	48,684

The future services amounts due as at 31 March 2021 reflect an adjustment for the RPI indexation of the unitary payment applied during 2020/21.

The amount charged to operating expenses during the year in respect of services was £6,754k (2019/20 £6,606k).

24.1 Analysis of amounts payable to service concession operator

	Gross Payments	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Unitary payment	**14,332**	14,007
Consisting of:		
- Interest charge	**1,497**	1,654
- Repayment of finance lease liability	**2,038**	1,881
- Service element and other charges to operating expenses	**7,108**	6,950
- Capital lifecycle maintenance		
- Revenue lifecycle maintenance	**732**	758
- Contingent rent	**2,525**	2,371
- Addition to lifecycle prepayment	**422**	393
Total	**14,322**	14,007

The addition to lifecycle prepayment relates to a rent free period at the end of the contract £422k (£393k 2019/20). Service element and other charges to operating expenses includes the operating lease payments for the land element of the properties £424k (£414k 2019/20).

25 Provisions

	Current		Non-current	
	Year ended 31 March 2021	Year ended 31 March 2020	**Year ended 31 March 2021**	Year ended 31 March 2020
	£000	£000	**£000**	£000
Pensions relating to other staff	**147**	146	**1,464**	1,481
Legal claims	**79**	100		
Redundancy	**2,668**	3,171		
Other	**916**	1,030	**4,079**	756
Total	**3,810**	4,447	**5,543**	2,237

	Pensions relating to other staff	**Legal claims**	**Redundancy**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**
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
At 1 April 2020	1,627	100	3,171	1,786	6,684
Arising during the year	97	59	131	3,301	3,588
Change in discount rate	47				47
Used during the year	(147)	(52)			(199)
Reversed unused	(5)	(28)	(634)	(92)	(759)
Unwinding of discount	(8)				(8)
At 31 March 2021	**1,611**	**79**	**2,668**	**4,995**	**9,353**
Expected timing of cash flows:					
Between 1 April 2021 and 31 March 2022	147	79	2,668	916	3,810
Between 1 April 2022 and 31 March 2026	588			3,808	4,396
Thereafter	876			271	1,147
TOTAL	**1,611**	**79**	**2,668**	**4,995**	**9,353**

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 £0k (£29k 2019/20).

Other provisions comprise the commitment placed on the Trust in ensuring it meets its obligations in respect of dilapidation costs £645k (£645k 2019/20), IT software contracted out services vat £435k (£466k 2019/20), Pension Final Pay Controls £336k (£336k 2019/20), Pension Annual Allowance (as per national guidance) £271k (£231k 2019/20) and leases £109k (£109k 2019/20). There is a new provision of £3,200k in relation to the compensation on termination due for exiting one of the PFI properties.

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.

£9,856k is included in the provisions of the NHS Litigation Authority at 31 March 2021 in respect of the clinical negligence liabilities of the Trust (31 March 2020 £8,438k).

26 Contingent liabilities

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Other	**51**	40
Total	**51**	40

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 - £51k in 2020/21 and £40k in 2019/20). 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	6,354
Cash at bank and in hand	92,300
Total at 31 March 2020	98,654
Receivables	**4,318**
Cash at bank and in hand	**111,695**
Total at 31 March 2021	**116,013**

Ageing of over due receivables included in Financial Assets

Receivables overdue by:	
1-30 days	**92**
31-60 days	**142**
61-90 days	**10**
91-180 days	**36**
Greater than 180 days	**(185)**
	95

27.2 Financial liabilities - carrying amount

	£000
Embedded derivatives	
Payables	14,698
PFI and finance lease obligations	19,535
Provisions under contract	5,987
Total at 31 March 2020	40,220
Embedded derivatives	
Payables	**25,354**
PFI and finance lease obligations	**17,497**
Provisions under contract	**8,647**
Total at 31 March 2021	**51,498**

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 2021 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 2020/21 the percentage increase in the unitary payment was 2.61%, equalling a monetary increase of £182k (2.37%, £155k in 2019/20).

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%.

2020/21 Uplift in unitary payment	**Actual uplift at 2.61%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	(3)	62	168
Recognised in operating expenses	185	261	388
Recognised in surplus/deficit	182	323	556
	182	323	556
Net impact of sensitivities on surplus/(deficit)		**(141)**	**(374)**

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)**

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 2020/21, 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 (2020/21)	**240**	**78**	**22**	**46**
University of Leeds (2019/20)	273	58	10	51

In 2020/21, the Trust had £4k of related party transactions with its charitable fund (2019/20 £4k).

28.2 Related party transactions - commitments (year ended 31/3/2022)

	Income £000
Leeds Clinical Commissioning Groups	114,254
NHS England	39,295
	153,549

These commitments are material transactions relating to NHS bodies. The figures are draft, and the Leeds CCG value is derived from the 2020/21 uplifted block but excludes 2021/22 MHIS.

The Trust has no expenditure commitments with related parties for the year ending 31 March 2022.

28.3 Related party transactions - UK Government ultimate parent

	Income		Expenditure	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Department of Health and Social Care	**1,934**	1,850		22
Other DHSC Group bodies	**176,559**	162,000	**7,577**	10,383
Other	**586**	361	**29,424**	26,964
Total	**179,079**	164,211	**37,001**	37,369

	Receivables		Payables	
	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000	**Year ended 31 March 2021 £000**	Year ended 31 March 2020 £000
Department of Health and Social Care	444	209		3
Other DHSC Group bodies	2,006	3,818	**2,461**	2,300
Other	497	420	**2,798**	182
Total	**2,947**	4,447	**5,259**	2,485

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	497		2,798	
Balances with Local Authorities				
Balances with NHS bodies	2,449		2,460	
Intra Government balances	**2,946**		**5,258**	
Balances with bodies external to Government	2,913	5,664	22,894	
At 31 March 2021	**5,859**	**5,664**	**28,152**	
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**	

Notes to the accounts

30 Third party assets

The Trust held £327k cash and cash equivalents at 31 March 2021 (£323k 2019/20), which relates to monies held on behalf of service users. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 Losses and special payments

There were 2 cases of losses totalling £0k (21 in 2019/20 totalling £7k) and 25 special payments totalling £27k (13 in 2019/20 totalling £11k) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

Losses	**Number**	**Value £000**
Cash - other	2 (2)	0 (0)
Bad debts - other	0 (19)	0 (7)
Total	**2 (21)**	**0 (7)**
Special payments		
Ex-gratia - loss of personal effects	20 (9)	4 (1)
Ex-gratia - personal injury with advice	5 (4)	23 (10)
Ex-gratia - other	0 (0)	0 (0)
Special severance payments	0 (0)	0 (0)
Total	**25 (13)**	**27 (11)**

Figures in brackets relate to 2019/20.

32 Events after the reporting period

There were no events after the reporting period that had an impact on the Trust's 2020/21 accounts (2019/20: none).

33 Charitable Fund

	Year ended 31 March 2021 £000	Year ended 31 March 2020 £000
Income	**112**	4
Expenditure	**(27)**	(20)
Net movement in funds	**85**	(16)
Current assets	**162**	114
Current liabilities	**(1)**	(34)
Total Charitable Funds	**161**	80

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
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