Annual Report and Accounts

2009 - 2010

ANNUAL REPORT AND ACCOUNTS 2009 - 2010

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Content

Page

1 About the Trust
1.1 Introduction 7
1.2 Our Profile 7

2 The Chairman's Summary 9

3 Directors Report
3.1 The Chief Executive's Report – A Review of Our Business 11
3.2 The Board of Directors 15
3.3 Director's Statement as to Disclosure to Auditors 16
3.4 Going Concern 16
3.5 Equal Opportunity Employers Statement 16
3.6 Accounting Policies 16
3.7 Compliance with the Code of Governance 16

4 Operating and Financial Review
4.1 Service User Care – Principal Activities of our Trust 19
4.2 Key Organisational Risks 22
4.3 Service User and Carer Experience 23
4.4 Partner Relations 24
4.5 Public Consultations 24
4.6 Valuing Our Staff 24
4.7 Corporate Social Responsibility 31
4.8 Sustainability and Climate Change 32
4.9 Mental Health Act Managers 33
4.10 Confidentiality of Information 34
4.11 Financial Performance 35
4.12 Estates and Service Strategy 41
4.13 Health and Safety 42
4.14 Counter Fraud 43

5 Board of Governors
5.1 Composition of the Board of Governors 45
5.2 Changes to the Board of Governors 46
5.3 Meetings of the Board of Governors 47
5.4 Duties of the Board of Governors 47
5.5 Working Together 48
5.6 Sub-committees of the Board of Governors 49
5.7 Register of Governors' Interests 49

6 Board of Directors
6.1 Introduction 51
6.2 Profile of Members of the Board of Directors 52
6.3 Meetings of the Board of Directors 54
6.4 Register of Directors' Interests 54

Page

6.5 Evaluation of the Board of Directors and its Sub-committees 54
6.6 The Audit Committee 54
6.7 The Nominations Committee 55
6.8 Other Sub-committees of the Board of Directors 55

7 Membership
7.1 The Constituencies and Eligibility to Join 59
7.2 Number of Members 59
7.3 Developing a Representative Membership 60
7.4 Membership Recruitment 60
7.5 The Membership Office 60

8 Remuneration Report
8.1 Introduction 61
8.2 Remuneration of the Non-Executive Directors 61
8.3 Remuneration of the Executive Directors 62
8.4 Performance Appraisals 63
8.5 Senior Employees Pension Entitlements, Remuneration and Benefits in Kind 63

9 Quality Report
9.1 Overview of the Organisational Effectiveness 68
9.2 How we have Prioritised our Quality Improvement Initiatives 69
9.3 Our Selected Measures 69
9.4 Information on the Review of Services 86
9.5 Participation in Clinical Audits and National Confidential Enquiries 86
9.6 Participation in Clinical Research 90
9.7 Commission for Quality Innovation Framework (CQUIN) 91
9.8 Care Quality Commission 91
9.9 Information on Quality of Data 92
9.10 Review of Quality Performance 92
9.11 Statements from our Partners 96

10 Annual Accounts and Statements
10.1 Statement on Internal Control 99
10.2 Statement of Chief Executive's Responsibilities as Accounting Officer 103
10.3 The Directors Statement of Responsibility 104
10.4 Independent Auditors Report to the Board of Governors 105
10.5 Audit Arrangements 106
10.6 Annual Accounts 106

Service User, David Yates

About the Trust

1.1 Introduction

Our ambition is straightforward:

Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives

This ambition statement is underpinned by three strategic end goals that describe our commitment to excellent quality care in terms of outcomes for the people who use our services:

- **People achieve their agreed goals for improving health and improving lives**
- **People experience safe care**
- **People have a positive experience of their care and support**

Achieving our ambition means putting quality at the heart of everything we do. We will demonstrate our commitment to quality and to the people who use our services, their families and their carers, by behaving according to our values:

- **Respect and dignity**
- **Commitment to quality of care**
- **Compassion**
- **Improving lives**
- **Working together for people**
- **Everyone counts**

Put simply, we aim to extend our national reputation for safe care into the other areas of quality, service user outcomes and experience. Our challenge is to achieve this ambition whilst driving up productivity and reducing cost. Our success will be reported annually in our Quality Account.

Newsam Centre, Courtyard

1.2 Our Profile

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 all community services previously provided by the NHS Trust transferred to the PCT 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 the Leeds Partnerships NHS Foundation Trust was formed under the National Health Service Act 2006. Authorisation as a Foundation Trust was granted by Monitor, the independent regulator of NHS Foundation Trusts. We continue to provide mental health and learning disability services but are no longer performance managed by the local Strategic Health Authority.

Leeds Partnerships NHS Foundation Trust provides specialist mental health and learning disability services to over 619,710 adults within the Leeds metropolitan boundary. We employ around 2400 substantive staff and work with over 200 committed volunteers and can call on around 350 bank staff. All these people provide mental health and learning disability services to over 2,000 people each day.

Service users are at the heart of our organisation. We constantly strive to provide the best possible care and support, working closely with related organisations, and working in partnership with our local communities, our core purpose is to improve the mental health and well being of the people of Leeds and provide effective, accessible and modern mental health and learning disability services.

About the Trust

We provide our services in many different settings. We provide care in people's own homes and we operate from over 48 dispersed sites in the Leeds area. As part of our estates portfolio we have a number of main hospital and community sites from which health services are provided. Our main sites include St Mary's Hospital, The Mount, The Newsam Centre, and The Becklin Centre. Our sites are made up of a mix of owned, leased and PFI facility managed premises (further information about our Estates Strategy can be found in Section 4.12).

Services are provided in four service directorates: Adult Mental Health Services, Learning Disability Services, Specialist Services, and Older People's Mental Health Services. The services we provide include:

- Acute Community Services
- Addictions Services
- Care Home Services
- Community Learning Disability Teams
- Continuing Treatment and Care
- Day Services
- Eating Disorders
- Gender Identity
- Intensive Interaction
- Liaison Psychiatry
- Mental Health In-reach and Court Diversion
- Organic and Functional Inpatient
- Personality Disorder
- Post Traumatic Stress Disorder
- Psychology
- Psychotherapy
- Self Harm
- Young People Dementia Services
- Acute Inpatient
- Assertive Outreach
- Chronic Fatigue
- Community Mental Health Services
- Crisis Resolution
- Early Intervention
- Forensic Low Secure
- Healthy Living Team
- Learning Disability Inpatients
- Memory Service
- Mental Health Intermediate Care
- Perinatal Services
- Pharmacy
- Psychiatric Intensive Care
- Psychosexual Services
- Rehabilitation and Recovery Services
- Supported Living

Our service directorates are supported by a number of corporate directorates and support services these being:

- Estates and Facilities
- Finance and Performance
- Human Resources
- Information and Knowledge Services
- Communications
- Medical and Allied Professions
- Nursing
- Planning
- Social Inclusion

Kate Gye, Therapy Suite, Becklin Centre

The Chairman's Summary

Once again another year has passed and we have reached the end of 2009/10, a year that has seen the Trust and wider NHS face an ever more financially challenging climate. However, the Board of Directors, staff and Governors have risen to that challenge to ensure the Trust continues to provide safe and clinically effective care to service users and their families.

In 2009/10 the Board of Governors has seen a number of changes. The Board of Governor elections in August 2009 resulted in the appointment of new Governors whom I am delighted to welcome to the Trust and the return of some familiar faces I am glad to see back. There were also a number of changes to our Appointed Governors who represent the interests of the organisations we have identified as our primary partners within the local health economy. I very much welcome the opportunity of continuing the excellent working partnership we have forged with those organisations.

This year the Board of Governors has fulfilled its statutory duties in respect of the re-appointment of one Non-Executive Director and the appointment of a new Chair of the Trust. In November 2009 the Board of Governors re-appointed Linda Phipps as a Non-Executive Director for a period of three years; and in February 2010 Governors appointed Frank Griffiths as the in-coming Chair of the Trust. He will take over from me on the 1 April 2010 when I retire. I am very pleased to report that the Board of Governors undertook these duties with the utmost tenacity and integrity and have made two excellent appointments.

2009/10 also saw a change to the Board of Directors. On 1 October 2009 we welcomed Jill Copeland onto the Board of Directors as Director of Strategic Development. Jill, previously one of our appointed Governors, has been seconded from NHS Leeds into this post and brings with her a wealth of experience and knowledge of the local health economy. Jill has recently led on the work to revisit and refresh our aim and strategic goals. This work has benefited from the full involvement of Governors and staff to ensure our direction and strategy are truly responsive to local needs.

In writing this I would like to celebrate the achievements of all our staff. These include, amongst many other things our successful registration with the Care Quality Commission, the achievement of Level 1 Risk Management Standards and an excellent achievement in the national Patient Safety Awards. I would like to thank staff for the tremendous amount of effort and work that went into these achievements.

Another way in which we celebrated the successes of colleagues was through our annual Trust Awards evening. This allows an opportunity to nominate and vote for colleagues who have made a difference to the organisation. This was a highly successful evening organised by the staff at the Andrew Sims Center. Congratulations to all who were either nominated or received an award. However, it should not be forgotten that many colleagues are not nominated but provide an equally valued service to service users and carers and I would like to thank everyone for their hard work during 2009/10 in delivering and developing services.

As we turn to a new financial year, amidst a challenging economic climate, we strive always to continually improve the quality of care for our patients, whilst delivering financial efficiency improvements. As this report shows, the Trust has a strong basis upon which to meet this challenge and to continue to improve quality and productivity over the coming years as NHS resources become more stretched. Within this context our aim is to improve health and improve lives whilst building upon our partnership approach with our commissioners.

On the 31 March 2010 I retire from my position as Chairman of this Trust. I have very much enjoyed my time with the Trust and being part of what I am sure will be the continuing success of Leeds Partnerships NHS Foundation Trust.

Thank you

Ian Hughes, Chairman (until 31 March 2010)

Ian Hughes, Chairman (until 31 March 2010)

Time to Change event

Directors' Report

3.1 The Chief Executive's Report – A Review of Our Business

This is the third Annual Report of the Leeds Partnerships NHS Foundation Trust since our Authorisation by Monitor in August 2007.

Thousands of people rely on our mental health and learning disability services, and we are here with one vital purpose: to support each and every one of those people to achieve better health and better lives. This is described in our new Trust ambition statement, developed by our Governors with the support of service users, carers, staff and partner organisations:

Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives

We are proud of our achievements over the last 12 months. We have listened to people who use our services, their families and their carers and made our services better in response to what they have said. Our wider work as a Public Benefit Corporation has had a positive impact in forcefully challenging stigma and discrimination through the "Time to Change" programme. We have won national awards for our work, including the Health Service Journal and Nursing Times mental health award for patient safety.

Moving forward, we will continue our work to review our Trust strategy in response to new policies and the changing economic environment. Our aim is to put quality at the heart of all that we do, extending our national reputation for safe care into the other areas of quality: service user outcomes and experience. This report is an opportunity not only to set out likely future directions, but also to reflect on the last 12 months. We have moved forward in so many different ways and what follows is an illustration of some of our areas of activity.

3.1.1 Care Services Directorate

At the heart of our Trust are the clinical services that we provide for people with serious and enduring mental health problems and learning disabilities. What follows are some headlines concerning the work of these services over the past year.

Adult Mental Health Services

During 2009/10 services for working age adults have been using a range of service improvements technologies and techniques to improve the effectiveness of their work. Examples of this include advanced accreditation by the University of Leeds as a Practice Development Unit and the utilisation of the NHS Institute's "Productive" series.

- **Complementary to one of the strands of the Trust's patient safety work, the in-patient service continues to work with the West Yorkshire Police to reduce the numbers of unauthorised absences from in-patient wards.**

During 2009/10 the service has also sharpened its focus on broader factors that influence health. For example, work has been taken forward with partner agencies from the City's housing service, Adult Social Care, and the voluntary sector, to address and improve how we meet the housing and accommodation needs of service users. This has produced extremely positive results both for service users and the partner agencies. Access to meaningful activity whilst an in-patient and also activity and employment in the community have been important areas of work. In addition, access for service users who are inpatients to a range of therapeutic activities has improved. In community settings, through our Trust co-funding a Knowledge Transfer Partnership (KTP), we are exploring how to improve specialist employment advice availability for service users. This is a joint project with partners from Leeds MIND and the University of Leeds. The impact of this KTP will be evaluated in November 2010.

Specialist Services

Our Trust continues to provide a range of specialist services both to the residents of Leeds and a wider population. During 2009/10 services continued to develop including:

- **Providing more forensic services.**
- **Improving our service for people with mental health problems and physical illnesses.**
- **Providing alcohol treatment services in the general hospitals.**

Directors' Report

- Developing people who work in our Personality Disorder Service and extending this service across Yorkshire and the Humber.
- Providing a wider range of pharmacy services, and introducing "tele-pharmacy" to enable improved working across different sites.

Old Peoples Mental Health Services

These services are in the process of being redesigned to ensure that they reflect the changing needs of older people as well as taking forward key elements of the national Dementia Strategy. Some of the key elements of this process during 2009/10 included:

- The agreement of the strategy to improve older people's mental health services by both the Board of Governors and the Board of Directors.
- A comprehensive programme of engagement with key stakeholder groups about our proposed changes.
- Good partnership working with the NHS Leeds Continuing Care team and the Adult Social Care Directorate of Leeds City Council to improve care pathways in order to reduce the number of people whose discharge from hospital was delayed.
- A focus on improvements to the inpatient discharge/ transfer pathway which resulted in a significant reduction in the number of people whose discharge was delayed.
- A successful "Just Checking" pilot which provided tele-care equipment to aid in the assessment of older people living alone.

Learning Disability Services

Among its other activities, the Learning Disability service has worked hard with service users on better meeting the communication needs of people with learning disabilities. This has included service users being involved in designing new hospital signage based on the service's "easy on the *i*" design style. As a result, the main signage board at the front of St. Mary's Hospital, has been re-designed into colour coded signs and symbols for each of the services provided on the hospital site.

Service users have also been involved in the development of 'logos' to help them have a better understanding of the importance of leading healthy lifestyles. The logos focus on:

- Eat Well
- Be Active
- Get Checked Out
- Stay Well

The logos were launched at a "Big Health Event, Your Health Matters" which took place during June 2009. This was led by the Learning Disability service in partnership with NHS Leeds and various stakeholders.

Partnerships and Social Inclusion

The Trust engages in a number of initiatives to embed recovery principles, diversity and social inclusion for people who use our services and their carers.

- Our Trust is one of six participating in the national "Pacesetters" programme in Yorkshire and the Humber. Pacesetters projects focus on tackling issues in the areas of health inequalities, disability, race, gender and sexual orientation. Our sexual orientation project has been used by the Department of Health as an example of good practice at national level.
- We have established "Building Your Trust", a quarterly service user and carer engagement workshop.
- We have implemented a Trust-wide "Mindful Employer" action plan to promote positive mental health for all of us as colleagues.
- We have participated in the national Sainsbury Centre for Mental Health "Centres of Excellence" programme.
- Partnerships have been established with education providers and the Personal Community Development Learning Network.

Directors' Report

- **We actively support an "Arts and Minds" programme. Arts and Minds has been selected as the regional pilot for the National Institute of Adult Continuing Education, Learning Skills Council, and the Inclusion Institute's programme to stimulate demand for learning. Arts and Minds produced publicity for our highly successful local anti-stigma campaign in partnership with "Artlink". This campaign is directly linked to the national anti stigma programme, "Time to Change".**

Facilities

Our Facilities service continued to maintain the high scores awarded to our Trust following the national externally assessed Patient Environment Action Team (PEAT) process. Our Trust was awarded either "high" and/or "excellent" standards in all of our clinical areas.

A substantial works programme was undertaken to improve the quality of our buildings and also meet the environmental agenda, including carbon reduction targets.

Nursing

Our Nursing development team worked with our clinical areas in strengthening the nursing contribution to care. Examples of their work include:

- **Developing and ensuring the implementation of the Essence of Care Benchmarks.**
- **Enabling a highly successful nursing conference with national speakers on professional issues.**
- **Developing a Nursing Medication Competency framework.**

The Team's work featured in the Department of Health's "High Impact Actions" for nursing.

3.1.2 Medical Directorate

Patient Safety

Following last year's "Year of Patient Safety", we have worked hard to continue delivering improvements in the safety and reliability of all our services. In February 2010 we were delighted when this was recognized in the National Patient Safety Awards organised by the Health Service Journal and the Nursing Times. We won the mental health category outright and were highly commended runners-up in the board leadership category. In making the award the judges described our programme for improving patient safety as "truly ground-breaking". We are not complacent, however, and know there is much more we can do in this area. Equally, we are using this achievement as a platform to continue building the overall quality of our clinical services. The work to refresh and update our overall Trust strategy has been organised exclusively around the three components of quality described in the "Darzi" review, which are safety, clinical effectiveness and patient experience, and this will drive specific programmes of work to achieve improvements in all those areas during 2010/11.

Learning, Teaching and Research

We have maintained and developed our profile in learning, teaching and research. With the dissolution of the former West Yorkshire Mental Health Research and Development Consortium, we have formed a new partnership with South West Yorkshire Partnerships NHS Foundation Trust to work together on promoting high quality research in the field of mental health and learning disabilities. On behalf of the West Yorkshire Clinical Local Research Network we have hosted two posts which have been successful in facilitating people in our Trust to recruit into prestigious research studies overseen by the national Mental Health Research Network. We have continued to engage service users in research design and identifying priorities.

We also welcomed into our Trust the Northern School of Child and Adolescent Psychotherapy.

3.1.3 Finance and Performance Directorate

During the year we carried out a detailed due diligence process as a pre-cursor to the transfer of the Yorkshire & Humber Commercial Procurement Collaborative into the Trust. This transfer date is now expected to take place on the 1st June 2010. The CPC handles procurement for the majority of organisations across the Yorkshire and The Humber Region and will also provide a platform to drive a number of back- office efficiencies over the coming years.

We carefully prepared our application for registration with the Care Quality Commission (CQC). I am pleased to say that our Trust was granted an unqualified registration with the CQC.

With regards to our ratings on governance and financial risk by Monitor, we rigorously assessed our performance during the year. Our intention is always to fully understand

Directors' Report

our position on key issues of performance and accurately report our finding to our regulator. Monitor assess the Trust on a quarterly basis, and it is on this basis that I can report.

3.1.4 Human Resources

Our staff are our most valuable resource and it is only through their hard work and dedication that we will achieve our ambition. We recognise achievements through our annual Trust Awards which again was a very successful event with over 150 nominations for 12 categories covering contribution to improving services, patient safety, involvement and volunteer of the year to name a few.

In September 2009 we started a project to implement electronic rostering (e-rostering) across all of our in-patient units. Our intention is to improve staff utilisation, release time for clinical work, and increase the quality of what we provide, as well as increasing productivity. E-rostering complements the roll-out of the Productive Ward and Productive Community programmes which have already had a significant and positive impact on what nurses do day to day.

We have put in place a Workforce Review Group to help us to positively manage vacancies, turnover, and redeployment to ensure that the needs of our services are met and our colleagues are treated in a fair and equitable manner.

We have listened to staff through our annual NHS Staff Survey and have we developed an action plan to address the issues and concerns which have emerged.

We continue to develop our managers' leadership and management capability with the development of a new programme *"Fit for the Future"* for all of our front line managers and leaders.

We will be implementing a new appraisal scheme for staff which focuses on performance and the achievement of clear and measurable objectives and is aligned to our Trust strategy, values, and behaviours.

We value the contribution that our colleagues make in delivering top quality services. To help people make this contribution we continue to help people to return to work after a period of sickness, as well as developing a health and wellbeing strategy for our colleagues.

In all of these areas we work in close collaboration with the representatives of our staff, "Staffside". I am grateful to Staffside for the constructive and mature approach they adopt to ensuring that, together, we always aspire to be the best employer that we can be.

3.1.5 Conclusion

Though the future is very challenging we remain an organisation with ambition. We are already serving the public well, but there is more we need to do to improve.

We remain financially stable. This has not been at the expense of service users, carers, or staff and we have continued to make investments in our services to improve the experience of those who use, or work in, our services. Assuming that we will keep a steady hand on the tiller in using our resources to best effect, our focus over the next year remains on still more improvements in the quality of the services we provide.

Our membership continues to grow. Our Board of Governors, working with their membership or partner agencies, continue to help us to deepen our involvement with the communities we are proud to serve.

What we have managed to do is through a team effort and I want to take a moment to thank all of the staff, volunteers and Governors of our Trust for their commitment. We only do what we do through the work of our people and everybody, either directly or indirectly, contributes to creating a better future for service users and carers. In particular I want to thank the outgoing Chair of the Trust, Ian Hughes, for his work in developing mental health and learning disability services in the City over many years. April 2010 sees us welcoming our new Chair, Frank Griffiths.

I also want to take this opportunity to welcome to our Trust Jill Copeland who is our Director of Strategic Development.

In summary, I am proud of our Trust's achievements to date, whilst being realistic about the challenges we face. As we have done in the past, we will only be successful in facing these challenges through rigor and focus, and also by ensuring that we continue to behave according to the values of the Trust drawn from the NHS Constitution. As a reminder these are:

- **Respect and dignity**
- **Commitment to quality of care**

Directors' Report

- **Compassion**
- **Improving lives**
- **Working together for people**
- **Everyone counts**

These values will help us to realise our new ambition which is that:

Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives.

Chris Butler
Chief Executive

More information about the Trust's principal activities can be found in Section 4, full details of the financial report can be found in Section 4 and Section 10 and details of the R&D developments can be found in Section 9.

3.2 The Board of Directors

The Board of Directors provides a wide range of experience and expertise and continues to demonstrate the vision and oversight that allows us to continue to meet our ambition. For further information about the Board of Directors see Section 6.

At the end of 2009/10 the Board of Directors comprised of 6 Non-Executive Directors and 7 Executive Directors. Jill Copeland has been seconded for a period of 2 years from NHS Leeds to the Board of Directors as the Director of Strategic Development.

The Non-Executive Team

7. Ian Hughes (Chairman of the Trust until 31 March 2010), **9.** Linda Phipps, **10.** Niccola Swan (Deputy Chair until 30 September 2009), **4.** Allan Valks (Senior Independent Director), **11.** Merlin Wilce and **Inset Picture 1,** Catherine Coyle, (Deputy Chair from 1 October 2009)

The Executive Team

8. Chris Butler (Chief Executive), **6.** Mike Doyle (Director of Corporate Development), **5.** Stephen Griffin (Director of Human Resources), **2.** Michele Moran (Director of Service Delivery and Chief Nurse), **1.** Guy Musson (Director of Finance and Performance), **3.** Dr David Newby (Medical Director) and **Inset Picture 2,** Jill Copeland (Director of Strategic Development.)

Directors' Report

3.3 Directors' Statement as to Disclosure to the Auditors

For each individual who is a Director at the time this annual report was approved, so far as the Directors are aware there is no relevant audit information of which the auditors are unaware and the Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

3.4 Going Concern

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

3.5 Equal Opportunity Employer Statement

The Trust believes in fairness, equality and above all values diversity in all aspects of its work.

Leeds Partnerships NHS Foundation Trust is committed to eliminating discrimination and is committed to the fair treatment of everyone taking into account amongst other things, their gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion, disability, mental health needs, age, domestic circumstances, social class, sexual orientation, beliefs or trade union membership. The Trust is firmly committed to tackling discrimination.

If unfair discrimination occurs it will be taken very seriously and may result in formal action being taken, including disciplinary action.

Everyone who comes into contact with the Trust can expect to be treated with respect and dignity and to have proper account taken of their personal, cultural and spiritual needs.

The Trust also aims to ensure that it employs and develops a healthcare workforce that is diverse, non-discriminatory and appropriate to deliver modern healthcare. Valuing the differences of each team member is a fundamental component of the Trust. It enables its staff to create respectful work environments.

In this way the Trust is able to deliver quality care and services whist giving service users the opportunity to reach their full potential.

More information about the policies and procedures applied in respect of equal opportunities can be found in Section 4.

3.6 Accounting Policies

Accounting policies for pensions and other retirement benefits are set out in note 1.4.1 to the Annual Accounts, see Section 10; and details of senior employees' remuneration can be found in the Remuneration Report, see Section 9.

3.7 Compliance with the Code of Governance

In September 2006 Monitor issued the Code of Governance, whilst this has now been replaced with a version issued on 1 April 2010. This annual report shows how we comply with the Code that was issued in September 2006.

The Board of Directors considers that, except where mentioned below, throughout 2009/10 the Trust has met the requirements of the Code of Governance. Non-compliance or limited compliance is reported below.

Main Principle A.3: - "All directors should be able to exercise one full vote". Two Directors on the Board of Directors are non-voting , the Director of HR, and the Director of Strategic Development. Whilst not all Executive Directors have one full vote the decision to have two non-voting Directors ensures that when a vote is taken the majority votes remain with the Non-Executive Directors.

Code Provision A.3.2: - "At least half the board, excluding the chairman, should comprise non-executive directors". Between 1 April and 30 September 2009 there were 5 Non-Executive Directors (excluding the Chairman) and 6 Executive Directors (5 with voting rights and one non-voting). From 1 October the executive team was increased to 7 (5 with voting rights and two non-voting). The Board made the decision to increase the executive team to strengthen the skills and experience on the Board. However, in relation to the balance of influence the Board considers that by having 5 Non-Executive Directors (excluding the Chairman) and 5 voting Executive Directors this is sufficient to ensure that, should a vote be taken the balance of influence lays with the Non-Executive Directors and Executive Directors.

Code Provision C.2.1: - "Re-appointment (of the Chief Executive) by the Non-Executive Directors followed by re-approval by the Board of Governors thereafter should be made at intervals of no more than five years. All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairman and Non-Executive Directors and subject to re-appointment at intervals of no more than five years". The process of appointing the Chief Executive and Executive Directors

Directors' Report

is in full compliance with the requirements of the Code of Governance. However, the Chief Executive and Executive Directors are employed on permanent contracts (except for the current Director of HR who is employed on a temporary contract and the Director of Strategic Development who is seconded to the organisation from NHS Leeds) as this provides continuity for the organisation and there are no plans to move away from this.

Code Provision C.2.3: - "The names of Governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make an informed decision on their election. This should include prior performance information such as attendance record at Governor meetings and other relevant events organised by the NHS Foundation Trust for Governors". The attendance record at formal meetings of the Board of Governors is relevant and is made available to voters when elected Governors stand for re-election. However attendance at other events organised by this Trust is not included. This is because elected members come from a wide variety of backgrounds and are able to devote different amounts of time to the role therefore we do not, therefore, want to appear to penalise Governors who can only come to the formal Board of Governors meetings.

Code Provision D.2.1: - "The Chairman with the assistance of the secretary of the boards if applicable should use the performance evaluations as the basis for determining individual and collective professional development programmes for directors relevant to their duty as board members". The Chairman of the Trust is not solely responsible for determining the individual and collective professional development programmes for Directors. The Board of Governors agree the method of appraisal for both the members of the Board of Directors and the Board of Governors. The Chairman of the Trust determines the development programme for Non-Executive Directors and the Chief Executive determines the development programme for Executive Directors. There is also an annual process of evaluation which is undertaken by the Board as a whole and from this come jointly agreed objectives, some of which may then roll forward into individuals' development plans.

Code Provision E.1.1: - "Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and taxpayers and to give these Directors keen incentives to perform at the highest levels". We do not operate a system of performance related pay or bonuses.

Code Provision E.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 definition of 'senior management' for this purpose should be determined by the board but should normally include the first layer of management below Board level". The Board has determined that the definition of 'senior management' will be limited to members of the Board of Directors only. All other staff remuneration is covered by the NHS Agenda for Change pay structure. In addition to this the Remuneration Committee does not agree the pension rights for Executive Directors as this is determined by the NHS pension scheme.

Code Provision G.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. This information should be used to review the Trust's membership strategy, taking into account any emerging best practice from the sector". This function is primarily carried out by the Board of Governors' Membership Committee and not the Board of Directors, although one of the Non-Executive Directors is a member of this Committee. The Board of Directors does set the direction for the Membership Strategy and this is communicated to the Board of Governors.

Patient Safety Awards 2010

Service user, David Yates, using the Snozelen Room at The Mount

Operating and Financial Review

4.1 Service User Care – Principal Activities of Our Trust

Leeds Partnerships NHS Foundation Trust puts at the heart of everything it does the health and safety of its service users, staff and carers. Our principal activity is the provision of healthcare to eligible service users.

The Trust continues to perform well operationally, as well as financially in the current challenging economic climate. We also continue to achieve the targets expected of all NHS organisations. We attain good outcomes in the many external assessments to which we are subject to each year, and we take our social and environmental responsibilities seriously, both as a major employer and through our active involvement in the community we serve.

4.1.1 Principal Activities of the Trust

4.1.1.1 Adult Mental Health Service Directorate

Our Adult Mental Health directorate provides a range of secondary mental health services accessible to the adult population of Leeds. We aim to provide high quality, safe, responsive and consistent specialist mental health services. These services can be divided into two primary care pathways. The acute care pathway provides acute inpatient services, a Crisis Resolution and Home Treatment Service and acute community services. Our community care pathway provides Community Mental Health Teams, Assertive Outreach, Psychological Therapy Services and a Rehabilitation and Recovery Service.

Key achievements during 2009/10

The Adult Mental Health directorate's key focus in this year has been to develop ways in which service users can achieve the most flexible, quickest and safest service that meets their needs whilst providing care in the least restrictive environment. Key achievements include:

- **Increasing efficiency and safety –** Changing the way Community Mental Health Teams and the Psychological Therapy Service works applying a "whole system" approach to the way service users move through the system of care giving greater efficiency and improvement in quality and safety.

- **Reduction in delayed transfers of care –** Taking part in a multi-agency project looking at how to streamline care pathways for acute inpatients with accommodation needs so that housing problems are resolved before being discharged.

- **Working with West Yorkshire Police –** Offering student police officers a valuable opportunity to see mental health services in practice, helping to strengthen links and understanding between the Trust and the police force.

- **Psychological Therapy Services –** We have fully embedded the changes to the service which we started last year. This has created a single point for accessing the service allowing more flexible use of resources across the service, and offering patients a choice of appointments to suit their needs.

- **Healthy Living Team –** The service has been reviewed to better meet the physical needs of service users. A standardised healthy living tool has been developed and launched throughout all services.

Key issues and risks for the future development of the Adult Mental Health Services directorate

During 2010/11 the directorate will review all of its systems of care in order to ensure it continues to deliver safe, high quality services whilst maximising the use of available resources. It also aims to implement integrated care pathways across all service areas in order to improve care and access to services.

The directorate will further develop all its services using feedback from service users and carers and will ask for views, experiences and ideas from a wide range of service users and carers, particularly those that would not normally participate in conventional feedback exercises.

More information about the Adult Mental Health directorate's key achievements and developments can be found in the Annual Plan for 2010/11, which is on the Trust's website.

4.1.1.2 Specialist Services Directorate

The Specialist Services directorate is a collection of 9 specialist services operating on a local, regional and national basis. The services respond to the requirements of multiple commissioners and are all managed by a partnership of professional managers and senior clinicians.

During 2009/10 the directorate has focused on developing partnerships both in and outside the Trust, and has promoted the services through a number of publications.

Key achievements during 2009/10 include:

- **Forensic Services –** Extended the

Operating and Financial Review

provisions of the women's only service to support other providers in the Yorkshire and The Humber region to meet the requirements of the policy paper "Into the Mainstream".

- **Liaison Psychiatry –** The Chronic Fatigue service, in conjunction with an ex-service user has published a book on the management of Chronic Fatigue.

- **Personality Disorder –** Service users have published a quarterly newsletter "VALIDATE" and have participated in the delivery of training and have helped to support other service users.

- **Yorkshire Centre for Eating Disorders –** We have introduced a community-based model of care for individuals with severe and enduring anorexia nervosa.

- **Addictions service –** Established a Masters degree in Public Health Addictions Module in conjunction with the University of Leeds.

Key issues and risks for the future development of the Specialist Services directorate

During 2010/11 the directorate will continue its drive to establish and promote outcome measurement as a quality indicator for service delivery. Services will continue to grow in areas to meet new commissioning intentions and evolve to recognise the changing requirements of service users and skills of staff.

There will also be an emphasis on research, teaching and service model developments to ensure services and staff deliver up to date, effective care.

More information about the Specialist Services directorate's key achievements and developments can be found in the Annual Plan for 2010/11, which is on the Trust's website.

4.1.1.3 Older People's Mental Health Services Directorate

The Older People's directorate provides a range of secondary mental health services to older people in Leeds. The range of services includes:

- **Community Mental Health Services**
- **Care Home Services**
- **Memory Service**
- **Younger People with Dementia**
- **Day Treatment Service**
- **Community Rehabilitation Service**
- **Intermediate Care and Rapid Response Service**
- **Liaison Mental Health Service**
- **Mental Health Inpatient Service**
- **Dementia Inpatient Service**

Each of the above services operates a multi-disciplinary approach to providing care and treatment for service users. Each service will have a core team of staff comprising of nurses, occupational therapists, doctors, support workers and administrators. In addition teams will have access to psychologists, therapists, physiotherapists, and a dietician.

Key achievements during 2009/10

The focus of the Older People's directorate has been to work closely with key stakeholders to develop and agree a range of service improvements.

Key developments include:

- **Good partnership working with NHS Leeds Continuing Care team and Adult Social Care to improve the inpatient discharge/transfer pathway, resulting in a significant reduction in the number of people whose discharge is delayed.**
- **Successful reduction in the number of people whose discharge is delayed.**
- **Successful "Just Checking Pilot" providing telecare equipment to aid in the assessment of older people living alone.**
- **Agreement to the strategy to improve the Older People's Mental Health Service by both the Board of Directors and the Board of Governors.**
- **Completing a comprehensive programme of formal engagement with key stakeholder groups on the proposed new service changes.**

Key issues and risks for the future development of the Older People's Mental Health directorate

Operating and Financial Review

- **Gaining final agreement from commissioners to implement improvements to services.**
- **Supporting staff in working in different ways to ensure our workforce is used in the most effective and efficient way.**
- **Achieving financial balance by indentifying and implementing efficiencies within agreed timescales.**
- **The ability to meet agreed timescales on a number of estates and accommodation changes due to the range of departments and organisations involved.**

More information about the Older People's Mental Health directorate's key achievements and developments can be found in the Annual Plan for 2010/11, which is on the Trust's website.

4.1.1.4 Learning Disability Services Directorate

The Learning Disability Services directorate continues to strive in its determination to provide the best services possible, to adults with severe learning disabilities and additional complex health needs and/ or challenging behaviour.

It provides a range of health and social care services including community, inpatient, day care and Specialised Supported Living. Services such as nursing, psychiatry, psychology and therapy services are delivered by staff trained in the speciality of learning disabilities.

Strong service user involvement and influence are essential to the way learning disability services are provided. Referrals are received through a single point of access and operate on a three tiered service model. The model means that service users receive the correct level and type of care in an appropriate and timely manner.

Key achievements during 2009/10 include:

- **The Specialised Supported Living Service (SSLS), which is a registered Domiciliary Care Agency, retained a rating of "excellent" by the Care Quality Commission for the fourth consecutive year.**
- **The profile of Intensive Interaction within the directorate has been raised by hosting an international conference and by supporting staff to present at regional, national and international events.**
- **The Productive Ward initiative has been implemented in an acute inpatient service, resulting in increased time staff spend with patients. It has also seen a reduction in incidents and staff sickness absence.**
- **Two community teams successfully completed work on Creating Capable Teams.**
- **Day Services have been reviewed and restructured to increase the number of service users having access to specialist health day-care provision.**
- **A successful health event 'Your Health Matters' was led by the Learning Disability Services directorate in partnership with NHS Leeds and various other health care providers.**

Key issues and risks for the future development of the Learning Disability services directorate

- **The directorate has process mapped the delivery of psychological therapies to service users and has found that there are some efficiencies that can be made in the referral pathway. Changes to the pathway, will be made in 2010 to ensure that services are provided in the most timely and appropriate manner.**
- **The directorate will continue work to ensure that the Community Learning Disability Teams (CLDTs) are appropriately located and accessible to service users across the city.**
- **Allied Health Professional Services such as Dietetics, Physiotherapy, Occupational**

Operating and Financial Review

Therapy and Speech and Language Therapy are working to capacity. The directorate will review the systems currently in place to ensure that these are the most efficient way of delivering therapy services.

- **The directorate has agreed that there is a need for further involvement of carers in our services. We will be asking carers where they think we are performing well and not so well in order to help them as carers of people with learning disabilities.**

More information about the Learning Disability directorate's key achievements and developments can be found in the Annual Plan for 2010/11, which is on the Trust's website.

4.2 Key Organisational Risks

We have a number of key risks, which the Board of Directors continues to monitor. To ensure these are sufficiently mitigated there is a comprehensive risk management process, which includes individual risk review templates for each risk, a thorough programme of review carried out by the Risk Management and Governance Committee, and a regular report of progress for each specific risk is being presented to the Board of Directors bi-monthly.

At the end of March 2010 the following were our key risks:

Table 4A

Risk	Potential Impact
Sufficiency of operational data to support Trust business; and the inability to record activity accurately.	• FT status and our submissions to Monitor. • Directorate monthly budget reports. • Service Level Agreements with our commissioners. • Patient care through omitted, untimely or inaccurate data. • Performance through incomplete data leading to assumptions of poor performance. • Poor performance issues may not be addressed due to assumptions of lack of data. • Trust business and future business development affected as we are unable to determine pressure points and take appropriate action, with some business decisions based on invalid or inappropriate information. • Future initiatives or directives e.g. Payment by Results or any change that requires accurate and adequate data collection.
Access to appropriate Psychological Therapies across the Trust.	• Insufficient capacity to meet demand for psychological therapies.
Failure of Medicines Management processes and practice resulting in an unacceptable level of medication errors.	• Non-completion of allergy status. • Incorrect identification of patients. • Errors in the reconciliation of medicines. • Lack of knowledge of medicines.
Insufficient funding for Out of Area Treatment placements.	• Potential overspend of £1.44 m based on current funding against required levels of expenditure. • Significant business impact on the Trust.
Inadequate staffing resources to provide Physiotherapy Services to Tier 1, Sector C in the Learning Disability directorate.	• Speed/rate of response and types of services that service users with complex and multiple physical health needs receive from Physiotherapy. • Physiotherapy staff will have to provide interventions across two tiers of service and potentially manage unsafe clinical caseload levels.
Inadequate staffing resources to provide Dietetics services to services across Tier 1, 2 and 3 services of the Learning Disabilities directorate.	• Insufficient capacity to meet demand for Dietetic services.
Inability to recruit and retain speciality doctors.	• Inability to maintain the level of medical assessment of new referrals. • Effects on continuing care of existing service users in inpatient and outpatient settings. • Adhoc cover on out of hours rota.
Recording and reporting of mandatory training is not standardised within the Trust.	• Affect our declaration of compliance against Care Quality Commission domain C11b – mandatory training. • Failure to achieve level 1 of NHS Litigation Authority inspection – particularly in relation to Standard 2: competent and capable workforce.

Operating and Financial Review

4.3 Service User and Carer Experience

4.3.1 Feedback from People who use our Services

We gather feedback from people who use our services and their carers through a wide range of methods, including national and local surveys. Individual services each have methods for gathering feedback at a local level and we are establishing a standardised approach across the organisation.

The national mental health community and inpatient surveys are used by the Care Quality Commission to benchmark our performance in terms of service user experience. We are required to undertake the community survey one year and the inpatient survey the next. However, we have decided that we will carry out both surveys each year so we can benchmark our performance more regularly.

The 2009 voluntary community survey showed that overall 60% of respondents reported that the care they had received in the last 12 months had been either excellent or very good, and only 7% thought the care was poor. 50% of respondents said they had definitely had enough say in decisions about their care and treatment. These figures are broadly similar to other voluntary participating Trusts and are about the same from the previous year.

The 2009 compulsory inpatient survey showed that overall 54% of respondents rated the care they received in hospital as excellent or very good, which compares favourably with other Trusts.

The results of the surveys are reported to the Board of Directors and the Board of Governors. They are also included in our Quality Accounts.

Each of the directorates has an action plan in place in response to the survey findings and these are performance managed through regular directorate performance reviews. Some examples of actions identified as a result of the surveys are outlined below:

OBJECTIVE: Increase the amount of time nursing staff spend with inpatients and improve the levels of confidence and trust inpatients have with the nursing staff in working age adult services.
ACTION: All patients to have at least three one to one sessions with their primary worker documented in their notes each week; and increase the opportunity for ward staff to have sessional time in the therapy suite to engage in therapeutic activities.

OBJECTIVE: Improve access to counselling in Older Peoples Mental Health services.
ACTION: Roll out the framework for improving access to psychological, vocational and occupational therapies.

OBJECTIVE: All service users to be given information on the purposes of medications for their condition, and information about any relevant and significant side effects they may encounter.
ACTION: Ensure medication advice leaflets are provided on discharge and Information leaflets are available for all inpatients and outpatients.

Both surveys were carried out again in the Spring of 2010 and the results will be available later in the year. For more detailed information visit the Care Quality Commission website **www.cqc.org.uk**

4.3.2 Public and Patient Involvement

We have in place an Involving People Policy and Consultation Procedure that sets out the principles, values and standards for involving service users and their carers in line with the NHS Act 2006 and the Real Involvement guidance.

The Involving People Council provides leadership for involvement across the Trust and reports to the Diversity and Social Inclusion Strategy Group. Each clinical directorate has a lead for involvement. They report to the Involving People Council and are responsible for developing and leading involvement activity in their directorate. The Local Involvement Network (LINk) is now established in Leeds and we are building a positive relationship with it and we are working jointly on a communications protocol. The Trust is also represented on the citywide Patient and Public Involvement Group as well as an NHS Yorkshire and The Humber network.

4.3.3 Volunteers

Volunteers at the Trust are very valuable to our organisation and enhance the daily routine of the service user adding to the quality of their stay at the Trust. They provide a wide range of dedicated services, which include befriending on the wards or in the community, and assisting in walking groups. We would like to thank our volunteers for their time and dedication in carrying out their valuable role.

4.3.4 Patient Advice and Liaison Services (PALS)

The Patient Advice and Liaison Service (PALS) is an important way in which the views of service users and carers in both mental health and learning disability services can influence

Operating and Financial Review

and help develop those services.

PALS is an accessible, confidential and free service that supports service users, carers, family members and staff who may have any concerns about Trust services. PALS is not an advocacy service nor a formal complaints service, and experience has shown that with early intervention the need for issues escalating into a formal complaint can often be avoided. However, the PALS team do work alongside both advocacy and the complaints team and will make referrals to these services when appropriate.

During the period 1 April 2009 to 31 March 2010 the team handled 556 cases, from across the organisation. These cases ranged from requests for information through to more complex issues around clinical care and communication.

People are encouraged to give feedback, good or bad, on how they feel the Trust provides services. The team capture and record the issues raised and feed these back into the organisation to influence development and improvement.

4.3.5 Dealing with Concerns – our Complaints Service

There are occasions when service users, their relatives, carers or advocates feel that it is necessary to make a formal complaint about the care and treatment they have received. The Trust is committed to ensuring that complaints are dealt with openly, promptly and fairly; and that people will not be treated adversely as a result of having made a complaint.

The Trust always fully investigates complaints in line with the NHS complaints regulations and aims to ensure that individual concerns are addressed and appropriate actions are implemented to learn lessons, to improve services, and to help to ensure there is not a re-occurrence of similar events in the future.

From 1 April 2009 to 31 March 2010, 56 formal complaints were received compared with 74 formal complaints received during 2008/09. To ensure we comply with NHS complaints regulations we aim to respond to all complaints within 30 working days or longer with the agreement of the complainant.

Examples of how services have been changed following the receipt and investigation of complaints are:

- **The establishment an agreement between Acute Community Services and Crisis Resolution and Home Treatment Team to develop joint care plans.**
- **The reinforcement of the Trust's Observation and Search Procedure to ensure staff fully comply with this.**
- **The implementation of "plan your week" and "your views" sessions between service users and staff at the Newsam Centre.**

4.4 Partner Relations

We contribute to partnership working through a range of citywide groups and processes. We are a member of the Leeds Strategic Partnership, the Healthy Leeds Partnership, the Compact Implementation group and the Leeds Arts Partnership.
We also contribute to a number of specific work-streams to ensure we effectively contribute to the development and improvement of health outcomes for people who use our services and we are represented on a group led by NHS Leeds overseeing the development of citywide mental health needs assessment. The Trust is also a member of the Health Proposals Working Group, which is a sub-committee of Health Scrutiny, which reviews all proposed significant and substantial service changes.

We have a formal partnership agreement in place with Volition (an alliance of voluntary sector organisations in Leeds that either provide mental health services for, or work with people who have mental health needs), the Older People's Forum and the Learning Disability Forum as well as Adult Social Care, with regular meetings to review partnership working. We have brokered partnerships with a diverse range of mainstream providers (for example, Supporting People and Park Lane College) and have set specific Key Performance Indicators for partnership working to enable us to measure the implementation of our Recovery and Social Inclusion Strategy.

4.5 Public Consultations

There were no formal consultations in 2009/10. Formal engagement activity is currently taking place with regard to the Older People's Mental Health Strategy and a public engagement event took place at the Civic Hall at the end of March 2010.

4.6 Valuing our Staff

Staff are 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.

Operating and Financial Review

At the end of March 2010 we employed 2446 staff, and 349 bank staff; and had 220 volunteers.

4.6.1 Equality and Diversity

4.6.1.1 Approach to Equality and Diversity and how we have met our Publication Duties

The Trust has adopted an integrated approach to equality and diversity and our aims are outlined within the Single Equality Scheme 2007-2010 and associated action plan. This states that we will not only meet the specific and general duties set out in equality legislation, but also meet our moral and ethical obligations to our service users, carers and staff.

We have met our statutory publication duties through the publication of our refreshed Single Equality Scheme in May 2009, our Single Equality Scheme annual report in March 2010 and the publication of the results of our race equality impact assessments.

The Single Equality Scheme is closely aligned to our Recovery and Social Inclusion Strategy, which aims to promote the well being, recovery and inclusion of people who use our services. This supports people with mental health problems and learning disabilities to live as full and equal citizens of their local communities.

The equality and diversity service is led by the Head of Diversity, who reports to the Associate Director of Partnerships and Social Inclusion. Performance against targets is monitored in the following ways:

- **Equality and diversity objectives are agreed within directorate annual business plans. These were reviewed during the year through our Performance Group and performance managed through Directorate Performance Reviews.**
- **Quarterly performance reporting to the Social Inclusion and Diversity Strategy Group, the Resources Committee, through to the Board of Directors.**
- **Quarterly reporting to the Social Inclusion and Diversity Forum, with membership open to all our service users, carers, clinicians, other mental health workers and our Governors all of whom inf uence and support the implementation of the strategy.**

Team Atay with Leeds United's Liam Darville and Josh Falkingham at the Get Moving event

Operating and Financial Review

4.6.1.2 Summary of Performance – Workforce and Membership Statistics

Table 4B below shows the make up of our workforce and membership in respect of age, ethnicity, gender and disability.

Table 4B

	Staff				Public and Service User & Carer Membership			
	2008/09		2009/10		2008/09		2009/10	
	Number	%	Number	%	Number	%	Number	%
AGE								
16 - 20	3	0%	5	0%	-	-	-	-
21 - 40	1087	46%	1125	46%	1382	12%	1111	10%
41 - 55	1051	44%	1071	44%	5833	52%	6319	55%
55+	245	10%	245	10%	-	-	-	-
No date of birth stated	-	-	-	-	3941	36%	4076	35%
Total	**2386**	**100%**	**2446**	**100%**	**11156**	**100%**	**11506**	**100%**
ETHNICITY								
White	2047	86%	2098	86%	9507	85%	9777	85%
Mixed	19	1%	27	1%	186	2%	194	2%
Asian	126	5%	120	5%	389	3%	422	4%
Black	155	6%	171	7%	240	2%	270	2%
Other	39	2%	30	1%	168	2%	149	1%
No ethnicity stated	-	-	-	-	666	6%	694	6%
Total	**2386**	**100%**	**2446**	**100%**	**11156**	**100%**	**11506**	**100%**
GENDER								
Male	718	30%	734	30%	4698	42%	4828	42%
Female	1668	70%	1712	70%	6458	58%	6678	58%
Transgender (not captured)	-		-		-	-	-	-
Total	**2386**	**100%**	**2446**	**100%**	**11156**	**100%**	**11506**	**100%**
DISABILITY								
	24	**1.0%**	**130**	**5%**	Not captured		Not captured	

Operating and Financial Review

4.6.1.3 Future Priorities and Targets for Equality and Diversity

We have identified the following as priorities for 2010/11:

- **Our current Single Equality Scheme runs until December 2010 and in September 2010 we will undertake a refresh of the scheme and an extensive consultation will be undertaken with our service users, carers, staff, partners and community. This will be an opportunity to review progress to date and identify equality, diversity and social inclusion priorities for our future scheme in line with requirements within the Equality Act.**
- **A series of equality and diversity programmes have been devised, in addition to the current e-learning package, which is mandatory for all staff. We will use these programmes to train around 600 staff by March 2011.**
- **Through partnership work with local schools and colleges, and the introduction of apprenticeships for people under 21 we will look to develop a workforce that further ref ects the communities we serve.**
- **Work will be undertaken with local disability organisations and Jobcentre Plus to actively promote our staff vacancies and the support we provide for people with disabilities.**

4.6.2 Disability and Employment

Our Recruitment and Selection Procedure takes full account of the guidance in the Disability Discrimination Act and we have committed to the "Mindful Employer" charter. We are also "✓✓" Employer, which demonstrates commitment to supporting people with disabilities.

We have supportive employment practices in place including a support package within the Management of Sickness Absence Procedure, a Supporting Staff at Work Framework, Staff Support Service and a bespoke Occupational Health Service. For futher information on our Occuaptionsal Health Service see below. These procedures and services support the employment and retention of disabled employees and the implementation of reasonable adjustments to take account of individuals needs. Currently 5% of our staff have a declared disability based on voluntary notification.

Our sickness procedures take account of upcoming individual needs related to disability and provides for disability leave as a reasonable adjustment to support people to remain in work. We have made reasonable adjustments to working environments through the purchase of specialised equipment and have made necessary alterations to premises in respect of access to buildings. In addition to this our diversity training package aims to raise awareness of a wide range of diversity issues including disability to minimise discrimination in all aspects of employment. Whilst we do not have specific training courses for staff, the needs of individuals' with disabilities will be addressed through the appraisal process.

4.6.3 Staff Engagement

Key to the successful implementation of our new strategic objectives is staff engagement and feedback. We have a number of ways in which we engage with staff.

- **We use our intranet system known as Staffnet. This was very effectively used as part of our nominations process for our Trust Awards. Through this we obtained over 150 nominations for 12 categories awards. We have also used this to gain staff views on the values that we have recently launched.**
- **The Chair and Chief Executive continue to hold regular events at various sites where staff can come along and "Meet the Boss".**
- **Our Staff Governors meet with the Chairman and Chief Executive on a regular basis and feedback issues that have been raised by staff.**
- **We continue to fund trade union representatives' time and work closely with Staffside.**

Operating and Financial Review

We have plans in place to develop a Staff Engagement Strategy, part of which will be to engage staff more frequently than the current annual staff survey using both technology and more traditional face to face methods to ensure we have real-time information and dialogue with staff on key issues.

4.6.3.1 Results from the NHS Staff Survey 2009

This is the seventh annual Staff Survey in which we have participated. For the 2009 survey our staff's response rate was 48%. Table 4C below shows our performance in respect of response rate, and the Table 4D shows the four ranking scores as presented in the findings by the Care Quality Commission.

Table 4C

2008/09		2009/10		
Trust %	National Average %	Trust %	National Average %	Trust improvement/ deterioration
55	55	48	55	- 7%

Table 4D

	2008/09		2009/10		Trust improvement/ deterioration
	Trust %	National Average %	Trust %	National average %	Increase/ decrease in % points
Top Four Ranking Scores					
% of staff receiving job-relevant training, learning or development in last 12 months	82%	81%	86% (in top 20%)	81%	+4%
% of staff receiving health & safety training in last 12 months	88%	75%	91% (in top 20%)	75%	+3%
Work pressure felt by staff	3%	3%	3%	3%	Nil effect
% of staff believing trust provides equal opportunities for career progression or promotion	88%	88%	94%	90%	+6%
Bottom Four Ranking Scores					
% of staff having equality & diversity training in last 12 months	24%	35%	27%	42%	+3%
% of staff suffering work-related injury in last 12 months (the lower the score the better)	8%	8%	11%	8%	+3%
% of staff using flexible working options (the higher the score the better)	74%	72%	66%	72%	-8%
% of staff witnessing potentially harmful errors, near misses or incidents in last month (the lower the score the better)	35%	31%	33%	29%	-2%

Operating and Financial Review

4.6.3.2 Action Plan to Address Areas of Concern

In April 2010 the Board of Directors identified the following priority areas as the main actions to be taken following the analysis of the 2009 staff survey results.

Table 4E

Objective	Actions	Timescale
To improve internal communications Reference: NHS Constitution Staff Pledge 4 Staff survey questions 31, 32 and 33	• Review of internal communications (audit and focus groups) with recommendations. • Monthly mini-survey questions to staff via internal emails/staffnet pilot, including feedback loop. • Staff/Trust achievements routinely featured in Trust-wide emails, staffnet, internet, Newsline as appropriate. • Communicate staff and service user survey results to all employees via email and manager led briefings incorporating feedback process.	July 2010 July 2010- March 2011 July 2010-March 2011 31 May 2010
To focus on specific training and development issues that require improvement Reference: NHS Constitution Staff Pledge 2 Staff survey questions 11, 12, 13, 14, 15, 16, 6a, 5a to h	• Monthly monitoring of equality and diversity training by directorate with target of 80% coverage by 31 March 2011. • Assess written information given to staff as a consequence of their appraisal/ review and implement improvements where required. • Identify where level of Care Programme Approach (CPA) training needs to be improved and ensure that the Trust reaches at least the national average by March 2011. • Review progress in September 2010. • Ensure all mandatory training course attendance levels achieve 80% by March 2011. Review progression on 30 June and 30 September 2010.	By 31 March 2011 By 30 September 2010 By 30 September 2010 By 31 March 2011 By 30 September 2010 By 31 March 2011

To focus on issues relating to employee health and wellbeing
Reference:
NHS Constitution Staff Pledge 3
Staff survey questions 32a, to e. 33 a to c 29 a to c, 30a
	• Conduct a joint review of:
	  • Work related injuries.
	  • Violence from service users/relatives.
	  • Impact of work environment on health and wellbeing.
	• Using a task/finish group of managers, staff and trade union representatives with recommendations for action to bring about improvements.
	  • Introduce infection control messages/ requirements into all Trust briefings/ publications with effect from 1 June.
	  • Seek responses from all CTMs about audit of hand washing facilities in their work location.
		By 31 October 2010
		By 1 June 2010
		By 30 June 2010

To further improve job satisfaction and staff recognition	• Introduce regular staff awards prizes based on performance appraisal scores.	Commencing in October 2010
To ensure the Staff Survey is seen by staff as an effective process	• Publication of key results and action plan for 2010/11. • Publication of review of progress.	By 31 May 2010 By 31 October 2010

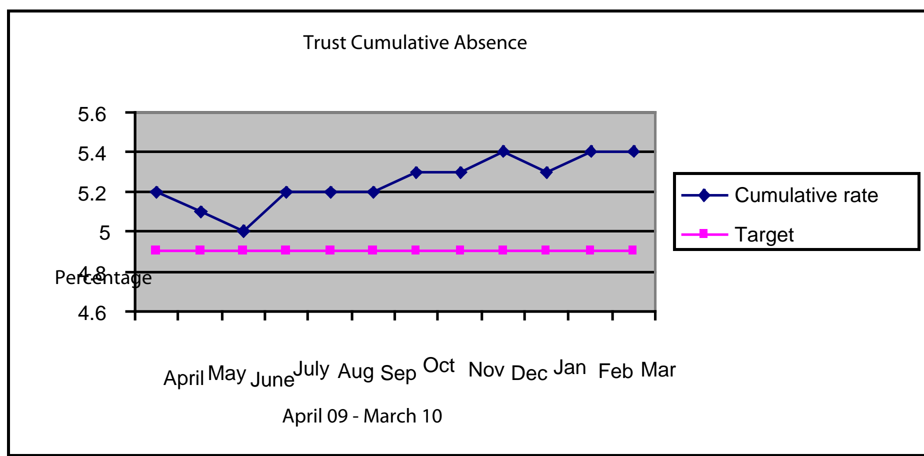
Operating and Financial Review

4.6.3.3 Future Priorities and Targets

In the light of the findings from the Staff Survey there have been a number of future priorities and targets identified these include:

- **Increasing the response rate for the staff survey to above 55%, which is the current average for Trusts. We will do this by improving communication of the survey and giving feedback to staff on what has changed as a result of their responses.**
- **Continue to monitor action plans to ensure these are completed and that the outcome of the survey is communicate to all staff.**

Table 4F



At the end of March 2010 the sickness absence rate was 5.4%. Analysis of the reasons for this found that approximately 0.4% was due to colds and flu, some of which were thought to have been swine flu related.

The target absence rate for 2010/11 has been set at 4%, which we will try and achieve over the next 12 months. Compared with other similar Trusts across the country our sickness absence rates are similar but we are striving to improve attendance and reduce costs wherever possible. The 2009/10 measures for reducing sickness absence will continue with full implementation of the revised Managing Sickness Absence Procedure along with implementing the recommendations of the Boorman report on Health and Well-being for Staff.

4.6.4 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 a mental health and learning disabilities trust.

Within the Occupational Health Service there have been a number of achievements during 2009/10 including:

- **Helping staff return to work quickly and safely.**
- **Completion of a pilot "Beating the Blues" programme, which has proved beneficial for employees with mild to moderate anxiety or depression.**
- **Making sure all our systems are efficient in respect of the vaccination recall process, which has resulted in time saved by the administration team and an increased attendance at appointments.**

4.6.5 Developing people

We have taken an innovative and progressive approach to leadership and management development. It has concentrated on three core areas namely accredited programmes; coaching; and action learning, all of which are underpinned by the Knowledge and Skills Framework and the Leadership Qualities Framework.

We have seen the further development of the Institute of Leadership & Management (ILM) programmes with the continued uptake of the ILM Level 7 in Leadership, Mentoring and Executive Coaching. We are the only NHS accredited centre to offer this project which is designed for experienced senior leaders, and we market this programme across our organisation, partner agencies in the NHS, and organisations in the private and voluntary sector.

Operating and Financial Review

The Leadership Design Forum Group set up in 2008 looked at ways in which we could engage with leaders across the organisation. One of the key outcomes has been the development of the "Fit for the Future" Programme, which is aimed at predominantly band 7 managers, and commenced in May 2010. This programme will link high quality leadership and management with high quality care by developing over 170 managers across the Trust and giving them a recognised qualification aligned to ILM level 5. The band 7 programme is seen as a pivotal enabler of the Annual Plan, Quality Innovation Productivity & Prevention (QuIPP) Strategy, Cost Improvement Programmes, New Ways of Working and Organisational Development and Workforce strategies.

4.7 Corporate Social Responsibility

4.7.1 Social Inclusion

In 2009 a Recovery and Social Inclusion Strategy was developed that set out our vision for promoting the well-being, recovery and inclusion of people who use our services. The strategy contains fifteen objectives that address different elements of people's lives, such as education, employment and financial inclusion.

For more information go to http://www.leedspft.nhs.uk/service_users/Recandsocialincl

We have made significant progress against each of the fifteen objectives over the last year and have plans for the coming year to take this work further.

We have made progress by establishing a number of partnerships with education providers such as Park Lane, College of Art & Design, Leeds College of Music, Swarthmore and Leeds Libraries that have provided music and DJ and physical fitness at Newsam Centre, visual arts at Asket Croft, drama at Becklin, email and internet courses and a long established partnership with Leeds Metropolitan University with its PLUS course for carers.

To support the implementation of the Recovery and Social Inclusion Strategy a quarterly Diversity and Social Inclusion Forum has been established where service users, carers, staff and partner organisations can influence and shape its implementation. The Forum attracts a diverse mix of participants and has produced a number of actions plans for taking elements of the agenda forwards.

In line with national priorities, as set out in Public Service Agreement (PSA) 16 (Social Inclusion) we are undertaking a programme of work to improve the vocational outcomes of people who use our services and become an exemplar employer. We have successfully worked in partnership with Leeds Mind to co-locate employment specialists in our community teams and we now have vocational leads in each of those teams who are champions for promoting employment. We have a partnership with the School of Healthcare at the University of Leeds to research the business case for employment support in clinical settings. We are currently participating in the Sainsbury Centre for Mental Health 'Centres of Excellence' programme and are working closely with Job Centre Plus and other partners across the city to streamline vocational pathways for people using our services.

In addition to improved vocational outcomes, PSA 16 also sets out expected improvements in the settled accommodation status of people experiencing mental health problems. The Trust has worked closely in partnership with NHS Leeds, Supporting People and Volition on an 'Accommodation Pathway' project to improve the housing situation of people leaving adult acute inpatient care. As a result of this initiative an interagency protocol has been developed that is improving health and social outcomes for people in inpatient care and reducing delays in discharge due to insecure housing or homelessness.

4.7.2 Reducing Stigma

We have progressed our commitment to challenge stigma experienced by people who use our services in a wide variety of ways over the last year. The following are examples of ways in which we have done this:

- **Commissioned the One in Four theatre company to perform a piece of forum theatre on the topic of stigma at our 2009 AGM, alongside a debate on stigma which included the director of the national Time to Change campaign.**
- **Hosted the national Time to Change team at a road show in Leeds City centre aimed at members of the public and were successful in getting over 200 people signed up.**
- **Held a "Get Moving" football tournament in partnership with Leeds United Football Club and Adult Social Care in which over eighty people with experience of mental distress participated.**
- **Worked with the Leeds International Film Festival to show a film and host a debate**

Operating and Financial Review

about mental health and stigma on the screen.

- Had a presence at a number of festivals including Leeds Pride, West Indian Carnival and Light Night. We aim to build this further over the next year.

4.8 Sustainability and Climate Change

4.8.1 Commentary

We are committed to protecting the built and natural environments both locally and globally. We recognise the importance of incorporating an environmentally sustainable approach into the healthcare and other activities we deliver, incorporating this into our Social Corporate Responsibility.

We are addressing the Government's aim of "well-being" by raising environmental awareness amongst our staff and the communities in which we work, because the environments in which we live and work are linked to health.

We are ensuring that all managers with strategic and operational responsibility have access to the relevant environmental information and guidance, to allow them to make informed management decisions. In addition to this specialist environmental management functions within the Facilities Department will provide professional guidance on our environmental performance.

We will continue to work with our suppliers and contractors, other key external stakeholders, such as the Carbon Trust, and statutory bodies in order to deliver a holistic approach that takes into account technical, financial, social and environmental developments.

Sustainability reporting is being carried out to measure against previous baselines and where necessary set new ones in order to track our environmental performance and impact over time.

The overall sustainability programme is led by the Board of Directors, which has provided resources both technical and managerial, to effectively minimise our impact on the environment, including our carbon footprint.

Our Carbon Management Plan is designed to minimise the impact of climate change, by reducing the greenhouse gasses we produced from our consumption of gas and electricity and other business activities.

It will also help us fulfil our commitment to carrying out all aspects of our activities with due consideration to sustainability, whilst providing high quality patient care. The Board of Directors will review this Plan annually through Board reports, and chart progress against our key targets and objectives.

The implementation of carbon reduction projects will be led by the Facilities Department with the Waste & Environmental Manager providing technical leadership on the Trust's Carbon Management Plan.

4.8.2 Summary of Performance – Non-Financial and Financial

Waste Minimisation and Management

Table 4G - Clinical Waste

	Tonnage	Cost (£)
2008/09	53.70 te	29,886
2009/10	62.69 te	36,023

The method of disposal is incineration, with heat recovery, by appointed contractor SRCL.

Table 4H - General Waste

	Cost (£)
2008/09	59,123
2009/10	47,895

The method of disposal or recovery and landfill by appointed contractor Biffa.

Operating and Financial Review

Table 4I - Use of finite resources

	2008/09		2009/10	
	Unit	Cost (£)	Units	Cost (£)
Natural gas	48,502 (GJ)	329,152	62,958 (GJ)	569,901
Electricity	18,295 (GJ)	345,313	19,880 (GJ)	443,225
Water	36,673 (m^3)	41,615	31,762 (m^3)	35,450

The slight increase in healthcare waste and reduction in general waste costs are related to the training and awareness programme delivered to the Trust's Waste champions in the early part of 2009. Hence, the figures represent improvements made in legal compliance and related management of healthcare waste following this training.

4.8.3 Future Priorities and Targets

We propose to set annualised targets for the achievement of our objectives and review performance against them. Our performance will then be tracked against our longer vision to ensure we are able to achieve our long term objectives. The short-term objectives are:

- **By 2010 reduce energy consumption of gas and electricity by 15% from 2000 levels and progress towards a 10% carbon reduction by 2015 from 2007 levels.**
- **Development of the Trust's Travel Plan by the end of 2010.**
- **Introduce environmental staff awareness programme and circulate information via our intranet site and environmental newsletter Enviro-line.**
- **Work with multi-disciplinary agencies to capitalise on city wide and regional environmental projects.**
- **Reduce water consumption which has an impact on carbon emission.**

4.9 Mental Health Act Managers

Mental Health Act Managers are members of the public, who have been 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 and hear appeals from service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders.**
- **To discharge those service users who no longer meet the criteria to be detained or be subject to Supervised Community Treatment as a result of a Community Treatment Order.**

This year the Mental Health Act Managers have got to grips with the requirements of the revised Mental Health Act, which has meant participating in the development of new administrative processes for hearings and renewals of detention and to take account of the introduction of Community Treatment Orders. The Managers have attended training sessions on Supervised Community Treatment, the role of Independent Mental Health Advocates and information governance to provide them with a more in-depth knowledge of these provisions and requirements.

As well as holding appeals, Mental Health Act Managers make periodic informal visits to our wards and units. Service users, detained under the Act, can discuss with the Managers any non-clinical issues they may have concerns about such as social and environmental care and well-being.

We are very appreciative of the time and commitment the Mental Health Act Managers and the Non-Executive Directors have given this year, particularly during a time of change in mental health law. Once again we wish to place on record our thanks to the Mental Health Act Managers for the dedication and skill they apply when undertaking this vital role.

Operating and Financial Review

Table 4J

Mental Health Act Managers for the period 1 April 2009 to 31 March 2010	
Robert Seymour (Chair)	
Peter Gallant (Secretary to the MHA Managers)	
Enid Atkinson	Peter Coltman
Kathleen Fenwick	John Fothergill
Roger Helm	Nancy Hill
Brian Kemp	Kate Kershaw
Jenny Roper	Angela Senior
Linda Shaffner	Savi Tyndale-Biscoe
Pat Varley	Gordon Wilson
Michael Yates	
Non-Executive Directors that sat on Hearing Panels for the period 1 April to 31 March 2010	
Ian Hughes	Merlin Wilce
Linda Phipps	

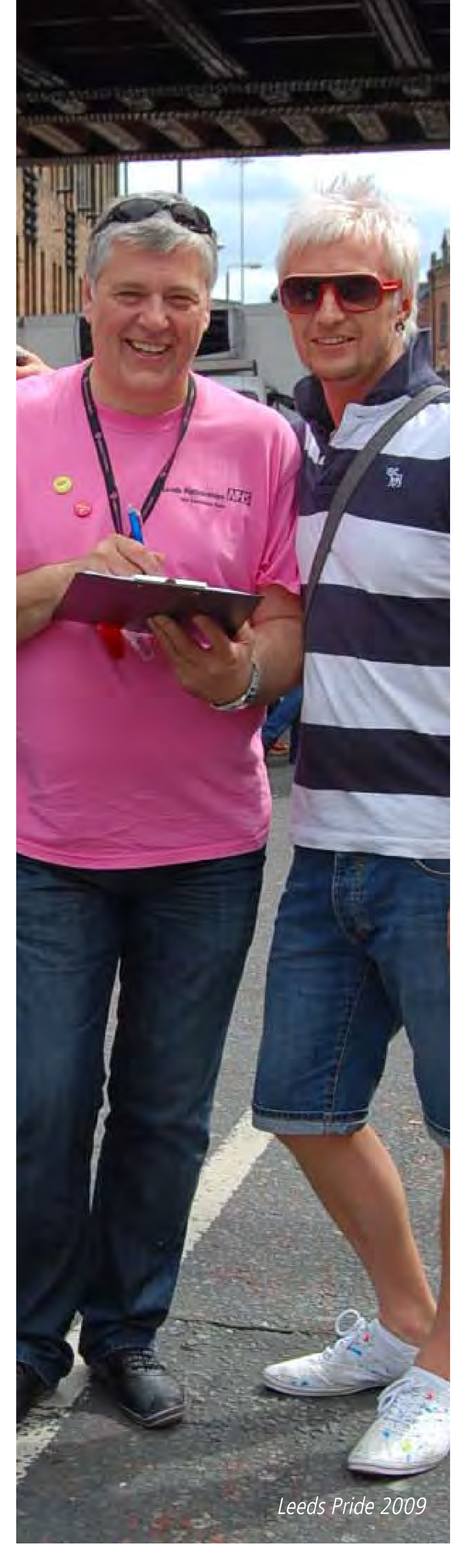
4.10 Confidentiality of Information

We are committed to ensuring that all information for which we have responsibility is kept safely and is used appropriately by individuals authorised to have access to such information. We take incidents very seriously and these are investigated fully so we can learn lessons and take action to prevent similar incidents occurring.

4.10.1 Monitor Reportable Incidents

In line with reporting requirements the Board of Directors is satisfied that an analysis of our Information Governance incident reporting records for 2009/10 contains no incidents, which have either a volume, or severity that would place them in the class of a Serious Untoward Incident.

Our summary of non-serious untoward incidents data related incidents is included below.



Leeds Pride 2009

Operating and Financial Review

Table 4K– Summary of Other Personal Data Related Incidents in 2009/10

Category	Nature of Incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	0
II	Loss of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	0
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	0
IV	Unauthorised disclosure	1
V	Other	3

4.11 Financial Performance

The year ended 31 March 2010 was the second full year of operation as a Foundation Trust and the overall performance of the Trust continued to be strong. The EBITDA margin attracts the largest weighting. It derives from the operating income and expenses (net *earnings*) *before* accounting for *interest, taxation, depreciation* or *amortisation.* It shows how the Trust is able to generate cash through normal activities, thereby allowing it to invest in services and meet financial obligations as a going concern.

EBITDA was again strong at £9.7m against a plan of £7.6m giving a margin of 7.9% against a plan of 6.2%.

4.11.1 Financial Risk Rating

The overall financial health of the Trust is assessed by Monitor, the foundation trust regulator. This is done through a number of risk ratings. A minimum risk rating of '3' provides Monitor with assurance that a foundation trust is in good financial health. This Trust is pleased to report that it is currently assessed as '4' by Monitor, in line with the 2009/10 plan.

Time to Change Event, 2009

Operating and Financial Review

Table 4L

	Metrics		Rating	
	Plan	Actual	Plan	Actual
Achievement of plan: EBITDA	100%	127.4%	5	5
Underlying Performance: EBITDA margin	6.2%	7.9%	3	3
Financial efficiency: Return on assets	6.6%	11.5%	5	5
Financial efficiency: Surplus margin	1.4%	2.1%	3	4
Liquidity	20 days	25 days	3	3
Overall rating			**4**	**4**

4.11.2 Revenue Position

Table 4M

	Plan £ million	Actual £ million	Variance from Plan £ million
Income			
Clinical income	110.8	110.8	0.0
Non-clinical income	11.1	12.2	1.1
Total income	121.9	123.0	1.1
Expenses			
Pay costs	-91.1	-89.1	2.0
Drug costs	-2.1	-2.0	0.1
Other non-pay costs	-21.1	-22.2	-1.1
Total expenses	-114.3	-113.3	1.0
EBITDA	**7.6**	**9.7**	**2.1**
Impairments	0.0	-0.9	-0.9
Profit/Loss on asset disposal	0.0	-0.9	-0.9
Interest received	0.2	0.2	0.0
Interest expenses	-3.0	-3.9	-0.9
Depreciation	-3.1	-3.1	0.0
Dividend payable	-0.5	-0.4	0.1
Other non-operating income	0.5	0.0	-0.5
Net surplus	**1.7**	**0.7**	**-1.0**

Operating and Financial Review

A surplus of £0.7m was achieved compared with a plan of £1.7m. This was, however, after accounting for impairments of £0.9m and a further £0.9m loss on asset disposal of Maple House and would therefore have otherwise been £2.5m. This gave a margin of 2.1% against the planned figure of 1.4%.

Table 4N

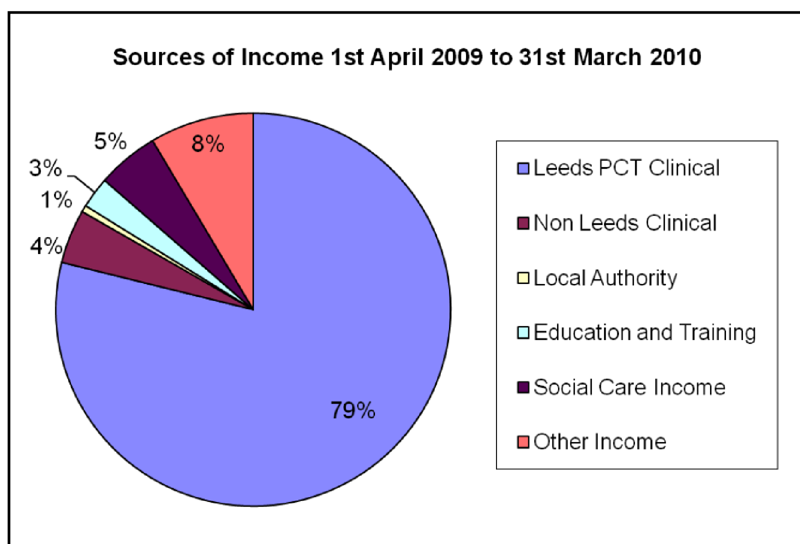
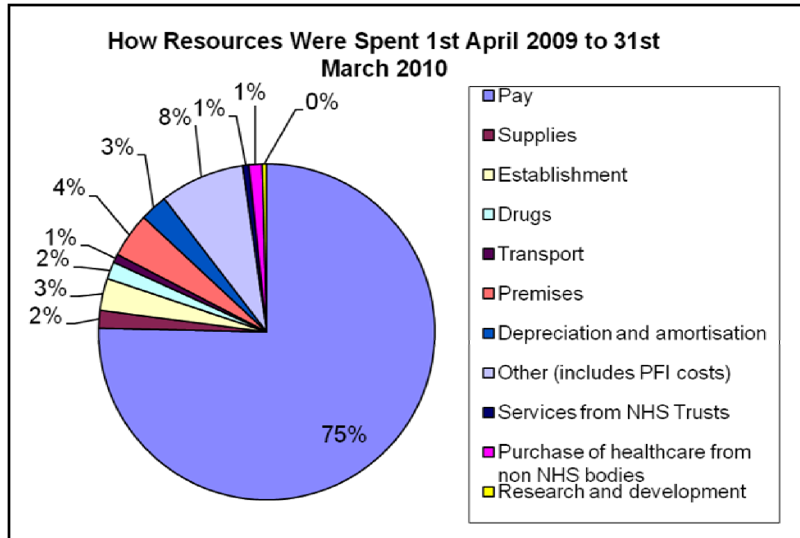


Table 4O



These graphs show the source and application of money received during 2009/10. The Trust contracted with NHS Leeds (formerly known as Leeds PCT) for 79% of its income (82% in 2008/09) but also had contracts with other PCTs, the Yorkshire and the Humber Strategic Health Authority and the Local Authority for the provision of clinical and education training services.

Income

Whilst total operating income was £1.1m in excess of plan, clinical income associated with the provision of services was on plan. The higher than planned non-clinical income was associated with research and development income and Private Finance Initiative recharges to NHS Leeds, both offset against correspondingly higher expenditure.

Pay

Pay was £2.0m lower than plan. This did, however, include a £0.6m write back associated with the provision for enhanced hours set aside in 2008/09. The underlying pay under-spend was therefore nearer £1.4m. This mainly related to delays in the recruitment to new posts and vacancies in the early part of 2009/10.

Non-Pay – Out of Area Treatments (OATs)

In respect of non-pay, the most significant real terms variance related to an over-spend of £0.7m in respect of service users referred by the Trust to other providers, (OATs). Measures introduced to increase capacity at the Trust during the year have resulted in far fewer transfers to other providers and consequently reduced this expenditure going forward.

Cash Releasing Efficiency Savings (CRES)

Cash releasing efficiency savings (CRES) can be defined as plans, which achieve an actual reduction in costs or increase in income. In 2009/10 there were plans to deliver £3.5m CRES, a sum that was broadly delivered. The majority of CRES schemes were based on cost reductions. Whilst a number of schemes took time to become embedded, a number of under-spending pay budgets offset lower than expected planned savings.

Operating and Financial Review

4.11.3 Investments in Quality 2009/10

In addition to the increase in the capital programme for 2009/10, a number of investments totalling in excess of £0.5m were made in respect of revenue (day-to-day) expenditure:

- **New pharmacy and accompanying technical staff posts to complement the tele-pharmacy development to further improve the management of medicines.**
- **A new patient safety manager, clinical audit and clinical guidelines posts were recruited to in order to ensure the constant emphasis of the safety of clinical services.**
- **An increased estate maintenance programme was implemented to complement the long-term improvement of the quality of the building stock.**

4.11.4 Capital Expenditure

The initial capital programme of £3.5m was increased during the year to £5m, with significant new investment being planned for cooling systems in the PFI units, the introduction of new anti-barricade doors and a range of other estate improvements. It is notable that in respect of the design of the doors, the Trust has developed a new innovative design, which whilst taking time to develop, is a major development in safety and security. Although a large proportion of these schemes were not completed in 2009/10, due to both technical and practical service considerations, it is anticipated that these will be delivered in 2010/11, for which funds have already been set aside.

Table 4P

Main schemes under-spent during 2009/10 were as follows:	
PFI cooling schemes	-£0.6m
Information technology	-£0.2m
Anti barricade doors etc	-£0.2m
Fire works / self-harm doors	-£0.2m
All other schemes	-£0.3m
Total	**-£1.5m**

Gareth Flanders, Patient Safety Manager

Operating and Financial Review

4.11.5 The Statement of Financial Position *(formerly known as the Balance Sheet)*

Table 4Q

	Plan £ m	Actual £ m	Variance £ m
Assets			
Assets, Non-Current, Total	**57.7**	**54.6**	**-3.1**
Assets, Current			
Inventories	0.1	0.1	0.0
Trade and Other Receivables, Current	3.0	3.6	0.6
Accrued Income	0.0	0.0	0.0
Prepayments, Current	1.0	1.0	0.0
Cash	14.4	17.4	3.0
Non-Current Assets held for sale	0.0	0.3	0.3
Assets, Current, Total	**18.5**	**22.4**	**3.9**
Total Assets	**76.2**	**77.0**	**3.5**
Liabilities			
Liabilities, Current			
Deferred Income, Current	-1.3	-2.1	-0.8
Provisions, Current	-0.1	-0.9	-0.8
Trade and Other Payables, Current	-5.4	-6.7	-1.3
Accruals, Current	-4.2	-3.6	0.6
Finance Leases, Current	-0.1	-0.1	0.0
PFI leases, Current	-0.9	-0.9	0.0
PDC dividend payable, Current	0.0	0.0	0.0
Liabilities, Current, Total	**-12.0**	**-14.3**	**-2.3**
NET CURRENT ASSETS (LIABILITIES)	**6.5**	**8.1**	**1.6**
Liabilities, Non-Current			
Deferred Income, Non-Current	-1.0	-1.1	-0.1
Provisions, Non-Current	-1.3	-2.0	-0.7
Other Financial Liabilities, Non-Current, Total	-34.7	-34.6	0.1
Liabilities, Non-Current, Total	**-37.0**	**-37.7**	**-0.7**
TOTAL ASSETS EMPLOYED	**27.2**	**25.0**	**-2.2**
Taxpayers' and Others' Equity			
Public dividend capital	19.5	19.5	0.0
Retained Earnings (Accumulated Losses)	1.0	-0.3	-1.3
Donated Asset Reserve	0.0	0.0	0.0
Revaluation Reserve	7.4	6.5	-0.9
Miscellaneous Other Reserves	-0.7	-0.7	0.0
TAXPAYERS EQUITY, TOTAL	**27.2**	**25.0**	**-2.2**
TOTAL ASSETS EMPLOYED	**27.2**	**25.0**	**-2.2**

Dr Easton, Becklin Pharmacy

Operating and Financial Review

2009/10 saw the introduction of International Financial Reporting Standards, which had a significant impact on the way in which the financial position of the Trust is reported. The key change is that the value of the PFI buildings, although not owned by the Trust, together with the corresponding debt associated with them, have now been brought into the books of the Trust for the first time. In reporting on the Statement of Financial Position the Board of Directors report that there were no post balance sheet events and there were no significant asset revaluations during 2009/10.

4.11.6 Loans and Working Capital

Table 4R

	Plan	Actual	Variance
Cash & investments	£14.4m	£17.4m	£3.0m
Days (no of days liquidity)	**20**	**25**	**4**

We had £17.4 m cash at the end of March 2010, which was £3m above the plan. The reasons for the higher than planned figure were as follows:

Operating under-spends	**£1.6m**
Improvement in working capital	**£0.9m**
Slippage on capital programme	**£0.5m**

As a Foundation Trust, greater emphasis is placed on the management of working capital, ie the money and assets that an organisation can call upon to finance its day-to-day operations. Trusts have to be able to meet commitments in the short term without necessarily relying on receiving any extra income.

Building up cash reserves allows the Trust to develop new services and invest in the estate without the need for borrowing. Table 4R shows that the Trust has sufficient liquidity to meet its commitments.

All cash funds were deposited with the Office of the Paymaster General and the Government Banking Service as at 31 March 2010. It should be noted that during the year, surplus funds are deposited temporarily in low risk deposit accounts with either U.K. commercial clearing banks or the H.M. National Loans Fund, in line with the Trust's Treasury Management Policy.

4.11.7 Exposure of the Trust to Financial Risks

Price risk - The Trust has relatively low exposure to price risk; this is for three main reasons. Firstly salary costs are the single biggest component of cost. The multi-year pay deal agreed for the majority of staff lasts up to 2010/11 and has already been factored into financial plans. Indications looking ahead are that significant pay restraint will apply in the public sector as part of the fiscal recovery programme.

Secondly, income assumptions are set out each year through the NHS Operating Framework. Assumptions made going forward regarding inflationary / deflationary changes have been assumed to be extremely challenging in the future. In particular, real reductions in PCT income of around 2% per annum have been factored into plans post 2010/11 with a zero uplift for inflation applying in 2010/11.

Finally, most income by value is on a 'block' basis rather than 'pay as you go' and it is unlikely, for the significant part of the Trust's income stream that this will change before the year 2012/13.

Credit risk - This is minimal as the majority of the customers of the Trust are public sector organisations and in particular are NHS entities.

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 Primary Care Trusts, 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. It is assumed that there will be no asset sales for the foreseeable future other than the Wilson's Arms site. The capital programme will be funded through a combination of future depreciation and existing cash resources.

Cash f ow 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; the Trust decided not to renew the working capital facility of £8.5m on its expiry in July 2009 due to the build up of adequate working capital.

Operating and Financial Review

4.11.8 Disclosure for the Payment of Creditors

The Trust adopts the Better Payment Practice Code, which requires payment of all 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 section 10.

4.11.9 Outlook for the Future

After years of steady growth, the financial outlook for the NHS is one of much lower growth. Plans for 2010/11 are built on firm assumptions, as contracts for income have been agreed and a very prudent view of future finances beyond 2010/11 has been taken. After 2010/11, future growth monies are assumed to be solely linked to improvements in quality, requiring investment in line with the additional resources potentially to be made available. Furthermore, it has been assumed that a 2% per annum real cut will be made in PCT income after 2010/11, for the foreseeable future.

Reliance on discretionary budgets is very low. In 2010/11, the Trust is planning to acquire the business of the Yorkshire and The Humber Commercial Procurement Collaborative. This acquisition is due to take place on the 1st June 2010. Due diligence has been carried out and a modest contribution to surplus of £0.3m has been factored in to budget plans for 2010/11.

There will also be the need to reduce the overall costs of the workforce. Financial estimates regarding the cost of any such reductions have been built into the plans.

Plans for any strategic growth, including potential acquisitions of services, will only be transacted subject to appropriate due diligence to ensure, not only the maintenance and improvement in service quality, but that the organisation remains a viable going concern.

We anticipate gradually moving from predominantly block-based income to more cost-per-case contracts, with the introduction of a 'payment by results' (pay per treatment) mechanism by 2012/13. Based on current projections of demand and taking account of the NHS Leeds strategic plan, no significant reductions in income are forecast, other than the deflator referred to above.

4.12 Estates and Services Strategy

Our estate comprises owned and leased premises, and PFI buildings. The PFI premises are under 10 years old and were designed to modern legislative requirements and standards. Equitix, our PFI provider, provides all the facilities' services under an agreed performance framework. The major advantage of this is that our PFI partner is contractually bound to maintain the services and premises to agreed standards over the life of the contract, and so we work closely with our PFI provider to make sure they deliver high quality services.

We have in place a 5-year Estates and Capital Revenue Programme that is aligned to our business and service plans ensuring that the accommodation is fit for the provision of care service. This has been put in place to ensure premises are fit for purpose and provide an appropriate therapeutic and working environment for both service users and staff and to ensure assets deliver value for money.

A major element of the Estate and Services Strategy is the redevelopment of St Mary's Hospital and to relocate offsite corporate services and those clinical services, which are not geographically based on this site. This will enable economy of scale opportunities to be made in the provision of modern fit for purpose premises. Redundant buildings stock and land will then be disposed of to provide capital receipts and revenue income in order to maintain the new premises.

The principal factors underpinning the Estate and Service Strategy include:

- **The changing care provision reducing the overall need for acute inpatient beds and a move to providing services in more community settings.**
- **Keeping all properties in the estates portfolio under review to ensure they continue to meet all service user, legislative and statutory requirements; and are as productive and effective as possible.**
- **Effective operational management of the estate linked through a rolling programme of maintenance and planned works to ensure we maintain the premises to acceptable standards.**

Operating and Financial Review

- **A managed disposal programme to dispose of those buildings which are declared surplus, and for which the costs of repair would otherwise be incurred. These capital receipts can then be reinvested in provision of healthcare services.**

During 2009/10 the Fire Risk Assessment Programme of Work as required under the Regulatory Reform Order, was undertaken and also major works were completed in accordance with the National Audit of Violence in order to improve service users' safety. Significant improvements were actioned to the estate in line with phase two of the Disability Discrimination Act programme. Detailed reviews and a pilot study for improving PFI cooling and ventilation and thus enhancing the environment were undertaken and this will help to facilitate future capital scheme investment for related initiatives on a planned rolling programme.

4.13 Health and Safety

We are committed to ensuring the health, safety and welfare of our employees. We also fully accept our responsibility for others who may be affected by our work activities. Health and safety is managed proactively on the basis of risk assessment with the aim of minimising the potential for injury and ill health.

Union-appointed Safety Representatives have an important and valued role in representing the interests of all staff (including those who are not in a union), consulting with management and supporting our health and safety arrangements. Their rights as Safety Representatives are outlined in the Safety Representatives: Consultation with Employees Policy. We also have a joint executive level Staffside meeting, which leads the Health and Safety agenda across the organisation.

We have in post competent people to provide specialist assistance in managing health and safety matters, including members of the Risk Management Department, a senior nurse for infection control and a Fire Officer. The Facilities Department has a special responsibility to ensure that health and safety issues are fully considered in the design and maintenance of our premises.

We recognise that we have a responsibility and a duty of care to provide a safe and secure environment, free from the risks of crime which may arise when providing a public service. This includes protection of service users, staff, visitors and their property, and the physical assets of the organisation, whilst we endeavour to provide a welcoming friendly environment for both service users and staff. We have a nominated Security Management Director, Security Champion (non Executive Director) and two appointed Local Security Management Specialists who have responsibility for investigating all security breaches, creating a pro-security culture within the Trust and liaison with stakeholders e.g. NHS Security Management Service and Police.

Managers are responsible for providing a safe working environment and ensuring the health, safety and welfare of employees, volunteers and others within the services for which they have managerial control. They also have a responsibility for the safety of service users, carers and public accessing our premises. Assessing what is 'reasonably practicable' requires managers to

Leeds United's Liam Darville, at the Get Moving event

Operating and Financial Review

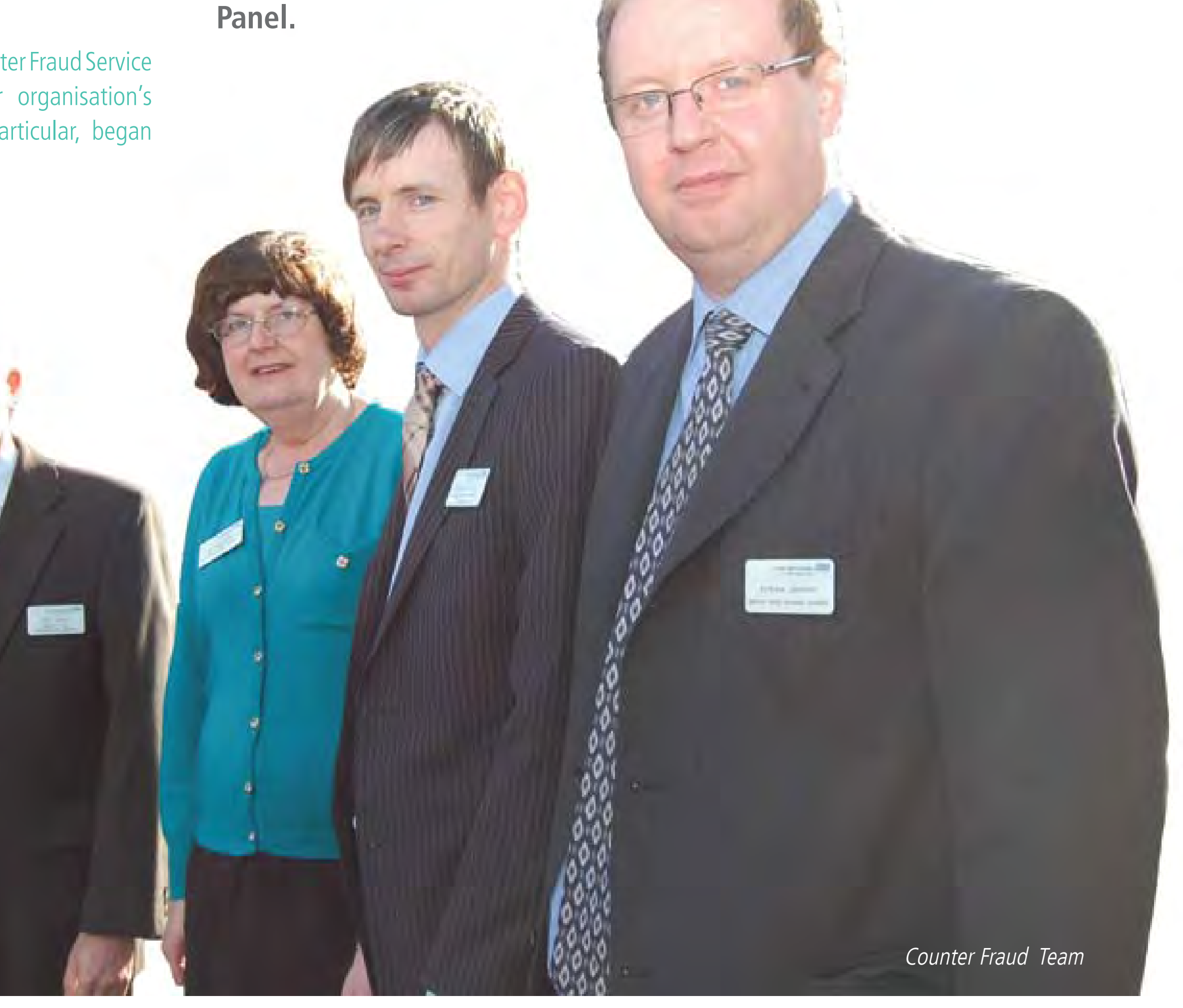
make balanced and pragmatic decisions, based on considerations of the level of risk against the cost and practicality of action necessary to reduce the risk.

4.14 Counter Fraud

Local Counter Fraud Services are provided by an in-house team. In December 2009 the results of a mandatory external assessment of counter fraud arrangements were released and our organisation was awarded a level 4 signifying "health body performing strongly" and indicated there were four areas of innovation worthy of wider adoption by the NHS. No other NHS body in the Counter Fraud Region received this level.

During 2009/10 the Local Counter Fraud Service continued to strengthen our organisation's response to fraud and, in particular, began taking the counter fraud message to staff groups that may be familiar with the subject. In addition, procedures and systems to deter, prevent and detect fraud were improved, including:

- **The CRB disclosure process for involving volunteer applications – ensuring that full documentation was being used to enable the evaluation of volunteers with criminal records to be properly and fairly evaluated by our organisation's Disclosure Panel.**
- **The agency locum procedure – ensuring that the existing procedure was recorded and deputising arrangements for authorising documentation were in place.**



Counter Fraud Team

Jenny Roper, Governor, Public: Leeds North West

Board of Governors

5.1 Composition of the Board of Governors

The Board of Governors is made up of individuals who have been elected by local people and who are representative of our membership constituencies. It also includes appointed individuals from a range of partner organisations. The Board of Governors is chaired by the Chairman of the Trust, who ensures the link between the Board of Governors and the Board of Directors; and the Deputy Chair of the Trust is also the Deputy Chair of the Board of Governors. Monitor also requires each Foundation Trust to have a Lead Governor, and Governors have nominated Andrew Marran as the current Lead Governor.

The Board of Governors is what gives the public a voice in helping to shape and influence the future of mental health and learning disability services in Leeds.

Table 5A – Number of Seats in each Governor Constituency

Constituency	No of seats
Public	9
Service User & Carer	12
Staff	6
Appointed	10

Governors elected or appointed to the initial Board of Governors in August 2007 were allocated a term of office of either 2 years or 3 years. This allocation was done by drawing lots at the first meeting of the Board of Governors, and was carried out to ensure that all Governors did not come to the end of their term of office at the same time. However, any Governor subsequently elected or appointed to the Board of Governors will be elected or appointed for a term of office for a maximum of three years and may serve up to three terms.

The Tables 5B and 5C list the Governors that have served on the Board of Governors during 2009/10.

Table 5B – Elected Governors

Name	Constituency	Maximum term of office elected for (years)	Date appointed from	Date Term of office ends
Joanna Blythe	Public: Leeds Non-resident	3	3.12.08	2.12.11
Rona Dailey	Public: Pudsey	3	3.12.08	2.12.11
Gina Greenley	Public: Central	3	3.12.08	2.12.11
Roger Harrington **	Public: Leeds East	2	17.8.07	16.8.09
Alec Hudson	Public: Morley and Rothwell	2	17.8.07	16.8.09
	(Re-elected)	3	17.8.09	16.8.12
Fiona Keighley *	Public: Leeds North West	3	28.10.08	21.4.09
Andrew Marran	Public: Elmet	3	17.8.07	16.8.10
John Mason	Public: Leeds North East	3	17.4.08	16.4.11
Jennifer Roper	Public: Leeds North West	3	16.7.09	15.7.12
William Walker *	Public: Leeds West	3	16.7.09	26.10.09
Ann Louise Butler **	Service User: Leeds	2	17.8.07	16.8.09
Betty Finch ***	Service User: Leeds	3	17.8.09	16.2.10
Andy Parker	Service User: Leeds	2	17.8.07	16.8.09
	(Re-elected)	3	17.8.09	16.8.12
Tricia Thorpe	Service User: Leeds	2	17.8.07	16.8.09
	(Re-elected)	3	17.8.09	16.8.12
Linda Tingle	Service User: Leeds	3	17.8.07	16.8.10
Maria Trainer	Service User: Leeds	3	17.8.07	16.8.10
Andrew Bottomley	Carer: Leeds	3	17.4.08	17.4.11
Cheryl Grant ***	Carer: Leeds	3	17.8.07	16.2.10
Janette Howlett	Carer: Leeds	3	17.8.07	16.8.10
Margaret Orchard *	Carer: Leeds	3	17.4.08	6.4.09
Jackie Worthington	Carer: Leeds	2	17.8.07	16.8.09
	(Re-elected)	3	17.8.09	16.8.12
Ron Sweeney	Carer: Non-Leeds	3	17.8.07	16.8.10
Lawrence Atkins **	Staff: Clinical	2	17.8.07	16.8.09
Chris Collins	Staff: Clinical	3	17.8.07	16.8.10
Vince Hitchiner	Staff: Clinical	3	17.8.07	16.8.10
Pamela Morris	Staff: Non-Clinical	2	17.8.07	16.8.09
	(Re-elected)	3	17.8.09	16.8.12
Dave Shelley	Staff: Non-Clinical	3	17.8.07	16.8.10

* Indicates those Governors that have resigned during 2009/10 before the end of their term of office
** Indicates those Governors that resigned during 2009/10 at the end of their term of office
*** Indicates those Governors that were removed from their office by the Board of Governors during 2009/10

Board of Governors

Table 5C – Appointed Governors

Name	Appointing Organisation	Term of Office (years)	Date appointed from	Date Term of office ends
Jill Copeland *	NHS Leeds	2	17.8.07	16.8.09
	(Re-appointed)	3	17.8.09	30.9.09
Colin Clark	Equitix Ltd	3	9. 4.09	8.4.12
Jan Egan *	Leeds Older Peoples Forum	3	18.1.08	16.11.09
Dawn Freshwater	University of Leeds	3	18.1.08	17.1.11
Pip Goff	Volition	2	17.8.07	16.8.09
	(Re-appointed)	3	17.8.09	16.8.12
Peter Harrand	Leeds City Council	2	17.8.07	16.8.09
	(Re-appointed)	3	17.8.09	16.8.12
Richard Hogston	Leeds Metropolitan University	3	17.8.07	16.8.10
Clare Linley	Leeds Teaching Hospitals NHS Trust	3	17.8.09	16.8.12
Mark Milsom	West Yorkshire Police	3	17.8.07	16.8.10
June Goodson-Moore	NHS Leeds	3	15.10.09	14.10.12
Philip Norman **	Leeds Teaching Hospitals NHS Trust	2	17.8.07	16.8.09
Amanda Robinson *	Leeds Local Medical Committee	2	17.8.07	16.8.09
	(Re-appointed)	3	17.8.09	10.2.10
Kate Rivers	Leeds Voluntary Sector Learning Disabilities Forum	3	15.2.10	14.02.13

* Indicates those Governors that have resigned during 2009/10 before the end of their term of office

** Indicates those Governors that resigned during 2009/10 at the end of their term of office

5.2 Changes to the Board of Governors

At the start of the year we had 33 Governors in post. Over the year there have been a number of changes to the individuals holding the position of Governor including a number of changes amongst our Appointed Governors.

5.2.1 Elected Governors

The changes within our elected Governors are detailed in Table 5B above.

Elected Governors nominate themselves and are elected on a first past the post system of voting, and elections are carried out in accordance with our Constitution.

In 2009/10 we held one round of elections in the summer of 2009, and 13 seats were included. Eight had arisen due to Governors coming to the end of their term of office, four due to the early resignation of Governors and one seat, that of service user non-Leeds, had never been filled.

Table 5D shows the seats that we were successful in filling in the summer 2009 elections.

Table 5D

Elected unopposed:		Elected by ballot:	
Public: Morley and Rothwell	Alec Hudson (re-elected)	Service User: Leeds resident	Betty Finch
Public: Leeds West	William Walker	Service User: Leeds resident	Andy Parker (re-elected)
Public: Leeds North West	Jenny Roper	Service User: Leeds resident	Tricia Thorpe (re-elected)
Carer: Leeds resident	Jackie Worthington (re-elected)	Staff: Non-clinical	Pamela Morris (re-elected)

Board of Governors

For the balloted seats election turn out was 16.8% in the Service User: Leeds resident constituency and 31.2% in the Staff: Non-Clinical Constituency.

Seats in the areas of Public: Leeds East (1 seat), Service User Non-Leeds (1 seat), Carer: Leeds Resident (1 seat) and Staff: Clinical (2 seats) remained vacant. These seats will go forward into the elections due to take place in the summer of 2010.

In addition to these five vacant seats the summer 2010 elections will also include other vacancies that have arisen during 2009/10; one seat in the Constituency of Public: Leeds West due to the early resignation of William Walker and two seats in Carer: Leeds resident and Service User: Leeds Resident due to Cheryl Grant and Betty Finch respectively being removed by the Board of Governors.

The summer 2010 elections will also see eight seats included where Governors' terms of office have come to an end.

5.2.2 Appointed Governors

Appointed Governors are nominated by those organisations we have identified as partner organisations.

During 2009/10 there were a number of changes to our Appointed Governors. Philip Norman from Leeds Teaching Hospitals NHS Trust resigned at the end of his term of office and was replaced by Clare Linley. Jill Copeland from NHS Leeds resigned early, taking up a secondment into our organisation as Director of Strategic Development, and was replaced as Governor by June Goodson-Moore. Jan Egan from the Leeds Older People's Forum Voluntary Sector Reference Group resigned early and another voluntary sector partner organisation was chosen, Leeds Voluntary Sector Learning Disabilities Forum, which appointed Kate Rivers as Governor. Colin Clark was appointed as Governor by Equitix Ltd, our PFI partner. Amanda Robinson who had served two terms of office stepped down early during her second term due to her stepping down as Chair of the Leeds Local Medical Committee, and we are awaiting confirmation as to who will be appointed into this vacancy.

At the end of their first term of office two of our appointed Governors were re-appointed to a second term by their organisations, these are Pip Goff (Volition) and Councillor Peter Harrand (Leeds City Council).

5.3 Meetings of the Board of Governors

During 2009/10 the Board of Governors formally met five times. All Board of Governors' meetings are open to members of the Trust and members of the public. Notice of these meetings is published in the local newspaper and on our website **www.leedspft.nhs.uk.**

Table 5E on page 52, details the number of meetings attended by each Governor during 2009/10. This is shown out of a maximum of 5 meetings unless a Governor has either resigned from, or joined the Board of Governors part-way through the financial year.

5.4 Duties of the Board of Governors

A valuable part of our Foundation Trust is our Board of Governors, which has clear links to the Board of Directors. However, it is the Board of Directors that is responsible for the operational management of the Trust, although the Board of Directors takes account of the views of the Governors when developing its strategy and forward plans.

The primary duty of the Board of Governors is to represent the interests of members and partner organisations. In addition to this there are a number of key statutory tasks the Board of Governors must carry out. These include:

- **Advising the Board of Directors on strategic direction.**
- **Appointing (and removing) the Chairman of the Trust and Non-Executive Directors.**
- **Approving the appointment of the Chief Executive.**
- **Appointing (and removing) the external auditor.**
- **Receiving the annual accounts, the auditors report and the annual report.**
- **Ensuring the Board of Directors does not breach the Trust's Terms of Authorisation as set by Monitor.**

During 2009/10 the Board of Directors has worked with the Board of Governors to develop services, improve care and support it in carrying out some of its statutory duties. The main formal areas of work undertaken by the Board of Governors include:

- **Developing a new strategy, including a refresh of our**

Board of Governors

aim and values, and agreeing new strategic goals and their associated targets and measures.

- Participating in PEAT inspections on our wards and units.
- On the recommendation of the Audit Committee appointing PricewaterhouseCoopers LLP as our external auditors.
- Appointing Andrew Marran as Lead Governor.
- Appointing the Deputy Chair of the Trust.
- Re-appointing Linda Phipps as a Non-Executive Director.
- Appointing Frank Griffiths as the Chairman of the Trust (from 1 April 2010).
- Reviewing the remuneration of the Chairman of the Trust and the other Non-Executive Directors.

In addition Governors have attended several external events including those run by the Foundation Trust Governors Association, the Foundation Trust Network and our regional Governors network.

5.5 Working Together

The work of the Board of Directors and the Board of Governors is closely aligned, and minutes of the meeting of each Board are presented to the other. The Chairman of the Trust provides a formal link between the two Boards and it is his responsibility to ensure an appropriate flow of information. During the period reported

Table 5E – Number of Meetings Attended by each Governor

Name	Appointed or Elected	Attendance	Name	Appointed or Elected	Attendance
Lawrence Atkins **	E	1/2	Joanna Blythe	E	4/5
Andrew Bottomley	E	3/5	Anne Louise Butler **	E	1/2
Colin Clark *	A	5/5	Chris Collins	E	4/5
Jill Copeland **	A	2/3	Rona Dailey	E	5/5
Jan Egan **	A	2/3	Betty Finch * ***	E	0/3
Dawn Freshwater	A	2/5	Pip Goff	A	4/5
June Goodson-Moore *	A	0/2	Cheryl Grant ***	E	0/5
Gina Greenely	E	2/5	Peter Harrand	A	5/5
Roger Harrington **	E	2/2	Vince Hitchiner	E	3/5
Richard Hogston	A	4/5	Janette Howlett	E	5/5
Alec Hudson	E	5/5	Fiona Keighley **	E	0/0
Clare Linley *	A	2/3	Andrew Marran	E	5/5
John Mason	E	4/5	Mark Milsom	A	2/5
Pamela Morris	E	4/5	Philip Norman **	A	2/2
Margaret Orchard **	E	0/0	Andy Parker	E	4/5
Kate Rivers *	A	1/1	Amanda Robinson **	A	3/4
Jennifer Roper *	A	3/3	Dave Shelley	E	4/5
Ron Sweeney	E	5/5	Tricia Thorpe	E	4/5
Linda Tingle	E	2/5	Maria Trainer	E	3/5
William Walker * **	E	0/2	Jackie Worthington	E	5/5

* Indicates those Governors that were elected or appointed part way through 2009/10 and therefore may not have had the opportunity to attend all meetings.
** Indicates those Governors that resigned part way through 2009/10 and may not have had the opportunity to attend all meetings.
*** Indicates those Governors that were removed from their office by the Board of Governors part way through 2009/10 and therefore may not have had the opportunity to attend all meetings.

Board of Governors

the Director of Corporate Development, the Head of Corporate Governance and the Personal Assistant to the Director of Corporate Development have been in attendance.

The Board of Governors may invite the Chief Executive, or any other member of the Board of Directors to attend. During the period of reporting each member of the Executive Team has attended one or more meetings of the Governors or has made presentations. In addition to this the Non-Executive Directors have also been at the meetings to listen to the debate and understand the issues raised by the Board of Governors.

Executive and Non-Executive Directors have taken a number of steps to understand the views of the Governors and members:

- **The Chairman and the Director of Service Delivery and Chief Nurse have jointly held a series of informal sessions for Governors to which they can bring issues and concerns.**
- **Staff Governors have met with the Chairman and Chief Executive on a regular basis.**

5.6 Sub-Committees of the Board of Governors

The Board 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 the light of this the Board of Governors has appointed two sub-committees to focus on specific work streams. These Committees are the Appointments and Remuneration Committee and the Membership Committee. Both these Committees report formally to the Board of Governors.

- **The Appointments and Remuneration Committee – this committee reviews and makes recommendations to the Board of Governors regarding appointments to vacant posts within the Non-Executive Director team, and also sets the level of remuneration made to members of the Non-Executive Team. Further information about this committee can be found in the Remuneration Report in Section 8.**
- **The Membership Committee – this committee reviews and makes recommendations to the Board of Governors in respect of the development of the membership, progress against the membership strategy, and the election process.**

5.7 Register of Governors' Interests

Under the provisions of the Constitution, we are required to have a Register of Interests to record formally declarations of interests of Governors. In particular, the Register will include details of all directorships and other relevant material interests, which have been declared.

Members of the Board of Governors must declare on appointment 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 Board of Governors. Members of the Board of Governors are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at each meeting.

The Register of Interests is maintained by the Head of Corporate Governance and is available for inspection by members of the public on request. The Head of Corporate Governance can be contacted by ringing 0113 3055930 or emailing cath.brand@leedspft.nhs.uk

Joanna Blythe, Public: Leeds Non-resident

Chris Butler, Chief Executive and Ian Hughes, Chairman (until 31 March 2010)

Board of Directors

6.1 Introduction

The Board of Directors is the legally responsible body 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 strategy and policy. It does this by:

- **Setting the overall strategic direction.**
- **Monitoring performance against objectives.**
- **Providing effective financial stewardship.**
- **Ensuring high quality, effective and service user focused services.**
- **Ensuring high standards of corporate governance and personal conduct.**
- **Promoting effective dialogue between us and our local communities.**

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

Whilst the Executive Directors are responsible for the day-to-day operational management of the organisation, the Non-Executive Directors share corporate responsibility for ensuring the Trust is run efficiently, economically and effectively. Non-Executive Directors use their expertise, and experience to help achieve this.

Table 6A – The Board of Directors as at 31 March 2010

Non-Executive Team	
Ian Hughes	Chairman of the Trust
Catherine Coyle	Non-Executive Director
Linda Phipps	Non-Executive Director – (Deputy Chair until 30.9.08)
Niccola Swan	Non-Executive Director – (Deputy Chair from 1.10.08)
Allan Valks	Non-Executive Director – (Senior Independent Director from 1.8.07)
Merlin Wilce	Non-Executive Director
Executive Team	
Chris Butler	Chief Executive
Jill Copeland	Director of Strategic Development (seconded to the Trust from 1.10.09) (non-voting)
Mike Doyle	Director of Corporate Development
Stephen Griffin	Director of Human Resources (appointed from 11.4.08) (non-voting)
Michele Moran	Director of Service Delivery and Chief Nurse
Guy Musson	Director of Finance and Performance
David Newby	Medical Director

At the end of 2009/10 the Board of Directors comprised of 6 Non-Executive Directors (including the Chairman) and 7 Executive Directors (including the Chief Executive). One of the Executive Directors, Jill Copeland, has been seconded from NHS Leeds to the Board as Director of Strategic Development for a period of 2 years.

Stephen Griffin, who was appointed as the Director of Human Resources in 2008/09 on a part-time basis, continues to work for the Trust on that basis and is supported in his role by an Associate Director of HR.

Ian Hughes has been the Chairman of this Foundation Trust since authorisation on the 1 August 2007. At its meeting on the 16 February 2010, and following a comprehensive appointment process, the Board of Governors appointed Frank Griffiths as the in-coming Chairman. Frank will take up his post on the 1 April 2010, following Ian's retirement on the 31 March 2010.

All the Non-Executive Directors are considered to be independent in both judgement and character, and 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 the Chairman of the Trust had no other significant commitments that affected his ability to carry out his duties to the full and was therefore able to allow sufficient time to undertake those duties.

Non-Executive Directors, including the Chairman of the Trust are appointed by the Board of Governors, should it be necessary to remove either the Chairman of the Trust or any of the other Non-Executive Directors this will also be done by the Board of Governors in accordance with the Trust's Constitution.

Board of Directors

6.2 Profile of Members of the Board of Directors

Ian Hughes, Chairman of the Trust (until 31 March 2010).
Ian has been a Non-Executive Director/Chairman in the NHS since 1986, first in Calderdale, then, in 1998 he was appointed as the Non-Executive Chairman of Leeds Community and Mental Health Teaching NHS Trust, which became Leeds Mental Health Teaching NHS Trust. Latterly he was appointed as Chairman of Leeds Partnerships NHS Foundation Trust.

His other part-time involvements are as Professor of Pharmacology in the University of Leeds, as a lay member of the General Osteopathic Council, and with the Richmond Fellowship (a mental health charity), the General Social Care Council, the Bar Council and the Judicial Appointments Commission.

Catherine Coyle, Non-Executive Director (Deputy Chair)
Catherine is currently a strategic communications consultant on Government funded environmental projects. In her spare time she is active in the community and until recently was a Non-Executive member of Scarborough, Whitby, and Ryedale PCT where she acted as children's champion, working closely with Surestart to improve services in the area. She was also information governance lead and member of the Northern Mental Health & Learning Disability Chairs' Group.

Prior to becoming a Non-Executive Director of the Trust, Catherine worked as a senior manager at Yorkshire Television gaining valuable commercial and business development experience establishing new and emerging market opportunities both nationally and internationally. She was also directly responsible for a range of programming, which picked up a host of awards for community coverage, including BT and the Cooperative Society media awards.

Linda Phipps, Non-Executive Director
Prior to joining the Trust as a Non-Executive Director on 1 February 2006, Linda was Chair of East Leeds Primary Care Trust.

She already has experience of mental health services having previously served on the Board of Directors of the Leeds Mental Health Service Teaching NHS Trust before taking up the post with East Leeds PCT, and is a Trustee of Mental Health Matters. Linda has a special interest in governance and risk, and chairs the Trust's Risk Management and Governance Committee.

Linda's background is in senior commercial management in the transport and local government sectors. Currently she has a portfolio of non-executive and management consultancy roles, particularly in coaching, facilitation and rapporteur work.

Niccola Swan, Non-Executive Director
Prior to becoming a Non-Executive Director of the Trust in January 2007, Niccola spent 25 years with Barclays Bank working in corporate banking, credit risk, operations and retail. She ended her career there as Regional Director of the North East. For four years she was the Barclays Group Diversity Director and so advises the Trust's Diversity Strategy Group, as well as chairing the Resources Committee.

On leaving Barclays Niccola was Deputy Chief Executive of the Employers' Forum on Disability, a membership organisation, which helps employers recruit, retain and serve disabled people. She left this role in July 2008 and now has a portfolio career. She is a trustee and the treasurer of Rethink (which used to be known as the National Schizophrenia Fellowship), a member of the Disability and Employment Advisory Committee which advises the Minister for Disabled People, and is a Director of Dignity in Dying which campaigns for greater choice at end of life. She writes and trains on diversity, and is a magistrate and a Home Start volunteer.

Merlin Wilce, Non-Executive Director
Merlin's background is in education where he was a Principal Lecturer in Health Policy at Leeds Metropolitan University. He has been an Associate Lecturer at the Open University for the last decade or so and was a visiting lecturer at the University of Leeds for a 13 year period, mainly at the former Nuffield Institute for Health.

Prior to becoming a Non-Executive Director in September 2002, Merlin was a Mental Health Act Commissioner and was on the Management Committee of a voluntary organisation providing community mental health services in Leeds. He also served as the Chair of Leeds Community Health Council. He is currently a Lay Member of the Mental Health Review Tribunal.

Allan Valks, Non-Executive Director (Senior Independent Director)
Allan is currently a Chartered Accountant, working as a Director in the Corporate Finance Team at BDO Stoy Hayward LLP. Prior to joining the Trust he was a Non-Executive Director of the North East Leeds PCT from its inception in April 2002 until October 2006.

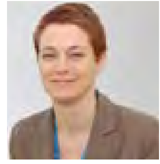
Allan has experience of working with the Department of Health NHS Foundation Trust implementation branch, Monitor and existing NHS Foundation Trusts as well as extensive experience in the commercial sector. He currently chairs the Audit Committee.

Chris Butler, Chief Executive
Chris joined the then Leeds Mental Health Teaching NHS Trust as its Chief Executive in January 2005.
Chris has a broad range of experience, first as a nurse and latterly as a PCT Chief Executive in London. He has also been a Senior Civil Servant. He has experience in

Board of Directors

primary care; commissioning – both local and strategic; service provision; and the working of Government. Chris is keen to ensure that he is directly connected to the experience of staff, service users, and carers by spending as much time as he can in the Trust's services, and by directly engaging with staff and with groups representing people who use its services.

Nationally Chris has an extensive network of contacts with the Chief Executives of other mental health trusts and leaders in the professions.



Jill Copeland, Director of Strategic Development

Jill graduated in Philosophy and holds a Masters in Business Administration from Manchester Business School.

She has worked in healthcare for over 20 years, beginning at the Department of Health where she developed policy in many areas including NHS services, finance and human resources. In 2001 Jill joined the NHS Modernisation Agency, directing national programmes that delivered better care for patients and productivity gains by applying engineering methods to delivering NHS services. From 2004, Jill directed the Making Leeds Better programme which developed community-based services for people with long term conditions. In 2006 Jill joined NHS Leeds as Executive Director of Strategic Development, where she led on strategy, partnerships, commissioning for priority groups (including mental health and learning disability services), organisational development through World Class Commissioning and estates.

Jill is committed to working in partnerships to support people to achieve their goals for improving health and improving lives.

Mike Doyle, Director of Corporate Development

Mike qualified as a Registered Mental Health Nurse in 1974 and as a Registered General Nurse in 1975. Mike worked in a variety of nursing roles including a Charge Nurse and a Community Psychiatric Nurse before becoming a Director of Nursing.

In his managerial career Mike has managed a number of Acute Hospitals and has been a Director in the mental health services in Leeds since 1992, undertaking a broad range of responsibilities. Mike has spent his career working in York, Sheffield and Leeds. He has a Masters Degree in Health Service Studies.

Stephen Griffin, Director of Human Resources

Stephen has worked as a Director of Human Resources for several NHS Trusts in Yorkshire and the North East including teaching hospitals. He has also worked for a national trade union and the Department of Health on major change projects in the NHS. Steve holds a masters degree and is professionally qualified.

Michele Moran, Director of Service Delivery and Chief Nurse (Joint Deputy Chief Executive)

Michele qualified as a nurse in 1986 and subsequently as a Midwife, and in 1991 as a Health Visitor; she also holds a Masters Degree in Health Service Management. Michele started her managerial career at Bradford Community Trust. Michele has been a senior manager in a wide range of NHS settings, from GP practices to acute settings.

Michele has been a member of several Royal College of Nursing Strategic forums and also a member of the Standing Nursing Midwifery Advisory Committee. She has undertaken CHI (Commission for Health Improvement) reviews, focusing on Mental Health Services. Currently Michele is a member of the NHS Confederation Research Network on the Executive Board and has also been chosen to be part of the NHS Talent Pool 'IMAS' and has recently undertaken a short secondment alongside PricewaterhouseCoopers LLP. Michele has recently been elected as Chair of the Foundation Trust Network (FTN) Clinical Leads Network. Michele is also part of the Top 200 leadership pool.

Guy Musson, Director of Finance and Performance (Joint Deputy Chief Executive)

Guy began his NHS finance career at the former Leeds Area Health Authority in 1975, qualifying in 1982. Holding a number of posts in Yorkshire, his last post before joining the Trust in February 2005 was Director of Finance and Commissioning at East Leeds PCT.

Guy is also a member of the pool of Interim Management and Support (IMAS) NHS consultants. The IMAS scheme facilitates the deployment of selected senior NHS managers on temporary assignments with NHS organisations seeking particular expertise in developing their organisations or resolving issues. His first assignment has been with a large acute NHS Trust wishing to proceed to Foundation Trust status.

Dr David Newby, Medical Director

David graduated in medicine from Christ's College Cambridge and Sheffield University Medical School before specialist training in psychiatry in Leeds and Manchester. He worked as a Consultant in General Adult Psychiatry in Leeds for 14 years, but for much of that time also had responsibility for providing a liaison psychiatry service to Wharfedale General Hospital in Otley.

As a former Associate Medical Director for Continuing Professional Development, he played a key part in the establishment of the Andrew Sims Centre, a national training provider in mental health. He chairs the network board for the West Yorkshire Comprehensive Local Research Network and worked with the Department of Health and the NHS Confederation to produce national guidance on the employment of Consultant Psychiatrists. Dr Newby was appointed as Medical Director for the Trust in April 2002.

Board of Directors

6.3 Meetings of the Board of Directors

The Board of Directors meets monthly, with four meetings a year held in public. In addition to the formal Board of Directors meetings, the Directors hold workshop sessions regularly throughout the year and use this time to explore new emerging issues or use the time for development. In addition to the 12 scheduled Board of Directors meetings one extraordinary meeting also took place on the 4 June 2009 to receive the annual accounts for 2008/09.

Table 6B – Attendance at the Board of Directors' meetings

Name	Attendance	Name	Attendance
Ian Hughes (chair)	13/13	Chris Butler	11/13
Jill Copeland *	6/6	Catherine Coyle	9/13
Mike Doyle	10/13	Stephen Griffin	9/13
Michele Moran	12/13	Guy Musson	13/13
David Newby	11/13	Linda Phipps	11/13
Niccola Swan	10/13	Allan Valks	12/13
Merlin Wilce	12/13		

*Jill Copeland joined the Trust on 1 October 2009 and therefore did not have the opportunity to attend all meetings.

6.4 Register of Directors' Interests

Under the provisions of the Constitution, we are required to have a Register of Interests to record formally declarations of interests of Directors. In particular, the Register will include details of all directorships and other relevant material interests, which both Executive and Non-Executive Directors have declared.

Members of the Board of Directors must declare on appointment 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 Board of Directors. Members of the Board of Directors are also required to declare any conflicts of interest that arise in the course of conducting Trust business, specifically at each meeting of the Board.

The Register of Interests is maintained by the Head of Corporate Governance and is available for inspection by members of the public on request. The Head of Corporate Governance can be contacted by ringing 0113 3055930 or emailing **cath.brand@leedspft.nhs.uk**

6.5 Evaluation of the Board of Directors and its Sub-Committees

The Board of Directors undertakes a formal evaluation of its performance and effectiveness on an annual basis, with the results being analysed by the Clinical Audit Team, using recognised evaluation tools. Any actions to address areas of development are agreed by the Board of Directors.

In addition to this each Board of Directors' sub-committee undertakes an annual evaluation of its own effectiveness. The outcome of the review is fed back into the sub-committee for it to determine what action is required. The Risk Management and Governance Committee review the overall results from the sub-committee effectiveness.

In addition to the evaluation of the Board of Directors as a whole, each member of the Board of Directors has an annual appraisal and Personal Development Plan, which is reviewed on a regular basis.

6.6 The Audit Committee

The Audit Committee is the primary governance committee. It provides a means of independent and objective review and seeks high-level assurance on the effectiveness of our governance, risk management and internal control systems. It also provides assurance of independence for internal and external audit.

Membership of the Audit Committee is made up of Non-Executive Directors as shown in table 6C below. In regular attendance at the Committee are the Director of Finance and Performance, the representatives from PricewaterhouseCoopers LLP (our external auditors), the Chief Internal Auditor, the Deputy Chief Internal Auditor (as the Local Counter Fraud Specialist), and the Head of Corporate Governance.

The table below shows the number of Audit Committee meetings attended by each member, out of a maximum of 7.

Table 6C - The Audit Committee

Name	Attendance
Allan Valks (chair)	7/7
Niccola Swan	6/7
Catherine Coyle	5/7
Merlin Wilce	5/7

Board of Directors

6.7 The Nominations Committee

The role of the Nominations Committee is to identify the skills, knowledge and experience required for vacant Board of Directors' posts for both Executive and Non-Executive posts and to be involved in the process of recruiting to such vacant posts. Where the vacant post is for a Non-Executive Director (including the Chairman of the Trust) the Nominations Committee will work in conjunction with the Board of Governors' Appointments and Remuneration Committee.

During the year the Nominations Committee has advised the Appointments and Remuneration Committee on the appointment of the Chairman of the Trust and the re-appointment of a Non-Executive Director.

The table below shows the number of Nominations Committee meetings each member attended (where they were eligible to attend) out of a maximum of 5.

Table 6D – The Nominations Committee

Name	Attendance	Name	Attendance
Ian Hughes (chair)	5/5	Chris Butler	5/5
Stephen Griffin	5/5	Linda Phipps	4/5
Niccola Swan	5/5	Allan Valks	5/5

6.8 Other Sub-Committees of the Board of Directors

6.8.1 The Remuneration Committee

Details of the work of the Remuneration Committee are included in the Remuneration Report (see Section 8).

6.8.2 The Resources Committee

The Resources Committee has been put in place to assure the Board of Directors on aspects of resources, including staff, estates and finances and to ensure there is an integrated approach to managing these resources.

The table below shows the number of Resources Committee meetings each member attended out of a maximum of 7.

Table 6E - The Resources Committee

Name	Attendance	Name	Attendance
Niccola Swan (chair)	7/7	Mike Doyle	5/7
Stephen Griffin *	4/7	Michele Moran	7/7
Guy Musson **	6/7	John Walker	3/7
Finance Representation **	1/7	HR Representation *	3/7

* HR representation on the Committee has been provided by the Director of HR or in his absence other senior members of the HR Department

** Finance representation on the Committee has been provided by the Director of Finance and Performance or in his absence other senior members of the Finance Department.

Allan Valks, Non-Executive Director attends the Resources Committee on an invitation basis to provide further NED challenge specifically in the area of financial resources.

Stamp Out Stigma Event

Board of Directors

6.8.3 The Risk Management and Governance Committee

The purpose of the Risk Management and Governance Committee is to assure the Board of Directors in areas of corporate and clinical governance, risk registers and risk management, and to review the Assurance Framework.

The table below shows the number of Risk Management and Governance Committee meetings each member attended out of a maximum of 6.

Table 6F – The Risk Management & Governance Committee

Name	Attendance	Name	Attendance
Linda Phipps (chair)	6/6	Victoria Betton *	2/6
Cath Brand	5/6	Don Brechin	6/6
Chris Butler	5/6	Mike Doyle *	5/6
Stephen Griffin *	0/6	Helen Wiseman *	4/6
Michele Moran*	3/6	Guy Musson *	3/6
David Newby *	5/6	Christine Woodward	6/6

* Where a member has been unable to attend a representative from their area has on occasions been sent to attend in their place.

6.8.4 The Information Management and Technology (IM&T) Governance Committee

It is the function of the IM&T Governance Committee to assure the Board of Directors there are systems of control in place related to all areas of information technology and knowledge management.

The table below shows the number of IM&T Governance Committee meetings each member attended out of a maximum of 4.

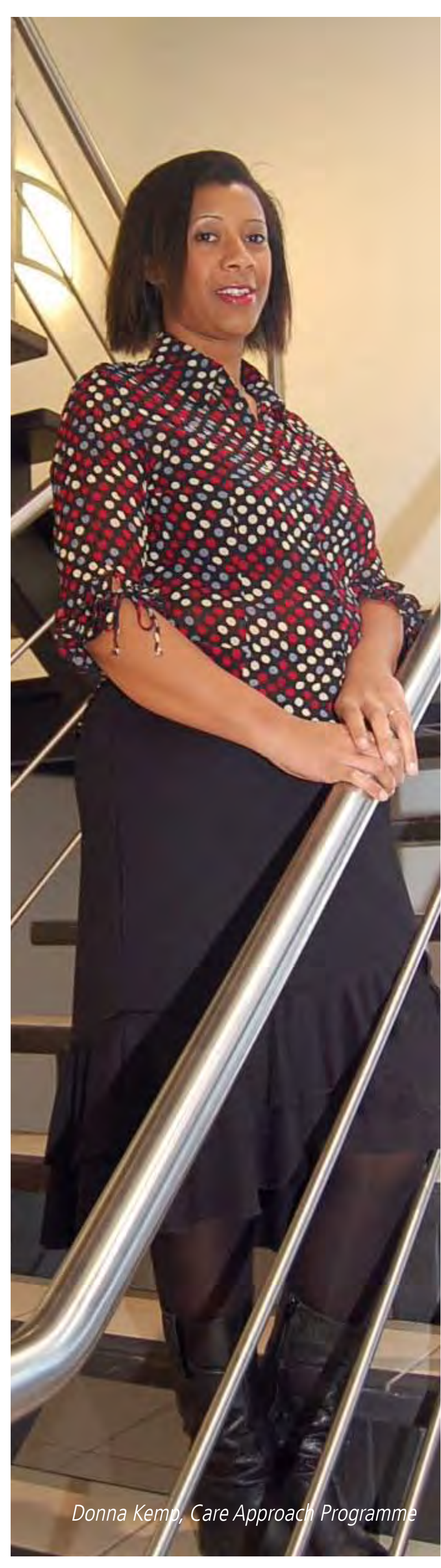
Table 6G – The IM&T Governance Committee

Name	Attendance	Name	Attendance
Ian Hughes (chair)	4/4	Heather Cook	3/4
Mike Doyle	2/4	Gerard Enright	4/4
Gail Hird	4/4	Gary Hostick *	1/3
David Newby	3/4	Lynn Parkinson **	1/1
Dave Shelley	4/4	Carl Starbuck	4/4
Matthew Watkins	3/4		

*Indicates members who stepped down from the Committee during 2009/10

**Indicates members who joined the Committee during 2009/10

During 2009/10 we have undertaken a "Rapid Improvement Event", facilitated by the NHS Institute for Innovation and Improvement. We have been working towards applying Lean principles to our Governance structure to ensure they remain efficient and effective. The event will be concluded in 2010/11 and changes made to our structures.


Donna Kemp, Care Approach Programme

Darran Bowman and Alicia Short, Voluntary Services

Paul Raisbeck, Time to Change Event, Victoria Quarter,

Membership

7.1 The Constituencies and Eligibility to Join

We have 3 membership constituencies:

- **Public**
- **Service User and Carer**
- **Staff**

The Public Constituency is divided into nine areas. There are eight that follow the boundary defined for the purpose of local government elections, and one further public constituency for Non-Leeds. Anyone (excluding staff) who resides within these boundaries can join the Public Constituency in which they live. There is one Governor elected from each of these nine areas.

The Service User and Carer Constituency is divided into 4 classes, Service User Leeds, Service User Non-Leeds, Carer Leeds, and Carer Non-Leeds. Anyone who has used our services or cares for someone who has used our services within the last 10 years can join the Service User and Carer Constituency. Their home address will determine if they can join the Leeds or Non-Leeds class. In the Service User and Carer Constituency there are a total of 12 elected seats on the Board of Governors.

The Staff Constituency is divided into 2 classes, Clinical and Non-Clinical Staff, any individual who is employed by us under a contract of employment will become a member unless they opt out. In addition to those people directly employed by us, people who exercise a function for us may also choose to be a member of the Staff Constituency. There are 4 Clinical Staff and 2 Non-Clinical Staff seats on the Board of Governors.

7.2 Number of Members

Membership has grown steadily to the current figure of **14,356.** Table 7A illustrates the breakdown, by Constituency of the total number of members as at 31 March 2010.

Table 7A – Total Membership by Constituency

Public Constituency	Number of Members
Elmet	569
Leeds East	856
Leeds North East	1321
Morley & Rothwell	725
Pudsey	753
Leeds Central	1925
Leeds North West	1685
West	1048
Non- Leeds Resident	1730
Total Public Members	**10612**
Service User and Carer Constituency	**Number of Members**
Service User Leeds Resident	450
Service User Non-Leeds Resident	48
Carer Leeds Resident	342
Carer Non-Leeds Resident	55
Total Service Users and Carer Members	**895**
Staff Constituency	**Number of Members**
Clinical	2183
Non Clinical	666
Total Staff Members	**2849**

Leeds Pride, 2009

Membership

7.3 Developing a Representative Membership

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. During the past 12 months, we have undertaken activities with gender, ethnicity and age-specific groups to ensure that the membership continues to be representative. We have targeted membership recruitment activities at minority communities through participation in key city events such as the West Indian Carnival, Leeds Pride and St Patricks Day parade. We have also held quarterly member engagement events targeted specifically at people using our services and their carers.

7.4 Membership Recruitment

In the past year, we have focussed on developing an engaged and involved membership via membership communications, including: updates, events, websites and by the highly regarded membership newsletter 'Building New Foundations'.

During this time, we also initiated a series of anti-stigma events, namely the Time to Change road show, which was held in the Leeds City centre and attracted a great number of members. We have also had related activity with local partnership organisations and special interest groups. This has both raised awareness of mental health issues and challenged the stigma that surrounds mental ill-health.

We also plan to develop a further series of exciting membership recruitment and engagement events including road shows, PR activity, public events and presentations at meetings organised by both voluntary groups and groups from diverse communities.

7.5 The Membership Office

The Membership Office is the initial point of contact for members to speak to someone within the Trust or Governors. The details are 0113 3055900 or email **FTmembership@leedspft.nhs.uk**

Adel & Warfedale
Otley & Yeadon
Leeds North West
Leeds North East
Moortown
Roundhay
Elmet
Pudsey
Bramley & Stanningley
Chapel Allerton
Killingbeck
Seacroft
Leeds West
Burmatofts & Richmond
Leeds East
Armley
City & Hunslet
Leeds Central
Temple Newsam
Kippax & Methley
Middleton Park
Morley and Rothwell

Pasang Sherpa, Climbing Everest to Stamp out Stigma

Remuneration Report

8.1 Introduction

This report contains details of senior managers' remuneration and pensions. The figures relate to those individuals who have held office as a senior manager of the Trust during 2009/10. A senior manager is defined as 'those persons in senior positions having authority or responsibility for direction or controlling the major activities of the Foundation Trust'. For this Trust the remuneration report covers the Executive and Non-Executive Directors.

8.2 Remuneration of Non-Executive Directors (Board of Governors' Appointments and Remuneration Committee)

The Appointments and Remuneration Committee, a sub-committee of the Board of Governors, sets the remuneration and terms of service for the Non-Executive Directors. This sub-committee comprises 4 members of the Board of Governors and is chaired by the Chairman of the Trust, except where the remuneration or terms of service for the Chairman of the Trust are being discussed.

The overarching policy for the remuneration of the Chairman of the Trust and the Non-Executive Directors is to award levels in line with other comparable NHS Foundation Trusts, using benchmarked figures from a number of sources; and to award annual uplifts. In past years the annual uplifts for Non-Executive Directors have been in line with those received by staff employed by us, however, for 2009/10 Non-Executive Directors received an uplift of only 1.5% with effect from 1 April 2009. This lower level was awarded by the Board of Governors having taken account of the prevailing economic climate and was in line with the 1.5% uplift received by Executive Directors.

In addition to the uplift of Non-Executives remuneration the Appointments and Remuneration Committee has considered and made recommendations to the Board of Governors in respect of the appointment of the Deputy Chair of the Trust, and the re-appointment of Linda Phipps as a Non-Executive Director. The Committee has also led the process for the appointment of Frank Griffiths as the new Chairman of the Trust.

The Appointments and Remuneration Committee receives advice from the Nominations Committee, which is a Sub-committee of the Board of Directors (see Section 6.7 for details of the membership of the Nominations Committee), and the Head of Corporate Governance. In addition to advice and support received from within the organisation the Committee is authorised under its Terms of Reference to engage external advice where it feels this is appropriate.

The table below shows the number of meetings each member attended out of a maximum of 2.

Table 8A – Appointments and Remuneration Committee

Name	Attendance	Name	Attendance
Ian Hughes (chair)	2/2	Colin Clark *	1/1
Dawn Freshwater *	0/1	Alec Hudson	1/2
Ron Sweeney	2/2	Allan Valks **	2/2

*Indicates members who joined the Committee part-way through 2009/10 and who may not have had the opportunity to attend all meetings.

**Allan Valks, Non-Executive Director and Senior Independent Director, attends each meeting in capacity of Deputy Chair of the Committee.

Ian Hughes, Catherine Coyle, Niccola Swan, Allan Valks, Linda Phipps and Merlin Wilce were appointed to their posts prior to the Trust being authorised as a Foundation Trust. At the Board of Governors meeting on 17 August 2007 Catherine Coyle, Niccola Swan, Allan Valks, Linda Phipps and Merlin Wilce were appointed as the initial Non-Executive Directors. The Board of Governors agreed their individual appointments to the end of their pre-existing period of appointment. Following a robust process of appointment Linda Phipps was re-appointed as a Non-Executive Director for a period of 3 years with effect from the 1 February 2010. Also at the Board of Governors meeting held 17 August 2007 Ian Hughes was appointed by the Board of Governors as the initial Chairman of the Trust for a period of 1 year (1 August 2007 to 31 July 2008). Ian was later re-appointed as Chairman of the Trust for a further period of 20 months running from 1 August 2008 to 31 March 2010. Ian will retire as Chairman of the trust on the 31 March 2010.

Remuneration Report

Louis Appleby,
Patient Safety Week event, 2009

Table 8B - Period of the appointments for each of the Non-Executive Directors

Name	Title	Dates
Ian Hughes	Chairman of the Trust	1.8.07 to 31.3.10
Catherine Coyle	Non-Executive Director (Deputy Chair)	1.8.07 to 31.1.11
Linda Phipps	Non-Executive Director	1.2.10 to 31.3.13
Niccola Swan	Non-Executive Director	1.8.07 to 30.11.10
Allan Valks	Non-Executive Director (Senior Independent Director)	1.8.07 to 30.11.10
Merlin Wilce	Non-Executive Director	1.8.07 to 8.9.10

8.3 Remuneration of the Executive Directors (Board of Directors' Remuneration Committee)

The Remuneration Committee sets the remuneration of the Executive Directors. This is a Sub-committee of the Board of Directors, and comprises of all the Non-Executive Directors and is chaired by the Chairman of the Trust.

The overarching policy of the Remuneration Committee is to follow the guidance given by the Department of Health in determining the pay and terms of service for Executive Directors.

The Remuneration Committee is independent of the Executive arm of the Board of Directors. However, it sometimes needs to take advice from Chris Butler the Chief Executive who has been invited to attend to provide information on how the Executive Directors have met their agreed objectives and information to support the development of the Executive Team. The Committee have also received advice from Stephen Griffin the Director of HR in relation to employment matters.

The table below shows the number of Remuneration Committee meetings attended by each member out of a maximum of 3.

Table 8C – The Remuneration Committee

Name	Attendance	Name	Attendance
Ian Hughes (chair)	3/3	Catherine Coyle	3/3
Linda Phipps	2/3	Niccola Swan	3/3
Merlin Wilce	3/3	Allan Valks	1/3

There is no performance related pay in any directors' current contract of employment. Where a salary requires review, a benchmarking exercise may be requested to make comparison against other similar NHS organisations.

Contracts for all Executive Directors are permanent, except for the Director of HR whose contract is on a temporary basis and the Director of Strategic Development who is on secondment from NHS Leeds for a period of 2 years. With regards to those Executive Directors who are on a permanent contract there is no proposal to issue short term or rolling contracts. The notice periods for Directors are set out in their employment contracts.

Remuneration Report

World Mental Health Day, Becklin Centre, 2009

Table 8D - Details of the contract start date for the Chief Executive and other members of the Executive Team.

Name	Title	Dates
Chris Butler	Chief Executive	1 January 2005
Jill Copeland	Director of Strategic Development	1 October 2009
Mike Doyle	Director of Corporate Development	12 August 1993
Stephen Griffin	Director of Human Resources	11 April 2008
Michele Moran	Director of Service Delivery and Chief Nurse	29 August 2005
Guy Musson	Director of Finance and Performance	7 February 2005
David Newby	Medical Director	8 April 2002

During the period of this report there have been no early termination of either contracts or appointments and therefore no compensation payments have been made to any member of the Board of Directors for early termination

8.4 Performance Appraisals

Whilst pay is not linked against performance, objectives are set for each executive Director in conjunction with the Chief Executive (the Chief Executives objectives are set in conjunction with the Chairman) and these are monitored and appraised through a series of one-to-one meetings which take place at various points in the year.

All members of the Board of Directors follow an agreed appraisal process comprising self appraisal, 360° peer appraisal and input from the appraiser. In May 2009 appraisals for the Executive Directors were carried out by the Chief Executive; the appraisals for the Chief Executive and the Non-Executive Directors were carried out by the Chairman of the Trust; and the appraisal of the Chairman of the Trust was carried out by the Senior Independent Director with input from members of the Board of Governors. To help support this process the Trust used an online appraisal tool hosted by the NHS Yorkshire and the Humber Strategic Health Authority.

The appraisal of individual Board members identified strengths and good performance, and areas for development. The appraisal looks at individuals' development needs, which informs tailored Personal Development Plans. The outcome of the appraisal is not linked to remuneration and no performance related pay is awarded to any member of the Board of Directors or any member of staff within the organisation.

8.5 Senior Employees Pension Entitlements, Remuneration And Benefits in Kind

The disclosure on senior employees' remuneration and pension entitlements is subject to audit by our external auditors PricewaterhouseCoopers LLP. The Auditors will read the narrative in this section and consider whether it is consistent with the annual accounts.

Table 8E sets out the pension entitlements for senior employees, it should be noted that the significant increase in cash equivalent transfer values is due to a change in the factors used in the calculation, which came into force on 1 October 2008 as a result of the Occupational Pension Scheme (Transfer Value Amendment) regulations.

Remuneration Report

Table 8E – Pension Entitlement for Senior Employees

Name and Title	Real Increase in pension at age 60 (bands of £2500)	Real Increase in pension lump sum at age 60 (bands of £2500)	Total accrued pension at age 60 at 31 March 2010 (bands of £5000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000)	Cash equivelent transfer value at 31 March 2009 £000	Cash equivelent transfer value at 31 March 2010 £000	Real Increase in cash equivelent transfer value £000	Employer-funded contribution to growth in CETV £000	Employer-contribution to stakeholder pension To nearest £000
Chris Butler - Chief Executive	0 - 2.5	5 - 7.5	10 - 15	30 - 35	163	216	45	31	0
Jill Copeland - Director of Strategic Development	0 - 2.5	0 - 2.5	30 - 35	1 90 - 95	472	526	15	11	0
Mike Doyle - Director of Corporate Development	(2.5) - 0	(2.5) - 0	40 - 45	30 - 135	1,009	1,097	37	26	0
Guy Musson - Director of Finance and Performance	0 - 2.5	2.5 - 5	45 - 50	140 - 145	894	1,013	75	52	0
Dr David Newby - Medical Director	5 - 7.5	10 - 12.5	65 - 70	195 - 200	1,237	1,442	143	100	0
Michele Moran - Director of Service Delivery and Chief Nurse	0 - 2.5	0 - 2.5	30 - 40	105 - 110	552	608	29	20	0

Non-Executive Directors do not receive pensionable remuneration and consequently there are no entries for them in respect of pensions.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Remuneration Report

Table 8F – Remuneration and Benefits in Kind for Senior Staff

Name and Title	2009 - 10		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind £
Chris Butler - Chief Executive	145 - 150	5 - 10	0
Mike Doyle - Director of Corporate Development	100 - 105	0 - 5	2,660
Guy Musson - Director of Finance and Performance	105 - 110	0 - 5	0
Dr David Newby - Medical Director	100 - 105	45 - 50	5,395
Michele Moran - Director of Service Delivery and Chief Nurse	105 - 110	0 - 5	0
Stephen Griffin - Director of Human Resources	55 - 60	0 - 5	0
Jill Copeland - Director of Strategic Development	70 - 75	0 - 5	0
Ian Hughes - Chairman of the Trust	40 - 45	-	966
Merlin Wilce - Non Executive Director	10 - 15	-	595
Linda Phipps - Non Executive Director	10 - 15	-	106
Nicola Swan - Non Executive Director	10 - 15	-	674
Allan Valks - Non Executive Director	10 - 15	-	0
Catherine Coyle - Non Executive Director	10 - 15	-	0

Claire Jones, Peartree Partnerships

The salary of the Director of Human Resources – Stephen Griffin, was paid through a recruitment agency; and Leeds PCT recharge the salary of Jill Copeland (Director of Strategic Development) who is on secondment to the Trust since October 2009. The figures for these two Directors are the gross costs as charged to the organisation.

The amounts shown as "Other Remunerations" for the Executive Directors include car allowances. The amount paid to David Newby includes a national clinical excellence award, which is externally funded, and the proportion of his salary paid to him for the clinical work he carries out.

"Benefits in Kind" in respect of the Chairman of the Trust and other Non-Executive Directors relate to the reimbursement of out of pocket expenses incurred whilst on Trust business, and those paid to Executive Directors are in respect of the Directors' lease car scheme.

Chris Butler, Chief Executive,
27 May 2010

World Mental Health Day, Becklin Centre, 2009

Quality Report

Statement on Quality from the Chief Executive

Specialist mental health and learning disability services operate in a complex environment. Our task is to help those who use our services to achieve their life aspirations. These aspirations are not just confined to health but also often encompass social care, the need for connectedness to family, friends and the wider community, and also all kinds of meaningful activity either at work or in the vocational sphere. These needs are played out in the context of the stigmatisation often experienced by people with mental health problems and learning disabilities and those who care for them.

If follows from this that for us in the Leeds Partnerships NHS Foundation Trust (LPFT), quality has a number of different dimensions. The most obvious are those obligations arising from the law and our regulators. Another aspect are those quality initiatives arising from what we learn ourselves about the lived experience of service users and carers who are being supported by our Trust. We use information drawn from data, such as our reports to the National Patient Safety Agency. As influential is what we learn from listening and responding to "patient stories". Also, as a Public Benefit Corporation, with our Governors, we are expanding our role in positively representing the issues of people with mental health problems and learning disabilities though media work and actively campaigning against discrimination.

The Trust Board of Governors and Trust Board of Directors have also recently agreed a new ambition statement for the Trust, this is:

Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives

The ambition statement is underpinned by three strategic goals that describe our commitment to excellent quality care in terms of outcomes for the people who use our services:

- **People achieve their agreed goals for improving health and improving lives**
- **People experience safe care**
- **People have a positive experience of their care and support**

Achieving our ambition means putting quality at the heart of everything we do. We will demonstrate our commitment to quality and to the people who use our services, their families and their carers, by behaving according to the NHS values:

- **Respect and dignity**
- **Commitment to quality of care**
- **Compassion**
- **Improving lives**
- **Working together**
- **Everyone counts**

Put simply, we aim to extend our national reputation for safe care into the other areas of quality: service user outcomes and experience. Our challenge is to achieve this ambition by driving up productivity and reducing cost. Our success will be reported annually in our Quality Accounts.

In summary, we aspire to be the best that we can be at what we do. We provide services to over 2,000 people every day though the work of approximately 2,800 staff. We operate from 48 sites across the metropolitan district of Leeds and further afield, spending over £114m of taxpayer's money. We are active in teaching, research and development. We continually change and improve, always striving to be better today than we were yesterday. We are never complacent and we know that there is always more we can do to improve the experience of service users and carers and our own staff.

This report illustrates only some key points on our journey of being the best we can be. I also want to take a moment to thank all of the staff of LPFT for their commitment. We only do what we do through the work of our people and everybody, either directly or indirectly, contributes to creating a better future for service users and carers.

I am happy to state that to the best of my knowledge the information included in our Quality Accounts is accurate.

Chris Butler, Chief Executive,
27 May 2010

Quality Report

9.1 Overview of Organisational Effectiveness Initiatives

The following achievements and initiatives are examples of the Trust's dedication to increasing and improving quality.

9.1.1 National Patient Safety Award

In the last year we have worked hard to continue delivering improvements in the safety and reliability of all our services. In February 2010 we were delighted when this was recognised in the National Patient Safety awards organised by the Health Service Journal and the Nursing Times. We won the mental health category outright and were highly commended runners-up in the Board leadership category. In making the award the judges described our programme for improving patient safety as "truly ground breaking". We are not complacent, however, and know there is much more we can do in this area. Equally, we are using this achievement as a platform to continue building the overall quality of our clinical services.

9.1.2 Trust Strategy

The work to refresh and update our overall Trust Strategy has been organised exclusively around the three components of quality described in the "Darzi" review (safety, effectiveness and patient experience) and this will drive specific programmes of work to achieve improvements in all those areas.

9.1.3 Employment Support

We have worked closely with JobCentre Plus and other partners to improve employment support to people using our services. We have co-located employment specialists from Leeds Mind within our Community Mental Health Teams and have vocational leads in each team. We have a social firm delivering our café service at the Becklin Centre and in 2010/2011 will expand this to another Trust site.

The city was also successful in securing regional money to fund a one year project to improve the employment pathway for people using our services.

9.1.4 Arts and Minds

In 2009/2010 Arts and Minds had a successful year working with over 400 service users and carers through creative and education projects, in partnership with a wide range of organisations including Artlink and Leeds College of Art and Design. Over 15,000 members of the public were reached through Arts and Minds participation in public events such as Light Night and Leeds West Indian Carnival. In 2010/2011 Arts and Minds are extending their programme to include a mental health and film project in partnership with the Leeds International Film Festival and Leeds Metropolitan University.

9.1.5 Access to Services

We have moved forward with initiatives to improve access to our services, for instance investing in resources needed to improve the speed of access to psychological therapies in our adult services. We have also continued to modernise the way we deliver services to make them more service user focussed, as in our redesign of services for older people with mental health needs.

9.1.6 Research and Development

We have maintained and developed our profile in learning, teaching and research. With the dissolution of the former West Yorkshire Mental Health Research and Development Consortium, we have formed a new partnership with South West Yorkshire Partnership NHS Foundation Trust to work together on promoting high quality research in the field of mental health and learning disabilities. On behalf of the West Yorkshire Clinical Local Research Network we have hosted two posts that have been successful in facilitating people in the Trust to recruit into prestigious research studies overseen by the national Mental Health Research Network. We have continued to engage service users in research design and identifying priorities.

9.1.7 Essence of Care Benchmarks

During the past 12 months the Trust has been actively implementing Essence of Care, with the main focus being on inpatient services. The benchmarking process on which 'Essence of Care' is implemented, helps practitioners to take a structured approach to sharing and comparing practice, enabling the identification of levels of excellence in care and developing action plans to improve practice which falls below the expected levels of excellence. Within the Trust an audit tool has been developed to enable each clinical area to be measured against the desired benchmark standard and in January 2010 a full audit of the Trusts 25 inpatient facilities was undertaken. A planned re-audit is scheduled for July 2010, which will include all clinical service areas within the Trust.

9.1.8 High Impact Actions

The Trust has actively reviewed staffing skill mix and focussed on developing and strengthening leadership, particularly in inpatient units. This work has resulted in a reduction of staff sickness absences and a reduction in the amount of money spent on the use of agency staff. Direct clinical benefits have been seen in an overall reduction of the occurrence of errors and in the number of service users going

Quality Report

absent without leave. The clear benefits for the Trust in terms of quality of care and integrity were recognised by this work being included as a good practice example in the Institute for Innovation and Improvement's *High Impact Actions for Nursing and Midwifery.*

9.2 How we have Prioritised our Quality Improvement Initiatives

The Trust priorities set out in the 2008-2009 Quality Report were as follows:

- **To further reduce the incidence of severe violence and aggression.**
- **Continue to take steps to ensure we are supporting our staff to work with the best clinical evidence available in the treatment and care of our patients.**
- **Maintaining, and where possible improving upon, the high level of patients who report that they have been treated with dignity and respect.**

Measures for these were identified and performance against these measures was reported to the Trust Board of Directors on a quarterly basis, through the performance report to the Trust Board.

These above priorities have been reviewed to ensure that they are consistent with the Trusts strategic direction.

Our Trust strategy is currently being reviewed and will run from 2010 to 2015. A new ambition statement has been developed, which is underpinned by three strategic end goals that describe our commitment to excellent quality care in terms of outcomes for the people who use our services. The development of our three strategic end goals was led by our Trust Board of Governors.

On the 25th March 2010 the Trust Board of Directors agreed that the Trust's top three priorities for quality improvement would be consistent with our three strategic end goals.

Our top three priorities for quality improvement are therefore:

Priority 1: People achieve their agreed goals for improving health and improving lives.

Priority 2: People experience safe care.

Priority 3: People have a positive experience of their care and support.

The Trust envisages that these three priorities will remain our Quality Accounts priorities until 2015, in line with our Trust Strategy. Each of the priorities, with our proposed initiatives for 2010-2011 are set out on the following pages.

9.3 Our Selected Measures

A wide consultation took place with Trust staff and key stakeholders over the period November 2009 to February 2010 to develop the measures for the 2009 /2010 Trust Quality Accounts. The consultation process included the Trust Board of Governors, service users and carers, clinical and non clinical staff and the voluntary sector. An extended Trust performance group meeting was held on the 1st March 2010 to review, refine and rank the measures for inclusion. These were agreed by the Trust's Executive Team and are set out on the following pages under each priority.

Progress against these measures will be reported to the Trust Board of Directors on a quarterly basis through the Trust performance report. The measures will also form part of our six monthly Directorate Performance Reviews and our annual Corporate Directorate Performance Reviews.

Benchmarking data with similar Trusts is also included, where available.

Quality Report

Priority 1

People achieve their agreed goals for improving health and improving lives	
Initiatives in 2009/10	**New Initiatives to be implemented in 2010/11**
• In 2009/2010 the organisation gave a commitment to promoting recovery focused practice. Tools such as Wellness Recovery Action Planning continued to be in use within the Trust. • A Leeds wide programme of training to refocus the Care Programme Approach has been developed and completed by staff from the Trust and partner organisations such as the Local Authority and Voluntary Sector. • The Citywide Care Programme Approach policy was developed and ratified for use following thorough consultation. • A physical health improvement procedure is now in place and a standardised healthy living tool has been developed for use throughout Adult services. • A citywide multi-agency steering group was established by the Trust to implement the requirements of the Green Light Framework. This sets standards for the provision of mental health services for service users with mild to moderate learning disabilities.	• A multi-professional task and finish group, which includes service users, has been established to work on priorities for embedding recovery focused practice throughout the organisation. The group's task will be to map the current position, identify priorities and oversee implementation. • The new National Institute for Clinical Excellence (NICE) assurance process will highlight/quantify areas where NICE evidence based interventions can be further implemented. • Integrated Care Pathway (ICP) development will specify the interventions that are recommended for specific presentations. • Our electronic health care record (PARIS) will be developed to support Integrated Care Pathways. • A 'language block' will be included on all public documents produced by the Trust, which makes clear that the document is available in other formats and other languages to ensure accessibility for all. • A Care Programme Approach information booklet will be developed in consultation with service users and partner agencies. Once finalised and agreed this will be available for service users. • A systemic understanding of outcome measurement will be developed along with systems for implementing this across the organisation.

Quality Report

Priority 1 - People achieve their agreed goals for improving health and improving lives

Performance of the Trust against selected measures

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
1. Carers offered an assessment of their needs as carers. Although we have valuable data from audit, we are developing our electronic systems to be able to provide real time data on our performance against this measure. Plans are in place to measure this indicator via electronic systems by end of May 2010	Annual Trust CPA audit	37% reported from CPA audit (1st September - 31st December 2008)	CPA audit data collection will commence in October 2010	
2. People have accessible information to support their care.	Random audit of annual increase in inclusion of the language block on all service directorate information.		2010/2011 = Baseline Year	
People reporting they received advice when receiving medication	Pharmacy Department User satisfaction survey	100 respondents 84% answered yes (Survey held Sept 2008-Oct 2008)	7 respondents 75% answered yes (survey held Sept 2009 – December 2009)	

Quality Report

Priority 1 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
3. Number of long-term inpatients over 12 months length of stay that have received an annual health review. We are developing our electronic systems to be able to provide real time data on our performance against this measure.	PARIS (Trust's electronic patient record system) Annual Physical Health Audit		2010-2011 will be a Baseline Year for data reporting from our electronic systems Data collection for the Annual Physical Health Audit will take place in May 2010.	
4. Number of patients admitted and remaining for more than 48 hours who were screened using an appropriate nutritional screening tool and recorded on PARIS.	PARIS (Trust's electronic patient record system)		A Trust wide nutritional screening tool went live on PARIS in March 2010 2010 -2011 will be a Baseline Year	

Quality Report

Priority 1 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
5. Re-admissions to inpatient care within 28 days of discharge.	PARIS (Trust's electronic patient record system)	2008/09 1426 patients discharged 89 readmissions Readmission rate = 6.2%	2009/10 1146 patients discharged 69 Readmissions Readmission rate = 6.0%	Q2 SHA Benchmarking Readmission Rates - Adult Acute Q2 SHA Benchmarking Readmission Rates - Older Peoples The graphs above show our adult and older peoples readmission rates in comparison with other mental health providers in Yorkshire and Humber for Q2 2009-2010 (which is the most current benchmarking information the Trust has received.

Quality Report

Priority 1 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
6. Number of patients on new CPA offered a copy of their care plan.	PARIS	85.89%	81.39%	
The Trust implemented new CPA on the 1st April 2010. Figures reported in 2008-2009 and 2009-2010 from PARIS are taken as a snapshot in December for those service users on both standard and enhanced CPA.	Trust Annual CPA Audit	51/247 (61%) Reported from CPA audit (1st September -30th December 2008)	Data collection will commence in October 2010	
7. People who use our services report 'yes definitely' to involvement in deciding what's in their care plan.	Annual Community Service User Survey	2009 LPFT 42% Nat. Ave. 39%	2010 LPFT 51% Nat. Ave. 53%	The graphs show our service user survey results for 2009 and 2010 in comparison with the national average

Quality Report

Priority 1 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
8. Within two years of publication we can demonstrate adherence against each NICE and other guideline for clinical care and treatment relevant to our Trust. The Trust is working with a revised process for implementation of NICE Guidance established in 2009. This process is intended to enable the Trust to demonstrate adherence to NICE Guidance within two years of publication, with adherence being demonstrated through clinical audit. Clinical audit takes place after the implementation phase of the process. All guidelines applicable to the Trust are scheduled for audit throughout 2010.	Clinical Audit Annual Programme		Baseline to be established in 2010/2011 from Clinical Audit Annual Programme.	

Quality Report

Priority 2

People experience safe care	
Initiatives in 2009/10	**New Initiatives to be implemented in 2010/11**
• Appointment of Trust wide Patient Safety Manager in August 2009. This is a pivotal role in promoting a proactive safety culture, where safe, quality patient care flourishes. • The Trust signed up to the national campaign 'Patient Safety First' which highlights the importance of patient safety within every aspect of care delivery and assists local and national initiatives by building on existing networks and creating new networks. This demonstrates the Trust's commitment to patient safety, implementing safety projects, monitoring improvement of practice and sharing of ideas. • Identification of further high impact initiatives to improve patient experience in this area which has included current scoping for Trust wide specific clinical risk training. • Trust Patient Safety week in September 2009 which focused on raising awareness and celebrating the success of active involvement in creating measurable reductions in avoidable harm. • Executive Safety Walk Around which encouraged interaction between staff to discuss their thoughts and experiences on issues relating to patient safety. • The Trust was approached by the Patient Safety First Team to produce a national podcast featuring local, regional and national activities around the UK. The Medical Director, Chief Pharmacist and Dispensary Manager took part and outlined current patient safety work in medicines management at LPFT. • Implementation of video conferencing in each pharmacy dispensary in order to facilitate remote clinical checking and approval of prescriptions.	• Continuation of the local use of tools from the National Audit of Violence (run by the Royal College of Psychiatrists), in order to continue monitoring and implementing effective service improvement. • Rolling out of Phase two mandatory specific Clinical Risk Management Training for all qualified staff, which includes enhancing skills in recognising possible triggers and methods to de-escalate high risk situations. • Benchmarking for Patient Safety with other similar mental health trusts within Yorkshire and the Humber. • Institute for Healthcare Improvement (IHI) data collection and input to enable evidence of practice and improvement. • Development of Executive Safety Walk Arounds into "Quality Walk Arounds". • Appointment of Trainee Doctors as "Safety Champions".

Quality Report

Priority 2 - People experience safe care

Performance of the Trust against selected measures

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
1. Service users report they always felt they experienced safe care. During 2010 – 2011 the Trust will re-run areas of the National Audit of Violence on a local level which will include service user experience.	National inpatient service user survey National Audit of Violence: Making it local	2009 LPFT 48% Nat. Ave 44%	2010 Survey currently underway	The graph shows our service user survey results for 2009 in comparison with the national average.
2. Staff believing that the Trust takes action to ensure errors, near misses and incidents do not happen again.	National Staff Survey	2008 LPFT 61% Nat. Ave. 55%	2009 LPFT 57% Nat. Ave. 55%	The graphs show our staff survey results for 2008 and 2009 in comparison with the national average.

Quality Report

Priority 2 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
3. Number of incidents reported to the National Patient Safety Agency (NPSA) per 1000 bed days (all categories). A high level of reporting is indicative of a good culture of safety. This measure was included in our Quality Report and remains in our Quality Accounts to ensure we retain our focus on maintaining a good culture of safety.	Risk Management Team (as reported to the National Patient Safety Agency)	April 2008 – Sept 2008: Incident rate per thousand bed days The above graph is taken from the NPSA benchmarking reports 'How do your patient safety incident reports compare with your peers'. The black bar represents the Trust's position.	April 2009 – Sept 2009: Incident rate per thousand bed days The above graph is taken from the NPSA benchmarking reports ' How do your patient safety incident reports compare with your peers' The black bar represents the Trust's position.	The graphs demonstrate that the Trust has remained in the top quartile for being a high reporter of incidents across all similar providers nation wide. Research has shown that an organisation with a high rate of reporting indicates a mature safety culture where reporting incidents is encouraged and treated fairly.

Quality Report

Priority 2 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
4. Number of incidents scoring NPSA level 1 and 2 severity. Having established a high level of reporting it is important to ensure that the vast majority of incidents result in no or low harm which are rated by the National Patient Safety Agency (NPSA) as severity 1 and 2. We also aim to continue reporting proportionately more zero harm incidents and fewer serious incidents in comparison with other Trusts.	Risk Management Team	Level 1 - 4454 Level 2 - 1168	Level 1 - 3861 Level 2 - 1274 The above figures are as of the 31st March 2010. Please note these figures may change due to further incidents being reported.	The NPSA cautions against direct comparison with other Trusts on the specific number of reports as even organisations in the same cluster can vary considerably in size and activity.

Quality Report

Priority 2 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
5. Number of incidents scoring NPSA level 3 or above. This is the number of incidents resulting in moderate harm. In last year's Quality Report a focus was placed on violence and aggression, slips trips and falls, medication errors and unauthorised absence from inpatient units. Although these areas are vitally important, as a Trust we are committed to reducing the number of any incidents causing moderate or greater harm.	Risk Management Team	Level 3 - 151 Level 4 – 17 Level 5 - 30	Level 3 - 84 Level 4 – 5 Level 5 - 7	The NPSA cautions against direct comparison with other Trusts on the specific number of reports as even organisations in the same cluster can vary considerably in size and activity.
6. Number of Serious Untoward Incidents. The Trust's Serious Untoward Incident figures will include those serious incidents which resulted in no harm.	Risk Management Team	Total of SUI for year =18	Total SUI for year 17	

Quality Report

Priority 2 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
7. Evidence of learning from incidents: Percentage of completed incidents to Trust Incident Review Group (TIRG) which have action plans that have been implemented.	Quarterly random audit of TIRG action plans.		1 Random Audit completed showing full implementation. 2010/2011 Benchmarking Year- Audits planned quarterly.	

Quality Report

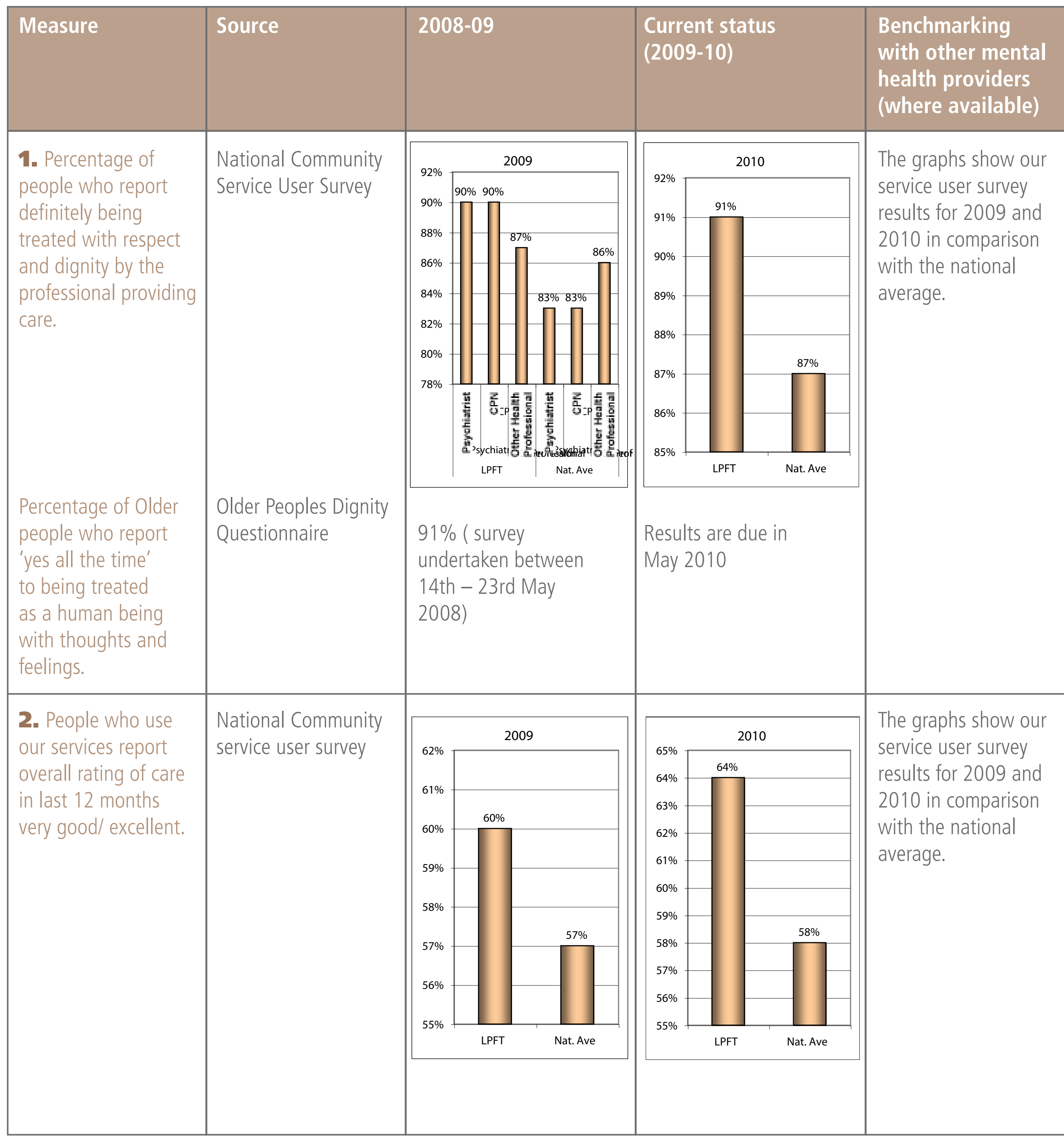
Priority 3

People have a positive experience of their care and support	
Initiatives in 2009/10	**New Initiatives to be implemented in 2010/11**
• Leeds Partnerships NHS Foundation Trust established two new regular events to engage with key stakeholders on strategic Trust wide issues. ° Building your Trust is a quarterly half-day event at the City Museum where service users, carers and public members of the Trust meet to debate relevant issues. Most recently approximately thirty participants had a useful debate about the Trust values that will inform our refreshed strategy. ° The Diversity and Social Inclusion Forum is a quarterly event bringing together service users, carers, staff and partner organisations to debate and action plan in relation to our Single Equality Scheme and Recovery and Social Inclusion Strategy. Most recently the group developed an action plan to increase the representation of diverse communities in our staffing groups. • The Carers Team went through a review by commissioners with positive feedback about the service received. • Participation in the Patient Opinion website to allow direct feedback from service users and carers. • Trust wide implementation of the Essence of Care approach across in-patient areas. • Dissemination of the Trust's Dignity Strategy as well as the Nursing and Allied Health Professions Strategies. • High visibility poster campaign provided via electronic computer 'wallpaper' highlighting dignity on all Trust computers. • Single sex accommodation priority improvements completed to schedule and ensuring 100% compliance with providing single sex accommodation.	• A systematic approach to gathering service user and carer experience is planned as part of wider Trust work on outcome measures. ° A standardised approach for capturing service user experience that can be reported across the Trust is currently in the piloting phase. ° A similar approach for gathering carer experience outcomes in relation to the Carers Charter is under development. This is currently being piloted in Learning Disability services with a further Trust-wide pilot taking place in the summer. • Regular member engagement events are being planned which will provide an opportunity for members to come together and learn about topics related to mental health and learning disabilities. • The Carers team will focus on working with Trust Governors to further develop carer involvement and deliver a new training programme for people who wish to get involved. • Continued development of the Trust intranet site hosting educational literature about dignity and respect. • Continuation of Essence of Care Benchmark implementation with the aim of all areas meeting the minimum A-B criteria. • Updating and dissemination of the Trust Dignity Strategy. • Maintaining Privacy and Dignity awareness via training, education and campaign initiatives.

Quality Report

Priority 3 - People have a positive experience of their care and support

Performance of the Trust against selected measures



Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
1. Percentage of people who report definitely being treated with respect and dignity by the professional providing care.	National Community Service User Survey			The graphs show our service user survey results for 2009 and 2010 in comparison with the national average.
Percentage of Older people who report 'yes all the time' to being treated as a human being with thoughts and feelings.	Older Peoples Dignity Questionnaire	91% (survey undertaken between 14th – 23rd May 2008)	Results are due in May 2010	
2. People who use our services report overall rating of care in last 12 months very good/ excellent.	National Community service user survey			The graphs show our service user survey results for 2009 and 2010 in comparison with the national average.

Quality Report

Priority 3 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
3. Expanding our ability to measure the experience of Service users. In year progress against milestones in implementing a standardised local service user questionnaire will be reported on.	Progress against milestones in implementation and roll out of standardised local service user questionnaire.		This is currently being piloted in Older Peoples Services with full Trust roll-out planned for October 2010.	
4. Developing the workforce to improve the experience of BME Service Users. In year progress against milestones in implementing the training programme will be reported on. The Trust is not required to undertake the Count me in Census in future years. The trust will scope out the future potential for undertaking this locally and amending it for our own purposes.	Progress against milestones in implementation and roll out of Training Programme.		Milestones: Training pilot across 4 inpatient wards May 2010 Evaluation of training pilot June 2010 Roll-out training from July 2010.	

Quality Report

Priority 3 - continued

Measure	Source	2008-09	Current status (2009-10)	Benchmarking with other mental health providers (where available)
5. Expanding our ability to measure the experience of carers. In year progress against milestones in implementing the standardised local carer questionnaire will be reported on.	Progress against milestones in implementation and roll out of standardised local Carers questionnaire.		This is currently being piloted in Learning Disability Services, with a further Trust wide pilot planned for the summer 2010. Review of process will take place in January 2011.	
6. Percentage of Carers who rate the support they receive from our Carers Team as 7/10 or better.	Ongoing Carers Team Satisfaction Questionnaire		63 responses were received between July2009 and February 2010. 90.5% rated support as 7/10 or better.	
7. Staff agreeing that they are satisfied with the quality of care they give to patients / service users. During 2010 – 2011 the Trust will re-run areas of the National Audit of Violence on a local level which will include staff experience.	National Staff Survey National Audit of Violence; making it local	2008 chart: LPFT 82%, Nat. Ave. 86%	2009 chart: LPFT 87%, Nat. Ave. 87%	The graphs show our staff survey results for 2008 and 2009 in comparison with the national average.

Quality Report

9.4 Information on the Review of Services

During 2009/2010 Leeds Partnerships NHS Foundation Trust provided four NHS services which were:

- **Learning Disabilities**
- **Adult Mental Illness**
- **Forensic Psychiatry**
- **Old Age Psychiatry**

Leeds Partnerships NHS Foundation Trust has reviewed all the data available to them on the quality of care in all of these NHS services.

The income generated by the NHS services reviewed in 2009/2010 represents 100% of the total income generated from the provision of NHS services by Leeds Partnerships NHS Foundation Trust for 2009/2010.

9.5 Participation in Clinical Audits and National Confidential Enquiries

During 2009/2010 three national clinical audits and one national confidential enquiry covered NHS services that Leeds Partnerships NHS Foundation Trust provides.

During 2009/2010 Leeds Partnerships NHS Foundation Trust participated in 50% of the national clinical audits (agreed by the Trust as appropriate based on information provided by the national audit project leads) and 100% of the national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Leeds Partnerships NHS Foundation Trust was eligible to participate in during 2009/2010 are as follows:

9.5.1 National Clinical Audits

- **National Clinical Audit of Access to Psychological Therapies – Did not participate** – Participation was considered not appropriate based on the fact that the project was gathering pilot data only during the Quality Account reporting period.
- **Prescribing Observatory for Mental Health (POMH-UK): Prescribing topics in mental health services** - Participated
- **Royal College of Physicians: National Audit of Continence Care** – Did not participate – Participation was considered appropriate but the Trust did not participate in this audit as a consequence of the lack of clarity of information regarding the project timetable, i.e. the project was on the 2010 timetable but data collection was scheduled for 2009. However it should be noted that the Trust participated in the 2006 audit of this topic.

9.5.2 National Confidential Enquiry

- **National Confidential Enquiry into Suicide and Homicide by People with Mental Illness - Participated**

The national clinical audit and national confidential enquiry that Leeds Partnerships NHS Foundation Trust participated in during 2009/2010, and for which data collection was completed during 2009/2010, are listed below alongside the number of cases submitted as a percentage of the number of registered cases required by the terms of that audit or enquiry.

9.5.3 National Clinical Audits

- **POMH-UK: Prescribing topics in mental health services**
  - **May 2009 –** Topic 8: Medicines Reconciliation
    Cases -47 (100% of those meeting the inclusion criteria)
  - **October 2009 –** Topic 6b: Assessment of side effects of depot antipsychotics (re-audit data collection)
    Cases – 91 (100% of those meeting the inclusion criteria)
  - **January 2010 –** Topic 1e: High dose and combined antipsychotics in acute adult inpatient settings (supplementary data collection)
    Cases – 90 (100% of those meeting the inclusion criteria)
  - **March 2010** – Topic 2e: Screening for the metabolic syndrome in community patients receiving antipsychotics (supplementary data collection)

Quality Report

Cases – 50 (33% representative sample of those meeting the inclusion criteria)

- **March 2010** – Topic 5c: Benchmarking the prescribing of high dose and combination antipsychotics on adult acute and PICU wards
  Cases – 90 (100% of those meeting the inclusion criteria)

9.5.4 National Confidential Enquiry

- **National Confidential Enquiry into Suicide and Homicide by People with Mental Illness**
  - Suicide Cases – 7/7 (100%)
  - Homicide Cases – 8/9 (89%)

9.5.5 National Clinical Audits

The reports of one national clinical audit were reviewed by the provider in 2009/2010 and Leeds Partnerships NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

- **January 2010** – Topic 5c: Benchmarking the prescribing of high dose and combination antipsychotics on adult acute and PICU wards (quarterly report)

Actions:

- Managers to monitor side effects monitoring as part of supervision
- Provide training to target areas on the use of Liverpool University Neuroleptic Side Effect Rating Scale (LUNSERs) and Abnormal Involuntary Movement Scale (AIMS) and stress the relevance of scales.
- Amend the Trust's Physical Health Policy
- Disseminate the audit findings via journal clubs, clinical governance councils.
- Disseminate the action plan to clinical governance councils

- **February 2010** – Topic 6b: Assessment of side effects of depot antipsychotics (re-audit report)

Actions:

- Side effects monitoring to become part of culture and monitored by managers as part of supervision
- Target areas where gains can be most easily made – Depot Clinic (training on use of LUNSERs, AIMs. Stress clinical relevance of scales)
- Target areas where gains can be most easily made – Older Adult community teams (training on use of LUNSERs, AIMS. Stress clinical relevance of scales)
- Target areas where gains can be most easily made – Newsam wards (training on use of LUNSERs, AIMs. Stress clinical relevance of scales)
- Include in physical health policy
- Disseminate report at journal clubs
- Disseminate audit and action plan to clinical governance councils
- Disseminate to pharmacy
- Disseminate to all involved in audit

- **March 2010** – Topic 1e: High dose and combined antipsychotics in acute adult inpatient settings (supplementary report)

Actions:

- Action not agreed at the time of reporting

9.5.6 Local Clinical Audits:

The reports of 27 local clinical audits were reviewed by the provider in 2009/2010. Seven of these reports contained details of neither recommendations nor proposed actions (two of these being projects carried out by Leeds University 4th year medical students). Leeds Partnerships NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided

Quality Report

No. 1 – Project 0305 NICE Guidelines (Bipolar)
- Discuss with Bipolar Guidelines Implementation Task Group
- Present in a journal club
- Consider publication for wider dissemination of findings

No.2 – Project 0267 Record Keeping (Specialist Services Directorate)
- Introduce new documentation to better meet the needs of record keeping requirements
- Share findings with ward team and Liaison Psychiatry Clinical Governance Council
- Continue use of laminated checklist on office wall
- Issues around documentation picked up by senior staff and raised with individuals concerned
- Hold each other accountable all of the time

No.3 – Project 0325 Prescription Chart audit (Specialist Services Directorate)
- Audit in 2010 – use Leeds Teaching Hospital Trust audit tool for next prescription chart audit. Clinicians to choose audit sample and timescale to reflect previous audits
- Review methodology and frequency
- Liaise with Audit Office LPFT
- Documentation – prescription and administration errors addressed locally. All omissions and errors highlighted to team
- Presentation of audit to Staff Team (Staff Meetings). Formal training session in February 2010
- Laminated instructions – 'prescribing' and 'administering' – common errors – in prescription chart folder and on notice-board in office.
- Check all IR1 forms related to prescription and administration of medicines. Highlight poor clinical practice (i.e. Administration interruptions) and address locally. Check LTHT/LPFT training packages- and implement in 2010 for administration of medicines
- Address prescribing through medical team

No.4 – Project 0045 Dementia Diagnosis and NICE Guidance
- Continue with the good standard set by the team using NICE guidelines in dementia diagnosis process
- Improve on the record keeping regarding the information indicating the consent to offer diagnosis and the outcome. Only 6% (2 assessments) sought or document consent of diagnosis disclosure (1.4.1.2)
- To go through Dementia NICE Guidelines in supervision with Senior House Officers (SHOs) and Staff Grades to achieve 100%.

No. 5 – Project 0169 NICE Guidance for Eating Disorders
- Design new proforma for initial assessments
- Information leaflets for patients to be given at time of assessment – to be put together in a pack for doctors to take to initial assessments
- Improve patient choice for treatment options (some staff currently being trained / accredited in Cognitive Analytic Therapy and Individual Person Centred Therapy)
- Leaflets from pharmacy to be used for explanation of medication side effects
- Contact GPs to get blood results (shared care) and document this for cases where there are concerns
- Use of a stamp for Alerts

No. 6 – Project 0316 Use of Patient Group Directives
- Re-audit every 2 years
- During ad hoc supervision/review of assessments physical health and allergy status to be checked
- Pharmacy policy to be updated in terms of use of Patient Group Directives by medical staff

No. 7 – Project 0231 Record Keeping (Older People's Directorate)
- Look at existing care plans and introduce a prompt section – raise this in the next team meeting
- Put up poster regarding standards for record keeping in communal staff area
- Continue weekly monitoring practices
- Raise at CTM meeting to compare practice across Directorate
- To re-audit using new minimum data set (incorporating PARIS)

No.8 – Project 0066 Record Keeping (Specialist Services Directorate)
- Raising staff awareness of minimum and supplementary data set requirements
- Develop plan in relation to the next audit
- Re-audit

No.9 – Project 0161 (NICE Guidance and Psychological Therapies)
- Produce summary report comparing these different data sources.
- Distribute report and comparative data to relevant bodies
- Discuss findings in relevant fora (e.g. Quality and Effectiveness Standards Forum, Executive Team)
- Directorate Clinical Governance Councils draw up action plans
- Clinical Audit Support Team to repeat audit

No.10 – Project 0053 Record Keeping (Adult Directorate)
- All new cases should have an assessment letter sent to the referrer within 3 months of first appointment –
- Caseload document could be amended to have checklist for assessment letters
- Outcome measures and process to be reviewed at away day – More appropriate checking and recording system in place
- Copying of correspondence to service users – Staff reminded of importance of this, and better means of recording it may be helpful
- Timeliness of case notes – Review to be had as to whether targets should be set for timeliness of notes to be typed

Quality Report

No. 11 – Project 0368 Anti-Depressant Medication and Electroconvulsive Therapy (ECT)

- Review antidepressant medications when patient prescribed ECT
- Antidepressant medication to be changed when patient administered ECT or post-ECT treatment
- Re-audit with change in clinical practice

No.12 – Project 0383 Communication of Medication Changes

- Increase the sample size to get a better picture of the audit and for comparing it with the previous audit
- Include duration of prescription as part of the audit questionnaire
- Discussion of audit findings at journal club with emphasis on change and improvement in communication
- Discussion of audit findings to the Multi Disciplinary Team with emphasis on change and improvement in communication
- To continue to educate new medical staff on importance of communication at local induction
- Re-audit in 12 months

No.13 – Project 0326 Ward-Based Therapeutic Group Programme

- Discuss whether recording the outcome data scores in detail in the discharge letters is necessary for all closed groups – Discuss within the Service Governance Council
- Consider whether the relaxation open group requires screening prior to beginning group – Discuss within the Service Governance Council

No.14 – Project 0342 Section 58 (Form 38/39)

- Responsible Clinician and junior Doctors to ensure T3 request forms for Second Opinion Appointed Doctors (SOAD) are adequately completed and treatment plan in medical notes for SAOD.
- Consultees to be made aware Code of Practice and clinical teams to ensure they are given sufficient notice about request for SOAD
- Protocol/checklist for nursing staff about whole process for completion of T2/T3 for proper coordination to reduce errors
- Redesign data collection form for improved clarity of questions.

No.15 – Project 0360 Management of Service Users with Opiate and Alcohol Addiction

- There should be clear and concise procedures for staff to follow with a suitable chart for documenting withdrawal symptoms and prescribed medication
- To use standardised, evidence based assessment scales for measuring symptoms of withdrawal
- Refer to Trust guidelines for the prevention and treatment of Wernicke-Korsakoffs syndrome
- Medicines Reconciliation Policy to be followed at all times
- To improve education and training for staff who are likely to deal with this client group.
- Link nurses on the acute adult wards to be involved in the Leeds 'dual diagnosis network keeping up to date with current issues and attending workshops etc
- Link nurses to educate other ward staff about procedures to follow/ reference sources available etc
- Re-audit after 1 year

No. 16 – Project 0392 Verbal Orders of Medication

- Email or fax copy of prescription authorization can also be considered as evidence of the authorization as an alternative to the doctor's signature. The nurses should then ask for written confirmation (via IT or fax) before administering the medications.
- A copy of the drug card can be faxed to the authorizing doctor to reduce prescribing errors (such as medication interactions)
- Failing to provide authorization via IT or fax, verbal order requests can still take place. However, there should be documented clear communication between the authorizing doctor and the doctor who signs the prescription who can then act as the 'deputy by arrangement'
- The time frame for the verbal order prescriptions to be signed should be set within 72 hours (and not within 24 hours)
- Highlight the verbal orders procedure according to the medicine code to all training doctors and staff nurses at induction and through e-learning process. The authorizing doctors should be reminded that the final responsibility in authenticating the prescription lies with the prescriber.
- Nurses to check for management plan formulated by the managing team in the patient's medical notes before requesting the verbal order.
- Compare the practice of verbal orders on the acute wards and other community in-patient units (e.g. Old age wards)

No. 17 – Project 0401 Routine Community Mental Health Team Referrals

- Clarify the standard for assessing routine referrals at managerial level i.e. Should routine referrals be seen within 30 calendar days or 30 working days
- Shorten time of response suggested in routine referral "opt-in" letters – change to "opt in" letter template
- Increase staff awareness of standards and record attempts to contact patients / assessments offered
- Consider ways of increasing awareness, e.g. posters in CMHT offices / reminders in any paperwork / discussion at CMHT meetings etc
- Decrease waiting time for medical

Quality Report

outpatient appointments. Consider how to shorten waiting times, e.g. specific assessment clinic , SHO/Registrar assessment clinic etc
- Re-audit needed after changes. Re-audit in 2010

No.18 – Project 0405 Discharge Summaries

- All doctors should be aware of the trust guidelines at the start of the post
- There should be at least one complete discharge summary in each volume of case notes
- Add certain headings to existing guidelines so important information is not missed – Smoking / alcohol / illicit drug use history, Forensic history (Guidelines exist for general Adult Psychiatry which include these headings – Old age Psychiatry guidelines should incorporate these headings)
- If doctors decide not to include information regarding the patients history that is documented elsewhere, then they should explicitly mention the date of the previous discharge summary to refer to and the doctor who dictated it
- The term key worker should be changed to care coordinator and should be included in the patient information section
- Certain information can be added by the clerk by looking into the PARIS notes if not dictated
- Legal status should be recorded in the patient information section – this is important for future reference (severity of the condition at the time of admission)

No. 19 – Project 0047 Behavioural Techniques

- Devote more time needs to devising, producing and reviewing behaviour programmes. This may require increased capacity within all professional groups in the multi disciplinary team to enable people the time needed to complete clinical assessments in a reasonable time frame, and produce Behaviour Programmes
- Ensure that Behaviour Plans are devise in collaboration with all staff specified in the Behavioural Techniques Policy and reviewed six monthly. In order to achieve this, this process could be made to coincide with the service user's Care Programme Approach.
- Clinical Team Manager of the Severe Challenging Behaviour Team to maintain a register of all people known to Leeds Partnerships NHS Foundation Trust who have aversive techniques as part of their programme, and to maintain a record of when Behaviour Programmes are reviewed. Professionals involved with service users to ensure that the Clinical Team Manager receives updated information about individuals.
- Continuing commitment to the training of all staff within the Learning Disability Directorate on the subjects of the management of challenging behaviour, and implementation of the Behavioural Techniques Policy. Relevant knowledge is clearly important and records show 20 out of 24 qualified members of staff have already attended the Trust's challenging behaviour training. The recent drive to encourage all staff to attend should improve the quality of the plans.
- Circulate electronically to all staff a template for the behavioural plan to encourage adherence to the layout specified in the behavioural techniques policy
- This audit should be repeated in April 2010

No. 20 - Project 0287 Clinical Supervision

- Supervision should be used as a way of supporting the progress of an individual's Personal Development Plan
- Agree standards for clinical supervision and all staff have access to competent supervisors
- Implement a process to measure the quality of supervision.
- Establish clear lines of communication to disseminate and feedback findings of the supervision audit
- Develop and implement standards for preceptorship developed across the directorate, and incorporate the specific supervision needs of preceptees
- Ensure availability of a number of evidence based models of supervision fit for the needs of clinicians and other front line staff
- Create a directorate wide map of current clinical supervision structures, and update on a regular basis, ensuring uptake of supervision is consistent across all professions and grades of staff
- All clinical supervision is documented in line with trust policy
- Supervisors are prepared for their role through both adequate training of supervision skills and knowledge of agreed Directorate and Trust standards
- All clinical staff to have access to the clinical supervision policy
- All clinical staff to prioritise monthly clinical supervision
- Ensure appropriate record keeping
- Clinical Supervision training
- Clarify clinical supervision arrangements for all Learning Disability Allied Health Professionals
- Ensure all members of staff have a clinical supervision supervisor for monthly sessions
- Identify individual supervisor as stated above. Group supervision to be accessed on top of this if required
- Supervision activity to be recorded by Clinical Team Managers / Band 6
- All staff to be given supervision booklets
- Confirmation of receipt of booklets to be evidenced by signatures
- Encourage supervisee / supervisor to complete supervision booklets.

9.6 Participation in Clinical Research

The number of patients receiving NHS

Quality Report

services provided or sub-contracted by Leeds Partnerships NHS Foundation Trust (LPFT) in April 2009 to March 2010, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee was 155.

In 2009/2010 the Trust was involved in conducting 37 clinical research studies, including nine National Institute for Health Research adopted studies. This compares favourably with the 29 clinical studies, including ten National Institute for Health Research studies conducted during 2008/2009, representing an increase in total study activity of 28%. This increasing number of clinical research studies demonstrates LPFT's commitment to improving the quality of care we offer and to making our contribution to wider health improvement.

One member of staff has been awarded a National Institute for Health Research Fellowship hosted by the University of Leeds. The Trust hosts the West Yorkshire Comprehensive Local Research Network funded posts of Lead Clinician and Clinical Studies Officer working on Mental Health Research Network projects. These posts have facilitated an important link with the Mental Health Research Network hub in Newcastle, and provided access and support to Trust staff wishing to engage with Mental Health Research Network supported studies. Whilst in its infancy, this development provides a significant opportunity to increase the level of National Institute for Health Research portfolio activity within the Trust, previously outside this network's activity.

As we move into a more challenging financial climate, research and innovation will become even more important in identifying the new ways of understanding, preventing, diagnosing and treating disease that are essential if we are to increase the quality and productivity of services in the future.

9.7 Commissioning for Quality and Innovation Framework (CQUIN)

A proportion of Leeds Partnerships NHS Foundation Trust's income in 2009/2010 was conditional upon achieving quality improvement and innovation goals agreed between Leeds Partnerships NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2009/2010 and for the following 12 month period are available on request from the Performance Team who can be contacted on 0113 305 5000.

For Leeds Partnerships NHS Foundation Trust the monetary total for the amount of income in 2009/2010 conditional upon achieving quality improvement and innovation goals was £480, 145. The monetary total for the associated payment in 2009/2010 was £480,145.

In 2009/2010 Leeds Partnerships NHS Foundation Trust was part of NHS Yorkshire and the Humber regional Commissioning for Quality and Innovation scheme. Payment against the indicators for 2009/2010 was based on all data being provided by specified deadlines for all indicators applicable to the Trust. For 2009/2010 the Trust provided all data within the timescales.

For 2009/2010 CQUIN data was reported to the Trust Board of Directors on a quarterly basis through the monthly performance report to the Trust Board.

In 2010/2011 Leeds Partnerships NHS Foundation Trust will be required to report performance against regional CQUINs, local CQUINs and Forensic CQUINs. Progress against 2010/2011 CQUINs will be monitored by the Trust on a monthly basis. Plans are in place to ensure that the Trust meets their CQUINs throughout 2010/2011.

9.8 Care Quality Commission

9.8.1 Registration Status

Leeds Partnerships NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered without conditions. A robust internal review process for assessing Trust compliance with each registration requirement was developed and implemented. Improvement plans have been developed for each regulation in order to further strengthen and maintain the Trust's position of compliance. These improvement plans are monitored by the Executive Team on a monthly basis. The Trust will continue to ensure that compliance against each registration requirement is monitored and maintained.

The Care Quality Commission has not taken enforcement action against Leeds Partnerships NHS Foundation Trust during 2009/2010.

9.8.2 Periodic Review

Leeds Partnerships NHS Foundation Trust is subject to periodic review by the Care Quality Commission and the last review was for 2008/2009. The Care Quality Commission's assessment of Leeds Partnerships NHS Foundation Trust following that review was 'Good'.

For 2008/2009 the Trust received a rating of 'Good' against the Care Quality Commission national priorities. The Trust was assessed against ten indicators. A score of 'achieved' was received for seven indicators, a score of 'underachieved' for two indicators (Delayed Transfers of Care and Green Light Toolkit) and a score of 'failed' for one indicator (Access to Crisis Resolution).

Performance against the Access to Crisis Resolution' indicator is reported to the Trust Board of Directors on a monthly basis through the Performance Report to the Trust

Quality Report

Board. Figures have increased in-year in light of a review of the service model in July 09. Using the CQC definition April 2009 – March 2010 figures show a percentage of 92.8% of admissions assessed by Crisis Resolution. For 2009/2010 the Care Quality Commission has published a threshold of 90% to fully achieve this priority. Using this threshold we have moved from a position of 'failed' in 2008/2009 to a position of 'achieved' in 2009-2010.

Performance against the 'Best Practice in Mental Health Services for People with a Learning Disability' indicator is reported to the Trust Board of Directors on a monthly basis through the Performance Report to the Trust Board. A Green Light Framework inter-agency steering group, chaired by the Associate Director of Adult Services, was established by the Trust in May 2009.

This group includes membership from each service directorate to ensure a Trust wide commitment to work on the Green Light Framework, as well as representation from NHS Leeds, Adult Social Care and Volition to ensure that work is undertaken on a Leeds wide basis. The group has developed action plans to achieve a 'green' rating for all 39 requirements of the toolkit. Extensive work has been carried out on the original 12 'key' requirements and the Trust has reported a 'green' status on all of these as at the 31st March 2010.

The Trust has maintained a focus on delayed transfers of care over the last year and internal performance thresholds of 5% were set to mitigate the risk of the Trust under-achieving this target in 2009/2010. Performance against this indicator is reported to the Trust Board of Directors on a monthly basis through the performance report to the Trust Board. For 2009/2010 the CQC will be using data from the period April 2009– August 2009 to assess performance against this indicator. For this period our cumulative delays are 3.7%. If the CQC maintain the same threshold of 7.5% applied in 2008/2009 then the Trust will fully meet this national priority.

The Trust will receive their performance rating against the 2009/2010 Care Quality Commission national priorities in the Autumn of 2010.

9.8.3 Special Reviews

In March 2009 Leeds Partnerships NHS Foundation Trust participated in the national Care Quality Commission review of Safeguarding Children. This review looked at Board assurance around child protection systems, including staff training and partnership working. The national report, outlining the findings, was published by the Care Quality Commission in July 2009. A key finding of the report was that nationally only 54% of NHS staff had completed safeguarding children training to level 1.

The Trust put an action plan in place to address the national findings of the Care Quality Commission with regard to safeguarding children training. Actions undertaken by the Trust included, continuing to advertise and encourage the completion of level 1a training on-line, the development of classroom based teaching sessions throughout Trust sites to enable staff to attend the training with ease and partnership working to enable staff to attend training sessions organised by NHS Leeds.

By the 31st December 2009 the Trust had demonstrated significant improvement in the numbers of eligible staff completing level 1 safeguarding training and was able to declare 93.49% compliance. By February 2010 figures had increased further to 98.25% of eligible Trust staff having received level 1 safeguarding children training.

9.9 Information on the Quality of Data

9.9.1 Statement on Data Quality

LPFT submitted records during Quarter 1-Quarter 4 2009/2010 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- Which included the patients valid NHS number was 98.4% for admitted patient care and 99.1% for outpatient care
- Which included the patient's valid General Medical Practice Code was 100% for admitted patient care and 100% for outpatient care

9.9.2 Information Governance Attainment Levels

Leeds Partnerships NHS Foundation Trust's score for 2009 – 2010 for Information Quality and Records Management assessed using the Information Governance Toolkit was 63%.

This is based on 18 of the 21 toolkit indicators for a theoretical maximum of 54, not 63. Omitted standards are:

407: A standard opt-out for Mental Health Trusts – we do not operate an A&E department
505: Leeds Partnerships NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2009-2010 by the Audit Commission
511: This also relates to Payment by Results and was not relevant to the Trust at this time

9.9.3 Clinical Coding Error Rate

Leeds Partnerships NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2009-2010 by the Audit Commission

9.10 Review of Quality Performance

Quality Report

9.10.1 Care Quality Commission Core Standards

Care Quality Commission Core Standards
The Healthcare Commission (HCC) was the independent watchdog for healthcare in England until the 1st April 2009. The Care Quality Commission then came into being and assumed the role of independent regulator of all health and adult social care in England.
In October 2009 the Trust received the results of the Care Quality Commissions Annual Healthcheck performance assessment for 2008/09. We received a score of 'Good' for quality of services and 'Good' for use of resources.

As a Foundation Trust the Trust's quality of financial management score is based on the annual financial risk rating awarded by Monitor. A rating of 'good' assesses the Trust as having a good financial performance, with a low to medium level of financial risk.

Prior to the 1st April 2010 every NHS Trust in England was responsible for ensuring it was complying with the Government's Standards for Better Health. As part of the annual health check, trusts were required to self-assess their performance against all 44 of these standards. For 2008/2009 the Trust received a rating of 'fully met' against core standards. A Trust can only achieve a score of 'fully met' if it declares no more than four failings to meet a standard during the year. These failings must have been corrected by the end of the year.

For 2008/2009 the Trust declared a gap in year with one core standard, C24: Emergency Preparedness. This gap related specifically to the frequency of communications cascade testing, which should be undertaken every six months. A test was undertaken in August 2008 and a further test in February 2009. The Trust therefore reported compliance with this standard by the 29th August 2008.

For 2009/2010 the Care Quality Commission will for the last time, be assessing all NHS organisations against the Government Standards for Better Health. In 2010 all English NHS trusts, NHS Foundation trusts and primary care trust providers will be required to register against new regulations.

As part of the Trusts Integrated Performance Framework, a robust internal review process for assessing compliance with each of the core standards is in place. Following this robust process the Trust's core standards declaration for 2009/2010 is that we are fully compliant with all core standards.

9.10.2 Registering with the Care Quality Commission in relation to Healthcare Associated Infections

From April 2010, every NHS Trust that provides healthcare directly to patients must be registered with the Care Quality Commission. In 2009/10 trusts were registered on the basis of their performance in infection control. To register as a provider of health services with the Care Quality Commission we comprehensively assessed our measures to control healthcare associated infections.

In providing services we will not compromise on having the highest standards. We also believe it to be critical that we are transparent with those who commission our services and the public, about our own levels of performance. Consequently in our declaration to the Care Quality Commission we specifically drew attention to our concern about the timeliness of our receiving pathology reports. We purchase this service from another NHS Trust.

On the 1st April 2009 the Care Quality Commission granted our application for registration subject to one condition specifically related to resolving this single issue. Whilst there was no evidence that this has had an adverse impact on patient care, we took immediate action to resolve the problem. We applied to the Care Quality Commission on the 8th May 2009 for the removal of the condition and were pleased to receive confirmation on the 26th May 2009 that our application had been successful and the condition had been removed with immediate effect.

The safety of people who use our services is our top priority and we will continue to openly develop and strengthen our systems to ensure the safety of patients and the quality of our services.

For 2009/2010 the Trust target for new Clostridium Difficile infections is no more than nine cases a year. April 2009 – March 2010 figures demonstrate 5 new cases of Clostridium Difficile infections. The Trust has therefore met its target.

9.10.3 National Priorities

Progress on performance against Monitor requirements, Care Quality Commission national priorities and our contractual performance requirements with NHS Leeds are presented on a monthly basis to the Trust Board of Directors, through the monthly performance report to the Board. This report is routinely shared with our main commissioners and can be found at the following website **http://www.leedspft.nhs.uk/about_us/performance.** Performance is also reported on at twice yearly Service Directorate Performance reviews, which are led by a panel of Executive and Non Executive Directors.

9.10.4 Monitor Assessments

Monitor is the independent regulator of Foundation Trusts. Using its assessment framework the Trust's overall 2009/2010 performance is shown below in comparison with the Trusts 2008/2009 performance.

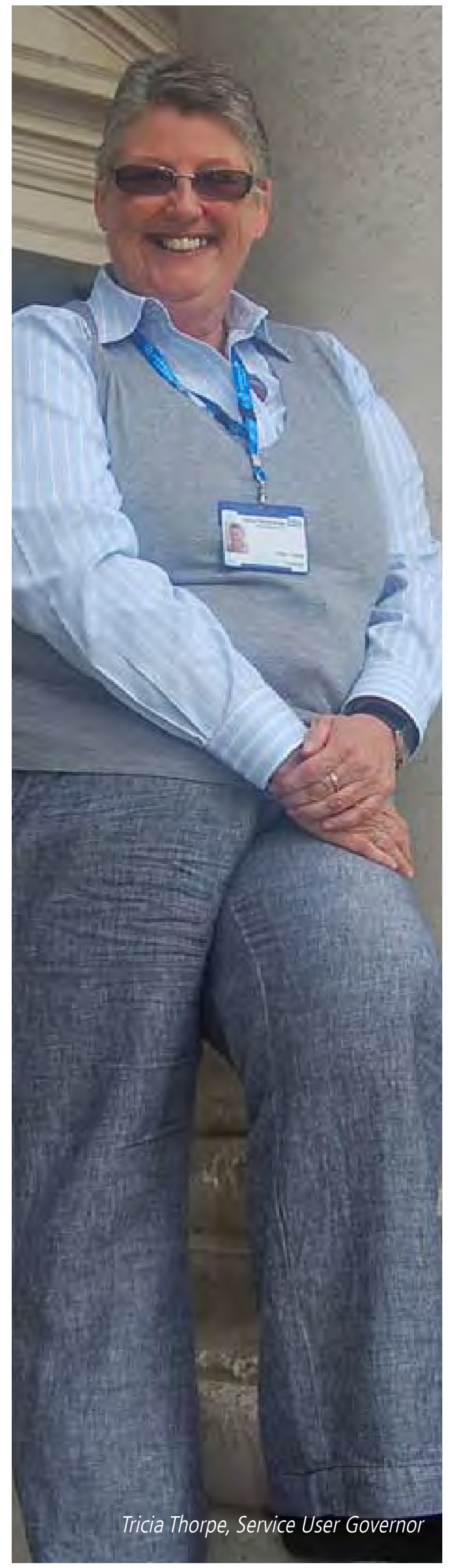
Quality Report

Healthcare Associated Infections	2008/09	2009/10
Number of cases of MRSA Bacteraemia	0	0
Number of cases of Clostridium Difficile	11	5

Risk ratings	Annual Plan 2008/09	Quarter 1 2008/09	Quarter 2 2008/09	Quarter 3 2008/09	Quarter 4 2008/09
Financial	3	3	3	3	3
Governance	Green	Green	Green	Green	Amber
Mandatory services	Green	Green	Green	Green	Green

Risk ratings	Annual Plan 2009/10	Quarter 1 2009/10	Quarter 2 2009/10	Quarter 3 2009/10	Quarter 4 2009/10
Financial	4	4	4	4	4
Governance	Green	Green	Green	Green	Green
Mandatory services	Green	Green	Green	Green	Green

The Governance rating for 2008/2009 dropped from green to amber as a result of underachievement of the delayed transfers of care target during that period. The Trust had previously declared that it would meet this target but when Monitor confirmed the construction it became apparent that across the whole year the threshold had not been met. Action plans in all relevant service areas resulted in significant improvements, with the Trust returning to a position of compliance in Q1 2009/10 and maintaining this position throughout the year.



Tricia Thorpe, Service User Governor

Quality Report

9.10.5 National Standards and Priorities

Monitor Targets

Monitor requires quarterly reporting on the following targets:

Monitor Target	2009/10	Threshold
7 day follow up achieved: The Trust must achieve 95% follow up of all discharges under adult mental illness specialities on CPA (by phone or face to face contact) within seven days of discharge from psychiatric inpatient care.	The Trust has maintained a position of compliance throughout 2009/2010. Quarter 4 figures demonstrated a 98.7% follow up rate. Compliance against this indicator continues to be monitored on a daily basis.	95%
Access to Crisis Resolution: The Trust must achieve 90% of adult hospital admissions where the service user has had a gate keeping assessment from Crisis Resolution Home Treatment services. Monitor allows for self declaration where face to face contact is not the most clinically appropriate action.	The Trust has maintained a position of compliance throughout 2009/2010. Quarter 4 figures demonstrated a 97.7% compliance rate.	90%
Minimising delayed transfers of care: The Trust must achieve no more than 7.5% of delays across the year. Monitor does not exclude delays attributable to social care.	The Trust has maintained a position of compliance throughout 2009/2010. Quarter 4 figures demonstrated a cumulative compliance average of 3.4%.	No more than 7.5%
Maintain level of crisis resolution teams (CRHT) set in 03/06 planning round.	The Trust is fully compliant with this requirement having had previous confirmation from the Department of Health and the Healthcare Commission that we may include Acute Community Services (ACS) as Crisis Services. The Trust's requirement for six teams is therefore met by having one CRHT and five ACS.	-

Care Quality Commission standards and priorities

The following table shows the Trust's performance against the Care Quality Commission core standards and national priorities.

Care Quality Commission standards and priorities	2007/08	2008/09	2009/10
Compliance with the CQC core Standards	40/41	43/44	44/44
Compliance with the CQC national priorities	Excellent	Good	To be confirmed by the CQC in October 2010

Jackie Worthington, Carer Governor at the Christmas event in the Victoria Quarter

Quality Report

9.11 Statements from our Partners

9.11.1 NHS Leeds comments on the Leeds Partnerships NHS Foundation Trust's Quality Accounts

NHS Leeds is Leeds Partnerships Foundation Trust's largest commissioner of services. We are pleased to be able to review and comment on the 2009/2010 Quality Account.

We have reviewed the Quality Account of Leeds Partnerships Foundation Trust and believe that it is an accurate reflection of the quality of services provided in the year being reported upon. We also believe that the information published in this Quality Account, that is also provided to the PCT as part of the contractual agreement, is accurate.

We are pleased to note LPFT's performance over the last year and its commitment to patient safety and experience, and we congratulate the Trust on winning the prestigious National Patient Safety Award for Mental Health. NHS Leeds is also pleased to acknowledge improvements and developments in areas such as delayed transfers of care, the reduction in number of reported incidents resulting in moderate harm or above, and the implementation of the Essence of Care approach in in-patient areas. We also commend their activity in engaging users and commitment to improve their experience of care.

In support of this, the drive to improve patient privacy and dignity and eliminate mixed-sex accommodation is welcomed and we are pleased that following a successful bid to the Department of Health's Privacy and Dignity Challenge Fund which was supported by NHS Leeds, the Trust made improvements to in-patient facilities to enable them to be able to declare that they had eliminated all mixed-sex accommodation.

For the forthcoming year, NHS Leeds has worked with Leeds Partnerships Foundation Trust in developing a range of quality initiatives as part of the national CQUIN (Commissioning for Quality and Innovation) scheme. We expect that the Trust will work hard to implement these initiatives and have confidence in their ability to meet the standards that we expect as commissioners of high quality care. In support of safety and effectiveness, for instance, we have asked that the Trust undertake work to ensure that patients who have drug dependency issues receive additional support and advice, and that the Trust reviews its arrangements and policies to ensure that patients do not have access to drugs whilst undergoing inpatient treatment.

Over the past year NHS Leeds and Leeds Partnerships Foundation Trust have worked positively together as commissioner and provider to ensure that the people of Leeds and surrounding areas receive high quality, safe and effective care, and we fully support the proposals outlined in this Quality Account.

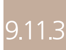
9.11.2 Leeds LINk comments on the Leeds Partnerships Foundation Trust's Quality Accounts

Leeds LINk would like to thank you for the opportunity to comment on the Leeds Partnership Foundation Trust's Quality Accounts for 2009/10. We welcome the report and agree with the 3 priorities set out in the accounts.

We are pleased to see that the Trust will be taking a standardised approach to local engagement, which we trust will take account of individuals' access and communication needs, and will not rely on written formats only (as the National Service User Surveys currently do). A range of methods will be needed to meet the needs of a diverse range of service users, including accessible formats and face-to-face engagement.

We welcome the emphasis in the document on meeting goals and achieving outcomes, both for people who use services and carers.

We feel overall that the Quality Accounts 2009/2010 are clear with little use of jargon. As a result, we aim to distribute the document to LINk members who are interested in mental health services and have requested the document on audiotape to meet the needs of some of those members.



9.11.3 Scrutiny Board comments on the Leeds Partnerships NHS Foundation Trust's Quality Accounts

As a key component of the new national quality framework for health care services, we are grateful for the opportunity to comment on the Trust's quality accounts for 2009/10.

We acknowledge and support the identified quality improvement priorities: We are heartened by the Trust's attempts to develop these priorities to reflect the views of service users and carers. However it is unclear whether the consultation process around the identified priorities included key partners of the Trust – including Leeds City Council. In developing the Trust's priorities, we believe the regular and routine involvement of other agencies is a key element. We feel that such involvement will go some way to continuing to raise the profile of the Trust's work and help to address the stigma that many service users still face.

We note the Trust's approach to establishing a 'baseline' for many of the identified performance measures, alongside its intention to benchmark performance with other mental health service providers. We trust that in future years, this approach will be enhanced by the inclusion of performance targets to help encourage year-on-year improvement.

Quality Report

As the new quality framework becomes more established, we are also keen to see the priority areas highlighted becoming an integral part of our quarterly performance management arrangements – thereby embedding the quality of health care service within our annual work programme.

However, we believe that, in part, the success of the new quality framework will hinge on how meaningful and accessible the quality accounts are to service users, carers and the public in general. While we recognise the requirements (in terms of content) associated with the production of the Trust's quality accounts, we would urge the Trust to:

- Include a glossary of terms within the main quality accounts;
- Consider producing a summary, easy to read version of its quality accounts, which highlights the main issues and
- key messages.

In summary, we broadly welcome the Trust's Quality Accounts for 2009/10 and look forward to working with the Trust (including the Trust Board and non-executive directors) over the coming year, establishing clearer and more consistent terms of engagement around our respective roles.

World Mental Health Day, 2009

Nigel Turton, Peartree Partnerships at World Mental Health Day, Becklin Centre, 2009

Annual Accounts

10.1 Statement on Internal Control

1) Scope of responsibility

This statement covers the period 1st April 2009 to 31st March 2010.

Leeds Partnerships NHS Foundation Trust's (LPFT) Board of Directors is accountable for internal control. The NHS Act 2006 designates the Chief Executive of the Board of Directors as Accounting Officer. 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.

LPFT forms part of the West Yorkshire health economy. As Accounting Officer I work closely with NHS Leeds who are the main commissioner of our Trust's services and ensure close liaison with the Yorkshire & The Humber Strategic Health Authority (SHA) on matters of strategic significance.

I also work closely with other partners to ensure the delivery and the development of services to service users, including Leeds City Council and partner agencies in the voluntary sector. I also maintain a close working relationship with the representatives of our Trust's staff, in particular the representatives of trade unions constituted as the Trust's 'Staffside'.

Significant partnership working is evident within the health economy to ensure that delivery arrangements are compliant with the expectations of the NHS Operating Framework and actions emerging from the Strategic Health Authorities strategy 'Healthy Ambitions'. Our Trust has a legally binding contract with NHS Leeds set within an integrated business plan promulgated with key stakeholders, including the SHA and Leeds City Council.

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 ongoing process designed to identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives of LPFT, to evaluate the likelihood of those risks being realised, the impact should they be realised and to manage them efficiently, effectively and economically.

The system of internal control has been in place in LPFT for the year ended 31 March 2010 and up to the date of approval of the annual report and accounts.

3) Capacity to handle risk

In this period, our Trust maintained an embedded and robust assurance framework indicating appropriate levels of control relating to risk within the framework of an approved risk management strategy.

There were clinical governance and assurance framework structures in place that reviewed risk including an overarching Trust Incident Review Group with Non-Executive Director representation.

These were complemented by a number of organisational and service based standards such as those of the National Institute for Health and Clinical Excellence and the relevant National Service Frameworks. Procedures were in place to review and to learn lessons from any serious incidents, complaints or claims.

Active programmes of learning existed within our Trust covering risk management, clinical risk assessment and root cause analysis, overseen by the Trust's Risk Management Department.

It is my view that our Trust had arrangements in place during this period to manage significant business risks as set out in the assurance framework.

The following gaps in assurance were identified in the Assurance Framework:

(i) Medicines Management

The training of all clinical staff has been reviewed to ensure that all clinical staff are competent to handle medicines. Additional pharmacy and technical staff have been put in place, telepharmacy introduced and a full medicines management action plan implemented. A complete roll-out of revised training will be achieved by September 2010.

(ii) Recruitment and Retention of Specialist Doctors

There have been a number of vacancies which have proved difficult to fill. In the short-term, the use of agency locums is available. In the medium term, mapping contract dates and using the opportunities of 'New Ways of Working' are being actioned whilst plans for the longer term include initiatives to promote a career in psychiatry.

(iii) Sufficiency of Operational Data

Whilst the Trust is fully compliant with the requirements of the 'Information Governance Toolkit', issues remain

Annual Accounts

regarding information to support the Leeds Addiction Unit services. Resolution will be fully achieved when this service migrates on to the PARIS information system in 2010.

4) The risk and control framework

Risk management is embedded in the organisation through its governance arrangements that span both clinical and non-clinical risk. Responsibility for risk management lies with LPFT's Board of Directors. The Risk Management and Governance Committee (RM&G) oversees assurance on the risk process, being responsible for the allocation of risk to the various other committees of the Board of Directors. Where deemed appropriate, the RM&G Committee retained ownership of risks suited to its own responsibilities.

Four principles have underpinned our Trust risk strategy. These are:

- **Transparency in managing risk.**
- **Co-ordination of assessment and management of risk.**
- **Public credibility in gaining confidence in policies.**
- **Effectiveness in the way risk is identified and responded to.**

Our Trust has in place a corporate risk register which captures all extreme risks. These are reported in summary form bi-monthly to the Board of Directors meeting. Each meeting of the Executive Team considers which, if any new risks ought to be considered.

Our Trust utilises a five by five matrix applied to the variables of likelihood and impact. Risks are assessed using a risk review template which considers existing controls and our Trust's capacity to manage the risk.

Risk is assessed and considered in a way that is reflective of the needs of our key stakeholders. This is achieved by including the following in our risk processes:

- **Non Executive Directors**
- **Patient and Public Involvement Team**
- **The Staff**
- **Service Users and Carers**

Risk is continuously being identified, evaluated and controlled through risk assessments, risk schedules and risk treatment plans covering actions and their sufficiency to mitigate risks.

Clinical risk management continues to be supported by a standardised approach to risk assessment, underpinned by the Care Programme Approach and supported by staff in our Trust's corporate and service directorates.

Our Trust maintains risk registers at both a corporate level and at a directorate level, underpinned by an assurance framework linked to the Care Quality Commission (CQC) core standards. This provides LPFT's Board of Directors with the opportunity to have a consistent oversight of risk and helps our Trust mitigate risk in an organisation where risks exist hand-in-hand with service developments and modernisation.

In February 2010, our Trust was re-assessed by the NHS Litigation Authority and was found to be compliant in all 50 areas of Risk Management Standards Assessment Level 1. All areas of weakness identified in the previous assessment had been fully addressed and our Trust is now focused on meeting the requirements of the level 2 assessment.
On the 1st April 2009 the CQC granted our application for registration in relation to Healthcare Associated Infections, subject to one condition. This condition referred to an issue previously identified by ourselves and brought to the attention of the CQC through its own review processes, concerning the timeliness of the receipt of pathology tests from an external provider.

Whilst there was no evidence that this had an adverse impact on patient care, we took immediate action to resolve the problem. We applied to the CQC on the 8th May 2009 for the removal of the condition and received confirmation on the 26th May 2009 that our application had been successful and the condition had been removed with immediate effect.

From April 2010 all NHS Trusts who provide regulated activities must be registered with the CQC under the new system in order to be legally allowed to operate. A robust internal review process for assessing compliance with each registration regulation was developed and implemented. The Trust received confirmation from the CQC on the 23rd March 2010 that its current registration status is fully registered without any conditions.

Our Assurance Framework classified objectives within the following domains:

- **Patient Safety**
- **Development of People and the Organisation**
- **Communication**
- **Partnerships and Social Inclusion**
- **Information Governance**
- **Environment**
- **Foundation Trust**

Risk sharing is common practice with other agencies such as NHS Leeds and the Directorate of Adult Social Care in Leeds City Council Social Services. There is some convergence of policies and procedures and in some cases, single management. This allows

Annual Accounts

for the involvement of stakeholders in risk management procedures.

As part of the Trust's Integrated Performance Framework, a robust internal review process for assessing compliance with each of the CQC core standards is in place. Following this robust process the Trust declared full compliance with all national core standards for 2009/10

Progress on performance against Monitor requirements, the CQC's national priorities and our contractual performance requirements with our main commissioner are presented on a monthly basis to the Board of Directors through the monthly performance report to the Trust's Board of Directors This report is routinely shared with our main commissioner and published on our Trust's website

Areas for quality improvement identified in the 2008/09 Quality Report were identified and performance managed throughout 2009/10. They were reported to the Board of Directors on a quarterly basis as a part of the comprehensive performance report.

Towards the end of 2009/10, our Trust agreed a new ambition statement for the Trust – 'working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives'.

In line with the objectives underpinning this ambition, our 2008/09 priorities in our Trust's quality report have been reviewed for our 2009/10 Quality Accounts to ensure they are consistent with our Trust's strategic direction. It is envisaged that these priorities will remain so until 2015, in line with the Trust's strategy.

5) Review of economy, efficiency and effectiveness of the use of resources

The Annual Plan covering the period up to 2012/13 sets out how the vision and objectives of our Trust will be delivered.

The Executive Team has responsibility for overseeing day-to-day operations of our Trust and for ensuring that resources are used economically, efficiently and effectively.

During the period, Monitor assessed our financial risk rating as '4'. On a scale of 1 to 5, 3 represents the level needed to satisfy Monitor's requirements.

Service directorate reviews continued to take place, each directorate being reviewed by Executive and Non-Executive Directors with particular reference to CQC core standards, Monitor targets and our Trust's strategic objectives. This provided assurance regarding both the quality of services and use of resources in each main service area as well as promoting a more considered view of future needs and objectives.

Issues identified in National Staff Survey results received from the CQC's predecessor body, Healthcare Commission, have been reviewed and action plans developed where appropriate. Similarly, issues identified in the Picker Institute Service User Survey have been similarly addressed.

As an NHS Foundation Trust, quarterly submissions are despatched to Monitor, requiring LPFT's Board of Directors to confirm that our Trust has met all core standards and national targets. Information on financial performance is also included. Monitor then assess submissions and subsequently confirm a rating for quality of services and use of resources. The Trust is currently assessed 'green' for quality of services and '4' for use of resources.

6) Quality Accounts

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

In determining the Trust's Quality Accounts priorities for 2009-2010 it was agreed by the Executive Team and the Trust Board of Directors that these needed to be consistent with the Trust's strategic direction. Our three priorities set out in our 2008-2009 Quality Report were therefore revised to be in line with our three strategic end goals, which have emerged as a result of the current refresh of our Trust strategy.

In order to compile measures for the 2009/10 Quality Accounts it was agreed that wide consultation was essential in order to ensure that as a Trust we focused on those areas of quality which were important to our key stakeholders. The Trust's Executive Team received a proposal on the consultation process in November 2009 and a wide consultation process took place with Trust staff and key stakeholders over the period November 2009 – February 2010. The consultation process included the Trust Board of Governors, service users and carers, clinical and non clinical staff and the voluntary sector.

Review of Effectiveness

In order to ensure that the measures in the Quality Accounts remained measurable and manageable in number it was agreed by the Executive Team that the Trust Performance Group would be central to the oversight of the Quality Accounts.

The Trust Performance Group meeting on the 1st March 2010 was extended into a Performance Group and Quality Accounts Workshop, where the measures identified from the consultation were reviewed, refined and ranked for inclusion in the Quality Accounts. These measures were agreed by the Trust's Executive Team and received by The Trust Board of Directors.

There have been no significant gaps or

Annual Accounts

weaknesses found in the systems of internal control in relation to the Quality Report.

Development of the 2009/10 Quality Accounts

Monitor's Quality Accounts requirements were published in Monitor's annual reporting guidance. The Performance Team, who lead on the Quality Accounts, identified and allocated leads against each requirement and put timescales in place for March 2010 for the initial collection of data and narrative.

Work continued throughout April and May 2010 to expand, refine and finalise our 2009/10 Quality Accounts to ensure the information included was the most up to date and accurate. The Executive Team and the Audit Committee were invited to provide comments to the Performance Team on the Quality Accounts up until the 10th May 2010.

Performance Reporting Processes

The performance information included in the Quality Accounts is in line with our performance which has previously been reported to the Board of Directors through the following mechanisms:

- **Progress on performance against Monitor requirements, Care Quality Commission national priorities and CQUIN requirements are presented to the Trust Board of Directors through the monthly performance report to the Trust Board.**
- **Submissions to the Board of Directors for sign off on our performance against Care Quality Commission registration requirements, core standards and national priorities.**
- **Quarterly submissions to the Board of Directors for sign off on our performance against Monitor targets.**

Data Quality Processes

Performance information is obtained from the Trust's PARIS patient administration and clinical information system. Checks on the data are made at a number of levels. There are checks not only within the PARIS system, but a suite of data quality checks has been incorporated in the Trust's data warehouse with errors notified back to source for correction. Data stored on the Trust's information system is seen as part of the clinical record and so may be used in management of care. Mandatory training is in place for staff in how to use the system. A Data Quality Improvement Project has been underway to assure and improve data quality in the Trust and Data Quality issues are addressed via the Trust's Data Quality Improvement Group. Performance reports and other information are available at team and directorate level to enable local validation.

Timetable for production of the 2009/10 Quality Accounts

The proposed initial timetable for sign off of the Trust's Quality Accounts was presented and agreed by the Executive Team. The timetable was updated in light of the publication of Monitor guidance and revisions were presented at further Executive Team meetings. At its March 2010 meeting the Board of Directors were also presented with the revised timetable. The Audit Committee received the timescales at their April 2010 meeting and reported assurance on the process being undertaken to produce the Quality Accounts.

Third Party Comments

Comments have been received from NHS Leeds and LINKs and included in our Quality Accounts.

Board sign off of final Quality Accounts

Our final draft version of our Quality Accounts was presented to our Board of Directors on the 27 May 2010 and the Trust Board of Directors reported assurance that the Quality Accounts are accurate.

7) Compliance with NHS Pension Scheme regulations

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

8) Compliance with Equality, Diversity and Human Rights Legislation

Control measures via our Trust's governance structure are in place to ensure that all our Trust's obligations under equality, diversity and human rights legislation are complied with.

9) Compliance with Climate Change Adaptation Reporting to Meet the Requirements under the Climate Change Act 2008

Our Trust has undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that our Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Our Trust has a detailed carbon plan which has been endorsed by the Carbon Trust and which is monitored internally by the Resources Committee.

10) Review of effectiveness

As Accounting Officer, I have responsibility for

Annual Accounts

reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of control is informed by the work of the internal auditors and the executive managers within LPFT who have responsibility for the development and maintenance of the internal control framework and 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 of Directors, the Audit Committee and the Risk Management & Governance Committee and a plan to address any weaknesses and ensure continuous improvement of the system is in place. In addition, the Board of Directors, its committees and the Board of Governors carry out an annual review of their effectiveness.

The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. In terms of integrated governance, the RM&G Committee brings together work-streams relating to the Assurance Framework, the risk register and the assessment of both clinical and non-clinical aspects of risk.

Our 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 our Trust through 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 system, which concludes that the payroll function is operational within an environment of effective control.

As well as providing audit scrutiny of the annual financial statements, our Trust's external auditors, PricewaterhouseCoopers LLP, provide assurance through the review of systems and processes as part of the annual audit plan.

As stated at the outset, the Board of Directors has accountability for ensuring an effective system of internal control is in place. This is achieved through various governance committees, which it reviews on an annual basis. These are the Risk Management & Governance Committee, the RM&G already referred to, the Resources Committee and the Information Management & Technology Governance Committee.

Our Trust's Audit Committee oversees the standards that each governance committee strives to achieve.

The Resources Committee of the Board of Directors continues to ensure that plans for services, workforce, finance and estate were and are integrated and provide good value. The Information Management and Technology and our Trust's Research Governance Committees supported necessary control mechanisms throughout our Trust. The Committees continue to meet at intervals throughout the year. Minutes and reports from the committees are received by both the Audit Committee and the Board of Directors.

The Executive Directors have personal responsibility for particular aspects of internal control within their individual portfolios.

Internal Audit reviews the system of internal control on an on-going basis. The Internal Audit Plan is derived from an assessment of risk areas within our Trust and includes all areas where Internal Audit is named in the Assurance Framework as a provider of assurance on the effectiveness of key controls.

Whilst several significant gaps were identified in the Assurance Framework during 2009/10, actions taken to resolve these issues have mitigated much of the potential risks and all residual issues have an action plan in place to fully mitigate.

In conclusion, our Trust constantly seeks ways in which to improve. This is consistent with our values as an organisation which are:

- **Respect and dignity**
- **Commitment to quality of care**
- **Compassion**
- **Improving lives**
- **Working together for people**
- **Everyone counts**

27 May 2010
Chris Butler
Accounting Officer.

10.2 Statement of the Chief Executive's Responsibilities as the Accounting Officer

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including responsibility for the propriety and regularity of public finance for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by

Annual Accounts

the independent regulator of NHS Foundation Trusts (Monitor).

Under the National Health Service Act 2006, Monitor has directed Leeds Partnerships NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Leeds Partnerships NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- **Observe the Accounts direction issued by Monitor, 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 have been followed, and disclose and explain any material departures in the financial statements.**
- **Prepare the financial statements on a going concern basis.**

The Accounting Officer is responsible for keeping proper records, which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him 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 taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

27 May 2010
Chris Butler
Accounting Officer.

10.3 The Directors Statement of Responsibility

The Directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure of the Trust for that period. In preparing these accounts the Directors are required to:

- **Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury.**
- **Make judgements and estimates that are reasonable and prudent.**
- **State whether applicable accounting standards have been followed, subject to any material departures disclosures and explained in the accounts.**

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 above-mentioned 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 confirm to the best of their knowledge and belief that they have complied with the above requirements in preparing the accounts.

27 May 2010
Chris Butler
Chief Executive

27 May 2010
Guy Musson
Director of Finance

Annual Accounts

10.4 Independent Auditors' Report to the Board of Governors

We have audited the financial statements of Leeds Partnerships NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Directors Responsibilities Statement the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Board of Governors of Leeds Partnerships NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come to save where expressly agreed by our prior consent in writing.

Scope of the financial statements

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

Opinion on financial statements

In our opinion the financial statements:

- **Give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash f ows for the year then ended; and**
- **Have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.**

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

In our opinion

- **The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and**
- **The information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.**

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- **Adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or**
- **The financial statements are not in agreement with the accounting records and returns; or**
- **We have not received all the information and explanations we require for our audit; or**
- **The statement on Internal Control does not meet the disclosure requirements set out in the NHS foundation Trust Annual Reporting Manual or is misleading or inconsistent**

Annual Accounts

with information of which we are aware from our audit; or

- **We have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.**

Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Ian Looker (Senior Statutory Auditor)
For and on Behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Benson House, 33 Wellington Street, Leeds, LS1 4JP

Date 1 June 2010

(a) The maintenance and integrity of the Leeds Partnerships NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matter and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since the were initially presented on the website.
(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

10.5 Audit Arrangements

The Trust's external auditors are PricewaterhouseCoopers LLP . All members of the audit team are independent of the Board of Directors and of staff members. Each year the audit team provide a statement in support of the requirements for their objectivity and independence.

The auditors provided audit services in accordance with the Code of Audit Practice. This covers the opinion on the annual accounts, financial aspects of corporate governance and the use of resources. Independent audits cost the Trust £52,300 in the period 2009/10.

During 20009/10 the Trust commissioned additional assurance work from PricewaterhouseCoopers LLP (the external auditors who undertook the audit of the Trust's financial statements). This cost the Trust an additional £9,200 and was related to the restatement of the opening balance sheet for International Financial Accounting Standards (IFRS) This work did not look at maximising opportunities from the introduction of IFRS and therefore the independence of the Trust's external auditors was not compromised.

10.6 Annual Accounts

Foreword to the accounts

Leeds Partnerships NHS Foundation Trust ("Trust") is required to "keep accounts in such form as Monitor (The Independent Regulator for NHS Foundation Trusts) may with the approval of Treasury direct" (Paragraph 24 (1) Schedule 7 of the National Health Service Act 2006 ("the 2006 Act"). The Trust is required to "prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Treasury direct" (Paragraph 25 (1) Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by Monitor, with the approval of the Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts (Paragraph 25 (2) Schedule 7 to the 2006 Act). In determining the form and content of the annual accounts Monitor must aim to ensure that the accounts present a true and fair view (Paragraph 25 (3) Schedule 7 to the 2006 Act).

Annual Accounts

STATEMENT OF COMPREHENSIVE INCOME	NOTE	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Operating Income	3 & 4	122,990	119,072
Operating Expenses	5	(118,206)	(114,078)
OPERATING SURPLUS / (DEFICIT)		**4,784**	**4,994**
FINANCE COSTS			
Finance income	10	198	659
Finance expense - financial liabilities	12	(3,876)	(3,844)
Finance expense - unwinding of discount on provisions	26	(32)	(32)
PDC Dividends payable		(342)	(1,223)
NET FINANCE COSTS		**(4,052)**	**(4,440)**
Surplus/(Deficit) from operations		732	554
SURPLUS/(DEFICIT) FOR THE YEAR		**732**	**554**
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on intangible assets		114	
Revaluation gains/(losses) and impairment losses property, plant and equipment		(1,684)	(1,573)
Increase in the donated asset reserve due to receipt of donated assets			15
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets		(2)	
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**(840)**	**(1,004)**

Annual Accounts

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2010	NOTE	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
Non-current assets				
Intangible assets	14	285	77	130
Property, plant and equipment	13	51,716	54,949	56,413
Trade and other receivables	18	2,624	2,414	2,207
Other Financial assets	28.1			
Total non-current assets		54,625	57,440	58,750
Current assets				
Inventories	17	52	65	57
Trade and other receivables	18	4,565	3,739	4,966
Non-current assets for sale and assets in disposal groups	20	337	337	1,800
Cash and cash equivalents	19	17,444	16,527	11,563
Total current assets		22,398	20,668	18,386
Current liabilities				
Trade and other payables	21	(10,270)	(9,591)	(9,590)
Borrowings	22	(1,037)	(942)	(857)
Provisions	26	(878)	(1,579)	(201)
Other liabilities	23	(2,141)	(1,682)	(1,628)
Total current liabilities		(14,326)	(13,794)	(12,276)
Total assets less current liabilities		**62,697**	**64,314**	**64,860**
Non-current liabilities				
Borrowings	22	(34,622)	(35,659)	(36,601)
Provisions	26	(1,957)	(1,338)	(1,363)
Other liabilities	23	(1,066)	(1,425)	
Total non-current liabilities		**(37,645)**	**(38,422)**	**(37,964)**
Total assets employed		**25,052**	**25,892**	**26,896**
Financed by (taxpayers' equity)				
Public Dividend Capital		19,509	19,509	19,509
Revaluation reserve		6,496	8,223	10,103
Donated Asset Reserve	13	28	30	15
Other reserves		(651)	(651)	(651)
Income and expenditure reserve		(330)	(1,219)	(2,080)
Total taxpayers' equity		**25,052**	**25,892**	**26,896**

The notes on pages 115 to 144 form part of this account.

The financial statements on pages 111 to 114 were approved by the Board on 27 May 2010 and signed on its behalf by:

Signed: .... (Chief Executive)　　Date: ......1/ 6 / 09......

Annual Accounts

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2009	19,509	8,223	30	(651)	(1,219)	25,892
Surplus/(deficit) for the year					732	732
Revaluation gains/(losses) and impairment losses on intangible assets		114				114
Revaluation gains/(losses) and impairment losses property, plant and equipment		(1,684)				(1,684)
Increase in the donated asset reserve due to receipt of donated assets						(2)
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets			(2)			
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		(156)			156	
Movement in year subtotal		**(1,727)**	**(2)**		**889**	**(840)**
Taxpayers' Equity at 31 March 2010	19,509	6,496	28	(651)	(330)	25,052

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital	Revaluation Reserve	Donated Assets Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2008	19,509	10,103	15	(651)	(2,080)	26,896
Surplus/(deficit) for the year					554	554
Revaluation gains/(losses) and impairment losses on intangible assets		(1,573)				(1,573)
Revaluation gains/(losses) and impairment losses property, plant and equipment			15			15
Increase in the donated asset reserve due to receipt of donated assets						
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets						
Transfers to the income and expenditure account in respect of assets disposed of		(171)			171	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(136)			136	
Movement in year subtotal		**(1,880)**	**15**		**861**	**(1,004)**
Taxpayers' Equity at 31 March 2009	19,509	8,223	30	(651)	(1,219)	25,892

Revaluation Reserve reflects movements in property plant and equipment values due to changes in economic and market fluctuations.

Donated Assets Reserves relates to contributions from the Kings Fund towards the cost of a conservatory at the Mother and Baby Unit at The Mount.

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

Income and Expenditure Reserve is the cumulative surplus position.

Annual Accounts

STATEMENT OF CASH FLOWS	NOTE	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Cash f ows from operating activities			
Operating surplus/(deficit) from continuing operations		4,784	4,994
Operating surplus/(deficit) of discontinued operations			
Operating surplus/(deficit) **Non-cash income and expense:**		**4,784**	**4,994**
Depreciation and amortisation	5	3,117	3,032
Impairments	5	942	424
(Increase)/Decrease in Trade and Other Receivables	18	(1,040)	1,020
(Increase)/Decrease in Inventories	17	13	(8)
Increase/(Decrease) in Trade and Other Payables	21	(5)	2,144
Increase/(Decrease) in Other Liabilities	23	100	
Increase/(Decrease) in Provisions	26	(82)	1,353
Other movements in operating cash flows		910	160
NET CASH GENERATED FROM/(USED IN) OPERATIONS **Cash f ows from investing activities**		**8,739**	**13,119**
Interest received		187	631
Purchase of intangible assets	14	(119)	
Purchase of Property, Plant and Equipment	13	(2,710)	(3,363)
Sales of Property, Plant and Equipment			486
Net cash generated from/(used in) investing activities **Cash f ows from financing activities**		**(2,642)**	**(2,246)**
Capital element of finance lease rental payments		(98)	(78)
Capital element of Private Finance Initiative Obligations		(844)	(779)
Interest element of finance lease		(354)	(359)
Interest element of Private Finance Initiative obligations		(3,522)	(3,485)
PDC Dividend paid		(374)	(1,223)
Cash flows from (used in) other financing activities		12	15
Net cash generated from/(used in) financing activities		**(5,180)**	**(5,909)**
Increase/(decrease) in cash and cash equivalents		917	4,964
Cash and Cash equivalents at 1 April		16,527	11,563
Cash and Cash equivalents at 31 March		**17,444**	**16,527**

Annual Accounts

1.0 Accounting policies

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/2010 NHS Foundation Trust ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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 and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.1.1 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 and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.1.2 Critical judgements in applying accounting policies

All critical accounting judgements are included in the individual subject notes as required by IAS1.122.

1.1.3 Key sources of estimation uncertainty

The following are the key assumptions concerning the future, and other key sources of estimation uncertainty at the Statement of Financial Position date, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year as required by IAS1.125

It is the policy of Leeds Partnerships NHS Foundation Trust to undertake 5 yearly valuations with interim valuations every 3 years. Under IFRS annual impairment reviews are required which may lead to additional revaluations where there is an indication of a material reduction in value. If there is an indication of this a full professional valuation will be commissioned in that year.

The lives of other property, plant and equipment are reviewed annually with estimates made for remaining asset lives.

1.2 Income recognition

Income is accounted for by applying the accruals convention The main source of income for the Leeds Partnerships 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.

1.3 Expenditure on employee benefits

Short Term Employee Benefits

Salaries, wages and employment-related payments 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 financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.4.1 Pension costs

Past and present employees, if they chose to be, are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales.

It is not possible for the Leeds Partnerships NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme. The cost to Leeds Partnerships NHS Foundation Trust of participating in the scheme is taken as equal to the contributions paid into the scheme for the reportable period .

Employers pension cost contributions are

Annual Accounts

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.

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

a) Full actuarial (funding) valuation

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

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

b) Accounting valuation

The valuation of the scheme liability as at 31 March 2010, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2010 with summary global member and accounting data.

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

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

Annual pensions

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

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

Pensions indexation

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

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

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 or regular employment effectively through illness or infirmity.

Death benefits

A death gratuity of twice their 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 Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

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.

Compensation for early retirement

Where a member of the Scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

Expenditure on other 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.

1.5 Property, plant and equipment

1.5.1 Recognition

Property, plant and equipment is capitalised if:

- **It is held for use in delivering services or for administrative purposes;**
- **It is probable that future economic benefits will**

Annual Accounts

f ow to, or service potential will be supplied to, the Leeds Partnerships 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**
- **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.

1.5.2 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. All assets are measured subsequently at fair value.

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. Revaluations, under IFRS, are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- **Land and non-specialised buildings – market value for existing use.**
- **Specialised buildings – MEA.**
- **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 2010.

Non-property assets were last indexed using the Consumer Price Indices for April 2009 as issued by the Office for National Statistics.

1.5.3 Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is normally charged to the income statement 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 expected to be obtained from the use of an item of property, plant and equipment, and where the cost of the item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

1.5.4 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 infinite life and is not depreciated.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement

Annual Accounts

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 tangible fixed assets are estimated by Leeds Partnerships NHS Foundation Trust as follows:

Short life engineering plant and equipment	5 years
Medium life engineering plant and equipment	10 years
Long life engineering plant and equipment	15 years
Vehicles	7 years
Furniture	10 years
Office and IT equipment	5 years
Short life medical and other equipment	5 years
Medium life medical equipment	10 years
Long life medical equipment	15 years
Mainframe type IT installations	8 years

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS Foundation Trust's professional independent valuers. The assessed lives of the individual building elements vary from a minimum of 5 years to a maximum of 188 years. Leaseholds are depreciated over the primary lease term.

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

1.5.5 Revaluation and impairment

At each reporting period end the Trust checks whether there is any indication that any of its Property, Plant or Equipment or intangible current assets have suffered an impairment loss. If there is indication of this the recoverable amount of the asset is estimated to determine whether there has been a loss and if so, its amount.

Property, Plant or Equipment impairments resulting from losses of economic benefits are charged to the Statement of Comprehensive income. All other impairments are taken to the revaluation reserve and reported in the Statements of Changes in Taxpayers Equity to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

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

1.5.6 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

Annual Accounts

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 20.

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 on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

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.

1.5.7 Donated assets

Donated assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated assets are valued and depreciates as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the Statement of Comprehensive income is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

1.6 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's ARM, 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 IAS 17.

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.**
- **c) Operating lease for the land.**

a) Services received

The service charge is recognised in operating expenses.

Leeds Partnerships NHS Foundation Trust have 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 IAS 17. 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.

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 costs.

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

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

c) Operating lease for the Land

The land that the PFI Building is classified as an operating lease in accordance with IAS 17.

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 (e.g. cash payments, 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,

Annual Accounts

the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Leeds Partnerships NHS Foundation Trust did make an initial "bullet" payment of cash upfront of c£5m. This was off set against the initial liability (based on the fair value cost of the building less the c£5m).

1.7 Intangible assets

1.7.1 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 fixed 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 5 and 10 years depending on the software licence.

1.7.2 Internally generated 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 assets.**
- **The project is technically feasible to the point of completion and will result in an 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 e.g. 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.**
- **The Trust can measure reliably the expenses attributable to the asset during development.**

1.7.3 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. Subsequently intangible assets are measured at fair value and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and 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'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

1.7.4 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.

1.8 Stocks and work in progress (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 17.

1.9 Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, balances with banks and investments in banks. Cash and the bank balances are

Annual Accounts

recorded at the current values of these balances in the NHS Foundation Trust's cash book. These balances exclude monies held in the 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.

1.10 Research and development

Expenditure on research is not capitalised. Expenditure on development is capitalised if it meets the following criteria:

- **There is a clearly defined project.**
- **The related expenditure is separately identifiable.**
- **The outcome of the project has been assessed with reasonable certainty as to:**
  - **Its technical feasibility.**
  - **Its resulting in a product or service which will eventually be brought into use.**
  - **Adequate resources exist, or are reasonably expected to be available, to enable the project to be completed and to provide any consequential increases in working capital.**

Expenditure so deferred is limited to the value of future benefits expected and is amortised through the income and expenditure account on a systematic basis over the period expected to benefit from the project. It is revalued on the basis of current cost. The amortisation charge is calculated on the same basis as used for depreciation i.e. on a quarterly basis. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. Where possible, NHS Foundation Trusts disclose the total amount of research and development expenditure charged in the Income and Expenditure account separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

1.11 Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over the 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 NHS Litigation Authority (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. The Leeds Partnerships 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 NHS foundation trust is disclosed at note 26.

Non-clinical risk pooling

The Leeds Partnerships NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises and these are the only amounts included in the accounts of The Leeds Partnerships NHS Foundation Trust.

1.12 Contingencies

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in note 27 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

Most of the activities of the 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. Recoverable 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.

Annual Accounts

1.14 Corporation tax

The 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 the 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, and where the profits there from exceed £50,000 per annum. Leeds Partnerships NHS Foundation Trust policy is to provide for Corporation Tax if it is required.

1.15 Foreign exchange

The functional and presentational currencies of the Trust are sterling.

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the Income and Expenditure Account.

1.16 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts, note 31, in accordance with the requirements of the HM Treasury Financial Reporting Manual.

1.17 Leases

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as a Property, Plant and Equipments and a liability is 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 asset and liability are recognised at the inception of the lease, and are 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. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

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.

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.

The Leeds Partnerships NHS Foundation Trust as lessee

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

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

Contingent rentals are recognised as an expense in the period in which they are incurred.

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

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 the NHS Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General and the Government Banking Service. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

The calculation is based, this year ending 31st March 2010, on the unaudited accounts of the Leeds Partnerships NHS Foundation Trust and not on a forecast as in previous years.

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

Annual Accounts

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 Income and Expenditure Account on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). Note 32 is compiled directly from the losses and compensations register which is prepared, as per the FT ARM, on a accruals basis.

1.20 Financial instruments and financial liabilities recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Derecognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the 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 with are not quoted in an active market. They are included in current assets.

The NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS debtors and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly 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 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.

Impairment of financial assets

At the statement of financial position date, the 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

"The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. None of them are expected to impact upon the Leeds Partnerships NHS Foundation Trusts financial statements. "

Amendment to IAS 24 Related Party Disclosures

IAS 27 (Revised) Consolidated and separate financial statements
Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues
Amendment to IAS 39 Eligible hedged items
IFRS 1 (Revised) First time adoption of IFRS
Amendments to IFRS 1 (revised) on first time adoption of IFRS additional exemptions
IFRS 2 Share based payments - Group cash-settled share based payment transactions
IFRS 3 (Revised) Business combinations
IFRS 9 Financial Instruments
Amendment to IFRIC 14, IAS 19 - Prepayments of a minimum funding requirement
IFRIC 17 Distributions of Non-cash Assets to Owners
IFRIC 18 Transfer of assets from customers
IFRIC 19 Extinguishing financial liabilities with equity instruments
Annual Improvements 2009
Annual Improvements 2010

1.22 Accounting standards issued that have been adopted early

The amendment to IFRS 8 Operating segments that was included in the April 2009 Improvements to IFRS has been adopted early. As a result, total assets are not reported by operating segment.

Annual Accounts

2 Operating segments

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 and are based on the directorate level split of the mental healthcare services offered. Segment information is presented on the same basis as that used for internal reporting purposes. LPFTs five principal operating and reporting segments in 2009/10 comprise adult, older, specialist services, learning disabilities (LD) and support living service (SSL). Refer to the annual report for details of services provided. Segmental reporting is a requirement of IFRS not UKGAAP. The 2008/09 comparatives are, therefore, based on the restated IFRS accounts.

	Adult		Older		Specialist		LD		SSL		TOTAL	
	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000
Income by segment												
Income from activities	**44,592**	43,455	**25,452**	24,689	**22,694**	21,779	**10,701**	10,373	**7,349**	7,036	**110,787**	107,332
Other operating income	**4,752**	4,753	**2,500**	2,495	**3,362**	2,984	**1,109**	950	**481**	558	**12,203**	11,740
TOTAL INCOME	**49,344**	48,208	**27,952**	27,184	**26,056**	24,763	**11,809**	11,323	**7,829**	7,594	**122,991**	119,072
TOTAL EXPENDITURE	**(44,996)**	(45,495)	**(25,669)**	(25,500)	**(23,947)**	(22,368)	**(11,053)**	(10,542)	**(8,564)**	(8,131)	**(114,229)**	(112,036)
EBITDA	**4,348**	2,712	**2,283**	1,684	**2,109**	2,395	**756**	782	**(735)**	(538)	**8,762**	7,035
Non Operating Income and Expenditure Total	**(2,981)**	(2,842)	**(2,166)**	(1,807)	**(1,364)**	(1,221)	**(588)**	(537)	**(122)**	(75)	**(7,221)**	(6,482)
Surplus/(Deficit) from continuing operations	**1,367**	**(129)**	**117**	**(123)**	**745**	**1,174**	**168**	244	**(856)**	**(612)**	**1,541**	**554**
Audit Adjustments												
Asset Revaluation											**(933)**	
Accruals Adjustment											**125**	
Unaccrued Invoices											**(5)**	
Losses & Comps											**3**	
Adjustment												
Revised Surplus/(Deficit) from continuing operations											**732**	554

a) Operating Income includes: £107m from English Primary Care Trusts (primarily £102m from Leeds PCT).

b) Expenditure includes:

Pay costs	£88.116m 09/10,	£85.935m 08/09
Premises	£5.107m 09/10,	£5.432m 08/09
Depreciation	£3.117m 09/10,	£2.979m 08/09
Establishment	£3.653m 09/10,	£4.331m 08/09

c) Depreciation: (£3.117m 09/10, £2.989m 08/09) is included in operating expenses in the accounts, but non operating expenses in service line reports.

d) 09/10 includes: £910k & 08/09 includes £165k for loss on disposal which is included in operating expenses in the accounts, but non operating expenses in service line reports.

e) 08/09 includes: £358k Income from Investments which is included in non operating income in the accounts, but in operating expenses in service line reports.

f) 09/10 includes: £860k and 08/09 includes £753k contingent rent adjustment which is included in non operating expenses in the accounts but in operating expenses in service line reports.

Items c, d, e and f have not been adjusted for in segmental reporting as this is how it is presented to Board.

Annual Accounts

3 Revenue from patient care activities

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
		23
NHS trusts	102,411	101,941
Primary care trusts	33	
Foundation trusts	679	1,118
Local authorities	3	
NHS other		
Non-NHS:	5,764	3,392
Income for Social Care Clients	1,897	867
Other	**110,787**	**107,341**

Leeds Partnerships NHS Foundation Trust has entered into a pooled budget arrangement with NHS Leeds and Leeds City Council. Under the arrangement funds are pooled under S75 of the NHS Act 2006.

As a provider of healthcare services the Leeds Partnerships NHS Foundation Trust does not make contributions to the pool, but receives funding from the pool to provide some of its services for People with Learning Disabilities.

There were no private patients in the year ended 2009/10 (£nil in 2008/09). This is in compliance with the Trusts Private patient income cap which is zero.

4 Other operating revenue

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Research and Development	**472**	389
Education and Training	**3,154**	3,149
Non-patient care services to other bodies	**2,631**	3,617
Other Income:		
Inter NHS Foundation Trust	**896**	10
Inter NHS Trust	**138**	595
Inter RAB	**4,622**	2,828
Inter Other WGA Bodies	**78**	8
Other (Outside WGA)	**212**	1,135
	12,203	**11,731**

Annual Accounts

5 Operating expenses

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Services from other NHS Trusts	**714**	708
Services from Foundation Trusts	**10**	
Purchase of healthcare from non NHS bodies	**1,481**	1,023
Executive Directors' costs	**851**	781
Non Executive Directors' costs	**155**	143
Staff costs	**88,116**	85,935
Drugs costs	**1,962**	2,141
Supplies and services - clinical (excluding Drugs)	**812**	698
Supplies and services - general	**1,188**	1,121
Consultancy services	**606**	579
Establishment	**3,653**	4,331
Transport	**969**	1,459
Premises	**5,107**	5,432
Provision for impairment of receivables	**97**	(77)
Depreciation on Property, plant and equipment	**3,117**	2,979
Amortisation of intangible Assets		53
Impairments and reversals of property, plant and equipment	**938**	424
Impairments and reversals of intangible assets	**3**	
Audit fees - statutory audit and regulatory reporting	**48**	55
Other auditor's remuneration	**9**	12
Clinical negligence	**240**	157
Disposal of property plant and Equipment	**910**	165
Research and development	**514**	382
Other	**6,706**	6,330
	118,206	114,831

£1,331k expenditure categorised as Purchase of Healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£911k 08/09). A further £150k (£112k 08/09) relates to expenditure with the Alzheimer's Society.

Other Expenditure includes £5646k in relation to PFI costs. These are primarily monthly service charge payments to the operators of the two PFI schemes to which the Foundation Trust is party (see note 25). In addition there is one of provision of £730k for permanent injury benefit.

Other auditors remuneration relates to the IFRS restatement fees charged by the external auditor. There is no specified limitation to the auditors liability.

Annual Accounts

6 Operating leases

6.1 As lessee

73% (by value) of the leasing arrangements are made up of rental of the land under the PFI Schemes/finance leases. The contract end dates for 'Equitix' and 'Revival' properties are July 2028 and August 2019 respectively. Other leases are for buildings, vehicles and other equipment.

Payments recognised as an expense	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Minimum lease payments	**1,460**	1,288
Sub-lease payments	**0**	0
Total	**1,460**	1,288
Total future minimum lease payments	**Year ended 31 March 2010 £000**	
Payable:		
Not later than one year	**1,738**	1,575
Between one and five years	**5,101**	4,456
After 5 years	**7,672**	8,146
Total	**14,511**	14,177

7 Employee costs and numbers

7.1 Employee costs

	2009/10 Total £000	Permanently Employed £000	Other £000	2008/09 Total £000	2008/09 Permanently Employed £000	2008/09 Other £000
Salaries and wages	**69,428**	**69,428**		68,177	68,177	
Social Security Costs	**5,229**	**5,229**		5,303	5,303	
Employer contributions to NHS Pension scheme	**8,734**	**8,734**		8,282	8,282	
Agency/Contract Staff	**5,576**		**5,576**	4,953		4,953
Employee benefits expense	**88,967**	**83,391**	**5,576**	86,715	81,762	4,953
Of the total above:						
Charged to capital	**79**			90		
Employee benefits charged to revenue						
There were no employee benefits paid in the year ended 2009/10 (£nil 2008/09) Details of the Directors' remuneration can be found in Section 8 of the annual report.	**79**			**90**		

Annual Accounts

7.2 Average number of people employed

	2009/10 Total £000	Permanently Employed £000	Other £000	2008/09 Total £000	2008/09 Permanently Employed £000	2008/09 Other £000
Medical and dental	180	161	19	182	182	
Ambulance staff						
Administration and estates	508	494	14	494	494	
Healthcare assistants and other support staff	60	60		61	61	
Nursing, midwifery and health visiting staff	1,236	1,235	1	1,230	1,230	
Nursing, midwifery and health visiting learners						
Scientific, therapeutic and technical staff	280	248	32	267	267	
Social care staff	10		10	7		7
Other	272		272	259		259
Total	2,546	2,198	348	2,500	2,234	266

7.3 Management costs

	2009/10 £000	2008/09 £000
Management costs	7,870	7,321
Income	121,767	119,070
	6.46%	6.15%

8 Retirements due to ill-health

During 2009/10 there were 6 (2008/09, 6) early retirements from the NHS Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £485k (2008/09: £278k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9 Better Payment Practice Code

	Year Ended 31 March 2010		Year Ended 31 March 2009	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	20,030	31,733	22,923	31,777
Total Non-NHS trade invoices paid within target	18,507	29,395	21,286	29,515
Percentage of Non-NHS trade invoices paid within target	92%	93%	93%	93%
Total NHS trade invoices paid in the period	835	8,113	725	7,200
Total NHS trade invoices paid within target	735	7,459	640	6,781
Percentage of NHS trade invoices paid within target	88%	92%	88%	94%

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

Annual Accounts

10 Finance income

	Year ended 31 March 2010 **£000**	Year ended 31 March 2009 £000
Finance Income	**198**	659
Bank accounts	**198**	659

11 Other gains and losses

	Year ended 31 March 2010 **£000**	Year ended 31 March 2009 £000
Gain/(loss) on disposal of property, plant and equipment	**(910)**	(164)
Total	**(910)**	(164)

The loss on disposal includes £909k relating to the demolition of Maple House.

12 Finance costs

	Year ended 31 March 2010 **£000**	Year ended 31 March 2009 £000
Interest on obligations under finance leases	325	335
Interest on obligations under PFI contracts:		
- main finance cost	2,691	2,756
- contingent finance cost	860	753
Total interest expense	**3,876**	**3,844**
Other finance costs		
Total	**3,876**	**3,844**

Annual Accounts

13 Property, plant and equipment

2009/10:	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2009	4,739	49,506		308	796	349	3,497	1,077	60,272
Additions purchased				2,923	61		411		3,395
Additions donated									
Reclassifications		2,165		(2,324)		11	148		
Reclassified as held for sale									
Disposals other than by sale		(909)			(42)		(231)		(1,182)
Revaluation/indexation gains	(82)	(1,423)			11	(6)		39	(1,461)
Impairments	(171)	(1,530)							(1,701)
At 31 March 2010	**4,486**	**47,809**		**907**	**826**	**354**	**3,825**	**1,116**	**59,323**
Depreciation at 1 April 2009		2,214			442	171	1,837	659	5,323
Disposals other than by sale					(41)		(231)		(272)
Revaluation/indexation gains	(82)	(1,423)			6	(3)		24	(1,478)
Impairments	82	850		6					938
Charged during the year		2,442			61	46	467	80	3,096
Depreciation at 31 March 2010		**4,083**		**6**	**468**	**214**	**2,073**	**763**	**7,607**
Net book value									
Total at 31 March 2010	**4,486**	**43,726**		**901**	**358**	**140**	**1,752**	**353**	**51,716**
Asset financing									
Owned	4,486	42,158		901	358	140	1,752	353	**50,148**
Finance Leased		1,540							**1,540**
Donated		28							**28**
Total at 31 March 2010	**4,486**	**43,726**		**901**	**358**	**140**	**1,752**	**353**	**51,716**

The latest revaluation of Land and Buildings was carried out by the Valuation Office with effective date 1st April 2010.

Annual Accounts

13 Property, plant and equipment - prior year

2008/09:	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction and payments on account £000	Plant and Machinery £000	Transport Equipment £000	Information Technology £000	Furniture & Fittings £000	Total £000
Cost or valuation at 1 April 2008	5,060	48,670		644	713	423	2,680	1,055	59,245
Additions purchased				2,343	41		256	44	2,684
Additions donated				15					15
Reclassifications		1,876		(2,683)	25		782		
Reclassified as held for sale	700								700
Disposals other than by sale				(11)		(85)	(221)	(49)	(366)
Revaluation/indexation gains					17	11		27	55
Impairments	(1,021)	(1,040)							(2,061)
At 31 March 2009	**4,739**	**49,506**		**308**	**796**	**349**	**3,497**	**1,077**	**60,272**
Depreciation at 1 April 2008					383	204	1,632	613	2,832
Disposals other than by sale						(85)	(221)	(49)	(355)
Revaluation/indexation gains		(575)			8	5		16	(546)
Impairments		413							413
Charged during the year		2,376			51	47	426	79	2,979
Depreciation at 31 March 2009		**2,214**			**442**	**171**	**1,837**	**659**	**5,323**
Net book value									
Total at 31 March 2009	**4,739**	**47,292**		**308**	**354**	**178**	**1,660**	**418**	**54,949**
Asset financing									
Owned	4,739	45,572		308	354	178	1,660	418	53,229
Finance Leased		1,690							1,690
Donated		30							30
Total at 31 March 2009	**4,739**	**47,292**		**308**	**354**	**178**	**1,660**	**418**	**54,949**

Annual Accounts

14 Intangible assets

2009/10:	Computer software purchased £000	Total £000
Gross cost at 1 April 2009	207	207
Additions purchased	119	119
Disposals other than by sale		
Revaluation/indexation	(41)	(41)
Gross cost at 31 March 2010	**285**	**285**
Amortisation at 1 April 2009	130	130
Disposals other than by sale		
Revaluation	(155)	(155)
Impairments	3	3
Charged during the year	22	22
Amortisation at 31 March 2010	-	-
Net book value		
Purchased	285	285
Donated		
Government granted		
Total at 31 March 2010	**285**	**285**

14 Intangible assets - prior year:

2008/09:	Computer software purchased £000	Total £000
Gross cost at 1 April 2008	282	207
Additions purchased		
Disposals other than by sale	(85)	(85)
Revaluation/indexation		
Gross cost at 31 March 2009	**207**	**207**
Amortisation at 1 April 2008	162	162
Reclassifications		
Reclassifications as held for sale		
Disposals other than by sale	(85)	(85)
Revaluation		
Impairments		
Charged during the year	53	53
Amortisation at 31 March 2009	**130**	**130**
Net book value		
Purchased	77	77
Donated		
Government granted		
Total at 31 March 2009	**77**	**77**

Annual Accounts

15 Impairments

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Abandonment of assets in course of construction	6	11
Other	3	149
Changes in Market Place	932	291
At 31 March	**941**	451

As part of an impairment review it was found that a fall in the BCIS index could indicate that a valuation was required. This was carried out by the Valuation Office and led to an impairment of the land and buidlings of £332k

16 Capital commitments

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

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Property, plant and equipment	**411**	465
Intangible assets	**31**	
Total	**442**	**465**

17 Inventories

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
Consumables	**52**	**65**	57
Total	**52**	65	57
Of which held at net realisable value:	52	65	57

17.1 Inventories recognised in expenses

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000
Inventories recognised as an expense in the period Write-down of inventories (including losses) Reversal of write-downs that reduced the expense	**57**	62
Total	**57**	62

Annual Accounts

18 Trade and other receivables

	Current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000	Non-current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
NHS receivables-revenue	**1,577**	1,082	2,068			
Other receivables with related parties	**84**					
Non-NHS receivables-revenue	**591**	701	842			
Provision for the impairment of receivables	**(152)**	(69)	(176)			
Prepayments	**978**	990	850	**1,687**	1,497	1,310
PDC Receivable	**32**					
VAT	**419**	539	604			
Other receivables	**1,036**	496	778	**937**	917	897
Total	**4,565**	3,739	4,966	**2,624**	2,414	2,207

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.
Other receivables includes £455k for rates rebates.

18.1 Receivables past their due date but not impaired

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
By up to three months	**661**	435	1,216
By three to six months	**137**	46	102
By more than six months	**11**	110	212
Total	**809**	591	1,530

18.2 Provision for impairment of receivables

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
Balance at 1 April	**69**	176	
Amount written off during the year	**(17)**	(117)	
Amount recovered during the year	**(14)**	(30)	
(Increase)/decrease in receivables impaired	**114**	40	68
At start of period for new Foundation Trust's			108
Balance at 31 March	**152**	69	176

Receivables written off in the period primarily consisted of debts relating to periods prior to 2007 where a major determining factor was the inability of external debt recovery to recover the debt or the costs of recovery were prohibitive. The increase in the amount provided for in the year ended 2009/10 has been provided for after taking all factors into consideration regarding the chances of recovery.

Annual Accounts

19 Cash and cash equivalents

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year ended 1 April 2008 £000
Balance at 1 April	**16,527**	11,563	6,822
Net change in year	**880**	4,964	4,741
Balance at 31 March	**17,407**	16,527	11,563
Made up of			
Cash with Government Banking Service	**17,349**	16,445	1,490
Commercial banks and cash in hand	**95**	82	73
Current investments			10,000
Cash and cash equivalents as in statement of financial position	**17,444**	16,527	11,563
Bank overdraft - Government Banking Service			
Bank overdraft - Commercial banks			
Cash and cash equivalents as in statement of cash f ows	**17,444**	**16,527**	**11,563**

20 Non-current assets held for sale

	Property, Plant and Equipment £000	Intangible assets £000	Total £000
Balance brought forward 1 April 2009	337		**337**
Plus assets classified as held for sale in the year			
Less assets sold in the year			
Less Impairments of assets held for sale			
Less assets no longer classified as held for sale, for reasons other than disposal by sale			
Balance carried forward 31 Mar 2010	337		**337**
Balance brought forward 1 April 2008	1,800		**1,800**
Plus assets classified as held for sale in the year			
Less assets sold in the year	(650)		**(650)**
Less Impairments of assets held for sale	(113)		**(113)**
Less assets no longer classified as held for sale, for reasons other than disposal by sale	(700)		**(700)**
Balance carried forward 31 Mar 2009	337		**337**

The asset held for sale is the land on the site of the former Wilson Arms public house which has been declared surplus. This asset was impaired by £113k in 2008/09. The sale was due to complete in 2009/10 but delays in planning permission mean that this will now occur in 2010/11.

Annual Accounts

21 Trade and other payables

	Current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000	Non-current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
NHS payables-revenue	**2,667**	2,947	1,346			
Amounts due to other related parties	**169**					
Non NHS trade payables - capital	**962**	277	941			
Accruals	**3,576**	3,785	3,502			
Other	**2,896**	2,582	3,801			
Total	**10,270**	**9,591**	**9,590**			

22 Borrowings

	Current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000	Non-current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
PFI liabilities	**915**	844	779	**32,086**	33,001	33,845
Finance lease liabilities	**122**	98	78	**2,536**	2,658	2,756
Total	**1,037**	**942**	**857**	**34,622**	**35,659**	**36,601**

The long term borrowing limit set by Monitor is £36,600k in 2009/10 (£11700k in 2008/09).The Trust has not breached the Prudential Borrowing Code (PBC).

23 Other liabilities

	Current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000	Non-current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
Deferred Income	**2,141**	1,682	1,628	**1,066**	1,425	
Total	**2,141**	**1,682**	**1,628**	**1,066**	**1,425**	

Annual Accounts

24 Finance lease obligations

Amounts payable under finance leases	Minimum lease payments		Present value of minimum lease payments	
	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	**Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000
Within one year	**423**	413	**410**	400
Between one and five years	**1,692**	1,652	**1,421**	1,386
After five years	**2,424**	2,897	**1,228**	1,429
Less future finance charges	**(1,881)**	(2,206)		
Present value of minimum lease payments	**2,658**	**2,756**	**3,059**	**3,215**
Included in:	**122**	98	**410**	400
Current borrowings	**2,536**	2,658	**2,649**	2,815
Non-current borrowings	**2,658**	**2,756**	**3,059**	**3,215**

The first Finance Lease arrangement is for the provision of two community units, for inpatient and day care for older people with severe mental illness together with a base for a community mental health team. The estimated capital value is £4,916,000. The scheme started in September 1998 and is contracted to end in September 2019. At the end of the contract the Trust has an option to renew for 10 years.

The present value of minimum lease payments at £3,059k (£3,215k 2008/09) is calculated from the minimum lease payments figures at £2,658k (£2,756k 2008/09) with the future finance charges at £1881k (£2206k 2008/09) added back. This figure is discounted at 0.49% (6.00% per annum) for 113 months (125 months 2008/09) which is the remaining life of the agreement.

25 Private Finance Initiative 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 £43,778,000. 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.

Total obligations for on-statement of financial position PFI contracts due:

	Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	
Not later than one year	**3,535**	3,535	
Later than one year, not later than five years	**14,140**	14,140	
Later than five years	**43,601**	47,136	
Sub total	**61,276**	**64,811**	
Less: interest element	**(28,276)**	(30,966)	
Total	**33,000**	**33,845**	

Where the £33m is the actual outstanding amount owed as per the Statement of Financial Position.

Annual Accounts

26 Provisions

	Current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000	Non-current Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	Year starting 1 April 2008 £000
Pensions relating to former directors						
Pensions relating to other staff	**161**	105	101	**1,957**	1,338	1,363
Legal claims	**139**	89	70			
Agenda for change			30			
Other (specify)	**578**	1,385				
Total	**878**	1,579	201	**1,957**	1,338	1,363
	Pensions relating to former directors £000	**Pensions relating to other staff £000**	**Legal claims £000**	**Agenda for change £000**	**Other £000**	**Total £000**
At 1 April 2008		1,464	70			**1,534**
Arising during the year		58	70	1	1,385	**1,514**
Used during the year		(105)	(40)	(10)		**(155)**
Reversed unused		(6)	(11)	(21)		**(38)**
Unwinding of discount		32				**32**
At 31 March 2009		1,443	89	(30)	1,385	**2,887**
At 1 April 2009		1,443	89		1,385	**2,917**
Arising during the year		811	97		264	**1,172**
Used during the year		(149)	(18)		(223)	**(390)**
Reversed unused		(19)	(29)		(848)	**(896)**
Unwinding of discount		32				**32**
At 31 March 2010		2,118	139		578	**2,835**
Expected timing of cash f ows:						
In the remainder of the spending review period to 31 March 2011		161	139		578	**878**
Between 1 April 2011 and 31 March 2016		644				**644**
Thereafter		1,313				**1,313**
TOTAL		2,118	139		578	2,835

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.

The legal claims provision is in respect of excess payments paid to NHS Litigation Authority for employers' and public liability claims. NHS Litigation Authority provides estimates of the likely outcome of the case and damages / costs to be paid. The provision is calculated based on these estimates.

Other provisions comprise unsocial hours sickness pay claims (£394k) and equal pay claims (£113k) and redundancy (£70k).The unsocial hours provision has been made following clarification from NHS Employers on the national agreement for Agenda for Change terms and conditions para 14.4. The equal pay provision relates to five equal pay claims lodged as a result of the implementation of Agenda for Change.

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 unwinding of discount on the provisions appears as a finance cost on the face of the Statement of Comprehensive Income

£429k is included in the provisions of the NHS Litigation Authority at 31 March 2010 in respect of clinical negligence liabilities of the NHS Foundation Trust (31 March 2009 £284k).

Annual Accounts

27 Contingencies

27.1 Contingent liabilities

	2009/10 £000	2008/09 £000	1st April 08 £000
Equal pay cases			
Other (specify)	71	56	39
Total	**71**	**56**	39

Contingent liabilities represent excess payments not provided for on legal cases being dealt with by NHSLA, on the Foundation Trust's behalf, and are primarily in respect of employer's liability. 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.

28 Financial instruments

Liquidity risk

The NHS Foundation Trust's net operating costs are incurred primarily under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The NHS Foundation Trust also largely finances its capital expenditure from funds generated through operating surpluses. Consequently there is not considered to be exposure to significant liquidity risks.

Treasury risk

The 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. Leeds Partnerships NHS Foundation Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investments. Trust treasury activity is subject to review by the Trust's internal auditors.

Foreign currency risk

A high percentage of the NHS Foundation Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds Partnerships NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Interest paid on PFI and finance leases is linked to RPI and RPIX and is therefore unaffected by interest rate changes.

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2010 are in receivables from customers, as disclosed in the Trade and other receivables note.

28.1 Financial assets

	At fair value through profit and loss £000	Loans and receivable £000	Available for sale £000	Total £000
Embedded derivatives				
Receivables		4,116		**4,116**
Cash at bank and in hand		11,562		**11,562**
Other financial assets				-
Total at 1st April 2008		15,678		**15,678**
Embedded derivatives				-
Receivables		3,666		**3,666**
Cash at bank and in hand		16,527		**16,527**
Other financial assets				-
Total at 31 March 2009		20,193		**20,193**
Embedded derivatives				-
Receivables		**4,445**		**4,445**
Cash at bank and in hand		**17,407**		**17,407**
Other financial assets				-
Total at 31 March 2010		**21,852**		**21,852**
Ageing of over due receivables included in Financial Assets				
Receivables overdue by:				
1-30 days		**485**		**485**
31-60 days		**150**		**150**
61-90 days		**26**		**26**
91-180 days		**137**		**137**
181-360 days		**5**		**5**
361+ days		**7**		**7**
	-	**810**	-	**810**

Annual Accounts

28.2 Financial liabilities

	At fair value through profit and loss £000	Other £000	Total £000	
Embedded derivatives				
Payables		9,572	9,572	
PFI and finance lease obligations		37,458	37,458	
Other borrowings				
Provisions under contract		1,464	1,464	
Other financial liabilities				
Total at 1st April 2008		**48,494**	**48,494**	
Embedded derivatives				
Payables		7,898	7,898	
PFI and finance lease obligations		36,601	36,601	
Other borrowings				
Provisions under contract		1,443	1,443	
Other financial liabilities				
Total at 31 March 2009		**45,942**	**45,942**	
Embedded derivatives				
Payables		**8,438**	**8,438**	
PFI and finance lease obligations		**35,658**	**35,658**	
Other borrowings				
Provisions under contract		**2,118**	**2,118**	
Other financial liabilities				
Total at 31 March 2010		**46,214**	**46,214**	

The fair value of financial instruments has been assessed to be the same as the book value as per IFRS 7

29 Related party transactions

Leeds Partnerships NHS Foundation Trust previously disclosed certain related party transactions. However, there are no related party transactions to disclose for 2009/2010 due to the fact that no senior management working for the trust have a position of significant influence in any organisations which the Trust transacts with.

During the period Leeds Partnerships NHS Foundation Trust had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. These entities are listed below:

	Income Year ended 31 March 2010 £000	Year ended 31 March 2009 £000	**Expenditure Year ended 31 March 2010 £000**	Year ended 31 March 2009 £000
Yorkshire and Humber Strategic Health Authority	**5,388**	5,150		
Leeds Primary Care Trust	**101,635**	100,261		
Leeds Teaching Hospitals NHS Trust			**3,575**	4,640
South West Yorkshire Partnerships NHS Foundation Trust	**1,272**			
Barnsley PCT	**1,594**	1,029		
Total	**109,889**	106,440	**3,575**	4,640

In addition, the NHS Foundation Trust has had a number of material transactions with other Government Departments and other central and local government bodies. Most of these transactions have been with Leeds City Council in respect of joint enterprises.

30 Third party assets

The Trust held £83k cash and cash equivalents at 31 March 2010 which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Annual Accounts

31 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	84		169	
Balances with Local Authorities	1,375		367	
Balances with NHS Trusts and Foundation Trusts	202		995	
Balances with Public Corporations and Trading Funds			1,305	
Intra Government balances	1,661		2,836	
Balances with bodies external to Government				
At 31 March 2010	**1,661**		**2,836**	
Balances with other Central Government Bodies	136		2,567	
Balances with Local Authorities	1,014		172	
Balances with NHS Trusts and Foundation Trusts	68		1,331	
Balances with Public Corporations and Trading Funds			467	
Intra Government balances	1,218		4,537	
Balances with bodies external to Government				
At 31 March 2009	1,218		4,537	

32 Losses and special payments

There were 72 (72 in 2008/09) cases of losses and 32 (28 in 2008/09) special payments totalling £50k (£75k in 2008/09) accrued during the year.

33 Events after the reporting period

The Trust has now finalised the hosting arrangements for the Commercial Procurement Collaborative (CPC) which is expected to take effect from the 1st June 2010. CPC has an annual turnover of £3m.

34 Transition to IFRS

If material, explain how the transition to IFRS has affected the reported financial position, financial performance and cash flows and provide the following reconciliations and information:

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Other Reserves £000	Public dividend capital £000
Taxpayers' equity at 31 March 2009 under UK GAAP:	**12,563**	**8,015**	30	**(651)**	**19,509**
Adjustments for IFRS changes:					
Private finance initiative	(12,467)	147			
Leases	(1,342)	91			
Others (Non current asset held for resale)		(3)			
Adjustments for:					
Impairments charged to I&E under UK GAAP	27	(27)			
	(1,219)	**8,223**	30	**(651)**	**19,509**
	£000				
Surplus/(deficit) for 2008/09 under UK GAAP	**1,192**				
Adjustments for:					
Private finance initiative	(600)				
Leases	(65)				
Others (impairment)	27				
Surplus/(deficit) for 2008/09 under IFRS	**554**				

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £4,964k. This net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.]

"Adjustments for IFRS changes" relates to differences in accounting for Equitix and Revival contracts on-statement of financial position.
This includes an impairment of the buidings of £5.7m following a revaluation by the valuer as at 1 April 2008. The remainder of the impact on the Retained Earnings is due to higher interest charges in the initial years of the contract.

	Retained earnings £000	Revaluation reserve £000	Donated asset reserve £000	Other Reserves £000	Public dividend capital £000
Taxpayers' equity at 1 April 2008 under UK GAAP:	**11,080**	**9,849**	**15**	**(651)**	**19,509**
Adjustments for IFRS changes:	(11,874)	154			
Private finance initiative	(1,286)	100			
Leases	**(2,080)**	**10,103**	**15**	**(651)**	**19,509**

Notes

Notes

About this Annual Report

Urdu
اگر آپ اس سالانہ رپورٹ کا ترجمہ بریل، آڈیو ٹیپ، کسی دیگر زبان یا کسی دیگر شکل میں چاہتے ہیں براہ کرم ڈائیورسٹی ٹیم سے **0113 2954413** پر یا ای میل diversity@leedspft.nhs.uk پر رابطہ کریں۔

Chinese:
如需本年度报告的磁带、录音带或者其他语言或其他格式，请联系
Diversity Team，电话：0113 2954413，或电子邮件：
diversity@leedspft.nhs.uk

Bengali
যদি আপনি বাৎসরিক রির্পোট চেল, a ডিও টেপ, a ন্য ভাষায় a থবা a ন্য কোন ফর্মাটে পেতে চান, a নুgহ করে ডা ভারসিটি টিমের সাথে যোগাযোগ করুন 0113 2954413 নmরে a থবা i -মেলে
diversity@leedspft.nhs.uk

Gujarati
જો તમને આ વાર્ષિક અહેવાલ બ્રેઇલ, ઑડીઓ ટેપ, કોઇ અન્ય ભાષામાં અથવા કોઇ પણ અન્ય ફૉર્મેટમાં જોઈતો હોય, તો કૃપા કરી ૦૧૧૩૨૯૫૪૪૧૩ ઉપર ડાઈવર્સીટી ટીમનો સંપર્ક કરો અથવા **diversity@leedspft.nhs.uk** ઉપર ઈ-મેલ કરો

Punjabi
ਜੇਕਰ ਤੁਸੀਂ ਇਹ ਸਲਾਨਾ ਰਿਪੋਰਟ ਬ੍ਰੇਲ 'ਚ, ਆੱਡਿਓ ਟੇਪ 'ਤੇ, ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ 'ਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0113 2954413 'ਤੇ ਡਾਇਵਰਸਿਟੀ ਟੀਮ ਨਾਲ ਸੰਪਰਕ ਕਰੋ ਜਾਂ **diversity@leedspft.nhs.uk** 'ਤੇ ਈਮੇਲ ਕਰੋ।

Kurdish
ئەگەر دەتەوێت ئەم ڕاپۆرتی ساڵانە بە دێری برەیل، شریتی دەنگ، یان بە زمان یان فۆرماتێکی دیکە بۆ تۆ ئامادە بکەین تکایە لە ڕێگەی ژمارە تەلەفۆنی **0113 2954413** یان ئیمەیڵی **diversity@leedspft.nhs.uk** لەگەڵ تیمی جۆراوجۆریی **Diversity Team** پەیوەندیی بکە.

Vietnamese:
Nếu quý vị muốn có bản báo cáo thường niên này bằng chữ Brail, hoặc bằng âm thanh, bằng một ngôn ngữ khác hoặc bất kỳ định dạng nào khác, vui lòng liên hệ với nhóm Diversity Team ở số 0113 2954413 hoặc thư điện tử diversity@leedspft.nhs.uk**.**

Russian
Если Вы хотите получить информацию по данному годовому отчету в шрифте Брайля, на аудио кассете, или на другом языке или в другом формате, пожалуйста, позвоните в отдел культурного разнообразия, по номеру: 0113 2954413 или на электронный адрес diversity@leedspft.nhs.uk.

Polish
Jeśli chciał(a)by Pan(i) otrzymać sprawozdanie roczne pisane brajlem, w formie nagrania dźwiękowego, w innym języku lub jeszcze w innej formie, proszę się skontaktować z Diversity Team pod numerem 0113 2954413 lub napisać e-mail na adres: diversity@leedspft.nhs.uk

Contact us

Leeds Partnerships NHS Foundation Trust

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Leeds LS15 8ZB
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www.leedspft.nhs.uk

Chief Executive

If you have a comment for the Chief Executive, please contact:
Chris Butler, Chief Executive
Tel: 0113 30 55913
Email: Julie.wortley-froggett@leedspft.nhs.uk

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@leedspft.nhs.uk

Membership

If you are interested in becoming a member of
Leeds Partnerships NHS Foundation Trust please contact:
The Membership Office
Tel: 0113 30 55900
Email: FTmembership@leedspft.nhs.uk
Web: www.getinvolved.co.uk

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 30 55977
Email: communications@leedspft.nhs.uk

Members of the Board of Directors and Board of Governors

Can be contacted by email at the addresses shown on our website at
Web: www.leedspft.nhs.uk
alternatively please contact
The Marketing & Communications Department
Tel: 0113 30 55977
Email: communications@leedspft.nhs.uk

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