Leeds Partnerships NHS
NHS Foundation Trust

# Annual Report and Accounts

# 2010 - 2011

improving health, improving lives

# Leeds Partnerships NHS Foundation Trust

# ANNUAL REPORT AND ACCOUNTS
# 2010 - 2011

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

# Content


*Graphic Facilitation by Tom Bailey, Arts and Minds*

# About our Trust

## 1 About our Trust

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 PCTs in Leeds, and the Trust was renamed the Leeds Mental Health Teaching NHS Trust; providing only mental health and learning disability services.

On 1 August 2007 Monitor, the independent regulator of Foundation Trusts, authorised us as a Foundation Trust, and we were formed as the Leeds Partnerships NHS Foundation Trust under the NHS Act 2006. We continue to provide mental health and learning disability services but are no longer performance managed by the local Strategic Health Authority or the Department of Health.

We provide specialist mental health and learning disability services to over 620,000 adults within the Leeds metropolitan boundary. We employ around 2430 substantive staff; we work with over 190 committed volunteers and can call on around 390 bank staff. All these people provide mental health and learning disability services and each day we provide help to over 2,000 people.

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 in partnership with our local communities. Our core purpose is to improve the mental health and wellbeing of the people of Leeds and the wider community and provide effective, accessible and modern mental health and learning disability services.

We provide our services in many different settings. We provide care in people's own homes and operate from a number of 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.

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

During 2010/11 there has been a lot of work undertaken to look at transforming the way in which services are delivered, moving from four care service directorates to three integrated care pathways. Further information about the Transformation Project can be found in Section 4.1.1.

The care service directorates are supported by a number of corporate directorates and support services. These are:

| | | |
|---|---|---|
| Estates and Facilities | Finance and Performance | Human Resources |
| Information and Knowledge Services | Communications | Membership |
| | Nursing | Planning |
| Medical and Allied Professions | Strategic Growth | |
| Partnerships and Social Inclusion | | |


*Charles Hewitt, Busters Cafe at The Mount*

# Directors' Report

## 2.1 The Chairman's Report

Our Annual Report has been written in the context of major changes in the NHS, both proposed and implemented. The major focus of late has been on the implications of the government's Health and Social Care Bill, currently in a House of Lords' siding as we are given a final chance to comment before it again trundles through the Parliamentary system.

Change, however, is a constant and our Trust has been busy in addressing the various challenges before us. Wherever possible we have been proactive; initiating, for example, a process which culminated in the adoption last September of a new five-year strategy – 'Improving health, improving lives'.

My executive colleagues have also responded magnificently to the challenge of structural change, for example in the response we made to the invitation to tender for additional mental health and learning disabilities provision in North Yorkshire & York. I look forward to a successful outcome to the process such that we can apply our highly regarded service model, appropriately resourced, to the people of York and elsewhere in the county.

Within the Trust we have set about transforming the way we organise our clinical services; borne out of a recognition that our endeavours should always focus unambiguously on the people who depend on us, most notably service-users and their carers. It must also mean that within a tight resource allocation we will have done our best to achieve maximum effectiveness for every pound spent.

On a personal level I have found my first 12 months as Chairman an invigorating experience, of both a steep learning curve with the summit still some distance away; and also because of the immense depth of professional support and goodwill available. The Trust has an outstanding Executive Team led by Chris Butler which was strengthened this year by the appointment of a substantive Director of Strategy and Partnerships. The executive is ably supported by colleagues within the various directorates, as evidenced by our recent series of performance reviews.

As Chairman I have focused on seeking to ensure the maximum effectiveness of our governance arrangements. There have been significant changes to the team of non-executive directors (NEDs). During the year we said goodbye to Catherine Coyle and Merlin Wilce. Both had served as NEDs before we became a foundation trust in 2007. They made a huge contribution to the organisation and we wish them well for the future. We increased the number of NEDs to six to match the number of executive directors and duly advertised for three new members of the Board of Directors and also for the two posts which became re-appointable during the year. I was delighted that the Board of Governors decided to re-appoint Allan Valks and Niccola Swan for a further period of two years; Allan is our Senior Independent Director and chairs the Audit and Assurance Committee, and Niccola leads on human resources. We successfully made three new appointments, of Aqila Choudhry, Gill Taylor and Keith Woodhouse, who will be leading, respectively, on diversity, growth and information management, as well as undertaking the wider role of being a NED. Linda Phipps was confirmed in her post early in 2010 and will support Allan as Deputy Chair of the Audit and Assurance Committee. I am confident that we now have non-executives with the relevant skills, knowledge and experience to provide challenge and support to the management team.

I have been enormously impressed by the way our Board of Governors has supported me and my fellow directors, and in the nature of governors' contribution to the future development of our Trust. Governors gave active support to the shaping of our five-year strategy and in the task of making the non-executive Board appointments. The response of governors to the opportunity of growing our service in North Yorkshire was crucial, and I in particular would wish to congratulate members for the collective maturity displayed throughout the year to this and other challenges. We shall continue to introduce changes to the way our Board of Governors works so as to ensure effective governance of Trust management.

**Frank Griffiths**
Chairman of Trust

# Directors' Report

## 2.2 The Chief Executive's Report – a Review of Our Business

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

We provide vital help and support to thousands of people who experience serious mental health problems and learning disabilities across the metropolitan district of Leeds and, for some of our services, regionally and nationally. Most of our work is done either in, or close to, people's homes. We continue to further de-institutionalise our services by providing still more alternatives to hospital admission. With regard to hospital services, we have made major inroads into ensuring that when a hospital bed is needed it is available in Leeds. We have significantly reduced the number of out-of-area treatments experienced by services users who are working age adults, however there is more work for us to do in this regard and it remains an area of focus for us. We are active in teaching, research and development, both to develop the professionals of the future and to continually improve what we do. Reflecting on this, working with service users, carers and other partners in the city, we have, over the years, revolutionised not only how services are delivered but, more recently, also posed a fundamental challenge to the stigma experienced by services users and carers.

Why do we do this? Last year, at our 2010 Members' Day we launched our new strategy. Our strategy is both simple in concept but ambitious in its scope. It summarises our purpose as:

***"Improving health, improving lives"***

You may observe that this purpose is not specific to either mental health or learning disability. Why is this? With our governors, we have agreed that people who use our services experience life in the way that everyone else does. In this context the experience of a mental health problems or a learning disability is just one facet of a person. Our task, therefore, is to work with services users and carers not only to directly address mental ill health or a learning disability, but also to see a person in the round, enabling them to recover from the experience of ill health, and to maximise their potential. It is about helping people to fully participate in society, just as we all want to when we recover from a period of ill health.

This is summed up in our ambition:

***"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"***

Partnerships are critical to us; we cannot achieve either our purpose or ambition alone. We unashamedly reach towards excellence in our work. We want excellence in service provision if we, or a family member, are ill. What we want for ourselves we also want to make a reality for service users and carers.

From these broad statements we are working towards three strategic end goals. These are:

- **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**

Our purpose, ambition, and strategic end goals have, over the past year, been the linchpin of our work. They are the tests against which we measure what we are currently doing or could do in the future. Further information on our strategy can be found in Section 3.

Significant policy and structural changes in the NHS, both at a national and local level have led us to review how care is provided. There is also a requirement that we deliver significant efficiency savings over the coming years. We pride ourselves on providing safe and effective services for our service users and their carers. To ensure that we continue to do this our Care Services Directorate has taken an innovative look at the way services are provided, and is working towards moving from four service directorates to three integrated care pathways. This is an exciting opportunity which will significantly change the way in which we work. It will allow us not only to improve the service user's journey but allow us to make efficiencies and drive up quality.

The Government's initiative 'Transforming Community Services' has led PCTs to divest their provider functions to other NHS organisations. This has provided a driver for NHS North Yorkshire and York (NHS NY&Y) to put their mental health, learning disability and substance misuse services out to tender. We saw this as an opportunity for us to grow our organisation in a way which was entirely consistent with our strategy. Having fully involved and gained the support of our Board of Governors we submitted a response to the tender and were successfully identified as a preferred provider. We are currently undertaking a thorough due diligence process and hope to be able to effect the safe transfer of services from NHS NY&Y during 2011/12 and creating an integrated Trust with our colleagues in the NY&Y area.

All NHS organisations have a statutory

# Directors' Report

obligation to present their Quality Accounts and these can be found in Section 9 of this report. For us, presenting this information goes beyond that statutory duty, as we pride ourselves on providing quality services and want to share with people the way in which we do this. The Quality Accounts provide clear and comprehensive details regarding the quality standard of the care and services that we provide.

One way in which the quality of services can be measured is by asking the people that use them what they think. Our annual Service User Survey in 2010 showed that 84% of people rated the care they had received from our mental health services in the last 12 months as either good, very good, or excellent. We take seriously the feedback we are given and work hard to ensure that we continually improve outcomes, safety and service user experience.

Another way in which the quality of our services can be measured is through inspections by our regulators. One of the highlights from this year was the outcome of a random inspection of our Specialised Supported Living Service in June 2010 by the Care Quality Commission (CQC). The CQC identified no issues that could be improved upon and awarded a three-star excellent rating.

We have also addressed the quality of the environment in which care is provided. This has included a programme of window replacement in some of our private finance initiative inpatient units which has led to us being able to better control the temperatures in the units, making a better care environment for our service users and staff.

I am also pleased to announce that on 1 August 2010, the Yorkshire & Humber Commercial Procurement Collaborative (CPC) transferred to our Trust from the Strategic Health Authority. The main role of the CPC is to drive better value through procurement for the NHS. The first eight months have been a great success with the CPC being rebranded NHSCPC, widening its footprint beyond Yorkshire & the Humber and generating significant financial benefit for both its customers and the Trust.

You may notice that I have not mentioned money. This is because, with my colleagues, I am clear that money should be no more than a means though which the ends are delivered. You will see from the report of our Chief Financial Officer that we have successfully managed our resources during the year whilst investing in improving what we do. 20011/12 will be challenging given the economic climate, but our positive track record in using resources well will stand us in good stead for whatever the future holds.

Finally, I want to take a moment to thank all of my colleagues and other partner agencies for their hard work and their commitment to our Trust's broader intentions. Partnership working can only be delivered through partnership behaviours underpinned by a commitment to values. For us in our Trust our values are:

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

I frequently have the opportunity to see how these values are being lived out in the various settings from which we provide services, from inpatient adult wards to providing social care for people with profound learning disabilities. None of us is perfect and we will not get it right all of the time, but every day I see people both in our Trust and our partner agencies working hard to change people's lives for the better. This is because I know that my colleagues have a purpose deeper than professional status or, for that matter, the need to earn a living. Recently I came across a quote from a nineteenth century educationalist. It refers to the vocation of teaching but it is equally relevant today to everyone who works in our Trust and, I would suggest, to anyone working in, or associated with, the caring professions,

***"In giving away our life, we shall discover the greatest mystery of all, that as we give away our life, our life grows wider and more intense."***

I am proud to be associated with such people working for such a great purpose.

**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 4.14 and Section 10, and details of the R&D developments can be found in Section 9.

# Directors' Report

## 2.3 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 and End Goals that we have set ourselves.

At the end of 2010/11 the Board of Directors comprised of seven non-executive directors, including the Chairman of the Trust, and six executive directors, including the Chief Executive.

### The Non-executive Team

- Frank Griffiths (Chairman of the Trust), Aqila Choudhry, Linda Phipps, Niccola Swan, Dr Gill Taylor, Allan Valks, and Keith Woodhouse.

### The Executive Team

- Chris Butler (Chief Executive), Jill Copeland (Director of Strategy and Partnerships), Dr Douglas Fraser (Medical Director), Stephen Griffin (Director of Human Resources), Michele Moran (Director of Service Delivery/Chief Nurse), and Guy Musson (Chief Financial Officer).

*(L-R) Guy Musson (Chief Financial Officer), Michele Moran (Director of Service Delivery/Chief Nurse), Frank Griffiths (Chairman of the Trust), Chris Butler (Chief Executive), Jill Copeland (Director of Strategy and Partnerships)*

During 2010/11 the following people also held positions on the Board of Directors:

- Catherine Coyle, Non-Executive Director (until 31 December 2010)
- Mike Doyle, Director of Corporate Development (until 30 April 2010)
- Merlin Wilce, Non-Executive Director (until 26 June 2010)

More detailed information about the Board of Directors and its members can be found in Section 6 and Section 8.

## 2.4 Equality and Diversity

We have adopted an integrated approach to equality and diversity and our strategic aims are outlined within our Single Equality Scheme and associated action plan.

Our second Single Equality Scheme (2011 to 2014) 'Respect', sets out how we will meet our statutory duties under the current equality and human rights legislation and it details our commitment to promoting equality and diversity which goes beyond the current legal duties.

The Respect scheme has been developed following the introduction of the Equality Act in October 2010. However, the revised specific public sector duties under the Act are not due to be announced until June 2011 and until this time the duties below apply.

The general duty of the legislation means that we must have due regard of the need to:

- **Eliminate unlawful discrimination**
- **Advance equality of opportunity**
- **Foster good relations**

# Directors' Report

The specific duties of our Respect scheme in relation to the equality legislation duties are to:

- **Identify which functions and policies are relevant to the general duty to promote equality**
- **Set out our arrangements for:**
  - **Assessing and consulting on the impact of proposed policies on the promotion of equality**
  - **Monitoring policies for any adverse impact on the promotion of equality**
  - **Publishing the results of assessments, consultation and monitoring**
  - **Ensuring public access to information and services**
  - **Training staff to carry out the duties**

We fulfil the requirements of these two specific duties through our equality impact assessment processes. Details of our Equality Impact Assessment Guide and details of assessments undertaken are published on our website **www.leedspft.nhs.uk .**

In relation to employment, the following specific duties apply:

- **Monitor the ethnicity, gender and disability of staff in post; and also applicants for jobs, promotion and training**
- **Monitor and publish annually details of ethnicity, gender and disability in:**
  - **Training**
  - **Grievances**
  - **Disciplinary procedures**
  - **Performance appraisal**
  - **Dismissals and other reasons for leaving**

We fulfil the requirements of these two specific duties through producing workforce monitoring details within the Single Scheme Annual Report. Details are published on our website **www.leedspft.nhs.uk.**

## 2.5 Equal Opportunity Statement

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

We are committed to eliminating discrimination and are committed to the fair treatment of everyone, taking into account their gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion, disability, mental health needs, age, domestic circumstances, social class, sexual orientation, marriage or civil partnerships, beliefs or trade union membership. We are firmly committed to tackling discrimination based on these values and human characteristics.

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

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

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

### 2.5.1 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 a "✓✓" employer, which demonstrates commitment to supporting people with disabilities.

We have supportive employment practices in place not only for those who we employ with a disability, but for those who may become disabled whilst they are working for us. These include: a support package within the Management of Sickness Absence Procedure; management of work related stress; Staff Support Service; and a bespoke Occupational Health Service. These procedures

# Directors' Report

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 individual needs related to disability and provide 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.

## 2.6 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 Trust's auditor is unaware; and the directors have taken all the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information, and to establish that the auditor is aware of that information.

## 2.7 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 in preparing the accounts.

## 2.8 Accounting Policies

Accounting policies for pensions and other retirement benefits are set out in the Annual Accounts in Section 10; and details of senior employees' remuneration can be found in the Remuneration Report in Section 8.

*Chapeltown Carnival, 2010*

*Verity Rushworth, Lavender Court, 2010*

*Dean Milner-Bell, Learning Disabilities Team*

# Our Strategy

## 3 Our Strategy

In 2010 we launched our new Trust strategy – ***Improving health, improving lives.***


Our strategy sets out our plans for 2010 to 2015 and has been developed by listening to the people who use our services, to their families and to their carers. People tell us that they want us to view them as whole people with physical as well as mental health needs; to support them towards recovery wherever possible; to provide care that is safe; to make sure that they have a positive experience of their care and support; and to work closely with other organisations to provide clear and effective pathways into other support services. Above all, people want a say in their care and treatment so that we focus on their individual goals for improving their health and lives.

We have also taken into account the national and local developments for mental health and learning disability services and the challenges and opportunities we see ahead of us.

We have chosen to describe our aspirations in a new ambition statement for Leeds Partnerships NHS Foundation 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.***

To support this ambition and respond to the people who use our services, we have developed three End Goals. We call these 'End Goals' as they are about the outcomes we are here to achieve, rather than how we will work to achieve these outcomes. As a result, the End Goals are all about people who use our services.

Our End Goals are:

| | |
|---|---|
| **End Goal 1** | People achieve their agreed goals for improving health and improving lives |
| **End Goal 2** | People experience safe care |
| **End Goal 3** | People have a positive experience of their care and support |

For our End Goals we have set ourselves some measures of success; some outcomes we want to achieve by 2015; and some milestones to track our progress every year until 2015. To make sure we achieve our ambition and the outcomes described in our three End Goals we have set ourselves seven organisational goals (or Means Goals). They are:

| | |
|---|---|
| **Means Goal 1** | We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion |
| **Means Goal 2** | We involve people in planning their care and in improving services |
| **Means Goal 3** | We work with partner organisations to improve health and lives |
| **Means Goal 4** | We value and develop our workforce and those supporting us |
| **Means Goal 5** | We improve our services through learning, research and innovation |
| **Means Goal 6** | We provide efficient and sustainable services |
| **Means Goal 7** | We govern our Trust effectively and meet our regulatory requirements |

For the majority of our Means Goals we have agreed a set of measures with clear annual milestones of where we expect to be each year and the standard we aim to achieve in 2015. Where measures are still in development we are involving our governors in agreeing what these should be. Our governance framework has been designed to support the delivery of our strategy and we have a standing group in place for each Means Goal. There are clear lines of accountability for the achievement of our strategic End Goals and the delivery of our Means Goals, and directorate and team business plans are aligned with our strategic objectives.

We are making good progress against our strategy and regular progress reports on our performance against each of the measures are presented to our Board of Directors and Board of Governors, and are published on our website. We expect to see further progress in 2011/12 and beyond. More information can be found in our Annual Plan which is published on our website **www.leedspft.nhs.uk .**

*Sad Santa Christmas Event, 2010*

# Operating and Financial Review

## 4.1 Service User Care – Principal Activities of Our Trust

We put the health, safety and wellbeing of our service users, staff and carers at the heart of everything we do; and our principal activity is the provision of free healthcare to eligible service users.

### 4.1.1 The Transformation Project

Significant policy and structural changes in the NHS, both at a national and local level have led us to review how care is provided. There is also a requirement that we deliver significant efficiency savings over the coming years. During 2010/11 we embarked on a major project that uses Lean and Six Sigma methodologies to re-design how we provide our care services. This is known as the Transformation Project and it will result in a move from providing care in four service directorates to providing care across three integrated care pathways:

- **The acute care pathway**
- **The community care pathway**
- **The regional and in-reach pathway**

There are a number of reasons why we decided to re-design our services. These included:

- **Reducing the burden of bureaucracy on front line staff, releasing time to care**
- **Making the best use of our skills and ideas**
- **Doing the right thing, at the right time, for the right reason**
- **Focusing on recovery and wellbeing**
- **Viewing the service user's journey as a whole and make transition between services simpler**
- **Reducing duplication and unnecessary variation in services, improving quality and improving efficiency in order to reduce overall cost**

The Transformation Project is being led by the Director of Care Services/Chief Nurse. There is a Project Board and Project Group with a number of work-streams reporting into these. Overall responsibility for the project rests with the Executive Team.

### 4.1.2 The Care Services Directorates

#### 4.1.2.1 Adult Mental Health Directorate

Our Adult Mental Health Directorate provides a range of secondary care mental health services accessible to the adult population. We provide high quality, safe, accessible and responsive services. Our adult mental health services can be divided into three care pathways:

- **An acute care pathway providing acute inpatient services, a crisis resolution and home treatment service and acute community services, which provide community alternatives to hospital admission**
- **A community care pathway providing community mental health teams, assertive outreach, psychological therapy services and a rehabilitation and recovery service**
- **A forensic service, which came into the directorate in September 2010 and which includes both inpatient and community services**

**Key achievements during 2010/11**

During 2010/11 staff in the Adult Mental Health Directorate worked hard to improve the services we provide and to enhance the service user experience. Some of these achievements are listed below.

- **Working in conjunction with the Recovery and Social Inclusion team we ensured that the experiences and ideas from a wide range of service users and carers were captured, particularly from those that would not normally participate in conventional feedback exercises. Individual services are using this feedback to help develop and plan service delivery for the future**
- **The Healthy Living team developed ways to work collaboratively with community teams to provide specialist support and advice**

# Operating and Financial Review

**for service users to allow them to promote physical health and wellbeing and increase the options for service users to choose healthy lifestyles**

- **Forensic services were integrated into the directorate which allowed us to give access to community services for forensic service users to prevent hospital admission**

**Some of the key priorities for the future:**

During the coming year and beyond our directorate will review the services to see how we can better provide care in the future ensuring we continue to deliver safe, high quality services which maximise the use of resources. Work to achieve this will contribute to the Transformation Project and the implementation of integrated care pathways across all service areas. This work will further improve health outcomes for service users and ease of access to services.

**The directorate will also:**

- **Continue work to reduce waiting times for psychological therapies to below 18 weeks for all service users requiring this service**
- **Redesign of the rehabilitation and recovery services in order to meet the needs of all service users including those who are currently in out-of-area placements. As part of this re-design the directorate will complete the move from Peel Court to Towngate House to ensure that the standard of accommodation better meets the changing needs of the rehabilitation and recovery service users in the future**

There are a number of risks and uncertainties that face the directorate. One of these is the rate of sickness which is above the Trust's target rate; and covering for sickness can have an effect on the cost of providing services. To tackle this the directorate has in place a sickness action plan which is being implemented and closely monitored by management. In addition to this, as we reduce the waiting time for psychological therapies there is a risk that the number of referrals to the service will increase. Therefore we continue to monitor demand and ensure that referrals to the service remain appropriate.

More information about the Adult Mental Health Directorate's key achievements and developments can be found in the Annual Plan for 2011/12, which is on the Trust's website **www.leedspft.nhs.uk .**

## 4.1.2.2 Specialist Services Directorate

The Specialist Services Directorate is a collection of seven 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. The directorate includes services which are nationally recognised as centres of excellence in clinical delivery, training and research; these include The Yorkshire Centre for Psychological Medicine, the Yorkshire Centre for Eating Disorders, Leeds Addiction Unit and the regional Personality Disorder Care Pathways Service.

**Key achievements during 2010/11 include:**

- **The launch of the Addiction Psychosocial Manual which has been adopted by the Safer Leeds Community Safety Partnership as a standard training manual for the Leeds drug treatment system, benefitting service users and staff with a consistent, evidence-based approach**
- **The first national cohort of trainers delivered training across the Yorkshire and the Humber Region in respect of the Pathway Development Knowledge and Understanding Framework, improving the understanding of personality disorder aetiology, presentation and treatment across agencies**
- **Development of a new eating disorders community service for service users with enduring illness reducing time spent in hospital and providing a community-based alternative for service users with long term needs**
- **Launch of the Yorkshire Centre for Psychological Medicine, promoting a specialist, national, liaison psychiatry**

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**inpatient service for service users with complex psychological and physical presentations**

**Some of the key priorities for the future:**
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, which will feed into the Transformation Project.

Specialist services are at risk in the current financial climate due to PCTs reducing out of area placements funding and non-urgent treatments approvals. The directorate needs to ensure it can evidence outcomes of treatment and health economy saving by the use of specialist service interventions. Marketing and promotion of services across stakeholder groups is essential. This work includes economic evaluation of the Personality Disorder Network and the Eating Disorders Annual Report.

More information about the Specialist Services Directorate's key achievements and developments can be found in the Annual Plan for 2011/12, which is on the Trust's website. **www.leedspft.nhs.uk .**

## 4.12.3 Older People's Services Directorate

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

- **Community Mental Health Teams**
- **Care Home Team**
- **Memory Service**
- **Younger People with Dementia Team**
- **Mental Intermediate Care Team**
- **Older People's Liaison Mental Health Service (based at St James Hospital)**
- **Mental Health Inpatient Service**
- **Dementia Inpatient Service**

**Key achievements during 2010/11 include:**

- **The introduction of a new management system including the development of the modern matron role with a specific remit to improve and enhance service user experience**
- **Transfer of services from Towngate House and Aire Court into The Mount in order to provide a more appropriate environment for service users, and to bring older people's services together**
- **Enhancing the level of staffing available on our mental health inpatient units to increase service user access to therapies and activities**

**Some of the key priorities for the future:**
The key priorities for the Older People's Directorate will be to support the Transformation Project and staff in working in different ways to ensure our workforce is used in the most effective and efficient way and that services are accessible and responsive to people of all ages.

**The directorate will also:**

- **Develop an equitable and consistent memory service, which will mean that people who may have dementia will receive speedy access to the service ensuring that an early diagnosis can be made. This will also mean that whatever your situation or wherever you live, the response to your needs will be the same**
- **Undertake a review of outpatient clinics, to free up senior medical time so that they can focus on supporting those people with the most complex needs and spend more time inputting into individual care as part of the team. This will form part of a wider review of the Community Mental Health Team, which aims to ensure that older people have access to a similar range of services as all adults and therefore do not experience discrimination**
- **Review and improve the**

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**dementia inpatient service, to better utilise the staffing resource, by increasing access to activities and therapies and improving the patient experience**

The overall risk to the developments within the Older People's Directorate relate mainly to the uncertainty within the wider healthcare system, due to the economic climate. This is of particular concern with regard to the needs of people who have dementia. Therefore, we will need to ensure that we have strong links into the city-wide transformation programme and that we are a key member and co-chair of the Leeds Dementia Board.

More information about the Older People's Directorate's key achievements and developments can be found in the Annual Plan for 2011/12, which is on the Trust's website **www.leedspft.nhs.uk .**

## 4.12.4 Learning Disability Services Directorate

The Learning Disability Services Directorate strives to provide the best possible specialist health and social care services to adults with learning disabilities and additional complex health needs and/or challenging behaviour.

The directorate provides a range of health and social care services including community services, inpatient, and day care. Services such as nursing, psychiatry, psychology and therapy services are delivered by staff trained in the speciality of learning disabilities. It currently provides healthcare via a three-tiered service model which is accessed through a single point of referral; and services are strategically driven by local and national policies and initiatives.

**The three tiers are as follows:**

- **Tier 1 – this is made up of three multi-disciplinary community learning disability teams**
- **Tier 2 – provides two specialist services which are the Severe Challenging Behaviour Team, and the Complex Multiple Impairment Team**
- **Tier 3 – provides inpatient services**

The directorate also provides supported living services to people with highly complex needs. It is commissioned by Adult Social Care and is funded through Supporting People Subsidy and the Adult Social Care block contract arrangements.

**Key achievements during 2010/11 include:**

- **The learning disability Your Health Matters campaign won the Mental Health & Well Being category at The Leeds Health Stars 2011 Awards**
- **To make publications more accessible to people with learning disabilities the 'easy on the i' design service, in conjunction with the Learning Disability Service User Reference Group has:**
  - **Designed the images accompanying the Trust values**
  - **Produced the easy-read version of the Trust strategy**
  - **Produced the easy-read version of the Trust Care Programme Approach Guide**
  - **Provided images for use by a number of organisations across Leeds**
- **The Your Health Matters campaign, and Your Heart Matters project have both been included as examples in the Yorkshire and the Humber Good Practice and Innovation Guide**
- **The Learning Disability Service User Involvement Team has expanded 'easy on the i' brand of accessible information. The team worked with service users on a range of projects, as well as linking up with other organisations and service user groups on joint initiatives**
- **There was a reduction in the length of stay, delayed discharges, waiting lists and response times in services, which means that we are able to see people in a more timely and efficient way resulting in better health care**
- **A reduction in psychology waiting lists in learning disabilities due**

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**to the recruitment of temporary staffing**

**Some of the key priorities for the future:**

The key priority for the Learning Disability Directorate is to support the Transformation Project utilising Lean and Six Sigma methodologies to re-design and develop services into a new learning disability pathway.

**The directorate will also:**

- **Continue the development of the 'easy on the i' symbols and promotion of the service we provide**
- **Use the Productive Community series in respect of the Community Learning Disability Team in sector C and the Complex Multiple Impairment Team**
- **Complete the roll out the Productive Ward throughout the whole of the inpatient service**
- **Move the Community Learning Disability Team Sector B to refurbished Aire Court site**

There are a number of risks and uncertainties for the Learning Disability Directorate. One of these is the future of the Specialised Supported Living Services which is due to the long term financial sustainability of the service. As a result we are in the process of preparing a revised contract proposal for 2012/13 onwards, which will ensure future cost pressures are fully funded.

More information about the Learning Disability Directorate's key achievements and developments can be found in the Annual Plan for 2011/12, which is on the Trust's website **www.leedspft.nhs.uk .**

### 4.1.2.5 Performance Framework

As part of the Trust's performance framework a cycle of service directorate performance reviews are in place, which provide a detailed focus on performance across each of our four service directorates. These reviews focus on performance against our external regulatory requirements including Monitor targets and Care Quality Commission registration and performance against our internal quality measures including progress against our annual plan objectives and progress against actions plans as a result of national service user survey results.

The reviews are led by a panel of executive and non-executive directors and are in place to further enhance assurance at Board level of our Trust performance and quality of our services. The reviews also provide the opportunity for common themes to be identified and for service directorates to showcase their achievements, allowing for the sharing and learning of good practice.

## 4.2 Other Significant Developments in 2010/11

### 4.2.1 Growing Our Trust

Our Board of Directors and Board of Governors have previously confirmed their support for organisational growth, and we have an agreed set of key principles and criteria for evaluating potential growth opportunities.

During 2010, NHS North Yorkshire and York launched a competitive tender for their mental health, learning disability and substance misuse services. This opportunity was entirely consistent with our principles and criteria for growth and the Trust engaged in the tender process. In January 2011 we were identified as the preferred provider for 'Lot 1' services, being those mental health, learning disability and substance misuse services in York, Selby and Tadcaster, together with a number of pan-regional services. We are now undertaking a full due diligence process to confirm the details of our bid, with a view to effecting the safe transfer of services in late 2011.

We are delighted to have this rare opportunity to significantly grow both our geographical service base and also the range of services that we provide. Our intention is to fully integrate Lot 1 services with existing Leeds services, creating a new integrated Trust.

### 4.2.2 Changes in Our Governance Framework

In 2010/11 we reviewed our governance structures using a Rapid Improvement Event and Lean methodology. We involved a significant number of our senior managers and directors; and with effect from 1 November 2010 the Board of Directors ratified our new governance framework, which clearly splits the functions of management and assurance.

The new framework took the existing assurance functions carried out by the previous Board of Directors' sub-committees and folded these into a new Audit and Assurance Committee, which is the primary assurance committee in the organisation. Further information about the Audit and Assurance Committee can be found in Section 6.

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The Executive Team has overall responsibility for the management functions in the Trust. Its role is to assist the Chief Executive in carrying out the duties of Accounting Officer; the achievement of the Means and End Goals in our strategy; the management and operation of all areas of services delivery; performance; risk management; and delivery of health outcomes. To support the Executive Team seven Standing Groups have been established, each one aligned to one of the Means Goals; putting our strategy at the heart of our day-to-day work.

**The tables below show our new governance framework.**

**Table 4A –** Leeds Partnerships NHS Trust Governance Framework (formal Board sub-committees for the Board of Governors and Board of Directors are shown in Table 4B)

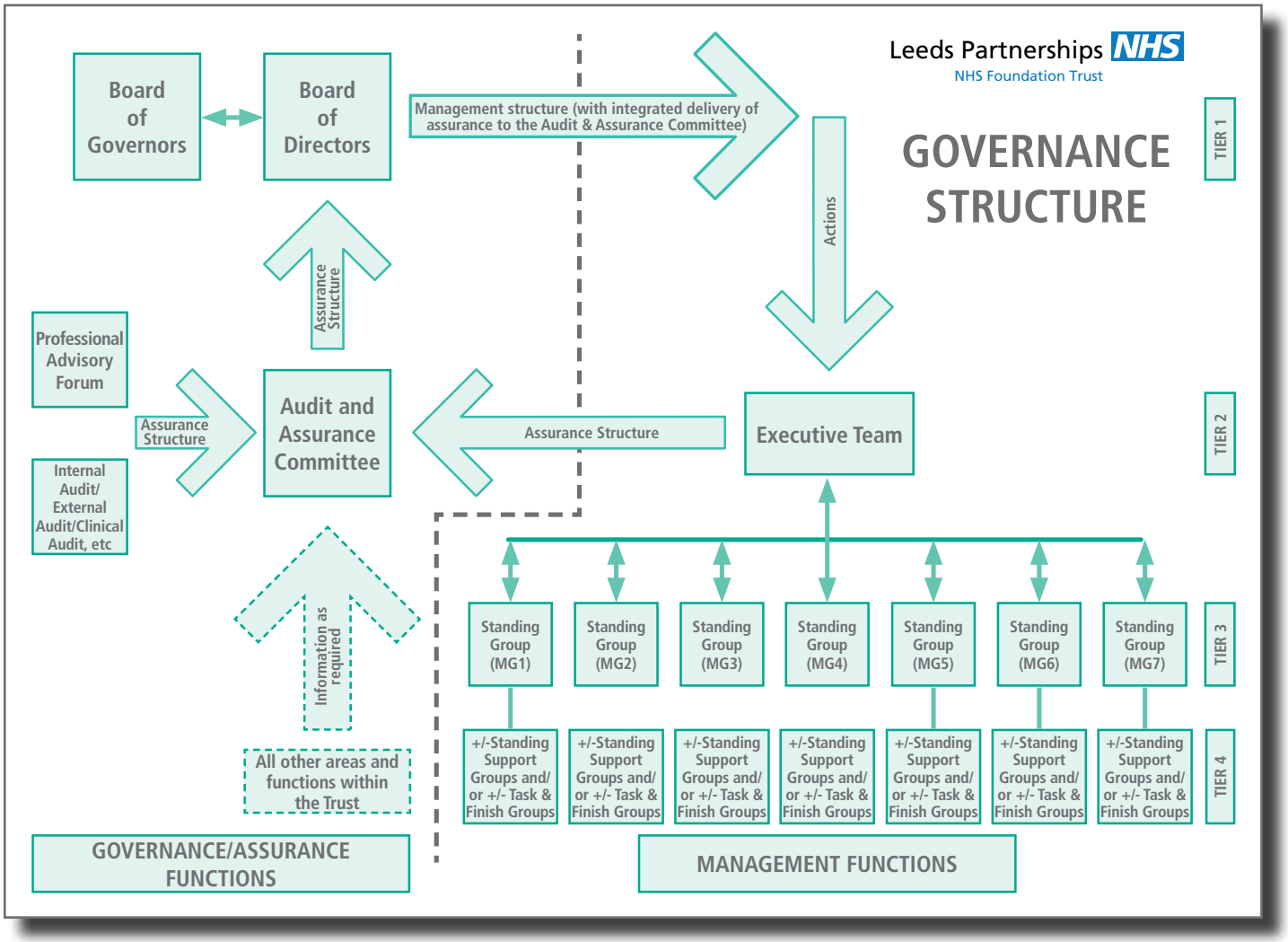

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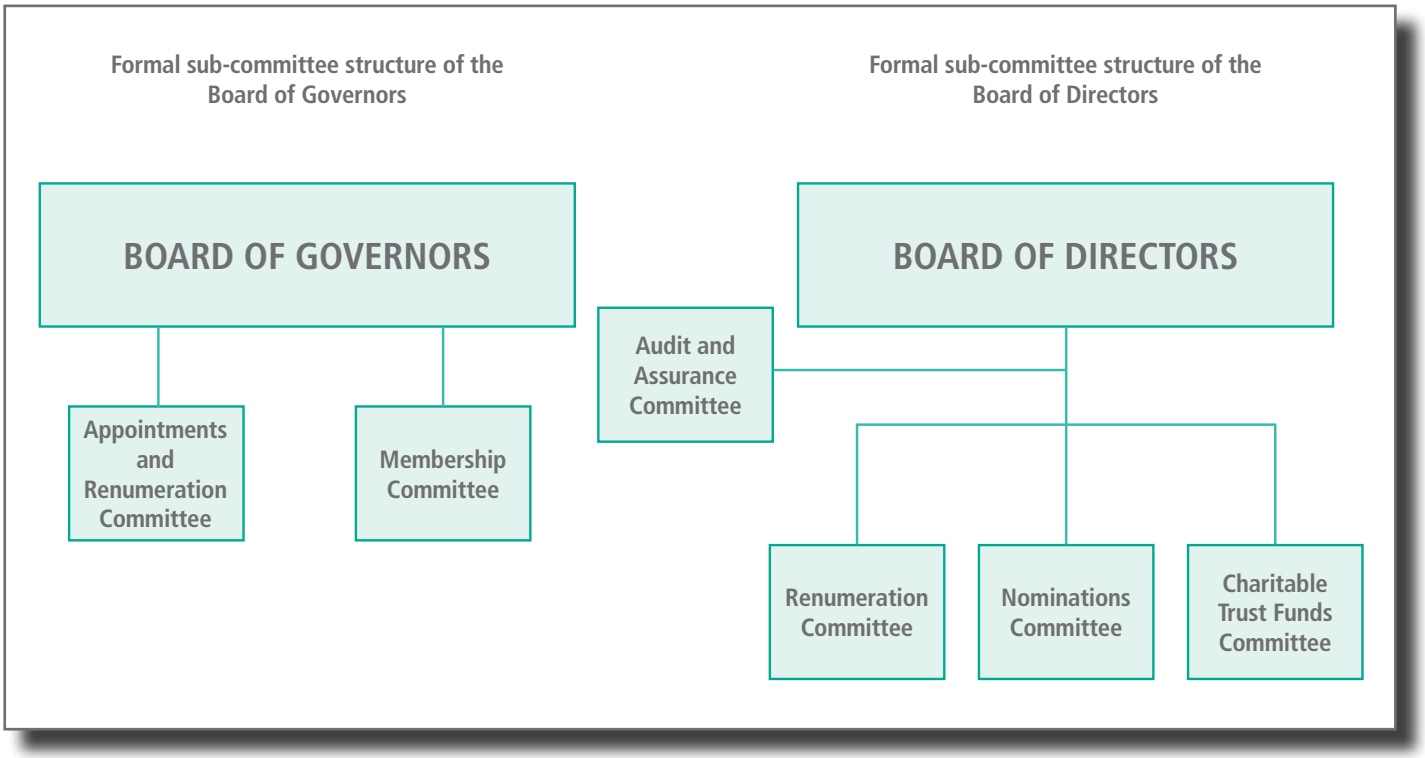
**Table 4B –** Formal Sub-committees of the Board of Governors and Board of Directors




**Further information about the work of these sub-committees can be found in Sections 5, 6 and 8**

## 4.3 How We Are Using Our Foundation Trust Status to Improve Patient Care

Our staff are fully committed to working in partnership with our service users, carers and partners to develop and improve our services. In addition to the people we have traditionally worked with, being a foundation trust brings the added benefit of being able to recruit a membership of people who are passionate about mental health and learning disability services. From that membership we are then able to form a Board of Governors; people elected and appointed, who have an important role in helping us to develop the way in which we deliver services.

During 2010/11 we have used the benefits of being a foundation trust in the following ways:

- **Members have been encouraged to participate in a wide range of activities including Building your Trust involvement events**
- **Through our governors members have been able to influence our strategy and the way we deliver our services**
- **Using the twilight 'Everything you need to know about….' sessions, members have been informed about the care and support for people who use our services. This means they are able to understand what we do**
- **At the Annual Members' Day in September 2010 our members were able to comment on, and influence our strategy and the way services are delivered**
- **Governors were fully involved in shaping our strategy and values**
- **Members and governors were**

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- **involved in nominations and the decision making processes for our Trust awards ceremony**
- **Governors were involved in shaping our plans for organisational growth**
- **The Board of Governors appointed three new non-executive directors and re-appointed two**

## 4.4 Service User and Carer Experience

### 4.4.1 Feedback from People Who Use Our Services (Our Service User Survey)

We gather feedback from people who use our services and their carers through a broad range of methods, including both local and national surveys.

At a local level we have established a standardised approach to receiving service user feedback, with an opportunity for each service to ask a number of specific questions. This survey is to be fully implemented in 2011/12 and the questionnaire will be distributed to service users on discharge or at the end of a specific intervention and will allow them to comment on the care they have received.

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 on a more regular basis. The questions that are asked in the national survey have also influenced our local questionnaire.

The 2010 compulsory community survey showed that overall, 64% of people who responded said that the care they had received in the last 12 months had been either excellent or very good.

The three key areas where results suggested that we performed slightly worse than last year were around care co-ordination, care plans and reviews, and talking therapies. Recommendations included:

- **Assessing the clinical pathway to the decisions on accessing talking therapies in the light of the difference between the proportion of service users having counselling/talking therapies and those who wanted talking therapies in the last 12 months**
- **Ensuring that all service users have access to a written or printed copy of their care plans**
- **Discussing with professionals ways of ensuring that service users understand the contents of their care plans**
- **Ensuring that all service users are told that they can bring a friend, relative or advocate to their care review meetings**

The 2010 voluntary inpatient survey showed that overall, 53% of respondents rated the care they received in hospital as excellent or very good, which compares favourably with other trusts. The percentage of respondents who said that they felt safe was slightly up on last year at 88% (85% for 2009/10). Similarly the percentage of respondents who reported that they were given enough time to discuss their treatment was up to 86% (it was 82% in 2009/10).

The results of all the surveys are reported to the Board of Directors and the Board of Governors. They are also included in our Quality Accounts. Each of our service directorates has an action plan in place in response to the survey findings and these are performance managed through regular directorate performance reviews.

Here are examples of some of the actions being taken in the directorates as a result of outcome of the service user survey.

- **Ensuring that all service users who meet the criteria for Care Programme Approach (CPA) receive a regular review of their care plan**
- **A CPA training programme has been designed for all care co-ordinators to improve the quality of the CPA meeting and plan to improve the overall experience of the service user and carer**
- **The Healthy Living Service has undertaken a number of projects working in partnership with other teams to increase options for service users to choose healthy options**

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**Both national surveys were carried out again in the spring of 2011 and the results will be available later in the year.**

## 4.4.2 Public and Patient Involvement

Throughout the year the clinical teams hold regular community meetings, to keep service users and carers up to date on local events and plans for wards and services. At these meetings staff often consult with service users about information on the wards, signage, plans to develop the services, etc. As a result of consultation we have: celebrated the opening of Lavender Court, a women only garden at The Becklin Centre; changed the windows at The Becklin Centre; and developed a wider range of activities for inpatient services. The changes that have taken place within the Older Peoples Directorate have all been consulted upon and people's opinions taken into consideration.

The Recovery and Social Inclusion team, along with the Personality Disorder Network, the Addictions Service and the various specialist services all have service user involvement groups which happen monthly. These groups often engage in creative activities to support other service users accessing the services. This includes the production of newsletters, creative writing, peer support, community visits as well as involvement in the recruitment and selection of staff. The team is also running a series of training courses for service users and carers around developing involvement skills.

We are currently developing a questionnaire to roll out across the organisation that will give us a real-time understanding of the service user experience, and a similar one for carers to complete. This will help us to form an accurate picture of the way in which our services are both perceived and understood by those who use them the most.

The development of the Involvement Leaders' Forum this year will bring together all those across the organisation who have any role in consultation, involvement and engagement. This will enable us to gather together all the involvement work and produce an annual overview of the activity that takes place.

Along with the Equality and Social Inclusion Forum and the Building Your Trust events, we are able to demonstrate a very comprehensive approach to service user and carer involvement.

## 4.4.3 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 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 our services. PALS is not an advocacy service nor a formal Complaints service, and experience has shown that with early intervention the need for issues to escalate 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 2010 to 31 March 2011 the PALS team handled 691 cases from across the organisation, compared with 556 cases in the corresponding period last year. 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 PALS team capture and record the issues raised and feed these back into the organisation to help influence development and improvement.

## 4.4.4 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. We are committed to ensuring that complaints are dealt with openly, promptly and fairly and that any future care will not be adversely affected as a result of having made a complaint.

We always fully investigate complaints in line with the NHS complaints regulations and aim 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 recurrence of similar events in the future.

During 2010/11 we received 56 formal complaints, the same number were also received during 2009/10. 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 person making the complaint).

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

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- **The introduction of a more robust system to manage requests for transfer of patients made to the Ministry of Justice**
- **A revised procedure to monitor the progress of referrals made to psychological therapies**
- **Improvements to closed circuit television systems on some Trust sites**

## 4.5 Partner Relations

### 4.5.1 Knowledge Transfer Partnership

We are engaged in a Knowledge Transfer Partnership with the School of Healthcare at the University of Leeds to develop and test a vocational support model that we can use in our organisation. Through action oriented research with our service users, clinicians and managers we are widening our understanding of how to support most effectively the diverse range of mental health service users we care for.

### 4.5.2 Improving Access and Outcomes for Service Users from BME Communities

We have a partnership project with community development workers from the voluntary sector organisation Touchstone, which in-reaches into four adult inpatient wards. The project aims to support the development of the workforce through cultural competence training and through action research to develop a deeper understanding of the needs and experiences of our service users from diverse communities.

### 4.5.3 Ambition Works

We are committed to supporting our service users to access employment, education and volunteering opportunities to help their recovery. We believe they have a right to live as full and equal citizens in their local communities, able to exercise independence, choice and control.

These are some of the ways in which we support our service users:

- **We are a Mindful Employer and aim to be an exemplar employer of people who experience mental health problems. We have reviewed and enhanced our recruitment and retention processes and we are working across the city in partnership with other employment agencies such as Job Centre Plus**
- **The Vocational Leads Pilot Project within our five adult Community Mental Health Teams aims to embed vocational support within clinical teams through partnership working. Employment specialists from Leeds Mind are co-located within our five Community Mental Health Teams and actively support people with mental health difficulties to access appropriate training, voluntary work and paid employment**
- **A partnership project is in the development stages with Leeds City College to increase access to accredited education opportunities for our mental health service users**
- **Our own voluntary services provides our service users with access to volunteering opportunities within the Trust**

### 4.5.4 Partnerships that Help Promote Understanding of Mental Health and Learning Disabilities

We have a number of partnerships that help to promote a better understanding of mental health and learning disabilities which helps in our campaign to stamp out stigma.

- **We have established a partnership with the Northern Film School to commission BA students to produce a series of films on the subject of mental health, learning disabilities and stigma**
- **The Diversity Team and Human Resources Department are working in partnership with NHS Leeds and Leeds City Council to support them in developing positive HR practice in relation to Mindful**

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Employer. The Diversity Team has delivered mental health awareness training, in partnership with Addleshaw Goddard, to public and commercial sector employers

- The Carers Team have forged a number of partnerships with organisations such as Touchstone Carers Group to deliver Carers Connections training on communicating with family members; with Willows to run three Carers Connections sessions on different themed topics on mental health; and with Adult Social Care to deliver Carers Connections sessions to day services and hostels
- Our Carers Team, in partnership with Carers Leeds and Arts and Minds, have received funding to develop an e-learning package for use by key workers for carers in both web-based and DVD formats. Key workers are those who may be required to identify and/or support carers as part of their work. Whilst this includes health and social care workers it also includes a wider range of public sector workers such as the police, library staff, leisure staff and others, alongside those in customer facing services such as high street banks and those working in voluntary and community organisations
- Within our Transformation Project there have been a series of workshops held with service users, carers, Trust staff and a range of partner organisations. The purpose of the workshops was to assess ourselves against the Centre for Mental Health organisational audit tool for recovery. Involving a wide range of partners enabled us to develop a robust assessment of our current position and develop a clear set of priorities for the future
- A partnership project between Arts and Minds, Yorkshire Dance and Trinity Arts has been funded through the Big Lottery, the Trust, Leeds City Council and Leeds Mind. It is a programme of voice and movement work run by professional facilitators at high quality venues such as Yorkshire Dance and Trinity Arts. The project aims to improve the physical and mental wellbeing of the adults recovering from mental health problems who are taking part. Participants have the opportunity to learn singing, dancing, and performance skills, and engage with the cultural life of Leeds through their involvement in the centres and the opportunities they offer
- The Older People's Directorate Acute Inpatient Mental Health Unit (AIMHU) is committed to providing a range of therapeutic options for patients requiring assessment and treatment. Complementary therapies and other wellbeing sessions are part of a project to increase the range of adjunct treatments available that may support people in their recovery. AIMHU is working in partnership with the Leeds Wellbeing Centre (run by the voluntary sector organisation, Multiple Choice) to pilot delivery of massage to patients
- A partnership with Leeds Mind to develop a community arts centre in North Leeds that focuses on mental health and inclusion. The Trust's Arts and Minds staff are co-located with Inkwell as a central point for arts and mental health in Leeds

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## 4.6 Corporate Social Responsibility

### 4.6.1 Engaging Employers

We have secured Yorkshire and the Humber Improvement Partnership funding to deliver mental health awareness training to 120 public and private sector staff in 2011. We have developed this into a range of products that we will be marketing to both the public and private sector in 2011/12. We will be doing this in partnership with a range of organisations, including Community Links.

### 4.6.2 Arts and Minds

We have undertaken a wide range of activity to promote the role of arts in health and social care as well as supporting people who use our services to participate in the cultural life of Leeds. Some highlights are set out below:

- **Our 'Film to Change' project engaged 32 participants in making their own films about mental health issues. The aim was to develop a series of short films that give an honest portrayal of mental distress in order to challenge stigma and discrimination. The films were premiered at the Leeds International Film Festival and the project was a runner up in the Lemos & Crane RISE awards**
- **Arts and Minds developed partnerships with a range of education providers to stimulate improved take-up of education. This included an art and design course run in community venues for older people, and three in-reach Leeds City College courses for forensic services and the Millside Recovery and Rehabilitation Unit**
- **Twelve music sessions were delivered to older people by the Leeds College of Music, and we have also developed a partnership with Yorkshire Dance to provide a dance group to people using our services**
- **Arts and Minds provided opportunities for individuals to display or perform their art. Our annual visual art exhibition at The Light was well received and we put on interactive activities during Leeds Light Night. Our Healing Voices choir gave two performances and launched their CD at Trinity Arts**

### 4.6.3 Time to Change

We have worked with many of our partners across the city to embed our 'Time to Change' campaign and to improve public attitudes towards mental health. Our Time to Change project worker post is the first of its kind in the country. The role is to co-ordinate people who take our anti-stigma messages to public events and festivals throughout the year. This year particular highlights were Leeds Pride and the West Indian Carnival as well as a rugby union match in February 2011. Our campaign was highly commended in the regional Health and Social Care Awards and the Leeds NHS Stars Awards.

We were delighted to gain Stephen Huison (Coronation Street) as a supporter and we enjoyed a trip to the Coronation Street set to interview Stephen about his views about stigma and discrimination.

'Dine to Change' was a dinner event for business leaders across the region to raise awareness of mental health and stigma. We were extremely grateful to Addleshaw Goddard for hosting the event at their city-centre offices and also to Hempsons Solicitors, Beachcrofts Solicitors, Equitix Ltd and Ringways Garage for their sponsorship of the event. At the event we were delighted to have Alastair Campbell with us to share his personal experiences of mental health and promote our messages about the effects of stigma and discrimination.

## 4.7 Valuing Our Staff

Our 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. At the end of March 2011 we employed 2,438 staff, had 392 bank staff; and 190 volunteers.

### 4.7.1 Volunteers

Around 7% of service users on the care programme approach (CPA) who are in contact with adult services (except forensics services) are in unpaid unemployment or

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voluntary work. This is often an important step in people's journey towards recovery and even paid employment.

Our own Voluntary Services Department is very active in recruiting people who have used our services, as well as people who are not former or current service users but are keen to support people who use our services.

It has been another busy and successful year for the Voluntary Services Department, by being at the centre of promoting volunteering and providing support to volunteers we have been able to make a positive impact on the quality of life within mental health and learning disability services.

This year we have introduced more people into volunteering with a significant number being people who have used the services.

For the first time we have managed to break into new areas placing volunteers in Trust Headquarters, Specialised Supported Living, the Time to Change project, Patient Advice and Liaison Service, as well as working in partnership with Staffside in organising a Design a Christmas Card competition with the Older People's Directorate.

We would like to give a big thank-you to all the volunteers, for the important work they contribute to improving the health and lives of the people who use our services.

## 4.7.2 'Staffside' – Working with the Trade Unions that Represent Our Staff

Staffside is the elected body of the representative trade unions in the Leeds Partnerships Foundation Trust. Staffside meets monthly to debate and question on behalf of the wider UNISON membership any issues raised by the individual trade unions or by the Trust. This committee enables the trade unions to negotiate with one voice. The JNCC (Joint Negotiation and Consultation Committee) is the meeting where all Staffside issues raised at the Staffside meeting are brought to the attention of the Trust.

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

During last year we have contributed to the strategic agenda of the Trust by being involved in the Transformation Project and the bid for North Yorkshire and York mental health services, Trust Strategy development and workforce issues through involvement in the Workforce & Development Standing Group. Additionally we have successfully worked in partnership with human resources and managers on supporting staff going through significant change, contributing to the job evaluation process to ensure fairness and equity in pay banding, supporting redeployment of staff to minimise redundancies, and negotiated a extension of time to the proposed market testing of soft facilities management services to enable staff to identify alternative cost savings and efficiencies.

We have also improved the information and advice to staff through the development of an internal intranet Staffside page. Staffside can be contacted by emailing Staffside@lpft.nhs.net .

## 4.7.3 Staff Engagement

Key to the successful implementation of our new strategic objectives is staff engagement and feedback. To support this important function we have a number of ways in which we engage with staff:

- **We use our intranet system known as Staffnet. We regularly test out staff views and opinions using a barometer-style survey. The results and findings and any subsequent actions are fed back to staff through internal communications**
- **We undertook extensive consultation when developing and implementing our strategy and staff signed up as value champions to support our values**
- **'What our Directors say' and 'What our Governors say' are regular briefings and updates for staff on what is happening at a strategic level across the Trust. The Chief Executive's blog has been well received, with over 500 staff regularly reading this**
- **As part of our leadership development we have introduced a Leaders' Lounge where front-line managers are able to discuss issues with senior leaders in the Trust**
- **Our Staff Governors meet with the Chairman and Chief Executive on a regular basis**

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*Janette Howlett, Carer Governor*

**and feedback issues that have been raised by staff**

- **We also continue to fund trade union representatives' time and work closely with Staffside**
- **We hold an annual Trust Awards Ceremony where we celebrate excellence and innovation**

We are currently developing a new survey tool which will engage with staff more frequently than the current annual staff survey. This will ensure we have real-time information and dialogue with staff on key issues.

## 4.7.4 Our Staff Survey

### 4.7.4.1 Results from the NHS Staff Survey 2010

This is the seventh annual Staff Survey in which we have participated. For the 2010 survey the response rate was 49%. Table 4C below show our performance in respect of response rate, and Table 4D shows the top four ranking scores as presented in the findings by the Care Quality Commission

**Table 4C**

| 2009/10 | | 20010/11 | | Trust improvement/ deterioration |
|---|---|---|---|---|
| Trust % | National Average % | Trust % | National Average % | Increase/ decrease in % points |
| 48 | 55 | 49 | 54 | +1% |

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Table 4D

| | 2009/10 | | 2010/11 | | Trust improvement/ deterioration |
|---|---|---|---|---|---|
| | Trust % | National Average % | Trust % | National average % | Increase/ decrease in % points |
| **Top Four Ranking Scores** | | | | | |
| % of staff experiencing physical violence from staff in last 12 months (the lower score the better) We are in the best 20% of trusts | 1% | 2% | 0% | 1% | -1% |
| % of staff experiencing harassment, bullying or abuse from staff in last 12 months (the lower score the better) We are in the best 20% of trusts | 14% | 16% | 8% | 14% | -6% |
| % of staff reporting errors, near misses or incidents witnessed in the last month (the higher the score the better) We are in the best 20% of Trusts | 97% | 97% | 99% | 97% | +2% |
| % of staff receiving job-related training, learning or development in last 12 months We are in the best 20% of trusts | 86% | 81% | 84% | 80% | -2% |
| **Bottom Four Ranking Scores** | | | | | |
| % of staff experiencing physical violence from patients, relatives or the public in last 12 months (the lower the score the better) | 19% | 18% | 18% | 14% | -1% |
| % of staff suffering work-related injury in last 12 months (the lower the score the better) | 11% | 8% | 9% | 8% | -2% |
| % of staff using flexible working options (the higher the score the better) | 66% | 72% | 64% | 67% | -2% |
| % of staff witnessing potentially harmful errors, near misses or incidents in last month (the lower the score the better) | 33% | 29% | 32% | 28% | -1% |

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## 4.7.4.2 Action Plan to Address Areas of Concern

An analysis of our staff survey results together with the Care Quality Commission (CQC) observations about our overall staff survey performance provides us with a basis for determining the main areas to focus on for our 2011/12 Staff Survey Action Plan.

The Trust's response to the 2010 Staff Survey is to focus on five key actions identified as areas for improvement during 2011/12. These are:

- **Improve the health and wellbeing of staff by implementing an action plan and objectives by 31 March 2012**
- **Reduce the incidence of violence and abuse to staff from service users, or their relatives and friends by implementing a review and improving processes by 31 December 2011**
- **Maintain and develop improved staff communication techniques and processes**
- **Ensure that each directorate reports at least 80% compliance with mandatory training at each quarter for all its staff**
- **Implement a new appraisal scheme across the Trust by March 2012**

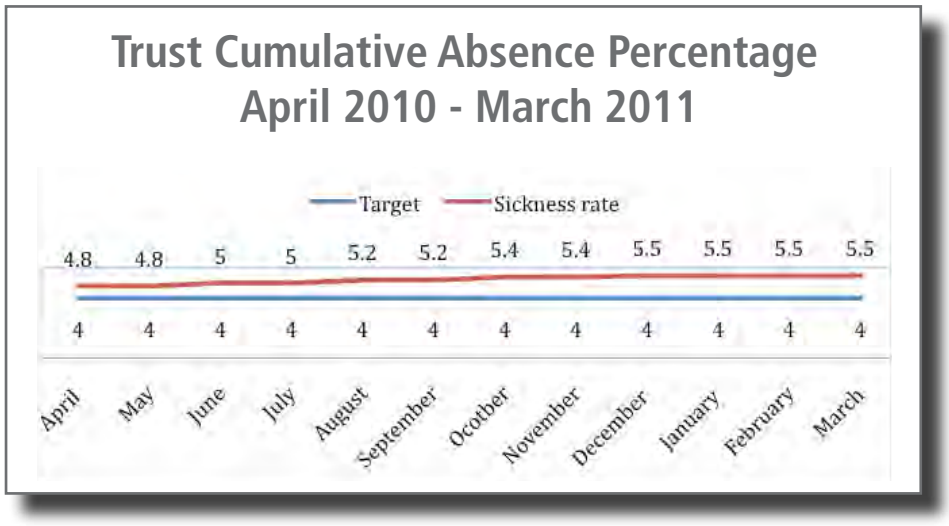
## 4.7.4.3 Future Priorities and Targets

In the light of the findings from the staff survey there have been a number of future priorities and targets identified. These include:

- **Continuing to monitor action plans to ensure these are completed and that the outcome of the survey is communicated to all staff**
- **Implement quarterly staff surveys to monitor and track improvements**

## 4.7.5 Sickness Absence

**Table 4E**




At the end of March 2011 the sickness absence rate was 5.5%, although our target was 4%. The target attendance rate for 2011/12 remains at 96%, and we will continue to try to achieve this over the next 12 months. Compared with other trusts across the country our sickness absence rates are similar, but we are striving to improve attendance and to reduce costs wherever possible.

The 2010/11 measures for reducing sickness absence will continue with full implementation of the Managing Sickness Absence Procedure along with implementing our Health and Wellbeing Framework and action plans based on the Boorman recommendations.

We have signed up to a Leeds-wide initiative to meet the NHS Sports and Physical Activity Challenge. The vision of this initiative is to give all NHS employees in Leeds opportunities to participate in sports or other physical activities. To support this initiative during 2011 we are participating in the Global Corporate Challenge with more than 40 teams across the Trust aiming to improve physical and mental wellbeing.

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## 4.7.6 Occupational Health Service

We continue to share our Occupational Health Service with South West Yorkshire Partnership Foundation Trust. It remains a nurse-led service created to meet the specific needs of staff in a mental health and learning disability trust.

The service delivers specialist mental health interventions including:

- **Anxiety management**
- **Relapse intervention plans**
- **Mental health assessments**
- **Signposting to specialist services**
- **Stress risk assessments based on the Health and Safety Executive stress management standards**

During 2010/11 the main achievements include:

- **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**
- **New pre-employment health questionnaire introduced as part of implementation of the Equality Act**
- **Development of a Health and Wellbeing Framework**

During 2011/12 our plans are to focus on areas of high absence in the Trust to reduce long-term absence by working collaboratively with managers on a number of strategies to support staff on long-term absence to return to work earlier by looking at short-term alternative work opportunities and the full utilisation of fit to work notes.

## 4.7.7 Developing People

We continue to play a leading role in the delivery of a range of experience and behavioural based leadership and management development programmes. This we have done in partnership with NHS Leeds and the Strategic Health Authority. These programmes make an important contribution to the leadership skills and capacity within our organisation, and provide a platform for talent management and succession planning of suitable candidates for managerial vacancies. Over 20 delegates who have previously attended these programmes have successfully gone on to be promoted within our organisation.

The Fit for the Future development programme has been running since mid 2010. The programme is addressing the specific needs of 130 front line leaders and managers, whilst also enabling the longer term aspirations of cultural and behavioural change to meet our challenges ahead. The programme aligns to an ILM level 5 qualification in leadership and management, giving each learner formal recognition for their development journey and ensures a qualified and skilled workforce in line with Department of Health requirements.

Included in the programme has been the introduction of a 'Leaders' Lounge' which aims to connect senior organisational leaders with our middle managers and allow them to talk about some of the key operational issues they are facing daily. We have delivered ten Leaders' Lounge sessions each month since the programme started with around 18 delegates and three senior leaders attending each one, thereby connecting 'ward to board'.

We have also developed a training programme for service improvement capability amongst our clinical staff. This has built skills around Lean and Six Sigma methodologies. An e-learning tool has been developed to support the cascade of learning as well as a three-day workshop which has been delivered to all delegates on the 'Fit for the Future' training programme, a total of 130 staff.

Over the past five years our portfolio of programmes has started the process of creating a critical mass of leaders who have been developed in a consistent manner. The transfer and application of this learning is at the heart of our ability to meet the new NHS landscape.

## 4.8 Mental Health Act Managers

Mental Health Act (MHA) managers are members of the public, who have been appointed by the Board of Directors, together

# Operating and Financial Review

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**
- **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**
- **Conduct ward visits to ensure service users understand their rights under Section 132 of the Mental Health Act**

This year the MHA managers have continued to develop their understanding of the requirements of the revised Mental Health Act, which has included the review of the administrative processes for hearings and renewals of detention; and to take account of the developments in practice for Community Treatment Orders. The managers have attended an externally facilitated training event on the role of the hospital manager; and developments in mental health law.

As well as holding appeals, MHA 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 or concerns about issues such as social and environmental care and wellbeing.

We are very appreciative of the time and commitment the MHA managers and the non-executive directors have given this year, particularly during a time of embedding change within mental health law and practice. Once again we wish to thank our MHA managers for the dedication and skill they apply when undertaking this vital role.

2010/11 has seen a number of changes in our MHA managers and we would like to record our particular thanks to Peter Gallant for his long commitment and dedication as the secretary to the MHA managers, to Peter Coltman and Savi Tyndale-Biscoe for their time and commitment spent as MHA managers and to Merlin Wilce for his commitment and support during his appointment as a non-executive director and MHA manager.

**Table 4F**

| Mental Health Act Managers for the period 1 April 2010 to 31 March 2011 | |
|---|---|
| Robert Seymour (Chair) | |
| Peter Gallant (Secretary to the MHA Managers) | |
| Enid Atkinson | Peter Coltman |
| Kathleen Fenwick | John Fothergill |
| Roger Helm | Nancy Hill |
| Ian Hughes | Brian Kemp |
| Kate Kershaw | Anesh Pema |
| Linda Phipps * | 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 | |
| Merlin Wilce | |
| *Linda Phipps is also a non-executive director of the Trust | |

## 4.9 The NHS Constitution

The NHS Constitution was published in January 2009. It establishes the principles and values of the NHS, and it also sets out the rights to which service users, public and staff are entitled; a range of pledges to achieve; and the responsibilities which the public, service users and staff owe to one another to ensure that the NHS operates fairly and effectively.

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From the 1 April 2010 all NHS bodies are legally required to have regard for the principles and values of the NHS Constitution in their decisions and actions. One way in which we ensure that the main areas of the constitution are embedded in our Trust is to reflect these in our strategy. This is how we have done this:

**Table 4G**

| | |
|---|---|
| **Means Goal 1**<br>**We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion** | • Access to health services<br>• Quality of care and environment<br>• Nationally approved treatments, drugs and programmes |
| **Means Goal 2**<br>**We involve people in planning their care and in improving services** | • Respect, consent and confidentiality<br>• Informed choice<br>• Involvement in your healthcare and in the NHS<br>• Complaint and redress |
| **Means Goal 4**<br>**We value and develop our workforce and those supporting us** | • Staff rights, pledges and duties |

Our strategy also sets out our values. These fully reflect the NHS values as set out in the NHS Constitution; however, these have been adapted to better reflect our services and those who use them. Our values are:

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

To ensure that we embed our values we have developed our plans in a number of ways. One of the main ways is that we have consulted with staff, service users and carers on the behaviours we would expect to see if we were truly living our values. We have then developed a range of posters, postcards and leaflets to ensure that our values and expected ways of behaving are clear and transparent.

This work will continue into 2011/12, therefore:

- **We will look at how to ensure that we communicate with each other in a values-based way, including reviewing our standardised letters to ensure that they are respectful and reflective of our values**
- **We will regularly review service user experience feedback to understand whether our service users experience values-based behaviour from our staff**
- **We have plans in place to embed our values in a number of our policies and procedures, including recruitment, personal development plans and appraisals**

Beyond the information directly captured in our strategy, there are many further examples of how we meet the requirements of the NHS Constitution across the Trust. A mapping exercise has been completed and will be refreshed annually.

## 4.10 Sustainability

### 4.10.1 Commentary

We monitor targets in respect of sustainability to minimise our impact on the environment, and our carbon footprint. We establish performance baselines and, where necessary, measure against previously set targets to track our impact on the environment over time.

# Operating and Financial Review

We have in place a Carbon Management Plan. This is designed to minimise the impact of climate change, by reducing the greenhouse gases we produce from our consumption of gas and electricity and various other business activities. The Carbon Management Plan also includes commitments towards improvements in waste handling and disposal, and travel planning (ie how our employees travel to, from and between our sites).

The Carbon Management Plan will help us fulfil our commitment towards carrying out all aspects of our activities with due consideration to the environment, whilst providing high quality care. The implementation of carbon reduction projects is led by the Facilities Department with the Waste and Environmental Manager providing leadership on the Carbon Management Plan.

Progress of the various initiatives is monitored by the Estates Standing Support Group which in turn reports to the Means Goal 6 Standing Group ("We provide efficient and sustainable services"). The Board of Directors will review this plan annually through Board reports, and chart progress against our key targets and objectives.

**Table 4H**

| Area | Type | Non-Financial Information | Financial Information |
|---|---|---|---|
| **Greenhouse Gas Emissions** | Direct Greenhouse Gas Emissions | In 2009/10* the Trust consumed **12,785,189 kWh of gas,** which equates to **2,429 tonnes of CO2e**.** | In 2009/10* the Trust spent **£545,287** purchasing gas. |
| | Indirect Energy Emissions | In 2009/10* the Trust consumed **5,195,137 kWh of electricity,** which equates to **2,233 tonnes of CO2e**.** | In 2009/10* the Trust spent **£570,662** purchasing electricity. |
| | Official Business Travel Emissions | **Grey Fleet***:**<br>In 2010/11 mileage travelled by the grey fleet amounted to **1,193,148 miles.**<br>**Lease Cars:**<br>In 2010/11 there were **170 lease** cars which travelled **675,650** business miles<br>The figure for CO2e** is not yet available. Further analysis of engine size and average emissions will be required. | **Grey Fleet:**<br>In 2010/11 the Trust spent **£546,992** on mileage for the Grey Fleet.<br>**Lease Cars:**<br>In 2010/11 the Trust spent **£91,332** on mileage for lease cars. |
| **Waste Minimisation and Management** | **Domestic Waste:**<br>For 2010/11 the figures for domestic waste are as follows:<br>• Total waste arising: **169,724 kg**<br>• Waste to landfill: **145,844 kg**<br>• Waste recycled: **23,880 kg**<br>• Waste incinerated: **0 kg** | | **Domestic waste:**<br>In 2010/11 the cost of disposing of domestic waste was **£41,870.** |
| | **Healthcare Waste:**<br>For 2010/11 the figures for healthcare waste are as follows:<br>• Total waste arising: **58,010 kg**<br>• Waste incinerated: **58.010 kg** | | **Healthcare waste:**<br>In 2010/11 the cost of disposing of healthcare waste was **£38,732.** |
| **Finite Resources** | In 2010/11 The Trust consumed **31,657m3** of water and sent away **28,642m3** in the form of sewage. | | In 2010/11 the total water and sewerage cost was **£152,175.** |

* The last full year for which figures are available. The final figures for 2010/11 are as yet unknown as they are subject to quarterly invoicing from our suppliers and verification and submission by our PFI partners.

** CO2e = Carbon Dioxide Equivalent and is a way of reporting all greenhouse gas emissions or reductions as one standard unit, and is used as a measure of our carbon footprint.

*** Grey Fleet = employee-owned vehicles used for Trust business purposes (home visits, meetings, conferences, etc).

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## 4.10.2 Future Priorities and Targets

Our Carbon Management Plan provides the framework for our environmental agenda in the next year and already has within it our goal of 25% reduction in carbon emissions by 2015 based on 2007 data. It is also very important that we establish a series of clear goals for the coming 12 months and beyond in relation to changes already taking place in waste handling and disposal, and staff travel to sites. This will be done in order that we can measure our performance in an objective way and benchmark results with previous years' and with other organisations (both NHS and external). These goals and ongoing results will form the basis of the periodic sustainability reports to the Board.

Looking forward to 2011/12 we anticipate seeing good environmental and financial returns from a number of initiatives which are being implemented now or in the very near future. These include:

- **Internal and external LED lighting installation**
- **Insulation and lagging of pipes and roof spaces**
- **Completion of the installation of thermostatic radiator valves into Trust managed properties**
- **100% implementation of Trust-wide recycling**
- **Establishment of the new Yorkshire and Humber healthcare waste contract and the opportunities this creates for segregation in clinical areas**
- **Implementation of a Trust-wide travel plan to include initiatives encouraging staff to travel using alternative means such as public transport, cycling and car-sharing**

## 4.11 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 it. We take incidents very seriously and these are investigated fully so we can learn lessons and take action to prevent similar incidents occurring.

## 4.11.1 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 2010/11 contains no incidents which have either a volume or severity that would classify them as a serious untoward incident.

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

**Table 4I– Summary of Other Personal Data Related Incidents in 2010/11**

| 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 | 5 |
| V | Other | 0 |

## 4.12 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

# Operating and Financial Review

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 non-executive director for security management (Linda Phipps). We also have 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 the police.

Managers are responsible for providing a safe working environment and for 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 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.

## 4.13 Counter Fraud

In February 2011, our local counter fraud specialists and the Trust received an assessment from Counter Fraud and Security Management's Quality Assurance Programme of level 3 signifying that the organisation is performing well, with no items for improvement noted in the assessment report.

Our local counter fraud specialists have continued to carry out work across all generic areas of counter fraud work. Presentations at staff induction sessions and to selected groups of staff have been carried out. Local counter fraud specialists have continued to be proactive in their work and our staff have continued to be alerted to potential and real fraud risks.

We have developed a strong deterrence and preventative culture and this has been a factor in there being no significant fraud occurrences in 2010/11.

## 4.14 Financial Performance

The Trust continued to achieve strong financial performance in the year ended 31 March 2011. 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 we have been able to generate cash through normal activities, thereby allowing us to invest in services and meet financial obligations as a going concern.

Despite receiving no increase for inflation in 2010/11 from our commissioners, EBITDA was again strong at £10.9m (£9.7m in 2009/10) against a plan of £8.9 m giving a margin of 8.6% (7.9% in 2009/10) against a plan of 7.0%.

The cash balance at 31 March 2011 was £21.8 m (£17.4m in 2009/10). Once again the Trust was able to maintain this without recourse to a working capital loan facility.

### 4.14.1 Financial Risk Rating

Our overall financial health is assessed by Monitor, the independent regulator for foundation trusts, which 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. On the basis of the financial results for 2010/11, a financial risk rating of 4 was achieved, which is in line with the 2010/11 plan.

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Table 4J

| | Metrics | | Rating | |
|---|---|---|---|---|
| | Plan | Actual | Plan | Actual |
| **Achievement of plan:** EBITDA | 100% | 122.8% | 5 | 5 |
| **Underlying performance:** EBITDA margin | 7.0% | 8.6% | 3 | 3 |
| **Financial efficiency:** Return on assets | 9.4% | 14.5% | 5 | 5 |
| **Financial efficiency:** Surplus margin | 1.6% | 2.9% | 4 | 4 |
| **Liquidity** | 17 days | 24 days | 3 | 3 |
| **Overall rating** | | | 4 | 4 |

## 4.14.2 Revenue Position

Table 4K

| | Plan £ million | Actual £ million | Variance from Plan £ million |
|---|---|---|---|
| **Income** | | | |
| Clinical income | 111.8 | 112.1 | 0.3 |
| Non-clinical income | 15.7 | 14.6 | -1.1 |
| Total income | 127.5 | 126.7 | -0.8 |
| **Expenses** | | | |
| Pay costs | -94.4 | -92.9 | 1.5 |
| Drug costs | -2.1 | -2.1 | 0.0 |
| Other non-pay costs | -22.1 | -20.8 | 1.3 |
| Total expenses | -118.6 | -115.8 | 2.8 |
| **EBITDA** | **8.9** | **10.9** | **2.0** |
| Profit/loss on asset disposal | 0.2 | 0.2 | 0.0 |
| Interest received | 0.2 | 0.2 | 0.0 |
| Interest expenses | -4.0 | -4.0 | 0.0 |
| Depreciation | -3.6 | -3.4 | 0.2 |
| Dividend payable | -0.4 | -0.3 | 0.1 |
| Other non-operating income | 0.9 | 0.3 | -0.6 |
| Land and buildings impairments | 0.0 | -0.2 | -0.2 |
| **Net surplus** | **2.2** | **3.6** | **1.4** |

A surplus of £3.6m was achieved compared with a plan of £2.2m. This gave a margin of 2.9% against the planned figure of 1.6%.

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A reconciliation of the original planned surplus and the actual is set out in Table 4L below.

**Table 4L**

| | | | | |
|---|---|---|---|---|
| Annual Plan surplus | | | | -£2.2m |
| Adjustments: | Revaluation impairments<br>Rates rebate deferral to 11/12<br>Non-operating income shortfall | £0.2m<br>£0.2m<br>£0.6m | | |
| | **subtotal** | | £1.0m | |
| | Additional operating income<br>Injury benefit write-back<br>Redundancy/acquisition reserve slippage | -£0.4m<br>-£0.4m<br>-£0.8m | | |
| | **subtotal** | | -£1.6m | |
| Adjusted surplus | | | | -£2.8m |
| | Operating under-spend (mainly pay) | | | -£0.8m |
| Final surplus | | | | **-£3.6m** |

**Table 4M**

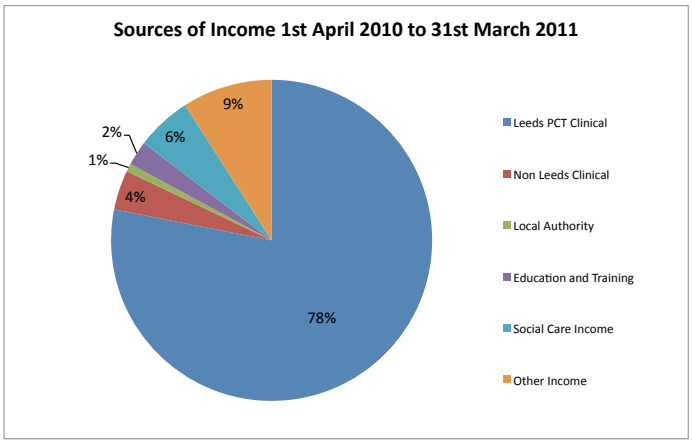
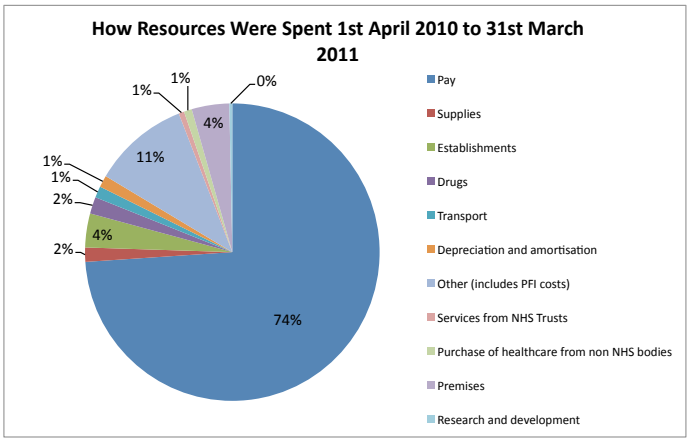



**Table 4N**




These graphs show where we received our money from and how we have used it during 2010/11.

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The Trust contracted with NHS Leeds (formerly known as Leeds PCT) for 78% of its income (78% in 2009/10). The Trust also received income from other PCTs for the provision of clinical services, largely for cost and volume, non-contracted activity and representing around 4% of Trust income. We received income from the Yorkshire and the Humber Strategic Health Authority education/ training services (SHA Learning and Development Agreement) which was around 5% of Trust income. We also received money from the Local Authority.

Income - clinical income associated with the provision of services was £0.3m more than plan, £0.6m over-recovery was due to one-off over-trading on Specialist Services and Learning Disabilities activity. This was offset by £0.2m shortfall on supported living income and £0.1m shortfall on adult in-patient activity.

Pay - All service directorate pay budgets were under-spent. Mostly this was related to medical vacancies and the adult psychology service development, related to reducing waiting times.

Miscellaneous other operating expenses - This includes the variances related to injury benefit provision (the provision of £0.4m was not required in 2010/11) and redundancy and acquisition reserve (reserve of £1.0m, £0.2m was spent in 2010/11).

Non-operating income - The £0.6m deficit against plan was due to the majority of the Accent funding being transferred (deferred) to 2011/12 (see the Capital Expenditure section below).

Cash Releasing Efficiency Savings - Cash releasing efficiency savings were £0.5m above plan. This includes £0.25m estates maintenance expenditure saving and £0.15m efficiency on the management of adult out of area treatments.

## 4.14.3 Investments in Quality 2010/11

During the year, an investment of £0.3m was set aside to ensure that waiting lists for psychological therapies were reduced. This investment was very successful in greatly reducing the waiting time for this service, and we are now in a position to sustain this improvement.

An increase in the capital programme was funded to develop the sites at Aire Court and Towngate House as part of the review of services for older people. These schemes are due for completion in the spring of 2011. Work on a £2 m scheme to replace the windows in the Becklin Centre, The Mount and The Newsam Centre finally got underway for completion in the spring of 2011. Replacing these windows will greatly enhance the airflow in these buildings resulting in a more comfortable temperature during hot weather.

## 4.14.4 Capital Expenditure

Capital expenditure at the end of the financial year was £4.6m against the plan of £6.2m. The difference is due to 2010/11 slippage on Aire Court, Towngate House and the PFI window replacement programme referred to above.

In November 2010 the Board of Directors was asked to approve a £1.9m increase to the capital expenditure programme which related to the PFI cooling work (window replacement programme). This was linked to the £2.0m cash received from Accent following the PFI asset transfer to Equitix in 2008/09. At March 2011, however, the actual expenditure against this scheme was only £0.3 m resulting in a deferral of £1.6m funding to 2011/12.

Two major schemes approved by the Trust Board of Directors relate to Aire Court and Towngate House. The Aire Court scheme slipped by £0.4m and Towngate House by £0.5m.

*Building Your Trust Event, 2010*

# Operating and Financial Review

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

Table 40

| | Plan £ m | Actual £ m | Variance £ m |
|---|---|---|---|
| **ASSETS** | | | |
| **Assets, Non-Current, Total** | **57.5** | **56.5** | **-1.0** |
| | | | |
| **Assets, Current** | | | |
| Inventories | 0.1 | 0.1 | 0.0 |
| Trade and other receivables | 2.8 | 2.8 | 0.0 |
| Prepayments | 1.0 | 0.9 | -0.1 |
| Cash | 15.9 | 21.8 | 5.9 |
| Non-current assets held for sale | 0.0 | 0.0 | 0.0 |
| | | | |
| **Assets, Current, Total** | **19.8** | **25.6** | **5.8** |
| | | | |
| **Total Assets** | **77.3** | **82.1** | **4.8** |
| | | | |
| **LIABILITIES** | | | |
| **Liabilities, Current** | | | |
| Deferred income | -1.2 | -5.3 | -4.1 |
| Provisions | -0.3 | -0.4 | -0.1 |
| Trade and other payables | -7.7 | -7.2 | 0.5 |
| Accruals | -3.9 | -3.9 | 0.0 |
| Finance leases | -0.1 | -0.1 | 0.0 |
| PFI leases | -1.0 | -1.0 | 0.0 |
| **Liabilities, Current, Total** | **-14.2** | **-17.9** | **-3.7** |
| | | | |
| **NET CURRENT ASSETS (LIABILITIES)** | **5.6** | **7.7** | **2.1** |
| | | | |
| **Liabilities, Non-Current** | | | |
| Deferred income | -0.6 | 0.0 | 0.6 |
| Provisions | -1.8 | -1.5 | 0.3 |
| Other financial liabilities | -33.5 | -33.5 | 0.0 |
| **Liabilities, Non-Current, Total** | **-35.9** | **-35.0** | **0.9** |
| | | | |
| **TOTAL ASSETS EMPLOYED** | **27.2** | **29.2** | **2.0** |
| **Taxpayers' and Others Equity** | | | |
| Public dividend capital | 19.5 | 19.5 | 0.0 |
| Retained earnings (accumulated losses) | 1.8 | 3.7 | 1.9 |
| Revaluation reserve | 6.5 | 6.6 | 0.1 |
| Miscellaneous other reserves | -0.6 | -0.6 | 0.0 |
| | | | |
| **TAXPAYERS' EQUITY, TOTAL** | **27.2** | **29.2** | **2.0** |


*Hugh Griffiths, National Director for Mental Health*

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## 4.14.6 Cash and Working Capital

**Table 4P**

| | Plan £ million | Actual £ million | Variance from Plan £ million |
|---|---|---|---|
| Cash & investments | 15.9 | 21.8 | 5.9 |
| **Days (working capital liquidity)** | **17** | **24** | **7** |

We had £21.8m cash at the end of March 2011, which was £5.9m above the plan. The main reasons for the higher than planned figure were as follows:

**Table 4Q**

| | |
|---|---|
| Operating surplus | £1.4m |
| Improvement in working capital | £4.5m |
| Slippage on capital programme | £0.9m |
| Decrease in non current payables (creditors) | -£0.9m |

As a foundation trust, greater emphasis is placed on the management of working capital, i.e. 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. The above table shows that we has sufficient cash to meet our commitments.

The surplus cash was deposited with the Government Banking Service as at 31 March 2011. It should be noted that it is our policy to deposit any surplus money we have temporarily in low risk deposit accounts with either U.K. commercial clearing banks or the H M National Loans Fund.

## 4.14.7 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 current position is that staff on Agenda for Change grades will receive no inflationary pay awards for the next two years apart from those staff earning less than £21k, who will receive £250 pay increase. Executive directors had no inflationary uplift in 2010/11 and this will continue for a further two years. After 2012/13, our financial plans assume pay awards may be at a similar level to the rate of increase in the consumer price index. These assumptions have already been factored into future financial plans.

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 circa 2% per annum have been factored into plans post 2011/12. The contractual position for 2011/12 has been agreed with commissioners based on a tariff deflator of -1.5%; a -2% position had been previously assumed.

Finally, most income is received on a 'block' contract basis rather than 'pay as you go' and it is unlikely, for the significant part of our income that this will change before 2013/14, when a system of paying for actual activity delivered is likely to be introduced to mental health services nationally. In 2012/13, this system will operate in 'shadow' form although income will still largely be received on a 'block' contract basis.

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

**Liquidity risk** - Liquidity risk is felt to be low. This is because operating costs are incurred primarily

*Tai Chi at the Becklin, 2010*

# Operating and Financial Review

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 sale of assets in 2011/12 although the development of the St Mary's Hospital site may facilitate future land sales on both that site and the St Mary's House site. The capital programme will continue to be funded through a combination of future depreciation and existing cash resources.

**Cash flow risk** - The main sources of income and expenditure are extremely predictable. The Trust is forecast to retain significant cash and other liquidity resources for the foreseeable future. Cash flow risk is therefore felt to be low due to the adequate level of cash reserves; the Trust has not sought a working capital loan facility due to the build-up of adequate working capital.

## 4.14.8 Disclosure for the Payment of Creditors

We adopt the Better Payment Practice Code, which requires payment of all our undisputed invoices by the due date or within 30 days of receipt of goods. Further information can be found in Note 9 of the Annual Accounts in Section 10 of this report.

## 4.14.9 Management Costs

Management costs are stated in annual accounts at note 7.3, the percentage (as a percentage of Trust income) has reduced from 6.40% (2009/10) to 6.28% (2010/11).

## 4.14.10 Outlook for the Future

In response to the country's economic situation, the Government has taken a number of measures which are designed to reduce public expenditure and reduce the national debt. The 2011/12 Operating Framework for the NHS in England was published in December 2010; this clearly signalled a lower level of resources for the future.

Much emphasis is placed on controlling costs and increasing efficiency with a headline inflation adjustment of -1.5% in 2011/12. This is the first time that a negative 'downshift' has been applied. The Government estimate that cost pressures will cost +2.5% in 2011/12, which therefore implies the need to achieve a minimum 4% efficiency through reduced costs, when combined with a drop of -1.5% in income.

This is the second year of significant income constraint as no inflation adjustment was received in 2010/11. Whilst no future year projections were issued as part of the Operating Framework for 2011/12, the Operating Framework for 2010/11 indicated a maximum tariff uplift of 0% up to and including 2013/14. Future planning projections place an increasing emphasis on reducing costs in the face of further income loss. The Trust will need to make savings of around £18m between 2011/12 and 2013/14, which is on average 5% over the next three years. The biggest challenge is in 2011/12 with a planned Cash Releasing Efficiency Savings of £7m, representing almost 6% of 2010/11 expenditure.

As in 2010/11, 1.5% of the current contract value is dependent on meeting quality improvements agreed with NHS Leeds. It has been assumed that such funding will be received in each year 2011/12 – 2013/14.

## 4.14.11 How We Involve Our Staff in Understanding Financial Performance

Financial plans are set in the context of an annual planning process looking ahead for three years. Key assumptions to be used are discussed at both the Executive Team and as part of Board of Directors' discussions to ensure understanding of the key assumptions being made and the impact on the Trust's financial risk ratings.

The majority of the management accounting function is embedded within the care services directorates, with finance managers forming part of the leadership teams at this level. This ensures consistency of understanding across the Trust on both service and financial objectives.

At the start of each year, a Budgetary Control Framework is approved by the Board of Directors and shared widely. It is published on the Trust intranet (Staffnet) and is available to all budget holders and describes the financial plan at both Trust and individual budget level to ensure transparency. All budget holders are required to formally sign off budgets at the start of each year.

The Board of Directors and Board of Governors receive regular information regarding the financial performance; the Board of Directors on a monthly basis and the Board of Governors on a quarterly basis. The financial reports are set out in a monthly performance report which highlights performance against plan, any significant variances, how these have occurred and what action is required, if any. On a quarterly basis this information is taken to the Board of Governors and explained to give assurance on the financial position.

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

Monthly service line reports are produced and discussed with clinical managers to enable them to better understand the relationship between service and resource use. These are reported in summary form to each Board of Directors' meeting.

A number of key budget holders attend training courses run by the Healthcare Financial Management Association (HFMA) and the Trust has also purchased a significant number of e-learning financial training packages for use over the next three years.

## 4.15 Regulatory Performance

Information about our non-financial performance, our regulatory ratings and performance against national standards and targets can be found in Section 9.

*Ruby Sagoo, Diversity Team*

*Tricia Thorpe, Service User Governor*

# Board of Governors

## 5.1 Composition of the Board of Governors

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. It is made up of people who have been elected by our membership and who are representative of our constituencies. It also includes people appointed 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.

**Table 5A – Number of Seats in each Governor Constituency**

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

Governors are either elected or appointed to the Board of Governors for a period of up to three years, with elections being carried out in accordance with the election rules in our Constitution.

The Tables 5B and 5C list the governors that have served on the Board of Governors during 2010/11.

**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 |
| Alec Hudson | Public: Morley and Rothwell | 3 | 17.8.09 | 16.8.12 |
| Andrew Marran | Public: Elmet | 3 | 17.8.07 | 16.8.10 |
| | (Re-elected) | 3 | 17.8.10 | 16.8.13 |
| 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 |
| Grace Mangwanya | Public: Leeds East | 3 | 17.8.10 | 16.8.13 |
| Sharron Plews | Public: West | 3 | 17.8.10 | 16.8.13 |
| Andy Parker | Service User: Leeds | 3 | 17.8.09 | 16.8.12 |
| Tricia Thorpe | Service User: Leeds | 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 |
| | (Re-elected) | 3 | 17.8.10 | 16.8.13 |
| Jonathan Butler | Service User: Leeds | 3 | 17.8.10 | 16.8.13 |
| Pamela Dolan | Service User: Leeds | 3 | 17.8.10 | 16.8.13 |
| Janette Howlett | Carer: Leeds | 3 | 17.8.07 | 16.8.10 |
| | (Re-elected) | 3 | 17.8.10 | 16.8.13 |
| Andrew Bottomley | Carer: Leeds | 3 | 17.4.08 | 17.4.11 |
| Jackie Worthington | Carer: Leeds | 3 | 17.8.09 | 16.8.12 |
| Annie Dransfield | Carer: Leeds | 3 | 24.3.11 | 24.3.14 |
| Bill Boland | Carer: Leeds | 3 | 24.3.11 | 24.3.14 |
| Ron Sweeney ** | Carer: Non-Leeds | 3 | 17.8.07 | 16.8.10 |
| Barry Tebb | Carer: Non-Leeds | 3 | 17.8.10 | 16.8.13 |
| Chris Collins ** | Staff: Clinical | 3 | 17.8.07 | 16.8.10 |
| Vince Hitchiner ** | Staff: Clinical | 3 | 17.8.07 | 16.8.10 |
| Heather Simpson | Staff: Clinical | 3 | 17.8.10 | 16.8.13 |
| Mahesh Jayaram | Staff: Clinical | 3 | 17.8.10 | 16.8.13 |
| Stephen Wright | Staff: Clinical | 3 | 17.8.10 | 16.8.13 |
| Jonathan King | Staff: Clinical | 3 | 24.3.11 | 24.3.14 |
| Pamela Morris | Staff: Non-clinical | 3 | 17.8.09 | 16.8.12 |
| Dave Shelley | Staff: Non-clinical | 3 | 17.8.07 | 16.8.10 |
| | (Re-elected) | 3 | 17.8.10 | 16.8.13 |

* Indicates those governors that have resigned during 2010/11 before the end of their term of office
** Indicates those governors that resigned during 2010/11 at the end of their term of office

# Board of Governors

Table 5C – Appointed Governors

| Name | Appointing Organisation | Term of Office (years) | Date appointed from | Date Term of office ends |
|---|---|---|---|---|
| Colin Clark | Equitix Ltd | 3 | 13.2.11 | 12.2.14 |
| Dawn Freshwater ** | University of Leeds | 3 | 18.1.08 | 19.7.10 |
| Pip Goff | Volition | 3 | 17.8.09 | 16.8.12 |
| June Goodson-Moore | NHS Leeds | 3 | 15.10.09 | 14.10.12 |
| Peter Harrand * | Leeds City Council | 3 | 17.8.09 | 20.7.10 |
| Richard Hogston | Leeds Metropolitan University | 3 | 17.8.07 | 16.8.10 |
| Kate Langan | Leeds Voluntary Sector Learning Disabilities Forum | 3 | 15.2.10 | 14.02.13 |
| 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 |
| Julia Turner | University of Leeds | 3 | 20.7.10 | 19.7.13 |
| Cllr Lucinda Yeadon | Leeds City Council | 1 | 21.7.10 | 20.7.11 |

* Indicates those governors that have resigned during 2010/11 before the end of their term of office
** Indicates those governors that resigned during 2010/11 at the end of their term of office

## 5.2 Changes to the Board of Governors

At the start of the year we had 28 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, and we are pleased to report that at the end of the year we had a total of 35 Governors.

### 5.2.1 Elected Governors

The changes to our elected governors are also detailed in Table 5B above.

Elections are carried out in accordance with the election rules as set out in our constitution. Members nominate themselves and are elected on a first past the post system of voting.

In 2010/11 we held two rounds of elections. The first was in the summer of 2010 and 16 seats were included. Eleven 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, has never been filled.

We were successful in filling seats as follows:

Table 5D

| Elected unopposed: | | Elected by ballot: | |
|---|---|---|---|
| Public: Elmet and Rothwell | Andrew Marran (re-elected) | Service User: Leeds | Maria Trainer (re-elected) |
| Public: Leeds East | Grace Mangwanya | Service User: Leeds | Jonathan Butler |
| Public: Leeds West | Sharron Plews | Service User: Leeds | Pamela Dolan |
| Carer: Leeds | Janette Howlett (re-elected) | Carer: Non-Leeds | Barry Tebb |
| Staff: Clinical | Heather Simpson | Staff: Non-clinical | Dave Shelley (re-elected) |
| Staff: Clinical | Mahesh Jayaram | | |
| Staff: Clinical | Stephen Wright | | |

# Board of Governors

For the balloted seats election turn-out was 13.5% in the Service User: Leeds constituency; 26.6% in the Staff: Non-clinical constituency; and 8.9% in the Carer: Non-Leeds constituency.

Seats in the areas of Service User Non-Leeds (one seat), Carer: Leeds (two seats) and Staff: Clinical (one seat) remained vacant. These seats went forward into the elections that started in spring 2011.

In March 2011 elections to the Board of Governors commenced to vacant seats in the constituencies of:

- **Carer: Leeds (three seats)**
- **Service User: Non-Leeds (one seat)**
- **Public: Leeds North East (one seat)**
- **Staff: Clinical (one seat)**

The elections will be fully concluded in 2011/12 when the ballot for the vacancy in the constituency of Public: Leeds North East closes; however, on 24 March 2011 following the close of nominations, there were four Governors elected unopposed. These are as follows:

### Elected unopposed:

**Table 5E**

| | |
|---|---|
| **Carer: Leeds** | **Annie Dransfield** |
| **Carer: Leeds** | **Bill Boland** |
| **Carer: Leeds** | **Andrew Bottomley (re-elected)** |
| **Staff: Clinical** | **Jonathan King** |

The seat of Service User: Non-Leeds still remains vacant.

## 5.2.2 Appointed Governors

The changes to our appointed governors are also detailed in Table 5C above.

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

During 2011/10 there were a number of changes to our appointed governors. With regard to our governor representing Leeds City Council, Councillor Peter Harrand stepped down on 20 July and was replaced by Lucinda Yeadon. There was also a change in the governor representing the University of Leeds; Dawn Freshwater stepped down on 20 July and was replaced by Julia Turner.

There were also two re-appointments made. Richard Hogston who is appointed governor for Leeds Metropolitan University was re-appointed for a second term of three years with effect from 17 August 2010; and Colin Clark who represents our PFI providers, Equitix, was re-appointed for a second term of three years with effect from 13 February 2011.

We would like to welcome all the new governors who have joined our Board for the first time, and thank those who have continued to contribute to the Board because they have been re-elected or re-appointed. To those governors that have left the Board of Governors during 2010/11, we would like to say thank you for the very valuable contribution they have made, and we hope they will continue to contribute as members to our strategic direction and to the way services are provided.

## 5.3 Meetings of the Board of Governors

During 2010/11 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, the agenda and papers are is published on our website **www.leedspft.nhs.uk.**

The table below details the number of meetings attended by each governor during 2010/11. This is shown out of a maximum of five meetings unless a governor has either resigned from, or joined the Board of Governors part-way through the financial year.

# Board of Governors

**Table 5F – Number of Meetings Attended by each Governor**

| Name | Appointed or Elected | Number of meetings eligible to attend | Number of meetings attended | Name | Appointed or Elected | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|---|---|
| Joanna Blythe | E | 5 | 4 | Bill Boland * | E | 0 | 0 |
| Jonathon Butler | E | 3 | 3 | Andrew Bottomley | E | 5 | 4 |
| Colin Clark | A | 5 | 4 | Chris Collins ** | E | 5 | 4 |
| Rona Dailey | E | 5 | 5 | Pamela Dolan * | E | 3 | 1 |
| Annie Dransfield * | E | 0 | 0 | Dawn Freshwater ** | A | 0 | 0 |
| Pip Goff | A | 5 | 3 | June Goodson-Moore | A | 5 | 3 |
| Gina Greenley | E | 5 | 3 | Peter Harrand ** | A | 5 | 3 |
| Vince Hitchiner ** | E | 2 | 2 | Richard Hogston | A | 5 | 3 |
| Janette Howlett | E | 5 | 5 | Alec Hudson | E | 5 | 5 |
| Mahesh Jayaram * | E | 3 | 3 | Jonathan King * | E | 0 | 0 |
| Clare Linley | A | 5 | 4 | Kate Langan | A | 5 | 2 |
| Grace Mangwanya | E | 3 | 3 | Andrew Marran | E | 5 | 5 |
| John Mason | E | 5 | 4 | Mark Milsom | A | 5 | 2 |
| Pamela Morris | E | 5 | 5 | Sharron Plews * | E | 3 | 2 |
| Jennifer Roper | E | 5 | 5 | Dave Shelley | E | 5 | 5 |
| Heather Simpson * | E | 3 | 3 | Ron Sweeney ** | E | 3 | 3 |
| Barry Tebb * | E | 3 | 3 | Tricia Thorpe | E | 5 | 2 |
| Linda Tingle ** | E | 3 | 2 | Maria Trainer | E | 5 | 5 |
| Julia Turner * | A | 3 | 2 | Stephen Wright * | E | 3 | 3 |
| Jackie Worthington | E | 5 | 5 | Cllr Lucinda Yeadon * | A | 3 | 2 |
| Andy Parker | E | 5 | 5 | Keith Wilson* | E | 0 | 0 |

* Indicates those governors that were elected or appointed part-way through 2010/11 and therefore may not have had the opportunity to attend all meetings.
** Indicates those governors that resigned part-way through 2010/11 and may not have had the opportunity to attend all meetings.

## 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 must take account of the views of the governors when developing 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 auditor's report and the annual report**
- **Ensuring the Board of Directors does not breach the Trust's Terms of Authorisation as set by Monitor**

During 2010/11 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:

# Board of Governors

- **Continuing to develop our strategy, including a refresh of our aim and values, and agreeing new strategic goals and their associated targets and measures**
- **Participating in Patient Environment Action Team (PEAT) inspections on our wards and units**
- **Appointing the deputy chair of the Trust**
- **Re-appointing Niccola Swan and Allan Valks as non-executive directors for two years through a competitive appointment process**
- **Appointing Keith Woodhouse, Aqila Choudhry, and Dr Gill Taylor as non-executive directors for three years through a competitive appointment process**
- **Reviewing the remuneration of the chairman of the Trust and the non-executive directors**

Further information about how governors have contributed to the development of services can be found in Section 4.3.

## 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. In attendance at each meeting are the Chief Executive and the Head of Corporate Governance.

The Board of Governors also invite other members of the Board of Directors to attend the public meetings. During the period of reporting each member of the Executive Team has attended one or more meetings of the Board of Governors or has made presentations to it. In addition to this the non-executive directors have also been in attendance to listen to the debate and understand the issues raised by the Board of Governors.

## 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 formal sub-committees to focus on specific areas of work. 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 the work of this committee in 2010/11 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 formally record declarations of interests of members of the Board of Governors. In particular, the Register will include details of all directorships and other relevant material interests, which have been declared.

On appointment, members of the Board of Governors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interest and those arising from their membership of the Board of Governors. Members of the Board of Governors are also required to declare any conflict of interest that arises 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 **catherine.brand@nhs.net .**


*(L-R) Chris Butler, Chief Executive and Dr Douglas Fraser, Medical Director*

# 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 our strategy. It does this by:

- **Setting our overall strategic direction**
- **Ensuring we provide high quality, effective and service user focused services**
- **Promoting effective dialogue with our local communities**
- **Promoting and abiding by our values**
- **Monitoring performance against objectives**
- **Providing effective financial stewardship**
- **Ensuring high standards of corporate governance and personal conduct**

The Chairman is responsible for ensuring 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 the corporate responsibility for ensuring that the Trust is run efficiently, economically and effectively. Non-executive directors use their expertise and experience to achieve this.

## 6.2 Composition of the Board of Directors

During 2010/11 there have been a number of changes to the composition and membership of the Board of Directors.

### 6.2.1 Non-executive Team

On 1 April 2010 Frank Griffiths took up the position of Chairman of the Trust. Mr Griffiths had been appointed through a competitive process by the Board of Governors on 16 February 2010. This appointment was made following the retirement of Mr Ian Hughes on 31 March 2010.

On 26 June 2010 Merlin Wilce stepped down as a non-executive director. Mr Wilce had been with the organisation since 1 August 2007 and was appointed as an initial non-executive director of our Foundation Trust. Prior to this he was first appointed to our predecessor organisation (Leeds Mental Health Services Teaching NHS Trust) on the 9 September 2002. Also in June the Board of Directors reviewed the composition of the Board and agreed an increase in the number of non-executive directors (including the Chairman of the Trust) from six to seven; and in July 2010 Monitor authorised the necessary change in the Constitution.

The Board of Governors then reviewed the process for the appointment of non-executive directors and made a decision to move to an open advertisement process. The first set of appointments made under this new process were concluded in September 2010 when the Board of Governors appointed Mr Keith Woodhouse and Ms Aqila Choudhry, both of whom took up their appointments on 18 October 2010 for a period of three years. In November 2010 the Board of Governors concluded the second set of non-executive director appointments with the re-appointment of Mrs Niccola Swan and Mr Allan Valks from 1 December 2010 each for a period of two years; and the appointment of Dr Gill Taylor, who took up her position on 2 January 2011 for a period of three years. Further information about the process of appointment and the way in which our committees carry out this function can be found in Section 8.

Also in December 2010 Mrs Catherine Coyle came to the end of her appointment. Mrs Coyle had been a non-executive director since 1 August 2007 when she was appointed as an initial non-executive director of our Foundation Trust. Prior to this she was appointed to our predecessor organisation (Leeds Mental Health Teaching NHS Trust) on 1 February 2007. Mrs Coyle was the Deputy Chair between 1 October and 31 December 2010.

### 6.2.2 Executive Team

There have also been a number of changes in the Executive Team during 2010/11.

Firstly, on 30 April Mike Doyle left the Trust. Mr Doyle had been with the Trust (and its predecessor organisations) since 12 August 1993. Latterly he had held the position of Director of Corporate Development. The areas of responsibility within Mr Doyle's portfolio were allocated to other members of the Executive Team.

On 9 November 2010 Dr David Newby retired from the Trust. Dr Newby had been with the Trust (and its predecessor organisation) since 8 April 2002 as our Medical Director. From 6 September until his retirement he was working in the Executive Team as Medical Director (Governance Projects) and also managed the handover process to Dr Douglas Fraser, who has

# Board of Directors

been acting into the role of Medical Director since 6 September 2010 for an initial period of one year.

One further change to the Executive Team was the substantive appointment of Jill Copeland on 17 November 2010 to the position of Director of Strategy and Partnerships to take effect from 1 April 2011. Ms Copeland had been previously seconded to this post on 1 October 2009, and was successfully appointed through open advertisement.

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 Human Resources.

The Board of Directors has seen a number of changes over the year. The Board would like to thank those colleagues that have left the Trust this year; Catherine Coyle; Mike Doyle; Dr David Newby and Merlin Wilce for all their hard work, support and dedication in helping to ensure that this Trust provides the best possible care for service users. Directors would also like to welcome Aqila Choudhry, Dr Douglas Fraser, Dr Gill Taylor and Keith Woodhouse who have joined the Board for the first time this year; and who will contribute to the work of the Board in taking it forward to ensure that it continues to improve health and improve lives.

## 6.2.3 Members of the Board of Directors

At the end of 2010/11 the Board of Directors comprised of seven non-executive directors (including the Chairman) and six executive directors (including the Chief Executive).

**Table 6A – Members of the Board of Directors as at 31 March 2011**

| Non-Executive Team | | |
|---|---|---|
| Frank Griffiths | Chairman of the Trust | 3 year appointment from 1.4.10 |
| Aqila Choudhry | Non-executive Director | 3 year appointment from 18.10.10 |
| Linda Phipps | Non-executive Director | 3 year appointment from 1.2.10 |
| Niccola Swan | Non-executive Director | 2 year appointment from 1.12.10 |
| Dr Gill Taylor | Non-executive Director | 3 year appointment from 2.1.11 |
| Allan Valks | Non-executive Director and Senior Independent Director | 2 year appointment from 1.12.10 |
| Keith Woodhouse | Non-executive Director | 3 year appointment from 18.10.10 |
| Executive Team | | |
| Chris Butler | Chief Executive | |
| Jill Copeland | Director of Strategy and Partnerships | |
| Dr Douglas Fraser | Medical Director | |
| Stephen Griffin | Director of Human Resources (non-voting) | |
| Michele Moran | Director of Service Delivery/Chief Nurse (joint Deputy Chief Executive from 23.4.10) | |
| Guy Musson | Chief Financial Officer (joint Deputy Chief Executive from 23.4.10) | |

# Board of Directors

The Board of Directors considers that it is balanced, complete and appropriate and this can be seen in the biographical details of Board members as set out below. To ensure that the Board of Directors remains balanced and complete the Nominations Committee has responsibility for continuity planning and for assessing the skills and experiences required on the Board when a vacancy arises. During 2010/11 the Nominations Committee has made such an assessment in respect of the five vacancies that arose. Posts were advertised for and appointments made which strengthened skills in the areas of information management, finance, workforce, strategic growth, organisational development, engagement and diversity.

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 has no other significant commitments that have affected his ability to carry out his duties to the full, and has therefore been able to allow sufficient time to undertake his duties.

Non-executive directors, including the Chairman of the Trust are appointed by the Board of Governors through an open advertisement process. 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.

## 6.3 Profile of Members of the Board of Directors

**Frank Griffiths, Chairman of the Trust**

Frank has been in post as Chairman of the Trust since 1 April 2010. He is the former Deputy Vice Chancellor of Leeds Metropolitan University, having retired in 2006. He also chairs two Leeds-based charities: the IGEN Trust, which provides careers advice and guidance to young people in schools and those seeking employment as young adults; and the Leeds-based Trust for Education, which has for the last ten years distributed over a million pounds to help people enter colleges and universities. Frank is also a member of the Board of the Hollybank Trust, based in Mirfield, which is a residential facility for profoundly disabled children and adults.

He has lived and worked in Leeds for over 20 years, having previously worked in a number of educational organisations in London and in Teesside.

**Aqila Choudhry, Non-executive Director**

Aqila is currently Chief Executive of People in Action (Leeds) UK, a charity that supports people with learning difficulties and disabilities in all aspects of their lives. She is a board member of Tenfold and also represents its Membership at the Leeds Partnership Board for Learning Disabilities.

She is currently a director of Chapeltown Development Trust and several other Charities, and is committed to enabling entrepreneurs to set up social enterprises and is in the process of doing so for People in Action involving people with learning disabilities. Aqila is also a voluntary sector representative at the Leeds Initiative Board of Leeds City Council.

Aqila has worked in the voluntary community and faith sector for over 20 years and is passionate about equality of opportunity and rights for all, especially vulnerable people including disabled, older people, women, children and young people. She is a sector representative at the Scrutiny Board (families and children) of Leeds City Council. Aqila managed volunteers at Chapeltown Citizens Advice Bureau and was a representative on boards of various project and organisations. She is one of the founder members of a community radio station based in Harehills, and is also a trainer and delivered training to multi-agency staff on the issue of domestic violence towards women by known men.

Aqila's commitment to improving communities and the lives of others led her to become a parliamentary candidate for the Liberal Democrats at the 2010 general election in Leeds North East, and she is their diversity champion for Yorkshire and the Humber.

**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 Primary Care Trust.

Linda's background is in senior commercial management in the transport and local government sectors. Currently she is a non-executive director of the Highlands and Islands Airport Limited, is a member of the Advisory Committee on Conscientious Objectors, and a lay member of AGNSS – the national Department of Health Advisory Group on National Specialised Services. She also undertakes consultancy in coaching, mediation, facilitation and rapporteur

# Board of Directors

work; and is a Trustee of Mental Health Matters.

Linda has a special interest in governance and risk.

**Niccola Swan, Non-Executive Director**

Niccola took up the post of Executive Director, Leeds Mind at the end of 2010. Leeds Mind, amongst many other activities, delivers services in employment, housing and wellbeing. Niccola is also a director of Volition Leeds, an alliance of voluntary sector mental health organisations.

Prior to becoming a Non-Executive Director of the Trust in January 2007, she 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.

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 went on to be a trustee and the treasurer of Rethink (which used to be known as the National Schizophrenia Fellowship), a member of the now disbanded Disability and Employment Advisory Committee which advised the Minister for Disabled People, and is a Director of Dignity in Dying which campaigns for greater choice at the end of life.

**Dr Gill Taylor, Non-executive Director**

Gill is a local business woman running a small company which provides management consultancy, executive coaching, facilitation and skills programmes with particular emphasis on change management.

Gill is a former local authority Chief Executive. She was also Chief Executive of the Academy for Sustainable Communities (a national non-departmental public body), a Corporate Director (Skills and Knowledge) for the Homes and Communities Agency and was a government policy advisor on sustainable communities and on community cohesion.

She is a Board member of Manningham Housing Association in Bradford and has a particular interest in housing, sustainable communities and leadership development.

**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 and Assurance Committee.

**Keith Woodhouse, Non-executive Director**

Keith has a background of programme and change management and has worked at director level within both private and public bodies over the last 10 years. His last executive role was with the Child Maintenance & Enforcement Commission, where he was responsible for the development and implementation of a new Child Maintenance Service. This included the overall management of the change programme, control of budgets in excess of £100m and the design, build and implementation of new IT.

Within the last four years Keith has also held a non-executive director post with Calderdale Primary Care Trust. Keith is very client/patient-centric in his approach to services and equally passionate about efficient and effective delivery of services.

**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 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 Strategy and Partnerships**

Jill graduated in Philosophy

# Board of Directors

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.

**Dr Douglas Fraser, Medical Director**

Douglas graduated from St George's Hospital Medical School in London in 1988. He completed his junior medical training on the St George's rotation in London and moved to Leeds to complete his higher psychiatric training in 1995. Douglas was appointed as a consultant psychiatrist in 1999 and worked in a community mental health team in west Leeds for almost ten years. He was also clinical tutor for seven years, during which time he had responsibility for the delivery of the local teaching programme for junior doctors.

He was appointed as Associate Medical Director for Adult Mental Health in 2008 and was also working as an inpatient consultant on a female acute admission ward. Douglas has been Medical Director since September 2010 and continues to work as a clinician in the Crisis Resolution and Home-based Treatment Team.

**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. Stephen holds a Masters Degree and is professionally qualified.

**Michele Moran, Director of Service Delivery and Chief Nurse, 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 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 is an Interim Management and Support (IMAS) partner and has undertaken a short secondment alongside PricewaterhouseCoopers LLP. Michele has recently been re-elected as Chair of the Foundation Trust Network (FTN) Clinical Leads Network. She is also part of the Top 200 leadership pool.

Michele spends a lot of her time in the services and with service users and is passionate about their care and safety.

**Guy Musson, Chief Financial Officer, 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 was subsequently tasked with project managing the transition to foundation status, which was achieved in August 2007. His portfolio now includes compliance & performance and commercial activities, the latter involving the successful acquisition of the Yorkshire & Humber Commercial Procurement Collaborative in August 2010.

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. Over the last two years he has worked in several organisations, including two large acute trusts and latterly the Department of Health where he undertook work related to the emerging role for Monitor as economic regulator and the NHS Trust Development Authority.

# Board of Directors

## 6.4 Meetings of the Board of Directors

The Board of Directors meets monthly, with four meetings a year held in public. In addition to the 12 scheduled Board of Directors' meetings, three extraordinary meetings also took place on 21 September, 9 November and 16 November 2010. Alongside the formal Board of Directors' meetings, members of the Board of Directors also hold workshop sessions regularly throughout the year and use this time to explore new emerging issues or use the time for development.

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

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Frank Griffiths (chair) | 15 | 15 | Chris Butler | 15 | 15 |
| Aqila Choudhry ** | 8 | 8 | Jill Copeland | 15 | 15 |
| Catherine Coyle * | 12 | 8 | Mike Doyle * | 1 | 1 |
| Dr Douglas Fraser ** | 10 | 8 | Stephen Griffin | 15 | 9 |
| Michele Moran | 15 | 14 | Guy Musson | 15 | 15 |
| David Newby * | 5 | 4 | Linda Phipps | 15 | 14 |
| Niccola Swan | 15 | 15 | Dr Gill Taylor ** | 3 | 3 |
| Allan Valks | 15 | 15 | Merlin Wilce * | 2 | 2 |
| Keith Woodhouse ** | 8 | 7 | | | |

* Indicates directors who left the Trust during 2010/11.
** Indicates directors who joined the Trust during 2010/11.

## 6.5 Register of Directors' Interests

Under the provisions of the constitution, we are required to have a Register of Interests to formally record declarations of interests of members of the Board 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.

On appointment members of the Board of Directors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interests and those arising from their membership of the Board of Directors. Members of the Board of Directors are also required to declare any conflict of interest that arises 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 **catherine.brand@nhs.net.**

## 6.6 Evaluation of the Board of Directors and its Sub-committees

Each year the Board of Directors undertakes a formal evaluation of its performance and effectiveness.

In the spring of 2010 the Board of Directors undertook an evaluation of Board effectiveness using a board development tool, which was developed by the NHS Institute for Innovation and Improvement. The NHS Institute presented a summary of its findings to the Board of Directors in a workshop in October 2010, concluding that the Board had developed as a very effective team with a well balanced Board committed to working together, with a clear focus on patient safety and a very strong relationship with the Board of Governors. The Board also identified four areas that it wanted to develop further and it put in place a development plan as part of its commitment to continuous improvement.

As part of the review of our governance framework, work has been ongoing to embed the new framework into the organisation. As part of this continuing work there will be an overall assessment of adequacy and effectiveness of the framework, which will be undertaken by a task and finish group within the management structure. This group will also devise and implement an effectiveness questionnaire, which will be required to be completed by each group and committee in the structure with an overall report being made to the Executive Team and the Audit and Assurance Committee. It is expected that this work will be completed in 2011/12.

## 6.7 Sub-committees of the Board of Directors

With effect from 1 November 2010 the new governance framework was ratified by the Board of Directors. This moved from having a number of Board sub-committees that carried out the assurance functions (i.e. the Audit Committee, the Risk Management and Governance Committee, the Resources Committee and the IM&T Committee) and folded the assurance functions of each of these committees into the new Audit and Assurance Committee.

The Audit and Assurance Committee, along with

# Board of Directors

the Remuneration Committee, the Nominations Committee and the Charitable Trust Funds Committee now make up the totality of the Board of Directors' sub-committee structure. Information about the work of the Remuneration Committee and the Nominations Committee can be found in Section 8. Our governance framework is also shown in Section 4 (Tables 4A & 4B).

## 6.8 The Audit Committee, and the Audit and Assurance Committee

The Audit and Assurance Committee is now the primary governance and assurance committee and is a sub-committee of the Board of Directors. It was formed on the 1 November 2010 as part of the new governance framework and its first meeting was held on 30 November 2010. Prior to 1 November 2010 the Board of Directors had an Audit Committee in place.

The Audit and Assurance Committee provides independent and objective review and seeks high-level assurance on the effectiveness of our governance (corporate and clinical), risk management and internal control systems. It receives assurance from the Executive Team and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit, External Audit, Clinical Audit, and the Professional Advisory Forum, again received through reports, minutes and attendance at meetings. Assurance is also brought to the Committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise; attending directorate performance reviews; 'walking the floor'; and talking to staff.

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

Membership of the Audit and Assurance Committee is made up of six non-executive directors as shown in table 6C below. In regular attendance at the committee are the Chief Executive, the Chief Financial Officer, and the Head of Corporate Governance. There is also representation from PricewaterhouseCoopers LLP (our external auditors), the Chief Internal Auditor, and the Deputy Chief Internal Auditor (as the Local Counter Fraud Specialist) as required.

Table 6C below shows the number of Audit and Assurance Committee meetings attended by each member. For the period 1 November 2010 to 31 March 2011 there were four meetings of the committee.

**Table 6C – The Audit and Assurance Committee (for the period 1 November 2010 to 31 March 2011)**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Allan Valks (chair) | 4 | 4 | Aqila Choudhry | 4 | 3 |
| Catherine Coyle* | 1 | 0 | Linda Phipps | 4 | 4 |
| Niccola Swan | 4 | 3 | Dr Gill Taylor** | 3 | 1 |
| Keith Woodhouse | 4 | 3 | | | |

* Catherine Coyle left the Trust on 31 December 2010.
** Dr Gill Taylor joined the Trust on 2 January 2011.

*Leeds Carnegie, February 2011*

# Board of Directors

Prior to the formation of the Audit and Assurance Committee the Audit Committee had as its membership four non-executive directors as shown in table 6D below. The table below also shows the number of meetings that were attended by each member. For the period 1 April to 31 October 2010 there were four meetings of the committee.

**Table 6D – The Audit Committee (for the period 1 April to 31 October 2010)**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Allan Valks (chair) | 4 | 4 | Catherine Coyle | 4 | 4 |
| Niccola Swan | 4 | 4 | Merlin Wilce* | 2 | 2 |

* Merlin Wilce left the Trust on 26 June 2010.

During 2010/11 the Audit Committee and the Audit and Assurance Committee in their turn have fulfilled the role of the primary governance and assurance committee. Each one has contributed to this work and during the year have: approved the audit plans for both the internal and external auditors and also the work plan for the Counter Fraud Service; received and reviewed both regular progress reports and the concluding annual reports for the work of Internal Audit and the Counter Fraud Team; received and reviewed the Assurance Framework, the Risk Management Process and conducted a review of the risk registers; and reviewed the Annual Accounts and any auditors' report on these accounts, prior to them being adopted by the Board of Directors.

A separate annual report for the Audit and Assurance Committee is produced and submitted to the Board of Directors and to the Board of Governors for information. This can be found on our website **www.leedspft.nhs.uk .**

Further information about the sufficiency of our internal control processes can also be found in the Statement on Internal Control in Section 10.

## 6.9 Other Sub-committees of the Board of Directors

### 6.9.1 The Charitable Trust Funds Committee

The Charitable Trust Funds Committee has been established to oversee the investment of charitable funds; to look at ways of maximising income; and to look at ways in which the money can be used in accordance with the purpose of the funds. The committee is made up of the Chairman of the Trust who chairs the meetings, one governor, a representative from Staffside and the Chief Financial Officer. It is attended by the Associate Director for Partnerships who gives support and advice to committee members.

*Arts and Minds Exhibition, 2010*

# Board of Directors

The table below shows the number of meetings that were attended by each member for that period.

**Table 6E – The Charitable Trust Funds Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| **Members of the Committee** | | | | | |
| **Frank Griffiths** (chair) * | 2 | 2 | **Catherine Coyle** (chair) ** | 2 | 2 |
| **Angela Gabriel** (Chair of Staffside) | 4 | 2 | **Janette Howlett**** (Governor) | 3 | 3 |
| **Guy Musson** | 4 | 2 | | | |
| **Attending on behalf of a member in their absence** | | | | | |
| **Carol Greaves****** (Deputy Director of Finance)) | N/A | 1 | **Dave Syms******* (Representative of Staffside) | N/A | 1 |

* Frank Griffiths was the chair of the committee from January 2011
** Catherine Coyle was the chair of the committee until December 2010
*** Janette Howlett was appointed as the governor representative with effect from
**** Carol Greaves attended one meeting on behalf of Guy Musson
***** Dave Syms attended one meeting on behalf of Angela Gabriel

## 6.9.2 The Resources Committee

The Resources Committee was 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 utilising these resources. It was a sub-committee of the Board of Directors for the period 1 April to 31 October 2010 and the table below shows the number of meetings that were attended by each member for that period.

**Table 6F –The Resources Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| **Members of the Committee** | | | | | |
| **Niccola Swan (chair)** | 5 | 5 | **Mike Doyle***** | 1 | 0 |
| **Stephen Griffin*** | 5 | 2 | **Michele Moran** | 5 | 5 |
| **Guy Musson** | 5 | 5 | **John Walker**** (Head of Facilities) | 5 | 3 |
| **Dr Douglas Fraser****** | 2 | 2 | | | |
| **Attending on behalf of a member in their absence** | | | | | |
| **Oliver Holdsworth** ** (Property Manager) | N/A | 2 | **Lindsay Jensen*** (Associate Director H.R) | N/A | 3 |

* HR representation on the committee has been provided by the Director of Human Resources or in his absence the Associate Director of Human Resources.
** Facilities representation on the committee has been provided by the Head of Facilities or in his absence the Trust Property Manager.
*** Mike Doyle left the Trust on 30 April 2010.
**** Dr Douglas Fraser came into post on 6 September 2010.

Note: Allan Valks, Non-executive Director, also attended the Resources Committee on an invitation basis to provide further non-executive challenge specifically in the area of financial resources.

# Board of Directors

## 6.9.3 The Risk Management and Governance Committee

The purpose of the Risk Management and Governance Committee was to provide assurance to the Board of Directors in areas of corporate and clinical governance, risk registers and risk management, and the Assurance Framework. It was a sub-committee of the Board of Directors for the period 1 April to 31 October 2010 and the table below shows the number of meetings that were attended by each member for that period.

**Table 6G – The Risk Management and Governance Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| **Members of the Committee** | | | | | |
| **Linda Phipps** (chair) | 4 | 4 | **Victoria Betton** (Associate Director of Partnerships and Social Inclusion) | 4 | 4 |
| **Cath Brand** (Head of Corporate Governance) | 4 | 4 | **Don Brechin** (Professional Head of Psychology) | 4 | 2 |
| **Chris Butler** | 4 | 4 | **Mike Doyle** ** | 1 | 0 |
| **Stephen Griffin** * | 4 | 0 | **Michele Moran** | 4 | 4 |
| **Guy Musson** | 4 | 4 | **David Newby** | 4 | 4 |
| **Helen Wiseman** (Professional Head of Allied Health Professionals) | 4 | 4 | **Christine Woodward** (Head of Risk Management) | 4 | 3 |
| **Attending on behalf of a member in their absence** | | | | | |
| **Lindsay Jensen** * | N/A | 4 | | | |

* Human Resources representation on the committee has been provided by the Director of Human Resources or in his absence the Associate Director of Human Resources.
** Mike Doyle left the Trust on 30 April 2010.

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

It was the function of the IM&T Governance Committee was to assure the Board of Directors that systems of control were in place relating to all areas of information technology and knowledge management. It was a sub-committee of the Board of Directors for the period 1 April to 31 October 2010 and the table below shows the number of meetings that were attended by each member for that period.

**Table 6H – The IM&T Governance Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| **Members of the Committee** | | | | | |
| **Heather Cook (chair 15.4.10)** (Head of Information and Knowledge) | 3 | 3 | **Mike Doyle** * | 1 | 0 |
| **Gerard Enright** (Computer Auditor) | 3 | 2 | **Dr Douglas Fraser** (chair 13.10.10) ** | 1 | 1 |
| **Gail Hird** (Head of Workforce Information) | 3 | 3 | **David Newby** (chair 15.7.10) | 3 | 3 |
| **Lynn Parkinson** (Associate Director – Adult Services) | 3 | 2 | **Dave Shelley** (Head of ICT) | 3 | 3 |
| **Carl Starbuck** (Information and Knowledge Manager) | 3 | 3 | **Matthew Watkins** (IT Services Manager) | 3 | 1 |

* Mike Doyle left the Trust on 30 April 2010.
** Dr Douglas Fraser came into post on 6 September 2010.

*Grace Mangwanya, Public Governor, Leeds East*


*Annual Members Day, 2010*

# Membership

## 7.1 The Constituencies and Eligibility to Join

We have three 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 area 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 four categories: 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 individuals 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 two categories: Staff: Clinical; and Staff: Non-clinical. Any individual who is employed by us under a contract of employment will become a member unless they opt out. In addition to those individuals directly employed by us, people who exercise a function for us may also choose to be a member of the Staff Constituency. There are four Clinical Staff and two Non-clinical Staff seats on the Board of Governors.

## 7.2 Number of Members

Membership has grown steadily to the current figure of **14,466.** 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 and Rothwell | 574 |
| Leeds East | 947 |
| Leeds North East | 1,371 |
| Morley and Outwood | 367 |
| Pudsey | 708 |
| Leeds Central | 2,408 |
| Leeds North West | 1,406 |
| Leeds West | 1,014 |
| Non-Leeds Resident | 1,742 |
| **Total Public Members** | **10,537** |
| **Service User and Carer Constituency** | **Number of Members** |
| Service User Leeds Resident | 462 |
| Service User Non-Leeds Resident | 47 |
| Carer Leeds Resident | 343 |
| Carer Non-Leeds Resident | 63 |
| **Total Service Users and Carer Members** | **915** |
| **Staff Constituency** | **Number of Members** |
| Clinical | 2,225 |
| Non-clinical | 789 |
| **Total Staff Members** | **3,014** |

*Leeds Asian Festival, 2010*

# 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 twelve months, we have undertaken activities with gender, ethnicity and age-specific groups to ensure that the membership continues to be representative. We have also started this year, to collect demographic information around disability and sexual orientation to inform specific work.

We have targeted membership recruitment activities at minority communities through participation in key city events such as the West Indian Carnival and Leeds Pride. We have also targeted a number of student events this year to increase our younger membership.

We continue to support the regular recruitment activities that now underpin our calendar of events. This year we have introduced a twilight member engagement event: "Everything you need to know about…" targeting specifically our public members, people using our services, and their carers.

## 7.4 Membership Recruitment and Engagement

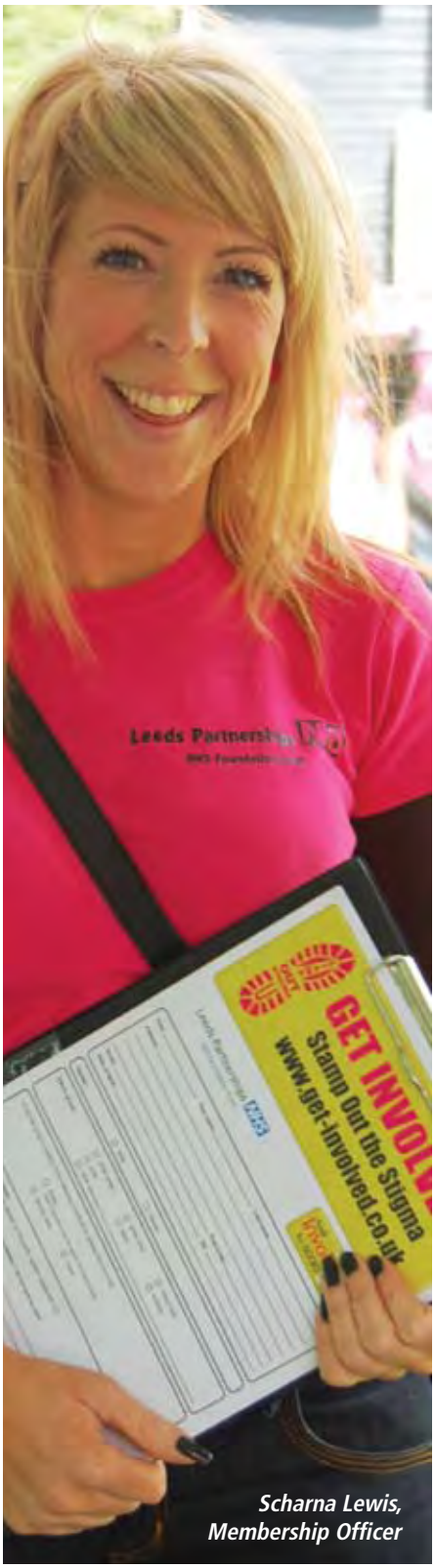
In the past year, we have continued to focus on developing an engaged and involved membership via membership communications, including updates, events, websites and by our highly regarded membership newsletter 'Building New Foundations'.

We have also cemented our working in partnership with our local Time to Change Team and engaged in a number of joint anti-stigma events, which included our Sad Santa Christmas campaign. We have had a successful series of city-wide events including attending Leeds Carnegie Rugby, Leeds United Stewards' training and other Leeds city centre events, all of which 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 plan to develop a further series of exciting membership recruitment and engagement events including road shows, 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 with our governors. The details are 0113 30 55900 or email **ftmembership.lpft@nhs.net**




*Scharna Lewis, Membership Officer*

# 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 2010/11. 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 senior managers are defined as the executive and non-executive directors.

This section also includes a description of the work of the committees that are involved in the appointments of both the executive and non-executive directors, and their respective salaries and remuneration.

The information in Sections 8.2 to 8.5 below is not subject to audit by our external auditors PricewaterhouseCoopers LLP; however, the auditors will read the narrative to ensure that it is consistent with their knowledge of the Trust.

## 8.2 The Appointments and Remuneration Committee (a sub-committee of the Board of Governors)

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

The Appointments and Remuneration Committee is a sub-committee of the Board of Governors. It sets the remuneration and terms of service for the non-executive directors, and it also plays a major role in the appointment of non-executive directors.

### 8.2.1 The Remuneration of Non-executive Directors

The overarching policy for the remuneration of the non-executive directors is to award levels of remuneration in line with other comparable NHS foundation trusts, using benchmarked figures from a number of sources.

### 8.2.2 Annual Percentage Uplift for Non-executive Directors for 2010/11

The policy for awarding annual percentage uplifts to non-executive directors is that the percentage awarded should be in line with that received by Trust staff. For 2010/11 the Board of Governors reviewed the annual uplift for non-executive directors and agreed that due to the prevailing economic climate there should be a zero percentage uplift applied in respect of non-executive directors. This decision was consistent with that taken in respect of executive directors for the period 2010/11.

### 8.2.3 Appointment of Non-executive Directors in 2010/11

In 2010/11 the Board of Governors agreed to change the process for the appointment of all non-executive directors (including those coming up for re-appointment) to an open advertisement process, and the Appointments and Remuneration Committee (along with the Board of Directors' Nominations Committee) was at the forefront of the appointment process for five non-executive directors; Aqila Choudhry, Keith Woodhouse, Niccola Swan, Allan Valks and Dr Gill Taylor.

The appointment of these five non-executive directors completes the non-executive director team. Details of appointment dates and periods for the team are detailed below.

**Table 8A**

| Name | Appointment dates | Period |
|---|---|---|
| Frank Griffiths | 1 April 2010 | 3 years |
| Aqila Choudhry | 18 October 2010 | 3 years |
| Linda Phipps | 1 February 2010 | 3 years |
| Niccola Swan | 1 December 2010 | 2 years |
| Dr Gill Taylor | 2 January 2011 | 3 years |
| Allan Valks | 1 December 2010 | 2 years |
| Keith Woodhouse | 18 October 2010 | 3 years |

The first step in the process for appointing a non-executive director is for the Nominations Committee to define the skills and experience required for the vacancy and to draft a role profile and person specification. The Appointments and Remuneration Committee then considers the role profile and person specification as recommended by the Nominations Committee, and agrees the timetable for the appointment process, which is signed off by the Board of Governors. An interview panel is formed which includes four governors (who are in the majority), the Chairman

# Remuneration Report

*Steve Taylor, Carers Team*

of the Trust (where the interviews are not for the position of Chairman of the Trust) and an independent assessor. The panel will then draw up a shortlist of candidates from the applicants. Any incumbent non-executive director who applies for the post will be guaranteed an interview. The panel will conduct the interviews and make an appointment based on merit. Once the panel has made its choice a recommendation will be made to the Board of Governors whose responsibility is to ratify the appointment.

## 8.2.4 Meetings of the Appointments and Remuneration Committee

The Appointments and Remuneration Committee meets as required. During 2010/11 it met three times. The committee is made up of a majority of governors and is chaired by the Chairman of the Trust. The Senior Independent Director will also attend meetings to act in the capacity of Deputy Chair, but will only attend those meetings where there is no conflict of interest in respect of the matters under discussion. Where either the Chairman of the Trust or the Senior Independent Director are excluded from the discussion the committee will be chaired by a governor. The Appointments and Remuneration Committee receives support and advice from the Director of Human Resources and the Head of Corporate Governance, and it is authorised under its terms of reference to engage external advice where it feels this is appropriate and with approval of the Board of Directors.

The table below shows the number of meetings that were attended by each member.

**Table 8B – The Appointments and Remuneration Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Frank Griffiths (chair) | 3 | 3 | Colin Clark | 3 | 3 |
| Dawn Freshwater * | 2 | 0 | Alec Hudson | 3 | 3 |
| Ron Sweeney * | 2 | 2 | | | |

* Indicates members who stepped down as governors part-way through 2010/11.

## 8.3 The Nominations Committee (a sub-committee of the Board of Governors)

The Nominations Committee is a sub-committee of the Board of Directors. Its role is to identify the skills, knowledge and experience required for vacant Board of Directors' posts for both executive and non-executive directors. Where the vacant post is for a non-executive director the Nominations Committee will work in conjunction with the Board of Governors' Appointments and Remuneration Committee. Where the vacant post is for an executive director the committee will lead on the appointment process.

# Remuneration Report


*Lavender Court*

The Nominations Committee meets as required. The committee is chaired by the Chairman of the Trust. Its membership is made up of the Chief Executive, the Director of Human Resources and two non-executive directors. During the year the committee has advised the Appointments and Remuneration Committee on the appointment of five non-executive director vacancies (as described in Section 8.2.3 above); and has led the process for two executive director vacancies: the Director of Strategy and Partnerships and the Medical Director.

The table below shows the number of meetings attended by each member.

**Table 8C – The Nominations Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Frank Griffiths (chair) | 3 | 3 | Chris Butler | 3 | 3 |
| Catherine Coyle* | 3 | 1 | Stephen Griffin | 3 | 3 |
| Linda Phipps* | 3 | 1 | Niccola Swan* | 1 | 1 |
| Allan Valks* | 1 | 1 | | | |

* Non-executive director representation on the committee is required; however, which non-executive directors actually attend the Committee is based on eligibility (i.e. whether there is a conflict of interest in respect of the matters under discussion) and on availability.

## 8.3.1 Appointment of Executive Directors in 2010/11

In 2010/11 there were two new appointments to the executive director team: the Director of Strategy and Partnerships and the Medical Director. The Remuneration Committee considered the job descriptions and person specifications for each of these posts. Both of these appointments were made through open advertisement. A substantive appointment was made to the position of Director of Strategy and Partnerships to take effect from 1 April 2011. For the Medical Director the interview panel made a decision to appoint Dr Douglas Fraser on a secondment basis for an initial period of one year commencing 6 September 2010.

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

The Remuneration Committee sets the remuneration for the executive directors and determines clinical excellence awards for consultants. This is a sub-committee of the Board of Directors, and is made up 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, Chief Executive who has been

# Remuneration Report

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 has also received advice from Stephen Griffin the Director of Human Resources in relation to employment matters; and from Dr David Newby, Medical Director, in relation to clinical excellence awards for consultants.

The table below shows the number of Remuneration Committee meetings that were attended by each member.

**Table 8D – The Remuneration Committee**

| Name | Number of meetings eligible to attend | Number of meetings attended | Name | Number of meetings eligible to attend | Number of meetings attended |
|---|---|---|---|---|---|
| Frank Griffiths (chair) | 2 | 2 | Aqila Choudhry ** | 1 | 1 |
| Catherine Coyle * | 2 | 1 | Linda Phipps | 2 | 2 |
| Niccola Swan | 2 | 2 | Dr Gill Taylor ** | 0 | 0 |
| Allan Valks | 2 | 2 | Merlin Wilce * | 1 | 1 |
| Keith Woodhouse ** | 1 | 0 | | | |

* Indicates non-executive directors who left the Trust part-way through 2010/11.
** Indicates non-executive directors who joined the Trust part-way through 2010/11.

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 executive directors are permanent, with the exception of Dr Douglas Fraser, the Medical Director, who is seconded to the position for an initial period of 12 months (commencing 6 September 2010); and Stephen Griffin, the Director of Human Resources whose contract is on a short-term basis. The notice periods for executive directors are set out in their employment contracts.

Details of the contract start date for the Chief Executive and other members of the Executive Team are as follows:

**Table 8E**

| Name | Title | Period |
|---|---|---|
| Chris Butler | Chief Executive | 1 January 2005 |
| Jill Copeland | Director of Strategy and Partnerships | 1 April 2011 |
| Dr Douglas Fraser | Medical Director (1 year secondment from) | 6 September 2010 |
| Stephen Griffin | Director of Human Resources | 11 April 2008 |
| Michele Moran | Director of Service Delivery and Chief Nurse | 29 August 2005 |
| Guy Musson | Chief Financial Officer | 7 February 2005 |

*Sandra Izu.Okoro, Practice Development Unit*

# Remuneration Report

## 8.5 Performance and Appraisals

Whilst pay is not linked to 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 of the Trust). These are monitored and appraised through a series of one-to-one meetings which take place at various points in the year.

Appraisals of the non-executive directors are carried out by the Chairman of the Trust; the Senior Independent Director conducts the appraisal of the Chairman of the Trust. The Chairman of the Trust carries out the appraisal of the Chief Executive, and appraisals for executive directors are carried out by the Chief Executive.

The appraisal of individual Board members identifies strengths and good performance, and also areas for development. The appraisal looks at individuals' development needs, which informs tailored Personal Development Plans (PDPs). 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.

## 8.6 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 consider whether the information contained in Sections 8.6.1 is consistent with the financial statements.

Accounting policies for pensions and other retirement benefits are set out in the notes to the Annual Accounts, see Section 10.

Table 8F 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.

*Melissa Briggs, Practice Development Unit*

# Remuneration Report

**Table 8F – Pension Entitlement for Senior Employees**

| Name and Title | Real Increase in pension at age 60 (bands of £2,500) | Real Increase in pension lump sum at age 60 (bands of £2,500) | Total accrued pension at age 60 at 31 March 2010 (bands of £5,000) | Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5,000) | Cash equivalent transfer value at 31 March 2009 £000 | Cash equivalent transfer value at 31 March 2010 £000 | Real Increase in cash equivalent 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 | 35 - 40 | 216 | 232 | 16 | 11 | 0 |
| **Mike Doyle -** Director of Corporate Development | (2.5) - 0 | (2.5) - 0 | 40 - 45 | 125 - 130 | 1,097 | 0 | (1,097) | (768) | 0 |
| **Guy Musson -** Director of Finance and Performance | 0 - 2.5 | 2.5 - 5 | 45 - 50 | 145 - 150 | 1,013 | 956 | (57) | (40) | 0 |
| **Dr David Newby -** Medical Director | 2.5 - 5 | 7.5 - 10 | 65 - 70 | 200 - 205 | 1,442 | 0 | (1,442) | (1,010) | 0 |
| **Dr Douglas Fraser** Medical Director | 15 - 17.5 | 47.5 - 50 | 25 - 30 | 75 - 80 | 0 | 380 | 215 | 151 | 0 |
| **Michele Moran -** Director of Service Delivery and Chief Nurse | 0 - 2.5 | 2.5 - 5 | 35 - 40 | 110 - 115 | 608 | 552 | (56) | (39) | 0 |
| **Jill Copeland -** Director of Strategy and Partnerships | 0 - 2.5 | 2.5 - 5 | 30 - 35 | 95 - 100 | 526 | 489 | (37) | (26) | 0 |
| **Stephen Griffin** Director of Human Resources | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

- Non-executive directors do not receive pensionable remuneration and consequently there are no entries for them in respect of pensions
- Stephen Griffin does not receive pensionable remuneration and consequently there are no entries for him in respect of pensions
- Dr Douglas Fraser started as Medical Director 6 September 2010, and therefore there is no comparison figure for 2009/10
- Decreased values in CETV's is due to the annual increase of public sector pensions changing from the Retail Prices Index (RPI) to the Consumer Prices Index (CPI)

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 8G – Remuneration and Benefits in Kind for Senior Staff**

| Name and Title | 2010 - 11 | | | 2009 - 10 | | |
|---|---|---|---|---|---|---|
| | Salary (bands of £5,000) £000 | Other remuneration (bands of £5,000) £000 | Benefits in kind Rounded up to the nearest £100 | Salary (bands of £5,000) £000 | Other remuneration (bands of £5,000) £000 | Benefits in kind Rounded up to the nearest £100 |
| **Chris Butler -** Chief Executive | 145 - 150 | 5 -10 | 0 | 145 - 150 | 5 -10 | 0 |
| **Mike Doyle -** Director of Corporate Development | 5 -10 | 70 - 75 | 0 | 100 - 105 | 0 - 5 | 2,700 |
| **Guy Musson -** Chief Financial Officer | 105 - 110 | 0 - 5 | 0 | 105 - 110 | 0 - 5 | 0 |
| **Dr David Newby -** Medical Director | 65 - 70 | 15 - 20 | 2,900 | 100 - 105 | 45 - 50 | 5,400 |
| **Dr Douglas Fraser** Medical Director | 50 - 55 | 15 - 20 | 1,700 | 0 | 0 | 0 |
| **Michele Moran -** Director of Service Delivery and Chief Nurse | 105 - 110 | 0 - 5 | 200 | 105 - 110 | 0 - 5 | 0 |
| **Stephen Griffin -** Director of Human Resources | 60 -65 | 0 | 0 | 55 - 60 | 0 - 5 | 0 |
| **Jill Copeland -** Director of Strategy and Partnerships | 110 - 115 | 0 | 0 | 70 - 75 | 0 - 5 | 0 |
| **Frank Griffiths -** Chairman of the Trust | 40 - 45 | 0 | 100 | 0 | 0 | 0 |
| **Merlin Wilce -** Non Executive Director | 0 - 5 | 0 | 100 | 10 - 15 | 0 | 600 |
| **Linda Phipps -** Non Executive Director | 10 - 15 | 0 | 200 | 10 - 15 | 0 | 100 |
| **Nicola Swan -** Non Executive Director | 10 - 15 | 0 | 500 | 10 - 15 | 0 | 700 |
| **Allan Valks -** Non Executive Director | 10 - 15 | 0 | 0 | 10 - 15 | 0 | 0 |
| **Catherine Coyle -** Non Executive Director | 5 - 10 | 0 - 5 | 0 | 10 - 15 | 0 | 0 |
| **Keith Woodhouse** Non Executive Director | 5 - 10 | 0 | 0 | 0 | 0 | 0 |
| **Aqila Choudhry** Non Executive Director | 5 - 10 | 0 | 0 | 0 | 0 | 0 |
| **Gillian Taylor** Non Executive Director | 0 - 5 | 0 | 200 | 0 | 0 | 0 |

- Benefits in kind in respect of the Chairman of the Trust and the non-executive directors relate to the reimbursement of out of pocket expenses incurred whilst on Trust business, and those paid to the executive directors are in respect of the Directors' lease car scheme

- The Director of Human Resources, Steve Griffin, was paid through an agency until 31st January 2011. Steve Griffin started an eleven month temporary contract with the Trust from 1st February 2011. The Salary for this director is as charged to the Trust for the period 1st April 2010 to 31st January 2011 plus Trust salary for the remaining two months. The amount paid to the agency was £56,886; of this amount £972 was reimbursement of travel expenses

- Jill Copeland was on a secondment from NHS Leeds from 1st October 2009 to 31st March 2011. The amount paid to NHS Leeds from 1st April 2010 to 31st March 2011 was £143,555; of this amount £972 was reimbursement of travel expenses

- Mike Doyle, Director of Corporate Development, left the organisation through redundancy on 30th April 2010. Dr David Newby retired as Medical Director on 9th November 2010. His successor, Dr Douglas Fraser, started as Medical Director on 6th September 2010

- The amounts shown as other remuneration for the executive directors include car allowances. The amount paid to Dr David Newby is classified as a bonus. This payment is a National Clinical Excellence Award and is fully funded by NHS Leeds. The amount paid to Dr Douglas Fraser includes the proportion of his salary paid to him for the clinical work he carries out. The amount paid to Mike Doyle includes £70,000 for redundancy payment

**Chris Butler,** Chief Executive,
3 June 2011

*Older Peoples' Consultation, 2010*

# Quality Accounts

## 9.1 The Chief Executive's Statement on Quality

Specialist mental health and learning disability services operate in a complex environment. During the year covered by this Quality Account, working with our governors, we have agreed a new strategy for our Trust. This places health and wellbeing at the heart of what we do from which we have derived a renewed purpose. Put simply this is,

***"Improving health, improving lives".***

What flows from this is our ambition statement,

***"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 is more than professionals doing things to patients. Our task is to help those people who use our services to achieve to the fullest extent possible their life aspirations. These aspirations are not just confined to health but often encompass social care, the need for connectedness to family, friends and the wider community and also meaningful participation in a wider society either at work or in the vocational sphere. This is not to say that treatment and active intervention by professionals is not needed or that it is unimportant. We know that what we do in terms of treatment and intervention is often critical in establishing the right environment for a person's broader aims to be expressed and actualised. In this context we fully accept the responsibility we have for providing safe and effective interventions in people's lives whilst knowing that these are no more than a means by which we help people achieve the broader aspirations that we all have of living life to the full. It is good to see that our broader intent is fully reflected in the Department of Health's Mental Health Strategy, "No Health Without Mental Health" (the Department of Health, 2 February 2011).

It follows from this that for us in 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 about ourselves through understanding 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 actively responding to, people's stories. Also, as a Public Benefit Corporation, with our governors, we are continuing to positively represent the issues faced by people with mental health problems and learning disabilities through media work, actively campaigning against discrimination, by taking our positive, yet challenging, message onto the streets of our city, and by engaging other key interest groups such as leaders in our business community.

In our new strategy we are keen to distinguish between end and means. Why are we keen on this? Put simply it is because that often people confuse what they are trying to do (the ends) with how they are going to do it (the means).

To get more precision on *what* we are here to do and *how* we are going to do it, our ambition statement is underpinned by three strategic end goals. These describe our commitment to excellent quality care in terms of outcomes for the people who use our services. These are that:

- **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**

These strategic end goals will be delivered by us focusing on a small number of means goals which summarise how we are going to do things. These are:

- **We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion**
- **We involve people in planning their care and in improving services**
- **We work with partner organisations to improve health and lives**
- **We value and develop our workforce and those supporting us**
- **We improve our services through learning, research and innovation**
- **We provide efficient and sustainable services**

# Quality Accounts

## We govern our Trust effectively and meet our regulatory requirements

Achieving our ambition, therefore, 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, and to each other, by behaving according to the NHS values:

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

Put simply, our intention is to extend our existing national reputation for providing safe care into the other areas of quality: service user outcomes and experience. Our challenge is to achieve this ambition whilst further driving up productivity and reducing cost. We have plans to do this by, among other things, redesigning how we deliver clinical services. This involves moving away from age related or speciality clinical directorates towards organisational structures designed around care pathways. Our intention is to remove artificial barriers to services based on age, as well as removing duplication and reducing variation which we know adversely impacts on the provision of high quality, safe, and effective services. Our successes 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 through the work of approximately 2,800 members of staff. We operate from 61 sites across the metropolitan district of Leeds and further afield, spending over £125m 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 the staff of Leeds Partnerships NHS Foundation 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.

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,
Leeds Partnerships NHS Foundation Trust
May 2011

*Chris Butler, Chief Executive*

# Quality Accounts

## 9.2 Our Priorities

### Our Trust Strategy

Our Quality Accounts are fully aligned with our 5-year strategy, which sets out our plans for 2010 to 2015. The strategy is designed around the three key elements of quality: effective outcomes, safe care, and positive service user and carer experience. These quality priorities are reflected in the priorities within our Quality Accounts.

Our strategy has at its heart the people who use our services, their families and carers. Development of our strategy was led by our governors, with the support of people who use our services, carers, staff, our main commissioners and partner organisations.

To ensure that our strategy is accessible to the public, we have developed both a summary version and an accessible version, which is designed for people with a learning disability. Our Trust strategy was launched at our first Annual Members' Day, held on 21 September 2010 at Leeds Civic Hall.

To support our ambition and respond to the people who use our services, we have developed three end goals, the quality priorities that we are here to achieve. Our end goals are:

- **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**

For each end goal we have set ourselves some measures of success, some outcomes we want to achieve by 2015 and some milestones to track our progress every year until 2015. In setting standards and milestones we have benchmarked ourselves, wherever possible, against known best performing NHS Trusts.

Our end goals are underpinned by seven means goals, or organisational goals, which state what we must do to achieve our ambitions and end goals. Our seven means goals are as follows:

- **We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion**
- **We involve people in planning their care and in improving services**
- **We work with partner organisations to improve health and lives**
- **We value and develop our workforce and those supporting us**
- **We improve our services through learning, research and innovation**
- **We provide efficient and sustainable services**
- **We govern our Trust effectively and meet our regulatory requirements**

Our governance framework has been designed to support the delivery of our five-year strategy and we have a standing group in place for each means goal. There are clear lines of accountability for the achievement of our strategic end goals and the delivery of our means goals, with the overall delivery of our strategy being overseen by the Means Goal 7 Standing Group. Regular progress reports on our performance against each of the measures are presented to our Board of Directors and Board of Governors, and published on our website **www.leedspft.nhs.uk .**

### Implementation of the Trust Values

The implementation of the NHS Constitution has enabled our Trust to develop and refresh our own values and tailor them to our own needs. The NHS values contained within the NHS Constitution have provided common ground for NHS organisations to achieve shared aspirations across the whole NHS and for the first time in the history of the NHS, what staff, service users and the public can expect from the NHS can be found in the NHS Constitution.

Our Board of Governors and Board of Directors strongly favoured adopting and developing the NHS values set out in the NHS Constitution as the new Trust values, which are intrinsic to the ongoing development of our new five-year Trust strategy. A consultation commenced on 8 March 2011, whereby governors, service users, carers and staff were invited to comment on our new tailored values.

The next stage of the development of the Trust values was to identify how we would expect people to behave in living out each of the values. This was discussed at a further consultation on the 16 March 2011 with governors, service users, carers and staff.

Following these consultations, we now have in place a set of behaviours which demonstrate our new Trust values.

# Quality Accounts

## 9.2.1 Overview of Organisational Effectiveness Initiatives

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

### Trust Strategy

We launched our strategy at our Annual Members Day in September 2010, with our new ambition statement *'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 strategy sets out a clear direction of travel for our Trust, with the Trust Board of Directors agreeing some stretching standards for us to work towards by 2015. Together with our staff, volunteers and partners, we believe we can make a real difference to people's health and lives and, by doing so, give hope for the future to the people who use our services, their families and carers.

### Nursing Strategy

Our nursing team has a defined three-year strategy which contains within it a robust performance framework examining areas such as essence of care benchmarks, focusing upon baseline audits and a medicines management agenda, looking at the reduction of the number of errors through the combination of proactive training and education and a rolling programme of competency based assessment. The strategy is there to assist nurses across the Trust to identify their contribution to the development of services, aligning professional accountability and responsibility with the development of patient and business needs.

### Governance Framework

Implementation of our new Trust governance framework that aims to streamline our governance and operational management structures went live from 1 November 2010. The new framework has a new Audit and Assurance Committee and seven means goal standing groups to support the Executive Team in delivering our new strategy 'Improving health, improving lives'.

### Social Inclusion

We have focused on improving employment outcomes for people using our mental health services by co-locating Leeds Mind employment specialists in our community mental health teams. We have a partnership with the School of Healthcare at the University of Leeds to research what works well in supporting people towards employment. We have vocational leads in clinical teams who meet regularly to share good practice and plan for improvements to employment support.

### Arts and Minds

We worked in partnership with a wide range of partners, such as Trinity Arts, Swarthmore Centre, Leeds College of Music and Yorkshire Dance to improve access to creativity and the arts for people using our mental health and learning disability services. We ran regular networking events for members of the network and held our annual visual art exhibition at The Light, Leeds.

### Diversity

We successfully applied to be a part of the Stonewall Healthy Lives programme and are now focusing efforts on improving the experience of our lesbian, gay and bisexual service users, carers and staff. We have worked closely with Touchstone Community Development Workers throughout the year and are proud of the work we have achieved in inpatient services. A keyring with pictures and symbols for people whose first language is not English has been piloted and is working well.

### Time to Change

We ran activities throughout the year as part of our campaign to shift public attitudes towards mental health in Leeds. This involved participating in a wide range of public events such as Leeds Pride, West Indian Carnival and Light Night. We engaged 32 people with experience of mental health problems in producing a series of short films on the subject of stigma that were premiered at the Leeds International Film Festival. We held a city-centre public event at Christmas to raise awareness of mental health issues over the festive period.

### Involving People

We set up a quarterly 'Building Your Trust' event for our service user, carer and public members to contribute to Trust-wide developments. Events have focused on topics such as development of our Trust values and our Trust strategy. We also established our 'Everything you need to know about…' early evening workshops on specific topics for our public members. Our first session, on the topic of memory loss was very well attended and received a positive evaluation. We are planning more events for 2011/12.

### Communications

We developed new methods to engage and involve our staff in development of our services. These include a monthly online barometer for staff views on particular topics, a 'What our Directors Say' and 'What our Governors Say' briefings and a regular survey of staff views about communications.

### Mental Health Awareness Training

We were successful in attracting funding to deliver mental health awareness training to

# Quality Accounts

public and business sector participants across the city.

### Cognitive Stimulation (Thinking Art Group)

We have developed this in partnership with the peer support network for dementia. The idea is based on a model from the Museum of Moving Art in New York where artefacts were chosen from the museum collection, presented and described by a museum staff member to a group of people with dementia and their carers to allow discussion. The group was a real success in the United States and some evidence was gathered that suggested improved cognition for participants as well as improved engagement and wellbeing.

### Productive Mental Health Ward

Our staff involved with 'The Productive Mental Health Ward: Releasing Time to Care' are changing the way they work in order to improve the effectiveness, safety and reliability of our inpatient services. The Trust hosted an event in December 2010 to share its successes with commissioners and other trusts in the region. Adopting the Productive Mental Health Ward will enable the Trust to compare the performance of its mental health facilities with that of others, learn from the best and make positive improvements for service users.

### Practice Learning Facilitation

We have continuously developed Practice Learning Facilitation which focuses upon the ongoing implementation and monitoring of mentorship arrangements and strategy. This is key in so far as we are a teaching hospital and this work serves the purpose of providing assurance against the Learning Development Agreement supporting our relationship with higher education institutions.

### Leeds Health Star Award

The 'Your Health Matters' project was successful at the 2011 Leeds Health Star Awards, winning the Mental Health and Wellbeing category. The award recognised the work undertaken to help people with learning disabilities take charge of their own health and to reduce the marginalisation of people with learning disabilities from mainstream services. A wide range of work has been done under the Your Health Matters umbrella, with notable examples including the accessible My Yearly Health-check document, which supports the work of our staff and of NHS Leeds in promoting annual health screening by General Practitioners and providing knowledge and skills to support people with learning disabilities to get more from health services.

### Nursing Conference

Over 100 delegates attended the second Annual Conference which covered nursing in the NHS of the future. Keynote speakers and workshops actively developed the context of nursing in the future.

### Physical Health Needs

The Healthy Living Team has developed a Google Maps page which shows services available in Leeds to help promote healthy lifestyles. Regular healthy living group sessions are held to provide advice around physical activity, smoking cessation, healthy eating and alcohol. Over 20 group sessions have been held since May 2010. The Gym Service is continuing to implement a programme of outreach to encourage and assist service users in accessing community based leisure facilities.

*Dawn Freshwater, Nursing Conference, 2010*

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## 9.2.2 How We Have Prioritised our Quality Improvement Initiatives

We set out in our 2009/10 Quality Accounts that our three priorities for quality improvement are consistent with our three strategic end goals and will remain in line with our Trust strategy until 2015.

Therefore our three top priorities for quality improvement remain as:

**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**

Each of these priorities, along with our initiatives for 2011/12, are set out on the following pages.

Progress against our priorities set out in our 2009/10 Quality Accounts are highlighted out on the following pages and were reported to our Board of Directors through the monthly Trust performance report, with each key priority reported upon on a quarterly basis. These are publically available documents and can be viewed on our website **www.leedspft.nhs.uk/about_us/performance .**

Progress against our priorities set out in our 2010/11 Quality Accounts will continue to be reported to the Board of Directors through the monthly performance report. These priorities will also form part of our service directorate and corporate directorate performance reviews.

## 9.2.3 Priority 1 – People Achieve Their Agreed Goals for Improving Health and Improving Lives

### Progress Against 2010/11 Initiatives

**a) 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**

A recovery workshop took place with the Trust Board of Directors in December 2010. A further Board workshop is planned for May 2011. The workshops will result in an audit, key priorities and action plan, which will feed into the Trust's Transformation Project.

The Trusts' Care Programme Approach documentation is currently being reviewed to include goal setting.

**b) The new National Institute for Clinical Excellence (NICE) assurance process will highlight/quantify areas where NICE evidence based interventions can be further implemented**

Our Clinical Guidelines Audit Programme was initiated in 2010. In 2010/11, the following progress was made which led to the first full audit cycle of the major mental health NICE guidelines undertaken in the Trust.

Audits were completed on the following guidelines:

- **Dementia**
- **Schizophrenia**
- **Depression**

Audits were initiated for the following guideline:

- **Anxiety**

Audits are in development for the following guidelines:

- **Bipolar**
- **Antisocial personality disorder**
- **Borderline personality disorder**
- **Violence**

The joint research project with TRiP-LaB is underway, and the research team are currently surveying clinicians' views to determine which factors affect their uptake of guidelines. The next phase of data collection will be a small number of short interviews with staff. The project will then enter the intervention phase, estimated to commence in September 2011, targeting interventions to enhance delivery.

**c) Integrated Care Pathway (ICP) development will specify the interventions that are recommended for specific presentations**

The core pathway has been developed and

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approved for use when developing new Integrated Care Pathways (ICP). As the Transformation Project is now moving to the ICP development phase, all efforts will be directed to the development of needs based ICPs to support the project. ICP development will continue to be monitored.

Training in Integrated Care Pathways (ICP) methodology has been completed in all directorates.

**d) Our electronic health care record (PARIS) will be developed to support Integrated Care Pathways**

ICP development on PARIS will be recommenced in conjunction with the PARIS Standing Support Group.

**e) 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 revised language block was produced in association with Learning Disability Services in May 2010, with a marketing and communication campaign commencing in June 2010. Audits will be undertaken on a quarterly basis.

**f) 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**

The accessible version of the design, following feedback received from consultation with service users, carers and clinicians, has been agreed and developed.

**g) A systemic understanding of outcome measurement will be developed along with systems for implementing this across the organisation**

- **Capability to deliver CORE (Clinical Outcomes in Routine Evaluation) is now live on PARIS (the Trust's electronic care record system) and a Core Net pilot is underway**
- **A Recovery Star pilot is underway, with the tool going live on PARIS in June 2011**
- **TOMs (Therapy Outcome Measures) went live on PARIS within the Learning Disabilities Directorate in January 2011**
- **Exploratory work is underway regarding HoNOS (Health of the Nation Outcome Scales) as an outcome measure. A pilot of this project went live on PARIS in January 2011**

**Initiatives to be Implemented in 2011/12**:

We will continue to develop a systemic understanding of outcome measurement along with systems for implementing this across the organisation.

We will further focus on weight management, nutritional health and smoking cessation to address the national prevalence of coronary heart disease amongst people with mental health and learning disabilities.

We are focusing on embedding recovery principles as we undergo a transformation project to further improve how we deliver services. We will hold a series of workshops and provide reports to our Board of Directors that enable us to assess our current position, set priorities and work towards them. We are involving people who use our services, carers, staff and partner organisations in this exciting project.

We will be delivering training for managers to support mental health and wellbeing in our organisation. We are also developing bespoke training products, in partnership with Community Links to public and commercial organisations to encourage local employers to be positive about mental health.

We will extend the productive series into community services. A pilot is currently being conducted within the Learning Disabilities Directorate. The Productive Series supports NHS teams to redesign and streamline the way they manage and work. This helps achieve significant and lasting improvements – predominately in the extra time given to patients, as well as improving the quality of care delivered whilst reducing costs.

We will undertake further development of the Associate Practitioner Programme within the Higher Education Sector, with the formal employment of this new staff group as a key workforce development contributing to New Ways of Working.

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## 9.2.4 Priority 2 – People Experience Safe Care

### Progress Against 2010/11 Initiatives

**a) 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**

An Audit of Violence Task and Finish Group has been established and is currently undertaking a piece of work on gaining staff experiences of violence and aggression in the workplace. An on-line poll was sent out to all Trust staff and the results are currently being used to form a more detailed staff questionnaire.

**b) 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**

All service directorates have now developed their bespoke training package in line with the agreed CORE (Clinical Outcomes in Routine Evaluation) elements. The delivery of Clinical Risk Training Phase Two has commenced across the Trust.

**c) Benchmarking for Patient Safety with other similar mental health trusts within Yorkshire and the Humber**

The Trust currently benchmarks its safety indicators (with incident reporting trends) against similar Mental Health and Learning Disability providers within the Yorkshire and the Humber region. This data is reported through the Performance Report to the Board of Directors on a six-monthly basis in line with the National Patient Safety Agency report 'How do your patient safety incident reports compare with your peers'?

The Trust, in conjunction with Bradford District Care Trust and South West Yorkshire Partnership NHS Foundation Trust, is looking at developing local benchmarking using process indicators in order to facilitate the sharing of best practice.

**d) Institute for Healthcare Improvement (IHI) data collection and input to enable evidence of practice and improvement**

Six Executive Team walk-arounds have taken place within the Trust. Details of these have been published on the Institute for Healthcare Improvements (IHI) website. Executives regularly visit service areas.

**e) Development of executive safety walk-arounds into quality walk-arounds**

"Quality Walk-Arounds" is a process designed to demonstrate top-level commitment to interaction with front line staff on issues of safety and quality and establishing lines of two way communication about safety and quality among front line staff, executives and managers.

Recommendations have been taken forward by the Trust's Patient Safety Manager. Further discussions are also taking place scoping out the possibility of linking the 'Quality Walk Arounds' with the 'Meet the Boss' programme.

**f) Appointment of Trainee Doctors as Safety Champions**

A Medical Patient Safety Champion was appointed and in conjunction with the Trust's Patient Safety Manager is scoping out future projects relating to policy formation and additional benchmarking to evidence learning.

### Initiatives to be implemented in 2011/12:

A nurse rotation programme proposal has recently been endorsed and is seen as a very creative and innovative approach to developing capable practitioners within nursing. A process of Higher Education Institution accreditation may be linked to this particular programme which will be developed in-house and managed within the nursing team with anything up to 60 staff in the rotation programme at any given time.

Narrowing of the Board to Ward Experience: Rolling out of our 'Quality Walk-Arounds' for Board members. These will take place within inpatient and community settings. Twelve 'Walk-Arounds' will be scheduled for 2011/2012 in collaboration with the 'Meet the Boss' programme.

Review the effectiveness of the current Core Trainee Doctor post in the Patient Safety Champion role in October 2011. Following this review it is anticipated to appoint a Foundation Year Doctor into a second Patient Safety Champion position for Doctors in Training.

Enhanced benchmarking for Patient Safety on a local, regional and national level. This will be undertaken through liaison with other healthcare providers to review local systems and processes within the reporting of patient safety events/issues.

Expansion of proactive patient safety initiatives across the Trust.

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## 9.2.5 Priority 3 – People Have a Positive Experience of Their Care And Support

### Progress Against 2010/11 Initiatives

**a) 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 standardised approach for gathering service user feedback is being implemented across the Trust. This feedback will enable us to measure the extent to which we are achieving our purpose of improving health and improving lives. We are implementing this over the spring and summer 2011.

- **A similar approach for capturing 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**

A web-based questionnaire to gather carer feedback is now operational and is part of the carers section on the Trust's website. Paper copies have also been sent out to inpatient areas and acute community services. In addition, the Carers Team have produced post cards directing carers to further support which also includes opportunities to give feedback on services received.

**b) 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 Building Your Trust events have been well received and further events are booked for the coming year. The March 2011 event included discussions on the recruitment of governors.

The member engagement forums "Everything you need to know about" programme began with a well attended event in January 2011 which focussed on dementia and memory loss. Further events have been scheduled for 2011/12.

The Trust is currently developing a programme of events for member recruitment over the coming months.

**c) The Carers Team will focus on working with governors to further develop carer involvement and deliver a new training programme for people who wish to get involved**

A Carers Involvement Group was established and meets on a bi-monthly basis. The group is supported by carer governors and the Carers Team. A training programme aimed at service users and carers who wish to become involved has been developed.

**d) Continued development of the Trust's intranet site hosting educational literature about dignity and respect**

The nursing intranet website was updated and includes a direct link to the Dignity in Care Network. This provides up to date information and educational literature relating to privacy, dignity and respect.

**e) Continuation of Essence of Care Benchmark implementation with the aim of all areas meeting the minimum A-B criteria**

The Essence of Care Benchmark implementation remains on track with a full service wide audit and action planning completed. Initial data analysis shows a Trust wide improvement towards meeting the A-B criteria. The Essence of Care Steering Group is currently reviewing the new Department of Health Essence of Care Guidance with the addition of the pain benchmark to inform the next audit cycle.

**f) Updating and dissemination of the Trust's Dignity Strategy**

The Trust's Dignity Strategy is under review to take into account findings from national published inspection reports by the Care Quality Commission.

**g) Maintaining Privacy and Dignity awareness via training, education and campaign initiatives**

Maintaining privacy and dignity awareness remains key in all areas, with recent initiatives including:

- **The Dignity Awareness Campaign repeated in December 2010, with plans to run similar events in 2011**

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- **Action plans have been developed as a result of the annual dignity audit of Older Peoples Services**

- **Focus on the privacy and dignity benchmark within Essence of Care and, in particular, the training and education of staff within service areas.**

**Initiatives to be implemented in 2011/12**

Through our Transformation Project we aim to achieve a pathway model of services that eliminates inequity and age discrimination and improves access to services.

We are working with partners across the city to develop an on-line wellbeing hub for people who are interested in mental health issues and want to co-produce information and converse about relevant topics. The hub will be hosted by Leeds Mind.

We are planning a city-wide six week arts and wellbeing festival that will be launched at an evening event on the 27 September 2011. We will deliver the festival in partnership with Yorkshire and Humber Arts Council and we aim to increase access to a huge variety of arts and cultural activity for people using our services.

We have developed a partnership with Leeds Mind to develop a community arts centre in North Leeds. The Arts and Mind network will be based at the site and it will enable more creative activities to take place for people using our services as well as participation from the wider local community.

We will be signing up to the Information Standard to help us assess, deliver and evaluate our information to ensure it consistently achieves a high standard. The Standard has been established to help people make informed choices about their lifestyle, conditions and treatment/care options and by providing a recognised and trusted quality mark that will indicate reliable sources of health and social care information.

## 9.2.6 Information on the Review of Services

During 2010/2011 the Trust provided four NHS services which were:

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

The 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 2010/2011 represents 100% of the total income generated from the provision of NHS services by the Trust for 2010/2011.

## 9.2.7 Participation in Clinical Audits and National Confidential Enquiries

NICE defines clinical audit as "a quality improvement process that seeks to improve patient care and outcomes through the systematic review of care against explicit criteria and the implementation of change". It is important that we have a good understanding about the quality of care and outcomes of care, so that the necessary plans can be made to ensure that we are doing all we can to promote and support the health and well-being of our service users. A comprehensive programme of clinical audit is one way in which this understanding can be achieved. The Trust therefore uses an annual plan to prioritise topics for audit, with the topics being agreed by the different clinician groups as requiring investigation. Clinical audit activity and findings are reported through the clinical governance structure – reaching from ward to board and across care services – so that knowledge is shared and the implementation of change is monitored. In this way we are provided with assurance that service users and staff benefit from this activity.

During 2010/2011 seven national clinical audits and one national confidential enquiry covered NHS services that the Trust provides. It is worthwhile noting that the National Audit of Dementia was specific to the provision of dementia care in acute general hospital settings, therefore did not cover services provided by the Trust.

During 2010/2011 the Trust participated in 86% 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 of the national clinical audits and national confidential enquiries which it was eligible to participate in.

**National Clinical Audits and National Confidential Enquiry:**

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and participated in during 2010/2011 are set out in the table below.

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The national clinical audits and national confidential enquiries that the Trust participated in and for which data collection was completed during 2010/11 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| Audit | Participation | % Cases submitted |
|---|---|---|
| Access to Psychological Therapies Royal College of Psychiatrists National Audit of Psychological Therapies | Yes | Part 1 100%<br>Part 2 65%<br>Part 3 100%<br>Part 4 In progress |
| Schizophrenia Royal College of Psychiatrists National Audit of Schizophrenia (NAS) | No * | N/A |
| Depression and Management of Long-Term Sickness Royal College of Physicians Depression and Long Term Sickness | Yes | 100% |
| Falls and Bone Health (Organisational Module Only) Royal College of Physicians Audit of Falls and Bone Health in Older People | Yes | 100% |
| Topic 7b Lithium Prescribing Observatory for Mental Health (POMH) UK Topics | Yes | 100% |
| Topic 8b Medicines Reconciliation Prescribing Observatory for Mental Health (POMH) UK Topics | Yes | 100% |
| Topic 9b Anti-Psychotics in Learning Prescribing Observatory for Mental Health (POMH) UK Topics | Yes | 100% |
| National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness NCI into Suicide and Homicide by People with Mental Illness | Yes | See Note 1 |

*Participation in the Schizophrenia Royal College of Psychiatrists National Audit of Schizophrenia (NAS) was considered **not appropriate** based on the fact that the project was gathering pilot data only during the Quality Account reporting period. Participation in the full audit scheduled for November 2011 is to be reviewed.

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***Note 1***

It is not possible to provide a percentage figure for cases submitted due to the process used by the National Confidential Inquiry for identification and verification of cases and subsequent data collection. However, it can be confirmed that information is submitted for 100% of cases identified by the National Confidential Inquiry team as potentially meeting their inclusion criteria – between 20-25 cases per annum.

The reports of two national clinical audits were reviewed by the provider in 2010/11 and the Trust intends to take the following actions to improve the quality of healthcare provided:

**Prescribing Observatory Mental Health (POMH) -UK Topic 2e Metabolic side effects of anti-psychotics**

Review of the findings from the national audit highlighted the need to further improve monitoring of anti-psychotic side effects, and it was agreed that (1) monitoring should be routinely discussed with the service user every six months at their Care Programme Approach meeting; (2) Assertive Outreach nurses be trained to take bloods; (3) Pharmacy to deliver an information session on psychotropics and physical health at a General Practitioner Target meeting.

**Prescribing Observatory Mental Health (POMH) -UK Topic 7b Lithium**

Participation in the audit highlighted two service users who had not had lithium testing as recommended, and as a result of the audit the omissions were followed up and rectified.

## Local Clinical Audits

The reports of 15 local clinical audits were reviewed by the provider in 2010/11. The Trust intends to take the following actions to improve the quality of healthcare provided.

**Anti-psychotic use in dementia patients in care homes**

Findings revealed that of 70 people in the audit, 57% in care homes with dementia had a diagnosis of Alzheimer's disease. 40% were prescribed anti-psychotics (the majority being atypical) and 100% were prescribed within British National Formulary limits. Based on the findings the project leads recommend undertaking a large scale study of antipsychotic use.

**Alcohol detoxification at Leeds Addiction Unit**

The project found that the Detox team delivered 96% successful detox with no adverse events, and a low drop-out rate at follow-up (23%). Although the findings did show good adherence to many standards, there was variation in some areas. The team plan to (1) establish the patient's stage of change at assessment; (2) file all blood results once signed by the key worker; and (3) do more motivational work relating to prescription and maintenance of antabuse.

**Electro-Convulsive Therapy (ECT) Service**

Findings revealed that the majority of people (67%) were being treated for severe depression, with twelve being the average number of sessions in a course of treatment. Adherence to standards that apply to Electro-Convulsive Therapy Services was high, with 64% of all areas investigated achieving scores of 90% to 100%. Areas for improvement were highlighted and agreed and it is planned to present the findings to doctors in training in future training sessions, to explore the use of an American Society of Anaesthesiologists (ASA) grading reminder box on the Electro-Convulsive Therapy form, and introducing explanatory notes to remind doctors about the difference between maintenance and continuation therapy.

**Behavioural and Aversive Techniques in Learning Disabilities**

This was a re-audit that reviewed the care regimes of 10 people who have learning disabilities and challenging behaviours. The findings revealed improvements in practice, but there were still areas of inconsistency. It was agreed the following actions be implemented to improve practice and care: (1) increase use of the behavioural plan template; (2) coordinate behaviour plan reviews with Care Programme Approach preparation; and (3) enable staff to attend the Challenging Behaviour Training.

**Driver and Vehicle Licensing Agency (DVLA) Guidelines**

This was a re-audit that showed an improvement in levels of awareness of Driver and Vehicle Licensing Agency guidelines and General Medical Council notification guidelines (up by 36% and 32%), and about revocation of licenses for people with personality disorders. It also appears that more doctors are aware that people with a diagnosis of acute psychotic and isolated manic episodes do not receive a life-time ban from driving. This knowledge could help recovery and rehabilitation for people in their social and occupational lives. The main actions to be taken to further improve practice are: (1) update the FACE (Functional Assessment of Care Environment) risk profile to include driving status; (2) include driving in future teaching sessions on risk assessment.

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### Memory Service referrals and consent

The audit findings revealed that of those notes reviewed 86% of referrals were from General Practitioners, with 52% first seen within two weeks of receipt of referral and 40% of initial assessments taking place within two weeks of receipt of referral. Following referral and assessment 62% went on to receive treatment from the Memory Service. However, results were lower for the completion of carers' needs assessments and establishing capacity. The following actions were agreed: (1) ensure all carers are offered an assessment; (2) ensure timescales between referral and appointment are reduced by setting up a single point of contact with administrative support; (3) standardise the service's approach for ascertaining capacity and consent.

### Mental Health Act (MHA) adherence on Older People's inpatient wards

The audit reviewed health records from both mental health and dementia wards. Findings showed adherence to standards was variable with higher rates of adherence on dementia wards than on mental health wards, especially with regard to Section 132 and Section 17 forms. Also adherence to specific aspects of care planning was lower on mental health wards, eg frequency of reading rights and commencement and end of three-months rule. It has been agreed that actions will be taken to ensure that: (1) nursing care plans reflect current needs; (2) all nursing staff attend an update on management of Mental Health Act documentation.

### Care of People with epilepsy and learning disability

This audit measured clinical practice and service provision against NICE (National Institute for Health and Clinical Excellence) guidelines and found a greater adherence to standards in connection with the care of those people with a more severe learning disability. Further it emerged that the responsibility for care provision should be determined by severity of the epilepsy. The main recommendation from this audit was that the role and input of epilepsy liaison nurses should be reviewed.

### Observation

This was a re-audit of observation and comparison with the previous year's findings showed both a reduction and an improvement in adherence rates. However, this cycle of audit was the first audit of the revised Trust procedure and included many additional areas, the majority of which showed good adherence rates. Each directorate and service reviewed their findings and agreed that the following actions should be taken to improve practice: (1) ensure use of correct terminology; (2) ensure reviews of observation are undertaken and documented as required; (3) ensure the agreed observation recording forms are used; (4) contribute to the review of the Trust's procedural document for observation.

### Learning Disabilities Psychological Therapies referrals

The project aimed to establish the reasons for referral, the service user profile, the staffing required to deliver interventions, and response to referrals. The findings revealed that referrals were most usually made for management of challenging behaviour, and that those referred were principally in the 35-55 age range, fairly evenly distributed between males and females, and predominantly white. 13% of all referrals were for Psychological Therapies, with the majority of referrals coming from another health professional within the directorate.

It was felt that the audit provided a wealth of information on the subject which needed more detailed investigation before making any specific recommendations for change.

### Availability of equipment for physical examinations

This was the first audit of the Trust's procedural document for physical health improvement. Inpatient areas participating in the audit reported having between 67% and 98% of the specified ward/unit equipment available to them, and between 27% and 75% of items of site equipment was available at the sites in the audit. Disposable neurological testing pins and tuning fork were the two items of equipment most frequently cited as not being available on a ward/unit. It was agreed that missing items of equipment were to be purchased and that a further robust process put in place to check availability and test functionality of all equipment.

### NICE (National Institute for Health and Clinical Excellence Guidelines) for Dementia (CG 42)

This audit aimed to establish the baseline position of the Trust in connection with adherence to the NICE guideline for dementia. The Older People's Directorate and Learning Disability Services Directorate participated in the audit, which found that 63% in the sample had structural imaging and 73% had a memory assessment. Results showed an improvement was required in the offering and completion of carer's needs assessments. Care plans showed good adherence to the specifics of the guideline (72% to 90%). The findings enabled areas for improvement to be identified and addressed, with the following actions being planned: (1) add reminder question to dementia assessment regarding offer of carer assessment; (2) consider structural imaging at Best interest meetings in Learning Disabilities to identify those for whom this is applicable; (3) improve the documentation of service user's capacity, (4) ensure assessments and care plans for people with dementia and non-cognitive symptoms include identified factors specified by the guideline.

### Service standards for the Eating Disorders Service

The project aimed to demonstrate that the

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Eating Disorders Service has systems in place to protect vulnerable patients from abuse, in response to six questions outlined by the independent investigation into the conduct of David Britten. The audit identified many areas of good practice as well as areas for improvement and the service has agreed actions to be implemented.

**Physical examinations on admission**

From an initial sample of 125 it was found that 105 had received a physical examination on admission, with 78% of these examinations being conducted within 24 hours of admission. The examination was most usually performed by an on-call doctor and variation was found in the detail of completion of the examination. In order to improve practice it is proposed that the findings from the audit are shared with all medical staff and that the requirements relating to physical examinations on admission form part of induction.

**Record keeping**

One unit within the Trust has undertaken the audit of record keeping on a regular basis as a way of improving practice, and this was the seventh cycle of data collection. The findings showed varying levels of adherence to the twenty-three aspects of record keeping under inspection. The following actions are planned to continue the improvement that has already been achieved through the conduct of this audit: 1) Clinical Team Manager to review areas for improvement with individuals at management supervision; 2) improve organisation of data on shared drive and 3) increase recording on PARIS (the Trust's clinical care record system).

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

The National Confidential Enquiry into Suicide and Homicide by People with Mental Illness was presented at the Trust Clinical Risk Management Group on 31 August 2010.

From this report, the key findings were reviewed and the following recommendations on how these findings can be incorporated into current practice at the Trust were proposed and agreed:

**1.** For current trends to be incorporated into the Clinical Risk Training (phase 2) core modules

**2.** Patient Safety Manager to incorporate the report within the update of the Procedure for Assessing and Managing Clinical Risk, (incorporating the FACE (Functional Assessment of Care Environment) Risk Profile and Risk Assessment Management and Audit System – RAMAS) to ensure best practice

**3.** To review if the Trust's trends on deaths by suicide could be benchmarked to the national trends

## 9.2.8 Participation in Clinical Research

The number of patients receiving NHS services provided or sub-contracted by the Trust from 1 April 2010 to 31 March 2011, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee was 1240, compared to 155 in 2009/10. In 2010/11, two projects accounted for the recruitment of 708 participants and 532 participants were recruited to National Institute for Health Research portfolio studies.

The Trust was involved in conducting 42 clinical research studies in mental health and learning disabilities in 2010/2011. Of these, 19 were National Institute for Health Research (NIHR) adopted studies. This compares favourably with the 37 clinical studies, of which nine were National Institute for Health Research (NIHR) studies conducted during 2009/10 (and 29, of which 10 were National Institute for Health Research (NIHR), in 2008/09). This increasing number of clinical research studies demonstrates the Trust's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff keep abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

We continue to maintain and develop our profile in learning, teaching and research. The new research partnership with South West Yorkshire Partnership NHS Foundation Trust has promoted high quality research in the field of mental health and learning disabilities.

The following research achievements are examples of the Trust's commitment to improving the quality of care we offer:

- **We are the lead site for a research project examining the prevalence and importance of unrecognised bipolar disorder among patients prescribed antidepressant medication in UK General Practice, funded by a research grant from the National Institute for Health Research (NIHR)**
- **258 of our service users completed a survey on their experiences of stigma and discrimination in mental health. This survey is part of a national study being carried**

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out over several years by the Institute of Psychiatry at Kings College London and the Mental Health Charity Rethink. The study is part of the time to change campaign (www.time-to-change.org.uk) whose vision is 'To make lives better for everyone by ending mental health discrimination'

- We continue to engage service users in research design, identifying research priorities, interview panels for research staff, participating in research projects and research governance

- We host the West Yorkshire Comprehensive Local Research Network (WYCLRN) funded posts of Lead Clinician and Clinical Studies Officer working on NIHR projects in mental health. These posts have facilitated an important link with the Mental Health Research Network (MHRN) hub in Newcastle, and provided access and support to Trust staff wishing to engage with Mental Health Research Network (MHRN) supported studies

- Leading to Quality is a research project funded by Yorkshire and the Humber Strategic Health Authority in which we are participating. It is examining the impact of leadership and culture on the effectiveness of teams and the quality of care received by adults who receive mental health services in the community and demonstrates our commitment to clinical research that improves patients' health and lives

- During 2010/2011 we had a minimum of 115 clinical staff participating in mental health and learning disability research approved by a research ethics committee

- In the last three years, seven publications have resulted from our involvement in National Institute for Health Research (NIHR), which shows our commitment to transparency and desire to improve patient outcomes and experiences across the NHS

- We are working in partnership with York University as part of the Leeds, York and Bradford Collaborations for Leadership in Applied Health Research and Care (CLAHRC) to implement the National Institute for Health and Clinical Excellence's (NICE) guideline on core interventions in the treatment and management of schizophrenia to ensure patients experience safe care

- 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

# Quality Accounts

## 9.2.9 Commissioning for Quality and Innovation (CQUIN)

A proportion of the Trust's income in 2010/2011 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 2010/2011 and for the following 12 month period are available online at:

**http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/_openTKFile.php?id=3275**

For the Trust, the monetary total for the amount of income conditional upon achieving quality improvement and innovation goals was £1,476,452. The monetary total for the associated payment in 2010/2011 was £1,476,452

In 2010/11 we were required to participate in regional, local and forensic CQUIN (Commissioning for Quality and Innovation) schemes. Progress against our CQUIN indicators was reported to the Board of Directors on a quarterly basis through our Trust performance report which can be found on our website **www.leedspft.nhs.uk .**

Our Executive Team also received a progress report on a monthly basis. Any risks to performance were identified within the reports and actions in place to improve performance were documented.

In 2011/2012 we will be required to report performance against local CQUIN's, which are in line with our Trust Strategy, and Forensic CQUIN's. These are set out below:

### Local CQUIN's

- **Improving clinical outcomes for people with a learning disability**
- **Improving the service user experience at Care Programme Approach review**
- **Engaging service users in acute adult inpatient settings in structured activity**
- **Reducing the length of stay for older people in inpatient settings**
- **Nutrition- achieving best practice standards as set out in Essence of Care across all inpatient settings**

### Forensic CQUINs

- **Essen Scale - To develop work done during 2010/2011 in regard to the implementation of the ESSEN Scale. A supportive ward atmosphere is recognised as a precondition for successful treatment in forensic psychiatry. The Essen Scale is a valid climate evaluation instrument**
- **Continuation of the use of HoNOS (Health of the Nation Outcome Scales) Secure**
- **Reducing length of stays**
- **25 hours meaningful activity**
- **Involvement, choice and responsibility**
- **Recovery planning**

Details of the above CQUINs (Commissioning for Quality and Innovation) and our performance against them will be reported to the Board of Directors on a quarterly basis and will be available publically through our Trust Performance report which is available on our website **www.leedspft.nhs.uk .**

Plans are in place to ensure that we meet our 2011/2012 CQUINs (Commissioning for Quality and Innovation) and further improve the quality of care for people who use our services.

## 9.2.10 Care Quality Commission

### Registration Status

The Trust is required to register with the Care Quality Commission and its current registration status is fully registered without any conditions.

The Care Quality Commission has not taken enforcement action against the Trust during 2010/2011.

Detailed assessments of compliance are undertaken on a quarterly basis, with sign off from Leads and Lead Directors. Assessments of compliance are reported on a quarterly basis to the Board of Directors via the Trust performance report. From March 2011 compliance with Care Quality Commission Registration formed a key area of the service directorate and corporate directorate performance reviews which are now held in the form of Board workshops.

# Quality Accounts

In order to further strengthen and maintain our position of compliance improvement plans were put in place for each registration regulation and have been monitored on a monthly basis by the Executive Team.

The Trust will continue to ensure that compliance against each registration requirement is monitored and maintained.

### Care Quality Commission Reviews

The Trust has participated in a special review by the Care Quality Commission relating to our Specialised Supported Living Service during 2010/2011.

On the 28 June 2010 our Specialised Supported Living Service received a random inspection by the Care Quality Commission. A random inspection is a short focused review of the service which is undertaken to make sure that the service is providing a good standard of care for those people who use it. The inspection involved the Care Quality Commission visiting service users, speaking to staff and looking at care records.

The Care Quality Commission identified no issues during this inspection visit that could be improved upon and the service was awarded a three star excellent quality rating.

Main findings from the inspection found that:

- **Care plans that were seen were detailed, covered all aspects of peoples individual support needs, were person centred and included individuals in decision making**
- **Risk assessments completed related to specific areas of individual needs and were reviewed regularly**
- **Clear policies and procedures are in place with regard to the administration and management of medications These provide clear guidance and information to staff about their responsibilities**
- **There are robust processes in place to help ensure people using the service are protected from the risks of harm or abuse**
- **The quality of the service continues to be reviewed and improvements are put in place where necessary**


*Chris Butler and carer, Geraldine Foley at the PLUS Carers Event, 2010*

# Quality Accounts

## 9.2.11 Information on the Quality of Data

### NHS Number and General Medical Practice Code validity

The Trust submitted 2,042 records during 2010/11 to the Secondary Uses Service for inclusion in the hospital episodes statistics which are included in the latest published data. The percentage of records in the published data:

- **Which included the patient's valid NHS Number was 99.7% for admitted patient care, 99.6% for outpatient care and 99.3% for all patients as submitted in the mental health minimum dataset**
- **Which included the patients valid General Medical Practice was 99.1% for admitted patient care, 99.6% for outpatient care and 99.1% for all patients as submitted in the mental health minimum dataset**

### Information Governance (IG) Toolkit Attainment Levels

The Trust's Information Governance Assessment Report overall score for 2010/11 was 79.3% and was graded 'green'.

We currently have approximately 97% compliance with Information Governance training for all staff, using the TIGER Essentials training tool. We continue to provide an Information Governance awareness briefing at staff induction for all new starters each month.

We have once again closed the financial year without a reportable Serious Untoward Incident data breach, based on the 'David Nicholson' incident grading scale.

Our commitment to providing a quality service on Freedom of Information Act (FoIA) has resulted in all incoming requests being processed within the statutory timescales, despite a 24% increase in overall FoIA requests over the year in comparison to 2009.

### Statement on Data Quality

The Trust has taken the following actions during 2010/11 to improve data quality:

- **A data quality policy has been approved which provides a framework for data quality assurance in the Trust. This highlights the importance of accurate data both in the provision of care and for corporate accountability. It also clarifies responsibilities**
- **Supporting procedures have been developed and implemented covering data collection and input to PARIS (the Trust's clinical care record system). These promote accurate and timely data collection**
- **Processes have been put in place to electronically trap identifiable data errors when they occur and to ensure that they are corrected**
- **The Data Quality Improvement Project has continued the theme better information, better care and has implemented a range of additional measures to improve quality**

Completeness of data recording continued to improve in 2010/11 with almost all services using the PARIS system. Information is being used for a wider range of purposes reflecting people's further increased confidence in the data.

The Trust will be taking the following actions to improve data quality:

- **During 2011/12 we will continue to ensure that the good practice that has been developed is embedded into everyday working practice throughout the Trust**

### Clinical Coding Error Rate

The Trust was not subject to the Payment by Results clinical coding audit during 2010/11 by the Audit Commission.

# Quality Accounts

## 9.3 Other Information (Including Performance Against National Targets)

### 9.3.1 Our Selected Measures

For each of our strategic end goals and strategic means goals we have set ourselves some measures of success. These measures were developed through wide consultation with staff, service users and carers, the Board of Governors and third party organisations

To ensure our Quality Accounts measures are in line with the strategic direction of the Trust and local quality schemes a review of our 2009/10 Quality Accounts measures took place to ensure that these are aligned with our strategy measures and 2011/12 local CQUIN measures.

The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of healthcare providers' income to the achievement of local quality improvement goals.

A shortlist of our strategy measures were circulated to our Board of Governors who were asked, for each priority, to vote on the measures they wanted including in our 2010/11 Quality Accounts.

Our final measures are set out under each priority on the following pages. The source of the measure demonstrates whether this is one of our strategy measures or one of our 2011/12 local CQUIN measures. Benchmarking data with similar Trusts is included where available.

Progress against our measures set out in our 2009/10 Quality Accounts were reported to our Board of Directors through the monthly Trust performance report, with each key priority reported upon on a quarterly basis. These are publically available documents and can be viewed on our website **www.leedspft.nhs.uk .**

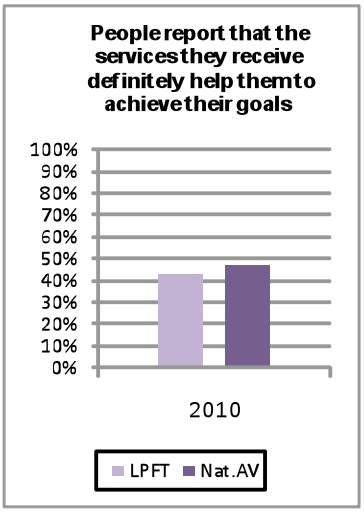
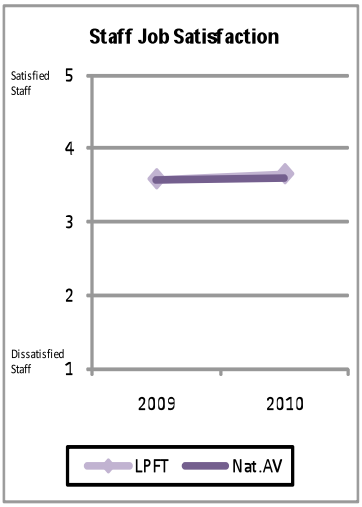
Progress against our measures set out in our 2010/11 Quality Accounts will continue to be reported to the Board of Directors through the monthly performance report. These measures will also form part of our service directorate and corporate directorate performance reviews.

*Michele Moran, Director of Care Services and Chief Nurse, Nursing Conference, 2010*

# Quality Accounts

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

**Performance of the Trust against selected measures**

| Measure | Source | Performance | Comments |
|---|---|---|---|
| **1.** People report that the services they receive definitely help them to achieve their goals<br><br>This question was new in the 2010 Community Service User Survey. | Strategy Measure / National Community Service User Survey |  <br>548 service users from our Trust responded to the 2010 National Community Service User Survey. | 2011 National Community Service User Survey results are due May 2011.<br><br>• This question will be added to our local routine patient experience survey in order to enable us to gather this information on a more frequent basis.<br><br>• We will change our care planning documentation and care programme approach (CPA) training to support the agreement of personal goals and measurement of the extent to which these goals have been achieved.<br><br>• We will use our yearly care plan audits and feedback tools, such as stories of people's experiences, to identify that this approach is working. |
| **2.** Staff job satisfaction | Strategy Measure / National NHS Staff Survey |  <br>Trust score is based on 385 staff who took part in the 2010 National NHS Staff Survey | Survey Software (SNAP) has been purchased to support the collection of staff reported measures. This will allow the Trust to undertake an on-line staff survey on a quarterly basis from April 2011.<br><br>The responses to the quarterly survey will triangulate with responses to the six monthly communications audit, barometer on staff views and any other ad-hoc surveys |

# Quality Accounts

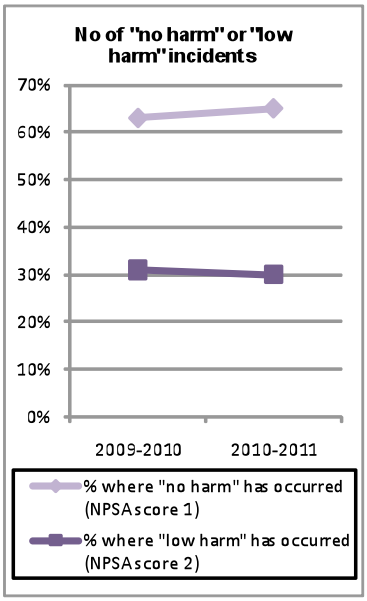
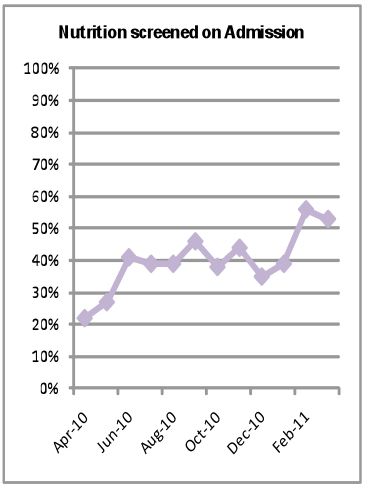
**Priority 1 - Continued**

| Measure | Source | Performance | Comments |
|---|---|---|---|
| **3.** All patients with a learning disability will have their clinical outcomes measured by a validated outcome measurement tool to improve patient care | Strategy Measure / CQUIN | 26 staff undertook the TOMs training tool in December 2010. A training strategy is currently being developed which will make provision for further training.<br><br>The Therapy Outcome Measure (TOM) tool went live in January 2011. To date a total of 28 service users have received the TOMs assessment. | 2011/12 will be the baseline year where the Therapy Outcome Measures (TOMs) tool will be implemented within our Learning Disability Services. The indicator will measure the numbers of staff trained in the tool, the number of patients who received the TOMs assessment and the subsequent outcomes of these assessments. |
| **4.** Reducing length of stay for older people by improving the housing pathway inpatient settings | CQUIN | During 2010/2011 there were 389 inpatients within Older People's Services. 377 of these had a valid recording of housing status (96.9%). | 2011/12 will be the baseline year where a pilot will be scoped out and implemented, working in partnership with other organisations, to reduce the length of stay for people in older adult acute care who experience delays due to housing issues. |
| **5.** Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being | Strategy Measure | A carers questionnaire has been in place since December 2010. Although a lower than expected response rate was received, over half of those responded felt that their own health needs were recognised and that they were supported to maintain their physical, mental and emotional health and well-being. | To actively promote the questionnaire further, postcards have been produced to direct carers to our website and communication has taken place with our services. |

# Quality Accounts

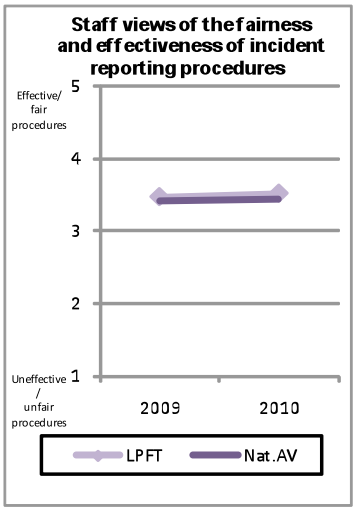
9.3.3 **Priority 2 - People experience safe care**

**Performance of Trust against selected measures:**

| Measure | Source | Performance | Comments |
|---|---|---|---|
| **1.** People who use our services report that they experienced safe care | Strategy Measure | 2011/12 will be the baseline year | This question will be added to our local routine patient experience survey in order to enable us to gather this information on a frequent basis. |
| **2.** Number of 'no harm' or 'low harm' incidents increases as % of total:<br>• % where 'no harm' has occurred (NPSA score 1).<br>• % where 'low harm' has occurred (NPSA score 2). | Strategy Measure / NPSA |  <br>All service user incidents – inpatient & community | We will aim to further reduce the number of incidents where harm has occurred. We will develop and implement an action plan to achieve our aim. |
| **3.** Nutrition - achieving best practice standards as set out in Essence of Care across all inpatient settings<br>• % of service users screened on admission<br>• % of service users screened on discharge<br>• % of service users identified at high risk on discharge with continuing plans in place | Strategy Measure / CQUIN |  <br>Trust wide performance for nutritional screening on admission recorded on Paris is at 53% for March 2011 | The Trust's Nutritional screening tool is now being rolled out Trust-wide.<br><br>Although Trust-wide performance for nutritional screening on admission recorded on Paris is at 53% for March 2011 some services are demonstrating higher performance. For quarter 4 2011/12 Older People's inpatient services performance was at 98.1%.<br><br>2011/12 will be the baseline year for Trust-wide performance to be measured on percentage of service users screened on discharge and percentage of service users identified at high risk on discharge with continuing plans in place. Trajectories will be set in Quarter 1 2011/12. |

# Quality Accounts

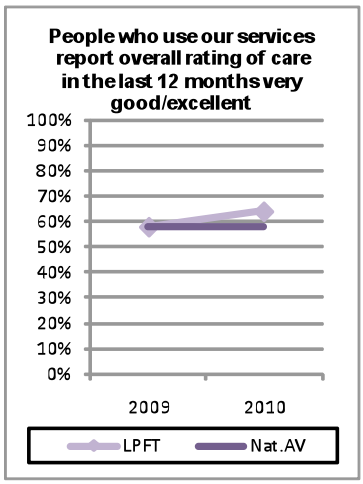
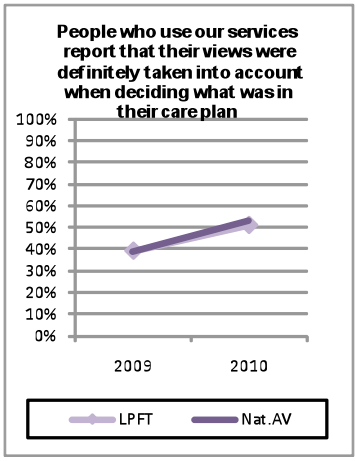
Priority 2 - **Continued**

| Measure | Source | Performance | Comments |
|---|---|---|---|
| **4.** Staff views of the fairness and effectiveness of incident reporting procedures | Strategy Measure / National NHS Staff Survey (2010) |  <br>Trust score is based on 385 staff who took part in the 2010 National NHS Staff Survey | Survey Software (SNAP) has been purchased to support the collection of staff reported measures. This will allow the Trust to undertake an on-line staff survey on a quarterly basis from April 2011.<br><br>The responses to the quarterly survey will triangulate with responses to the six monthly communications audit, barometer on staff views and any other ad-hoc surveys. |
| **5.** Evidence that we meet national guidelines for clinical care and treatment relevant to our Trust within 2 years of publication | Strategy Measure | The Trust will ensure that it is compliant with newly published clinical guidelines within two years of the publication date of the guideline.<br><br>In 2011 the Trust will have achieved this for 95% of newly published clinical guidelines and from 2012 onwards will achieve this for 100% of newly published clinical guidelines. The Trust's annual clinical audit programme includes audits for the eight major mental health guidelines that apply to the Trust and this audit cycle will be the main mechanism for determining compliance. All other guidelines will undergo a baseline assessment to determine compliance at the time of publication and further audit of these guidelines will be undertaken as required. | |

# Quality Accounts

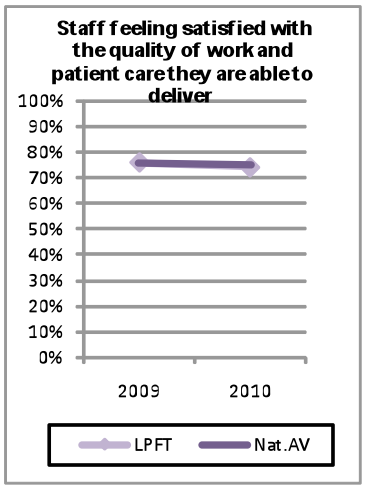
## 9.3.4 Priority 3 - People have a positive experience of their care and support

**Performance of Trust against selected measures:**

| Measure | Source | | Comments |
|---|---|---|---|
| **1.** People who use our services report overall rating of care in the last 12 months very good/ excellent | Strategy Measure / Mental Health Community Service User Survey |  <br>548 service users from our Trust responded to the 2010 national community service user survey. | 2011 service user survey results are due in May 2011<br>• This question will be added to our local routine patient experience survey in order to enable us to gather this information on a more frequent basis.<br>• We will change our care planning documentation and Care Programme Approach (CPA) training to support the agreement of personal goals and measurement of the extent to which these goals have been achieved.<br>• We will use our yearly care plan audits and feedback tools, such as stories of people's experiences, to identify that this approach is working. |
| **2.** People who use our services report that their views were definitely taken into account when deciding what was in their care plan | Strategy Measure / Mental Health Community Service User Survey |  <br>548 service users from our Trust responded to the 2010 national community service user survey. | 2011 service user survey results are due in May 2011<br>• This question will be added to our local routine patient experience survey in order to enable us to gather this information on a more frequent basis.<br>• We will change our care planning documentation and care programme approach (CPA) training to support the agreement of personal goals and measurement of the extent to which these goals have been achieved.<br>• We will use our yearly care plan audits and feedback tools, such as stories of people's experiences, to identify that this approach is working. |

# Quality Accounts

Priority 3 - **Continued**

| Measure | Source | Performance | Comments |
|---|---|---|---|
| **3.** Engaging service users in acute adult inpatient settings in structured activity | CQUIN | 2011/12 will be the baseline year where a programme of structured activity will be further developed in adult inpatient settings. Uptake of structured activity and service user feedback will be gathered and monitored. | A programme will be established in Q1 and implemented during Q2. A report on uptake will be produced in Q3 and a report of patient experience produced in Q4. |
| **4.** Improving the service user experience at Care Programme Approach (CPA) reviews | CQUIN | 2011/12 will be the baseline year where a local questionnaire will be developed by service users and implemented to gather service user feedback on the quality of their CPA reviews. | Findings from the 2010 Service User Community Survey demonstrate that 87% of Trust service users found their care programme approach review helpful. |
| **5.** Staff feeling satisfied with the quality of work and patient care they are able to deliver | Strategy Measure / National NHS Staff Survey (2010) |  <br>Trust score is based on 385 staff who took part in the 2010 National NHS Staff Survey | Survey Software (SNAP) has been purchased to support the collection of staff reported measures. This will allow the Trust to undertake an on-line staff survey on a quarterly basis from April 2011.<br><br>The responses to the quarterly survey will triangulate with responses to the six-monthly communications audit, barometer on staff views and any other ad-hoc surveys. |

# Quality Accounts

## 9.3.5 Performance Against Key National Priorities

### Performance Monitoring

Progress on performance against Monitor requirements, Care Quality Commission registration, our contractual performance requirements with NHS Leeds and our local requirements are presented on a monthly basis to the Board of Directors, through the monthly performance report. Any risks to performance are identified within the report and any necessary actions in place to ensure compliance and improvement are documented. This report is routinely shared with our main commissioners and can be found on our website **www.leedspft.nhs.uk .**

As part of the Trust's performance framework a cycle of Service Directorate performance reviews are in place which provide a detailed focus on performance across each of our four service directorates. These reviews focus on performance against our external regulatory requirements including Monitor targets and Care Quality Commission registration and performance against our internal quality measures including progress against our annual plan objectives and progress against actions plans as a result of national service user survey results. The reviews are led by a panel of executive and non executive directors and are in place to further enhance assurance at a Board level of our Trust performance and quality of our services. The reviews also provide the opportunity for common themes to be identified and for service directorates to showcase their achievements allowing for the sharing and learning of good practice. In March 2011 the service directorate reviews were revised to take place in the form of Board workshops. Corporate directorate performance reviews are also being revised to mirror the format of the service directorate performance reviews.

Our five-year Trust strategy sets out our Trust end goals, our means goals and our stretch quality measures for quality improvement. Progress against the strategy action plan was reported to the Board of Directors in February 2011 through the Performance Report. Progress against measures and milestones will be reported to the Board of Directors on a quarterly basis through the Performance Report.

We have a robust system of clinical governance in place which ensures that clinical services provide evidence-based, quality and safe services. We have robust processes in place for responding to and learning from complaints and serious untoward incidents. All critical incidents are reviewed and lessons learned are disseminated Trust-wide.

### Infection Prevention and Control

We are fully registered with the Care Quality Commission across both our health and social care services for Regulation 12: Cleanliness and Infection Control

The Trust's 2010/11 C.difficile threshold is not to exceed nine new cases of C.difficile infections during the year.

The table below demonstrates that we performed well below the threshold with two new cases of C.difficile infection reported during 2010/11. The figures also demonstrate an improvement since 2009/10. For every C.difficile infection that takes place a full root cause analysis investigation is carried out.

We have clear procedural guidance in place to direct staff with implementing the effective management of service users who are suspected or confirmed of having a C.difficile infection. The monitoring of "Essential Steps" is expected to further raise the Infection Prevention and Control standards across the Trust and reduce further the likelihood of such infections occurring.

Our Infection Prevention Control Team (IPCT) continues to facilitate an increased focus on practice, improving education and assessment standards, as well as a continuing improvement of environmental cleaning.

To date there have been zero cases of MRSA bacteraemia within our Trust. Education around MRSA continues to be provided through hand hygiene training sessions, the Infection Prevention and Control element of our staff induction sessions and our Infection Control Champion meetings.

| Healthcare Associated Infections | 2009/10 | 2010/11 |
|---|---|---|
| Number of cases of MRSA Bacteraemia | 0 | 0 |
| Number of new cases of Clostridium Difficile | 5 | 2 |

### Improving Access

We have maintained a position of compliance throughout 2010/11 with the Monitor targets; admission to inpatient services having access to Crisis Resolution and access to healthcare for people with a learning disability. We also achieved our 2010/11 CQUINs on assessments carried out by our Crisis Resolution team within four hours and the number of non acute adult patients seen within 14 calendar days of referral.

# Quality Accounts

## Safeguarding Adults

The last year has seen the Trust continue to strongly consolidate its place within the multi-agency approach to safeguarding adults in Leeds. The Trust's safeguarding personnel are present at all safeguarding boards and sub-committee meetings and as a result have been influential in the development policy, practice and strategy across Leeds. We have become more effective at recording our own safeguarding data whilst developing better systems and methods of accessing data held nationally and by the local authority on the Electronic Social Care Record (ESCR). This is crucial in ensuring that we are properly responsive when protecting vulnerable people who use our services from abuse or the threat of abuse.

In the coming year the focus of the work programme will be on building on the above while continuing to maintain a robust safeguarding infrastructure within the Trust. The overarching aim is to continue to develop a culture of awareness and knowledge where the abuse of vulnerable adults in all its forms cannot thrive.

## Safeguarding Children

Over the last year, we have appointed a designated Named Nurse for Safeguarding Children who has been involved in link worker development across the Trust. There has been a very strong subscription to mandatory training and other training with respect to child safeguarding within the Trust, as well as consistent procedure and policy development and audit including discharge planning. We have been involved in some serious case reviews and there has been strong adherence to action plans in this area. All of the actions prescribed to the Trust as a consequence of the 2009 Ofsted action plan relating to Ofsted's examination of Leeds Safeguarding Children Services have been adhered to. We are compliant with all of Section 11 (Children's Act 2004) requirements.

We are fully registered with the Care Quality Commission without any conditions with Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) – Safeguarding people who use services from abuse.

## Eliminating Mixed-Sex Accommodation

We are pleased to confirm that we are compliant with the Government's requirement to eliminate mixed-sex accommodation.

Service users admitted to any of our inpatient facilities have their own room and if rooms do not have en-suite facilities then same-sex toilets and same-sex bathrooms are close to their bed areas. The sharing of bathroom facilities with members of the opposite sex will only happen when clinically necessary, for example where patients need specialist equipment such as in our Learning Disabilities Respite Service for people with Complex Multiple Impairment. In our mixed-sex wards female service users have access to female-only areas.

Success in this area will continue to be measured by the Care Quality Commission inpatient survey, our local patient satisfaction surveys, Essence of Care Benchmark Audits, Clinical Governance groups and Board Reports. If our care should fall short of the required standard, we will report it. We will also set up an audit mechanism to make sure that we do not misclassify any of our reports and we will publish the results of the audit quarterly.

*Building Your Trust Event, 2010*

# Quality Accounts

### Patient Environment Action Team Assessment (PEAT)

PEAT is the annual inspection of inpatient units with 10 beds or above covering Environment, Food/Food Hydration, and Privacy and Dignity. The scores for each section are assessed and the results are returned from the National Patient Safety Agency (NPSA). Every Trust is therefore benchmarked and a scored performance obtained. Our independent assessment for the 2010 PEAT scores achieved overall good or excellent standards in all clinical areas. The tables below show our 2009 and 2010 PEAT scores.

| 2010 | | | |
|---|---|---|---|
| **Site Name** | **Environment Score** | **Food Score** | **Privacy & Dignity Score** |
| Aire Court | Excellent | Excellent | Excellent |
| The Mount | Good | Good | Excellent |
| Asket Croft | Good | Good | Excellent |
| St. Mary's Hospital PCT Unit | Excellent | Excellent | Excellent |
| Peel Court | Good | Good | Excellent |
| 1-5 Woodland Square | Good | Good | Excellent |
| Towngate House | Unit closed to in-patients | | |
| Millside CUE | Excellent | Good | Excellent |
| Newsam Centre | Good | Good | Excellent |
| Asket House | Good | Good | Excellent |
| Becklin Centre | Good | Good | Excellent |
| Parkside Lodge | Excellent | Good | Excellent |

| 2009 | | | |
|---|---|---|---|
| **Site Name** | **Environment Score** | **Food Score** | **Privacy & Dignity Score** |
| Aire Court | Good | Excellent | Excellent |
| The Mount | Good | Good | Excellent |
| Asket Croft | Good | Good | Excellent |
| St. Mary's Hospital PCT Unit | Excellent | Excellent | Excellent |
| Peel Court | Acceptable | Good | Excellent |
| 1-5 Woodland Square | Good | Excellent | Excellent |
| Towngate House | Good | Excellent | Excellent |
| Millside CUE | Excellent | Excellent | Excellent |
| Newsam Centre | Good | Good | Excellent |
| Asket House | Good | Good | Good |
| Becklin Centre | Good | Good | Excellent |
| Parkside Lodge | Excellent | Excellent | Excellent |

### Service User and Carer Involvement

As a foundation trust our service users, carers and members are extremely important to us in our review of the way in which we deliver our services and provide patient care. Through a wide range of involvement opportunities we regard our service users as experts through experience. They are the ones who know better than any about the quality of the care and the effectiveness of the interventions that they have received from us. Carers are also considered as vital partners with us, helping to influence the provision of services. Built into our strategy is the need to know that people feel they are listened to and that their opinions are taken seriously and dealt with in a respectful manner. Service users and carers are involved, consulted and encouraged to work in partnership with us across the board through the recruitment of staff, the development of services and policies, and the monitoring of our strategy. Service user and carer members are also encouraged to stand as members of the governing body to provide a steer on how the Trust carries out its business to meet the mental health and learning disability needs of the local community.

Below are some examples of how we involve service users and carers in the Trust:

- **As a result of what service users are telling us, the Trust now uses the Patient Opinion Website for feedback and postings. With a commitment from ourselves that every posting will generate a personal response addressing the issues raised**

# Quality Accounts

- As a result of comments at the 'Your Views' meetings at The Becklin Centre, work has been undertaken to address issues around the temperature of the ward, and visiting times. Daily activities are also influenced by comments received during the 'Your Views' meetings
- The Trust Board of Directors have committed themselves to a development programme which includes listening to people's stories, and Quality Walk-Arounds for members of the Executive Team
- Significant pieces of work have naturally included both service user and carer representation and involvement. Work around integration and transformation have involvement and consultation at their heart
- Service user opinion has been sought throughout all the service re-development within Older People's services
- Our corporate involvement events Building Your Trust and Social Inclusion and Diversity Forum continue to generate feedback. These events are evaluated and the findings are reported regularly in our membership newsletter Building New Foundations
- Our procedures for involvement are being revised in line with our new governance arrangements. An Involvement Leaders Forum will oversee involvement and consultation and ensure that service improvement ideas and feedback are all facilitated appropriately

### NHSLA Risk Management Standards

On 11th February 2010, Det Norske Veritas (DNV) on behalf of the NHS Litigation Authority (NHSLA) conducted a Level 1 assessment of Leeds Partnerships NHS Foundation Trust.

This assessment was based on the *NHSLA Risk Management Standards for Mental Health & Learning Disability Trusts 2009/10.*

The Trust was assessed against five standards each containing ten criteria giving a total of 50 criteria. In order to gain compliance at Level 1 the organisation was required to pass at least 40 of these criteria, with a minimum of seven criteria being passed in each individual standard.

Our Trust score is set out in the table below:

| Standard | 1 Governance | 2 Competent & capable workforce | 3 Safe environment | 4 Clinical Care | 5 Learning from Experience |
|---|---|---|---|---|---|
| Score | 10/10 | 10/10 | 10/10 | 10/10 | 10/10 |

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### Serious Untoward Incidents

Serious Untoward Incidents are investigated using Root Cause Analysis methodology and reports are presented to the Trust Incident Review Group.

Directorates are responsible for monitoring action plans and providing evidence to the Risk Management Team that actions have been implemented.

On a bi-monthly basis the Risk Management Team reviews action plans presented to the Trust Incident Review Group.

## Areas of Good Practice

- **Evidence of Care Programme Approach (CPA) being comprehensively used**
- **Evidence of joint working between Crisis Resolution Home Treatment Team and Community Mental Health Teams (CMHT) prior to service user discharge**
- **Evidence of Community Mental Health Team referrals being dealt with appropriately**
- **Evidence of good communication with families**

## Lessons Learnt

- **Dedicated lead person to be identified following a Serious Untoward Incident to coordinate communication with external parties**
- **When concern is raised by other agencies involved in service users care this should prompt/initiate a review of the Functional Assessment of Care Environment (FACE) risk profile**
- **Flagging up system to alert team members of the non arrival of service users attending Acute Community Services.**

### Monitor Assessments

Monitor is the independent regulator of Foundation Trusts. Using its assessment framework the Trust's overall 2010/2011 performance is shown below along with the

Trust's previous performance for 2009/2010. Prior to 2010/2011 for both annual risk assessment and in-year monitoring, Monitor assigned a risk rating in three areas - finance, governance and mandatory goods and services. From 2010 onwards the provision of mandatory goods and services is included in the governance risk rating.

| 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 |

| Risk ratings | Annual Plan 2010/11 | Quarter 1 2010/11 | Quarter 2 2010/11 | Quarter 3 2010/11 | Quarter 4 2010/11 |
|---|---|---|---|---|---|
| Financial | 4 | 4 | 5 | 5 | 4 |
| Governance | Green | Green | Green | Green | Green |

Plans are in place to ensure ongoing compliance with Monitor requirements.

# Quality Accounts

**Monitor Targets:**

Monitor requires quarterly reporting on the following targets:

| Monitor Target | 2010/11 | Threshold |
|---|---|---|
| Seven day follow up achieved: We must achieve 95% follow up of all discharges under adult mental illness specialities on Care Programme Approach (CPA) (by phone or face-to-face contact) within seven days of discharge from psychiatric inpatient care. | We have maintained a position of compliance throughout 2010/11, with performance above the threshold at 97.2%. | 95% |
| Care Programme Approach (CPA) patients having formal review within 12 months: We must ensure that at least 95% of adult mental health service users on Care Programme Approach (CPA) have had a formal review of their care within the last 12 months. | We have maintained a position of compliance throughout 2010/11<br><br>Quarter 4 figures demonstrate performance remains above the threshold at 97.6%. | 95% |
| Minimising delayed transfers of care: We must achieve no more than 7.5% of delays across the year. Monitor excludes delays attributable to social care. | We have maintained a position of compliance throughout 2010/11.<br><br>Quarter 4 figures demonstrate a cumulative rate of 0.4%. | No more than 7.5% |
| Access to Crisis Resolution: We 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. | We have maintained a position of compliance throughout 2010/11, with performance above the threshold at 96.5% | 90% |
| Data Completeness: Identifiers: We must ensure that 99% of our mental health service users have valid recordings of NHS number, date of birth, postcode, current gender. civil status, registered general practitioner organisational code and commissioner organisational code. | We have maintained a position of compliance throughout 2010/11<br><br>Quarter 4 figures demonstrate performance remains above the threshold at 99.6%. | 99% |
| Data Completeness: Outcomes: We must ensure that 50% of adult mental health service users on Care Programme Approach (CPA) have had at least one Health of the Nation Outcome Scale (HoNOS) assessment in the past 12 months along with valid recordings of employment and accommodation. | Trusts were asked to declare compliance with this target from Quarter 3 2010/11, where our performance was above target at 65%<br><br>Quarter 4 figures demonstrate performance remains above the threshold at 77%. | 50% |
| Access to healthcare for people with a learning disability: We must self certify on a quarterly basis whether we are meeting six criteria based on recommendations set out in Healthcare for All (2008) from 1-4 (with 4 being the highest score) | For the six recommendations five have been assessed as a level '4' (the highest rating) and one at a level '3'. | Not applicable as set out in the Compliance Framework 2010/11 and 2011/12 |

# Quality Accounts

## AA Annex A: Statements from NHS Leeds, Local Involvement Networks and the Overview and Scrutiny Committee

**NHS Leeds statement for Leeds Partnerships Foundation Trust's Quality Accounts 2010/2011**

NHS Leeds is Leeds Partnerships Foundation Trust's largest commissioner of services. Once again we are pleased to be able to review and comment on the 2010/2011 Quality Account.

We have reviewed the Account 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. To support this we have worked with LPFT in establishing a health informatics meeting as a sub group to the activity and finance group to resolve outstanding technical issues relating to information submission and therefore improve the quality of information provided to the PCT.

It is clear that Leeds Partnerships Foundation Trust has continued to improve its standards and quality of care, and its commitment to patient and public involvement is commended. We are also encouraged to read how CQUINs (Commissioning for Quality and Innovation incentives) are embedded in Trust strategy for achieving their goals.

We are pleased to note the continued commitment to improving patient safety and commend the actions taken and initiatives implemented. We would encourage the expansion of Executive Team 'walk-rounds' as proposed and see these as an essential component of the Trust's assurance processes. The direct observation of care by Trust Board members was highlighted as a key quality assurance initiative following publication of the Francis report into standards of care at a large foundation Trust in England.

Although the inclusion of percentages of 'no harm' and 'low harm' incidents is helpful and the reduction of harm as a measure is highlighted, we believe that a focus on reducing serious incidents is also vitally important, as is the appropriate reporting and compliance with serious incident policies. NHS Leeds welcomes the recent development of a joint Quality and Audit meeting which will provide the appropriate forum for the monitoring and development of patient safety initiatives.

NHS Leeds commends the benchmarking of safety indicators with other providers in the region, and notes that LPFT ranks amongst the best. However, NHS Leeds would suggest that the Trust should consider benchmarking of other serious incidents common to mental health providers such as outpatient suicides, to assure themselves and the public that they provide safe and effective care, even to patients outside of the Trust's care facilities. We note that this is mentioned but would welcome a greater focus on this area.

We are pleased to note the Trust's move towards implementation of measurement of outcomes, particularly the Therapy Outcome Measures within Learning Disabilities. NHS Leeds is pleased to support this work through the 2011-12 CQUIN Scheme.

Leeds Partnerships Foundation Trust and NHS Leeds have continued to work positively and collaboratively over the past year and we are confident that the Trust will continue to build on their achievements and perform well in 2011-12, under challenging and changing national circumstances.

**Leeds LINk statement for Leeds Partnerships Foundation Trust's Quality Accounts 2010/2011**

Leeds LINk is the local independent involvement network coordinating the patient voice in health and social care services. We are pleased to have this opportunity to make a statement to be included in Leeds Partnerships NHS Foundation Trust's Quality Accounts for 2010/11.

The values and priorities set out in the accounts complement the work of Leeds LINk and many of them address the concerns of LINk members, for example the end goals of people improving their health and lives; experiencing safe care; and having a positive experience when receiving health and support. We are also pleased that the trust involves people in planning their own care, works in partnership and promotes recovery and inclusion in the way it provides support. We would not expect otherwise from an organisation that is working to improve standards and that has adopted the NHS values wholeheartedly.

# Quality Accounts

The first of these values is respect and dignity, again an ongoing concern for the LINk, and we would like to see more evidence in the accounts that the trust is continuing to uphold Leeds' Dignity in Care standards.

We recognise the importance of the transformation programme within the trust that is beginning to break down barriers to services and is tackling age discrimination. Promoting equality and eliminating discrimination have been at the top of Leeds LINk's agenda since we began, so the trust's anti-stigma campaigning throughout the year has been welcomed by the LINk and we hope it will continue. We also hope that projects around the arts and wellbeing will continue.

The standard of reporting in the Quality Accounts is generally clear, but we would once again encourage the trust to explain complex terminology and to avoid jargon and abbreviations wherever possible.

While the Quality Accounts cover the previous year, when discussing them we were mindful of the challenges ahead in terms of financial constraints, and particularly of the effect that welfare reform will have on people with mental health needs and people with learning disabilities. We are keen to work with Leeds Partnerships Foundation Trust and other partners on any projects that can improve people's financial situation and reduce the stress of financial hardship, and look forward to hearing about work in this area.

By doing this, we hope to build on our good working relationship with Leeds Partnerships Foundation Trust which has already led to improvements for inpatients following an "enter and view" visit by the LINk, and a LINk awareness day at one of the trust's sites, which we will repeat this year. Regular meetings with trust representatives enable us to keep track of the recommendations we make for change, and we understand the trust values our input as a "critical friend".

### Scrutiny Board (Health) statement for Leeds Partnerships Foundation Trust's Quality Accounts 2010/2011

We are grateful for the opportunity to comment on the Trust's quality accounts for 2010/11. However, we note with some concern the earlier timetable introduced by Monitor, which takes no account of local circumstances and coincides with the build up to local elections. The timetable, coupled with competing priorities, has restricted our ability to give any serious consideration to the details provided. As such, we are unable to offer any detailed comments.

## AB Annex B: Feedback From the Board of Governors

On a quarterly basis the Trust Board of Governors receive an integrated performance report which addresses strategic objectives, regulatory and contractual requirements and progress against quality accounts priorities and measures.

The measures contained within the performance report are reflective of the measures contained within the Quality Accounts.

On each occasion, the Board of Governors has confirmed that they are assured that the Trust is meeting all the above requirements.

## AC Annex C: Statement of Directors' Responsibilities in Respect of the Quality Report

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) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- **The content of the Quality Report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2010-2011***
- **The content of the Quality Report is not inconsistent with internal and external sources of information including:**

- Board minutes and papers for the period April 2010 to June 2011;

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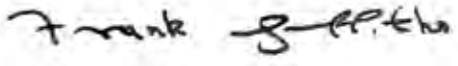
- Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
- Feedback from the commissioners dated 06/05/2011;
- Feedback from the governors dated March 2010 – April 2011
- Feedback from LINks dated 10/05/2011;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2010 – March 2011
- The national patient survey 2010
- The national staff survey 2010
- The Head of Internal Audit's annual opinion over the trust's control environment dated 20/04/2011;
- CQC quality and risk profiles dated September 2010 to March 2011

- **The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;**
- **The performance information reported in the Quality Report is reliable and accurate;**
- **There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;**
- **The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).**

**The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.**

**By order of the Board**



31 May 2011
**Frank Griffiths -** Chairman of The Trust

31 May 2011
**Chris Butler -** Chief Executive

# Quality Accounts

AD

## Annex D: Independent Auditor's Report to the Board of Governors of Leeds Partnerships NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Leeds Partnerships NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of Leeds Partnerships NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

### Scope and Subject Matter

We read the Quality Report for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual, and consider the implication for our report if we become aware of any material omissions.

### Respective Responsibilities of the Directors and Auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and consider whether it is inconsistent with:

- Board minutes for the period April to June 2011
- Papers relating to quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 6 May 2011
- Feedback from governors dated March 2010 – April 2011
- Feedback from LINks dated 10 May 2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Compliant Regulations 2009, dated April 2010 to March 2011
- The National Patient Survey 2010
- The National Staff Survey 2010
- The Head of Internal Audit's opinion over the Trust's controls environment dated 20 April 2011
- CQC quality and risk profiles dated September 2010 to March 2011

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

This report, including the conclusion, has been prepared solely for the Board of Governors of Leeds Partnerships NHS Foundation Trust as a body, to assist the Board of Governors in reporting Leeds Partnerships NHS Foundation Trust's quality agenda, and performance activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Board of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Leeds Partnerships NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

### Assurance Work Performed

We conducted this limited assurance engagement in accordance with International Standards on Assurance Engagements 3000 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report and
- Reading the documents

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

### Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting manual.


PricewaterhouseCoopers LLP
Chartered Accountants
Leeds
3rd June 2011

*Back: Dr Hiroko Akagi, The Leeds & West Yorkshire CFS/ME Service.*
*Front: Sue Stonley and Louise Penny, Yorkshire Centre for Psychological Medicine*

# Annual Accounts

## 10.1 Statement of the Chief Executive's Responsibilities as Accounting Officer

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including 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 NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

Under the NHS 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 cashflows 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 and**
- **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.

**3 June 2011**
**Chris Butler -** Chief Executive

## 10.2 Statement of the Directors' Responsibilities

The directors are required under the NHS 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.

**3 June 2011**
**Chris Butler -** Chief Executive

**3 June 2011**
**Guy Musson -** Chief Financial Officer

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## 10.3 Statement on Internal Control

### Scope of Responsibility

This statement covers the period 1 April 2010 to 31 March 2011.

Leeds Partnerships NHS Foundation Trust's (the Trust) 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.

The Trust forms part of the West Yorkshire health economy. As Accounting Officer I work closely with NHS Leeds who are the main commissioner of the 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 the Trust's staff, in particular the representatives of trade unions constituted as 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. The 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.

### 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 the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised and to manage them efficiently, effectively and economically.

The system of internal control has been in place in the Trust for the year ended 31 March 2011 and up to the date of approval of the annual report and accounts.

### Capacity to Handle Risk

In this period, the 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. Executive directors are designated responsibility for the management of specific Trust risks. At each meeting of the Executive Team, consideration is given to whether there are any new risks which need to be recognised. The assurance framework has been carefully examined to ensure that it takes full account of the Trust's revised strategy, the strategic end goals derived from it and any extreme risks associated with achieving these strategic end goals.

The Trust Incident Review Group, including non-executive director representation, has responsibility for reviewing all serious untoward incidents. A quarterly report is produced for the Trust's Audit and Assurance Committee containing details of Patient Advice and Liaison Service cases, complaints, claims and incidents. On a six-monthly basis the Board of Directors receives information regarding incident trends with regard to unexpected deaths as well as receiving monthly notifications of any Trigger to Board events, if or when they occur.

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 the Trust covering risk management, clinical risk assessment and root cause analysis, overseen by the Trust's Risk Management Department. Health & Safety (e-learning) training which includes a risk management module is mandatory for all staff, with updates every three years. Root cause analysis and report writing training has been delivered to all Lead Investigating Officers with an option of further training if required. Clinical risk assessment training has been developed within the Trust; this includes core modules with the specialist modules available within each clinical directorate. This training is mandatory for all clinicians (identified within the Trust's training needs analysis) with updates required every three years.

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

### The Risk and Control Framework

Risk management is embedded in the organisation through its governance arrangements that span both clinical and

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non-clinical risk. Responsibility for risk management lies with the Trust's Board of Directors. The subject of risk management has been debated in the Audit Committee and the more recent Audit and Assurance Committee, views being taken into consideration regarding the allocation of risks, the way in which they are managed and recorded to ensure both consistency and relevance with the Trust's goals and objectives.

In September 2010, the Trust launched its revised strategy. In the strategy are three strategic end goals. These are:

- **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**

These strategic end goals are supported by seven means goals to ensure their delivery. Each of these seven goals is monitored by specific groups, led by an executive director, which reports to the Trust's Executive Team. The groups are:

| | |
|---|---|
| **Means Goal 1** | We provide excellent quality, evidence based, safe care that promotes recovery and inclusion |
| **Means Goal 2** | We involve people in planning their care and in improving services |
| **Means Goal 3** | We work with partner organisations to improve health and lives |
| **Means Goal 4** | We value and develop our workforce and those supporting us |
| **Means Goal 5** | We improve our services through learning, research and innovation |
| **Means Goal 6** | We provide efficient and sustainable services |
| **Means Goal 7** | We govern our Trust effectively and meet our regulatory requirements |

Since November 2010, when the governance structure of the Trust was reviewed, delivery of goals is undertaken by the executive team and assurance regarding how this is done is overseen by an Audit and Assurance Committee. This committee has discharged the responsibilities of a number of previous sub-committees of the Board of Directors, including the former Risk Management and Governance Committee. During the year a new governance framework was established in the Trust. All non-executive directors, with the exception of the Chairman of the Trust, are members of the Audit and Assurance Committee.

The Executive Team is responsible for the allocation of risk to the various means goals groups. Where deemed appropriate, the Audit and Assurance Committee retains ownership of risks suited to its own responsibilities.

There is a clear and transparent process for bringing new risks to the attention of the relevant risk owner. All risks are assessed and mitigating actions sought where the level of risk is felt to be unacceptable. Where there is a significant risk of not meeting the Trust's objectives, a clear mitigation plan would be required to ensure that the integrity of the Trust's wider objectives is maintained. The Trust recognises that there will be a small number of high level risks that need to be recognised rather than fully mitigated. The risk management process is overseen by the Risk Management Department. The Trust has in place an electronic risk register which captures all extreme and high level risks.

This register applies a comprehensive assessment of risk using variables of impact and likelihood and considers existing controls and the Trust's capacity to manage the risk if it materialised. Extreme risks are reported in summary form to the Board of Directors meeting on a quarterly basis and each meeting of the Executive Team considers which if any new risks ought to be considered. High level risks are managed at clinical or corporate directorate level.

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.

Control measures are in place to ensure that all the organisation's obligations under

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equality, diversity and human rights legislation are complied with.

Data security risks are managed by ensuring that all staff who handle patient identifiable data have the requisite access permissions and have completed their mandatory information governance training. There are procedures for handling requests for the release of such information which are informed by the appropriate legislation. Any enquiries about the potential release of patient identifiable data without informed consent are directed to the Caldicott Guardian.

The data quality policy provides a framework for data quality assurance highlighting the importance of accurate data and clarifying responsibilities. The Trust's assessment report in respect of the Information Governance Toolkit was graded 'green'.

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 the Trust's corporate and service directorates.

Potential future risks include the future potential tariff deflators and withdrawal of funding due to the financial challenges facing the NHS and the wider economy. Assumptions about such risks have been factored in to the Trust's forward financial plans such that a minimum financial risk rating of 3 is maintained over the planning cycle.

The Trust is currently embarking on a transfer of services from NHS North Yorkshire & York, covering York, Selby and Tadcaster and some services which span North Yorkshire & York. Project resources have been put in place to ensure that there is sufficient capacity to cope with the increased burden this brings and due diligence in respect of both quality standards and finance is also being undertaken prior to any final transfer.

Clinical services in the Trust are undergoing a major transformation project over the next two years to ensure care continues to be delivered along appropriate care pathways in a cost effective way. Project management arrangements have been put in place. This transformation is the key part of the sustainable cost improvement plans that will be needed over the medium term.

For services currently provided by the Trust, all major service changes are considered by the Leeds Health Scrutiny Board as well as being considered by the Trust's Board of Governors. Where appropriate major service changes are also subject to broader public consultation.

Evidence that issues specific to equality and diversity has been considered is required before policy decisions are made. Those concerned with the development of policy are required to screen for equality relevance and carry out full impact assessments where potential inequalities are identified. A completed equality impact assessment document is required as part of the governance and ratification processes for all new and revised policies and procedures as detailed in the Trust's Procedure for the Development and Management of Procedural Documents and the Equality Impact Assessment Guidance.

The Trust's risk registers at both a corporate level and at clinical directorate level are underpinned by an assurance framework directly linked to the Trust's strategy.

This provides the Board of Directors with the opportunity to have a consistent oversight of risk and helps the Trust to mitigate risk in an organisation where risks exist hand-in-hand with service developments and ongoing modernisation.

The Trust maintained Risk Management Standards Assessment level 1 during 2010/11.

The Trust remained compliant with the Care Quality Commission (CQC) registration requirements, each core area being reviewed and certified as compliant each quarter by the appropriate executive director.

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

The 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 this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

## Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Annual Plan covering the period 2010/11 – 2012/13 sets out how the vision and objectives of our Trust will be delivered.

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

As an NHS foundation trust, quarterly submissions are despatched to Monitor requiring the Trust's Board of Directors to confirm that our Trust has met all CQC registration requirements and Monitor 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. Using the Monitor finance risk rating assessment, a rating of 4 was achieved at 31 March 2011. Governance remained 'green'.
Service directorate reviews continued to take place, each directorate being reviewed by executive and non-executive directors with particular reference to both the Monitor and

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CQC requirements and also our Trust's strategic objectives. This provides both assurance regarding 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.

The Trust employs Lean and Six Sigma methodology to continually modernise and improve clinical services and this ensures that resources are employed effectively and efficiently. All staff are required to undergo an annual appraisal, part of which is to identify training and development needs to ensure that the clinical workforce remains fit for purpose.

The Trust is fully registered with the CQC without any conditions for both health and social care services. As referenced earlier, detailed assessments of compliance are undertaken on a quarterly basis and signed off by executive directors and subsequently reported to the Board of Directors.

## 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 into the scheme are in accordance with the scheme rules and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

## Annual Quality Accounts

I have drawn on the content of the Quality Accounts contained within this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

The 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.

Our Quality Accounts are fully aligned with our five-year strategy, which sets out our plans for 2010 to 2015. The strategy is designed around the three key elements of quality: effective outcomes, safe care, and positive service user and carer experience. These quality priorities are reflected in the priorities within our quality accounts.

Our strategy has at its heart the people who use our services, their families and carers. Development of our strategy was led by our governors, with the support of people who use our services, carers, staff, our main commissioners and partner organisations.

We set out in our 2009/10 Quality Accounts that our three priorities for quality improvement are consistent with our three strategic end goals and will remain in line with our Trust strategy until 2015.

Therefore, our top three priorities for quality improvement in our 2010/2011 quality accounts remain in line with our three strategic end goals.

For each of our strategic end goals and strategic means goals we have set ourselves some measures of success. These measures were developed through wide consultation with staff, service users and carers, the Trust's Board of Governors and third party organisations.

To ensure our quality accounts measures are in line with the strategic direction of the Trust and local quality schemes it was agreed by the Executive Team that the 2009/10 measures should be reviewed to ensure that these are aligned with our strategy measures and 2011/12 local Commissioning for Quality and Innovation (CQUIN) measures.

In order to ensure that the measures in our Quality Accounts remained measurable and manageable in number it was agreed at our performance sub-group of the Board of Governors that a shortlist of strategy measures would be circulated to the Board of Governors for them to vote on which measures they would most like to see included in our 2010/11 Quality Accounts. A shortlist of our strategy measures was developed by the Trust's Annual Plan Standing Support Group and circulated to the Board of Governors. The measures which received the most votes under each priority were included in our 2010/11 Quality Accounts.

Our final measures are set out under each priority within our Quality Accounts. The source of the measure demonstrates whether this is one of our strategy measures or one of our 2011/12 local CQUIN measures. Benchmarking data with similar Trusts is included where available.

## Development of the 2010/2011 Quality Accounts

A quality accounts 2010/11 delivery cycle is in place, which was approved by the Executive Team. The delivery cycle is based on both Department of Health and Monitor guidance and sets out the processes and timescales for delivery of the 2010/11 Quality Accounts. The delivery cycle was presented to the February meeting of our Audit and Assurance Committee, where the committee reported sufficient assurance on the processes and timescales in place for sign-off of the 2010/11 Quality Accounts.

Monitor's final quality accounts requirements were published in Monitor's annual reporting manual. To ensure that the content of the quality accounts met the requirements set out in the NHS Foundation Trust Annual Reporting Manual the Performance Team, who lead on the quality accounts, identified and allocated

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leads against each requirement and put timescales in place for March 2011 for the collection of data and narrative.

Work continued throughout April and May 2011 to expand, refine and finalise our 2010/11 Quality Accounts to ensure the information included was the most current and accurate. The Executive Team, the Board of Directors and the performance sub-group of the Board of Governors were invited to provide comments to the Performance Team on the Quality Accounts throughout this period.

### Performance Reporting Processes

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

- **Monthly performance reports to the Executive Team and the Board of Directors, which set out performance against external requirements including Monitor targets, CQC Registration Regulations and our contractual requirements with our main commissioner**
- **Quarterly performance reports to the Trust's Board of Governors**
- **Monthly reports to the Executive Team and quarterly reports to the Board of Directors which set out performance against CQUIN requirements**
- **Submissions to the Board of Directors for sign-off on our performance against CQC Registration Regulations**
- **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 Patient Administration and Clinical Information (PARIS) system. The Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into the PARIS system. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in performance reports is both accurate and reliable. A data quality warehouse is utilised to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity. Reports are provided through the data warehouse and these are written and controlled by information analysts who have appropriate testing procedures in place to test and validate data.

The Trust works to the required standards of the Information Governance Toolkit, which includes appropriate standards for data quality including the undertaking of regular audits of data. The Trust is in compliance with the required level 2 standard of the toolkit.

The information analysts work closely with the Performance Team to ensure appropriate performance reports are provided. The Performance Team work closely with directorates to ensure information required for the reporting of measures of performance is collected appropriately and included in performance reports. These reports are reviewed on a regular basis to ensure new items are included such as CQUIN and Monitor updates. Information is supplied within a real-time framework in that the April Board meeting will review data for March. Data quality reports are utilised to ensure data is collected appropriately and reviewed on a regular basis. Performance measures are reported using the appropriate constructs and the Information and Performance Team work closely to ensure any changes to these constructs are taken into consideration. Areas of concern in the collection of data are reported to the appropriate Governance group for resolution with appropriate directorates/teams.

### Third Party Comments

Comments have been received from NHS Leeds and Leeds LINk and included in our Quality Accounts. The Scrutiny Board (Health) were grateful for the opportunity to comment on our Quality Accounts but were unable to offer any detailed comments due to the national timescales and competing priorities.

### Board Sign-off of the Final Quality Accounts

Our final draft version of our Quality Accounts was presented to our Board of Directors on the 3 June 2011. The Board of Directors reported assurance that the Quality Accounts are accurate, consistent with internal and external sources of information and present a balanced picture of the Trust's performance.

To ensure that our Quality Accounts are accessible to the public we will be developing an 'easy on the i' version which will be published on our website along with the full version of our Quality Accounts.

### Monitoring of Quality Accounts Initiatives and Measures

Progress against our 2009/10 Quality Accounts initiatives and measures were reported to the Board of Directors through the monthly performance report. Each key priority was reported upon on a quarterly basis.

Progress against our initiatives and measures set out in our 2010/11 Quality Accounts

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will continue to be reported to the Board of Directors through the monthly performance report. These measures will also form part of our service directorate and corporate directorate performance reviews.

A mid-year review of progress against our Quality Accounts will also be undertaken and will be reviewed by the Audit and Assurance Committee.

### Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, the Audit and Assurance Committee and plans to address weaknesses and ensure continuous improvement of the system is in place. In addition, the Board of Directors, the Audit and Assurance Committee and the Board of Governors carry out an annual review of their own 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 Audit and Assurance 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.

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

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

As well as providing audit scrutiny of the annual financial statements, the 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 was achieved through various governance committees, up to November 2010 when the Audit and Assurance Committee took on the responsibilities of the Risk Management and Governance Committee, the Resources Committee and the Information Management and Technology Governance Committee.

Up to November 2010, the Resources Committee of the Board of Directors continued to ensure that plans for services, workforce, finance and estate were integrated and provided good value. The Information Management and Technology supported necessary control mechanisms throughout our Trust. The committees continued to meet at intervals until November 2010, when all these committees were subsumed into the Audit and Assurance Committee. Minutes and reports from the committees were received by both the Audit Committee and the Board of Directors for that period. From November 2010 the minutes of the Audit and Assurance Committee have been received by the Board of Directors.

The executive directors have personal responsibility for particular aspects of internal control within their individual portfolios. They also have a lead responsibility for delivery of means goals group objectives, each covering other functional areas.

Internal Audit reviews the system of internal control on an ongoing basis. The Internal Audit Plan is derived from an assessment of risk areas within the 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.

I have drawn on the content of the Quality Accounts within this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

In conclusion, during the year we have continued to refine our systems of internal control, however, no significant control issues were identified.

**3 June 2011**

**Chris Butler -** Chief Executive

# Annual Accounts

## 10.4 Independent Auditors' Report to the Board of Governors of Leeds Partnerships NHS Foundation Trust

We have audited the financial statements of Leeds Partnerships NHS Foundation Trust for the year ended 31 March 2011, which comprises 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 the Independent Regulator of NHS Foundation Trust's ("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 and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (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 save where expressly agreed by our prior consent in writing.

### Scope of the Audit of the Financial Statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatements, 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 overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications in our report.

### 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 2011 and of its income and expenditure and cash flows for the year then ended to 31 March 2011**
- **Have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual**

### Opinion on Other Matters

In our opinion

- **The part of the Director's Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual**
- **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 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 with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Accounting Officer's Statement on Internal**

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**Control addresses all risks and controls or that risks are satisfactorily addressed by internal controls**

- **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**
- **We have qualified our report on any aspects of the quality report**

### Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of 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

**3 June 2011**

### Notes:

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 matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they 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 £51,185 in the period 2010/11.

PricewaterhouseCoopers LLP also carried out an audit of the Quality Accounts in accordance with Monitor's requirements and the cost of providing this service was £20,643.

Independence in respect of these two areas of work was maintained by the Trust having in place two separate Letters of Engagement, one for each piece of work. These outlined the process and the outcomes for each area of work and had two separate fee structures.

## 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).

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| STATEMENT OF COMPREHENSIVE INCOME | NOTE | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|---|
| Operating Income | 3 & 4 | 127,193 | 122,990 |
| Operating Expenses | 5 | (119,474) | (118,206) |
| **OPERATING SURPLUS** | | **7,719** | **4,784** |
| **FINANCE COSTS** | | | |
| Finance income | 10 | 231 | 198 |
| Finance expense - financial liabilities | 12 | (4,016) | (3,876) |
| Finance expense - unwinding of discount on provisions | 25 | (47) | (32) |
| PDC Dividends payable | | (270) | (342) |
| **NET FINANCE COSTS** | | **(4,102)** | **(4,052)** |
| **Surplus from operations** | | 3,617 | 732 |
| **SURPLUS FOR THE YEAR** | | **3,617** | **732** |
| **Other comprehensive income** | | | |
| Revaluation gains/(losses) and impairment losses on intangible assets | | 125 | 114 |
| Revaluation gains/(losses) and impairment losses property, plant and equipment | | 430 | (1,684) |
| Reclassification adjustments:- | | | |
| Transfer from donated asset reserve in respect of depreciation on donated assets | | (2) | (2) |
| **TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR** | | **4,170** | **(840)** |

'The notes on pages 126 to 161 form part of this account.

# Annual Accounts

| STATEMENT OF FINANCIAL POSITION AS AT 31 March 2011 | NOTE | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 13.1 | 437 | 285 |
| Property, plant and equipment | 14.1 | 53,236 | 51,765 |
| Trade and other receivables | 17 | 2,801 | 2,567 |
| **Total non-current assets** | | 56,474 | 54,617 |
| **Current assets** | | | |
| Inventories | 16 | 80 | 52 |
| Trade and other receivables | 17 | 3,677 | 4,563 |
| Non-current assets for sale and assets in disposal groups | 19 | | 337 |
| Cash and cash equivalents | 18 | 21,888 | 17,444 |
| **Total current assets** | | 25,645 | 22,396 |
| **Current liabilities** | | | |
| Trade and other payables | 20 | (11,110) | (10,270) |
| Borrowings | 21 | (1,140) | (1,037) |
| Provisions | 25 | (358) | (878) |
| Other liabilities | 22 | (5,349) | (2,141) |
| **Total current liabilities** | | (17,957) | (14,326) |
| **Total assets less current liabilities** | | **64,162** | **62,687** |
| **Non-current liabilities** | | | |
| Borrowings | 21 | (33,482) | (34,622) |
| Provisions | 25 | (1,468) | (1,957) |
| Other liabilities | 22 | | (1,066) |
| **Total non-current liabilities** | | **(34,950)** | **(37,645)** |
| **Total assets employed** | | **29,212** | **25,042** |
| **Financed by (taxpayers' equity)** | | | |
| Public Dividend Capital | | 19,509 | 19,509 |
| Revaluation reserve | | 6,644 | 6,496 |
| Donated Asset Reserve | | 26 | 28 |
| Other reserves | | (651) | (651) |
| Income and expenditure reserve | | 3,684 | (340) |
| **Total taxpayers' equity** | | **29,212** | **25,042** |

The notes on pages 126 to 161 form part of this account.

The financial statements on pages 122 to 161 were approved by the Board on 3rd June 2011 and signed on its behalf by:

Signed: ..... (Chief Executive)

Date: 3/ 6 / 11

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| 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 2010 - as previously stated | 19,509 | 6,496 | 26 | (651) | (330) | 25,052 |
| Prior period adjustment * | | | | | (10) | (10) |
| Taxpayers' Equity at 1 April 2010 - restated | 19,509 | 6,496 | 28 | (651) | (340) | 25,042 |
| Surplus for the year | | | | | 3,617 | 3,617 |
| Revaluation gains and impairment losses on intangible assets | | 125 | | | | 125 |
| Revaluation gains and impairment losses property, plant and equipment | | 430 | | | | 430 |
| 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 | | | (2) | | | (2) |
| Transfers to the income and expenditure account in respect of assets disposed of | | (214) | | | 214 | |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve | | (193) | | | 193 | |
| **Movement in year subtotal** | | **148** | **(2)** | | **4,024** | **4,170** |
| Taxpayers' Equity at 31 March 2011 | 19,509 | 6,644 | 28 | (651) | 3,684 | 29,212 |

| 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 | | | | | | |
| Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of on donated assets | | | (2) | | | (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 |

* the prior period adjustment has resulted from a change in IAS 17. Land leases are now no longer assumed to be operating leases.

**Description of Reserves:**

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

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

**c)** The Donated Asset Reserve is used to record transactions in respect of donated assets and is operated so as to ensure that there is no net cost or credit recognised in the foundation trust's surplus/deficit for the year. At all times, the balance on the donated asset reserve matches the carrying value of the foundation trust's donated assets.

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

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

The notes on pages 126 to 161 form part of this account.

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| STATEMENT OF CASH FLOWS | NOTE | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|---|
| **Cash flows from operating activities** | | | |
| Operating surplus/(deficit) from continuing operations | | 7,719 | 4,784 |
| **Operating surplus/(deficit)** | | **7,719** | **4,784** |
| **Non-cash income and expense:** | | | |
| Depreciation and amortisation | 5 | 3,377 | 3,117 |
| Impairments and reversals | 14.3 | 174 | 942 |
| (Increase)/Decrease in Trade and Other Receivables | 17 | 684 | (1,040) |
| Transfer from donated asset reserve for depreciation on donated assets | | (2) | |
| Increase/(Decrease) in provision for doubtful debts | | | |
| (Increase)/Decrease in Inventories | 16 | (28) | 13 |
| Increase/(Decrease) in Trade and Other Payables | 20 | 248 | (5) |
| Increase/(Decrease) in Other Liabilities | 22 | 2,142 | 100 |
| Increase/(Decrease) in Provisions | 25 | (1,056) | (82) |
| (Increase)/Decrease in Other Assets | 19 | 337 | |
| Other movements in operating cash flows | | 17 | 910 |
| **NET CASH GENERATED FROM/(USED IN) OPERATIONS** | | **13,612** | 8,739 |
| **Cash flows from investing activities** | | | |
| Interest received | 10 | 215 | 187 |
| Purchase of intangible assets | 13.1 | (188) | (119) |
| Purchase of Property, Plant and Equipment | 14 | (3,874) | (2,710) |
| Sales of Property, Plant and Equipment | | 18 | |
| **Net cash generated from/(used in) investing activities** | | **(3,829)** | **(2,642)** |
| **Cash flows from financing activities** | | | |
| Capital element of finance lease rental payments | 21 | (122) | (98) |
| Capital element of Private Finance Initiative Obligations | 21 | (915) | (844) |
| Interest element of finance lease | 12 | (347) | (354) |
| Interest element of Private Finance Initiative obligations | 12 | (3,669) | (3,522) |
| PDC Dividend paid | | (286) | (374) |
| Cash flows from (used in) other financing activities | | | 12 |
| **Net cash generated from/(used in) financing activities** | | **(5,339)** | **(5,180)** |
| **Increase/(decrease) in cash and cash equivalents** | | 4,444 | 917 |
| **Cash and Cash equivalents at 1 April** | | 17,444 | **16,527** |
| **Cash and Cash equivalents at 31 March** | | **21,888** | **17,444** |

For 2009/10 Other movements in operating cash flows include £909k relating to the demolition of Maple House.
The notes on pages 126 to 161 form part of this account.

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## 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 2010/2011 NHS Foundation Trust ARM issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), (in accordance with EU endorsed IFRS and IFRIC) and HM Treasury's Financial Reporting Manual 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

The accounts have been prepared under the historical cost convention modified to account for the revaluation of Property, Plant and Equipment, Intangible assets, inventories and certain financial assets and liabilities. For specialised operational property the modern equivalent asset valuation method has been used.

## 1.2 Segmental Reporting

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

## 1.3 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.

## 1.4 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 year.

## 1.5.1 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.

The scheme is not designed to be run in a way that would allow Leeds Partnerships NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as if it was 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 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**

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

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay

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and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

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

### b) Accounting valuation

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

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

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

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the NHS Pensions website. Copies can also be obtained from The Stationery Office. These accounts will also include information on principle actuarial assumptions used and a reconciliation of the present value of the pension obligation between the beginning and the end of the year for the plan as a whole. This information is not included in these accounts due to the timing of production.

### c) Scheme provisions

In 2010-11 the NHS Pension Scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

#### Annual Pensions

The 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 were based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2010/11, the increases are based on changes in the consumer price index in the twelve months ending 30th 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.

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**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.

## 1.5.2 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.

## 1.6 Property, plant and equipment

## 1.6.1 Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the 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 if any of the following apply
- the item has cost of at least £5,000 or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control or
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost

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.

A prior period adjustment has been applied due to a change in IAS 17. Land leases are now no longer automatically assumed to be operating leases.

## 1.6.2 Measurement

**Valuation**
All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. 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 – depreciated replacement cost based on providing a modern equivalent asset
- Non-operational land and buildings – fair value based on alternative use

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A valuation was last undertaken as at 31 March 2011.

Non-property assets were last indexed using the latest available Consumer Price Indices,

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being for January 2011, as issued by the Office for National Statistics.

### 1.6.3 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. The carrying amount of the part replaced is de-recognised.

### 1.6.4 Depreciation

Items of Property, Plant and Equipment are depreciated, using the straight line method, over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.
Freehold land is considered to have an indefinite life and is not depreciated.

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

The useful economic lives of 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.

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

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

Property, plant and equipment that has been reclassified as 'held for sale' ceases to be depreciated following reclassification.

Assets in the course of construction are not depreciated until the asset is brought into use.

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

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

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

## 1.6.5 Revaluation and Impairment

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

Impairments that arise from a clear consumption of economic benefit are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the I&E reserve for the amount of the impairment (or the remaining balance in the revaluation reserve relating to the asset if this is a lower amount).

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

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

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

## 1.6.6 Non-current assets held for sale

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

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- **the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales**
- **the sale must be highly probable i.e.: management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it**

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

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

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

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

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## 1.6.7 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, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments, other than those caused by a loss of economic benefits, are also taken to the donated asset reserve. 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.

## 1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FREM, are accounted for as 'on-Statement of Financial position' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with 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 fair value of service received in the year is recorded under the relevant expenditure heading within 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 cost.

The minimum lease payments of the finance lease component are split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each year is then calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in Finance Costs in the Statement of Comprehensive Income.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with 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 built on, 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.

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, 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

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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).

## 1.8 Intangible Assets

### 1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. The Trust holds software licences as Intangible assets. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Purchased computer software licences are capitalised as intangible 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.

### 1.8.2 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."**

**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, Leeds partnerships NHS Foundation Trust discloses 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**

### 1.8.3 Measurement

Revaluations and impairments of intangible assets are recognised and accounted for in the same manner as that for property, plant and equipment.
Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

### 1.8.4 Amortisation

Intangible assets are amortised on a straight

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line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is recognised in the Statement of Comprehensive Income.

## 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in- first out cost formula. Inventories are identified in Note 16.

## 1.10 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 recorded at the current values of these balances in the NHS Foundation Trust's cash book. These balances exclude monies held in the Leeds Partnerships NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Interest earned on bank accounts is recorded as "interest receivable" in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

## 1.11 Provisions

Leeds Partnerships 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, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 2.9% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recorded as an asset if it is virtually certain that reimbursement will be received and the amount of the receivable can be measured reliably.

### Clinical negligence costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over 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. 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 25.

### 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 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

## 1.13 Value added Tax

Most of the activities of Leeds Partnerships NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

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## 1.14 Corporation Tax

Leeds Partnerships NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disapplied, the foundation trust has no corporation tax liability.

## 1.15 Foreign Exchange

The functional and presentational 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 Leeds Partnerships NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts, note 29, 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 Leeds Partnerships NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding 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 implicit rate is that which discounts the minimum lease payments and any unguaranteed residual interest to the fair value of the asset at the inception of the lease.

The asset and liability are recognised as Property, Plant and Equipment at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires.
The annual rental is split over the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each financial year is then calculated by applying this finance rate to the opening lease liability for the financial year. The Finance Cost is recognised in Finance Costs in the Statement of Comprehensive Income.

Contingent rentals are recognised as an expense in the period in which they are incurred. The liability is derecognised when the liability is discharged, cancelled or expires.

### Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Contingent rentals are recognised as an expense in the period in which they are incurred

### Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land, in the PFI, is treated as an operating lease.

### 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.

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.

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HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by Leeds Partnerships NHS Foundation Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General, the Government Banking Service and PDC payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

In accordance with the requirements laid down by the Secretary of State (as the issuer of PDC) the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the financial statements. The dividend is not revised should any adjustment to net assets occur as a result of the audit of the financial statements.

## 1.19 Losses and Special Payments

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

Losses and Special Payments are charged to the relevant functional headings in the 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 31 is compiled directly from the losses and compensations register which is prepared, as per the FT ARM, on an accruals basis.

## 1.20 Financial Instruments and financial liabilities

### Recognition

Financial assets and financial liabilities which arise from contracts for the purchase and sale of non-financial items (such as goods or services), which are entered into in accordance with Leeds Partnerships 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.
Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policies for leases.

All other financial assets and financial liabilities are recognised when the foundation trust becomes a party to the contractual provisions of the instrument.

### Derecognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or Leeds Partnerships 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.

Leeds Partnerships NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS receivables and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of 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, Leeds Partnerships NHS Foundation Trust assesses whether any financial assets, other

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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.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as non-current liabilities. Interest for each financial year is calculated by applying the effective interest rate to the opening carrying amount of the liability. The interest cost is recognised in Finance Costs in the Statement of Comprehensive Income.

## 1.21 Accounting standards that have been issued but have not yet been adopted

### a) IASB standard and IFRIC interpretations

The following accounting standards have been issued but have not yet been adopted. The foundation trust cannot adopt new standards unless they have been adopted in the FT ARM issued by Monitor. The FT ARM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies. In some cases, the standards may be interpreted in the FT ARM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation and the likely impact on the assumption that no interpretations are applied by the FT ARM.

#### i. IFRS 7 – Financial Instruments: Disclosures

This is an amendment to the standard to require additional disclosures where financial assets are transferred 2011/12. The change should not have any significant impact on the foundation trust because its generally does not transfer financial assets between categories.

#### ii. IFRS 9 – Financial Instruments

This is a new standard to replace – eventually – IAS 39 Financial Instruments: Recognition and Measurement. Two elements of the standard have been issued so far: Financial Assets and Financial Liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two; Amortised Cost and 'Fair Value through Profit and Loss". At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

#### iii. IAS 24 (Revised) – Related Party Disclosures

This new standard seeks to reduce the extent of disclosures required by government entities whose transactions are principally with other government entities. It is due for adoption in 2011/12. This may potentially relieve the foundation trust from providing some of its related party disclosures with other entities within the Whole of Government Accounts boundary, unless Monitor chooses to adapt the standard in the FT ARM to retain the existing disclosures.

#### iv. IASB Annual Improvements 2010

The document makes minor changes to 6 standards and one IFRIC Interpretation. Two of the standards amended (IFRS 1 and IAS 34) do not apply to foundation trusts. The IFRIC Interpretation amended (13) is not relevant to foundation trusts. The remaining changes are to IAS1 and IAS27 and IFRS 3 and IFRS7. These changes are minor in nature and should have little or no impact for Leeds Partnerships NHS Foundation Trust.

#### v. IFRIC 14 – IAS 19 – The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction

This is an amendment to the IFRIC that applies from 2011/12. There should be no immediate impact for Leeds Partnerships NHS Foundation Trust because its LGPS defined benefit scheme is in deficit rather than in surplus and therefore Leeds Partnerships NHS Foundation Trust recognises a pension liability rather than a pension asset.

#### vi. IFRIC 19 – Extinguishing financial liabilities with equity instruments

This new IFRIC applies from 2011/12 but will have no impact because Leeds Partnerships NHS Foundation Trust has no equity instruments and therefore cannot issue them to settle financial liabilities.

### b) Government Financial Reporting Manual (FReM) changes

In preparing the FT ARM, Monitor must take account of the requirements of the Government FReM issued by HM Treasury. In some cases, where there is a compelling reason, Treasury

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may grant permission for Monitor not to adopt a change to FReM in the FT ARM. The following changes to the FReM are potentially applicable to NHS foundation trusts and may be incorporated into the FT ARM from 2011/12.

**i. Treatment of grants received**

Under the new approach, grants received towards the cost of an asset are recognised in income unless the funder imposes a condition on the grant e.g. that the it must be used to fund the construction or acquisition of an asset. If there are no conditions, or once all conditions have been met, the grant is recognised in full within income. If adopted in the FT ARM, the impact is likely to be an increase in volatility in annual results where capital grants are received or released once conditions have been met. When the change is applied, the existing government grants deferred account is likely to be realised to the income and expenditure reserve.

**ii. Donated assets**

The new approach for donated assets is effectively identical to that for grants above. Where donations are received without conditions, or if they have conditions, once these have been met they should be recognised in income. If brought into effect it would result in most, or all, donations being reflected in income in the year of receipt which could lead to greater volatility in the annual result. The existing donated asset reserve would be transferred to the income and expenditure reserve and – where it includes an element of asset revaluations - to the revaluation reserve.

**c) Other changes**

In 2011/12 it is likely that the FT ARM will delete the present exemption from consolidating NHS charitable funds that are controlled by foundation trusts. As described in note 28 the Leeds Partnerships NHS Foundation Trust's connected NHS charitable funds are classified as a subsidiary and therefore will need to be consolidated. The effect on Leeds Partnerships NHS Foundation Trust's accounts will be to include the charitable fund's income and expenditure. Income and expenditure between the foundation trust and the charitable fund will also be eliminated on consolidation. The assets, liabilities and reserves of the charitable fund will also be consolidated. The foundation trust's donated asset reserve largely represents past amounts received for the charitable funds and therefore will be eliminated on consolidation. (If the change in treatments of donated assets described above occurs then an amount equivalent to the donated asset reserve would be removed from the income and expenditure and revaluation reserves instead on consolidation.)

## 1.22 Accounting standards issued that have been adopted early by Leeds Partnerships NHS Foundation Trust

No new accounting standards or revisions to existing standards have been early–adopted in 2010/11

## 1.23 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates 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.

### 1.23.1 Critical judgements in applying accounting policies

The following are the critical judgements, apart from those involving estimations (see below) that management has made in the process of applying the foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Leeds Partnerships NHS Foundation Trust's main contract with NHS Leeds (formerly Leeds PCT) states that the Foundation trust will be paid for all treatments delivered in any financial year. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Where treatment is delivered over the year end, the income is apportioned between the financial years bases on the length of stay.

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

### 1.23.2 Key Sources of estimation uncertainty

The following are the key assumptions concerning

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the future, and other key sources of estimation uncertainty at the end of the reporting period, that have significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

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.

Modern Equivalent Asset valuation Specialist land and buildings in operational use are valued at depreciated Replacement Cost, using a Modern Equivalent Asset basis. The foundation trust's medium term strategic estates plan is for the services provided on the two existing sites to transfer to a single new site. Consequently, the MEA valuation for these sites is based on a single new site.

Impairment of property, plant and equipment
Only St Mary's Hospital and Aire Court of Leeds Partnerships NHS Foundation Trust's property assets are valued on a modern equivalent asset basis. As well as the assumptions around the site valuation, the valuation is based on assumptions about the market for specialised properties in the area. The valuation is undertaken by a professional valuer using a number of assumptions about property prices.

## 2 Operating segments

Leeds Partnerships NHS Foundation Trust provides mental health and learning disability services across the city of Leeds, to over 600,000 adults within the Leeds Metropolitan boundary. Most income by value is on a "block" basis than "pay as you go"

The Trust contracted with NHS Leeds (formerly known as Leeds PCT) for 80% of its income (79% in 2009/10) but also had contracts with other PCT's, the Yorkshire and the Humber SHA and the Local Authority for the provision of clinical and education training services

Services are provided in four service directorates: Adult Mental Health Services, Older Peoples Mental Health Services, Specialist Services and Learning Disability Services, which have been reported throughout the financial year. Learning Disability Directorate covers both Learning Disability (LD) and Specialised Supporting Living (SSL), reported separately. Hosted Services include Commercial Procurement Collaborative (CPC) and National Research Ethics Society, also reported separately.

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. The surplus or deficit for each segment is used to inform the Board of Directors on performance and to assist in negotiations with commissioners on the cost and resources needed to maintain services at a level consistent with the need of the population.Further detail of each directorate can be found in the Annual Report of the Foundation Trust.

*Gemma Wharton, Communications Team*

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| | Adult | | Older | | Specialist | | LD | | SSL | | Hosted Services | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
| **Income by segment** | | | | | | | | | | | | | | |
| Income from activities | **52,668** | 44,592 | **26,400** | 25,452 | **13,804** | 22,694 | **11,961** | 10,701 | **7,296** | 7,349 | | | **112,129** | 110,787 |
| Other operating income | **5,286** | 4,752 | **2,687** | 2,500 | **3,026** | 3,362 | **1,036** | 1,109 | **499** | 481 | **2,063** | | **14,598** | 12,203 |
| **TOTAL INCOME** | **57,954** | 49,344 | **29,087** | 27,952 | **16,830** | 26,056 | **12,997** | 11,809 | **7,795** | 7,829 | **2,063** | | **126,727** | 122,991 |
| **TOTAL EXPENDITURE** | **(53,220)** | (44,996) | **(25,711)** | (25,669) | **(15,395)** | (23,947) | **(11,046)** | (11,053) | **(8,702)** | (8,564) | **(1,756)** | | **(115,831)** | (114,229) |
| **EBITDA** | **4,734** | 4,348 | **3,376** | 2,282 | **1,435** | 2,110 | **1,951** | 756 | **(907)** | (735) | **307** | | **10,896** | 8,762 |
| **Non Operating Income and Expenditure Total** | **(3,780)** | (2,981) | **(2,203)** | (2,166) | **(650)** | (1,364) | **(501)** | (588) | **(100)** | (122) | **(18)** | | **(7,253)** | (7,221) |
| **Surplus/(Deficit) from continuing operations** | **954** | 1,367 | **1,173** | 117 | **785** | 745 | **1,450** | 168 | **(1,007)** | (856) | **289** | | **3,643** | 1,541 |
| **Audit Adjustments** | | | | | | | | | | | | | | |
| Asset Revaluation | | | | | | | | | | | | | **11** | (933) |
| Accruals Adjustment | | | | | | | | | | | | | **(37)** | 125 |
| Unaccrued Invoices | | | | | | | | | | | | | | (5) |
| Losses & Comps Adjustment | | | | | | | | | | | | | | 3 |
| **Revised Surplus/ (Deficit) from continuing operations** | | | | | | | | | | | | | **3,617** | 732 |

**a) Income includes:** £116m from NHS Trusts (primarily £102m from NHS Leeds).

**b) Expenditure includes:**

| | |
|---|---|
| Employee Expenses | £92.687m 10/11, £88.967m 09/10 |
| Premises | £5.336m 10/11, £5.107m 09/10 |
| Depreciation | £3.377m 10/11, £3.117m 09/10 |
| Establishment | £4.026m 10/11, £3.653m 09/10 |

**c) Depreciation & fixed asset impairment:** (£3.551m 10/11, £3.117m 09/10) is included in operating expenses in the accounts, but non operating expenses in service line reports.

**d) 10/11 includes:** £55k and 09/10 includes £910k for profit/loss on disposal which is included in operating expenses in the accounts, but non operating expenses in service line reports.

**e) 10/11 includes:** £0k and 09/10 includes £860k contingent rent adjustment which is included in non operating expenses in the accounts but in operating expenses in service line reports.

**f) 10/11 includes:** £214k (£176k profit on asset disposal and £38k reversal of impairment) and £252k other payments which are included in operating income in the accounts but in non operating income in service line reports.

***Items c, d, e and f have not been adjusted for in segmental reporting as this is how Leeds Partnerships NHS Foundation Trust reports to the Board of Directors.***

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## 3 Revenue from patient care activities

| | Year Ended 31 March 2011 £000 | Year Ended 31 March 2010 £000 |
|---|---|---|
| NHS trusts | | |
| Primary care trusts | 104,004 | 102,411 |
| Foundation trusts | 21 | 33 |
| Local authorities | 1,020 | 1,086 |
| NHS other | | 3 |
| Non-NHS: | | |
| Income for Social Care Clients | 7,061 | 7,232 |
| Other | 6 | 22 |
| **Total Revenue from patient care activities** | **112,112** | **110,787** |

Leeds Partnerships NHS Foundation Trust participates in a pooled budget arrangement with NHS Leeds and Leeds City Council as a provider of services.

As a provider of healthcare services, 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 was no private patient income in the year 2010/11 (£nil in 2009/10). This is within Foundation Trust's private patient cap, which is 1.5% of total patient related income.

All income from patient care activities is mandatory.

## 4 Other Operating Revenue

| | Year Ended 31 March 2011 £000 | Year Ended 31 March 2010 £000 |
|---|---|---|
| Research and Development | **403** | 472 |
| Education and Training | **3,122** | 3,154 |
| Non-patient care services to other bodies | **2,721** | 2,631 |
| Other Income: | | |
| Inter NHS Foundation Trust | **1,126** | 896 |
| Inter NHS Trust | **189** | 138 |
| Inter RAB | **6,307** | 4,622 |
| Inter Other WGA Bodies | **58** | 78 |
| Other (Outside WGA) | **941** | 212 |
| Gain on disposal of assets held for sale | **176** | |
| Reversal of impairments of property, plant and equipment | **38** | |
| **Total Other Operating Revenue** | **15,081** | **12,203** |

*Alastair Campbell, Annual Members Day, 2010*

# Annual Accounts

## 5 Operating expenses

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Services from Foundation Trusts | 6 | 10 |
| Services from other NHS Trusts | 814 | 714 |
| Services from other NHS bodies | 31 | |
| Purchase of healthcare from non NHS bodies | 980 | 1,481 |
| Employee expenses - Executive Directors | 824 | 851 |
| Employee expenses - Non Executive Directors' costs | 177 | 155 |
| Employee expenses - Staff | 91,863 | 88,116 |
| Drugs costs | 2,090 | 1,962 |
| Supplies and services - clinical (excluding Drugs) | 866 | 812 |
| Supplies and services - general | 968 | 1,188 |
| Establishment | 4,026 | 3,653 |
| Research and development | 438 | 514 |
| Transport | 625 | 969 |
| Premises | 5,336 | 5,107 |
| Increase/(decrease) in provision for impairment of receivables | (23) | 97 |
| Depreciation on Property, plant and equipment | 3,285 | 3,095 |
| Amortisation of intangible Assets | 92 | 22 |
| Impairments and reversals of property, plant and equipment | 141 | 938 |
| Impairments and reversals of intangible assets | 71 | 3 |
| Audit fees - statutory audit and regulatory reporting | 72 | 48 |
| Other auditor's remuneration | | 9 |
| Clinical negligence | 247 | 240 |
| Loss on disposal of intangible fixed assets | 6 | |
| Loss on disposal of land and buildings | | 910 |
| Loss on disposal of other property plant and Equipment | 11 | |
| Consultancy services | 577 | 606 |
| Patient's travel | 33 | 32 |
| Redundancy | 102 | 81 |
| Early retirement | (405) | 67 |
| Losses, ex-gratia and special payments | 56 | 15 |
| Other | 6,165 | 6,511 |
| **Total Operating Expenses** | 119,474 | 118,206 |

£868k expenditure categorised as Purchase of Healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£1,331k 09/10). A further £112k (£150k 09/10) relates to expenditure with the Alzheimer's Society.

Other Expenditure includes £5,606k (£5,646k in 09/10) in relation to PFI costs. These are primarily monthly service charge payments to the operators of the two PFI schemes to which Leeds Partnerships NHS Foundation Trust is party (see note 24).

Other auditors remuneration for 2009/10 relates to the IFRS restatement fees charged by the external auditor.

Details of the Directors' remuneration can be found in Section 8 of the annual report.

There is no specified limitation to the auditors liability.

# Annual Accounts

## 5.1 Auditors Remuneration

The Board of Governors appointed PricewaterhouseCoopers LLP ("Pwc") as external auditors of the Foundation Trust for the five year period commencing April 2010. The audit fee was £52k (2009/10 £61k) excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007.

## 6 Operating leases

## 6.1 As lessee

38% (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.

The Revival properties are for the land at two community units, Millside and Towngate House, for inpatient and day care for older people with severe mental illness together with a base for a community mental health team.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 Equitix contract is for the seven mental health units, Becklin, Newsam, The Mount, Asket Croft, Asket House, Parkside Lodge and Woodhouse Hall, providing a comprehensive range of mental health services. The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028.

Other building leases include a 15 year lease on Trust headquarters at Thorpe Park and other non specialised properties used for clinical purposes. Vehicle leases are for cars supplied to qualifying staff under a vehicle lease scheme. Other equipment leases are mainly for photocopy equipment in the various Trust properties.

| **Payments recognised as an expense** | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 **£000** |
|---|---|---|
| Minimum lease payments | 1,713 | 1,460 |
| Sub-lease payments | 0 | 0 |
| **Total** | **1,713** | 1,460 |
| **Total future minimum lease payments** | **Year ended 31 March 2011 £000** | **Year ended 31 March 2010 £000** |
| Payable: | | |
| Not later than one year | 1,650 | 1,738 |
| Between one and five years | 4,919 | 4,456 |
| After 5 years | 6,728 | 8,146 |
| **Total** | **13,297** | 14,340 |

# Annual Accounts

## 7 Employee costs and numbers

### 7.1 Employee costs

| | Year Ended 31 March 2011 | | | Year Ended 31 March 2010 | | |
|---|---|---|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** | Total | Permanently Employed | Other |
| | **£000** | **£000** | **£000** | £000 | £000 | £000 |
| Salaries and wages | **72,733** | **68,972** | **3,761** | 69,428 | 65,918 | 3,510 |
| Social Security Costs | **5,466** | **5,466** | | 5,229 | 5,229 | |
| Employer contributions to NHS Pension scheme | **9,089** | **9,089** | | 8,734 | 8,734 | |
| Agency/Contract Staff | **5,399** | | **5,399** | 5,576 | | 5,576 |
| **Employee benefits expense** | **92,687** | **83,527** | **9,160** | 88,967 | 79,881 | 9,086 |
| The 2009/10 comparator split has been updated in line with 2010/11 classifications | | | | | | |
| **In addition to the above:** | | | | | | |
| Charged to capital | **70** | | | 79 | | |
| Directors benefits charged to revenue | | | | | | |
| Employee benefits charged to revenue | **70** | | | **79** | | |

Details of the Directors' remuneration can be found in Section 8 of the annual report.
There were no employee benefits paid in the year ended 2010/11 (£nil 2009/10)

### 7.2 Average number of people employed (wte)

| | Year Ended 31 March 2011 | | | Year Ended 31 March 2010 | | |
|---|---|---|---|---|---|---|
| | **Total** | **Permanently Employed** | **Other** | Total | Permanently Employed | Other |
| | **(wte)** | **(wte)** | **(wte)** | (wte) | (wte) | (wte) |
| Medical and dental | **173** | **163** | **10** | 180 | 161 | 19 |
| Ambulance staff | | | | | | |
| Administration and estates | **524** | **513** | **11** | 508 | 494 | 14 |
| Healthcare assistants and other support staff | **55** | **55** | | 60 | 60 | |
| Nursing, midwifery and health visiting staff | **1,223** | **1,221** | **2** | 1,236 | 1,235 | 1 |
| Nursing, midwifery and health visiting learners | | | | | | |
| Scientific, therapeutic and technical staff | **285** | **257** | **28** | 280 | 248 | 32 |
| Social care staff | **10** | | **10** | 10 | | 10 |
| Other | **295** | | **295** | 272 | | 272 |
| **Total** | **2,565** | **2,209** | **356** | 2,546 | 2,198 | 348 |

# Annual Accounts

## 7.3 Management costs

| | Year Ended 31 March 2011 £000 | Year Ended 31 March 2010 £000 |
|---|---|---|
| Management costs | 7,991 | 7,870 |
| Income | 127,193 | 122,990 |
| Management costs as a percentage of income | 6.28% | 6.40% |

## 7.4 Staff exit packages

| Exit package cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
|---|---|---|---|
| Less than £10,0000 | 6 (0) | 0 (0) | 6 (0) |
| £10,001 - £25,000 | 3 (1) | 0 (1) | 3 (2) |
| £25,001 - £50,000 | 0 (0) | 0 (0) | 0 (0) |
| £50,001 - £100,000 | 0 (0) | 0 (0) | 0 (0) |
| £100,001 - £150,000 | 0 (0) | 0 (0) | 0 (0) |
| £150,001 - £200,000 | 0 (0) | 0 (0) | 0 (0) |
| Total number of exit packages by type | **9 (1)** | **0 (1)** | **9 (2)** |
| **Total resource cost (£000)** | **102 (11)** | **0 (10)** | **102 (21)** |

Figures in brackets relate to last year

The above reporting requirements cover the total costs of exits agreed in the year. They include payments under the Civil Service Compensation Scheme (CSCS), payments under any other compensation schemes where applicable (e.g. some NDPBs) and any other payments made (special severance payments).

Exit packages for senior managers can be found in the Directors Remuneration Report. For 2010/11 this figure is £nil (2009/10 £70k).

## 8 Retirements due to ill-health

During 2010/11 there were 5 (2009/10, 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 £307k (2009/10: £485k). 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 2011 | | Year Ended 31 March 2010 | |
|---|---|---|---|---|
| | **Number** | **£000** | Number | £000 |
| Total Non-NHS trade invoices paid in the period | **19,283** | **33,192** | 20,030 | 31,733 |
| Total Non-NHS trade invoices paid within target | **17,228** | **30,793** | 18,507 | 29,395 |
| Percentage of Non-NHS trade invoices paid within target | **89%** | **93%** | 92% | 93% |
| Total NHS trade invoices paid in the period | **1,270** | **6,786** | 835 | 8,113 |
| Total NHS trade invoices paid within target | **1,099** | **5,672** | 735 | 7,459 |
| Percentage of NHS trade invoices paid within target | **87%** | **84%** | 88% | 92% |

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.

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## 10 Finance income

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Bank accounts | **231** | 198 |
| **Total** | **231** | 198 |

This figure includes accrued interest of £16k (2009/10 £11k)

## 11 Other gains and losses

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Gain/(loss) on disposal of intangible assets | **(6)** | |
| Gain/(loss) on disposal of property, plant and equipment | **(11)** | (910) |
| **Total** | **(17)** | (910) |

The 2009/10 loss on disposal includes £909k relating to the demolition of Maple House.

## 12 Finance costs

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Interest on obligations under finance leases | 347 | 325 |
| Interest on obligations under PFI contracts: | | |
| - main finance cost | 2,620 | 2,691 |
| - contingent finance cost | 1,049 | 860 |
| **Total interest expense** | **4,016** | 3,876 |
| Other finance costs | | |
| **Total** | **4,016** | 3,876 |

# Annual Accounts

## 13.1 Intangible assets

| 2010/11: | Computer software purchased £000 |
|---|---|
| Gross valuation at 1 April 2010 | 285 |
| Additions purchased | 197 |
| Disposals other than by sale | (20) |
| Revaluation/indexation | (25) |
| **Gross valuation at 31 March 2011** | **437** |
| Accumulated amortisation at 1 April 2010 | |
| Disposals other than by sale | (13) |
| Revaluation | (150) |
| Impairments | 71 |
| Charged during the year | 92 |
| **Accumulated amortisation at 31 March 2011** | - |
| **Net book value** | |
| Purchased | 437 |
| Donated | |
| Government granted | |
| **Total at 31 March 2011** | **437** |

## Intangible assets - prior year:

| 2009/10: | Computer software purchased £000 |
|---|---|
| Gross cost at 1 April 2009 | 207 |
| Additions purchased | 119 |
| Disposals other than by sale | |
| Revaluation/indexation | (41) |
| **Gross valuation at 31 March 2010** | **285** |
| Accumulated amortisation at 1 April 2009 | 130 |
| Disposals other than by sale | |
| Revaluation | (155) |
| Impairments | 3 |
| Charged during the year | 22 |
| **Accumulated amortisation at 31 March 2010** | **-** |
| **Net book value** | |
| Purchased | 285 |
| Donated | |
| Government granted | |
| **Total at 31 March 2010** | **285** |

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 3 and 10 years depending on the software licence. The remaining economic life is assessed each year.
Quotations were sought for the software licences and this led to an impairment of £71k.

# Annual Accounts

## 14.1 Property, plant and equipment

| 2010/11: | 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 2010 - as previously stated | 4,486 | 47,809 | | 907 | 826 | 354 | 3,825 | 1,116 | 59,323 |
| Prior Year Adjustment | 50 | | | | | | | | 50 |
| Cost or valuation at 1 April 2010 - restated | 4,536 | 47,809 | | 907 | 826 | 354 | 3,825 | 1,116 | 59,373 |
| Additions purchased | | | | 4,040 | 19 | 85 | 313 | | 4,457 |
| Additions donated | | | | | | | | | |
| Reclassifications | | 1,980 | | (2,199) | 56 | | 163 | | |
| Reclassified as held for sale | | | | | | | | | |
| Disposals | | | | | (65) | (65) | | | (130) |
| Revaluation/indexation gains | 44 | (136) | | | 14 | 28 | | 61 | 11 |
| Impairments | (35) | (11) | | | | | | | (46) |
| **At 31 March 2011** | **4,545** | **49,642** | | **2,748** | **850** | **402** | **4,301** | **1,177** | **63,665** |
| Accumulated depreciation at 1 April 2010 - as previously stated | | 4,083 | | 6 | 468 | 214 | 2,073 | 763 | 7,607 |
| Prior Year Adjustment | 1 | | | | | | | | 1 |
| Depreciation at 1 April 2010 - restated | 1 | 4,083 | | 6 | 468 | 214 | 2,073 | 763 | 7,608 |
| Disposals | | | | | (65) | (37) | | | (102) |
| Revaluation/indexation gains | | (535) | | | 8 | 17 | | 45 | (465) |
| Impairments | | 69 | | 34 | | | | | 103 |
| Charged during the year | | 2,611 | | | 72 | 51 | 470 | 81 | 3,285 |
| **Accumulated depreciation at 31 March 2011** | **1** | **6,228** | | **40** | **483** | **245** | **2,543** | **889** | **10,429** |
| **Net book value** | | | | | | | | | |
| **Total at 31 March 2011** | **4,544** | **43,414** | | **2,708** | **367** | **157** | **1,758** | **288** | **53,236** |
| **Asset financing** | | | | | | | | | |
| Owned | 4,495 | 18,138 | | 2,708 | 367 | 157 | 1,758 | 288 | 27,911 |
| Finance Lease | 49 | 1,391 | | | | | | | 1,440 |
| PFI | | 23,859 | | | | | | | 23,859 |
| Donated | | 26 | | | | | | | 26 |
| **Total at 31 March 2011** | **4,544** | **43,414** | | **2,708** | **367** | **157** | **1,758** | **288** | **53,236** |
| NBV Protected Assets at 31 March 2011 | 3,574 | 42,584 | | | | | | | 46,158 |
| NBV Unprotected Assets at 31 March 2011 | 970 | 830 | | 2,708 | 367 | 157 | 1,758 | 288 | 7,078 |
| **NBV Total at 31 March 2011** | **4,544** | **43,414** | | **2,708** | **367** | **157** | **1,758** | **288** | **53,236** |

The prior period adjustment has resulted from a change in IAS 17. Land leases are now no longer assumed to be operating leases.

The latest revaluation of Land and Buildings was carried out by the Valuation Office with effective date 1st April 2011. The DV's judgement was that all movements were to do with price and not change in economic benefit. The Trust is in agreement with this.

Specialist land and buildings in operational use are valued at depreciated Replacement Cost, using a Modern Equivalent Asset basis. The foundation trust's medium term strategic estates plan is for the services provided on the two existing sites to transfer to a single new site. Consequently, the MEA valuation for these sites is based on a single new site.

Non specialist land and buildings in operational use are valued at Open Market Value, assuming existing use.

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

# Annual Accounts

## 14.2 Property, plant and equipment - prior year

| 2009/10: | Land | Buildings excluding dwellings | Dwellings | Assets under construction and payments on account | Plant and Machinery | Transport Equipment | Information Technology | Furniture & Fittings | Total |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £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** |
| Accumulated 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 |
| **Accumulated 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** |
| NBV Protected Assets at 31 March 2010 | 3,511 | 42,901 | | | | | | | 46,412 |
| NBV Unprotected Assets at 31 March 2010 | 975 | 825 | | 901 | 358 | 140 | 1,752 | 353 | 5,304 |
| NBV Total at 31 March 2010 | **4,486** | **43,726** | | **901** | **358** | **140** | **1,752** | **353** | **51,716** |

## 14.3 Classification of impairments for Parliamentary budgeting purposes

| | Year ended 31 March 2011 | Year ended 31 March 2010 |
|---|---|---|
| | £000 | £000 |
| Abandonment of assets in course of construction | 34 | 6 |
| Over specification of assets | 107 | |
| Changes in Market Place | 71 | 935 |
| Reversals of impairments | (38) | |
| **At 31 March** | 174 | 941 |

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 buildings of £107k and reverse impairment of £38k. Quotations were sought for software licences and this led to an impairment of intangible assets of £71k.

# Annual Accounts

## 15 Capital commitments

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

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Property, plant and equipment | **2,211** | 411 |
| Intangible assets | | 31 |
| **Total** | **2,211** | 442 |

## 16 Inventories

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Consumables | **80** | 52 |
| **Total** | **80** | 52 |
| Of which held at net realisable value: | 80 | 52 |

## 16.1 Inventories recognised in expenses

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Inventories recognised as an expense in the period<br>Write-down of inventories (including losses)<br>Reversal of write-downs that reduced the expense | **16** | 57 |
| **Total** | **16** | 57 |

# Annual Accounts

## 17 Trade and other receivables

| | Current | | Non-current | |
|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
| NHS receivables-revenue | **1,636** | 1,577 | | |
| Other receivables with related parties | **64** | 84 | | |
| Non-NHS receivables-revenue | **395** | 591 | | |
| Provision for the impairment of receivables | **(128)** | (152) | | |
| Prepayments | **888** | 976 | **1,835** | 1,630 |
| PDC Receivable | **48** | 32 | | |
| VAT | **260** | 419 | | |
| Other receivables | **514** | 1,036 | **966** | 937 |
| **Total** | **3,677** | 4,563 | **2,801** | 2,567 |

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.
Credit scoring is not applied to Other Receivables
Other receivables includes £ nil (2009/10 £455k) for rates rebates

## 17.1 Receivables past their due date but not impaired

| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
|---|---|---|
| By up to three months | **647** | 661 |
| By three to six months | **34** | 137 |
| By more than six months | | 11 |
| **Total** | **681** | 809 |

The trust does not consider the above debtors, past their due date, to be impaired, based on previous trends and experience.

## 17.2 Provision for impairment of receivables

| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
|---|---|---|
| **Balance at 1 April** | **152** | 69 |
| Amount written off during the year | **(20)** | (17) |
| Amount recovered during the year | **(1)** | (14) |
| (Increase)/decrease in receivables impaired | **(3)** | 114 |
| At start of period for new Foundation Trust's | | |
| **Balance at 31 March** | **128** | 152 |

The increase in the amount provided for in the year ended 2010/11 has been provided for after taking all factors into consideration regarding the chances of recovery.

# Annual Accounts

## 18 Cash and cash equivalents

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Balance at 1 April | **17,444** | 16,527 |
| Net change in year | **4,444** | 917 |
| **Balance at 31 March** | **21,888** | 17,444 |
| **Made up of** | | |
| Cash with Government Banking Service | **21,702** | 17,349 |
| Commercial banks and cash in hand | **186** | 95 |
| **Cash and cash equivalents as in statement of financial position** | **21,888** | 17,444 |
| **Cash and cash equivalents as in statement of cash flows** | **21,888** | 17,444 |

## 19 Non-current assets held for sale

| | Property, Plant and Equipment £000 | Intangible assets £000 | Total £000 |
|---|---|---|---|
| Balance brought forward 1 April 2010 | 337 | | **337** |
| Less assets sold in the year | (337) | | **(337)** |
| Balance carried forward 31 Mar 2011 | - | - | **-** |
| | | | |
| Balance brought forward 1 April 2009 | 337 | | 337 |
| Less assets sold in the year | | | |
| Balance carried forward 31 Mar 2010 | 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. The sale was due to complete in 2009/10 but delays in planning permission mean that this did not occur until 2010/11.

## 20 Trade and other payables

| | Current | | Non-current | |
|---|---|---|---|---|
| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
| NHS payables-revenue | **2,760** | 2,667 | | |
| Amounts due to other related parties | **4** | 169 | | |
| Non NHS trade payables - capital | **1,554** | 962 | | |
| Accruals | **3,879** | 3,576 | | |
| Other | **2,913** | 2,896 | | |
| **Total** | **11,110** | 10,270 | **-** | - |

# Annual Accounts

## 21 Borrowings

| | Current | | Non-current | |
|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
| PFI liabilities | **991** | 915 | **31,095** | 32,086 |
| Finance lease liabilities | **149** | 122 | **2,387** | 2,536 |
| **Total** | **1,140** | 1,037 | **33,482** | 34,622 |

The trust has a prudential borrowing limit of £35,700k in 2010/11 (£36,600k in 2009/10). The trust has actually borrowed £0 in 2010/11 (£0 in 2009/10). The Trust is not currently paying to receive a working capital facility.

The trust has not breached the Prudential Borrowing Code (PBC).

| | 2010/11 | | 2009/10 | |
|---|---|---|---|---|
| **Financial ratio** | **Actual ratios** | **Approved PBL ratios** | **Actual ratios** | **Approved PBL ratios** |
| Minimum dividend cover | 26x | >1x | 9x | >1x |
| Minimum interest cover | 3x | >2x | 2x | >2x |
| Minimum debt service cover | 2.2x | >1.5x | 1.5x | >1.5x |
| Maximum debt service to revenue | 4% | <10% | 4% | <10% |

The trust has Monitor approval to seek a working capital facility of £8.5m (£8.5m in 2009/10) but has not entered into arrangements to utilise this facility

Leeds Partnerships NHS Foundation Trust is required to comply and remain within a prudential borrowing limit (PBL).This is made up of two elements:

the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests (above) set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long-term borrowing limit; and

the amount of any working capital facility approved by Monitor. Further information on the *Prudential Borrowing Code for NHS Foundation Trusts and Compliance Framework* can be found on Monitor's website

## 22 Other liabilities

| | Current | | Non-current | |
|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year starting March 2011 £000** | Year ended 31 March 2010 £000 |
| Deferred Income | **5,349** | 2,141 | | 1,066 |
| **Total** | **5,349** | 2,141 | - | 1,066 |

# Annual Accounts

## 23 Finance lease obligations

| Amounts payable under finance leases | Minimum lease payments | | Present value of minimum lease payments | |
|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
| Within one year | **469** | 452 | **455** | 438 |
| Between one and five years | **2,064** | 2,023 | **1,576** | 1,519 |
| After five years | **1,946** | 2,378 | **1,223** | 1,313 |
| Less future finance charges | **(1,943)** | (2,195) | | |
| Present value of minimum lease payments | **2,536** | 2,658 | **3,254** | 3,270 |
| Included in: | | | | |
| Current borrowings | **149** | 122 | **455** | 438 |
| Non-current borrowings | **2,387** | 2,536 | **2,799** | 2,832 |
| | **2,536** | 2,658 | **3,254** | 3,270 |

The 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 £3,254k (£3,270k 2009/10) is calculated from the minimum lease payments figures at £2,536k (£2,658k 2009/10) with the future finance charges at £1,943k (£2,195k 2009/10) added back. This figure is discounted at 0.49% (6.00% per annum) for 101 months (113 months 2009/10) which is the remaining life of the agreement.

# Annual Accounts

## 24 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.

More detail is provided in the PFI accounting policy in note 1.

### Minimum amounts payable under the contract:

### Asset financing component

| | Gross Payments | | Present values of payments | |
|---|---|---|---|---|
| | **Year ended 31 March 2011** | Year ended 31 March 2010 | **Year ended 31 March 2011** | Year ended 31 March 2010 |
| | **£000** | £000 | **£000** | £000 |
| Not later than one year | **4,584** | 4,366 | **4,413** | 4,203 |
| Later than one year, not later than five years | **18,335** | 17,464 | **14,839** | 14,134 |
| Later than five years | **51,951** | 53,848 | **25,037** | 25,173 |
| Sub total | **74,870** | 75,678 | **44,289** | 43,510 |
| | | | | |
| Less: finance cost attributable to future periods | **(42,784)** | (42,677) | **(12,203)** | (10,509) |
| **Total** | **32,086** | 33,001 | **32,086** | 33,001 |

| | Gross Payments | |
|---|---|---|
| | **Year ended 31 March 2011** | Year ended 31 March 2010 |
| | **£000** | £000 |
| Not later than one year | **5,395** | 5,139 |
| Later than one year, not later than five years | **21,581** | 20,555 |
| Later than five years | **61,146** | 63,379 |
| **Total** | **88,122** | 89,073 |

The future services amounts due as at 31 March 2011 reflect an adjustment for the RPI indexation of the Unitary Payment applied during 2010/11.

The amount charged to operating expenses during the year in respect of services was £5,280 (2009/10 £5,156).

# Annual Accounts

## 25 Provisions

| | Current | | Non-current | |
|---|---|---|---|---|
| | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 | **Year ended 31 March 2011 £000** | Year ended 31 March 2010 £000 |
| Pensions relating to former directors | | | | |
| Pensions relating to other staff | **128** | 161 | **1,468** | 1,957 |
| Legal claims | **121** | 139 | | |
| Agenda for change | | | | |
| Other (specify) | **109** | 578 | | |
| **Total** | **358** | 878 | **1,468** | 1,957 |

| | **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 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** |
| At 1 April 2010 | | 2,118 | 139 | | 578 | **2,835** |
| Arising during the year | | 47 | 108 | | 29 | **184** |
| Change in discount rate | | (89) | | | | **(89)** |
| Used during the year | | (128) | (67) | | (84) | **(279)** |
| Reversed unused | | (399) | (59) | | (414) | **(872)** |
| Unwinding of discount | | 47 | | | | **47** |
| At 31 March 2011 | | 1,596 | 121 | | 109 | **1,826** |
| **Expected timing of cash flows:** | | | | | | |
| In the remainder of the spending review period to 31 March 2012 | - | 128 | 121 | - | 109 | **358** |
| Between 1 April 2016 and 31 March 2017 | | 512 | | | | **512** |
| Thereafter | | 956 | | | | **956** |
| TOTAL | - | 1,596 | 121 | - | 109 | **1,826** |

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 (nil 10/11; £394k 09/10) and equal pay claims (£109k 10/11; £113k 09/10) and redundancy (nil 10/11; £70k 09/10).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.
£42k is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the NHS Foundation Trust (31 March 2010 £429k).

Leeds Partnerships NHS Foundation Trust has no expected reimbursements for any class of provision made.

# Annual Accounts

## 26 Contingencies

### 26.1 Contingent liabilities

| | Year ended 31 March 2011 £000 | Year ended 31 March 2010 £000 |
|---|---|---|
| Other (specify) | **59** | 71 |
| **Total** | **59** | 71 |

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.

## 27 Financial instruments

Leeds Partnerships NHS Foundation Trust's financial assets are classified either as "Loans and receivables" or "As available for Sale" financial assets. All the Trust's financial liabilities are classified as "Other Liabilities".

Leeds Partnerships NHS Foundation Trust undertakes active financial risk management to manage its exposure to risk, particularly credit risk and treasury risk. Similar to general risk management, financial risk management requires identifying its sources, measuring it, and implementing plans to address them.

# Annual Accounts

## 27.1 Financial assets - carrying amount

| | Loans and receivables<br>£000 | Available for sale<br>£000 | Total<br>£000 |
|---|---|---|---|
| Embedded derivatives | - | | - |
| Receivables | 4,445 | | 4,445 |
| Cash at bank and in hand | 17,444 | | 17,444 |
| Other financial assets | | | - |
| **Total at 1st April 2010** | 21,889 | - | 21,889 |
| Embedded derivatives | - | | - |
| Receivables | 3,447 | | 3,447 |
| Cash at bank and in hand | 21,888 | | 21,888 |
| Other financial assets | | | - |
| **Total at 31 March 2011** | 25,335 | - | 25,335 |
| **Ageing of over due receivables included in Financial Assets** | | | |
| Receivables overdue by: | | | |
| 1-30 days | 397 | | 397 |
| 31-60 days | 235 | | 235 |
| 91-180 days | 15 | - | 15 |
| 181-360 days | 34 | | 34 |
| 361+ days | | | - |
| | 681 | - | 681 |

# Annual Accounts

## 27.2 Financial liabilities - carrying amount

| | At fair value through profit and loss £000 | Other £000 | Total £000 |
|---|---|---|---|
| Embedded derivatives | | | |
| Payables | | 6,641 | 6,641 |
| PFI and finance lease obligations | | 35,658 | 35,658 |
| Other borrowings | | | |
| Provisions under contract | | 2,118 | 2,118 |
| Other financial liabilities | | | |
| **Total at 1st April 2010** | - | 44,417 | 44,417 |
| Embedded derivatives | | | |
| Payables | | **9,091** | **9,091** |
| PFI and finance lease obligations | | **34,622** | **34,622** |
| Other borrowings | | | |
| Provisions under contract | | **1,826** | **1,826** |
| Other financial liabilities | | | |
| **Total at 31 March 2011** | - | **45,539** | **45,539** |

## 27.3 Fair values of loans and receivables and other financial liabilities

The fair value of current loans and receivables are considered to be equal to their carrying amounts. There are no non-current loans and receivables.
The fair values of current other financial liabilities are considered to be equal to their carrying amounts.

## 27.4 Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Leeds Partnerships NHS Foundation Trust's activities are incurred primarily under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. Consequently the Trust's financial risks are relatively small in comparison with commercial entities. The Trust does not use financial instruments to alter or hedge its risk and therefore their importance to the Trust's finances are similarly relatively low.

### Credit risk

This is the risk that other parties may not pay amounts that are due from them to Leeds Partnership NHS Foundation Trust, But 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 2011 are in receivables from customers, as disclosed in the Trade and other receivables note.

Leeds Partnerships NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. Leeds Partnership NHS foundation Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investors. Trust treasury activity is subject to review by the Trust's internal auditors.

# Annual Accounts

## 27.4 Financial risk management (cont)

### Liquidity Risk

Leeds Partnerships 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. Leeds Partnerships 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 (the inability of paying financial liabilities).

### Market Risk

Market risk comprises three elements: Currency risk, Interest rate risk and Price risk.

### Foreign Currency risk

This is the risk that Leeds Partnerships NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure, consequently exposure to currency risk is not significant.

### Interest rate risk

This is the risk that Leeds Partnerships NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities e.g. borrowing and financial assets. However a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds Partnerships NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

### Price risk

As explained in note 24, Leeds Partnerships NHS Foundation Trusts annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard.The annual adjustments are reflected in Finance Costs (contingent rent), Operating Expenses and Property Plant and Equipment Additions respectively.

For 2010/11 the percentage increase in the unitary payment was 4.4%, equalling to a monetary increase of £500,840.

The table below shows a sensitivity analysis of the impact on cash payments and on the surplus/deficit for the year if the uplift had been between 3.7% and 5.5%.

| 2010/11 Uplift in Unitary Payment | Actual uplift at 4.4% £000 | Uplift at 3.7% £000 | Uplift at 5.5% £000 |
|---|---|---|---|
| Recognised in Finance Costs | 147 | 91 | 170 |
| Recognised in Operating Expenses | 272 | 202 | 300 |
| Recognised in Surplus/deficit | 419 | 293 | 470 |
| Recognised in Property, plant and Equipment Additions | | | |
| | | | |
| | 419 | 293 | 470 |
| | | | |
| **Net impact of sensitivities on Surplus/(Deficit)** | | **126** | **(51)** |

# Annual Accounts

## 28 Related party transactions

During the period Leeds Partnerships NHS Foundation Trust had the following material transactions with entities which are considered related parties to members of the Board of Directors of the Trust.

| Dearden Consultancy | Payments to Related Parties<br>**£000** | Receipts from Related Parties<br>**£000** | Amounts owed to Related Parties<br>**£000** | Amounts due from Related Parties<br>**£000** |
|---|---|---|---|---|
| 2009/10 | 68 | - | - | - |
| 2010-11 | 68 | - | - | - |

In 2010/11, the trust had £15k of related party transactions with its charitable funds (2009/10 £52k)
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 | | Expenditure | |
|---|---|---|---|---|
| | **Year ended 31 March 2011**<br>**£000** | Year ended 31 March 2010<br>£000 | **Year ended 31 March 2011**<br>**£000** | Year ended 31 March 2010<br>£000 |
| Yorkshire and the Humber Strategic Health Authority | **7,241** | 5,388 | **91** | 43 |
| North Yorkshire and York Primary Care Trust | **1,312** | 541 | **38** | 31 |
| Leeds Primary Care Trust | **101,573** | 101,635 | **390** | 438 |
| Leeds Teaching Hospitals NHS Trust | **375** | 269 | **3,067** | 3,575 |
| South West Yorkshire Partnerships NHS Foundation Trust | **1,228** | 1,272 | **108** | 297 |
| Barnsley PCT | **1,898** | 1,594 | **15** | 39 |
| **Total** | **113,627** | 109,889 | **3,709** | 3,575 |

| | Debtors | | Creditors | |
|---|---|---|---|---|
| | **Year ended 31 March 2011**<br>**£000** | Year ended 31 March 2010<br>£000 | **Year ended 31 March 2011**<br>**£000** | Year ended 31 March 2010<br>£000 |
| Yorkshire and the Humber Strategic Health Authority | **585** | 197 | **3** | 9 |
| North Yorkshire and York Primary Care Trust | **329** | 105 | **19** | 17 |
| Leeds Primary Care Trust | **135** | 374 | **123** | 205 |
| Leeds Teaching Hospitals NHS Trust | **78** | 73 | **512** | 502 |
| South West Yorkshire Partnerships NHS Foundation Trust | **79** | 81 | **43** | 47 |
| Barnsley PCT | | 42 | **25** | 34 |
| NHS Business Services Authority | | | **1,444** | 1,305 |
| **Total** | **1,206** | 872 | **2,169** | 2,119 |

In addition, Leeds Partnerships 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 - income £1,043k (£746 last year); Expenditure £1,314k (£862k last year)' Debtors £64k (£82k last year) and creditors £4k (£169k last year).

# Annual Accounts

## 29 Third Party Assets

The Trust held £153k cash and cash equivalents at 31 March 2011 (2010: £83k) which relates to monies held by Leeds Partnerships NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

## 30 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 | | | | |
| Balances with Local Authorities | 815 | | 203 | |
| Balances with NHS Trusts and Foundation Trusts | 885 | | 1,117 | |
| Balances with Public Corporations and Trading Funds | | | 1,444 | |
| Intra Government balances | 1,700 | | 2,764 | - |
| Balances with bodies external to Government | 1,977 | 2,801 | 8,346 | |
| **At 31 March 2011** | **3,677** | **2,801** | **11,110** | - |
| | | | | |
| Balances with other Central Government Bodies | | | | |
| Balances with Local Authorities | 1,459 | | 536 | |
| 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 | 2,902 | 2,567 | 7,434 | |
| **At 31 March 2010** | **4,563** | **2,567** | **10,270** | |

## 31 Losses and Special Payments

There were 15 (72 in 2009/10) cases of losses and 32 (32 in 2009/10) special payments totalling £58k (£50k in 2009/10) during the year.

## 32 Events after the reporting period

In early 2011, Leeds Partnerships NHS Foundation Trust was named as the preferred provider for the mental health, learning disability and substance misuse services for NHS North Yorkshire and York. A full due diligence process to confirm the details of the bid is currently being undertaken, with a view to effecting the safe transfer of services in late 2011. This will enable the Trust to significantly grow both its geographical service base and the range of services provided.

# 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 রিপোর্ট ব্রেল, এ ডিও টেপ, এ না ভাষায় এ থবা এ না কোন অর্মাট পেতে চান, এ নেড় করে ডা ডাইভার্সিটি টিমের সাথে যোগাযোগ করুন 0113 2954413 নাম্বারে এ থবা। এমেল diversity@leedspft.nhs.uk

**Gujarati**

જો તમને આ વાર્ષિક અહેવાલ બ્રેઇલ, ઓડીઓ ટેપ, કોઇ અન્ય ભાષામાં અથવા કોઇ પણ અન્ય ફોર્મેટમાં 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, ਆਡਿਓ 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 دۆزی بریل، تێپێکی دەنگ، بان بە زمان یان فۆرماتێکی تر بێت تکایە پەیوەندی بکەن تکایە لە ڕێگەی ژمارە تەلەفۆنی **0113 2954413** یان تیمەوە **Diversity Team** لەگەل تیمی جۆراوجۆریی **diversity@leedspft.nhs.uk** پەیوەندی بکە.

**Vietnamese:**

**Nếu quý vị muốn có bản báo cáo thường niên này bằng chữ Brail, hoặc băng 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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LS15 8ZB
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Web: 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@nhs.net

## 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.lpft@nhs.net

## 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.lpft@nhs.net
Web: www.leedspft.nhs.uk/membership

## Communications

If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:
The Communications Team
Tel: 0113 30 55900
Email: communications.lpft@nhs.net

## Members of the Board of Directors and Board of Governors

Can be contacted by email at the addresses shown on our website at
www.leedspft.nhs.uk/about_us/directors
www.leedspft.nhs.uk/about_us/governors

improving health, improving lives

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