

# Annual Report and Accounts

1 April 2011  
to 31 March 2012





**Leeds and York Partnership NHS Foundation Trust**

**ANNUAL REPORT AND ACCOUNTS  
1 April 2011 to 31 March 2012**

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





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'Gay OK' Campaign 2011



# 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. As a foundation trust 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.

A further development for the Trust was the transfer of mental health and learning disability services from NHS North Yorkshire and York on 1 February 2012. To reflect the new geographical area in which services are now provided we became the Leeds and York Partnership NHS Foundation Trust.



*What's Your Goal Campaign, York Walls Walk 2012*





*Susan Tyler, Director for Workforce Development at the Love Arts Festival 2011*

# Directors' Report

## 2.1 THE CHAIR'S ADDRESS

It is an enormous privilege to chair this organisation and I am pleased that in introducing our Annual Report there is so much that is positive contained within it.

The context for this report is one of major change, both in the wider political economy and within the Trust itself. The Health and Social Care Act 2012 is gradually being implemented with as yet some considerable uncertainty about its effects; the law of unintended consequences will inevitably have an impact in due course.

We were able to anticipate some elements of the legislation before enactment, such as opting to change from a 'Board' to a Council of Governors; and also in taking an early decision to make all our Board of Directors' meetings public. We are also testing new ways of engagement more directly with the public by starting our Council and Board meetings with an opportunity to hear from those attending about issues of concern they might have, and during our meetings we are 'targeting' key aspects of our discussions. It is too early to evaluate these changes in the culture of our meetings but hopefully they will make us more visible to the people we serve.

The other key area of change has been the successful integration of services from NHS North Yorkshire and York. With effect from the 1 February we became the 'Leeds and York Partnership' and even though we planned a one hundred day transition period, full managerial and operational integration was achieved well within that time span. The entire project was complex and lengthy from the initial tender stage in the autumn of 2010 through to February this year and all the staff involved deserve huge praise for their unstinting effort in achieving a successful outcome.

Our work continues within the Trust to transform the way we provide our clinical services. This is borne out of recognition that we must do the right things, in the right order, in the right place, with the right outcome. I am committed to ensuring that we focus unambiguously on the people who depend on us, most notably service users and their carers, balanced with remaining within a tight resource allocation to ensure that we will have done our best to achieve maximum effectiveness for every pound spent.

Change also comes to us in respect of those we work with. 2011/12 has seen a change in the composition of the Board of Directors and the Council of Governors. In December 2011 we saw Stephen Griffin retire as Director of Human Resources and welcomed Susan Tyler as the executive Director for Workforce Development, who joined us on 1 January 2012. The composition of our Council of Governors changed to reflect the new geographical area in which we now provide services and I am pleased to be able to report that the elections, which concluded in April 2012, brought new governors to work alongside those remaining. I have been enormously impressed by the way our Council of Governors has supported me and my fellow directors in the development of our Trust. Governors played a crucial role in the transfer of services from NHS North Yorkshire and York and I in particular would wish to congratulate them for the collective maturity displayed throughout the year to supporting this and other changes.

Change is inherent in our daily lives and it is only by having people working within our organisation who are committed to providing excellent care for our service users, and by our organisation being financially stable, well governed and legally constituted that we are able to rise to the challenge of these developments effectively.

Finally, I would like to say that I am immensely proud of the achievements of our staff, governors and partners during 2011/12 and I look forward to 2012/13 knowing that we will again successfully meet any changes that are ahead of us.

I very much hope that you will enjoy reading this report and finding out more about the work we have done.

*Frank Griffiths*

**Frank Griffiths**  
Chair of Trust



*Frank Griffiths*



# Directors' Report

## 2.2 THE CHIEF EXECUTIVE'S REPORT – A REVIEW OF OUR BUSINESS

During the year covered by this Annual Report we became a new organisation. Wednesday 1 February 2012 saw the end of the Leeds Partnerships NHS Foundation Trust (LPFT) and the emergence of the Leeds and York Partnership NHS Foundation Trust (LYPFT). This marked the successful conclusion of a tender process to become the provider of local mental health, learning disability and substance misuse services across York, Selby, Tadcaster and Easingwold, along with being a provider of some services across the whole of North Yorkshire. Also as a result of this change we have extended the range and scope of some of our tertiary services such as forensic psychiatry.

This was not a crude 'take-over' of these services by LPFT; the title of the transfer project was Better Together. Going forward this is also important as it is my intention that we will respectfully listen to each other, paying careful attention to the experience of service users and carers. We will adopt and spread what works well for people and change what needs to be improved. There is no doubt in my mind that if this is done well that together the totality of the services provided will be better than the sum of their parts.

There has been a lot of change in the NHS during 2011/12. This has been driven by a government who, as elected representatives, desire change in how the NHS with social care both commissions and provides services.

The legislative changes have had an effect in respect of our commissioners, examples include NHS Leeds being linked, or 'clustered', with NHS Bradford and Airedale; the ongoing

development of Clinical Commissioning Groups (CCGs), with the Leeds North CCG leading on mental health commissioning on behalf of the Leeds CCGs, and the Vale of York CCG leading on mental health and learning disability services across North Yorkshire and York. Health and Wellbeing Boards have also been established in both York and Leeds, each with their own way of working. Clearly there is much work ahead of us to build partnerships with our new commissioners to ensure we remain the provider of choice.

There is a risk that the leadership of any organisation ends up being distracted by such deep-reaching and rapid changes. In this context, during 2011/12 it has been vital for our Trust to hold fast to our purpose, which is described in our strategy. This places health and wellbeing at the heart of what we do. Put simply this is:

***'Improving health, improving lives'***

Linked to 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 broader intent is fully reflected in the Department of Health's mental health strategy, No Health Without Mental Health (Department of Health, 2 February 2011). All of us have aspirations for what life holds for us and we continue to pay great attention

to enabling people who use our services to achieve to the fullest extent possible the good things they wish for themselves. The aspirations of service users often encompass social care; the need for connectedness to family, friends and the wider community; meaningful participation in a wider society either at work or in the vocational sphere. Treatment and active intervention by professionals is sometimes needed and the way this is provided is vitally important as it often provides a springboard for a person's broader aims to be achieved. These broader issues are not solely pertinent to those who use our mental health services; it is as true for those service users with a learning disability and their carers who are involved with our health and social care services.

Our strategy summarises this and 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.**

It is, therefore, our responsibility to provide safe and effective care whilst knowing that these are no more than a means by which we help people achieve their broader aspirations of living life to the full.

As an organisation we aspire to provide high quality services and the term 'quality' has a number of different dimensions. The most obvious are the obligations arising from the law and/or our regulators. Another aspect of quality is what we learn about ourselves through, for example, the outcome of inspections. During 2011/12 we have had five inspections by the Care Quality Commission

# Directors' Report

(CQC). Four of which were part of the national targeted inspections programme of service that care for people with a learning disability. I am pleased to say that whilst some concerns were highlighted by the CQC, staff quickly actioned the necessary changes and the CQC was fully assured on their revisit. (Further information about these inspections is in section 9).

We are committed to continuing to improve the services we provide. All of our improvements must also increase quality and productivity whilst reducing cost. This is in the context of the NHS saving £20 billion over the next few years. We will do this by, amongst other things, continuing to redesign how we deliver clinical services through our transformation programme. This involves moving away from age-related or speciality clinical directorates towards organisational structures designed around care pathways. We will remove artificial barriers to services based on age. Additionally we will eliminate waste by removing duplication and reducing variation which we know adversely impacts on the provision of high quality, safe, and effective services. During 2011/12 we have made significant progress with this project and we continue to have service user support for the changes we are making.

With our governors, we are also continuing to face up to the issues faced by people with mental health problems and learning disabilities. We do this through media work, actively campaigning against discrimination by taking our positive, yet challenging, message onto the streets of our cities and towns. To make progress we are also engaging with other key interest groups such as leaders in our business community. Looking forward, with partner agencies and groups, it is our intention to step up a gear with regard to addressing the stigma and discrimination experienced by people with

learning disabilities.

In summary, we are here to:

- **Provide excellent quality, evidence-based, safe care that promotes recovery and inclusion**
- **Involve people in planning their care and in improving services**
- **Work with partner organisations to improve health and lives**
- **Value and develop our workforce and those supporting us**
- **Improve our services through learning, research and innovation**
- **Provide efficient and sustainable services**
- **Govern our Trust effectively and meet our regulatory requirement.**

This is not an easy thing to do. We are not a complacent organisation and our experience shows us that there are always ways in which we can improve. Key to this is continuing to put quality at the heart of everything we do. How will we do this? We are a 'people organisation' and in this context we will demonstrate our commitment to the people who use our services, their families and their carers, and to each other, by behaving according to our values:

- **Respect and dignity**
- **Working together**
- **Compassion**
- **Commitment to quality of care**

- **Improving lives**
- **Everyone counts.**

This Annual Report, which includes the Quality Accounts at section 9, illustrates only some of the key points on our journey of being the best we can be.

In concluding I also want to take a moment to thank the staff and governors of Leeds and York Partnership NHS Foundation Trust for their professionalism and the deep commitment they show to their work, 24 hours a day seven days a week. We only do what we do through the work of our people. Everybody working in our Trust either directly or indirectly contributes to creating a better future for service users and carers.



**Chris Butler**  
Chief Executive

# 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 the end goals that we have set ourselves.

At the end of 2011/12 the Board of Directors was made up of seven non-executive directors, including the Chair of the Trust, and six executive directors, including the Chief Executive.

### The Non-executive Team

■ Frank Griffiths (Chair 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), Michele Moran (Chief Operating Officer/Chief Nurse and Deputy Chief Executive), Guy Musson (Chief Financial Officer and Deputy Chief Executive), and Susan Tyler (Director of Workforce Development),



(L-R) Michele Moran (Chief Operating Officer/Chief Nurse), Frank Griffiths (Chair of the Trust), Chris Butler (Chief Executive), Jill Copeland (Director of Strategy and Partnerships)

During 2011/12 the following also held positions on the Board of Directors:

■ Stephen Griffin, Director of Human Resources, (retired on 31 December 2011).

Further and 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

The Equality Act (2010) requires public sector organisations to:

- Publish equality information on an annual basis
- Develop and publish four-year equality objectives by April 2012.

We have undertaken a review of our performance to meet our statutory duties under the Equality Act 2010 so that we can further develop our equality, diversity and human rights performance. This information is published on our website [www.leedsandyork.nhs.uk](http://www.leedsandyork.nhs.uk)

We have used the Equality Delivery System (EDS) which is a framework developed through the NHS, to help us to assess our equality performance and to identify our equality priorities under the following four areas:

- Better health outcomes for all
- Improved patient access and experience
- Empowered, engaged and included staff
- Inclusive leadership.

We implemented the EDS framework through



# Directors' Report

consultation and involvement with our key stakeholders and local interest groups who represent the views of people from different equality groups. These groups are known as 'protected characteristics' under the Equality Act 2010 and include representation of people through age, gender, gender reassignment, race, disability, religion or belief, sexual orientation, pregnancy or maternity and marriage or civil partnership.

We involved our local voluntary, community and faith organisations, our staff, our service users and carers in the consultation process.

Through this consultation process the following four-year equality objectives have been identified and will be embedded within our business planning and performance monitoring processes during 2012/13:

- **To improve the collection, analysis and use of equality data and monitoring for protected groups**
- **To develop a consistent approach across the local NHS economy in respect of equality leadership, staff empowerment and access to development opportunities**
- **To further develop the involvement and engagement of protected groups and local interests including service users, carers, staff, third sector, Clinical Commissioning Groups and the local authority**
- **To improve access and service user experience and choice for protected groups.**

## 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 our service users and staff.

We are committed to eliminating discrimination and to the fair treatment of everyone, taking into account their gender, race, colour, ethnicity, ethnic or national origin, citizenship, religion or belief, disability, mental health needs, age, domestic circumstances, social class, sexual orientation, marriage or civil partnership, beliefs or trade union membership, gender reassignment, pregnancy or maternity. 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 whilst 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 "✓✓" (known as two ticks) employer, which demonstrates commitment to supporting people with disabilities to successfully attain and retain employment within the Trust.

We have supportive employment practices in place not only for those that 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; the Staff Support service and a bespoke Occupational Health service. These procedures and services support the employment and retention of disabled employees and the implementation of reasonable adjustments to take account of an individual's needs. Currently 4.5% 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

# Directors' Report

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. Details of senior employees' remuneration can be found in the Remuneration Report in Section 8.

## 2.9 OUR AUDITORS

External audit services are provided by PricewaterhouseCoopers LLP (PwC). The Council of Governors appointed PwC for three years from 1 June 2009 to 31 May 2012. At its meeting in February 2012 the Council of Governors agreed that this contract should be extended for a further two years, after which these services will be subject to competitive tender.

Internal audit and counter fraud services were provided in-house until 31 May 2011. With effect from 1 June 2011 RSM Tenon was appointed to provide both internal audit and counter fraud services for a period of three years until 31 May 2014. This contract was secured through a competitive tender process.



*Building Your Trust Event, 2011*

## 2.10 COMPLIANCE WITH THE CODE OF GOVERNANCE

The Board of Directors considers that, except where mentioned below, throughout 2011/12 the Trust has met the requirements of the Code of Governance. Non-compliance or limited compliance is reported as follows:

**Main Principle A.3:** - "All directors should be able to exercise one full vote". Up until the end of December 2011 the post of Director of Human Resources was filled on a part-time basis. This post did not have a vote on the Board of Directors. However, with the substantive appointment of the Director of Workforce Development on 3 January 2012 all directors on the Board of Directors now have one full vote.

# Directors' Report

**Code Provision C.2.1:** - *"Re-appointment (of the Chief Executive) by the non-executive directors followed by re-approval by the Council of Governors thereafter should be made at intervals of no more than five years. All other executive directors should be appointed by a committee of the Chief Executive, the Chair and non-executive directors and be subject to re-appointment at intervals of no more than five years".* The process of appointing the Chief Executive and executive directors is in full compliance with the requirements of the Code of Governance. However, the Chief Executive and executive directors are employed on permanent contracts, with the exception of the Medical Director who is currently on secondment until such time as a substantive appointment is made. There are no plans to move away from substantive executive directors being on a permanent contract as this provides continuity for the organisation.

**Code Provision C.2.3:** - *"The names of governors submitted for election or re-election should be accompanied by sufficient biographical details and any other relevant information to enable members to make*

*an informed decision on their election. This should include prior performance information such as attendance record at governor meetings and other relevant events organised by the NHS Foundation Trust for governors".* Attendance at events, other than the Council of Governors is not made available because elected members come from a wide variety of backgrounds and are able to devote different amounts of time to the role. Therefore we do not want to appear to penalise governors who are only able to attend the formal Council of Governors' meetings.

**Code Provision D.2.1:** - *"The Chair, with the assistance of the secretary of the board, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for directors relevant to their duty as board members".* The Chair of the Trust is not solely responsible for determining the individual and collective professional development programmes for directors. The Council of Governors agrees the method of appraisal for both the members of the Board of Directors and the Council of

Governors. The Chair of the Trust determines the development programme for non-executive directors and the Chief Executive determines the development programme for executive directors. There is also an annual process of evaluation which is undertaken by the Board as a whole and from this come jointly agreed objectives, some of which may then roll forward into individuals' development plans.

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

**Code Provision G.1.6:** - *"The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement. This information should be used to review the Trust's membership strategy, taking into account any emerging best practice from the sector".* This function is primarily carried out by the Council of Governors' Membership Committee and not the Board of Directors, although the committee is supported by the Director of Strategy and Partnerships.



## 2.11 POLITICAL AND CHARITABLE DONATIONS

The Board reports that there have not been any political or charitable donations and that it is not the policy of LYPFT to make any such payments.



What else would  
help you in your  
'journey'  
through our services?

Easy to  
understand  
information

Write your  
ideas / comments  
on a label and  
tie it to the  
luggage!



# Our Strategy

## 3 OUR STRATEGY

In 2010 we launched our new Trust strategy – Improving health, improving lives – setting out our plans for 2010 to 2015. In 2011/12 we have continued to embed our strategy, refining definitions of strategy measures and ensuring that its reporting systems are robust.

The strategy is designed around the three key elements of quality: effective outcomes, safe care, and positive service user and carer experience. At its heart are the people who use our services, their families and carers. To ensure that our strategy is accessible to the public, we have developed both a summary version and an easy read version, which is designed to be accessible to people with a learning disability.

A summary of our strategy is shown below:

<b>Summary: Improving health, improving lives</b>						
<b>Purpose</b>	Improving health, improving lives					
<b>Values</b>	Respect and dignity	Commitment to quality of care	Working together	Improving lives	Compassion	Everyone counts
<b>Ambition</b>	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.					
<b>End goals</b>	<b>1</b>	People achieve their agreed goals for improving health and improving lives	<b>2</b>	People experience safe care	<b>3</b>	People have a positive experience of their care and support
<b>Means goal 1</b>	We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion					
<b>Means goal 2</b>	We involve people in planning their care and in improving services					
<b>Means goal 3</b>	We work with partner organisations to improve health and lives					
<b>Means goal 4</b>	We value and develop our workforce and those supporting us					
<b>Means goal 5</b>	We improve our services through learning, research and innovation					
<b>Means goal 6</b>	We provide efficient and sustainable services					
<b>Means goal 7</b>	We govern our Trust effectively and meet our regulatory requirements					

Our three end goals are the quality priorities that we are here to achieve. 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. Directorate and team business plans go on to describe detailed local implementation plans.

During 2012/13 we will undertake a full strategy refresh; and will consult with a broad range of stakeholders to ensure that our strategy remains relevant, particularly in light of the new North Yorkshire and York services that have transferred to our Trust this year.

Since these services have transferred we provide several new services, notably Child and Adolescent Mental Health Services (CAMHS) and primary care mental health services, including Improving Access to Psychological Therapies (IAPT). We must also respond to the needs of the new geographical area that we cover: we now provide mental health and learning disability services across York, Selby, Tadcaster and Easingwold; as well as providing certain specialist services across the whole of North Yorkshire. We will consult with new colleagues and partners to ensure that our refreshed strategy properly reflects assessed need in these localities.

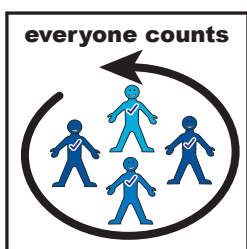
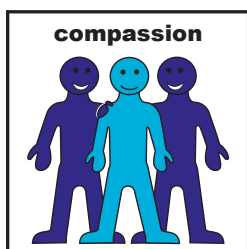
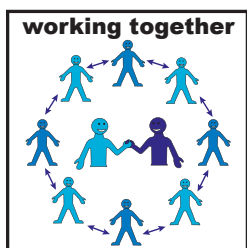
### Implementation of the Trust values

Our Trust welcomed the publication of NHS Values, as set out in the NHS Constitution, and these are central to our strategy. As well as setting out what we aim to achieve, we have described how we will behave whilst doing so. In consultation with governors, service users, carers and staff, we have tailored the values to describe what they each mean, and some of the behaviours that might be expected if we are meeting them.

Our Charter of Values is shown on the following page.

During the coming year we will work with new colleagues in North Yorkshire and York to share our values, as part of the broader cultural integration work programme.

More information regarding our strategy can be found in our Annual Plan which is published on our website [www.leedsandyorkpft.nhs.uk](http://www.leedsandyorkpft.nhs.uk).



# Charter of Values

**How we go about our work, everyday, is influenced by our values – the beliefs that we hold dear and that guide how we behave.**

We commit to living our values every day and we will show this commitment to our values in the way we behave.

## Trust Values

### 1 Respect & dignity

*"We value and respect every person as an individual. We challenge the stigma surrounding mental ill health and learning disabilities. We value diversity, take what others have to say seriously, and are honest about what we can and can't do."*

### 2 Commitment to quality of care

*"We focus on quality and strive to get the basics right. We welcome feedback, learn from our experiences and build on our successes."*

### 3 Working together

*"We work together across organisational boundaries to put people first in everything we do."*

### 4 Improving lives

*"We strive to improve health and lives through providing mental health and learning disability care. We support and empower people to take the journey of recovery in every aspect of their lives."*

### 5 Compassion

*"We take time to respond to everyone's experiences. We deliver care with empathy and kindness for people we serve and work alongside."*

### 6 Everyone counts

*"We work for the benefit of the whole community and make sure nobody is excluded or left behind. We recognise that we all have a part to play in making ourselves and our communities healthier."*

# 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, carers and staff at the heart of everything we do. Our principal activity is the provision of free healthcare to eligible service users.

### 4.1.1 The transformation programme

The aim of the transformation programme is to re-design the way in which clinical services are delivered. It aims to make services better, simpler and more efficient by applying proven service improvement methodologies to all clinical and clinical-related services provided by the Trust.

Transformation is following an innovative approach using Lean, Six Sigma methodologies. This will determine how clinical services are structured and delivered to maximise activities that add value to service users and eliminate inefficiency and unnecessary variation.

This is supported by the development of a core integrated care pathway and individual needs-based integrated care pathways that provide an evidence-based approach to the delivery of care to service users.

Integrated care pathway design places service users and carers experience at the centre of the process with the aim of:

- The right people
- Doing the right things
- In the right order
- In the right place
- With the right outcome

- Paying attention to the patient experience
- Comparing planned care with care actually given.

Improving the quality of care provided to service users is a major part of the transformation programme. We have involved service users in the mapping of existing services and held 'voice of the customer' workshops to inform the analysis and design phases of the work. Service users have told us how to make our services simpler, better and more efficient. Practical examples include the suggestion that "if there was one assessment (with information used by all parts of the service), this would be easier", and that individual service users wanted services "to focus on recovery and wellbeing".

We aim to increase the amount of time available for staff to spend with service users because service users tell us they find "one-to-one time with clinical staff valuable". We will do this by making paperwork easier to complete and improve the technology available to clinical staff.

This approach has been used to ensure that our services follow the Trust strategy 'Improving health, improving lives', which promotes excellent mental health and learning disability care that supports people to achieve the very best that they can for their health and wellbeing.

We are working with partners in the health and voluntary sectors in the transformation of clinical services. The development of innovative services and new models of care will be encouraged. Recovery and social inclusion principles are incorporated into new service models. Joint working with Leeds City Council

Adult Social Care staff is taking place and this will explore the principles of self-directed care and personal budgets.

The transformation programme will deliver redesigned clinical services which do not discriminate in respect of age and are based around integrated care pathways which will describe a logical and evidence-based standard of care that service users should expect to receive.

### 4.1.1 Community services

In 2011/12 we reviewed community mental health and learning disability services. Process mapping of community services identified a number of efficiencies that could be made by reducing duplication and unnecessary variation in the care delivered. This led to some of our processes being re-designed and a number of test projects were undertaken. Clinical staff developed new ways of working, streamlined assessment and formulation processes and assessed the benefits of new technologies. As a result of this a new service model for community mental health services and community learning disability services was developed and this new model will be implemented in 2012/13.

In 2011/12 we also reviewed the services that we provide in the Leeds community. Clinical staff and experts have looked closely at the way we provide these services and have identified a number of ways that we can make them better, simpler and more efficient. We have identified a number of changes that will make our services easier to use, allow clinical staff to spend more time with service users and simplify assessment and planning of care. We will introduce a new service model in 2012/13

# Operating and Financial Review

with a single point of access to our services based on the individual needs of every service user.

## 4.1.1.2 Alternative to hospital services

The transformation programme has carried out mapping and analysis of a range of alternatives to hospital services. This work also identified areas where efficiencies can be made and service quality improved.

Design projects were commissioned to inform a new service model that will be implemented along with changes to community mental health and community learning disability services. These have resulted in the development of a single point of access and single point of urgent referral. This establishes a central service, supported by staff from locality teams. The single point of access will assess referrals and ensure that service users are directed to the most appropriate care in the right environment to meet their needs. A new model to deliver a range of intensive community-based services has also been developed.

In 2011/12 we have also reviewed day care services and intensive support services provided to the Leeds community. These services provide support to service users in their own homes. These services, which offer an alternative to hospital admission, have been re-designed by clinical teams to work alongside the new community service models. The new single point of access will ensure that service users, carers and other health professionals have easy access to clinical services and support from a range of staff to meet their individual needs. Urgent care will be easy to access when needed and links to

existing locality-based community services improved by the new model.

## 4.1.1.3 Inpatient services

The Service Improvement Team has commenced process mapping of the inpatient services in Leeds.

We have started to look at the inpatient services provided by the Trust. Clinical teams have started to review the Leeds-based inpatient facilities and identified opportunities to improve these services. Analysis and redesign work will take place in 2012/13.

## 4.1.1.4 North Yorkshire and York

Following the formation of the LYPFT in February 2012 the transformation approach will also review the services in North Yorkshire and York. Data collection and process mapping of existing services will be carried out using York-based clinical staff, working with existing Transformation Team members. This work will commence in 2012/13.

## 4.1.2 Principal activities of the Trust

### 4.1.2.1 Adult Mental Health and Older People's Directorate

Over the next year the Adult and Older People's directorates will come together to form a single service which will make sure that all service users have equal access to a range of services based on need rather than age. The services will continue to strive to provide the highest quality safe care, focused on achieving effective and positive outcomes for service users. The services will also continue to provide

assessment and care which recognises the different needs of service users, and employ staff who have skills in meeting these needs. Community mental health teams, psychological therapies and acute community services will be located together to make sure that service users can move between services via a smooth care pathway.

The directorate will provide a range of acute and community services to service users over the age of 18 which will focus on service user need. The range of services includes:

- **Community mental health teams**
- **Care Home Team**
- **Memory Service**
- **Crisis Resolution Service (including A&E psychiatric liaison)**
- **Acute community services**
- **Younger People with Dementia Team**
- **Psychological therapies**
- **Mental Intermediate Care Team**
- **Assertive Outreach Team**
- **Older People's Liaison Mental Health Service (based at St James Hospital)**
- **Mental Health Inpatient Service**
- **Dementia Inpatient Service**
- **Rehabilitation and recovery services**
- **Healthy Living Service**
- **Inpatient and community forensic services.**



# Operating and Financial Review

## Key achievements for the Adult Directorate during 2011/12

During 2011/12 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.

■ Waiting times for service users who need psychological therapies have again been reduced with no service users waiting longer than 12 weeks for an appointment with the service. The number of people waiting has reduced from 425 to 75 and we will continue to monitor the waiting list, aiming to reduce this even further in 2012/13

■ By better using the capacity across both hospital inpatient services and the acute community alternative services, such as home based treatment and acute community services, we have been able to reduce the number of people who need to receive inpatient care treatment outside of Leeds. We know from service user feedback that they value being treated locally because it helps them maintain contact with carers and other support and helps them recover faster. In the last year we have reduced by 30% the number of days that service users have been treated outside of Leeds and we will continue to aim to further reduce this

■ The Adult Directorate has worked closely with colleagues from the Leeds Addiction Unit and other relevant partner agencies to better meet the needs of service users needing help with both their mental health and addiction. We are confident that, by developing closer links with services providing specialist addictions services, and by increasing training opportunities for staff working with this complex group of people that services now

better meet the needs of this service user group

■ We have moved the rehabilitation and recovery services that were provided at Peel Court to new premises at Towngate House. This means that all the inpatient services in rehabilitation and recovery are now delivered from modern buildings and have, therefore, significantly improved the experience of service users.

## Key achievements for the Older People's Directorate during 2011/12

■ Significant work has continued throughout 2011 to develop The Mount as a centre of excellence. The mental health wards have used the AIM'S (accreditation for Acute Inpatient Mental Health Services) process to develop a wide range of best practice standards. In October 2011 it was confirmed that they were successful in being awarded this nationally-recognised accreditation

■ The dementia care mapping project undertaken with Bradford University is well underway and is helping us to make changes in this area of care. We are also developing clear pathways of care that will help us deliver person centred care to all our service users

■ As well as supporting Sterling University in health support worker training, practical person centred training packages are being developed for our dementia services

■ There is a twice-yearly event for carers of service users with dementia and through this group we are able to identify areas for change. For example at the last meeting we identified access to outside space and excessive heat on wards as priority areas and we are developing

actions to address these issues.

## Some of the key priorities for the future

There has been much work undertaken within the Adult and Older People's Directorates to transform and improve the experience of service users across the care pathways. Much of this work will see changes to the way in which services are delivered. A key aim of these changes will be to make sure there is as little disruption as possible for service users. Where we can, we will maintain the current relationships between service users and the teams who see them in the community. In the next year we will be introducing integrated care pathways across services to provide safe, high quality care in a consistent way, which makes the best use of our resources.

As well as the improvements planned through the transformation programme there will be other service changes which will be delivered in the next year, all of which will seek to improve the experience of service users:

■ We will open a new 17 bed secure rehabilitation ward at the Newsam Centre which will provide care for Leeds residents who are currently receiving this care elsewhere in the country. For service users whose needs continue to be best met in non-Leeds services the directorate has recruited two case managers who will continue to monitor whether the needs of these service users can be met by local services

■ We will build upon the work we have already done to look at innovative ways of providing psychological, vocational and occupational therapies and transfer this into the transformation programme. This work will

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help both in the development of a number of integrated care pathways and with the development of roles in our teams

■ We will deliver the action plans which have been developed following the dementia care mapping work that has been undertaken within the directorate. This work looks at how service users with dementia experience the care that is delivered to them and the effect this has on their wellbeing

■ Plans are being developed to expand the services that can be offered by our Crisis Resolution Team through the creation of a 'flexible care environment'. This will mean that people who are brought to the Becklin Centre as a 'place of safety' by the police service can receive more therapeutic activities and care as well as assessment of their mental health.

There are a number of risks and uncertainties that face the directorate in the next year. We recognise that the services we provide are one part of a much wider group of partners who support people with mental illness. In the current economic climate some of these other services are being reduced and we will continue to work with partners to help minimise any impact for our service. We also need to become better at showing the positive outcomes our services create. To help us evidence this we will be introducing a number of outcome measures in the next year, including the offer to service users to tell us of their experience of our services. Finally we understand that whilst we are trying to minimise the disruption that changing our services may have, we will work with service users to make sure that these are managed and that they happen at a pace which service users are comfortable with.

## 4.122 Specialist Services Directorate

The Specialist Services Directorate is a collection of eight specialist services operating on a local, regional and national basis. The services respond to the requirements of multiple commissioners, with many of the services now being commissioned by the North of England Specialist Commissioning Group. The directorate is working towards achieving nationally-defined specifications and standards in preparation for the NHS National Commissioning Board. Directorate staff are working closely with commissioners to ensure service user need and experience is at the forefront of service changes and that the expertise in our specialist services is recognised.

During 2011/12 the directorate has continued to develop outcome measurement as a quality indicator for service delivery. Research, teaching and evaluation of services has helped ensure that services are up to date, use effective interventions and are participating in service development on local, regional and national levels. This will place the directorate in the best position to promote the excellence of our services within the new commissioning frameworks.

### Key achievements during 2011/12

- **The Addiction Service has two additional senior nurse posts to increase the provision of the service and to specifically increase the detoxification clinics for people leaving Leeds Teaching Hospitals Trust early for continued treatment of their alcohol use disorders**
- **The Addiction Service Co-production Group, which is service user-led, continues to go from strength to strength with an expanded range of activities for service users**
- **The Gender Identity Service has implemented a multidisciplinary prescribing clinic bringing together the skills and knowledge of a prescribing doctor, pharmacist and consultant endocrinologist**
- **The Personality Disorder Clinical Network has led on the development of an effective clinical pathway across adult services for people with a personality disorder**
- **A single point of referral has been established for the Personality Network services, which has improved access for service users**

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■ **The Prison Mental Health In-reach Service has formed effective links and working arrangements with the newly formed Primary Care Mental Health Team in HMP Leeds. These links include shared governance arrangements and significantly improved follow up arrangements and liaison across Leeds for those individuals seen within court and approved premises.**

## 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 to meet the needs of our new commissioners and recognise the changing requirements of service users and skills of staff. Directorate staff will be fully engaged in the transformation programme and all services are being process mapped and evaluated to ensure that the best quality of care is delivered within the best staffing structures.

There are some risks and uncertainties that face the directorate in the coming year. Many of the specialist services have now moved under the Specialist Commissioning Group framework. While this offers opportunity for development and partnerships, it raises challenges in meeting new national specifications while integrating effectively with local pathways and ensuring financial allocations are appropriate and adequate.

Some services are at risk in the current

financial climate due to PCTs reducing their out of area placements funding and non-urgent treatments approvals. The directorate needs to ensure it can evidence outcomes of treatment, and marketing and promotion of services is essential.

## 4.123 North Yorkshire and York Directorate



*View from the York Walls*

The North Yorkshire and York Directorate delivers community and inpatient services to adults of all ages and also to children and adolescents with mental health problems, learning disabilities and substance misuse problems in the York, Selby, Tadcaster and Easingwold areas. Forensic community services and low-secure inpatient services are provided to adults in the whole of North Yorkshire and York and to the Yorkshire and Humber region. The Child and Adolescent Mental Health Service also provides highly specialised inpatient services to the whole of North Yorkshire and York and hosts the North of England section of the National Mental Health Service for Deaf Children and Families. All services continue to strive to provide the highest quality safe care focused on achieving effective and positive outcomes for all service users.

## Key achievements for the Directorate during 2011/12

■ The Meadowfields Older People's unit has been involved in a King's Fund project to 'enhance the healing environment'. The entire team has been involved in this initiative which has greatly improved the dining area and the kitchen facilities. Both areas can now be used for activities and provide a pleasant and relaxing area for service users and carers

■ Staff from the Older People's Directorate have been working with Yorkshire Film Archive to develop a memory bank for use in reminiscence work. Meadowfields and Mill Lodge used the resource with groups of service users and carers. Staff have spent time developing memory boxes relating to the film theme. This has helped unlock memories and generate discussion. Bradford Dementia Group has been involved in evaluating the benefits of this work and has highlighted the tangible effect on mood and the improvement of wellbeing, communication and engagement

■ The Child and Adolescent Mental Health Service (CAMHS) for deaf children has been established as a permanent service following independent evaluation of a pilot undertaken by the University of York

■ The specialist CAMHS Service has run three innovative projects whereby service users have made short animated films with two local professional animators as guidance to service providers. These have included films about improving communication with deaf children; therapeutic support that helped within anorexia nervosa; and a young people's perspective on what it is like to have Asperger syndrome. The last of these won an international award at the Edinburgh Science and Arts Festival

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■ There has been a refurbishment and improvement to the acute mental health wards at Bootham Park Hospital to provide individual rooms, some with en-suite, and full single-sex accommodation

■ A new Veterans, Vulnerable Adults and Dependents Service (VVADS) has been implemented. This provides a specialist psychological therapy through the Improving Access to Psychological Therapy (IAPT) service to the population of Catterick Garrison in partnership with the Ministry of Defence

■ The Learning Disability Service has opened White Horse View and developed a clear discharge pathway for men with complex and challenging needs.

## Some of the key priorities for the future

The key strategic issue for the North Yorkshire and York services is to ensure that their transfer maintains and improves existing areas of excellence and quality, whilst delivering save and effective services. The North Yorkshire and York Mental Health and Learning Disability services will benefit from joining an organisation whose core business is providing mental health and learning disability services. It will also benefit from joining an established foundation trust with an excellent record of achievement. The new organisation will build strength from the expertise of colleagues in both Leeds and York.

■ Community and inpatient services will be reviewed within the Trust's transformation programme to ensure that the pathway for service users is clear and that each service user receives the service they need in the right place at the right time

■ Progress the development of a new inpatient women's low-secure mental health service to enhance the care pathway for women within the low-secure service

■ The Learning Disability Service will develop the Easingwold site to provide services for people with autism, and enhance the care pathway for women currently receiving care out of area

■ Plans are being developed to expand the services offered by our Intensive Home Treatment Team through the creation of a Section 136 suite. This will mean that people can be brought to the new unit as a 'place of safety' by the police service to receive assessment of their mental health needs in a therapeutic environment as opposed to police cells.

There are a number of risks and uncertainties that face the directorate in the next year. We recognise that the services that we provide in the directorate are one part of a much wider group of partners who support people with mental illness. In the current economic climate some of these other services are being reduced and we will continue to work with partners to help minimise any impact to our service.

## 4.124 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 who have additional complex health needs and / or challenging behaviour.

The directorate provides a range of health and social care services including community,



*Learning Disabilities Week 2011*

inpatient, and day care services. Services such as nursing, psychiatry, psychology and therapy services are delivered by staff trained and/or experienced in the speciality of learning disabilities. The directorate currently provides healthcare through a tiered service model which is accessed through a single point of referral. Services are strategically driven by local and national policies and initiatives. Transformation of the Trust's services will, however, see changes to this model in the future.

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



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Service user involvement continues to develop, by consulting and working with service users on various projects, as well as linking up with other organisations and service user groups.

## Key achievements during 2011/12

- The learning disability 'Your Health Matters' campaign, won the Mental Health and Wellbeing category at the Leeds Health Stars Awards in 2011

- The directorate was a finalist for the Nursing Times Awards in 2011 with the 'Your Heart Matters' project

- 'YourHeartMatters' booklets were launched across Leeds. A booklet for the Leeds Cardiac Rehabilitation Service was produced alongside a nurses guide, followed by a general guide for people with learning disabilities

- The directorate has increased its links with partner organisations which has improved access to services for people with learning disabilities, for example access to the Intermediate Care Team. This resulted in shadowing opportunities for both organisations, and staff training being supported through the learning disability e-learning package

- 'Ventures' Day Service has established a number of new therapeutic groups, including a sports and fitness group, a relaxation programme and a dance and movement group

- Work on an easy-read guide to the Care Programme Approach (CPA) was recognised as highly commended at the 2011 Care Programme Approach Association Awards

- The Specialised Supported Living Service was successfully relocated to fully refurbished and accessible premises at 1 Woodland Square.

## Some of the key priorities for the future

- Continue to support the transformation programme utilising Lean and Six Sigma methodologies to re-design and develop services into a new learning disability pathway

- Establish the Fulfilling Lives Project which will include the recruitment of two resource workers, the refurbishment of the Faith Centre and start day service alternatives for up to five service users per session during 2012

- Continue the development of the easy on the 'i' symbols

- Continue to deliver expertise to Social Services staff in order to improve competencies in Rebound Therapy, thus enabling staff to support maintenance programmes

- To continue to benefit from implementing the Productive Community series within the community learning disability teams.

There are a number of risks and uncertainties that face the directorate in the next year. We recognise that the services we provide are one part of a much wider group of partners who support people with learning disabilities. In the current economic climate some of these other services are being reduced and we will continue to work with partners to help minimise any impact to our service. There are some changes in the nature and complexity of the learning disability service user population and

this is being addressed in our transformation work. Whilst making any changes within our services we will work with service users and carers to make sure that these are managed and that they happen at a pace with which service users are comfortable.

## 4.2 GROWING OUR TRUST

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 mental health, learning disability and substance misuse services in York, Selby and Tadcaster, together with a number of pan-regional services.

Following a full due diligence process and a detailed review of the transaction by Monitor we successfully transferred staff and services from North Yorkshire and York to our Trust on 1 February 2012. Our Trust was renamed the Leeds and York Partnership NHS Foundation Trust and we now have over a thousand new members of staff.

During 2012/13 we will be focused on integrating the North Yorkshire and York structures and processes with our existing Leeds structures and processes. Because of this, we have no current plans to undertake further major growth transactions until this important integration work is complete. We will, however, continue to monitor growth opportunities as they arise, both by scanning published tender and procurement opportunities and by engaging with local, regional and national commissioners to

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respond to gaps in current provision. During 2012/13 we plan to undertake a full refresh of our market analysis, in order to inform the Board in setting our future growth and investment strategy.

## 4.3 HOW WE ARE USING OUR FOUNDATION TRUST STATUS TO IMPROVE SERVICE USER CARE

We were authorised as a foundation trust (FT) in August 2007. Since this time we have made good use of the benefits of FT status, maintaining a strong financial position whilst making full use of our financial strength to improve services. In 2011/12 we successfully acquired mental health and learning disability services in the North Yorkshire and York area. This means that we are able to offer the residents of North Yorkshire and York the same high quality service as is provided to the residents of Leeds. This has meant our annual turnover is now in the region of £170 million and we employ around 3,400 members of staff.

We are committed to working in partnership with the people who use our services, their families and friends and our external 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 Council of Governors; people elected and appointed, who have an important role in helping us to develop the way in which we deliver services.

During 2011/12 we have used the benefits of being a foundation trust in the following ways:

- Members and governors have been able to participate in the development and integration work with North Yorkshire and York, including a very broad consultation around the name of the new organisation

- Members have been encouraged to participate in a wide range of activities including the Love Arts Festival, 'Everything you need to know about' events, and a variety of Building your Trust involvement events

- 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 and to promote positive mental wellbeing. Members have also identified future areas of interest that they would like to know more about. This insight will be used to shape future events

- At the Annual Members' Day, in September 2011, our members were able to comment on our anti-stigma work and to understand how the arts influence our mental health and wellbeing. Members had the opportunity to influence the early stages of our transformation programme and the way services may be delivered in the future

- Through our governors, members have been able to influence our direction of travel and the way we deliver our services

- One of our governors has been closely involved in the development of our 'Get Me?' learning disability stigma campaign that we will launch in the summer

- Governors continue to be fully involved in reviewing the measures for our strategy

- Governors agreed the membership trajectory for the development of members in the North Yorkshire and York region over the next five years

- Governors have been involved in the Patient Environment Action Team (PEAT) inspections.

## 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 our service users 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 2012/13 and the questionnaire will be distributed to service users on discharge or at the end of a specific intervention. This allows 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 to 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. We are currently undertaking our inpatient survey and will be reporting the results later in the year.

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The 2011 community survey showed that overall 63% of people who responded said that the care they had received in the last 12 months had been either excellent or very good. Year-on-year data indicates that many information and involvement related scores have improved since the start of the survey. For instance, involvement in decisions about medication and overall care, and on having an out-of-hours telephone number to call. Scores relating to frequency of treatment have declined: i.e. service users being seen in the last month. A significant number of scores remained similar to the results of the previous year.

The results of all the surveys are reported to the Board of Directors and the Council 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.

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

- Carers for service users in the Older People's Directorate met with staff from the Liaison Psychiatry service to discuss interface issues between acute and mental health services. Feedback from this event is being actively used to develop solutions to their areas of concern
- Service users' feedback in the Rehabilitation and Recovery Service has led to the creation of a group room and relaxation room at Asket House
- Service user feedback of their experience of the Section 136 service has informed the Response Team's training programme
- The Gender Identity Service provide both a hormone information group for clients who have not yet begun hormone treatment and one-to-one counselling appointments with the team pharmacist if they prefer to speak to someone about hormones on an individual basis. This is to ensure full understanding of the treatment provided and the advantages and disadvantages of the treatment. Clients can then make an informed decision regarding hormone treatment
- The Learning Disability Directorate has set up a service user led project developing health resources for the city
- Feedback about the need for information to be accessible has led to the Learning Disability Directorate opening a multi-media suite to promote the use of multi-media profiling and new approaches to making information more accessible.
- Provision of internet access for service users in the Rehabilitation and Recovery Service
- Changes to the windows in inpatient units following feedback from service users that ward temperatures were too high
- Concerns raised about access to outside space and fresh air at The Mount has led to the development of the garden project
- Feedback from service users has shaped the development of the 'menu of group interventions' across inpatient and acute community services. This has generally received very positive feedback from service user

carers up to date on local events and plans for wards and services. The meetings are an opportunity for people who use our services to give feedback and share ideas about issues such as information on the wards, signage, and plans to develop the services. As a result of involving people who use our services we have:

- Celebrated the opening of Lavender Court, a women only garden at the Becklin Centre
- Changed the windows at the Becklin Centre
- Developed a wider range of activities for inpatient services.



*New windows for the Becklin Centre*

Recent developments that have taken place within the Older People's Directorate have all been consulted upon and people's opinions taken into consideration.

## 4.4.2 Public and patient involvement

Many of our clinical teams routinely hold community meetings to keep service users and

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The Recovery and Social Inclusion Team, along with the Personality Disorder Network, the Addictions Service and a number of various specialist services all have service user involvement groups which meet 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 more immediate 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 questionnaire will be rolled out across our services from April 2012.

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

Along with the Diversity and Social Inclusion Forum and the Building Your Trust events, we are able to demonstrate a 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 works alongside both Advocacy and the Complaints Team and will make referrals to these services when appropriate.

During the period 1 April 2011 to 31 March 2012 the PALS Team handled 783 cases from across the organisation, compared with 691 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 captures and records the issues raised and feed these back into the organisation to help learn, influence development, and ensure continuous 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 the period 1 April 2011 to 31 March 2012 the Trust received 54 formal complaints, compared with 56 formal complaints received in the corresponding period last year. To ensure we comply with NHS complaints regulations and locally agreed timescales, 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 we have learned from our mistakes and services have been changed are:

- **Revising the policy for re-referral for alternative therapy**
- **Amending the Trust policy for use of email contact with service users**
- **Revising the protocol for information forwarded to other agencies and providing training to relevant staff**
- **Revising the procedure for obtaining clinical information from other agencies prior to admission to the Perinatal Unit**
- **Improving the standard of footpaths leading to the Newsam Centre.**



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## 4.5 PARTNER RELATIONS

### 4.5.1 Knowledge Transfer Partnership

In 2011/12 we concluded a Knowledge Transfer Partnership (KTP) with the School of Healthcare at the University of Leeds which developed and tested a vocational support model that we can use in our organisation. Through action-oriented research with our service users, clinicians and managers we have widened our understanding of how to support most effectively the diverse range of mental health service users. As a result of the KTP we have established ongoing monitoring and evaluation of employment outcomes. This allows us to measure the social and economic impact of the work of employment specialists within our community teams. The employment specialists work for Leeds Mind and are co-located within our Community Mental Health Teams.

### 4.5.2 Improving access and outcomes for service users from black and minority ethnic (BME) communities

We have a partnership project with community development workers from the voluntary sector organisation Touchstone, which reaches into five adult inpatient wards. The project aims to support the development of the workforce through cultural competence training. Through action research it also aims 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 Jobcentre 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 Service provides our service users with access to volunteering opportunities both within and external to 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 campaigning work to reduce stigma.

- The Diversity Team and the Human Resources Department work in partnership with NHS Leeds and Leeds City Council to support them in developing positive human resources practice in relation to Mindful Employer®

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

- The Carers Connections training programme that sits within the Mental Health Carers Team provides training and information opportunities for carers to help support them in their caring role. These opportunities continue to be in partnership with other organisations such as Willow Young Carers, Carers Leeds, Leeds Metropolitan University and Leeds City Council. Some training this year has been provided with the Recovery and Social Inclusion Team and has been aimed at bringing carers, service users and staff together to gain a shared understanding of mental health issues, such as depression and crisis planning

- Our Carers Team, in partnership with Carers Leeds and Arts and Minds, has received funding to develop an e-learning package for use by key workers for carers in both web-based and DVD formats. The e-learning package is now complete and is hosted within the Skills for

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Care website resources. The two modules are designed to help front line staff that may come into contact with carers to support them in the identification and signposting for support

■ A partnership has been established with Leeds Mind to develop a community arts centre, Inkwell, in north Leeds that focuses on mental health and inclusion. Our Arts and Minds staff are co-located with Inkwell as a central point for arts and mental health in Leeds. The renovation work has been completed and the centre is now available for commercial hire.

## 4.6 CORPORATE SOCIAL RESPONSIBILITY

### 4.6.1 Engaging employers

We have previously secured Yorkshire and the Humber Improvement Partnership funding to deliver mental health awareness training to public and private sector staff. This training took place in 2011 and we have developed this into a range of products that we market to both these sectors.

### 4.6.2 Arts and Minds

We have undertaken a wide range of activities that use arts within our services to enable service users to participate in the cultural life of Leeds. Below are some of the highlights of 2011/12:

■ Our first Love Arts Festival ([www.loveartsleeds.co.uk](http://www.loveartsleeds.co.uk)) took place last autumn with over 55 events during seven weeks plus a month of fringe activities at Kirkgate market. We developed partnerships with 38 arts organisations and recruited 63 volunteers who supported our events. We made direct contact with an estimated 100,000 people over the

course of the festival and reached an estimated 10,000,000 through our media profile during that time. We are currently planning our 2012 festival with sister-events taking place in the York area



*Scharna Lewis, Membership Officer*

■ We have developed a partnership with the Northern Film School to produce a series of short films challenging mental health stigma. The films will be premiered in May 2012

■ Arts and Minds continued to develop partnerships with a range of education providers to stimulate improved take-up of education. This year Leeds Art College provided four bespoke 30-week art and design courses in community venues for groups including women only and people with dementia

■ Arts and Minds has expanded the opportunities for individuals to display or perform their art. Alongside our annual members' exhibition at The Light in Leeds we have co-ordinated two further exhibitions at Temple Works and Leeds Library gallery. We have also launched a new website that

includes a virtual gallery where our members can display and sell their work. Our current membership has increased by 193 to a total of 781 members. We have engaged with 727 service users, 108 carers, and 139 staff through a range of creative networking events, training workshops, and presentations.

### 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, which is jointly funded by ourselves and NHS Airedale, Bradford and Leeds, co-ordinates volunteers who take our anti-stigma messages to public events and festivals throughout the year.



In 2012 we are running an Olympics and Paralympic Games-inspired campaign, entitled What's your Goal? This explores the relationships between physical health and mental wellbeing. We are attending events and festivals throughout the year to promote our campaign. We are encouraging members of the public to set a goal for themselves and then represent their goal on a piece of bunting.

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We will connect all the pieces of bunting together to create one collective goal, which is to break the Guinness World Record for the longest line of bunting.

Our 2012 Love Arts festival will be part of our What's your Goal? campaign and is inspired by the cultural Olympiad. It will explore connections between arts, mental health and wellbeing and will focus on participation. We hope to reach thousands of members of the public and influence their views about mental health and learning disability stigma.

## 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 2012 we employed around 3,400 staff, 420 bank staff and 250 volunteers.

### 4.7.1 Volunteers

Our 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 those who have used the services.

We introduced a volunteer experience feedback questionnaire in May 2011 and we received positive feedback on the service and ideas for future development. Areas which have been implemented include a newsletter to enable volunteers to keep in touch and a volunteer forum to exchange ideas and best practice to further improve the service.

Volunteers continue to support a variety of services within the Trust including our Addiction Services, the Time to Change project and our Supported Living Services. Our volunteers have supported at a number of our events including the Love Arts Festival and our carers event.

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 Trust. Staffside meets at least monthly to debate and question on behalf of the wider union membership any issues raised by the individual Trade Unions or by the Trust. This committee enables the trade unions to negotiate with one voice. The JNCC (Joint Negotiation and Consultation Committee) is the meeting where all issues raised at Staffside meetings are brought to the attention of the Trust.

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

During the past year Staffside has contributed to the strategic agenda of the Trust by continuing involvement in the implementation of the transformation programme and communication with staff. Furthermore involvement in the first '100 days' plan after the recent transfer of services from NHS North Yorkshire and York has established Staffside input across the new Trust.

Staffside has continuing involvement in Trust Strategy development and workforce issues through involvement in the Workforce and Development Standing Group. Additionally it has successfully worked in partnership with Human Resources and managers to support staff going through significant change due to the ongoing transformation programme. Staffside members continue to contribute to the job evaluation process under Agenda for Change to ensure fairness and equity in pay banding. It also continues to support Staff who are redeployed, in order to minimise any redundancies.

Staffside also provides information and advice to staff through the development of an internal intranet page. They can be contacted by emailing [staffside.lypft@nhs.net](mailto:staffside.lypft@nhs.net).

### 4.7.3 Staff engagement

Key to the successful implementation of our 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 to regularly test out staff views and opinions using a staff opinion / barometer-style survey. The results and findings and any subsequent actions are fed back to staff

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through internal communications

■ '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 is well received, with over 500 staff regularly reading this



*Jonathan Butler, Service User Governor*

■ As part of our leadership development we 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 Chair and Chief Executive on a regular basis and feedback issues that have been raised by staff

■ We have introduced a Senior Leaders Forum consisting of directors' direct reports which discusses strategic issues, topical issues, business planning and provides feedback to teams and staff on these areas

■ We undertook a cultural audit across both Leeds and North Yorkshire and York staff and feedback was given to staff through internal communications

■ A series of 'Better Together' workshops have taken place with staff in North Yorkshire and York led by executive directors as part of the integration of services

■ As part of the transformation programme staff have been involved in the design of new services through process mapping and have been consulted on the new service models. Regular staff road-shows have informed staff of the change process. In addition, weekly communication briefings asks for feedback from staff and responses are published

■ We have developed a dedicated Human Resources Staffnet page which includes frequently asked questions and provides advice and guidance to staff going through change

■ 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.

## 4.7.4 Our staff survey

### 4.7.4.1 Results from the NHS staff survey 2011

This is the ninth annual staff survey in which we have participated. For the 2011 survey the response rate was 53%. Table 4A below show our performance in respect of response rate, and Table 4B shows the top and bottom four ranking scores as presented in the findings by the Care Quality Commission.

**Table 4A**

2010/11		2011/12		Trust improvement/deterioration
Trust	National average	Trust	National average	Increase/decrease in % points
%	%	%	%	
49	54	53	54.5	+4%

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Table 4B

	2010/11		2011/12		Trust improvement/ deterioration
	Trust %	National average %	Trust %	National average %	Increase/ decrease in % points
<b>Top four ranking scores (we are in the best 20% of Trusts)</b>					
Work pressure felt by staff (The lower the score the better)	2.96	3.01	2.97	3.08	-0.01%
Percentage of staff having equality and diversity training in the last 12 months (The higher the score the better)	65	47	65	53	No change
Percentage of staff working extra hours (The lower the score the better)	64	65	62	65	-2%
Percentage of staff experiencing harassment, bullying or abuse. (The lower the score the better)	0	1	12	13	+12%
<b>Bottom four ranking scores (We are in the worst 20% of Trusts)</b>					
Percentage of staff having well structured appraisals in last 12 months (The higher the score the better)	42	40	30	39	-12%
Percentage of staff using flexible working options (The higher the score the better)	64	67	60	67	-4%
Percentage of staff appraised in last 12 months (The higher the score the better)	87	82	72	83	-15%
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (The lower the score the better)	18	14	18	12	No change



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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 observations about our overall staff survey performance provides us with a basis for determining the main areas to focus on for our 2012/13 staff survey action plan.

The Trust's response to the 2011 staff survey is to focus on a maximum of two areas (still to be agreed) where the Trust has scored lower compared with other mental health and learning disability trusts. These are:

- **Trust commitment to work-life balance**
- **% using flexible working options**
- **% receiving job related training, learning or development in last 12 months**
- **% appraised in last 12 months**
- **% having well structured appraisals in last 12 months**
- **% appraised with personal development plans in last 12 months**
- **% witnessing potentially harmful errors, near misses or incidents in last month**
- **% experiencing physical violence from patients, relatives or the public in last 12 months**
- **% feeling pressure in last 3 months to attend work when feeling unwell**

- **% reporting good communication between senior management and staff**
- **Staff job satisfaction**
- **Staff motivation at work.**

Although the overall staff survey results for 2011 indicated a worse position on the previous year, this has to be considered in conjunction with a number of external and internal factors currently facing the Trust. Issues such as the health and social care reforms and changes to the pension scheme at national level, together with Trust transformation and the impact of the North Yorkshire and York integration may account for some of the less positive outcomes of the survey. Work is being undertaken within the Trust to address the areas where responses were poor and to seek to improve Trust performance in the 2012 survey.

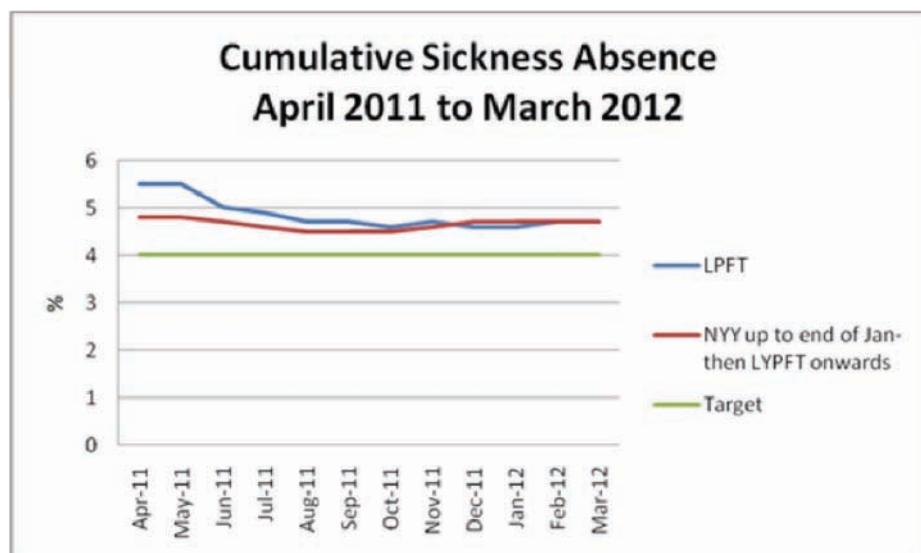
## 4.7.4.3 Future priorities and targets

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 4C



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At the end of March 2012 the sickness absence rate was 4.7%, although our target was 4%. The target attendance rate for 2012/13 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 graph above shows the sickness levels both for staff that transferred from NHS North Yorkshire and York and for the Leeds Partnerships NHS Foundation Trust (both up to the end of January 2012) and then the combined rate from February 2012.

We will continue to focus on reducing sickness absence utilising our Managing Sickness Absence Procedure along with implementing our Health and Wellbeing Framework and action plans based on the Boorman recommendations. As part of the integration plan for our new organisation we will review procedure and practice in North Yorkshire and York to identify best practice. We will also develop the advice sessions across the new Trust for managers, which incorporate a case conference approach to managing sickness cases in partnership with managers and Occupational Health.

We have implemented an absence management task group to support the development of sickness action plans and will lead on the continuous improvements in the reporting arrangements for managers on sickness and other workforce issues. An attendance management pilot programme (long-term absence / early referral) was launched in the Adult Directorate, concentrating on the ward-based staff. Scheduled review meetings are currently taking place to maintain the work of the pilot programme.

Other pro-active work has involved the utilisation the Health and Safety Executive's Stress Risk Assessment tool and a bespoke coaching tool, the 'Wheel of Wellbeing', which focuses on the wellbeing of staff.

We have also developed a short awareness course for first line managers to familiarise them with the early stages of the Managing Sickness Absence Procedure which will be rolled out during this year. In 2012/13 we plan to review and improve our Managing Sickness Absence Procedure and consider implementing the Bradford Index as part of that review.

The Trust has removed the entitlement to unsocial pay supplements as part of occupational sick pay for all new employees with effect from 1 July 2011 and for existing employees who take up a new contract of employment with the Trust.

In 2011/12 we 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 2012/13 we are participating in the Global Corporate Challenge for the second year running.

## 4.7.6 Occupational Health Service

We continue to share our Occupational Health Service with South West Yorkshire Partnership Foundation Trust (SWYPFT). It remains a nurse-led service created to meet the specific needs of staff in a mental health and learning disability trust; and latterly a community services trust. The team now provides occupational health services for 8,500 employees in the region.

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
- Advice on health and wellbeing
- Counselling and support.

During 2011/12 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
- Implementation of the health and wellbeing action plan
- Long-term absence / early referral pilot project in the

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**Adult Directorate aimed at areas of high absence to increase referral rates to occupational health and ensure timely interventions to mitigate long-term absence. This project contributed to a decrease in sickness rates in the Adult Directorate from 6.7% in August 2010 to 5% in August 2011**

- **Dedicating resources during October to December to providing seasonal flu immunisations clinics**
- **Achieving an increase in vaccines and immunisations for staff compared with 2010.**

## 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. For 2011 we have worked in partnership with Leeds Community Healthcare and NHS Airedale, Bradford and Leeds.

These programmes make an important contribution to the leadership skills and capacity within our organisation. They also provide a platform for talent management and succession planning of suitable candidates for managerial vacancies. Several delegates who have previously attended these programmes have successfully gone on to be promoted within our organisation.

The Fit for the Future development programme was completed in December 2011. The programme aimed to address 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 was aligned to an ILM level 5 qualification in Leadership and Management, giving each learner a formal recognition for their development journey. It also ensured a qualified and skilled workforce in line with Department of Health requirements.

A particular success within the Fit for the Future programme has been the inclusion of the 'Leaders' Lounge'. This engagement tool aimed 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 delivered ten Leaders' Lounge sessions each month over the course of the programme. We started with around 18 delegates and three senior leaders attending each session, thereby connecting 'ward to board'. It is our intention to continue to use this model in our engagement strategy and in particular as a way of integrating the staff that transferred from North Yorkshire and York.

We remain committed to achieving a fully qualified workforce by supporting all staff to achieve a minimum of a Level 2 vocational qualification. We recognise the key role of our support staff and provide a range of training opportunities designed to support staff in providing the best levels of care to our service users to respond to the changes in the new care pathways and to enable career progression.

This year we are working to introduce apprenticeship contracts to new employees, supporting individuals to gain workplace experience and achieve nationally-recognised qualifications, whilst enabling us to support

our workforce plan and the local population.

Our in-house training provider, the Andrew Sims Centre, continues to provide an extensive programme of training events to a national audience of mental health professionals. Responsive to NICE guidance and the latest developments in mental health and learning disability care, the centre provides Trust staff with quality local learning events that support high quality evidence-based care and the opportunity to network with national subject experts.

## 4.8 MENTAL HEALTH ACT MANAGERS

Mental Health Act (MHA) managers are members of the public, appointed by the Board of Directors, together with a number of non-executive directors to 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**
- **Meet with service users to ensure they understand their rights under Section 132 of the Mental Health Act.**



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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. In 2012/13 this function will be expanded to take into account services within the North Yorkshire and York Directorate.

This year the MHA managers produced a report for the Board of Directors highlighting their activity in respect of managers' hearings and reviews for 2010/11. The MHA managers' findings on ward visits were also included in the report and an action plan was agreed to address some of the managers' findings. The action plan included a process for monitoring and improving the performance against the Trust's standard times for conducting a manager's hearing.

We are appreciative of the time and commitment the MHA managers and the non-executive directors also acting as MHA managers have given this year, particularly during a time of significant change to the organisation and the transfer of services from North Yorkshire and York. To ensure the MHA manager function is integrated a group has been set up to look at the systems, policies and procedures and ensure they are equitable across the new organisation. This work is planned to conclude in spring 2012 when a final report will be made to the Board of Directors.

Once again we wish to thank our MHA managers for their dedication and the skill they apply when undertaking this vital role.

The table below shows those people who have been MHA managers during 2011/12. This

year has seen a number of changes in our managers and we would like to record our particular thanks to Gordon Wilson for his long commitment and dedication as a MHA manager. We welcome Andrew Marran who is also on the Council of Governors. We also welcome colleagues joining us from North Yorkshire and York and would like to record our thanks to Brian Councill for accepting the role of deputy chair which will support our efforts in developing a consistent approach for this function across the new organisation.

**Table 4D**

Mental Health Act managers for the period 1 April 2011 to 31 March 2012	
Robert Seymour (Chair)	
Enid Atkinson	Chris Collins
Kathleen Fenwick	John Fothergill
Roger Helm	Nancy Hill
Ian Hughes	Brian Kemp
Kate Kershaw	Andrew Marran
Anesh Pema	Jenny Roper
Angela Senior	Linda Shaffner
Pat Varley	Gordon Wilson
Michael Yates	
Non-executive directors also acting as Mental Health Act managers during the period 1 April 2011 to 31 March 2012	
Linda Phipps	Aqila Choudhry
Mental Health Act managers joining the Trust from North Yorkshire and York during the period 1 February 2012 to 31 March 2012	
Brian Councill	Lindsay Councill
Maggie Archer	Jill Hetherton
Wendy Henry	Tom McGuffog
Heather Limbach	Roger Mattingly
Bernard Marsden	Anne Rice
Jennifer Patrick	Mike Walsh
David Walkden	
Keith Wood	

## 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

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owe to one another to ensure the NHS operates fairly and effectively.

From 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. In addition, both our financial regulators and our quality regulators have specific requirements relating to the NHS Constitution:

- From 2010/11 Monitor has required that NHS foundation trusts should self-certify that they have regard to the NHS Constitution
- As part of the Care Quality Commission (CQC) registration requirements, trusts are required to assess whether they take into account relevant guidance, including that from CQC's Schedule of Applicable Publications.

On this basis, an annual review of our assurance of compliance with the requirements of the NHS Constitution forms part of the Trust's Strategy Delivery Cycle.

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 4E

Our strategy	NHS Constitution
<b>Means Goal 1</b> We provide excellent quality, evidence-based, safe care that promotes recovery and inclusion	<ul style="list-style-type: none"> <li>• Access to health services</li> <li>• Quality of care and environment</li> <li>• Nationally approved treatments, drugs and programmes</li> </ul>
<b>Means Goal 2</b> We involve people in planning their care and in improving services	<ul style="list-style-type: none"> <li>• Respect, consent and confidentiality</li> <li>• Informed choice</li> <li>• Involvement in your healthcare and in the NHS</li> <li>• Complaint and redress</li> </ul>
<b>Means Goal 4</b> We value and develop our workforce and those supporting us	<ul style="list-style-type: none"> <li>• Staff rights, pledges and duties</li> </ul>

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 can be found at Section 3.



Building Your Trust Event 2012

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During 2011/12 we have worked to embed the Trust's values in a number of ways including:

- Displaying the Trust's values and behaviours across the organisation, with posters showing our Values Charter and the Trust strategy summary being displayed across the main Trust sites

- Every member of staff receiving a values postcard, some of which feature our 'values champions': service users and staff members from our services, who want to champion a particular value

- Every member of staff receiving their own summary copy of the five-year strategy

- Our new appraisal and development scheme encompassing a section on discussing our values, asking the appraisee to demonstrate how values are lived out through their work and what can be improved

- A statement relating to values being included in the Trust's standard job description template and guidance being developed to help to recruit for values

- A statement relating to values being included in the terms of reference of each of our main Trust meetings and our values being displayed on the agenda at meetings of the Board of Directors and Council of Governors

- Reporting Trust values from real people's perspectives in three out of four editions of Building New Foundations during 2011

- The Chief Executive's blog regularly referring to Trust values and anecdotal evidence indicating that values are becoming part of routine cultural narrative

- Trust values being fully incorporated into the Trust Awards for 2011

- Reviewing our standard letters to ensure that they are respectful and reflective of our values

- Regularly reviewing service user experience feedback to understand whether they experience values-based behaviour from our staff.

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.

## 4.10 SUSTAINABILITY

### 4.10.1 Commentary

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

We have in place a Carbon Management Plan which was approved by the Board in November 2011. This is designed to minimise the impact of the Trust's activities on climate change; by reducing the greenhouse gases we produce from our consumption of gas and electricity and various other business activities. The plan also includes commitments towards improvements in waste segregation and disposal, and travel planning; for example how our employees travel to, from and between our sites.

The Carbon Management Plan has helped us to fulfil our commitment towards carrying out our activities with due consideration to the environment, whilst continuing to provide 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. The Board of Directors will review this plan annually through Board reports, and chart progress against our key targets and objectives.



*Electric Car, 2011*

# Operating and Financial Review

Table 4F

Area	Type	Non-financial information	Financial information
Greenhouse gas emissions	Direct greenhouse gas emissions	In <b>2010/11*</b> the Trust consumed <b>12,483,052 kWh of gas</b> , which equates to <b>2,292 tonnes of CO2e **</b> . This is a 2.4% improvement on 2009/10	In <b>2010/11*</b> the Trust spent £324,259 purchasing gas.
	Indirect energy emissions	In <b>2010/11*</b> the Trust consumed <b>5,643,520 kWh of electricity</b> , which equates to <b>3,053 tonnes of CO2e</b> . This is 8% more than reported for 2009/10 but this partly reflects improved data gathering on previous years. Additionally, many of the Trust’s energy reducing projects were not yet in place in 2010/11.	In <b>2010/11*</b> the Trust spent £555,004 purchasing electricity.
	Official business travel emissions	<b>Grey fleet***:</b> In <b>2011/12</b> mileage travelled by the grey fleet amounted to <b>1,190,958 miles</b> .  <b>Lease cars:</b> In <b>2011/12</b> there were <b>197 lease</b> cars: <b>Petrol: 96</b> cars contracted for <b>371,050</b> miles <b>Diesel: 100</b> cars contracted for <b>498,100</b> miles  There is also <b>1 electric car</b> in the fleet used by the Crisis Resolution Team at the Becklin Centre. This vehicle is classified as being emission-free.  The figure for CO2e for grey fleet travel is not known at this point in time.	<b>Grey fleet:</b> In <b>2011/12</b> the Trust spent £560,645 on mileage for the Grey Fleet.  <b>Lease cars:</b> In <b>2011/12</b> the Trust spent £115,430 on mileage for lease cars:  <b>Petrol = £55,658</b> <b>Diesel = £59,772</b>
Waste minimisation and management	<b>Domestic waste:</b> For <b>2010/11*</b> the figures for domestic waste are as follows: <ul style="list-style-type: none"><li>• Total waste arising: <b>169,724 kg</b></li><li>• Waste to landfill: <b>145,844 kg</b></li><li>• Waste recycled: <b>23,880 kg</b></li><li>• Waste incinerated: <b>0 kg</b></li></ul>	<b>Domestic waste:</b> In <b>2010/11*</b> the cost of disposing of domestic waste was <b>£41,870</b> .	
Finite resources	<b>Healthcare waste:</b> For <b>2011/12</b> the figures for healthcare waste are as follows: <ul style="list-style-type: none"><li>• Total bulk waste: <b>52,760 kg (9% less than 2010/11)</b>. This figure also includes York properties (Feb/Mar 2012 only) of this:<ul style="list-style-type: none"><li>• <b>Waste landfilled</b> (offensive 18.01.04): <b>34,294kg 65%</b> (2011 = 0)</li><li>• <b>Waste autoclaved</b> (infectious 18.01.03): <b>18,202kg 34%</b> (2011 = 0)</li><li>• <b>Waste incinerated</b> (infectious/pharmaceutical 18.01.03/09): <b>118kg (&lt;1%)</b> (2011 = 100%)</li></ul></li></ul>	<b>Healthcare waste:</b> In 2011/12 the cost of disposing of all healthcare waste was <b>£39,410</b> . The above figure includes all bulk <u>and</u> non-bulk collections and represents a 50% reduction in overall costs for healthcare waste compared with the previous contract for 2010/11.	
	In <b>2010/11*</b> The Trust consumed <b>31,657m3</b> of water and sent away <b>28,642m3</b> in the form of sewage.	In <b>2010/11*</b> the total water and sewerage cost was <b>£152,175</b> .	

\* The last full year for which figures are available. The final figures for 2011/12 are as yet unknown as they are subject to quarterly invoicing from our suppliers and verification and submission by our PFI partners for many of our larger sites.

\*\* 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).



# Operating and Financial Review

## 4.10.2 Future priorities and targets

The Trust's Carbon Management Plan continues to provide the framework for our environmental agenda in the next year and beyond. Within it is our goal of 25% reduction in carbon emissions by 2015 based on 2007 data. It is also increasingly important that we monitor results for the coming 12 months and beyond in relation to changes in waste handling and disposal already in effect, and the impact of recent initiatives aimed at influencing staff travel behaviour to and from our sites. This will allow us to measure our performance in an objective way and benchmark results with previous years and other organisations (both NHS and external). These goals and ongoing results will form the basis of the periodic sustainability reports to the Board of Directors.

The coming financial year will also provide us with an excellent opportunity to further embed sustainability into the Trust as we have provided input into the consideration of the development of a new Trust building in Leeds. This allows for the possibility of low and zero carbon technologies being included at the very beginning of the project.

In addition to this is the incorporation of the mental health services element of buildings previously managed by NHS North Yorkshire and York into the new Trust's portfolio. Opportunities have already been identified for operational improvements in waste handling at York sites which will realise savings that can be achieved in a relatively short space of time. In the coming months there will also be an opportunity to review the existing Leeds-focused Carbon Management Plan with that of the NHS North Yorkshire and York in order

to produce a Trust-wide plan with new targets and fresh initiatives for the whole estate.

In 2012/13 we anticipate seeing good environmental and financial returns from a number of initiatives which are being implemented now or in the near future. These include:

- **Consistent implementation of both healthcare and domestic waste improvements across all York sites to match that of the Leeds Trust-managed sites**
- **Continuing implementation of travel plan initiatives for St Mary's Hospital, many of which will benefit staff across the Trust, for example the cycle loan and car-share schemes will complement the already existing public transport discount scheme**
- **100% implementation of Trust-wide recycling to include PFI third party managed sites**
- **Contribution into the design and plans for a new build which if developed will have regard to the Carbon Management Plan requirement to develop a BREEAM excellent-rated building**
- **Opportunities from within the transformation programme for**

**estates efficiencies and further potential rationalisation, in particular getting more out of the buildings already occupied.**

## 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 2011/12 contains no incidents which have either a volume or severity that would classify them as a Serious Untoward Incident, reportable to Monitor and the Information Commissioner's Office.

Our summary of data-related non-serious untoward incidents is included on page 42.

# Operating and Financial Review

**Table 4G - Summary of other personal data related incidents in 2011/12**

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	4
V	Other	1

**This table includes those breaches rated as level 1 or 2, as defined by DoH letter from David Nicholson, NHS Chief Executive, gateway reference #9912.**

In compiling this report, the Trust has considered breach incidents for data for which it was / is the data controller, as defined by the Data Protection Act (1998).

This report therefore covers data for which the former Leeds Partnerships NHS Foundation Trust was the data controller, for the period 1 April 2011 to 31 March 2012, and data for which the current Leeds and York Partnership NHS Foundation Trust is the data controller, for the period 1 February 2012 to 31 March 2012.

In doing so, only breaches occurring and reported since 1 February 2012 have been considered for the newly-acquired services in North Yorkshire and York, with reporting responsibilities for breaches in these services prior to this date the responsibility of NHS North Yorkshire and York, as data controller at that time.

## 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 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 an appointed Local Security Management Specialist who has 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

The Local Counter Fraud Specialist (LCFS)

# Operating and Financial Review

provision at our Trust is provided by RSM Tenon. Their fraud solutions arm specialises in all aspects of counter fraud and investigations work across the public, corporate and not-for-profit sectors. RSM Tenon is the largest commercial provider of the LCFS provision in the NHS, with a large integrated team with accredited and experienced LCFS personnel.

In January 2012, our LCFS and the Trust received an assessment from NHS Protect's Quality Assurance Programme of level 3. This signifies that the organisation is performing well, with no items for improvement noted in the assessment report.

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

The Trust has developed a strong deterrence and preventative culture and this has been a factor in there being no significant fraud occurrences in 2011/12.

## 4.14 FINANCIAL PERFORMANCE

With effect from 1 February 2012 the Trust provides services in North Yorkshire and York. The figures presented below include two months actual figures from this date (for February and March 2012). However; it is important to note that due to a technical accounting requirement the Trust's Annual Accounts (set out in Section 10 of this report)

must show the full 12 months figures for these services. This accounting requirement has no effect on our overall financial position as income matches expenditure for the 10 months prior to the 1 February 2012.

Our overall financial health is assessed by Monitor, the independent regulator for foundation trusts. This assessment is done through a number of metrics with EBITDA margin being the most important one. EBITDA is 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 our normal activities, thereby allowing us to invest in services and meet financial obligations as a going concern. For the financial year ended 31 March 2012 we continued to achieve strong financial performance.

Despite receiving no increase for inflation in the income we received from our commissioners during 2011/12, EBITDA was again strong at £11.3 million (£10.9 million in 2010/11) against a plan of £9.1 million. This has given us a margin of 7.7% (8.6% in 2010/11) against a plan of 6.4%.

The cash we held at 31 March 2012 was £23.5 million (£21.8 million in 2010/11) and once again the Trust was able to maintain this level of cash without having to use any loan facility.

### 4.14.1 Financial risk rating

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 2011/12 a financial risk rating of '4' was achieved, which was in line with our plan for this year.





# Operating and Financial Review

Table 4H

	Metrics		Rating	
	Plan	Actual	Plan	Actual
<b>Achievement of plan:</b> EBITDA	100%	126.1%	5	5
<b>Underlying performance:</b> EBITDA margin	6.6%	7.7%	3	3
<b>Financial efficiency:</b> Return on assets	8.2%	12.1%	5	5
<b>Financial efficiency:</b> Surplus margin	2.1%	3.8%	4	5
<b>Liquidity</b>	26 days	27 days	4	4
<b>Overall rating</b>			<b>4</b>	<b>4</b>

## 4.142 Revenue position

Table 4I

	Plan £ million	Actual £ million	Variance from Plan £ million
<b>Income</b>			
Clinical income	126.8	130.8	4.0
Non-clinical income	15.7	16.0	0.3
Total income	142.5	146.8	4.3
<b>Expenses</b>			
Pay costs	-100.6	-101.0	-0.4
Drug costs	-2.2	-2.3	-0.1
Other non-pay costs	-30.6	-32.1	-1.5
Total expenses	-133.4	-135.4	-2.0
<b>EBITDA</b>	<b>9.1</b>	<b>11.3</b>	<b>2.2</b>
Profit/loss on asset disposal	0.0	-0.2	-0.2
Interest received	0.4	0.3	-0.1
Interest expenses	-3.1	-2.8	0.3
Depreciation	-3.6	-3.4	0.2
Dividend payable	-0.4	-0.3	0.1
Other non-operating income	1.8	1.8	0.0
Land and buildings impairments	0.0	-0.9	-0.9
Non Operating Expense	-1.1	-1.3	-0.2
<b>Net surplus</b>	<b>3.1</b>	<b>4.5</b>	<b>1.4</b>

The table above shows our income, expenditure and the overall surplus. In 2011/12 a surplus of £4.5 million was achieved compared to our plan to achieve £3.1 million. This gave a margin of 3.8% against the planned figure of 2.1%.

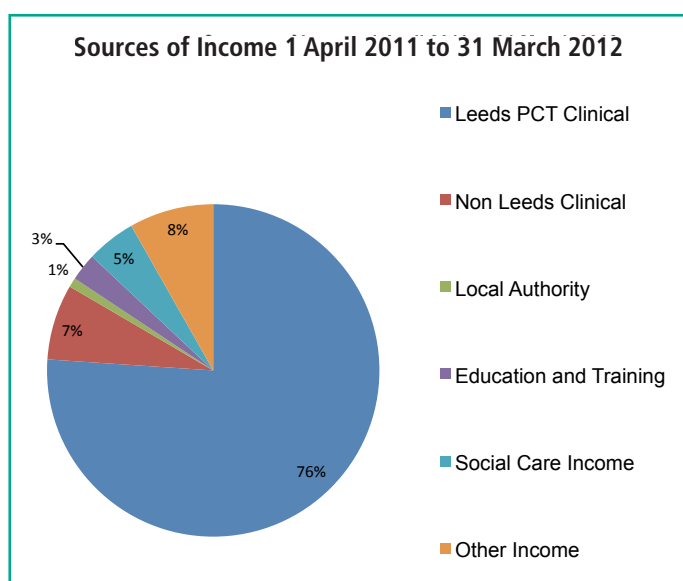
# Operating and Financial Review

A reconciliation of the original planned surplus of £3.1 million and the actual surplus of £4.5 million is set out in the table below.

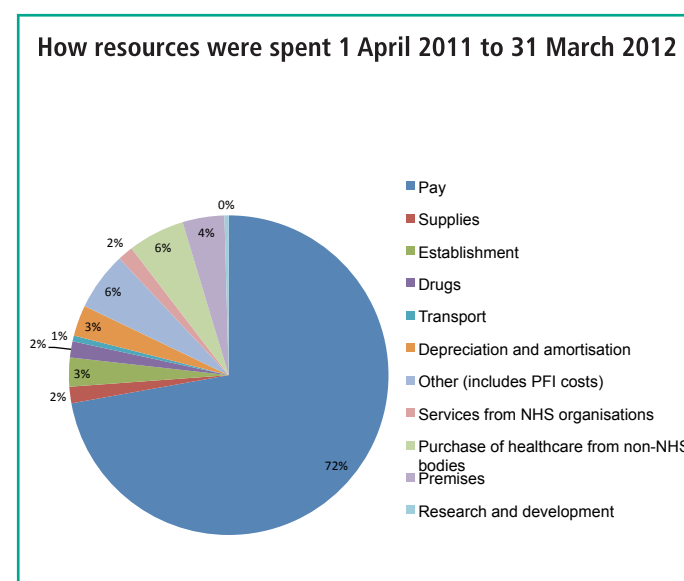
**Table 4J**

Planned surplus				-£3.1m
Adjustments:	Additional NHS Leeds Income	-£4.0m		
	Other Operating Income	-£1.7m		
	<b>subtotal</b>		-£5.7m	
	Commercial Procurement Collaborative surplus shortfall	£1.1m		
	Operating expenditure deficit	£1.7m		
	Non-operating expenditure overspend	£0.5m		
	Non-operating income shortfall	£0.3m		
	Net pay overspend	<u>£0.7m</u>		
	<b>subtotal</b>		<u>£4.3m</u>	<u>-£1.4m</u>
Final surplus				<b><u>£4.5m</u></b>

**Table 4K**



**Table 4L**



Tables 4K and 4L show where we received our money from and how we have used it during 2011/12.

The Trust contracted with the PCT NHS Airedale, Bradford and Leeds (formerly known as the NHS Leeds) for 76% of its income (78% in 2010/11). The Trust also received income from other PCTs to provide clinical services. This represents 7% of our income and included two months of contracted income from NHS North Yorkshire and York, with cost and volume and non-contracted activity. We also received 3% of our income from the Yorkshire and the Humber Strategic Health Authority as part of the SHA Learning and Development Agreement.

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**Income** - Clinical income was £4.0 million above our plan for the year. This was due to the additional low-secure Out of Area Treatment (OATs) income received from NHS Airedale, Bradford and Leeds.

Other operating income was £0.3 million above plan. This was made up of an income deficit of £1.45 million for the NHS Commercial Procurement Collaborative, although this was offset by a £0.7 million over-recovery on the education and training / research and development income with a further £0.35 million additional funding being received in March. These amounts offset against education and training expenditure.

**Pay** - Overall pay costs for both permanent staff and agency staff was £0.4 million over-spent against our plan. This was made up of a £1.6 million under-spend on pay for permanent staff and a £2.0 million over-spend on pay for agency staff. The overspend of £0.4 million was largely accounted for by the Adult Services Directorate and the Learning Disability Directorate.

**Non pay** - £0.8 million of the non pay over-spend was off-set by additional income recovery for research and development, and education and training. It should also be noted that non-recurrent Private Finance Initiative (PFI), rates and OATs transport were the main areas of additional cost.

**Loss on asset disposal** - The £0.2 million for 2011/12 related to a loss on the disposal of computer software licences.

**Impairment and other non-operating expenditure** – We revalued our assets (land and buildings) in 2011/12. This resulted in the value of Aire Court being reduced (impaired) by £0.9 million. This was off-set by reduced depreciation and Public Dividend Capital (PDC) costs. These reduced costs were a result of

changes to the capital programme (see section 4.14.3).

**Cash Releasing Efficiency Savings (CRES)** – The overall amount we saved was £1.1 million below plan as at 31 March 2012. The key area of shortfall was in relation to the NHS Commercial Procurement Collaborative (CPC) income. The business plan in place for the NHS CPC is being re-assessed, with a planned surplus of between £0.3 million and £0.5 million forecast for 2012/13.

## 4.14.3 Capital expenditure

We have allocated funding of £6.9 million for capital expenditure which is around £2 million more than we planned to spend. This is largely due to a new rehabilitation unit which is being developed on the Seacroft site (£1.55 million will be spent across 2011/12 and 2012/13). NHS Airedale, Bradford and Leeds has agreed and paid a £4 million capital and revenue funding stream all of which has been accounted for in 2011/12.

Full year capital expenditure is £5.5 million, with commitments of £6.2 million. This includes £1.4 million actual spend on the Seacroft rehabilitation unit in this financial year. This is analysed into the main categories of capital expenditure in the table below:

**Table 4M**

	Allocated funding	Committed expenditure	Actual spend
	£m	£m	£m
Estates	0.75	0.73	0.66
PFI	2.03	2.03	1.86
IT	1.17	0.65	0.44
Service strategy	2.81	2.67	2.40
Other	0.17	0.14	0.10
<b>TOTAL</b>	<b>6.93</b>	<b>6.22</b>	<b>5.46</b>

With respect to service strategy spend:

- **Aire Court was completed in May 2011**
- **The Towngate House scheme was completed in December 2011**
- **Decanting work for the new rehabilitation scheme started in December and building work started in early January.**

Work on The Mount sensory garden started in March and it is anticipated that it will be completed early in 2012/13.

The amount spent on information technology (IT) is lower than planned which is due to some schemes being linked to potential work on the systems in North Yorkshire and York, and the need to progress these as one whole scheme. Interim IT service transformation support was agreed at £0.1 million. A further IT service transformation pilot is expected to be run and the future funding allocation may change.



# Operating and Financial Review

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

Table 4N

	Plan £ m	Actual £ m	Variance £ m
<b>ASSETS</b>			
<b>Assets, Non-Current, Total</b>	<b>56.7</b>	<b>56.7</b>	<b>0.0</b>
<b>Assets, Current</b>			
Inventories	0.1	0.1	0.0
Trade and Other Receivables, Current	3.2	5.5	2.3
Prepayments, Current	1.0	0.8	-0.2
Cash	17.6	23.5	5.9
Non-current assets held for sale	0.4	0.7	0.3
<b>Assets, Current, Total</b>	<b>22.3</b>	<b>30.6</b>	<b>8.3</b>
<b>Total Assets</b>	<b>79.0</b>	<b>87.3</b>	<b>8.3</b>
<b>LIABILITIES</b>			
<b>Liabilities, Current</b>			
Deferred Income, Current	-1.9	-3.0	-1.1
Provisions, Current	-0.3	-0.3	0.0
Trade and Other Payables, Current	-5.3	-10.6	-5.3
Accruals, Current	-3.8	-4.5	-0.7
Finance Leases, Current	-0.2	-0.2	0.0
PFI leases, Current	-1.0	-1.1	-0.1
<b>Liabilities, Current, Total</b>	<b>-12.5</b>	<b>-19.6</b>	<b>-7.1</b>
<b>NET CURRENT ASSETS (LIABILITIES)</b>	<b>9.8</b>	<b>11.0</b>	<b>1.2</b>
<b>Liabilities, Non-Current</b>			
Deferred Income, Non-Current	0.0	0.0	0.0
Provisions, Non-Current	-1.5	-1.5	0.0
Other Financial Liabilities, Non-Current, Total	-32.3	-32.2	0.1
<b>Liabilities, Non-Current, Total</b>	<b>-33.8</b>	<b>-33.7</b>	<b>0.1</b>
<b>TOTAL ASSETS EMPLOYED</b>	<b>32.7</b>	<b>33.9</b>	<b>1.2</b>
<b>Taxpayers' and Others Equity</b>			
Public dividend capital	19.5	19.1	-0.4
Retained earnings (accumulated losses)	6.8	8.9	2.1
Revaluation reserve	7.0	6.5	-0.5
Miscellaneous other reserves	-0.6	-0.6	0.0
<b>TAXPAYERS' EQUITY, TOTAL</b>	<b>32.7</b>	<b>33.9</b>	<b>1.2</b>



Dr Phil Hammond, Love Arts Festival, 2011

# Operating and Financial Review

## 4.14.5 Cash and working capital

Table 40

	Plan £ million	Actual £ million	Variance from Plan £ million
Cash and investments	17.6	23.5	5.9
<b>Days (working capital liquidity)</b>	<b>26 days</b>	<b>27 days</b>	<b>1 day</b>

At 31 March 2012 we held a £23.5 million cash balance, which was £5.9 million above our plan. The main reasons for cash being higher than planned are as follows:

Table 4P

Operating surplus	£1.8m
Improvement in working capital	£3.4m
Decrease in non current payables (creditors)	£0.7m

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. Foundation trusts have to be able to meet commitments in the short term without necessarily relying on receiving any extra income.

Building up cash reserves allows the Trust to develop new services and invest in the estate without the need for borrowing. Table 40 above shows that we have sufficient cash to meet our commitments.

The surplus cash we had at the end of the year was deposited with the government banking service. It is our policy to deposit any temporary surpluses in cash that we have in low risk deposit accounts with either United Kingdom commercial clearing banks or the H.M. National Loans Fund.

## 4.14.6 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 our costs. The current position is that staff on Agenda for Change grades will receive no inflationary pay awards for 2012/13 apart from those staff earning less than £21k, who will receive £250 pay increase. Executive directors had no inflationary uplift in 2011/12 and this will continue for a further year. For 2013/14 our financial plans assume a pay award of 1% in line with government policy. After 2013/14 they assume a similar level to the rate of increase in the consumer price index. These assumptions have already been factored into our future financial plans.

Secondly, income assumptions are set out each year through the NHS Operating Framework, which outlines the business and planning arrangements for the NHS issued by the Department of Health. Assumptions made regarding inflationary / deflationary changes have been assumed

to be extremely challenging in the future. In particular, reductions in PCT income of around 2% per annum have been factored into our plans after 2012/13. The contractual position for 2012/13 has been agreed with commissioners based on a tariff deflator of -1.8%; although we had assumed -2%.

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 nationally to mental health services. In 2012/13 this system will operate in 'shadow' form although income will still 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 through legally binding contracts for services provided to PCTs, which in turn are financed from money received from Parliament. Assumptions about future income have been revised to take into account of the new market conditions.

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

# Operating and Financial Review

future years depending on the Trust's capital expenditure plans, specifically in relation to the relocation of learning disability services and the development of rehabilitation facilities.

## 4.14.7 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 Annual Report.

## 4.14.8 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 2012/13 NHS Operating Framework was published in December 2011 and this clearly signalled a lower level of resources for the future.

Much emphasis is placed on controlling costs and increasing efficiency with an expected inflation adjustment of -1.5% in 2012/13. This is the second year that a negative 'downshift' has been applied. The government estimate that cost pressures will cost +2.5% in 2012/13, which therefore implies the need to achieve a minimum 4% efficiency through reduced costs, when combined with a drop of -1.5% in income.

Whilst no future year projections were issued as part of the NHS Operating Framework for 2012/13, the 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 needs to make savings of around £20 million between 2012/13 and 2014/15, which is on average 5% over the next 3 years.

For 2012/13, CQUIN funding of 2.5% has been agreed with commissioners. This is dependent on meeting quality standards and improvements. It has been assumed that such funding will be received for financial years 2012/13, 2013/14 and 2014/15.

## 4.14.9 How we involve our staff in understanding financial performance

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

Finance managers are integrated within the care service directorates forming part of the leadership teams at this level. This ensures consistency and 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's intranet (Staffnet) and is available to all budget holders. The framework 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 the Council of Governors receive regular information regarding the financial performance, (the Board of Directors on a monthly basis and the Council 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 Council 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.

Quarterly service line reports are produced and discussed with clinical managers to enable them to better understand the relationship between service and resource use.

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 two 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 the Quality Accounts in Section 9.





*Tricia Thorpe, Service User Governor with Ruby Wax, Love Arts Festival, 2011*



# Council of Governors

## 5.1 COMPOSITION OF THE BOARD OF GOVERNORS

The Council of Governors is what gives the public a voice in helping to shape and influence the future of mental health and learning disability services provided by the Trust. 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 Council of Governors is chaired by the Chair of the Trust, who ensures the link between the Council and the Board of Directors; and the Deputy Chair of the Trust is also the Deputy Chair of the Council of Governors. Monitor also requires each Foundation Trust to have a Lead Governor, and governors have nominated Andrew Marran.

With effect from 10 February 2012 Monitor authorised a change in our constitution which had the effect of changing the composition of the Council of Governors so that it was reflective of the new geographical areas in which we provide services. The tables below show the composition from 1 February to 9 February 2012; and from 10 February 2012 onwards.

**Table 5A – Composition of the Council of Governors**

**Establishment up to 9 February 2012**

Constituency Name	No of seats
Public: Central	1
Public: Leeds North East	1
Public: Leeds North West	1
Public: Leeds West	1
Public: Leeds East	1
Public: Pudsey	1
Public: Elmet and Rothwell	1
Public: Morley and Outwood	1
Public: Non-Leeds Resident	1
Service user: Leeds	5
Carer: Leeds	5
Service user: Non-Leeds Resident	1
Carer: Non-Leeds Resident	1
Staff: Clinical	4
Staff: Non-clinical	2
University of Leeds	1
Leeds Metropolitan University	1
Leeds Teaching Hospitals NHS Trust	1
West Yorkshire Police	1
Equitix Ltd	1
Volition	1
Tenfold	1
NHS Leeds	1
Leeds City Council	1
Leeds Local Medical Committee	1
<b>TOTAL</b>	<b>37</b>

**Establishment from 10 February 2012**

Constituency Name	No of seats
Public: Leeds Central	1
Public: Leeds North East	1
Public: Leeds North West	1
Public: Leeds West	1
Public: Leeds East	1
Public: Pudsey	1
Public: Elmet and Rothwell	1
Public: Morley and Outwood	1
Public: York Central	1
Public: York Outer	1
Public: Selby and Ainsty	1
Public: North Yorkshire and York County-Wide	1
Public: Rest of England and Wales	1
Service user Leeds	4*
Service user Leeds (Learning Disability)	1
Service user York and Selby	2
Service user North Yorkshire and York County-Wide	1
Carer Leeds	4*
Carer Leeds (Learning Disability)	1
Carer York and Selby	2
Carer North Yorkshire and York County-Wide	1
Service user and Carer rest of the UK	1
Clinical Staff Leeds	3*
Clinical Staff North Yorkshire and York	1
Non-clinical Staff Leeds and North Yorkshire and York	2
Equitix Ltd	1
Volition	1
Tenfold	1
York Council for Voluntary Services	1
NHS Airedale, Bradford and Leeds	1
NHS North Yorkshire and York	1
Leeds City Council	1
City of York Council	1
North Yorkshire County Council	1
Leeds Local Medical Committee	1
York Local Medical Committee	1
<b>TOTAL</b>	<b>47</b>

\*From 10 February 2012 this seat had one extra governor in post over the agreed establishment. Monitor has authorised this transition arrangement, and the number of governors will revert to establishment at the point where the extra governor in the constituency comes to the end of their term of office.

# Council of Governors

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

Tables 5B and 5C list those governors that have served on the Council of Governors during 2011/12.

**Table 5B – Elected Governors**

Name	Constituency	Maximum term of office elected for (years)	Date appointed from	Date Term of office ends/ended
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 Outwood	3	17.8.09	16.8.12
Andrew Marran	Public: Elmet and Rothwell	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
Keith Wilson	Public: Leeds North East	3	9.5.11	8.5.14
Andy Parker	Service user: Leeds	3	17.8.09	16.8.12
Tricia Thorpe	Service user: Leeds	3	17.8.09	16.8.12
Maria Trainer	Service user: Leeds	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	17.8.10	16.8.13
Andrew Bottomley	Carer: Leeds	3	17.4.08	16.4.11
	(Re-elected)	3	17.4.11	16.4.14
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
Barry Tebb **	Carer: Non-Leeds	3	17.8.10	9.2.12
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	9.2.12
Dave Shelley **	Staff: Non-clinical	3	17.8.10	9.2.12

\* Indicates those governors that resigned during 2011/12 at the end of their term of office

\*\* Indicates those governors that had to step down during 2011/12 due to a change in the constitution

# Council of Governors

Table 5C – Appointed Governors

Name	Appointing Organisation	Term of Office (years)	Date appointed from	Date Term of office ends/ended
Colin Clark	Equitix Ltd	3	13.2.11	12.2.14
Pip Goff	Volition	3	17.8.09	16.8.12
June Goodson-Moore	NHS Airedale, Bradford and Leeds	3	15.10.09	14.10.12
Richard Hogston *	Leeds Metropolitan University	3	17.8.07	9.2.12
Kate Langan	Tenfold	3	15.2.10	14.02.13
Clare Linley *	Leeds Teaching Hospitals NHS Trust	3	17.8.09	9.2.12
Mark Milsom *	West Yorkshire Police	3	17.8.07	9.2.12
Julia Turner *	University of Leeds	3	20.7.10	9.2.12
Cllr Lucinda Yeadon	Leeds City Council	3	21.7.11	20.7.14

\* Indicates those governors that had to step down during 2011/12 due to a change in the constitution

For the balloted seat of Leeds North East the election turn-out was 7.8%.

Following the successful transfer of services from North Yorkshire and York we changed the composition of the Council of Governors to ensure that it was reflective of where we provide our services. In March 2012 a second round of elections commenced for the new seats and vacancies in existing seats commenced. This election will be fully concluded on 12 April 2012.

During 2011/12 there were five governors who came to the end of their term of office, and who did not stand for re-election. These were John Mason, governor for Leeds North East; Rona Dailey, governor for Pudsey; Gina Greenley, governor for Leeds Central; Joanna Blythe, governor for Public non-Leeds resident; and Dave Shelley, governor for Staff non-clinical. The Trust would like to thank these governors for all their hard work and support to the development of the services we provide.

## 5.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2011/12 there have been a number of changes to the individuals holding the position of governor on our Council of Governors.

### 5.2.1 Elected governors

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 2011/12 we held two rounds of elections. The first was in the spring of 2011 and six seats were included.

We were successful in filling seats as follows:

#### Elected unopposed:

Carer: Leeds	Bill Boland
Carer: Leeds	Andy Bottomley
Carer: Leeds	Annie Dransfield
Staff: Clinical	Jonathan King

#### Elected by ballot:

Public: Leeds North East	Keith Wilson
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### 5.2.2 Appointed governors

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

During 2011/12 there were a number of changes to our appointed governors. Firstly Lucinda Yeadon our appointed governor for Leeds City Council was appointed for a second term with effect from 20 July 2011.

When our new Constitution came into effect on 10 February 2012 there was a change in the composition of our Council of Governors; this meant that four of our appointed governors came to the end of their term of office early. These were Richard Hogston, governor for



# Council of Governors

Leeds Metropolitan University; Julia Turner, governor for the University of Leeds; Clare Linley, governor for Leeds Teaching Hospitals NHS Trust; and Mark Milsom, governor for West Yorkshire Police.

Although there will no longer be representation on the Council from these organisations the Trust is looking at other ways of continuing to work with these partners.

## 5.3 MEETINGS OF THE COUNCIL OF GOVERNORS

During 2011/12 the Council of Governors formally met five times. All Council of Governors' meetings are open to members of the Trust and members of the public; although there are occasionally matters which need to be discussed in a private session of the meeting.

Notice of public meetings, the agenda and papers are published on our website [www.leedsandYorkpft.nhs.uk](http://www.leedsandYorkpft.nhs.uk).

The table below details the number of meetings attended by each governor during 2011/12. This is shown out of a maximum of five meetings unless a governor has either resigned from, or joined the Council of Governors part-way through the financial year.

**Table 5D – 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
Bill Boland *	E	5	4	Grace Mangwanya	E	5	4
Andrew Bottomley	E	5	4	Andrew Marran	E	5	5
Jonathan Butler	E	5	5	John Mason **	E	0	0
Joanna Blythe **	E	4	2	Mark Milsom **	A	5	1
Colin Clark	A	5	5	Pamela Morris	E	5	5
Rona Dailey **	E	4	4	Andy Parker	E	5	5
Pamela Dolan	E	5	3	Sharron Plews	E	5	0
Annie Dransfield *	E	5	4	Jenny Roper	E	5	5
Pip Goff	A	5	5	Dave Shelley	E	5	5
June Goodson-Moore	A	5	3	Heather Simpson	E	5	4
Gina Greenley **	E	4	3	Barry Tebb	E	5	2
Richard Hogston **	A	5	1	Tricia Thorpe	E	5	5
Janette Howlett	E	5	5	Maria Trainer	E	5	3
Alec Hudson	E	5	2	Julia Turner **	E	5	2
Mahesh Jayaram	E	5	3	Keith Wilson *	E	5	5
Jonathan King *	E	5	3	Jackie Worthington	E	5	5
Kate Langan	A	5	0	Stephen Wright	E	5	3
Clare Linley **	A	5	4	Lucinda Yeadon	E	5	2

\* Indicates those governors that were elected or appointed part-way through 2011/12 and therefore may not have had the opportunity to attend all meetings.

\*\* Indicates those governors that resigned or completed their term of office part-way through 2011/12 and may not have had the opportunity to attend all meetings.

# Council of Governors

## 5.4 DUTIES OF THE COUNCIL OF GOVERNORS

A valuable part of our foundation trust is our Council 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 Council of Governors is to represent the interests of members and partner organisations to provide a link between the membership and the Board of Directors. In addition to this there are a number of key statutory tasks set out in legislation that the Council of Governors must also carry out. These include:

- **Appointing (and removing) the Chair of the Trust and non-executive directors**
- **Approving the appointment of the Chief Executive**
- **Appointing (and removing) the external auditor**
- **Receiving the annual report and accounts, and the auditor's report on these.**

Monitor's Code of Governance also requires the Council of Governors to ensure the Board of Directors does not breach the Trust's Terms of Authorisation which it does through receiving the Performance Report.

In June 2012 the Health and Social Care Act will come into force. This will see a change in some of the duties of our governors.

Two of these will be:

- **To hold the non-executive directors individually and collectively to account for the performance of the Board**
- **To represent the interests of members as whole and of the public.**

We will be working closely with our governors over the coming months to ensure that they are equipped with the skills and knowledge that they need to carry out the role.

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 Council of Governors is closely aligned with minutes of the meetings of each being presented to the other. The Chair of the Trust provides a formal link between the two entities 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 Council of Governors also invites other members of the Board of Directors to attend public meetings, in particular the Chief Financial Officer to present the performance report, and the Chief Operating Officer/Chief Nurse to present papers about care services. During the period of reporting each member of the Executive Team has attended one or more meetings of the governors or has made presentations to them. In addition to this the non-executive directors have also been

in attendance to listen to the discussion and understand the issues raised by the Council of Governors so this can inform their input to the Board of Directors and other areas of their work.

In 2011/12 there have been a number of joint workshops in respect of the transfer of services from North Yorkshire and York at which directors and governors have received in depth presentations to allow a better understanding of the services. These workshops have informed the discussion at both Board of Directors' and Council of Governors' meetings.

We have also introduced a facilitated discussion session into the formal Council of Governors' meetings. This is to ensure that for key strategic papers all governors have a protected opportunity to effectively contribute to the discussion and the overall decision of the Council. This helps to ensure that the Board of Directors is able to take account of the views of all governors in a formal way.

## 5.6 SUB-COMMITTEES OF THE COUNCIL OF GOVERNORS

The Council of Governors may not delegate any of its responsibilities; however, it can choose to carry out its duties either through individual governors or through groups and committees. In the light of this the Council 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 Council of Governors.

- The Appointments and Remuneration Committee – this committee reviews and makes

# Council of Governors

recommendations to the Council 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 2011/12 can be found in the Remuneration Report in Section 8.

■ The Membership Committee – this committee reviews and makes recommendations to the Council 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 Council 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 Council of Governors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between

their personal or private interest and those arising from their membership of the Council of Governors. Members of the Council of Governors are also required to declare any conflict 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 telephone on 0113 3055930 or by email [catherine.brand@nhs.net](mailto:catherine.brand@nhs.net).



*Jonathan Butler, Service User Governor, Learning Disability Week, 2011*





*Ann Shuter, Service User Governor, Learning Disabilities*





*Frank Griffiths, Chair of the Trust*

# 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, having regard of the views of the Council of Governors**
- **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 Chair of the Trust 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 Chair of the Trust chairs both the Board of Directors and the Council of Governors and ensures there is effective communication between the two entities, and that where appropriate, 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

### 6.2.1 Non-executive team

There have been no changes to the non-executive directors during 2011/12.

### 6.2.2 Executive team

There have been two changes in the executive directors during 2011/12.

Mr Stephen Griffin, Director of Human Resources, retired on 31 December 2011. Mr Griffin had worked for the Trust since April 2008 as an executive director and had fulfilled the role on a part-time basis. Following Mr Griffin's retirement Mrs Susan Tyler was appointed to the substantive post of Director of Workforce Development and took up post on 1 January 2012.

The Board wishes to thank Mr Griffin for his hard work, support and dedication in helping to ensure that this Trust provides the best possible care for service users. The Board would also like to welcome Mrs Tyler to the team and looks forward to working with her in the future.

In addition to the substantive changes the Board would also like to report that the secondment of Dr Douglas Fraser into the post of Medical Director has been extended beyond its initial period of one year, which ended on 6 September 2011. Dr Fraser's secondment will continue until such time as a substantive appointment is made to Medical Director.

## 6.2.3 Members of the Board of Directors

At the end of 2011/12 the Board of Directors comprised of seven non-executive directors (including the Chair of the Trust) and six executive directors (including the Chief Executive).



Stephen Griffin

# Board of Directors

Table 6A – Members of the Board of Directors as at 31 March 2012

Non-executive Team		
Frank Griffiths	Chair 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
Nicola Swan	Non-executive Director	2 year appointment from 1.12.10
Dr Gill Taylor	Non-executive Director (Deputy Chair from 1 January 2012)	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 (Deputy Chair until 31 December 2011)	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	
Susan Tyler	Director of Workforce Development	
Michele Moran	Chief Operating Officer/Chief Nurse and joint Deputy Chief Executive	
Guy Musson	Chief Financial Officer and joint Deputy Chief Executive	

\*During 2012/13 there are three known changes that will take place to the Board of Directors. On 31 May 2012 Guy Musson will leave the Trust to work independently in the healthcare sector. The Nominations Committee is overseeing the process for making a substantive appointment to this forthcoming vacancy. In light of this change the period of appointment for our non-executive director with significant financial experience, Allan Valks, has been extended for six months until May 2012.

Also within the non-executive team Nicola Swan and Linda Phipps will come to the end of their term of office on 30 November 2012 and

31 January 2012 respectively; neither Nicola nor Linda are eligible to be re-appointed. The Nominations Committee will work with the governors' Appointments and Remuneration Committee to support the Council of Governors in making new appointments to these posts.

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. 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 Chair 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 as Chair.

Non-executive directors, including the Chair of the Trust are appointed by the Council of Governors through an open advertisement process. Should it be necessary to remove either the Chair of the Trust or any of the other non-executive directors this will also be done by the Council of Governors in accordance with the Trust's Constitution.



# Board of Directors

6.3

## PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS



**Frank Griffiths, Chair of the Trust**

Frank has been in post as Chair of the Trust since 1 April 2010, when he was appointed for a period of three years. He is the former Deputy Vice Chancellor of Leeds Metropolitan University, having retired in 2006. As Chair of the Trust, Frank chairs the Board of Directors, and its sub-groups: the Nominations Committee; the Remuneration Committee; and the Charitable Trust Funds Committee. Frank also chairs the Council of Governors and its sub-groups: the Appointments and Remuneration Committee and the Membership Committee.

In addition to his role in the Trust 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 was appointed as a non-executive director on 18 October 2010 for a period of three years. She is currently a member of the Audit and Assurance Committee, a member of

the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required. In addition to this as part of her portfolio Aqila takes a special interest in diversity and minority groups.

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 those with a disability, older people, women, children and young people. Aqila managed volunteers at Chapeltown Citizens Advice Bureau and was a representative on boards of various project and organisations; she was a trainer and delivered training to multi-agency staff on the issue of domestic violence towards women by known men; and was one of the founder members of a community radio station based in Harehills.

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; a board member of Tenfold and represents its membership at the Leeds Partnership Board for Learning Disabilities; a director of Chapeltown Development Trust and several other charities; a voluntary sector representative at the Leeds Initiative Board of Leeds City Council; and is a sector representative at the Scrutiny Board (families and children) of Leeds City Council.

Aqila 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. Her 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**

Linda was appointed as a non-executive director on the 1 February 2010 for a period of three years, which is her final term of office under the Constitution. She is currently the Deputy Chair of the Audit and Assurance Committee, a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required. Linda is a Mental Health Act manager and in addition to this as part of her portfolio Linda takes a special interest in governance and risk management.

Linda first joined the organisation on the 1 February 2006 (before it was authorised as a foundation trust). Prior to joining this Linda was a non-executive director of the former Leeds Community and Mental Health Services Teaching NHS Trust; the chair of East Leeds Primary Care Trust; a member of national Franchising Panel to franchise poorly performing NHS bodies, a member of the national Beacon Councils Panel to promote best practice; and a non-executive director of the Highlands and Islands Airport Limited with Board lead on risk. Linda also has a background in senior commercial management in the transport and local government sectors.

In addition to her role on the Board of LYPFT, Linda is a non-executive director on two of the portfolio Audit and Risk Committees of the Scottish Government; a Trustee of the national mental health charity Mental Health Matters; a member of the Advisory Committee on Conscientious Objectors; a Lay Member of the Department of Health Advisory Group on National Specialised Services, and a Member of the national Specialised Services Patient and Public Engagement Steering Group. She also undertakes consultancy in coaching, mediation, facilitation and rapporteur work.



# Board of Directors



## **Niccola Swan, Non-Executive Director**

Niccola was appointed as a non-executive director on 1 December 2010 for a period of two years, which is her final term of office under the Constitution. She is currently a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required. In addition to this as part of her portfolio Niccola takes a special interest in workforce and workforce development issues.

Niccola first joined the organisation on the 1 December 2007 (before it was authorised as a foundation trust). Prior to becoming a non-executive director she spent 25 years with Barclays Bank working in corporate banking, credit risk, operations and retail. She finished her career there as Regional Director of the north east. During her time at Barclays she gained experience in retail banking, corporate banking and risk management; she was also Barclays' Group Diversity Director for four years.

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), and a member of the now disbanded Disability and Employment Advisory Committee which advised the Minister for Disabled People.

Niccola is a director of Dignity in Dying which campaigns for greater choice at the end of life. At the end of 2010 she was appointed as an executive director of Leeds

Mind which amongst many other activities, delivers services in employment, housing and wellbeing; and is also a director of Volition Leeds, which is an alliance of voluntary sector mental health organisations.



## **Dr Gill Taylor, Non-executive Director (Deputy Chair of the Trust with effect from 1 January 2012)**

Gill was appointed as a non-executive director for a period of three years on 2 January 2011. She is a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee, which she attends as required. As part of her portfolio Gill takes a special interest in change management and organisational development.

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

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 community cohesion.

With effect from May 2012, Gill became Principal Advisor to the Local Government Association to improve the performance of local government, share good practice and

support councils at risk through the facilitation of their improvement programmes.



## **Allan Valks, Non-executive Director (Senior Independent Director)**

Allan was appointed as a non-executive director on 1 December 2010 for a period of two years (extended by the Council of Governors for six months to 31 May 2013) which is his final term of office under the Constitution. He is currently the Chair of the Audit and Assurance Committee, a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required. Allan is also the Senior Independent Director. In addition to this, as part of his portfolio, Allan takes a special interest in financial matters.

Allan first joined the organisation on 1 December 2007 (before it was authorised as a foundation trust). Prior to this he was a non-executive director of the North East Leeds Primary Care Trust (from its inception in April 2002 until October 2006), and has worked for the Department of Health NHS Foundation Trust Implementation Branch, Monitor and with existing NHS foundation trusts.

Allan has had extensive experience in the commercial sector, is an experienced management consultant and has carried out training for national and international bodies on financial matters. He also has experience in commercial business management, marketing and sales strategy, business and staff development.

Allan is a chartered accountant (ACA) currently working as a director within the Public Sector Team at BDO Stoy Hayward LLP, a position to which he was appointed in 2005.

# Board of Directors



**Keith Woodhouse,**  
**Non-executive Director**  
**(Deputy Chair of the**  
**Trust until 31 December**  
**2011)**

Keith was appointed as a non-executive director on 18 October 2010 for a period of three years. He is currently a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required. Keith also attends the transformation Programme Board which oversees the transformation of the way in which our services are provided. In addition to this as part of his portfolio Keith takes a special interest in information management and IT.

Keith has a background of programme and change management and over the last 10 years has worked at director level within both private and public bodies. His last executive role was with the Child Maintenance and 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 service user-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, and continued his appointment as Chief Executive following our authorisation as a foundation trust.

Chris has a broad range of experience firstly as a nurse, and later in his career as Chief Executive of Kingston Primary Care Trust; Director of Operations and Nursing and Deputy Chief Executive in South West London and St. George's Mental Health Trust. Chris has also been a senior civil servant and has experience in primary care; commissioning, both at a local and strategic level; service provision; and the working of government.

Chris is currently Vice Chair of the Yorkshire and the Humber Local NHS Education and Training Board; a member of the Department of Health's Better Training, Better Care taskforce; and is a member of the national NHS Top Leader programme.

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 was appointed to the substantive post of Director of Strategy and Partnerships on 1 April 2011. She is committed to working in partnerships to support people to achieve their goals for improving health and improving lives.

Jill graduated in philosophy and holds a Masters in Business Administration from Manchester Business School. She has worked in healthcare for over 20 years with experience in national policy making, commissioning and provision of healthcare. Jill began her career at the Department of Health where she developed policy in many areas including NHS services, finance, PFI and human resources, and was private secretary to the NHS Chief Executive.

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 a wide range of services including those for children, people with long-term conditions; older people, people with mental health problems and people with learning disabilities; leading the World Class Commissioning development programme; and managing estates and facilities.



**Dr Douglas Fraser,**  
**Medical Director**

Douglas has been seconded into the position of Medical Director from 6 September 2010. 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

# Board of Directors

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 also worked 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.



**Michele Moran, Chief Operating Officer/Chief Nurse, and Deputy Chief Executive**

Michele joined the then Leeds Mental Health Teaching NHS Trust on 29 August 2005, and continued her appointment following our authorisation as a foundation trust.

Michele qualified as a nurse in 1986 and subsequently as a midwife. In 1991 she also qualified as a health visitor, and holds a Masters Degree in Health Service Management.

Michele started her managerial career at Bradford Community Trust and has extensive management experience at both senior management and board level in a wide range of NHS organisations, including GP, community, primary care, mental health, learning disability and 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. She is an Interim Management and Support (IMAS) partner and has undertaken a short secondment alongside PricewaterhouseCoopers LLP to work on acute reconfiguration and strategic footprint for clinical and organisational restructure. Michele has recently been re-elected as Chair of the Foundation Trust Network Clinical Leads Network, and she is 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, and Deputy Chief Executive**

Guy joined the then Leeds Mental Health Teaching NHS Trust on 7 February 2005, and continued his appointment following our authorisation as a foundation trust. Whilst at the Trust, Guy was tasked with project managing the transition to foundation status, which was achieved in August 2007.

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 and was at East Leeds PCT where he was Director of Finance and Commissioning.

Guy is 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.



**Susan Tyler, Director of Workforce Development**

Susan was appointed to the substantive post of Director of Workforce Development on 1

January 2012.

Susan has worked for a number of Trusts across West and South Yorkshire including as Deputy Director of HR at Mid-Yorkshire Hospitals NHS Trust and HR Director at Barnsley NHS Foundation Trust. During her career she has also held a number of senior roles in training and organisational development. Susan has experience across all aspects of health care provision including acute, primary care and mental health / learning disabilities. She holds a Masters degree, MCIPD and ILM Level 5 in coaching and mentoring.

## 6.4 MEETINGS OF THE BOARD OF DIRECTORS

The Board of Directors meets monthly, and with effect from January 2012 it now holds all its meetings in public, although items which are of a confidential nature (as defined by pre-determined criteria) will be taken in a private session. In 2011/12 the Board of Directors met on 13 occasions with six of these meetings being in public.

# Board of Directors

**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)	13	13	Chris Butler	13	13
Aqila Choudhry	13	13	Jill Copeland	13	13
Linda Phipps	13	12	Dr Douglas Fraser	13	12
Nicola Swan	13	12	Stephen Griffin *	10	7
Dr Gill Taylor	13	10	Michele Moran	13	12
Allan Valks	13	13	Guy Musson	13	13
Keith Woodhouse	13	11	Susan Tyler **	3	3

\* Indicates directors who left the Trust during 2011/12.

\*\* Indicates directors who joined the Trust during 2011/12.

## 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. None of the interests declared conflict with their role as a director.

Members of the Board of Directors are also required to declare any conflict 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 telephoning 0113 3055930 or by email [catherine.brand@nhs.net](mailto:catherine.brand@nhs.net).

## 6.6 EVALUATION OF THE BOARD OF DIRECTORS AND ITS SUB-COMMITTEES

The Board of Directors is committed to continuous improvement and has undertaken 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 development tool that had been developed by the NHS Institute for Innovation and Improvement.

The 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 and well balanced team, committed to working together, having a clear focus on patient safety and a very strong relationship with the Council 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. This plan has been used as a basis for the Board's ongoing development and progress has been plotted against the action plan with refreshes being presented and discussed at Board workshops.

## 6.7 SUB-COMMITTEES OF THE BOARD OF DIRECTORS

The sub-committees of the Board of Directors comprises the Audit and Assurance Committee, the Remuneration Committee, the Nominations Committee and the Charitable Trust Funds Committee. (Information about the work of the Remuneration Committee and the Nominations Committee can be found in Section 8).

## 6.8 THE AUDIT AND ASSURANCE COMMITTEE

The Audit and Assurance Committee is the primary governance and assurance committee, and it is a formal sub-committee of the Board of Directors.

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 and assures the Board of Directors in respect of its level of assurance. 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



# Board of Directors

through the work of Internal Audit, External Audit, Clinical Audit, and the Professional Advisory Forum, again received through reports and attendance by key personnel at its 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.

The Audit and Assurance Committee 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 was, until the meeting on 21 March 2012, made up of six non-executive directors as shown in table 6C below. With effect from March 2012 only four non-executive directors make up the substantive membership of the committee (Allan Valks, Linda Phipps and Aqila Choudhry), however the other non-executive directors are invited attend on an ad-hoc basis as and when they feel it appropriate.

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) and RSM Tenon, who provide our internal audit and counter-fraud services.

Table 6C below shows the number of Audit and Assurance Committee meetings attended by each member during 2011/12.

**Table 6C**

Name	Number of meetings eligible to attend	Number of meetings attended
Allan Valks (chair)	11	10
Aqila Choudhry	10	10
Dr Gill Taylor *	11	9
Linda Phipps (Deputy Chair)	11	10
Nicola Swan *	10	10
Keith Woodhouse *	10	7

\* With effect from 21 March 2012 was not a substantive member of the committee.

During 2011/12 the Audit and Assurance Committee has fulfilled the role of the primary governance and assurance committee and has carried out its role through the approval of the work plans for both the internal and external auditors; the Counter Fraud Service and the Clinical Audit Department. It has received and reviewed both regular progress reports and the concluding annual reports for the work of Internal Audit, the Counter-fraud Team and Clinical Audit, which have allowed the committee to determine its level of assurance in respect of progress with the work and the findings.

The committee has had significant input to the development of the Assurance Framework, the risk management process and has conducted a review of the risk registers. As part of its statutory duty



*Love Arts launch, 2011*

# Board of Directors

it has reviewed the Annual Accounts, the Board statements for the Annual Plan and the Quality 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 Council of Governors for information. This can be found on our website at [www.leedsandyorkpft.nhs.uk](http://www.leedsandyorkpft.nhs.uk).

Further information about the sufficiency of our internal control processes can also be found in the Annual Governance Statement 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 ways in which the money can be used in accordance with the purpose of the funds. The Committee is made up of the Chair 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.

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

Table 6E

Name	Number of meetings eligible to attend	Number of meetings attended	Name	Number of meetings eligible to attend	Number of meetings attended
<b>Members of the Committee</b>					
<b>Frank Griffiths</b> (chair)	<b>3</b>	<b>3</b>	<b>Angela Gabriel</b>	<b>3</b>	<b>0</b>
<b>Janette Howlett</b>	<b>3</b>	<b>2</b>	<b>Guy Musson</b>	<b>3</b>	<b>1</b>
<b>Attending on behalf of a member in their absence</b>					
<b>Cathy Ellis *</b>	<b>N/A</b>	<b>1</b>	<b>Carol Greaves **</b>	<b>N/A</b>	<b>1</b>
<b>Richard Lawton ***</b>	<b>N/A</b>	<b>1</b>	<b>David Syms ****</b>	<b>N/A</b>	<b>1</b>

\* Cathy Ellis attended one meeting on behalf of Angela Gabriel

\*\* Carol Greaves attended one meeting on behalf of Guy Musson

\*\*\* Richard Lawton attended one meeting on behalf of Guy Musson

\*\*\*\* David Syms attended one meeting on behalf of Angela Gabriel





Super  
Hero

to talk, it's  
to change  
and mental health discrimination

Leeds Partnerships NHS  
and Foundation Trust

Stamp out stigma  
Donate

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STAMP OUT  
STIGMA

Buddy and the membership team



# Membership

## 7.1 THE CONSTITUENCIES AND ELIGIBILITY TO JOIN

We have three membership constituencies:

- Public
- Service User and Carer
- Staff

Until 1 February 2012 the Public constituency was divided into nine areas. These represented the eight local government constituencies defined for the purpose of local government elections, and one further public constituency for non-Leeds. From 1 February 2012 with the new integrated Leeds and York Trust, these constituencies changed from nine to 13. 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 13 areas.

Previously the Service User and Carer constituencies were divided into four categories. With changes to the Trust taking effect from 1 February 2012 we made these constituencies more representative by adding a Service User Leeds (Learning Disability) and a Carer Leeds (Learning Disability) constituency. These two posts are in addition to the Service User Leeds; Service User Non-Leeds; Carer Leeds; and Carer Non-Leeds. We have also created new Service User and Carer constituencies for York and North Yorkshire, again in line with local government boundaries. 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, York and Selby, North Yorkshire and York Countywide class. In the Service User and Carer Constituency there are a total of 17 elected seats on the Council of Governors.

The Staff constituency was previously divided into two categories: Staff: Clinical; and Staff: Non-clinical. From 1 February 2012 these constituencies have been amended to incorporate the views of our staff in North Yorkshire and York too. There are now three different staff constituencies: Staff Clinical Leeds; Staff Clinical North Yorkshire and York and Non-clinical Staff Leeds and North Yorkshire and York.

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 Council of Governors. (See section 5.1 for further information about the composition of the Council of Governors).

## 7.2 NUMBER OF MEMBERS

Membership has grown steadily to the current figure of **16,104**. Table 7A illustrates the breakdown, by constituency, of the total number of members as at 31 March 2012.

**Table 7A – Total membership by constituency**

Public Constituency	Number of Members
Elmet and Rothwell	593
Leeds East	951
Leeds North East	1368
Morley and Outwood	372
Pudsey	737
Leeds Central	2341
Leeds North West	1489
Leeds West	1037
North Yorkshire and York Countywide	169
York Outer	64
Selby & Ainsty	116
York Central	107
Rest of England and Wales	1596
<b>Total public members</b>	<b>10940</b>
Service User and Carer Constituency	Number of Members
Service user Leeds Resident	537
Service user Leeds (Learning Disability)	19
Service user York and Selby	20
Service user North Yorkshire and York	7
Carer Leeds Resident	380
Carer Leeds (Learning Disability)	0
Carer York and Selby	11
Carer North Yorkshire and York Countywide	3
Service User and Carer rest of UK	76
<b>Total service user and carer members</b>	<b>1053</b>
Staff Constituency	Number of Members
Clinical Staff Leeds	2272
Clinical Staff North Yorkshire and York	918
Non-clinical Staff Leeds, North Yorkshire and York	921
<b>Total staff members</b>	<b>4111</b>

# Membership

## 7.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, with no significant deficits. During the past 12 months, we have undertaken activities with gender, ethnicity and age-specific groups to ensure that the membership continues to be representative. This year we have also started 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, York Pride 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. In 2011 we introduced a twilight

member engagement event: 'Everything you need to know about' targeting specifically our public members, people using our services, and their carers. We plan to continue these and roll out to our members in North Yorkshire and York.

## 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 are currently planning a new integrated magazine 'Imagine' for members and staff.

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 Let's get Elfy 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 carried out related activity with local partnership organisations and special interest groups. This activity 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. They can be contacted by telephone on (0113) 3055900 or by email

[ftmembership.lypft@nhs.net](mailto:ftmembership.lypft@nhs.net).



Membership stall at Knarsborough Bed Race, 2011

# 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 2011/12. 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 organisation.

## 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 Chair of the Trust.

The Appointments and Remuneration Committee is a sub-committee of the Council 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 2011/12

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 2011/12 the Council 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 and staff for the period 2011/12.

## 8.2.3 Appointment of non-executive directors in 2011/12

During 2011/12 there were no appointments or re-appointments of non-executive directors and staff. Details of the non-executive director team are detailed in the table below.

**Table 8A**

Name	Date Appointed	Period	Date Appointment Ends
Frank Griffiths	1 April 2010	3 years	31 March 2013
Aqila Choudhry	18 October 2010	3 years	17 October 2013
Linda Phipps	1 February 2010	3 years	31 January 2013
Niccola Swan	1 December 2010	2 years	30 November 2012
Dr Gill Taylor	2 January 2011	3 years	1 January 2014
Allan Valks	1 December 2010	2 years	30 November 2012 *
Keith Woodhouse	18 October 2010	3 years	17 October 2013

\* In 2012/13 the Council of Governors agreed to extend Allan Valks' term of appointment by six months until 31 May 2013

Where it is necessary to make a non-executive director appointment the first step in the process 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 Council of Governors. An interview panel is formed which includes a majority of governors, the Chair of the Trust (where the interviews are not for the position of Chair 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.



# Remuneration Report



*Aqila Chouhry, Non-executive director*

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 Council of Governors whose responsibility is to ratify the appointment.

## 8.2.4 Meetings of the Appointments and Remuneration Committee

There were no meetings of the Appointments and Remuneration Committee during 2011/12 as no non-executive director appointments were made during the period.

## 8.3 THE NOMINATIONS COMMITTEE (a sub-committee of the Board of Directors)

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 Council of Governors' Appointments and Remuneration Committee. Where the vacant post is for an executive director the committee will lead on the appointment process.

The Nominations Committee meets as required. It is chaired by the Chair of the Trust and its membership is made up of the Chief Executive, the Director of Workforce Development and two non-executive directors. During the year the committee has led on the process for the appointment of three executive director vacancies, the posts of Medical Director, the Director of Workforce Development and the Chief Financial Officer. The appointment of the Director of Workforce Development was made through a competitive process, using an open advert and was concluded in January 2012. The appointment of a substantive Medical Director and Chief Financial Officer is expected to conclude during 2012/13.

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

**Table 8B – 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)	5	5	Chris Butler	5	5
Aqila Choudhry*	5	2	Stephen Griffin**	4	4
Nicola Swan*	5	4	Dr Gill Taylor*	5	1
Susan Tyler ***	1	1	Allan Valks*	5	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.

\*\* Indicates directors that left the Trust part way through 2011/12

\*\*\* Indicates directors that joined the Trust part way through 2011/12

# Remuneration Report



Love Arts Festival

## 8.3.1 Appointment of executive directors in 2011/12

In 2011/12 there was one new appointment to the executive director team: the Director of Workforce Development. The Remuneration Committee considered the job description and person specification for this post, which was made through open advertisement. Susan Tyler was appointed to the post with effect from 1 January 2012.

## 8.4 THE REMUNERATION COMMITTEE (a sub-committee of the Board of Directors)

The Remuneration Committee sets the remuneration for the executive directors, those senior managers who are on Agenda for Change band 9, and considers clinical excellence awards for consultants. This is a sub-committee of the Board of Directors. It is made up of all the non-executive directors and is chaired by the Chair of the Trust.

With regard to executive directors the overarching policy of the Remuneration Committee is to follow the guidance given by the Department of Health in determining their pay and terms of service. However, when awarding percentage pay uplifts the committee is always mindful of the percentage awarded to staff, which is used as benchmark. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports.

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 is invited to attend to provide information on how the executive directors have met their agreed objectives. In relation to employment matters, the committee has also received advice from Stephen Griffin the Director of Human Resources (up until 31 December 2011) and Susan Tyler the Director of Workforce Development (from 1 January 2012).

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

Table 8C – 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)	5	5	Aqila Choudhry	5	5
Linda Phipps	5	3	Nicola Swan	5	4
Dr Gill Taylor	5	4	Allan Valks	5	5
Keith Woodhouse	5	4			

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.



# Remuneration Report

Contracts for executive directors are permanent and therefore open ended, with the exception of Dr Douglas Fraser who has been seconded to the post of Medical Director until such time as a substantive appointment is made. The period of notice for each member of the executive team is three months as set out in their contracts.

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

Table 8D

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 (secondment from)	6 September 2010
Michele Moran	Chief Operating Officer/Chief Nurse	29 August 2005
Guy Musson	Chief Financial Officer	7 February 2005
Susan Tyler	Director of Workforce Development	1 January 2012

## 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 Chair 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 Chair of the Trust; the Senior Independent Director conducts the appraisal of the Chair of the Trust. The Chair 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

Accounting policies for pensions and other retirement benefits are set out in the notes to the Annual Accounts, see Section 10. 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 Section 8.6.1 is consistent with the financial statements.





# Remuneration Report

## 8.6.1 Pension entitlements for senior employees

Table 8E – Pension entitlement for senior employees (subject to audit)

Name and Title	Real Increase in pension at age 60  (bands of £2,500) £000	Real Increase in pension lump sum at age 60  (bands of £2,500) £000	Total accrued pension at age 60 at 31 March 2012  (bands of £5,000) £000	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000) £000	Cash equivalent transfer value at 31 March 2011  £000	Cash equivalent transfer value at 31 March 2012  £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
<b>Chris Butler -</b> Chief Executive	0 - 2.5	5 - 7.5	10 - 15	40 - 45	232	289	57	40	0
<b>Guy Musson -</b> Chief Financial Officer	0 - 2.5	2.5 - 5	50 - 55	150 - 155	956	1,035	79	55	0
<b>Dr Douglas Fraser</b> Medical Director	0 - 2.5	5 - 7.5	25 - 30	86 - 90	380	476	96	68	0
<b>Michele Moran -</b> Chief Operating Officer and Chief Nurse	0 - 2.5	2.5 - 5	35 - 40	115 - 120	552	649	97	68	0
<b>Jill Copeland -</b> Director of Strategy and Partnerships	0 - 2.5	0 - 2.5	35 - 35	95 - 100	489	562	73	51	0
<b>Susan Tyler</b> Director of Workforce Development	75 - 10	25 - 27.5	35 - 40	105 - 110	0	668	166	116	0
<b>Stephen Griffin</b> Director of Human Resources	0	0	0	0	0	0	0	0	0

- It should be noted that non-executive directors do not receive pensionable remuneration and consequently there are no entries for them in respect of pensions; and Susan Tyler started as Director of Workforce Development 1 January 2012.
- Stephen Griffin did not receive pensionable remuneration and consequently there are no entries for him in respect of pension.

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

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

# Remuneration Report

Table 8F – Remuneration and Benefits in Kind for Senior Staff (subject to audit)

Name and Title	2011 - 12			2010 - 11		
	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Benefits in kind
	£000	£000	Rounded up to the nearest £100	£000	£000	Rounded up to the nearest £100
<b>Chris Butler</b> - Chief Executive	145 - 150	5 - 10	0	145 - 150	5 - 10	0
<b>Mike Doyle</b> - Director of Corporate Development	0	0	0	5 - 10	70 - 75	0
<b>Guy Musson</b> - Chief Financial Officer	105 - 110	0 - 5	0	105 - 110	0 - 5	0
<b>Dr David Newby</b> - Medical Director	0	0	0	65 - 70	15 - 20	29
<b>Dr Douglas Fraser</b> Medical Director	85 - 90	25 - 30	35	85 - 90	20 - 25	23
<b>Michele Moran</b> - Chief Operating Officer and Chief Nurse	105 - 110	0 - 5	1	105 - 110	0 - 5	2
<b>Stephen Griffin</b> - Director of Human Resources	40 - 45	0 - 5	0	60 - 65	0 - 5	0
<b>Jill Copeland</b> - Director of Strategy and Partnerships	110 - 115	0	0	110 - 115	0 - 5	0
<b>Susan Tyler</b> - Director of Workforce Development	20 - 25	0	1	0	0	0
<b>Frank Griffiths</b> - Chair of the Trust	40 - 45	0	0	40 - 45	0	1
<b>Merlin Wilce</b> - Non executive Director	0	0	0	0 - 5	0	1
<b>Linda Phipps</b> - Non executive Director	10 - 15	0	1	10 - 15	0	2
<b>Nicola Swan</b> - Non executive Director	10 - 15	0	0	10 - 15	0	5
<b>Allan Valks</b> - Non executive Director	10 - 15	0	0	10 - 15	0	0
<b>Catherine Coyle</b> - Non executive Director	0	0	0	5 - 10	0 - 5	0
<b>Keith Woodhouse</b> Non executive Director	10 - 15	0	3	5 - 10	0	0
<b>Aqila Choudhry</b> Non executive Director	10 - 15	0	0	5 - 10	0	0
<b>Gillian Taylor</b> Non executive Director	10 - 15	0	8	0 - 5	0	2

- Susan Tyler started as Director of Workforce Development on 1 January 2012 replacing previous Director Stephen Griffin.
- The amounts shown as 'Other Remuneration' for the executive directors include car allowances. The amount paid to Dr Douglas Fraser includes the proportion of his salary paid to him for the clinical work he carries out.
- 'Benefits In Kind' in respect of the Chair 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.

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

	Highest earner (a)	Median salary (b)	Ratio (a versus b)
<b>2011/12</b>	<b>181,585</b>	<b>26,071</b>	<b>6.97</b>

To calculate the median salary we have used data that is generated from our payroll system and our agency staffing system. All staff that were employed by the trust on 31st March 2012 are included in the calculation.

For Agency staff, the calculation is based on the number of the agency staff who worked for the trust on 31st March 2012. The agency fee was identified and removed based on invoices previously paid.



28 May 2012, Chris Butler, Chief Executive



*Chris Butler receiving the Global Corporate Challenge trophy*





*Voluntary Services, volunteers at Inkwell, Leeds*



# Quality Accounts

## 9.1 INTRODUCTION

The term “quality” has a number of different dimensions. The most obvious are our obligations arising from the law and/or our regulators. Another aspect are those quality initiatives which emerge from what we learn about ourselves through, for example, the outcome of inspections, or understanding the lived experience of service users and carers who are being supported by us. We also continue to use information drawn from data, such as our reports to the National Patient Safety Agency. The monthly ‘Performance Report’ to our Board of Directors reports if we have experienced a ‘never event’, as defined by the Department of

Health in service provision, as well as reporting on a number of things that our Board has decided that it wishes to know about with regard to the quality of service provision. We call these ‘trigger to Board’ events. If we think that something has gone wrong we routinely look at this using a ‘root cause analysis’ and respond to what we learn.

We are not a complacent organisation and our lived experience shows us that there are always ways in which we can improve. Key to this is continuing to put 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.**

The Quality Accounts illustrate only some of the key points on our journey of being the best we can be.



*Annual Members Day, 2011*

# Quality Accounts

## 9.2 OVERVIEW OF ORGANISATIONAL EFFECTIVENESS INITIATIVES

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

### Integrated organisation

On 1 February 2012, Leeds Partnerships NHS Foundation Trust merged with mental health and learning disability services in York, Selby and Tadcaster, as well as providing some county wide services across North Yorkshire. Our integrated organisation became the Leeds and York Partnership NHS Foundation Trust. As an integrated organisation we are now bringing together shared knowledge, skills and experience to deliver the highest quality mental health and learning disability services to the people of Leeds, York, Selby, Tadcaster, Easingwold and parts of North Yorkshire.

### Transformation programme

Improving the quality of care provided to service users is a major part of our transformation programme. It will deliver redesigned clinical services which are non-age bounded and which are based around integrated care pathways. We have involved service users in the mapping of existing services and held 'voice of the customer' workshops to inform the analysis and design phases of the work. Service users have told us how to make our services simpler, better and more efficient. Practical examples include the suggestion that "if there was one assessment (with information used by all parts of the service) this would be easier". Individual service users wanted services "to focus on my recovery and wellbeing". We aim to increase the amount of time available for staff to spend with service users because service users tell us "they



find one to one time with clinical staff valuable". We will do this by making paperwork easier to complete and improving the technology available to clinical staff.

### Clinical team of the year award

Our Yorkshire Centre for Eating Disorders has been nationally recognised for its work treating people who have eating disorders by winning a 'Beat' (formerly Eating Disorders Association UK) award. Our Yorkshire Centre for Eating Disorders was nominated for the award by a service user, reflecting its history of strong partnership with service users and carers, as well as good clinical outcomes. As an early implementer of new quality standards for eating disorder services as well as having a keen focus on innovative research and new treatments, our Yorkshire Centre for Eating Disorders has grown to become one of the largest services of this kind in the UK.

### Star Wards – The Full Monty Award

Ward 2 at Bootham Park Hospital in York, successfully qualified for the Full Monty Award in March 2012. The award is given to wards who have implemented all 75 Star Wards ideas. StarWards provides practical ideas for improving the daily experience and treatment outcomes of acute mental health inpatients. The award also recognises outstanding effort and achievement among Star Wards members.

### Nursing strategy

Our nursing team has continued to work within a defined three-year strategy which came to its conclusion in 2011. Significant areas of development through the three-year strategy included work on Essence of Care, Medications Management, the establishment of education and training development, and progress in preceptorship development. Following a period of review new objectives have been established for 2012 in line with the Chief Nursing Officer's 'Energise for Excellence: Call for Action'. This robust performance framework has been used



# Quality Accounts

effectively over the last 12 months allowing a range of locally developed indicators to be measured and monitored. This framework will continue to be a key focus in 2012.

## Nursing conference

Over 100 delegates attended the third annual conference with the theme of Nursing Leadership: Today and Tomorrow. Key note speakers and workshops actively considered the impact of the nursing profession on quality, safety, education and health care policy. We were awarded Royal College of Nursing accreditation for this conference.

## The Productive Mental Health Ward

All our inpatient areas are actively involved with 'The Productive Mental Health Ward: Releasing Time to Care' and teams are changing the way they work in order to further improve the effectiveness, safety and reliability of our services. Adopting the 'Productive Mental

Health Ward' has enabled us to compare the performance of our mental health facilities with that of others, learn from the best and make positive improvements for both staff, service users and carers.

## Accreditation for Acute Inpatient Mental Health Services (AIMS)

Significant work has continued throughout 2011 to develop The Mount in Leeds (Older People's Services) as a centre of excellence. The mental health wards have utilised the Accreditation for Acute Inpatient Mental Health Services process to develop a wide range of best practice standards and it was confirmed in October 2011 that the wards were successful in being awarded this nationally recognised accreditation.

Our Oakrise Acute Treatment and Assessment Unit in York also achieved Accreditation for Acute Inpatient Mental Health Services in 2011,

along with our learning disability unit, Parkside Lodge in Leeds.

Our Recovery Unit at Acomb Garth in York has just started working towards accreditation with the Royal College of Psychiatrists.

## Quality Assessment Framework - the Specialised Supported Living Service

A joint validation inspection by Leeds City Council, Adult Social Care and Supporting People was undertaken at Ivy Cottage in Leeds within our Specialised Supported Living Service in February 2012. The assessment visit focused particularly on areas of safeguarding and protection from abuse within the Quality Assessment Framework. The visit was extremely positive with staff demonstrating an excellent knowledge of the support and care needs of clients within the service. The service was validated at a Level A which means 'excellence' and is associated with providers striving to be leaders in their field.

## Implementation of e-rostering

E-rostering is an electronic way of efficiently managing when staff are needed at work. The system enables managers to quickly build their rosters, defining the number of employees (by skill mix) needed to meet the demands of the NHS.

We have successfully implemented and consolidated an e-rostering system to 28 wards/departments within the Trust. Using e-rostering has enabled us to ensure we have the right staff in the right place at the right time, allowed us to look at efficiencies in staff rosters and better utilise our substantive staff by reducing the need for temporary staff.

In 2012/13 we will be rolling out e-rostering



*Nursing Conference, 2011*

# Quality Accounts

to all areas and staff groups within the Trust.

## Access to psychological therapies

Our adult psychological therapy service has achieved a major success in clearing the waiting list for psychological therapies in Leeds. Traditionally, these services have long waiting times but the Leeds service has systematically reviewed, re-designed, improved and invested in its service in order to address this. This is a feat that few trusts in the country have been able to achieve.

## Vulnerable veterans and adult dependents

The Vulnerable Veterans and Adult Dependents is a bespoke Improving Access to Psychological Therapies service based at Catterick Garrison in North Yorkshire, the largest garrison in Europe. It specialises in working with veterans and dependants of serving personnel and aims to improve access to evidence based treatment for those who are experiencing common mental health difficulties. The service started to receive direct referrals in August 2010 and by the end of February 2012, it had received 570 referrals from the four surgeries that it covers. The service has offered over 2,800 patient contacts and over 1,700 hours of treatment. The service's performance continues to exceed national Improving Access to Psychological Therapy outcomes.

On the 1st April 2012, our Vulnerable Veterans and Adult Dependents will reach the end of its two year pilot. It has been re-commissioned by the NHS and will be increasing its footprint to include RAF Leeming in North Yorkshire. A scoping exercise will also be undertaken to examine the mental health needs of Veterans throughout North Yorkshire.

## King's Fund Project

Our Meadowfields Unit in York has been involved in a King's Fund Project to 'Enhance the Healing Environment'. The entire team has been involved in this initiative which has greatly improved the dining area and kitchen facilities. Signage has been improved throughout the unit and the staff have consulted with patients and carers to agree on the use of art work, with pictures of York being used to help orientate patients to specific areas of the unit. The project has had a positive impact on patient experience and has improved team working within the service.

## The Healthy Living Service

All service users referred to our healthy living team have an initial health assessment. This provides detailed information about our service users' health relating to the four areas of activity and exercise, smoking cessation, brief interventions for alcohol and healthy eating. Since its introduction there has been an increase in the number of referrals for smoking cessation and healthy eating advice. This information helps the team to plan interventions and service development according to service user's needs.

## 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 within clinical teams who meet regularly to share good practice and plan for improvements to employment support.

## Focus on recovery

A key part of our project to transform our clinical

services, is to embed recovery principles within our day to day work. By recovery principles we mean a focus on three things: hope for the future; enabling people to take control of their lives; and supporting people to be active citizens in their communities. We ran a series of workshops in early 2011 to identify key priorities for embedding recovery principles and appointed a project worker to help us take them forward.



## Arts and Minds

Our first Love Arts Festival [www.loveartsleeds.co.uk](http://www.loveartsleeds.co.uk) took place in the autumn with over 55 events held over seven weeks and a month of fringe activities at Kirkgate market in Leeds. We developed partnerships with 38 arts organisations and recruited 63 volunteers who supported our events. We made direct contact with an estimated 100,000 people over the course of the festival and reached an estimated 10,000,000 through our media profile. We are currently planning our 2012 festival with sister events taking place in the York area.

## The Northern Film School

We have developed a partnership with the Northern Film School to produce a series of short films challenging mental health stigma. This involved providing mental health awareness training to 60 students. A film brief was given to the students who were required to pitch their film ideas to a panel of people with experience of using and working in mental

# Quality Accounts

health services and film experts. The films are due to be premiered in May 2012.

## Partnership working

As a foundation trust we value our close working relationships with all our partner organisations. Working together in partnership means that we are able to share good practice and learn from each other. We value our partners, particularly those in the voluntary sector who act as critical friends, which provides us with a useful arena for debate and consultation. Our Council of Governors has a number of non-elected governor seats to ensure a formal link with our partners. This has enhanced our work and provided us with a better understanding of how we as an organisation are viewed across the city, as well as how we set our priorities for future work. Working with partner organisations to improve health and lives is one of the means goals within our strategy and together we want to work towards ending discrimination for people with mental health conditions and learning disabilities. We are looking forward to developing new partnerships in North Yorkshire and York as well as further developing our existing links in Leeds.

## Leadership development

Over the last year we have continued to embed our experiential learning philosophy through providing cutting edge leadership development programmes both internally and on behalf of the Leeds health economy. The Fit for the Future development programme was provided for approximately 130 Band 7 leaders, with early evaluation and feedback indicating that this development has been well received and effective.

One of the outcomes of our Fit for the Future programme has been each delegate developing an innovation report on how they believe their

services can be improved for the benefit of our service users. All innovation reports have been put forward to the Executive Team for consideration.

The Leeds Leadership Centre, hosted by ourselves, provided a portfolio of accredited learning programmes for over 250 leaders within the Leeds health economy. The Centre's core purpose remains as 'enabling organisations to meet their strategic aims and aspirations, by realising staff's potential through high quality, experiential, accredited learning programmes'. This aligns to and supports Department of Health drivers, as well as Yorkshire and the Humber's Strategic Health Authority's vision for a qualified workforce.

Our investment and support for developing our staff remains at the heart of how we will meet the challenges that lie ahead. Following the integration of services with North Yorkshire and York in February 2012, we have gained committed and enthusiastic staff, and we will ensure they can realise their potential through the varied learning opportunities we provide.

## 'Your Heart Matters'

Our Learning Disabilities Team worked with

partners in NHS Airedale, Bradford and Leeds, and the Cardiac Rehabilitation Nursing Team to develop 'Your Heart Matters'. The project was part of the national Pacesetters programme, and was launched during Learning Disability Awareness Week 2011. The project developed a range of materials to support people with learning disabilities to maintain good heart health, and recover successfully from cardiac problems. It also included material for cardiac rehabilitation nurses which supported people with learning disabilities to access the same range of support and services available to the general population of Leeds. This work was acknowledged nationally and locally, being short listed for a Nursing Times award 2011, and receiving a Health Stars award in 2011.

## The Autism Diagnostic Service

A pilot autism diagnostic service has been in place since September 2011 involving health professionals from our learning disability and mental health services working together to provide seamless provision, meeting the need of all those who are referred for diagnosis including those where the IQ is unclear. The service offers initial screening followed by a more thorough developmental assessment.



*Your Heart Matters - Learning Disabilities Team*



# Quality Accounts

9.3

## 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 2012/13, are set out on the following pages.

Progress against our priorities set out in our 2010/11 Quality Accounts are reported on the following pages and have been reported to our Board of Directors through our monthly performance report, with each key priority reported on a quarterly basis. These are publicly available documents and can be viewed on our website [www.leedsandyork.nhs.uk](http://www.leedsandyork.nhs.uk)

Progress against our priorities set out in this

year's Quality Accounts will continue to be reported to our Board of Directors through our monthly performance report.

P1

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

#### Progress against 2011/12 initiatives:

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

The following initiatives are examples of work that has been undertaken within the Trust:

- Capability to deliver Clinical Outcomes in Routine Evaluation is live on PARIS (our electronic clinical care record system) and a Core Net pilot is underway
- A Recovery Star pilot tool is live on PARIS
- Therapy Outcome Measures is live on PARIS within the Learning Disabilities Directorate, and more widely amongst occupational therapy colleagues
- Patient reported outcome measures are being developed by project leads and it remains likely that EQ-5D (outcome measure) will become a national mandated Patient Reported Outcome Measure
- Improved reporting structures are being designed in order to provide the appropriate outcomes measure data at service user, clinician, team, service and corporate level
- The Trust's Payment by Results project has reviewed its links with the Trust's outcome measures work to ensure the work being undertaken is aligned and mutually supportive.

**b) 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.**

The following initiatives are examples of work that have been undertaken within the Trust:

- A consultant dietician has been employed to support the introduction of revised hospital menus which will include a 'healthier choice' option in line with national guidelines
- Updated hospital menus are currently being piloted at the Newsam Centre in Leeds. A catering folder has been developed for dieticians to access nutritional analysis of all meals for specialist diets
- Our Healthy Living Service is running a project funded by NHS Airedale, Bradford and Leeds to support service users to use community leisure centres. Uptake of Leeds Bodyline cards (membership cards) is being used as an outcome measure. There have been over 35 new referrals to this project
- Our Healthy Living Service and our Assertive Outreach Team are piloting a drop-in physical health assessment clinic. Here Assertive Outreach Team service users who are not accessing primary care can have their annual physical health check and receive advice regarding healthy living, healthy eating and smoking cessation.

**c) We are focusing on embedding recovery principles as we undergo a transformation programme to further improve how we deliver services. We will hold a series of workshops and provide reports to our Board of Directors that enables us to assess our current position, set priorities and work towards them. We are involving people who use**

# Quality Accounts

## **our services, carers, staff and partner organisations in this exciting project.**

We held a series of workshops, involving service users, carers, staff and partner organisations, to undertake a recovery audit of the Trust. As a result a number of priority areas were identified for development, as part of the transformation programme, that we believed embedded recovery and improved outcomes for people using our services.

## **d) 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.**

A number of meetings have taken place with public and private companies with a view to delivering training. A Time to Change 'human library' event took place at British Gas headquarters in November 2011.

## **e) We will extend the productive series into community services. A pilot is currently being conducted within the Learning Disabilities Directorate.**

Productive Community Services continues within two of the Trust's community learning disability teams. The programme lead has engaged with colleagues in North Yorkshire and York services where a number of community teams have made good progress with the productive initiative. Networks have been established to share good practice across the organisation.

## **f) 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.**

The 2010/11 cohort of Associate Practitioners, supported by the Trust, all successfully completed the course. Clinical areas factored the role of Associate Practitioner within their workforce plans. We engaged the support of both the Strategic Health Authority and Higher Education Institution in continuing development of the programme as well as developing work based learning support.

## **Initiatives to be implemented in 2012/13:**

i. We are involved in an exciting new research project 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. The research project, 'Leading to Quality', involves all NHS mental health provider organisations in Yorkshire and the Humber and will also form part of the evaluation of our Trustwide transformation programme.

ii. In order to ensure that we are meeting the needs of our service users, we are taking a systematic approach to measuring clinical outcomes. We are using the three main clinical outcome measures to identify service user needs at the beginning of the care episode, and will use these to measure progress over time.

## **■ Clinical outcomes in routine evaluation**

## **■ Health of the nation outcome scales**

## **■ Therapy outcome measure.**

Initial work has demonstrated that the Trust is helping people improve their wellbeing on

these measures, and the next step will be to implement this work systematically across the organisation.

iii. Within the North Yorkshire forensic service, a tracking system that identifies the service user's pathway is in development and the service user will receive a 'road map' identifying their agreed goals. The tracking system will allow monitoring of the care pathway for a person and help to continually monitor information and service provision and outcomes for staff and service users. This initiative is linked to the implementation of the Shared Pathway, which is a national requirement for all secure services.

iv. We have developed a 2012 membership campaign entitled 'What's your Goal?' to recruit new members and engage with our existing members. The campaign is inspired by the Olympic Games and Paralympic Games and explores the relationship between physical health and mental wellbeing. We are encouraging people to set a goal and represent that goal on a piece of bunting. In November 2012 we will be connecting all the pieces of bunting together in an attempt to break the Guinness World Record for the longest line of bunting. Our record breaking attempt is an effective way to gain public interest in our campaign and symbolises our aim to bring people together around a common purpose.

v. We continue to focus on embedding recovery principles as we undergo a transformation programme to further improve how we deliver services. We will continue to undertake work that enables 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.

# Quality Accounts

P2

## Priority 2 - People experience safe care

### Progress against 2011/12 initiatives:

**a) 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.**

Our Associate Director of Nursing and Clinical Standards Development Nurse reviewed the Department of Health's 'Flying Start' programme intended for newly qualified staff, or staff within preceptorship programmes. This programme now features as a significant part of the nurse rotation programme and has been made bespoke to our Trust's needs. Discussions took place with Leeds Metropolitan University about the possibility of accrediting the nurse rotation programme as an 'M' level module and work has progressed in this area.

**b) 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 2011/12 in collaboration with the 'Meet the Boss' programme.**

'Quality Walk Arounds' have taken place during 2011, based in a variety of settings across Adult, Older People's, Learning

Disability and Specialist Services Directorates. The 'Quality Walk Arounds' have now been extended to include both non-executive directors and executive directors. Initial scoping is underway to include the North Yorkshire and York sites within this process.

**c) 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.**

With the support of the Patient Safety Manager and the Associate Director for Doctors in Training, specific projects are being prepared to run in conjunction with established work streams relating to the patient safety agenda for the Trust. These projects are related to medication safety, in partnership with the Pharmacy Department, risk assessment with the Clinical Audit Department, and training through the Doctors in Training programme.

**d) 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.**

We continue to use and enhance a variety of national and locally generated benchmark indicators for quality and patient safety, which include:

■ NPSA 'How do you compare to your peers' national and regional statistics of patient safety incidents

■ Statistical Process Control on unexpected deaths of services users in receipt of Trust services

■ Incorporation of the extended National Patient Safety Agency 'Never Events' into Board reporting

■ Continuation of monthly reporting of the Trust's 'Trigger to Board' events.

With the additional North Yorkshire and York services, these indicators will be included within the Trust's data sets and analysis.

**e) Expansion of proactive patient safety initiatives across the Trust.**

Patient safety remains a top priority within the Trust. In order to continue advancing patient safety, a number of initiatives have commenced on an individual team, directorate and trust-wide basis. These initiatives are based around the following work streams and are monitored through Risk Management, the Trust's Means Goal 1 / 2 Standing Group and Means Goal 5 Standing Group:

- Promotion of best practice
- Benchmarking standard of care
- Striving to be 'An Organisation with a Memory', through the lessons learned process.

### Initiatives to be implemented in 2012/13:

i. Within the 2012 nursing strategy work plan focused work will take place on both records review and audit and Mental Health Act training development. Objectives will build upon the successful work carried out



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over the previous three years in relation to Essence of Care benchmarks, medication management, infection control standards and safeguarding awareness and knowledge.

ii. Development and extension of the Section 136 service in Leeds is aimed to increase both the physical space and capacity of the Section 136 service and also to provide a flexible care environment which will allow a greater range of therapeutic activities to take place. The suite will include bedrooms to allow service users who are not fit to be assessed when they are first brought to the unit to be nursed until assessment is possible. The suite will also allow service users requiring assessment by the Crisis Resolution Service to come to the Becklin Centre in Leeds and receive care whilst they are waiting for assessment. This may be for short periods and will be beneficial for service users who may struggle to maintain their safety during this period.

iii. Narrowing of the Board to Ward Experience: Expansion of the Quality Walk Arounds program for Board members to include North Yorkshire and York services. As in 2011/12 an additional 12 'walk arounds' will be scheduled across the Trust and reported to our Board of Directors.

iv. Further enhancement to the role of the Patient Safety Champion from Doctors in Training in the pursuit of safer care delivery.

v. Expansion of our previous benchmarking for patient safety on a local, regional and national level to include North Yorkshire and York services.

vi. Continued expansion of proactive patient safety initiatives across the Trust.

## **P3 Priority 3 - People have a positive experience of their care and support**

### **Progress against 2011/12 Initiatives:**

**a) Through our transformation programme we aim to achieve a pathway model of services that eliminates inequity and age discrimination and improves access to services.**

A new model for community mental health services has been developed following the analysis of existing services. The new model was informed by three implementation projects which considered the use of technology in the community, included an early implementer site at Aire Court in Leeds to develop new ways of working and reviewed the medical input to out-patients and other clinical settings.

The new model will be delivered through locality based teams with clinical staff working together across all age ranges to ensure that service users receive the care and services they require. Plans to implement the new service are being developed for June 2012, allowing time to introduce a single point of access and urgent referral systems, in addition to closely aligned clinic and home treatment services.

Service users will follow an agreed care pathway which will ensure their needs are assessed, delivered and regularly reviewed. A core integrated care pathway has been developed with clinical teams. Needs based pathways covering dementia, psychosis and common mental health problems are now being developed.

**b) 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.**

The on-line wellbeing hub has developed over the year. A city wide group is running a 'community journalist' course to a group of people with personal experience of mental health issues during March/April 2012. They will be supported to create blogs for the 'wellbeing web'. Funding is being identified to enable continuation of the project.

**c) 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.**

The Love Arts Festival took place between 27 September and 16 November 2011. The purpose of the festival was to raise awareness of mental health issues and our Time to Change campaign. A further Love Arts festival will take place in October 2012 and will be part of a wider year long Olympic and Paralympic Games inspired 'What's your Goal?' campaign.

**d) 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 participating from the wider local community.**

The Inkwell Community Arts Centre conversion work has been finalised with space being

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developed for multi-functional use and room hire. Arts and Minds and our Time to Change project workers are based at the centre.

**e) 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 trust quality mark that will indicate reliable sources of health and social care information.**

The Trust's Producing Information Policy has been reviewed and an audit of information took place in December 2011 to assess compliance with the policy. We are now setting up a plan for all information to be reviewed and updated over the coming year. A procedure for all information to be edited and designed by the communications team is in the process of being developed.

## **Initiatives to be implemented in 2012/13:**

i. Through our transformation programme

our aim continues to achieve a pathway model of services that eliminates inequity and age discrimination and improves access to services.

ii. In order to improve the experience of service users and their carers and to improve the efficient use of resources we will be opening a new 17 bedded secure rehabilitation inpatient facility in Leeds. Historically service users who have required this service have been placed in out of area units meaning that they have not received their care locally in Leeds. The new local unit will improve the ability for these service users to follow a local care pathway with a clear focus on recovery.

iii. We are aiming to improve access to outside space for all service users at our older people's inpatient unit in Leeds that will enable therapeutic activities.

iv. Through the implementation of our equality objectives we aim to further develop our equality performance:

**a. We will undertake further analysis of service user survey results and complaints by protected characteristics to identify and address any variations in satisfaction rates.**

**b. We will develop a consistent approach across the local NHS economy in respect of equality leadership, staff empowerment and access to development opportunities.**

**c. We will further develop the involvement and engagement of protected groups and our 'local interests' including service users, carers, staff, third sector, clinical commissioning groups and the local authority.**

**d. We aim to improve access, experience and choice for service users from Black and Minority Ethnic communities through the implementation of a joint action plan with Touchstone Community Development Service.**

v. We aim to continue to develop The Mount in Leeds as a centre of excellence for acute inpatient care and treatment for older people with dementia and older people with acute and complex mental health needs.



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## 9.4 INFORMATION ON THE REVIEW OF SERVICES

During 2011/12 Leeds and York Partnership NHS Foundation Trust provided six NHS services which were:

- Learning Disabilities
- Adult Mental Illness
- Forensic Psychiatry
- Old Age Psychiatry
- Child and Adolescent Psychiatry
- Improving Access to Psychological Therapies.



Guy Musson, 'Bring on the talent' event

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

The income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by Leeds and York Partnership NHS Foundation Trust for 2011/12.

## 9.5 PARTICIPATION IN CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

The National Institute for Health and Clinical Effectiveness 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 (including the Audit and Assurance Committee) – 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.

This report covers the clinical audit activity for the former Leeds Partnerships NHS Foundation Trust only, due to the integration of North Yorkshire and York Services taking place towards the end of the reporting year. All future reports will provide feedback on clinical audit activity for all services within Leeds and York Partnership NHS Foundation Trust.

During 2011/12 two national clinical audits and one national confidential enquiry covered NHS services that Leeds and York Partnership NHS Foundation Trust provides.

During 2011/12 the Trust participated in 100% 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 enquiries

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in and participated in during 2011/12 are as follows:

- Prescribing Observatory for Mental Health UK
- National Confidential Enquiry into Suicide and Homicide by People with Mental Illness.
- National Audit of Schizophrenia

The national clinical audits and national confidential enquiries that the Trust



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participated in, and for which data collection was completed during 2011/12 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
Prescribing Observatory for Mental Health UK (a) Topic 1F & 3F - High Dose Anti-Psychotic Prescribing (b) Topic 6C - Side Effects of Anti-Psychotics (c) Topic 7C - Lithium Monitoring	Yes	See Note 1
National Confidential Enquiry into Suicide and Homicide by People with Mental Illness	Yes	
National Audit of Schizophrenia	Yes	84%

## Note 1

It is not possible to provide a percentage figures for cases submitted to either the Prescribing Observatory for Mental Health UK projects, or the National Confidential Enquiry, due to the way in which the samples are generated. However, it can be confirmed that:

- (a) Samples for each Prescribing Observatory for Mental Health UK project is representative of all those to whom the topic is applicable, and
- (b) information is submitted for 100% of cases identified by the National Confidential Enquiry team as potentially meeting their inclusion criteria – between 20-25 cases per annum.

The reports of four national clinical audits were reviewed by the provider in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided:

### Prescribing Observatory Mental Health UK Topic 6 Side effects of depot antipsychotics

This national audit aimed to assess practice against targets for the assessment of side effects of depot antipsychotics. Actions are in place to ensure antipsychotic side effects are monitored routinely and regularly, people

receiving depot preparations are maintained under regular clinical review and the side effects associated with antipsychotic drugs are 'assessed using standardised methods and validated rating scales'.

### Prescribing Observatory Mental Health UK Topic 7 Monitoring of patients prescribed lithium

This national audit aimed to assess practice against standards for monitoring patients prescribed lithium. Actions are in place to ensure specific tests/measures are completed

before initiating treatment with lithium and during maintenance treatment.

### Prescribing Observatory Mental Health UK Topic 9 Antipsychotic prescribing in people with a learning disability

This national audit aimed to assess practice against standards for prescribing antipsychotics to people with a learning disability. Actions are in place to improve the systematic monitoring of side effects of anti-psychotic medication by (1) providing laminated copies of summary tables in clinic rooms and on wards, and (2)

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including a copy of the guideline in the Doctors in Training Induction Pack.

## **Prescribing Observatory Mental Health UK Topic 11 Antipsychotic prescribing in people with dementia**

This national audit aimed to assess practice against standards for prescribing antipsychotics to people with dementia. Actions are in place to ensure clinical indications for antipsychotic treatment are clearly documented in the clinical records, the potential risks and benefits of antipsychotic medication are considered and documented prior to initiation as well as being discussed with the patient and/or carer(s) and, medication is regularly reviewed and the outcome of the review is documented in the clinical records.

## **Local Clinical Audits**

The reports of 22 local priority clinical audits were reviewed by the provider in 2011/12 and the Trust intends to take the following actions to improve the quality of healthcare provided. Only those projects that had action plans agreed within the reporting period are included in this report.

## **Efficiency of electroconvulsive therapy machines**

This project aimed to assess clinical practice relating to the threshold dose delivered by the Electroconvulsive Therapy machines (old and new) in use in the Trust since March 2000. Actions are in place to ensure that every Electroconvulsive Therapy session adheres with the new Electroconvulsive Therapy titration chart and to explore the option of treating all patients with ultra-brief pulse stimulus.

## **Compliance of high-dose antipsychotic monitoring (red cards)**

This project aimed to assess clinical practice relating to the compliance of high-dose antipsychotic therapy monitoring within forensic services as detailed in the Royal College of Psychiatrists Consensus Statement. Actions are in place to implement baseline monitoring for all service users prior to initiation of antipsychotic therapy, devise alert stickers, produce patient information leaflets and provide training/briefing sessions to further educate staff.

## **Self-administration of medicines guidelines audit**

This project aimed to assess clinical practice relating to the Self-administration of Medicines Policy being adhered to in practice on elderly acute mental health wards. Actions are in place to redesign key forms (assessment, monitoring and review) to create a more user friendly format, to further develop the guidelines and to produce patient information leaflets.

## **Medical management of seclusion in learning disability inpatients**

This project aimed to assess clinical practice relating to the medical management of secluded patients at Parkside Lodge in Leeds. Actions are in place to include information on staff roles and responsibilities in the Seclusion Record Book and to include the seclusion policy and guideline within the new trainee induction programme.

## **Use of antipsychotics in care home dementia patients (Towngate House, Leeds)**

This project aimed to assess clinical practice relating to dementia patients in care homes diagnosed with non-cognitive symptoms and

behaviour that challenges and who have been started on antipsychotics. Actions are in place to organise teaching sessions to all care home staff, educate doctors about clear documentation of the indications, alternatives considered and plans for reduction and cessation of antipsychotics and to review all care home dementia patients on antipsychotics in order to consider stopping the medication.

## **Audit of adherence to antipsychotic prescribing guidelines in management of challenging behaviour with learning disability and anti-social disorder**

This project aimed to assess clinical practice relating to adherence to standards of care in antipsychotic prescribing for the management of challenging behaviour in adults with learning disabilities and anti social disorder. Actions are in place to present the findings at a Royal College of Psychiatrists annual meeting, develop recommendations within Consultant Psychiatrist meetings and to discuss further at a Regional Psychiatric Forum.

## **Use of patient group directions for the supply of medications within crisis resolution home treatment**

This project aimed to assess clinical practice relating to the use of patient group directions. Actions are in place to retrain staff as per the Medicines Management Code and support the use of patient group directions by medics to supply one-off doses of specific medicines.

## **Benzodiazepine prescribing in Becklin Centre (Leeds) inpatients**

This project aimed to assess clinical practice relating to compliance with the current guidelines set out in the British National Formulary regarding doses and length of

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benzodiazepine prescribing. Actions are in place to disseminate and share findings with doctors and relevant governance groups within the Trust.

## **Audit of the National Institute for Health & Clinical Excellence Guideline for depression**

This project aimed to assess clinical practice relating to compliance with the key priorities for the National Institute for Health & Clinical Excellence Guideline for Depression. Actions are in place to review, at least annually and document a discussion/best interests assessment of the risks and benefits of continued antidepressant treatment, developing a National Institute for Health & Clinical Excellence prompt system for all guidelines for clinicians, improve clinical notes and General Practitioner letters to inform of the rationale for choice of depressants, support the use of the Psychological/Vocational/Occupational Therapy framework and to explore a suitable additional outcome measure that can be introduced within the clinic setting.

## **Audit of the National Institute for Health & Clinical Excellence Guideline for bipolar disorder**

This project aimed to assess clinical practice relating to compliance with the key priorities for the National Institute for Health & Clinical Excellence Guideline for bi-polar disorder. Actions are in place to prompt to advise of common/serious side effects and to use the choice and medication website as part of the medicines management core pathway.

## **Audit of the National Institute for Health & Clinical Excellence Guideline for anxiety**

This project aimed to assess clinical practice relating to compliance with the key priorities for the National Institute for Health & Clinical Excellence Guideline for anxiety. Actions are in place to ensure a formal review of current and past treatment and advice regarding the potential benefits of psychological and pharmacological treatments is included in the initial holistic assessment and to promote the incorporation into care pathways.

## **Audit to assess adherence to adequate medication dispensing recording within Crisis Resolution Home Treatment**

This project aimed to assess clinical practice relating to the recording of medications dispensed by Crisis Resolution Home Treatment practitioners to patients on home based treatment. Actions are in place to ensure bank staff are aware of procedures at the start of their shift and to ensure reminder notices remain in place across locations

## **Documentation of initiation and monitoring of antipsychotic medication**

This project aimed to assess clinical practice relating to the weekly Multi-disciplinary Team reviews in inpatient settings of service users on a trial of antipsychotic medication in order to establish adherence to National Institute for Health & Clinical Excellence guidelines. Actions are in place to organise a 'standard approach' for documentation in ward rounds.

## **Monitoring of prolactin levels in patients prescribed anti-psychotics**

This project aimed to assess clinical practice relating to monitoring prolactin levels in inpatients at the Becklin Centre in Leeds, on anti-psychotic medication, in accordance with the Maudsley Guidelines. Actions are in place to raise awareness of findings and guidelines

and to inform the Pharmacy department of the audit findings.

## **Project 442 Section 136 documentation**

This project aimed to assess clinical practice relating to Section 136 documentation. Actions are in place to ensure one individual is responsible for ensuring forms are fully completed following each assessment, improve communication between the service and the police as well as providing further knowledge and awareness of mental illness to the police.

## **Essence of Care**

This project aimed to assess clinical practice within each team relating to care provision and clinical practice adherence to the Essence of Care Benchmarks. Actions are in place to develop a local working group to improve the support and input available to people with continence issues, to continue to sign post people and carers towards services and resources that enable them to manage aspects of self care, to provide a wider choice of support for clients pre-treatment on the care pathway to achieve improved outcomes for health and well being and to provide a specific service area within the outpatients waiting area to improve environment issues relating to health and wellbeing.

## **Referrals to children and young people's social care**

This project aimed to assess clinical practice relating to referrals made by our staff to Children and Young People's Social Care. Actions are in place to create and share a checklist and make other safeguarding practitioners in health and social care aware of necessary guidance.



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## Annual suicide audit

This project aimed to assess clinical practice relating to all suicides occurring within a specified time period within our Trust. Actions are in place to continue to incorporate suicide prevention into our governance plans and to maintain the current levels of risk management training within the Trust.

## Clinical supervision

This project aimed to assess clinical practice of engagement in clinical supervision over a one-year period. Actions are in place to engage all staff in the appraisal process, to remind staff of the requirement to maintain written discussions through business/management meetings and to ensure joint completion of

the Trust's evaluation of clinical supervision every six months.

## Care Programme Approach quality standards

This project aimed to assess clinical practice relating to the standards for Care Programme Approach. Actions are in place to further improve completion and documentation of the annual physical health checks and, ensure those meeting the Green Light criteria can be identified.

## Monitoring side effects whilst prescribing antipsychotics at Malham House

This project aimed to assess clinical practice

relating to physical monitoring of service users on antipsychotics. Actions are in place to implement the use of monitoring proformas, assess the viability of a monthly monitoring clinic and pursue approval for direct access to blood results.

## Occupational needs assessments

This project aimed to assess clinical practice relating to the assessment of occupational needs of our client group following admission to acute inpatient services. Actions are in place to have a system of regular reporting on the number of occupational therapy assessments activity and to improve the quality of documented references to occupational issues in treatment plans/assessments.



Time to Change volunteers at the Love Arts Festival, 2011

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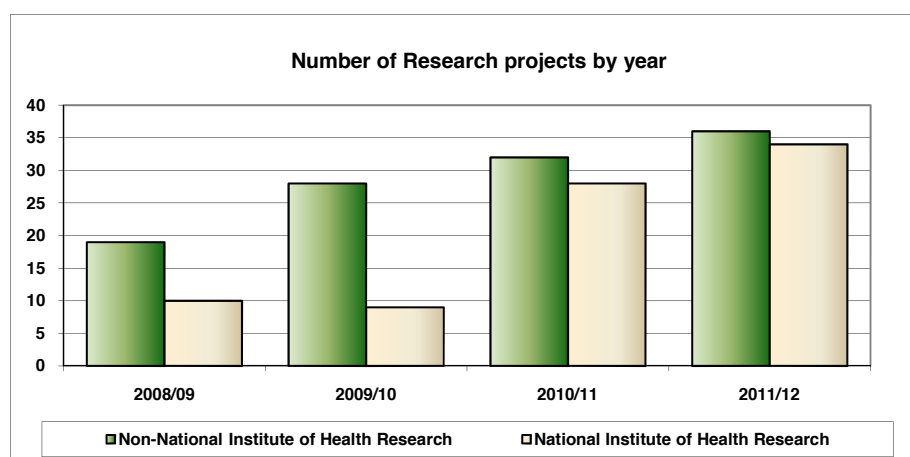
## 9.6 PARTICIPATION IN CLINICAL RESEARCH

The number of patients receiving NHS services provided or sub-contracted by Leeds and York Partnership NHS Foundation Trust from 1 April 2011 to 31 March 2012, that were recruited during that period to participate in research approved by a NHS Research Ethics Committee was 1384.

Total recruitment was made up of:

- **694 patients recruited to National Institute of Health Research adopted studies**
- **690 recruited to non National Institute of Health Research adopted studies i.e. local and student.**

Leeds and York Partnership NHS Foundation Trust was involved in conducting 70 clinical research studies in mental health and learning disabilities in 2011/12. Of these, 34 were National Institute of Health Research adopted studies. This compares favourably with previous years, illustrated by the graph below. This increasing number of clinical research studies demonstrates our 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 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 newly integrated Trust, incorporating experienced research-active NHS staff from North Yorkshire and York services, will promote high quality research in the field of mental health and learning disabilities across the Yorkshire and Humber region.

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

- We host the West Yorkshire Comprehensive Local Research Network funded posts of Research Clinical Lead and Clinical Studies Officer working on National Institute of Health Research projects in mental health. These posts have facilitated an important link with the Mental Health Research Network hub in Newcastle, and provided access and support to Trust staff wishing to engage with Mental Health Research Network supported studies. Five further West Yorkshire Comprehensive Local Research Network funded posts have also been secured. These developments provide a significant opportunity to increase the level of National Institute of Health Research portfolio activity within Leeds and York Partnership NHS Foundation Trust, previously outside this network's activity
- We continue to engage service users in research design; identifying research priorities, interview panels for research staff, participating in research projects and research governance
- Leading to Quality is a research project funded by Yorkshire and the Humber Strategic Health Authority in which we are participating. The project examines the impact of leadership and culture on the effectiveness of teams and the quality of care received by adults using mental health services in the community. This demonstrates our commitment to clinical research that improves patients' health and lives
- During 2011/12 we had 103 clinical staff participating in mental health and learning disability research approved by a research ethics committee

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■ 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 on a number of addictions research projects and to implement the National Institute for Health & Clinical Excellence's guideline on core interventions in the treatment and management of schizophrenia to ensure patients experience safe care

■ Our engagement with a range of clinical research as the lead site for seven National Institute of Health Research funded projects also demonstrates our commitment to testing and offering the latest medical treatments and techniques. These projects cover unrecognised bipolar disorder; a new self-harm intervention; an early parenting intervention for families with young children showing severe attachment problems; validation of an outcome measure for those treated for substance dependence; cognitive behavioural therapy for depression in adolescents; translation of the strengths and difficulties questionnaire into British sign language and autism spectrum social stories in schools.

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

9.7

## COMMISSIONING FOR QUALITY AND INNOVATION

A proportion of Leeds and York Partnership

NHS Foundation Trust's income in 2011/12 was conditional upon achieving quality improvement and innovation goals agreed between Leeds and York Partnership 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 2011/12 and for the following 12 month period are available online at

[www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

For Leeds and York Partnership NHS Foundation Trust, the monetary total for the amount of income conditional upon achieving quality improvement and innovation goals was £1,425,495 (Leeds Services) and £83,000 (North Yorkshire and York Services). The monetary total for the associated payment in 2011/12 was £1,508,495.

In 2011/12 we were required to participate in local and forensic Commissioning for Quality and Innovation schemes. Progress against our Commissioning for Quality and Innovation indicators was reported to our Board of Directors on a quarterly basis through our Trust performance report which can be found on our website at [www.leedsandyork.nhs.uk](http://www.leedsandyork.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 2012/13 we will be required to report performance against a National Commissioning for Quality and Innovation

indicator and local Commissioning for Quality and Innovation indicators, which have been agreed with our main commissioner and are aligned with our Trust strategy. We will also be required to report against Commissioning for Quality and Innovation indicators to the Specialist Commissioning Group for the following services:

- **Child and Adolescent Mental Health Service**
- **Low Secure Service**
- **Perinatal Service**
- **Gender Service**
- **Eating Disorder Service**
- **Personality Disorder Service.**

Details of our 2012/13 Commissioning for Quality and Innovation indicators and our performance against these will be reported to our Board of Directors on a quarterly basis and will be available publicly through our Trust Performance report which is available on our website at [www.leedsandyork.nhs.uk](http://www.leedsandyork.nhs.uk).

Plans are in place to ensure that we meet our 2012/13 Commissioning for Quality and Innovation indicators and continue to further improve the quality of care for people who use our services.



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9.8

## CARE QUALITY COMMISSION

### Registration Status

Leeds and York Partnership NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is fully registered.

The Care Quality Commission has not taken enforcement action against Leeds and York Partnership NHS Foundation Trust during 2011/12.

Detailed assessments of compliance are undertaken on a quarterly basis, with sign off from leads and lead directors within the Trust. Assessments of compliance are reported on a quarterly basis to our Board of Directors via our Trust performance report. Compliance with Care Quality Commission Registration forms a key area of our service directorate and corporate directorate performance reviews.

In order to further strengthen and maintain our position of compliance internal mock unannounced inspections are planned across services.

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

### Care Quality Commission reviews

The Trust has participated in five special reviews by the Care Quality Commission relating to the following areas during 2011/12:

#### Ward 40, Liaison Psychiatry Service (Leeds)

The Care Quality Commission carried out a responsive review to Ward 40 on the 4 May

2011 based on concerns identified during a Mental Health Act Commissioner visit. The Care Quality Commission found Ward 40 to be compliant with Outcome 1: Respecting and Involving People who use Services and Outcome 21: Records. Minor concerns were identified with Outcome 7: Safeguarding People who use Services from Abuse and Outcome 13: Staffing. A moderate concern was identified with Outcome 4: Care and Welfare of People who use Services, regarding the absence of policies and training for staff about the application of the Mental Health Act, and a compliance action was received.

An action plan was put in place, with actions including: ensuring hard copies of policies and procedures relating to the Mental Health Act 1983, Mental Capacity Act and Deprivation of Liberty Safeguards are available on the ward; ensuring staff attend refresher training around these areas; implementing and reviewing the preceptorship training package; and encouraging the use of the Occupational Self Assessment tool with all service users.

A follow up visit was carried out by the Care Quality Commission to Ward 40 on the 14 October 2011. The Care Quality Commission confirmed that significant improvements had been made to all areas identified and the Trust was found to be compliant with all the outcomes reviewed. The Care Quality Commission did issue an improvement notice around the storage of oxygen and the medicines drug box to ensure these had been risk assessed. Risk assessments are undertaken on a three-monthly basis.

#### Learning Disability Service - Parkside Lodge (Leeds)

The Care Quality Commission carried out a

responsive review to Parkside Lodge on the 17 August 2011 based on an anonymous telephone call they had received regarding restraint practices. The Care Quality Commission found Parkside Lodge to be compliant across all areas, with no areas of concern. The main findings of the review were that:

- Systems were found to be in place for planning and delivering care
- People using the service are safe and have a nutritionally balanced diet which supports their health and meets their needs
- There are systems and processes in place to help ensure people using the service are protected from abuse, or risk of abuse and their human rights upheld
- The environment at Parkside Lodge is comfortable and safe for people who live on the unit
- Staff have induction training and additional training is provided regularly to make sure they are able to understand and meet people's needs.



A recommendation was suggested by the Care Quality Commission with regard to Outcome

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4 on ensuring service user and/or their representatives are included in reviews of risk assessments and care needs in the weekly Multi-disciplinary Team meetings. The team addressed this recommendation and Multi-Disciplinary Team attendance is incorporated into patient weekly activity plans.

## Learning Disability Service - 3 Woodland Square (Leeds)

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission carried out a visit to 3 Woodland Square on the 25 and 26 October 2011. The Care Quality Commission identified moderate concerns with Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding People who use services from abuse relating to the updating of records and two compliance actions were received.

An action plan was put in place, addressing the issues raised at the inspection, with all actions being completed by the end of January 2012. Actions included: the introduction of person centred health action planning tools for all service users; the introduction of accessible care plans across the service; a review of the current system for logging informal enquiries to a safeguarding co-ordinator and the review of care plans to include best interest decisions specifically with regard to locked door procedures.

A follow up visit was carried out by the Care Quality Commission to 3 Woodland Square on the 6 March 2012, where it was found to be fully compliant with both Outcome 4 and Outcome 7.

## Low Secure Forensic Service – Ward 3, Newsam Centre (Leeds)



As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission carried out a visit to Ward 3 Newsam Centre on the 5 and 6 December 2011. Ward 3 Newsam Centre is a low secure forensic inpatient ward for patients who may have been involved with the criminal justice system. Five of the beds offer a service to patients with forensic mental health needs and learning disabilities.

The review focused on two outcomes; Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding people who use services from abuse. As a result of the review a moderate concern was identified with Outcome 4 and a major concern identified with Outcome 7 and compliance actions were received by the Trust.

An action plan was put in place, addressing the issues raised at the inspection, with all actions being completed by the end of April 2012. Actions included: all learning disability service users to have a Health Action Plan in place; all service users to receive information

in a format that meets their needs; the establishment of a central adult safeguarding referral email inbox; and the development of individual safeguarding care plans.

A follow up visit was carried out by the Care Quality Commission to Ward 3 Newsam Centre on the 1 May 2012, where it was found to be fully compliant with both Outcome 4 and Outcome 7.

## Learning Disability Service - White Horse View (North Yorkshire and York Services)

As part of the targeted inspection programme to services that care for people with learning disabilities the Care Quality Commission carried out a visit to White Horse View on the 20 and 22 December 2011. The review focused on two outcomes; Outcome 4: Care and Welfare of People who use Services and Outcome 7: Safeguarding People who use Services from Abuse. The Care Quality Commission found White Horse View to be fully compliant with both outcomes but in order to maintain this for Outcome 4 some improvements were required. An action plan has been put in place with actions including; to develop care plans and risk assessments which are accessible to service users, ensuring patients involvement in care planning is fully documented and the development of an advocacy plan for each patient,

Reports have been analysed internally and appropriate actions have been taken. The Trust is confident that none of the issues and concerns raised within the report are systemic issues across the organisation. A system of internal mock unannounced CQC inspections is now in place to provide further assurance around compliance with CQC requirements.

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## 9.9 INFORMATION ON THE QUALITY OF DATA

### NHS Number and General Medical Practice Code validity

Leeds and York Partnership NHS Foundation Trust submitted 2,489 records during 2011/12 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 99.8% for admitted patient care, 100% for outpatient care and 99.8% for all service users as submitted in the Mental Health Minimum Dataset
- Which included the patient's valid General Medical Practice Registration Code was 100% for admitted patient care, 100% for outpatient care and 98.8% for all patients as submitted in the Mental Health Minimum Dataset.

### Information Governance Toolkit attainment levels

Leeds and York Partnership NHS Foundation Trust's Information Governance Assessment Report overall score for 2011/12 was 79% and was graded 'Green'.

The Trust has an ongoing programme of information governance training which is now refreshed annually. From a basis of 97% of all staff having received information governance training in the past, the Trust has now delivered new or refresher training to 47% of all staff (including bank staff and staff within North Yorkshire and York services) in the last 12 months. Annual refresher training is being actively pursued and improves monthly.

We have once again closed the financial year without a reportable Serious Untoward Incident data breach, based on the David Nicholson incident grading scale. This includes data from North Yorkshire and York services for which we have data controller status from 1 February 2012.

Our commitment to providing a quality service on the Freedom of Information Act has resulted in all incoming requests being processed within the statutory timescales. 2011 saw a slight reduction in overall Freedom of Information Act requests over the year in comparison to 2010.

### Statement on data quality

Leeds and York Partnership NHS Foundation Trust has taken the following actions during 2011/12 to improve data quality:

- The procedures covering the collection and input of data to the PARIS clinical information system have been updated to reflect evolving good practice. Corporate procedures for data quality assurance have also been revised
- The Data Quality Policy has been amended to include the Core Patient Database system used by York services
- Awareness raising initiatives have been pursued to promote awareness of the importance of data quality and the policy and procedures
- We have exceeded the target contained both in our Trust strategy and our service contract with NHS Leeds, to ensure that commissioning datasets reconcile to local contract monitoring reports within +/- 4%.

Leeds and York Partnership NHS Foundation Trust will be taking the following actions to further improve data quality during 2012/13:

- Improving awareness of data quality issues, including the policy, amongst Trust staff based within North Yorkshire and York services
- Implementing data quality improvement initiatives for North Yorkshire and York services data
- Maintaining the data quality assurance processes that are in place Trustwide.

### Clinical coding error rate

Leeds and York Partnership NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2011/12 by the Audit Commission.



# Quality Accounts

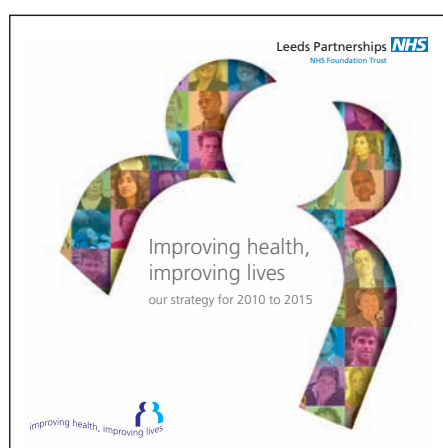
## 9.10 OUR SELECTED MEASURES

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 Council 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 2010/11 Quality Accounts measures took place to ensure that these are aligned with our strategy measures and 2012/13 local Commissioning for Quality and Innovation measures.

As a refresh of our strategy is planned for September 2012 our governor's performance

group and our Executive Team agreed that the strategy measures included within our 2010/11 Quality Accounts would remain in place for our 2011/12 Quality Accounts to enable consistency and to allow progress to be demonstrated.



Our 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 2012/13 local Commissioning for Quality and Innovation measures.

Progress against our measures set out in our 2010/11 Quality Accounts were reported to our Board of Directors through the monthly Trust performance report, with each measure reported upon on a quarterly basis. These are publicly available documents and can be viewed on our website [www.leedsandYork.nhs.uk](http://www.leedsandYork.nhs.uk)

Progress against measures set out in our 2011/12 Quality Accounts will continue to be reported to the Board of Directors through the monthly performance report. These measures also form part of our service directorate and corporate directorate performance reviews.



*Marjorie Wallace, Chief Executive of SANE, Leeds at the Black Dog Campaign, 2011*

# Quality Accounts

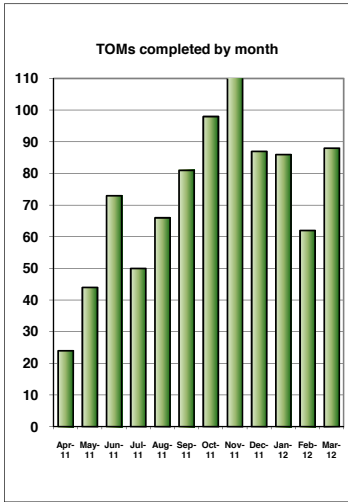
## P1 Priority 1 - People achieve their agreed goals for improving health and improving lives

### Performance of the Trust against selected measures

Measure	Source		Comments												
1. People report that the services they receive definitely help them to achieve their goals	Strategy measure from the national Community Service User Survey	<div><p>People report that the services they receive definitely help them to achieve their goals</p><table border="1"><thead><tr><th>Year</th><th>LPFT (%)</th><th>Nat Av. (%)</th></tr></thead><tbody><tr><td>2010</td><td>43</td><td>47</td></tr><tr><td>2011</td><td>41</td><td>44</td></tr></tbody></table></div> <p>586 service users from our Trust (Leeds) responded to the 2011 national Community Service User Survey.</p>	Year	LPFT (%)	Nat Av. (%)	2010	43	47	2011	41	44	<p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>Actions have been undertaken and are in place to support clinicians in agreeing goals with service users and planning care, support and treatment to facilitate this, including:</p> <ul style="list-style-type: none"><li>Care planning documentation and care programme approach (CPA) training has been revised to support personal goal setting and measurement</li><li>Quality of care planning is monitored via case load management</li><li>Post review questionnaire results show that 75% of service users reported that they were definitely involved in agreeing the goals in their care plan.</li></ul>			
Year	LPFT (%)	Nat Av. (%)													
2010	43	47													
2011	41	44													
2. Staff job satisfaction	Strategy measure from the national NHS Staff Survey	<div><p>Staff Job Satisfaction</p><table border="1"><thead><tr><th>Year</th><th>LPFT (Score)</th><th>Nat Av. (Score)</th></tr></thead><tbody><tr><td>2009</td><td>3.5</td><td>3.5</td></tr><tr><td>2010</td><td>3.6</td><td>3.6</td></tr><tr><td>2011</td><td>3.4</td><td>3.5</td></tr></tbody></table></div> <p>Trust score is based on 425 staff (Leeds) who took part in the 2011 national NHS Staff Survey.</p>	Year	LPFT (Score)	Nat Av. (Score)	2009	3.5	3.5	2010	3.6	3.6	2011	3.4	3.5	<p>It has been agreed through the Trust's Means Goal 4 Standing Group that future local staff surveys should be based around specific themes and it is anticipated that the first survey will focus on staff's health and wellbeing. The results of the 2011 Staff Survey shows a slight decrease from last year's score. Work is being undertaken within the Trust to address issues and to seek to improve Trust performance in the 2012 survey.</p>
Year	LPFT (Score)	Nat Av. (Score)													
2009	3.5	3.5													
2010	3.6	3.6													
2011	3.4	3.5													

# Quality Accounts

## Priority 1 - Continued

Measure	Source	Performance	Comments
<p><b>3.</b> All patients with a learning disability will have their clinical outcomes measured by a validated outcome measurement tool to improve patient care</p>	Commissioning for Quality and Innovation measure	 <p>The chart above shows the number of Therapy Outcome Measure's completed by month during 2011/12</p>	<p>The 2010/11 measure focused on implementation of the Therapy Outcome Measure tool within Learning Disability Services. The graph demonstrates a significant increase in the amount of Therapy Outcome Measure's that have been completed over 2010/11.</p> <p>In 2011/12 we will further develop this measure to focus on capturing and reporting outcomes for service users within our Community Learning Disability Services.</p>
<p><b>4.</b> To improve the health and wellbeing of service users in adult rehabilitation community units in the following health domains: smoking cessation, weight management and substance misuse (alcohol)</p>	Commissioning for Quality and Innovation measure	2012/13 will be the baseline year	<p>A questionnaire will be developed with service users which will ask about current need in the areas of smoking cessation, weight management and substance misuse (alcohol) and if people's needs are being met. Recommendations from the results of the questionnaire will be implemented across the services.</p>
<p><b>5.</b> Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being</p>	Strategy measure	<p>64% of carers who responded to the questionnaire stated that they were "very satisfied" (29%) or "satisfied" (35%) that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and wellbeing. This figure has now established the Trust's baseline score.</p>	<p>It is recognised that the current response rate to the questionnaire is low and it is envisaged that this will increase during 2012/13. The carers' satisfaction questionnaire will be rolled out across the Trust, along with the service user 'Your Views' questionnaire, from June 2012.</p>

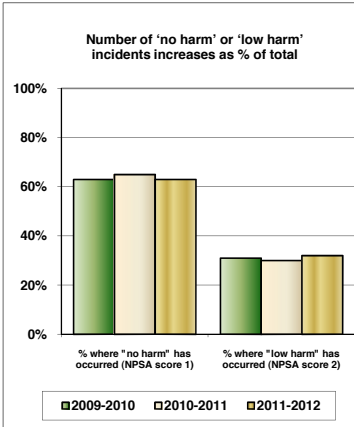
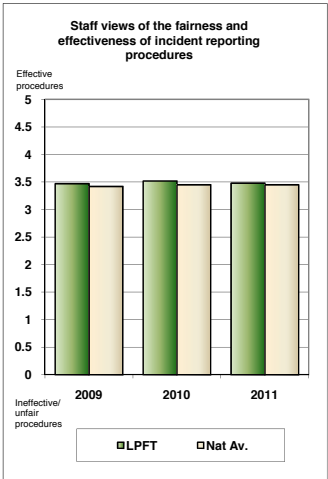


# Quality Accounts

P2

## Priority 2 - People experience safe care

### Performance of Trust against selected measures:

Measure	Source	Performance	Comments
<b>1.</b> People who use our services report that they experienced safe care	Strategy measure	Baseline to be set at end of June 2012 from local survey results	We are currently putting internal systems in place to regularly survey our service users on this measure.
<b>2.</b> Number of 'no harm' or 'low harm' incidents increases as % of total: <ul style="list-style-type: none"> <li>% where 'no harm' has occurred (National Patient Safety Agency score 1).</li> <li>% where 'low harm' has occurred (National Patient Safety Agency score 2).</li> </ul>	Strategy measure	 <p>All service user incidents – inpatient and community</p>	<p>The 'First Do No Harm' document continues to outline our direction and aspirations in the delivery of safer therapeutic care. On review of incidents, we have a high level of reporting and a low degree of harm when incidents occur. Organisations with a high rate of reporting indicates a mature safety culture. This maturity enhances openness and provides a truer reflection of current practice which allows for more robust action planning</p>
<b>3.</b> Staff views of the fairness and effectiveness of incident reporting procedures	Strategy measure from national NHS Staff Survey	 <p>Trust score is based on 425 staff (Leeds) who took part in the 2011 national NHS Staff Survey</p>	<p>Feedback from staff continues to be collected through a variety of means including barometer polls. A review is taking place on implementing local quarterly staff surveys to enable this information to be collected on a more frequent basis.</p>

# Quality Accounts

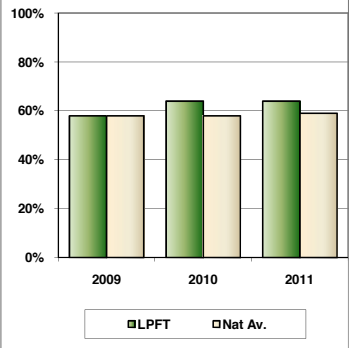
## Priority 2 - Continued

Measure	Source	Performance	Comments
<b>4.</b> Evidence that we meet national guidelines for clinical care and treatment relevant to our Trust within 2 years of publication	Strategy measure	In 2011/12 the Trust achieved this target for 100% of newly published clinical guidelines.	Current performance will be maintained by continuing to receive national guidance through the Clinical Guidelines and Clinical Outcomes Standing Support Group which considers relevance and assesses compliance with the guideline including consideration of the evidence to support compliance.  Adherence to National Institute of Health & Clinical Excellence Guidance is a central part of the Trust's Clinical Audit Plan.
<b>5.</b> NHS Safety Thermometer: Improve the collection of data in relation to pressure ulcers, falls, urinary tract infection in those with a catheter and venous thromboembolism (VTE)	Commissioning for Quality and Innovation measure	To be determined by end of July 2012 in line with national requirements.	The Trust will revise our current data collection systems and implement the NHS Safety Thermometer to contribute towards establishing a national baseline of performance on the four identified areas of pressure ulcers, falls, urinary tract infection in patients with catheters and venous thromboembolism.
<b>6.</b> Improving the implementation of action plan goals following a serious untoward incident which relates to a community patient suspected suicide	Commissioning for Quality and Innovation measure	To be determined by end of June 2012	Quarterly reports will be produced detailing compliance and exception reporting.

# Quality Accounts

## P3 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 from the mental health Community Service User Survey	<p>People who use our services report overall rating of care in the last 12 months very good/excellent</p>  <p>586 service users from our Trust (Leeds) responded to the 2011 national Community Service User Survey</p>	<p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>Mental health data is triangulated through service user feedback tools and people's stories that provide in-depth feedback about their experiences of our services.</p>
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 from the mental health Community Service User Survey	<p>People who use our services report that their views were definitely taken into account when deciding what was in their care plan</p>  <p>586 service users from our Trust (Leeds) responded to the 2011 national Community Service User Survey.</p>	<p>We are currently putting internal systems in place to regularly survey our service users on this measure.</p> <p>The following supports collaborative working with service users and co-production of care plans in order for us to improve in this area:</p> <ul style="list-style-type: none"> <li>City-wide Care Programme Approach (CPA) policy</li> <li>Trustwide Care Programme Approach training available as well as directorate specific</li> <li>CPA documentation revised and implemented August 2011.</li> </ul>



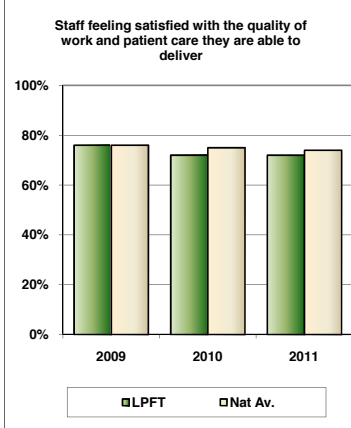
# Quality Accounts

## Priority 3 - Continued

Measure	Source	Performance	Comments
<b>3.</b> Engaging service users in acute adult inpatient settings in structured activity	Commissioning for Quality and Innovation measure	2012/13 will be the baseline year where a programme of structured activity will be further developed in Older Peoples 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.
<b>4.</b> Improving the service user experience at Care Programme Approach (CPA) reviews	Commissioning for Quality and Innovation measure	<p>A total of 97 completed questionnaires were received giving a response rate of 21.7%, which is broadly in line with response rates to national Service User Surveys.</p> <p>Results from the local survey showed:</p> <ul style="list-style-type: none"> <li>■ 52% of people said they were definitely given a choice about how their review would be held</li> <li>■ 79% of people said they were given a chance to talk to their care co-ordinator before the review about what would happen</li> <li>■ 69% of people said they were told they could bring a friend, relative or advocate to their review</li> <li>■ 79% of people said they were given a chance to express their views at the review</li> <li>■ 75% of people said they were definitely involved in agreeing the goals in their care plan</li> <li>■ 84% of people said everything was said in a straightforward way at the review</li> <li>■ 85% of people reported they were asked how they were feeling at the review</li> <li>■ 65% of people reported they definitely found the review helpful.</li> </ul>	<p>The local questionnaire is being extended across all appropriate community teams during 2012/13.</p> <p>Action plans have been developed and implemented based on the 2011/12 local survey results.</p>

# Quality Accounts

## Priority 3 - Continued

Measure	Source	Performance	Comments
<b>5.</b> Staff feeling satisfied with the quality of work and patient care they are able to deliver	Strategy measure / national NHS Staff Survey (2011)	 <p>Trust score is based on 425 staff (Leeds) who took part in the 2011 national NHS Staff Survey</p>	Feedback from staff continues to be collected through a variety of means including barometer polls. A review is taking place on implementing local quarterly staff surveys to enable this information to be collected on a more frequent basis.

Our external auditors have reviewed the returns submitted by our Trust for our local indicator 'Improving the service user experience at Care Programme Approach (CPA) reviews', which was selected by our Governors. The criteria for this indicator is set out below:-

**The Care Programme Approach review has been undertaken to satisfy the CQUIN indicator set by NHS Airedale, Bradford and Leeds for 2011/12, which requires:**

- To devise a service user feedback tool and collect feedback for those undertaking a Care Programme Approach review in the data collection period
- To detail service user feedback and collate an action plan for improvement
- To capture and report the number of Care Programme Approach reviews that took place in the data collection period, and the response rate for questionnaire returns.

**The questionnaire was not undertaken Trust-wide, but rather in selected community teams within each of the four directorates:**

1. Adult Directorate: East Community Mental Health Team, North East Community Mental Health Team, Assertive Outreach Team
2. Older People's Directorate: North East Community Mental Health Team, North West Community Mental Health Team
3. Specialist Services Directorate: Chronic Fatigue Service, Personality Disorder Network
4. Learning Disabilities Directorate: Severe and Challenging Behaviour Team.

The satisfaction rate for each questionnaire has been calculated as: the number of service users reporting a favourable experience as a percentage of all returned questionnaires, excluding item non-response.

# Quality Accounts

## 9.11 PERFORMANCE AGAINST KEY NATIONAL PRIORITIES

### Performance monitoring

Progress on performance against Monitor requirements, Care Quality Commission registration, our contractual performance requirements with our commissioners 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.leedsandYork.nhs.uk](http://www.leedsandYork.nhs.uk)

As part of the Trust's performance framework a cycle of service directorate performance reviews and corporate directorate performance reviews are in place which provide a detailed focus on performance across each of our service and corporate 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 our strategy measures. 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 directorates to showcase achievements, allowing for the sharing and learning of good practice.

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 and performance against milestones and measures is 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.

We have increased our engagement with the Council of Governors around performance through the governors' performance meeting. Feedback from the governors who attend this meeting has been extremely positive with the governors reporting a better understanding and more involvement with performance.

Our Council of Governors receives our performance report on a quarterly basis along with the Monitor quarterly monitoring return in order to provide them with assurance that we are meeting our terms of authorisation.

### Staff Survey 2011

Although the overall staff survey results for 2011 indicated a worse position compared to the previous year, this has to be considered in conjunction with a number of external and internal factors currently facing the Trust. Issues such as the health and social care reforms and changes to the pension scheme at national level, together with Trust transformation and the impact of the North Yorkshire and York

integration may be attributable for some of the less positive outcomes of the survey. Work is being undertaken within the Trust to address issues and to seek to improve Trust performance in the 2012 survey.

### 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 2011/12 clostridium difficile infection threshold agreed with our main commissioner is not to exceed nine new cases of clostridium difficile infections during the year for Leeds services. Leeds services have performed well below the threshold with one new case of clostridium difficile infection reported during 2011/12. The figures also demonstrate an improvement since 2010/11. For every clostridium difficile infection that takes place a full root cause analysis investigation is carried out. There have been no cases of clostridium difficile infection reported for 2011/12 within North Yorkshire and York services.

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 clostridium 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. The roll out of 'Essential Steps' monitoring across North Yorkshire and York commenced in March 2012.

Our Infection Prevention Control Team (IPCT) continues to facilitate an increased focus on



# Quality Accounts

practice, improving education and assessment standards, as well as a continuing improvement of environmental cleaning.

To date there have been zero cases of meticillin-resistant staphylococcus aureus (MRSA), meticillin-sensitive staphylococcus aureus (MSSA) or escherichia coli bacteraemia within our Trust. Our IPCT closely monitor MRSA colonisation results, following up individual cases and feeding back to both the Infection Prevention and Control Committee and the Professional Advisory Forum on a monthly basis. The Infection Prevention Control Team is working closely with our Pharmacy Department to ensure that the treatment is completed in order to further reduce the risk of MRSA in all of the Trust's inpatient areas.

Leeds Healthcare Associated Infections	2009/10	2010/11	2011/12
Number of cases of MRSA Bacteraemia	0	0	0
Number of new cases of Clostridium Difficile	5	2	1

North Yorkshire and York Healthcare Associated Infections	2011/12
Number of cases of MRSA Bacteraemia	0
Number of new cases of Clostridium Difficile	0

The Infection Prevention Control Team is responsible for setting a programme which incorporates all Department of Health standards. The Infection Prevention Control Team over the last year has ensured that:

- **Families and service users have been able to access information and make informed choices**
- **Screening and diagnostic services have been effective and carried out to a high standard**
- **Results are communicated to staff, service users and families effectively**
- **Service users and staff are given comprehensive support pre and post-diagnosis.**

The Infection Prevention Control Team works with 73 Infection control Champions across Leeds and 15 across North Yorkshire and York services to collect key performance data on infection prevention and control which enables us to observe trends, benchmark our performance, monitor improvements and compare ourselves against national standards. We undertake monthly mini-audits to ensure that our standards of infection control remain high within our clinical areas

and are continually reviewing our processes to ensure these remain robust and effective.

The Infection Prevention Control Team provides over 100 hours of face to face training for staff to access, covering mandatory training, MRSA screening and aseptic technique. Further training is provided for link champions.

## Improving access

We have maintained a position of compliance throughout 2011/12 with the Monitor targets: admission to inpatient services having access to Crisis Resolution and Access to Healthcare for people with a learning disability. We have also exceeded our milestones on our strategy measures; 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.

## Safeguarding adults

We have continued to further improve and ensure a robust response to safeguarding alerts throughout the year. Through Care Quality Commission reviews of our services and the new draft Quality Assurance Framework, which is being developed by the Leeds Safeguarding Adults Partnership Board, we have put further processes in place to continuously improve the capturing and recording of all our safeguarding data.

We have further built on our staff awareness with safeguarding adults by continuing to provide Level 1 training in the classroom and also establishing an online training programme. A key important aspect of improving awareness is also through the learning which comes from staff actively

# Quality Accounts

participating in the safeguarding processes. Our Safeguarding Enquiry Coordinators and safeguarding leads guide teams through the safeguarding processes and their relationships with the Mental Capacity Act and Deprivation of Liberty Safeguards. Through this support the quality of referrals and the understanding demonstrated by staff has further improved.

Our integrated Trust now incorporates a geographical area embracing three Safeguarding Adults Boards, which we have representation upon. We have recently recruited a safeguarding officer to further strengthen the integrated safeguarding service across our whole organisation.



## Safeguarding children

We have contributed extensively over the past year to the OFSTED inspection process. This work took place over the summer period during which we supported our health colleagues within Leeds Teaching Hospitals NHS Trust and NHS Airedale, Bradford and Leeds in contributing to the health component of the review process. We were very pleased with the OFSTED report which indicated a move forward and overall demonstrated a marked improvement on the previous year's report.

The Named Nurse Safeguarding Children contributes to a number of Leeds Safeguarding Children Board sub-groups within the city and with the integration of services from North Yorkshire and York we now have representation

on three Safeguarding Children's Boards across the geographical patch. The Named Nurse Safeguarding Children has also assumed the role of Domestic Violence Lead for the Trust. We have achieved the Domestic Violence Quality Mark Level 1 and we are currently working towards Level 2.

A network of named nurses from mental health trusts has been established to share and improve practice. The Named Nurse for Safeguarding Children for Leeds and York Partnership NHS Foundation Trust is a member of this group. The focus of 2012 is to work together on standards for training and supervision.

The Care Programme Approach has been adapted to encourage staff to 'think family' and consider the needs of the child and this won a National Care Programme Approach award in 2011. The Safeguarding Children team continue to work closely with the Care Programme Approach team within the Trust ensuring there is a formal record of child safeguarding concerns, when appropriate, within this process.

A care pathway on safeguarding children is currently being developed in line with the transformation process which will further ensure staff receive and follow clear guidance in relation to safeguarding children.

Safeguarding children sections have been added to the record keeping and supervision audits and two separate audits have been undertaken this year on quality of referrals to social care and attendance at case conferences. Action plans are put in place as a result of

audits to further improve the quality of our services.

Over the last year we have strengthened our training delivery with the provision of an in house monthly Level 1 classroom based session together with an e-learning option. Specific teams have also received training delivered in their own areas to ensure we continue to maintain a high standard of compliance with basic awareness training.

## Eliminating mixed sex accommodation

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

Service users admitted to any of our inpatient facilities will have their own room and if rooms do not have en-suite facilities then same-sex toilets and same-sex bathrooms will be 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

# Quality Accounts

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 have in place a monthly audit mechanism to make sure that we do not misclassify any of our reports and we will publish the results of the audit quarterly.

## Patient Environment Action Team (PEAT) assessment

Patient Environment Action Team Assessment 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. Every Trust is therefore benchmarked and a scored performance obtained. The tables on the right show our 2010 and 2011 Patient Environment Action Team Assessment scores.

Responsibility for the Patient Environment Action Team Assessment process has transferred to the NHS Information Centre, who will issue the results for 2012. Following the inspections for 2012, the Trust will produce an action plan for each of the sites inspected which details areas where improvements can be made. This plan and the actions required will be monitored through the Trust's governance framework and reported to the Board of Directors. 2012 will see the Trust format and methodology for this process being applied to properties in both Leeds and York as a consistent approach to maintaining/improving the Patient Environment Action Team Assessment scores. The action plan will be presented to senior managers in May 2012 for comments, with all actions to be completed by the end of December 2012.

## Leeds Services

2011			
Site name	Environment score	Food score	Privacy and dignity score
Aire Court	Excluded due to the refurbishment scheme		
The Mount	Excellent	Excellent	Excellent
Asket Croft	Good	Excellent	Excellent
St. Mary's Hospital PCT Unit	Excellent	Excellent	Excellent
Peel Court	Excluded due to its planned closure		
1-5 Woodland Square	Excellent	Excellent	Excellent
Towngate House	Unit closed to inpatients		
Millside CUE	Good	Good	Excellent
Newsam Centre	Good	Good	Excellent
Asket House	Good	Good	Excellent
Becklin Centre	Good	Good	Excellent
Parkside Lodge	Excellent	Good	Excellent

2010			
Site name	Environment score	Food score	Privacy and 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 inpatients		
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



# Quality Accounts

## North Yorkshire and York Services

2011			
Site name	Environment score	Food score	Privacy and dignity score
Bootham Park Hospital	Acceptable	Good	Excellent
Clifton House	Good	Excellent	Excellent
Worsley Court	Acceptable	Excellent	Good
Limetrees	Good	Excellent	Excellent
Meadowfields CUE	Good	Excellent	Good
Mill Lodge CUE	Good	Good	Good
Peppermill Court	Acceptable	Good	Excellent
Acomb Garth	Acceptable	Excellent	Good

2010			
Site name	Environment score	Food score	Privacy and dignity score
Bootham Park Hospital	Acceptable	Good	Acceptable
Clifton House	Acceptable	Good	Excellent
Worsley Court	Acceptable	Good	Good
Limetrees	Good	Good	Good
Meadowfields CUE	Good	Good	Good
Mill Lodge CUE	Acceptable	Good	Acceptable
Peppermill Court	Acceptable	Acceptable	Excellent
Acomb Garth	Acceptable	Good	Excellent

## Service User and Carer Involvement

Involving the people who use our services, their families and friends, is something that is at the heart of our strategy. We have made the commitment to improve health and improve lives, and this can only be done through working in partnership. Through a wide variety of involvement opportunities we encourage people to share their experiences of our organisation, and we are committed to learning from listening to their stories. Carers are considered as vital partners helping to influence the provision of services, and as a commitment to carers we have developed new constituencies of foundation trust membership to ensure that the carer's voice is heard. People who have used our services and carers are involved, consulted and encouraged to work in partnership with us across the organisation; through the recruitment of staff, the development of services and policies, and the monitoring of our strategy. We are currently exploring new social media ways of communicating with our partners, and are rolling out a trust wide experience questionnaire to ensure we receive the best kind of feedback possible.

Below are a few examples of the ways in which we involve people who use our services and carers in the Trust:

- Our transformation programme has had a large amount of discussion, consultation, imagination and engagement with both service user and carer involvement. This has significantly influenced the different elements of the project moving forward into the future
- 'Your Views' meetings in inpatient ward areas continue to provide a rich source of views and ideas for service improvement. Daily activities and patient facilities are regularly reviewed in these meetings and any changes which take place are fed back at each meeting



- The Board of Directors continues to invite people to come along and tell their stories as part of the Boards' development. Our Board have heard stories from service users and carers over the last 12 months, and have found these to be an extremely helpful source of feedback

# Quality Accounts

■ The Patient Opinion Website continues to be a useful forum for feedback and postings. Over the year we have been acknowledged by Patient Opinion for our commitment to responding in a personal and timely fashion to every posting

■ The expansion of our services into North Yorkshire and York has involved service users, carers and members of the public in consultations on the appropriate direction of travel for the organisation. The Board of Directors consulted on the name of the new organisation and the future development of partnership working across the wider patch

■ Our quarterly corporate involvement events 'Building Your Trust', 'Everything you need to know about...' and the Diversity and Social Inclusion Forum continue to generate feedback. These events are evaluated and the findings are reported regularly in our membership newsletter 'Imagine', and on the Trust website. We are looking for opportunities to develop these initiatives in North Yorkshire and York

■ Working in partnership with people who have used services in North Yorkshire and York an initial involvement meeting has been set up for the establishment of an involvement network

■ Our procedures for Involvement have been revised in line with the new governance arrangements with an Involvement Leaders Forum taking place regularly. This forum ensures that service improvement ideas and feedback are all facilitated appropriately, and provides an arena for those with involvement responsibility to share good practice and support each other. This will

be rolled out across North Yorkshire and York services.

## NHS Litigation Authority Risk Management Standards

Prior to the date of transfer of services in North Yorkshire and York both organisations had achieved a Level 1 in relation to the NHS Litigation Authority Risk Management Standards assessment. On the basis that both organisations were at a Level 1 the integrated organisation's current position is a Level 1.

An informal visit by the NHS Litigation Authority Risk Management Standards assessor was carried out on the 23 February 2012 and a formal re-assessment at Level 1 has been arranged for the 12 and 13 February 2013. In preparation for the formal reassessment an action plan will be developed and implemented.

## Serious Untoward Incidents

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

Systems and processes have been introduced by the Risk Management Team through 2011/12 to improve communication with the Coroners office and working closely with NHS Airedale, Bradford and Leeds to improve the timescales for the completion of investigation and learning from serious incidents. Examples of these are:

### Coroner

- One point of contact for the coroner both into and out of the organisation
- Development of a cause of death request form
- Single point of contact for Coroner

inquests to ensure that the organisation is aware of all inquests, witnesses and to ensure staff and carers are provided with the appropriate support.

## NHS Airedale, Bradford and Leeds timescales

■ Incidents are scheduled into the Trust Incident Review Group agenda once Risk Management has been informed of the incident

■ If the final report is not completed by the scheduled date an interim report is submitted

■ Reviewed template agreed for interim reports

■ A monthly report detailing all scheduled reports and known inquests is produced for the Trust Incident Review Group for monitoring purposes.

The Trust will continue to work with outside agencies to ensure that the recent improvement in reporting and investigation of incidents is maintained and improved.

Monthly reports are presented to the Board of Directors and the Council of Governors following each meeting of the Trust Incident Review Group which provide an overview of the incidents, investigation and any lessons learnt.

# Quality Accounts

## Monitor assessments

Monitor is the independent regulator of foundation trusts. Using its assessment framework the Trust's overall 2011/12 performance is shown below along with the Trust's previous performance.

Prior to 2011/12 for both annual risk assessment and in-year monitoring, Monitor assigned a risk rating in 3 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.

The Trust currently has a 'Green' governance risk rating and a financial risk rating of 4. The previous amber-red risk ratings have been due to compliance actions being received by the Care Quality Commission as a result of inspections. The Trust has addressed each compliance action in a timely and effective manner.

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

Risk ratings	Annual Plan 2011/12	Quarter 1 2011/12	Quarter 2 2011/12	Quarter 3 2011/12	Quarter 4 2011/12
Financial	4	4	4	4	4
Governance	Green	Amber-Red	Amber-Red	Amber-Red	Green



# Quality Accounts

## Monitor targets

The table below shows the Trust's performance against Monitor targets. Due to the successful transfer of services from North Yorkshire and York on the 1 February 2012 performance is shown separately by Leeds services and as an integrated organisation from the 1 February onwards (LYPFT).

Monitor Target	2010/11	Threshold
7 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.	<p>We have maintained a position of compliance throughout 2011/12.</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate a 96.5% follow up rate.</p> <p><b>LYPFT</b> – March figures demonstrate a 96.8% follow up rate.</p>	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.	<p>We have maintained a position of compliance throughout 2011-2012</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate performance at 95.4%</p> <p><b>LYPFT</b> – March figures demonstrate performance at 91.2%. The Trust has an investment adjustment with Monitor to achieve compliance by 30 June 2012. Performance is above trajectory.</p>	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.	<p>We have maintained a position of compliance throughout 2011/12.</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate a cumulative average of 0.4%.</p> <p><b>LYPFT</b> – March figures demonstrate a cumulative average of 3.2%.</p>	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.	<p>We have maintained a position of compliance throughout 2011/12.</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate a 94.4% compliance rate.</p> <p><b>LYPFT</b> – March figures demonstrate a 97.8% compliance rate.</p>	90%

# Quality Accounts

## Monitor Targets (continued)

Monitor Target	2010/11	Threshold
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, registered general practitioner organisational code and commissioner organisational code.	<p>We have maintained a position of compliance throughout 2011/12</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate performance at 99.9%.</p> <p><b>LYPFT</b> – March figures demonstrate performance at 99.9%.</p>	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.	<p>We have maintained a position of compliance throughout 2011/12</p> <p><b>Leeds Services</b> – Quarter 4 figures demonstrate performance at 80%.</p> <p><b>LYPFT</b> – March figures demonstrate performance at 55.8%.</p>	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)	<p><b>Leeds Services</b> – for the 6 recommendations 5 have been assessed as a level '4' (the highest rating) and 1 at a level '3'.</p> <p><b>North Yorkshire and York Services</b> – for the 6 recommendations 3 have been assessed as a level '4' (the highest rating) and 3 at a level '3'.</p>	Not Applicable as set out in the Compliance Framework 2011/12
Meeting Commitment to Serve New Psychosis Cases by Early Intervention Teams. This target is only applicable to North Yorkshire and York services as Early Intervention is provided by Aspire within Leeds.	Performance for 2011/12 demonstrates LYPFT has exceeded the contract target, with 55 new cases of psychosis supported by the Early Intervention Team.	95% of contract value (contract value is 34 new cases)

# Quality Accounts

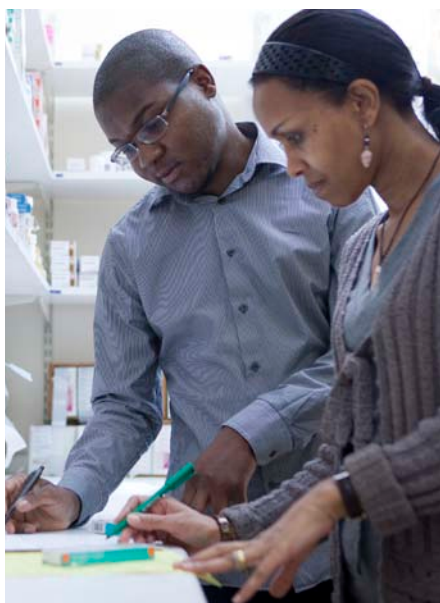
Our external auditors have reviewed the returns submitted by our Trust for two indicators mandated by Monitor. The criteria for the two Monitor indicators is set out below:

## 1) Minimising delayed transfers of care

- The indicator is expressed as a the number of delayed transfers of care per number of patients admitted to the Trust (this is in accordance with Monitor's compliance framework)
- The indicator (both numerator and denominator) only includes adults aged 18 and over
- The numerator is the number of non-acute patients (aged 18 and over) whose transfer of care was delayed summed across the quarter
- The denominator is the number of non-acute patients (aged 18 or over) admitted to the trust, summed across the quarter
- Delayed transfers of care attributable to social care are excluded
- A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed; and a patient is ready for transfer when:
  - A clinical decision has been made that the patient is ready for transfer; AND
  - A multi-disciplinary team decision has been made that the patient is ready for transfer; AND
  - A decision has been made that the patient is safe to transfer.

## 2) Crisis resolution

- The indicator is expressed as proportion of inpatient admissions gatekept by the crisis resolution home treatment teams in the year ended 31 March 2012
- The indicator should be expressed as a percentage of all admissions to psychiatric inpatient wards



- Patients recalled on Community Treatment Orders should be excluded from the indicator
- Patients transferred from another NHS hospital for psychiatric treatment should be excluded from the indicator
- Internal transfers of service users between wards in the trust for psychiatry treatment should be excluded from the indicator
- Patients on leave under Section 17 of the Mental Health Act should be excluded from the indicator

- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded
- An admission should be reported as gatekept by a crisis resolution team where they have assessed\* the service user before admission and if the crisis resolution team were involved\*\* in the decision-making process which resulted in an admission

\* An assessment should be recorded if there is direct contact between a member of the team and the referred patient, irrespective of the setting, and an assessment made. The assessment may be made via a phone conversation or by any face-to-face contact with the patient

\*\* 'Actively involved' requires face to face contact unless it can be demonstrated that face to face contact was not appropriate or possible. For each case where face to face contact is not deemed appropriate, a self-declaration that the face to face contact was not the most appropriate action from a clinical perspective is required

- Where the admission is from out of the Trust's area and where the patient was seen by the local crisis team (out of area) and only admitted to this trust because they had no available beds in the local areas, the admission should only be recorded as gatekept if the crisis resolution team assure themselves that gatekeeping was carried out.



# Quality Accounts

## **A** **Annex A: Statements from Primary Care Trusts, Local Involvement Networks and Overview and Scrutiny Committees**

### **NHS Airedale, Bradford and Leeds Statement for Leeds and York Partnership NHS Foundation Trust's Quality Accounts 2011/12**

NHS Airedale, Bradford and Leeds welcomes the opportunity to comment on this Quality Account from Leeds and York Partnership NHS Foundation Trust. 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 Primary Care Trust as part of the contractual agreement, is accurate.

As the Trust is the main provider of mental health services in the city of Leeds, we have continued to work closely and in partnership with the Trust in developing services that meet the needs of the population of Leeds and beyond. Examples of work undertaken include enhancing community services for people with eating disorders, and self harm pathway work which brings together Leeds and York Partnership NHS Foundation Trust, the voluntary sector and NHS Airedale, Bradford and Leeds.

It is clear that the Trust has made good progress on many of the priorities outlined in last year's account, particularly in the development of outcome measures, an area that will continue to develop nationally. We are also pleased to note the work that has taken place to support

general health improvement, including a focus on weight management, nutritional health and smoking cessation.

We are particularly pleased to note the successful achievement of the jointly developed Commissioning for Quality and Innovation goals. This includes some leading work on the development of therapy outcome measures for people with learning disabilities, and the development of a comprehensive programme of inpatient activities.

We are supportive of the priorities proposed for the forthcoming year, including proposals to improve access to services for all ages and user groups, the continued work in user engagement from the wider population, the transformation work relating to improved patient pathways and the opening of a new locked rehabilitation unit

During the past year the Care Quality Commission has made a number of unannounced visits to various Trust sites, to assess compliance with the required standards. Whilst we are pleased to note that in general, the CQC found that standards of care provided to service users is good, we have noted their concerns relating to safeguarding reporting processes and record keeping made on successive visits. However, the Trust has responded quickly and robustly to the inspectors' findings, and we are pleased to note that the Care Quality Commission have declared the Trust fully compliant in their follow-up inspections. We are pleased that the Trust has included a summary of the inspector's findings in this Account.

We note the Trust's continued commitment to patient safety, although it is clear that progress against the priorities identified last year has been varied. Over the past year the Primary

Care Trust has expressed concern in relation to the delays in reporting of serious untoward incidents and in completing associated investigations and action plans. We welcome the improvements made by the Trust in this area and their brief comment on reporting timescales made in the account; however we will continue to work with the Trust to ensure that all serious incidents are reported and investigated in keeping with agreed policy.

We note the results of the 2011 national staff survey that shows some areas of concern in relation to staff satisfaction and appraisal. We hope that the Trust takes these results into account in the work proposed on frequent local staff surveys and associated actions as a key contributor to quality and patient experience.

As indicated earlier, the Primary Care Trust and Trust have developed very positive working relationships. We acknowledge the organisational changes that have taken place during the year in relation to the successful bid to provide services to York, Selby, Tadcaster and Easingwold. The amount of work that this has required does not appear to have detracted from the focus and commitment to services provided to patients in Leeds and to the continued relationship with the Primary Care Trust, and we commend the Trust for this.

The introduction of the Health and Social Care Bill means that there will be significant changes in how services are commissioned in future, and this is the last year that the Primary Care Trust will be required to provide comment on Quality Accounts. We would like to thank the Trust for their commitment to partnership working, and wish them well for the future. We have no doubt that the Trust will continue to work positively, collaboratively

# Quality Accounts

and constructively with new commissioning organisations and its client group and carers in striving to provide the people of Leeds with the best mental health care services possible.

## Leeds LINK statement for Leeds and York Partnership NHS Foundation Trust's Quality Accounts 2011/12



Leeds LINK is the independent involvement network bringing local people, community groups and organisations together, with the aim of improving health and social care services. We are pleased to have this opportunity to make a statement to be included in Leeds and York Partnership NHS Foundation Trust's Quality Accounts for 2011/12.

The priorities for quality improvement are ones which Leeds LINK would endorse, as we believe they reflect the concerns of our members and the wider public: that people achieve their goals for improving health and lives; experience safe care; and have a positive experience of care and support. That people using services remain safe, and are treated with respect and dignity is of a paramount concern to Leeds LINK. The information that the Trust gathers about people's experience of care is invaluable to us in our role of monitoring local services.

As well as the information that the Trust collects, we would urge people to come to us

directly with comments about services, both positive and negative. We would like the Trust to utilise Leeds LINK as an empowerment tool for people who use its services by making people aware of the LINK at an early stage. We hope that Leeds LINK will have opportunities in the coming year to visit some of the Trust's services to encourage people to get involved.

Achieving goals or outcomes is clearly the purpose of excellent care and support, and we welcome the developments in measuring outcomes, in both mental health and learning disability services, that the Trust is implementing across the whole organisation. We're pleased to learn about other positive developments and initiatives, particularly the clearing of waiting lists for psychological therapies; the focus on improving people's physical health; the work on embedding recovery principles; and the aim to develop equality performance and to engage with a diverse range of groups and communities. Leeds LINK could play an active role to support this engagement.

We would like to see more emphasis in the Quality Accounts about wellbeing and prevention, reflecting the work that is being carried out in the Trust's community services to prevent health deterioration and maintain good mental wellbeing.

Reading through the Quality Accounts, and considering both the work that has been carried out last year, and new projects that are planned for the next, we felt that involvement of the LINK could be improved, and that the Trust could provide us with information or ask our opinion on a more regular basis. This applies to large projects such as the transformation programme, as well as smaller pieces of work, such as the policy about

producing information. In other cases we would like to offer our support, for example by encouraging more carers to fill in the Trust's carers' questionnaire.

Leeds LINK notes the recent Care Quality Commission report; we support their emphasis on person centred care planning demonstrating enlightened practice, vigilant safeguarding, good procedure and practice.

We recognise that the transformation project has involved people who use the Trust's services, as we would expect, and we have been informed about the project. Leeds LINK can bring an independent opinion, rooted in a wide range of experience, which we believe would add further value to the project. We trust this will be sought in future.

This brings us to our final point, about our desire to continue to work in partnership with Leeds and York Partnership NHS Foundation Trust. Despite concerns raised above, we have developed a good relationship with the Trust. We recognise that Leeds LINK shares responsibility in maintaining this relationship and in ensuring that we are fully involved, to meet our aim of improving health services. We will therefore revisit our work around mental health and encourage greater participation in these issues from our members.

## Scrutiny Board (Health) - Leeds - Statement for Leeds and York Partnership NHS Foundation Trust's Quality Accounts 2011/12

Comments were requested from the Scrutiny Board (Health) but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Accounts.

# Quality Accounts

B

## Annex B: 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 as amended 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 2011/12
- 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 2011 to June 2012
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012
  - Feedback from the commissioners dated 9 May 2012
  - Feedback from the governors dated April 2011 – March 2012
  - Feedback from LINKs dated 8 May 2012
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2011 – March 2012
  - The latest national patient survey 2011
  - The latest national staff survey 2011
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 24 May 2012
  - CQC quality and risk profiles dated April 2011 - March 2012
- 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](http://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](http://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**



28 May 2012

**Frank Griffiths** - Chair of The Trust



28 May 2012

**Chris Butler** - Chief Executive

# Quality Accounts

## C Annex C: Independent Auditors Limited Assurance Account to the Council of Governors of Leeds and York Partnership NHS Foundation Trust

We have been engaged by the Council of Governors of Leeds and York Partnership NHS Foundation Trust to perform an independent assurance engagement in respect of Leeds Partnerships NHS Foundation Trust's Quality Report (the 'Quality Report') and the specified performance indicators contained therein.

### Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- Minimising delayed transfers of care as set out in the Quality Report
- Admissions to inpatient services had access to crisis resolution home treatment teams as set out in the Quality Report.

We refer to these national priority indicators collectively as the 'specified indicators'.

### 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 referred to in the Quality Report (the 'Criteria'). The directors are also responsible for their assertion and conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ('FTARM') issued by

the Independent Regulator of NHS Foundation Trusts ('Monitor'). In particular, the directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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 Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM
- The Quality Report is materially inconsistent with the sources specified below and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes for the period April 2011 to June 2012
- Papers relating to quality reported to the Board over the period April 2011 to June 2012
- Feedback from the commissioners dated 09/05/2012
- Feedback from LINKs dated 08/05/2012
- The Trust's complaints report published under regulation 18 of the Local Authority

Social; Services and NHS Compliant Regulations 2009, dated April 2011 to March 2012

- The latest National Patient Survey
- The latest National Staff Survey
- Care Quality Commission quality and risk profiles dated April 2011 to March 2012 and
- The Head of Internal Audit's opinion over the Trust's controls environment dated 24/05/2012.

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.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Leeds and York Partnership NHS Foundation Trust as a body, to assist the Council of Governors in reporting Leeds and York Partnership 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 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Indicators. To the fullest extent permitted by law, we do not



# Quality Accounts

accept or assume responsibility to anyone other than the Council of Governors as a body and Leeds and York Partnership 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 '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:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators
- Making enquiries of management
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation
- Comparing the content requirements of the FT ARM 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

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used

for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materiality different measurement can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set in the FT ARM and the directors' interpretation of the Criteria in the Quality Report.

The nature, form and content required of the Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts / organisations / entities.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Leeds and York Partnership NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM

- The Quality Report is materially inconsistent with the sources specified in the Quality Report and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

## Emphasis of matter – specified indicators covered by report

We draw your attention to the fact that, as explained in the Directors' statement, the reported performance in relation to the specified indicators does not include the services provided by North Yorkshire and York PCT from 1 April 2011 to 30 January 2012. Our procedures in relation to the specified indicators relate only to the performance reported for Leeds Partnership NHS Foundation trust (1 April 2011 to 30 January 2012) and Leeds and York Partnership NHS Foundation Trust (1 February to 31 March 2012). Our conclusion is not modified in this respect.

  
PricewaterhouseCoopers LLP  
Chartered Accountants  
Leeds

30 May 2012

The maintenance and integrity of the Leeds and York Partnership NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance or criteria since they were initially presented on the website.



*Ruby Wax at the Annual Members' Day 2011*



# Annual Accounts

## 10.1 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER FOR PREPARING THE FINANCIAL STATEMENTS

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 Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

Under the NHS Act 2006, Monitor has directed Leeds and York Partnership 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 and York Partnership NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

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

- **Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis**
- **Make judgements and estimates on a reasonable basis**

- **State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements 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.



28 May 2012  
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.



28 May 2012  
Chris Butler - Chief Executive



28 May 2012  
Carol Greaves - Deputy Chief Financial Officer signed on behalf of Guy Musson Chief Financial Officer

# Annual Accounts

## 10.3 ANNUAL GOVERNANCE STATEMENT FOR THE PERIOD 1 APRIL 2011 TO 31 MARCH 2012

### Scope of responsibility

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

I work closely with other partners to ensure the delivery and the development of services to service users, including Leeds City Council, the City of York Council, North Yorkshire County 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'.

Delivery arrangements are compliant with the expectations of the NHS Operating Framework. The Leeds and York Partnership NHS Foundation Trust (LYPFT) has a legally binding contract with NHS Airedale, Bradford and Leeds and NHS North Yorkshire and York, set within an integrated business plan.

### 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 policies, aims and objectives of LYPFT; 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 LYPFT for the year ended 31 March 2012 and up to the date of approval of the Annual Report and Accounts.

It should be noted that this system of control related to Leeds services from 1 April 2011 and services transferred from NHS North Yorkshire and York with effect from 1 February 2012, the date of transfer to LYPFT. This caveat relates to all aspects of the Annual Governance Statement.

### Capacity to handle risk

In this period, LYPFT 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 as to whether there are any new risks which need to be recognised. The Assurance Framework has been carefully examined and goals and any extreme risks associated with achieving these strategic end goals.

Internal audit reports and minutes of the Audit Committee of NHS North Yorkshire and York were received and assessed in respect of services transferred from NHS North Yorkshire and York.

No significant outstanding issues/actions were identified requiring urgent attention.

The Trust Incident Review Group (TIRG), including non-executive director representation, has responsibility for reviewing all serious untoward incidents. A quarterly report is produced for TIRG and Means Goal Standing Support Group 1 and 2, which contains 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. Both the Board of Directors and Council of Governors receive reports on serious untoward incidents.

These were complemented by a number of organisational and service-based standards such as those of the National Institute for 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 LYPFT covering risk management, clinical risk assessment and root cause analysis, overseen by the LYPFT's Risk Management Department. Health and Safety training is available via "e-learning" which includes a risk management module is mandatory for all staff, with updates every three years.

It is my view that LYPFT had arrangements in place during this period to manage significant business risks as set out in the Assurance Framework.



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## The risk and control framework

The Trust is now fully compliant with the registration requirements of the Care Quality Commission in respect of health and social care services.

Detailed assessments of compliance are undertaken on a quarterly basis and signed off by executive directors and subsequently reported to the Board of Directors. To maintain and further strengthen compliance, an internal cycle of CQC style inspections was agreed.

Whilst the Trust was subject to a number of CQC inspections in 2011/12 and a number of issues were raised, resulting in an amber-red governance status for the first 3 quarters of 2011/12, all necessary compliance actions have now been concluded in a timely and effective manner. The Trust was rated green for governance by Monitor at Quarter 4 2011/12.

With the transfer of services from NHS North Yorkshire and York, the Trust was required to put action plans in place which ensured that the Trust can monitor and improve care quality within the first six months from the date of transfer. These were put in place and are monitored each month by the Trust's Board of Directors.

Risk management is embedded in the organisation through its governance arrangements that span both clinical and non-clinical risk. Responsibility for risk management lies with LYPFT's Board of Directors. LYPFT have three strategic end goals which 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 Executive Team.

The delivery of these goals is overseen by the Executive Team which is responsible for the allocation of risk to the various means goals groups.

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 Trust 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. LYPFT 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 our LYPFT'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 reviewed further.

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 non-executive directors, the Patient and Public Involvement Team, staff, also 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 the equality, diversity and human rights legislation are complied with.

An internal audit of the Trust's Quality Governance Framework was undertaken which concluded that the controls upon which the Trust relies are suitable designed, consistently applied and effective. A similar review of LPFT systems was also undertaken by Deloitte as part of the North Yorkshire and York transaction. This concluded that the Trust demonstrates a high level of compliance when assessed both subjectively and objectively against Monitor's Quality Governance Framework.

Data security risks are managed by ensuring that all staff with access to 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 rated '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 LYPFT's corporate and service directorates. There is a robust system of clinical governance

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including handling of complaints and serious untoward incidents. All critical incidents are reviewed and the lessons learned disseminated Trust-wide.

## Key clinical risks

Services from NHS North Yorkshire and York, covering York, Selby and Tadcaster and some services which span North Yorkshire and York were transferred to LYPFT on the 1 February 2012. This was successfully executed. A 100 day post-transfer plan was put into effect on the date of transfer to ensure the safe transfer of services. The transaction fell under the scrutiny of Monitor and the Care Quality Commission, both regulators being content with the robustness of plans on both clinical and financial grounds.

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. Comprehensive 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.

LYPFT employs Lean 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 regular appraisal, part of which is to identify training and development needs to ensure that the clinical workforce remains fit for purpose.

For services currently provided by LYPFT, all major service changes are considered by Local Authority Health Scrutiny Boards as well as being considered by LYPFT's Council of Governors. Where appropriate major service

changes are also subject to broader public consultation.

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 LYPFT's forward financial plans such that a minimum financial risk rating of '3' is maintained over the planning cycle.

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.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

## LYPFT maintained Risk Management Standards Assessment Level 1 during 2011/12

LYPFT had undertaken risk assessments and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements are based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

## 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.

## Review of economy, efficiency and effectiveness of the use of resource

As an NHS foundation trust, quarterly submissions are despatched to Monitor, requiring LYPFT's Board of Directors to confirm that the Trust has met all CQC registration requirements and Monitor targets. Information on financial performance is also included. Monitor then assesses submissions and subsequently confirms 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 2012. Governance was '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 Care Quality Commission (CQC) requirements and also our Trust's strategic objectives. This provided 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.

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## Annual Quality Accounts

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) 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.

I have drawn on the content of the Quality Accounts included in 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 Quality Accounts are fully aligned with the Trust's strategy, 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.

Development of the Trust's 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 2010/11 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 2011/12 Quality Accounts remain in line with our three strategic end goals.

For each of our strategic end goals and 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 Council of Governors and third party organisations

To ensure that 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 measures should be reviewed to ensure that these are aligned with our strategy measures and local CQUIN (Commissioning for Quality and Innovation) 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 Council of Governors that a shortlist of strategy measures would be circulated to the Council of Governors for them to vote on which measures they would most like to see included in our 2011/12 Quality Accounts. A shortlist of our strategy measures was developed by the Trust's Annual Plan Standing Support Group and circulated to our Council of Governors. The measures which received the most votes under each priority were included in our 2011/12 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 2011/12 Quality Accounts

The delivery cycle for the Quality Accounts was presented to the Audit and Assurance

Committee, who reported sufficient assurance on the processes and timescales in place for sign off of the 2011/12 Quality Accounts.

Monitor's final Quality Accounts requirements were published in Monitor's NHS Foundation Trust Annual Reporting Manual. To ensure that the content of the Quality Accounts met the requirements set out in the manual leads were allocated against each requirement.

Work continued throughout April and May 2012 to expand, refine and finalise our 2011/12 Quality Accounts to ensure the information included was the most current and accurate. The Executive Team, the Trust Board of Directors and the performance sub-group of the Council of Governors were invited to provide comments 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 Council of Governors through the following mechanisms

- **Monthly performance reports to the Executive Team and Trust Board of Directors, which set out performance against external requirements including Monitor targets, CQC Registration Regulations, and our contractual requirements with our main commissioner**

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## ■ Quarterly performance reports to the Council 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 PARIS (patient administration and clinical information 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/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 Data 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 works closely with directorates to ensure the 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 the Performance Team works 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 Airedale Bradford and Leeds and LINKs and are included in our Quality Accounts. The Scrutiny Board (Health) in Leeds City Council was given

the opportunity to comment on our Quality Accounts but was unable to offer any formal comments due to the national timescales and competing priorities.

### Board sign off - final Quality Accounts

The final draft version of our Quality Accounts was presented to our Board of Directors on the 28 May 2012. Our 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 2010/11 Quality Accounts initiatives and measures was 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 2011/12 Quality Accounts will continue to be reported to the Board of Directors through the monthly performance report. These measures 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 our Audit and Assurance Committee.

### Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of



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internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Accounts which are included in 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, the Audit and Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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.

LYPFT 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 LYPFT 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 (LHT). Assurance is received from LHT and its internal auditors regarding both the performance and controls associated with the Electronic Staff Record system, which concludes that the payroll function is operational within an environment of effective control.

As well as providing audit scrutiny of the annual financial statements, 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, our Trust's Board of Directors has accountability for ensuring an effective system of internal control is in place. This was achieved primarily through the Audit and Assurance Committee. The minutes of the Audit and Assurance Committee were 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.

Clinical audit is the process used within the Trust to embed clinical quality at all levels of the organisation. This is achieved by creating a culture that is committed to learning and continuous organisational development in order to deliver demonstrable improvements in patient care through the development and measurement of evidence-based practice. Project topics are included on the clinical

audit programme using national guidelines for identification of external and internal priorities, and the findings used as assurance of (a) the quality of clinical care provided by the Trust, and (b) actions being taken to address areas for improvement.

Internal Audit reviews the system of internal control on an on-going basis. The Internal Audit Plan is derived from an assessment of risk areas within LYPFT 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 included in 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.

## Conclusion

No significant internal control issues have been identified or make specific reference to those significant internal control issues which have been identified in the body of the Annual Governance Statement above.



**Chris Butler**  
Chief Executive

28 May 2012

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## 10.4 INDEPENDENT AUDITORS' REPORT TO THE COUNCIL OF GOVERNORS OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

We have audited the financial statements of Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2012, 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 in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12. 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 Council of Governors of Leeds and York Partnership NHS Foundation Trust in accordance with paragraph 24 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.

Where the report is included on the client's website, include these notes unless the statement of directors' responsibilities clearly:

- States that the directors' responsibility for the maintenance and integrity of the website and
- Refers to the fact that uncertainty regarding legal requirements is compounded as information published on the internet is accessible in many countries with different legal requirements relating to the preparation and dissemination of financial statements:

a) The maintenance and integrity of the Leeds and York Partnership NHS Foundation Trust websites 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.

### 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 2011/12, of the state of the NHS foundation trust's affairs as at 31 March 2012 and of its income and expenditure and cash flows for the year then ended to 31 March 2012 and
  - Have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.
- Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

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 2011/12 and

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- 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 Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12 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 Annual Governance Statement 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 or
- We have qualified our report on any aspects of the Quality Report.

## Certificate

We certify that we have completed the audit of the financial statements 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

30 May 2012

## 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 provides 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, the use of resources and the Quality Accounts. Independent audits cost the Trust £68,462 in 2011/12.

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 and York Partnership 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 2012 £000	Restated Year ended 31 March 2011 £000
Operating income	3 & 4	181,166	127,191
Operating expenses	5	(172,516)	(119,474)
<b>OPERATING SURPLUS</b>		<b>8,650</b>	7,717
<b>FINANCE COSTS</b>			
Finance income	10	343	231
Finance expense - financial liabilities	12	(4,160)	(4,016)
Finance expense - unwinding of discount on provisions	25	(46)	(47)
PDC Dividends payable		(312)	(270)
<b>NET FINANCE COSTS</b>		<b>(4,175)</b>	(4,102)
<b>Surplus from operations</b>		<b>4,475</b>	3,615
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations			
<b>SURPLUS FOR THE YEAR</b>		<b>4,475</b>	3,615
<b>Other comprehensive income</b>			
Revaluation gains and impairment losses on intangible assets		68	125
Revaluation gains and impairment losses property, plant and equipment		557	430
Public Dividend Capital repaid		(390)	
<b>TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR</b>		<b>4,170</b>	4,170

The notes on pages 137 to 173 form part of this account.

All comparative figures for 2010/11, exclude the NYY contract, whilst 2011/12 include a full year's values. See Note 1.23.3




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STATEMENT OF FINANCIAL POSITION AS AT 31 March 2012	NOTE	Year ended 31 March 2012 £000	As at 1 April 2011 £000	Year ended 31 March 2011 £000	As at 1 April 2010 £000
<b>Non-current assets</b>					
Intangible assets	13.1	356	437	437	285
Property, plant and equipment	14.1	53,927	53,236	53,236	51,765
Trade and other receivables	17	2,370	2,801	2,801	2,567
<b>Total non-current assets</b>		<b>56,653</b>	<b>56,474</b>	<b>56,474</b>	<b>54,617</b>
<b>Current assets</b>					
Inventories	16	73	80	80	52
Trade and other receivables	17	6,376	4,818	3,677	4,563
Non-current assets for sale	19	665			337
Cash and cash equivalents	18	23,497	21,888	21,888	17,444
<b>Total current assets</b>		<b>30,611</b>	<b>26,786</b>	<b>25,645</b>	<b>22,396</b>
<b>Current liabilities</b>					
Trade and other payables	20	(15,095)	(11,977)	(11,110)	(10,270)
Borrowings	21	(1,253)	(1,140)	(1,140)	(1,037)
Provisions	25	(306)	(358)	(358)	(878)
Other liabilities	22	(2,957)	(5,623)	(5,349)	(2,141)
<b>Total current liabilities</b>		<b>(19,611)</b>	<b>(19,098)</b>	<b>(17,957)</b>	<b>(14,326)</b>
<b>Total assets less current liabilities</b>		<b>67,653</b>	<b>64,162</b>	<b>64,162</b>	<b>62,687</b>
<b>Non-current liabilities</b>					
Borrowings	21	(32,229)	(33,482)	(33,482)	(34,622)
Provisions	25	(1,502)	(1,468)	(1,468)	(1,957)
Other liabilities					(1,066)
<b>Total non-current liabilities</b>		<b>(33,731)</b>	<b>(34,950)</b>	<b>(34,950)</b>	<b>(37,645)</b>
<b>Total assets employed</b>		<b>33,922</b>	<b>29,212</b>	<b>29,212</b>	<b>25,042</b>
<b>Financed by (Taxpayers' Equity)</b>					
Public Dividend Capital		19,119	19,509	19,509	19,509
Revaluation reserve		6,549	6,644	6,644	6,496
Other reserves		(651)	(651)	(651)	(651)
Income and expenditure reserve		8,905	3,710	3,710	(312)
<b>Total taxpayers' equity</b>		<b>33,922</b>	<b>29,212</b>	<b>29,212</b>	<b>25,042</b>

The notes on pages 137 to 173 form part of these accounts.

Comparative figures for 1st April 2011 for Current Assets and Current Liabilities include the Noth Yorkshire and York Transforming Community Services balances.

The financial statements on pages 132 to 173 were approved by the Board on 28 May 2012 and signed on its behalf by:

Signed:  (Chief Executive)

28/ 5 / 12

Date: .....

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STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total £000
Taxpayers' equity at 1 April 2011	19,509	6,644		(651)	3,710	29,212
Surplus for the year					4,475	4,475
Revaluation gains and impairment losses on intangible assets		68				68
Revaluation gains and impairment losses property, plant and equipment		557				557
Public Dividend Capital repaid	(390)					(390)
Transfers to the income and expenditure account in respect of assets disposed of		(638)			638	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(82)			82	
Movement in year subtotal	(390)	(95)			5,195	4,710
<b>Taxpayers' Equity at 31 March 2012</b>	<b>19,119</b>	<b>6,549</b>	<b>-</b>	<b>(651)</b>	<b>8,905</b>	<b>33,922</b>

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Donated Assets Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total £000
Taxpayers' equity at 31 March 2010	19,509	6,496	28	(651)	(330)	25,052
Prior period adjustment *			(28)		18	(10)
Taxpayers' equity at 1 April 2010 - restated	19,509	6,496		(651)	(312)	25,042
Surplus/(deficit) for the year					3,615	3,615
Revaluation gains and impairment losses on intangible assets		125				125
Revaluation and impairment losses property, plant and equipment		430				430
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			4,022	4,170
<b>Taxpayers' Equity at 31 March 2011</b>	<b>19,509</b>	<b>6,644</b>	<b>-</b>	<b>(651)</b>	<b>3,710</b>	<b>29,212</b>

\* the prior period adjustment has resulted from a change in IAS 17. Land leases are now no longer assumed to be operating leases. The Donated Asset reserve has also now been written back to Income and Expenditure as per note c below.

#### Description of Reserves:

- Public Dividend Capital represents in substance, the Secretary of State for Health's 'equity' investment in the Trust. When the Trust's predecessor NHS Trust was established, the amount of PDC provided to it equated to the initial net assets of the Trust. The PDC balance is usually a constant amount but can change occasionally where the Trust receives additional PDC (usually to fund capital investment) or is asked to repay an element to the Secretary of State.
- 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.
- Following a change in the HM Treasury FReM and NHS Foundation Trusts ARM, the Donated Assets Reserve has been transferred to the Income and Expenditure Reserve. In future, where donations are received without conditions, or if they have conditions, once they have been met, they will be recognised in income.
- Other Reserves relates to the write off of an asset which was included in the original NHS Trust's asset base at inception.
- The Trust's surplus or deficit for the year is recognised in the Income and Expenditure Reserve, together with any other gain or loss for the financial year that is not recognised in any other reserve.

The notes on pages 137 to 173 form part of this account.

All comparative figures for 2010/11, exclude the NYY contract

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STATEMENT OF CASH FLOWS	NOTE	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
<b>Cash flows from operating activities</b>			
Operating surplus from continuing operations		8,650	7,717
<b>Operating surplus</b>		8,650	7,717
<b>Non-cash income and expense:</b>			
Depreciation and amortisation	5	3,372	3,377
Impairments and reversals	14.3	899	174
(Increase)/Decrease in Trade and Other Receivables	17	(1,090)	684
(Increase)/Decrease in Inventories	16	7	(28)
Increase/(Decrease) in Trade and Other Payables	20	3,765	248
Increase/(Decrease) in Other Liabilities	22	(2,666)	2,142
Increase/(Decrease) in Provisions	25	(64)	(1,056)
(Increase)/Decrease in Other Assets	19		337
Other movements in operating cash flows		153	17
<b>NET CASH GENERATED FROM OPERATIONS</b>		13,026	13,612
<b>Cash flows from investing activities</b>			
Interest received	10	330	215
Purchase of intangible assets	13.1	(85)	(188)
Purchase of Property, Plant and Equipment	14	(6,027)	(3,874)
Sales of Property, Plant and Equipment		390	18
<b>Net cash used in investing activities</b>		(5,392)	(3,829)
<b>Adjustment for net assets de-recognised on merger</b>			
<b>Cash flows from financing activities</b>			
Public Dividend Capital repaid		(390)	
Capital element of finance lease rental payments	21	(149)	(122)
Capital element of Private Finance Initiative obligations	21	(991)	(915)
Interest element of finance lease	12	(345)	(347)
Interest element of Private Finance Initiative obligations	12	(3,815)	(3,669)
PDC Dividend paid		(335)	(286)
<b>Net cash generated from/(used in) financing activities</b>		(6,025)	(5,339)
<b>Increase/(Decrease) in cash and cash equivalents</b>		1,609	4,444
<b>Cash and Cash equivalents at 1 April</b>		21,888	17,444
<b>Cash and Cash equivalents at 31 March</b>		23,497	21,888

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STATEMENT OF CASH FLOWS (continued)		2011/2012	2010/2011
Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow		£000	£000
(Increase)/Decrease in receivables as per SOFP		(1,127)	652
Adjustments for receivables movements not related to I&E:			
- Increase/(Decrease) in capital receivables			
- Financing transactions		37	32
(Increase)/Decrease in receivables adjusted for non-I&E items		(1,090)	684
Increase/(Decrease) in payables per SOFP		3,118	840
Adjustments for payables movements not related to I&E:			
- (Increase)/Decrease in capital payables		647	(592)
- Financing transactions			
Increase/(decrease) in payables adjusted for non-I&E items		3,765	248
Increase/(decrease) in Other Liabilities per SOFP		(2,666)	2,142
Adjustments for Other Liabilities movements not related to I&E:			
- EU ETS and LA pension liabilities			
Increase/(decrease) in Other Liabilities adjusted for non-I&E items		(2,666)	2,142
Increase/(decrease) in provisions per SOFP		(18)	(1,009)
Adjustments for provisions movements:			
- Adjustments for EU ETS on surrender of allowances			
- Unwinding of discount on provisions		(46)	(47)
Increase/(decrease) in provisions for non I&E items		(64)	(1,056)
Opening capital receivables			
Closing capital receivables			
Change in capital receivables in-year			
Opening capital payables		(1,554)	(962)
Closing capital payables		(907)	(1,554)
Change in capital payables in-year		647	(592)

All comparative figures for 2010/11, exclude the Noth Yorkshire and York contract

The notes on pages 137 to 173 form part of this account.



# Annual Accounts

## Notes to the accounts

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

### 1 Accounting policies

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 2011/2012 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, other than where new policies have been adopted, 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, 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 and York Partnership NHS Foundation Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

### 1.4 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, had they chosen

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](http://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 and York Partnership 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 and York Partnership 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. The 2008 actuarial valuation was suspended in 2010 due to the Hutton Report, hence the 2004 valuation is the most recent. 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

# Annual Accounts

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 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. From 1 April 2012, employee contributions will range from 5% to 10.9% with plans to carry out further consultation on employee contribution rises for 2013/14 and 2014/15.

## 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 2012, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2012 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 2011-12 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 30th September in the previous calendar year. From 2011/12, 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. Members in the 1995 Section receive a lump sum which is normally three times the annual pension payment. Members in the 2008 Section receive a lump sum which may be a maximum of 25% of the value of their fund at retirement.

### 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

For members who die in service a lump sum is payable of twice annual pensionable pay. For members who die after retirement an amount

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is payable which is the lesser of 5 times annual pension less pension already paid, or twice reckonable pay less any retirement lump sum taken. Other death benefits are also payable for members who have a deferred pension.

## **Additional Voluntary Contributions (AVCs)**

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

## **Transfer between funds**

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

## **Preserved benefits**

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

## **Compensation for early retirement**

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

## **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 and York Partnership NHS Foundation Trust**
- **it is expected to be used for more than one financial year**
- **the cost of the item can be measured reliably and if any of the following apply:**
  - **the item has a 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.

Due to a change in IAS 17 with regard to land leases, the Trust has reassessed its leases and those no longer meeting the requirements are 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.

Land and buildings used for the Trust's purposes are stated in the Statement of Financial Position at their revalued amounts being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. In accordance with IFRS and NHS policy, a full revaluation is performed every five years, with an interim revaluation in the third year after the full revaluation and an impairment review is undertaken in all other years. The Trust believes that this is sufficiently regular to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values

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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 full valuation was last undertaken as at 31 March 2010 and in the current year the assets were reviewed for impairment using the Modern Equivalent Asset method.

Non-property assets were last indexed using the latest available Consumer Price Indices, being for January 2012, 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 Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits or service potential expected to be obtained from the use of an item of property,

plant and equipment, and where the cost 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 property, plant and equipment are estimated by Leeds and York Partnership 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 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 Trust expects to obtain economic benefits or service



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potential from it. This period is specific to the Trust and may be shorter than the physical life of the asset itself.

Assets held under finance leases (including leased land) are depreciated over the shorter of their estimated useful economic lives or the lease period. Where the Trust will, or is reasonably certain to, acquire 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 lives, the components are treated as separate assets and depreciated over their own useful economic lives.

At the end of each reporting period a transfer is made from the revaluation reserve to income and expenditure reserve in respect of the difference between the depreciation expense on the revalued asset and depreciation expense based on the asset's 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 loss of economic benefit or service potential are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the 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 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, if so, its amount is written down to its recoverable 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.

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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.

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

## 1.7 Private Finance Initiative (PFI) transactions

PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial position' by the Trust. The underlying assets are recognised as property, plant and equipment at their fair value. An equivalent financial liability is recognised in accordance with 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 and York Partnership NHS Foundation Trust has adopted the approach that we incur the lifecycle costs evenly over the contract period as part of the unitary payment. This is due to the nature of the costs involved.

### b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to "fair value" by the District Valuer in accordance with the principles of 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.

### Other assets contributed by the Trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Leeds and York Partnership NHS Foundation Trust did make an initial "bullet" payment of cash upfront of 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

# Annual Accounts

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 and**
- **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 Statement of Comprehensive Income 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 and York Partnership NHS Foundation Trust discloses the total amount of research and development expenditure charged in the Statement of Comprehensive Income 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

Intangible assets are recognised initially at

cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequent intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for Property, Plant and Equipment, see notes 1.6.2 and 1.6.5.

## 1.8.4 Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is recognised in the Statement of Comprehensive Income.

## 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value using the first in- first out cost formula. Inventories are identified in Note 16. The Trust's inventories do not include drugs, but comprise stationery, oil and other work stores.

## 1.10 Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, balances with banks and investments in banks. Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Leeds and York Partnership NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Interest earned on bank accounts is recorded as "interest receivable" in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

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## 1.11 Provisions

Leeds and York Partnership 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 2.5% (2010/11 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 2.8% (2010/11 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 Trust pays an annual contribution to the NHSLA,

which, in return, settles all clinical negligence claims. Leeds and York Partnership NHS Foundation Trust does not include any amounts in its accounts relating to these cases. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

### Non-clinical risk pooling

The Leeds and York Partnership 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 and York Partnership 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 and York Partnership NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

## 1.14 Corporation tax

Leeds and York Partnership NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disappplied, the 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 Statement of Comprehensive Income.



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## 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 and York Partnership 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 and York Partnership 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 and York Partnership 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 of 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.

HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by Leeds and York Partnership NHS Foundation Trust, is paid over as 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

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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 Statement of Comprehensive Income 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 and York Partnership 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 Trust becomes a party to the contractual provisions of the instrument.

### De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or Leeds and York Partnership NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

### Classification and measurement

Financial assets are categorised as 'Loans and Receivables' and Financial liabilities are classified as 'Other Financial liabilities'.

### Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

Leeds and York Partnership NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS receivables and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of 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.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

### Impairment of financial assets

At the statement of financial position date, Leeds and York Partnership NHS Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying

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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 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 from 2012/13. The change should not have any significant impact on the Trust because it generally does not transfer financial assets between categories. It has not yet been adopted by the EU.

#### 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'. It is not likely to be adopted by the EU until the IASB has finished its financial instruments project.

#### iii. IFRS 10 – Consolidated financial statements

The objective of IFRS 10 is to establish principles for the presentation and preparation of consolidated financial statements when an entity controls one or more other entities. It has an effective date of 2013/14, but has yet to be adopted by the EU.

#### iv. IFRS 11 - Joint arrangements

The objective behind IFRS 11 is that a party to a joint arrangement determines the type of joint arrangement in which it is involved by assessing its rights and obligations and accounts for those rights and obligations in accordance with that type of joint arrangement. It has an effective date of 2013/14, but has yet to be adopted by the EU.

#### v. IFRS 12 - Disclosure of interests in other entities

IFRS 12 sets out the disclosure requirements for

all forms of interests in other entities, including subsidiaries, joint arrangements, associates and unconsolidated structured entities. It has an effective date of 2013/14, but has yet to be adopted by the EU.

#### vi. IFRS 13 - Fair value measurement

IFRS 13 constitutes guidance on fair value measurement and disclosure requirements for IFRSs and US generally accepted accounting principles (GAAP). It has an effective date of 2013/14, but has yet to be adopted by the EU.

#### vii. IAS 12 – Income tax amendment

IAS 12 requires an entity to measure the deferred tax relating to an asset depending on whether the entity expects to recover the carrying amount of the asset through use or sale. It can be difficult and subjective to assess whether recovery will be through use or through sale when the asset is measured using the fair value model in IAS 40 *Investment Property*. The amendment provides a practical solution to the problem by introducing a presumption that recovery of the carrying amount will, normally be through sale. It has an effective date of 2012/13 but has not yet been adopted by the EU.

#### viii. IAS 1 – Presentation of Financial Statements, on other comprehensive income

The amendments to IAS 1 Presentation of Financial Statements require companies preparing financial statements in accordance with IFRSs to group together items within other comprehensive income (OCI) that may be reclassified to the profit or loss section of the income statement. The amendments also reaffirm existing requirements that items in OCI and profit or loss should be presented as either a single statement or two consecutive statements. It has an effective date of 2013/14 but has yet to be adopted by the EU.

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## ix. IAS 27 – Separate financial statements

IAS 27 has the objective of setting standards to be applied in accounting for investments in subsidiaries, jointly ventures, and associates when an entity elects, or is required by local regulations, to present separate (non-consolidated) financial statements. It has an effective date of 2013/14 but has yet to be adopted by the EU.

## x. IAS 28 – Associates and joint ventures

The objective of IAS 28 (as amended in 2011) is to prescribe the accounting for investments in associates and to set out the requirements for the application of the equity method when accounting for investments in associates and joint ventures. [IAS 28(2011).1]. It has an effective date of 2013/14 but has yet to be adopted by the EU.

## 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 may grant permission for Monitor not to adopt a change in FReM in the FT ARM.

The following changes to the FReM are applicable to NHS Foundation Trusts and are incorporated into the FT ARM from this year.

### 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 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. 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.

### 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 has been transferred to the income and expenditure reserve

### c) Other changes

From 2013/14 the FT ARM will delete the present exemption from consolidating NHS charitable funds that are controlled by Foundation Trusts. The effect on Leeds and York Partnership NHS Foundation Trust will be to include the charitable fund's income and expenditure. Income and expenditure between the Trust and the charitable fund will be eliminated on consolidation. The assets, liabilities and reserves of the charitable fund will also be consolidated.

1.22

## Accounting standards issued that have been adopted early by Leeds and York Partnership NHS Foundation Trust

No new accounting standards or revisions to existing standards have been early-adopted in 2011/12.

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 Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

Leeds and York Partnership NHS Foundation Trust's main contract with NHS Leeds (formerly Leeds PCT) states that the 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



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income is apportioned between the financial years based on the length of stay.

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

## 1232 Key sources of estimation uncertainty

The following are the key assumptions concerning 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.

As a Foundation Trust, Leeds and York Partnership NHS Foundation Trust is required 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. It is the policy of the Trust to have annual valuations undertaken to cover this eventuality.

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 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 and York Partnership 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.

## 1233 Transfer of services from NHS North Yorkshire and York

On 1st February 2012, Leeds Partnerships NHS Foundation Trust took over as the provider for the mental health, learning disability and substance misuse services for NHS North Yorkshire and York (and changed its name to Leeds and York Partnership NHS Foundation Trust). In accordance with the 2011/12 FReM, and FT ARM this transfer has been accounted for using merger accounting. Therefore as the receiving body, the Trust has received a full 12 months worth of activity. Further, in accordance with the FT ARM, the Trust has not restated its prior period position. No assets or liabilities of NHS North Yorkshire and York were transferred to the Trust.



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The income and expenditure received from NHS North Yorkshire and York was:

Income 10 months to 31st January 2012	£32,580k
Expenditure 10 months to 31st January 2012	£32,580k
Income 2 months to 31st March 2012	£6,669k
Expenditure 2 months to 31st March 2012	£6,654k
Income 12 months to 31st March 2012	£39,249k
Expenditure 12 months to 31st March 2012	£39,234k

## 2 Operating segments

Leeds and York Partnership NHS Foundation Trust provides mental health and learning disability services across the cities of Leeds and York and parts of North Yorkshire, to over 1.8 million people.

The majority of Trust income (by value) is on a block basis. The Trust contracted with NHS Leeds (formerly known as Leeds PCT) for 62% of its income (80% in 2010/11) 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. The Trust contracted with NHS North Yorkshire & York for two months of 2011/12 with a value of £5.5m, however under merger accounting rules, a full year's income has been reported here.

Seven operating segments are reported below. The Leeds services are provided in six operating segments and one hosted services segment, which have been reported to the Board throughout the year. The operating segments include the six core service directorates; Adult Mental Health Services, Older Peoples Mental Health Services, Specialist Services, Learning Disability Services, Specialised Supported

Living and North Yorkshire and York. There is also an additional Hosted Services segment which includes Commercial Procurement Collaborative (CPC), National Research Ethics Society, Research & Development, the Care Pathways & Packages Project and the Northern School of Child & Adolescent Psychotherapy.

The Transforming Community Services of the

North Yorkshire and York (NYY) transferred service is being reported as a separate segment.

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 Trust.



*Ruby Wax with Gemma Wharton (left), Victoria Betton and Chris Butler*

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	Adult		Older		Specialist		LD		SSL		NYY		Hosted Service		Total	
	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended	Year ended
	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March	31 March
	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011	2012	2011
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Income by segment																
Income from activities	64,542	52,668	26,998	26,400	14,287	13,804	11,377	11,961	7,536	7,296	37,545		1		162,286	112,129
Other operating income	3,968	5,286	1,787	2,687	2,816	3,026	751	1,036	369	499	1,720		5,609	2,063	17,020	14,597
<b>TOTAL INCOME</b>	<b>68,510</b>	<b>57,954</b>	<b>28,785</b>	<b>29,087</b>	<b>17,103</b>	<b>16,830</b>	<b>12,128</b>	<b>12,997</b>	<b>7,906</b>	<b>7,795</b>	<b>39,265</b>	<b>-</b>	<b>5,610</b>	<b>2,063</b>	<b>179,306</b>	<b>126,726</b>
<b>TOTAL EXPENDITURE</b>	<b>(62,810)</b>	<b>(53,220)</b>	<b>(25,268)</b>	<b>(25,711)</b>	<b>(14,462)</b>	<b>(15,395)</b>	<b>(11,229)</b>	<b>(11,046)</b>	<b>(8,815)</b>	<b>(8,702)</b>	<b>(39,447)</b>		<b>(5,953)</b>	<b>(1,756)</b>	<b>(167,984)</b>	<b>(115,831)</b>
<b>EBITDA</b>	<b>5,700</b>	<b>4,734</b>	<b>3,517</b>	<b>3,376</b>	<b>2,641</b>	<b>1,435</b>	<b>899</b>	<b>1,951</b>	<b>(910)</b>	<b>(907)</b>	<b>(182)</b>		<b>(343)</b>	<b>307</b>	<b>11,322</b>	<b>10,896</b>
<b>Non Operating Income and Expenditure Total</b>	<b>(3,776)</b>	<b>(3,780)</b>	<b>(2,108)</b>	<b>(2,203)</b>	<b>(482)</b>	<b>(650)</b>	<b>(475)</b>	<b>(501)</b>	<b>22</b>	<b>(100)</b>			<b>(26)</b>	<b>(18)</b>	<b>(6,845)</b>	<b>(7,253)</b>
<b>Surplus/(Deficit) from continuing operations</b>	<b>1,924</b>	<b>954</b>	<b>1,409</b>	<b>1,173</b>	<b>2,159</b>	<b>785</b>	<b>424</b>	<b>1,450</b>	<b>(888)</b>	<b>(1,007)</b>	<b>(182)</b>	<b>-</b>	<b>(369)</b>	<b>289</b>	<b>4,477</b>	<b>3,643</b>
<b>Audit Adjustments</b>																
Asset Revaluation																11
Accruals Adjustment																(37)
Donated Asset Adjustment																(2)
<b>Revised Surplus/(Deficit) from continuing operations</b>																3,615

**a) Income includes:**

£160m from NHS Trusts (primarily £112m from NHS Leeds and £35m from NHS North Yorkshire and York).

**b) Expenditure includes:**

	11/12	10/11
Employee Expenses	£127.351m	£92.687m
Premises	£7.793m	£5.336m
Depreciation & Amortisation	£3.372m	£3.377m
Establishment	£5.093m	£4.026m

**c) Depreciation, Amortisation, Impairments of Property, Plant & Equipment and Impairments of Intangible Assets**

£4,379k 11/12, (£3,551k 10/11) are included in operating expenses in the accounts, but non operating expenses in service line reports.

**d) 2011/12 includes:**

£153k and 10/11 includes £55k for loss on disposal which is included in operating expenses in the accounts, but non operating expenses in service line reports.

**e) 2011/12 includes:**

£107k reversal of impairment and £1,753k other payments (10/11 - £214k profit on disposal, £252k other payments) which are included in operating income in the accounts but in non operating income in service line reports.

**f) The expenditure figures for North Yorkshire and York above includes an allocation of central overhead costs.**

**g) In the figures above, the following amounts have been allocated across the segments; depreciation £3,282k; amortisation £90k; finance income £343k and finance expense £4,206k**

*Items c, d and e have not been adjusted for in segmental reporting as this is how Leeds and York Partnership NHS Foundation Trust reports to its Trust Board.*

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## 3 Revenue from patient care activities

	Year Ended 31 March 2012	Year Ended 31 March 2011
	£000	£000
NHS trusts		
Primary care trusts	17	
Foundation trusts	151,650	104,004
Strategic Health Authorities	390	21
Local authorities	1,520	
Non-NHS:	1,515	1,020
Income for Social Care Clients	7,195	7,061
Other		6
<b>Total Revenue from patient care activities</b>	<b>162,287</b>	<b>112,112</b>

Leeds and York Partnership NHS Foundation Trust participates in a pooled budget arrangement with NHS Airedale, Bradford and Leeds and Leeds City Council as a provider of services.

As a provider of healthcare services, Leeds and York Partnership 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 2011/12 (£nil in 2010/11). This is within the 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 2012	Year Ended 31 March 2011
	£000	£000
Research and Development	844	403
Education and Training	3,587	3,122
Non-patient care services to other bodies	3,761	2,721
Other Income:		
Inter NHS Foundation Trust	2,057	1,126
Inter NHS Trust	1,622	189
Inter RAB	4,816	6,307
Inter Other WGA Bodies	24	58
Other (Outside WGA)	1,750	939
Gain on disposal of assets held for sale		176
Reversal of impairments of property, plant and equipment	105	38
Reversal of impairments of intangible assets	2	
Income in respect of staff costs where accounted on gross basis	311	
<b>Total Other Operating Revenue</b>	<b>18,879</b>	<b>15,079</b>



**Andrew Howorth,**  
Engagement and Involvement



# Annual Accounts

## 5 Operating expenses

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Services from Foundation Trusts	1,396	6
Services from other NHS Trusts	746	814
Services from PCT's	975	
Services from other NHS bodies	2	31
Purchase of healthcare from non NHS bodies	8,045	980
Employee expenses - Executive Directors	838	824
Employee expenses - Non Executive Directors' costs	176	177
Employee expenses - Staff	126,513	91,863
Drugs costs	2,766	2,090
Supplies and services - clinical (excluding Drugs)	1,297	866
Supplies and services - general	1,341	968
Establishment	5,093	3,939
Research and development	743	438
Transport	918	625
Premises	7,793	5,336
Increase/(decrease) in provision for impairment of receivables and amounts written off in year	(16)	(23)
Depreciation on Property, plant and equipment	3,282	3,285
Amortisation of intangible Assets	90	92
Impairments of property, plant and equipment	458	141
Impairments of intangible assets	7	71
Impairments of assets held for sale	542	
Audit fees - statutory audit and regulatory reporting	68	72
Internal auditor's remuneration	107	
Clinical negligence	340	247
Loss on disposal of intangible fixed assets	153	6
Loss on disposal of other property plant and equipment		11
Consultancy services	650	577
Patient's travel	42	33
Redundancy	449	102
Early retirement	46	(405)
Insurance	122	87
Losses, ex-gratia and special payments	2	56
Other	7,532	6,165
<b>Total Operating Expenses</b>	<b>172,516</b>	<b>119,474</b>

£8,045k expenditure categorised as Purchase of Healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£980k 10/11). The significant increase is due to the transfer of the low secure and rehabilitation out of area (OATs) budget to Leeds and York Partnership NHS Foundation Trust from NHS Leeds.

Other Expenditure includes £5,717k (£5,606k in 10/11) in relation to PFI costs. These are primarily monthly service charge payments to the operators of the two PFI schemes to which Leeds and York Partnership NHS Foundation Trust is party (see note 24).

Details of the directors' remuneration and that of the highest paid director, can be found in Section 8 of the annual report.

There is no specified limitation to the auditor's 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 £68k (2010/11 £52k) excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011.

## 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.

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
<b>Payments recognised as an expense</b>		
Minimum lease payments	3,122	1,713
<b>Total</b>	<b>3,122</b>	<b>1,713</b>
<b>Total future minimum lease payments</b>	<b>Year ended 31 March 2012 £000</b>	<b>Year ended 31 March 2011 £000</b>
Payable:		
Not later than one year	3,091	1,650
Between one and five years	7,341	4,919
After 5 years	5,360	6,728
<b>Total</b>	<b>15,792</b>	<b>13,297</b>

As a result of taking over the services from NHS North Yorkshire and York, we are required to pay NHS North Yorkshire and York an occupancy fee equal to the cost to NHS North Yorkshire and York of providing the buildings to the Trust. The Trust receives funding from NHS North Yorkshire and York to an equal amount. Therefore the Trust does not consider this to be an operating lease commitment.

# Annual Accounts

## 7 Employee costs and numbers

### 7.1 Employee costs

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	102,700	97,994	4,706	72,733	68,972	3,761
Social Security costs	7,800	7,800		5,466	5,466	
Employer contributions to NHS Pension scheme	12,462	12,462		9,089	9,089	
Termination Benefits	495	495				
Agency/Contract Staff	4,630		4,630	5,399		5,399
<b>Employee benefits expense</b>	<b>128,087</b>	<b>118,751</b>	<b>9,336</b>	<b>92,687</b>	<b>83,527</b>	<b>9,160</b>
There were no employee benefits paid in the year ended 2011/12 (Enil 2010/11).						
<b>In addition to the above:</b>	<b>2012 Total</b>			<b>2011 Total</b>		
Charged to capital				70		
Recharged income included within staff costs in note 5	(241)					
	<b>(241)</b>			<b>70</b>		

Full details of the directors' remuneration can be found in Section 8 of the Annual Report, of which a summarised version is given below.

The disclosures required under the Hutton report can also be found in section 8 of the Annual Report.

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
<b>Directors remuneration</b>		
Aggregate Emoluments to Executive Directors	679	771
Remuneration of Non-Executive Directors	176	177
Pension Cost	159	53
	<b>1,014</b>	<b>1,001</b>

Directors Emoluments include basic salary, other payments and benefits in kind.

Remuneration of non-executives include MH Act Managers £48k in 2011-12).

# Annual Accounts

## 7.2 Average number of people employed (wte)

	Year Ended 31 March 2012			Year Ended 31 March 2011		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	Number	Number	Number	Number	Number	Number
Medical and dental	226	220	6	173	163	10
Administration and estates	633	623	10	524	513	11
Healthcare assistants and other support staff	306	305	1	55	55	
Nursing, midwifery and health visiting staff	1,522	1,498	24	1,223	1,221	2
Scientific, therapeutic and technical staff	427	402	25	285	257	28
Social care staff	15	4	11	10		10
Other	252		252	295		295
<b>Total</b>	<b>3,381</b>	<b>3,052</b>	<b>329</b>	<b>2,565</b>	<b>2,209</b>	<b>356</b>

## 7.3 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 £10,000	2 (6)	0 (0)	2 (6)
£10,001 - £25,000	1 (3)	0 (0)	1 (3)
£25,001 - £50,000	4 (0)	0 (0)	4 (0)
£50,001 - £100,000	1 (0)	0 (0)	1 (0)
£100,001 - £150,000	0 (0)	0 (0)	0 (0)
£150,001 - £200,000	1 (0)	0 (0)	1 (0)
Total number of exit packages by type	<b>9 (9)</b>	<b>0(0)</b>	<b>9 (9)</b>
<b>Total resource cost (£000)</b>	<b>449 (102)</b>	<b>0(0)</b>	<b>449 (102)</b>

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 2011/12 this figure is £173k (2010/11 £nil).

## 8 Retirements due to ill-health

During 2011/12 there was 1 (2010/11: 5) early retirement from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £329k (2010/11: £307k). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.



# Annual Accounts

## 9 Better Payment Practice Code

	Year Ended 31 March 2012		Year Ended 31 March 2011	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	19,792	44,445	19,283	33,192
Total Non-NHS trade invoices paid within target	17,206	39,948	17,228	30,793
Percentage of Non-NHS trade invoices paid within target	87%	90%	89%	93%
Total NHS trade invoices paid in the period	900	7,057	1,270	6,786
Total NHS trade invoices paid within target	707	4,275	1,099	5,672
Percentage of NHS trade invoices paid within target	79%	61%	87%	84%

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

## 10 Finance income

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Bank accounts	343	231
<b>Total</b>	<b>343</b>	<b>231</b>

This figure includes accrued interest of £32k (2010/11 £16k)

## 11 Other gains and losses

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Gain/(loss) on disposal of intangible assets	(153)	(6)
Gain/(loss) on disposal of property, plant and equipment		(11)
<b>Total</b>	<b>(153)</b>	<b>(17)</b>

## 12 Finance costs

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Interest on obligations under finance leases	345	347
Interest on obligations under PFI contracts:		
- main finance cost	2,544	2,620
- contingent finance cost	1,271	1,049
<b>Total</b>	<b>4,160</b>	<b>4,016</b>

# Annual Accounts

## 13.1 Intangible assets

2011/12:	Computer software purchased £000
Gross valuation at 1 April 2011	437
Additions purchased	77
Disposals other than by sale	(176)
Reclassifications	22
Revaluation/indexation	24
<b>Gross valuation at 31 March 2012</b>	<b>384</b>
Accumulated amortisation at 1 April 2011	
Disposals other than by sale	(23)
Revaluation	(44)
Impairments	5
Charged during the year	90
<b>Accumulated amortisation at 31 March 2012</b>	<b>28</b>
<b>Net book value</b>	
Purchased	356
<b>Total at 31 March 2012</b>	<b>356</b>
Total at 31 March 2011	437

### Intangible assets - prior year:

2010/11:	Computer software purchased £000
Gross valuation at 1 April 2010	285
Additions purchased	197
Disposals other than by sale	(20)
Reclassifications	
Revaluation/indexation	(25)
<b>Gross valuation at 31 March 2011</b>	<b>437</b>
Accumulated amortisation at 1 April 2010	
Disposals other than by sale	13
Revaluation	(150)
Impairments	71
Charged during the year	92
<b>Accumulated amortisation at 31 March 2011</b>	<b>-</b>
<b>Net book value</b>	
Purchased	437
<b>Total at 31 March 2011</b>	<b>437</b>
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 in 2011/12 for the software licences and this led to an impairment of £5k.

# Annual Accounts

## 14.1 Property, plant and equipment

2011/12:	Land £000	Buildings excluding 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 2011	4,545	49,642	2,748	850	402	4,301	1,177	63,665
Additions purchased			4,977		56	355		5,388
Reclassifications		5,961	(5,960)	(1)		(22)		(22)
Reclassified as held for sale	(390)	(830)						(1,220)
Disposals	(390)				(23)	(412)		(825)
Revaluation/indexation gains/(losses)		107		15	(1)		52	173
Impairments	(65)	(32)						(97)
<b>At 31 March 2012</b>	<b>3,700</b>	<b>54,848</b>	<b>1,765</b>	<b>864</b>	<b>434</b>	<b>4,222</b>	<b>1,229</b>	<b>67,062</b>
Accumulated depreciation at 1 April 2011	1	6,228	40	483	245	2,543	889	10,429
Disposals					(23)	(412)		(435)
Reclassified as held for sale		(13)						(13)
Revaluation/indexation gains		(533)		10	(1)		43	(481)
Impairments		353						353
Charged during the year	1	2,585		72	47	493	84	3,282
<b>Accumulated depreciation at 31 March 2012</b>	<b>2</b>	<b>8,620</b>	<b>40</b>	<b>565</b>	<b>268</b>	<b>2,624</b>	<b>1,016</b>	<b>13,135</b>
<b>Net book value</b>								
<b>Total at 31 March 2012</b>	<b>3,698</b>	<b>46,228</b>	<b>1,725</b>	<b>299</b>	<b>166</b>	<b>1,598</b>	<b>213</b>	<b>53,927</b>
<b>Asset financing</b>								
Owned	3,650	22,482	1,725	299	166	1,598	213	30,133
Finance Lease	48	1,241						1,289
PFI		22,480						22,480
Donated		25						25
<b>Total at 31 March 2012</b>	<b>3,698</b>	<b>46,228</b>	<b>1,725</b>	<b>299</b>	<b>166</b>	<b>1,598</b>	<b>213</b>	<b>53,927</b>
NBV Protected Assets at 31 March 2012	2,778	45,373						48,151
NBV Unprotected Assets at 31 March 2012	920	855	1,725	299	166	1,598	213	5,776
<b>NBV Total at 31 March 2012</b>	<b>3,698</b>	<b>46,228</b>	<b>1,725</b>	<b>299</b>	<b>166</b>	<b>1,598</b>	<b>213</b>	<b>53,927</b>

The latest revaluation of Land and Buildings was carried out by the Valuation Office with effective date 1st April 2012. 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 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 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

2010/11:	Land £000	Buildings excluding 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
Reclassifications		1,980	(2,199)	56		163		
Disposals				(65)	(65)			(130)
Revaluation/indexation gains	44	(136)		14	28		61	11
Impairments	(35)	(11)						(46)
<b>At 31 March 2011</b>	<b>4,545</b>	<b>49,642</b>	<b>2,748</b>	<b>850</b>	<b>402</b>	<b>4,301</b>	<b>1,177</b>	<b>63,665</b>
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
<b>Accumulated depreciation at 31 March 2011</b>	<b>1</b>	<b>6,228</b>	<b>40</b>	<b>483</b>	<b>245</b>	<b>2,543</b>	<b>889</b>	<b>10,429</b>
<b>Net book value</b>								
<b>Total at 31 March 2011</b>	<b>4,544</b>	<b>43,414</b>	<b>2,708</b>	<b>367</b>	<b>157</b>	<b>1,758</b>	<b>288</b>	<b>53,236</b>
<b>Asset financing</b>								
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
<b>Total at 31 March 2011</b>	<b>4,544</b>	<b>43,414</b>	<b>2,708</b>	<b>367</b>	<b>157</b>	<b>1,758</b>	<b>288</b>	<b>53,236</b>
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
<b>NBV Total at 31 March 2011</b>	<b>4,544</b>	<b>43,414</b>	<b>2,708</b>	<b>367</b>	<b>157</b>	<b>1,758</b>	<b>288</b>	<b>53,236</b>
NBV Total at 31 March 2010	4,486	43,726	901	358	140	1,752	353	51,716

The prior period adjustment has resulted from a change in IAS 17. The Trust has reassessed its leases and those no longer meeting the requirements of IAS 17 are assumed to be operating leases.



# Annual Accounts

## 14.3 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Abandonment of assets in course of construction		34
Over specification of assets		118
Changes in Market Place	1,104	106
Reversals of impairments	(107)	(38)
<b>At 31 March</b>	<b>997</b>	<b>220</b>

## 15 Capital commitments

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

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Property, plant and equipment	457	2,211
<b>Total</b>	<b>457</b>	<b>2,211</b>

## 16 Inventories

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Consumables and work in progress	73	80
<b>Total</b>	<b>73</b>	<b>80</b>
Of which held at net realisable value:	73	80

### 16.1 Inventories recognised in expenses

	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Inventories recognised as an expense in the period	38	16
<b>Total</b>	<b>38</b>	<b>16</b>

# Annual Accounts

## 17 Trade and other receivables

	Current			Non-current	
	Year ended 31 March 2012 £000	As at 1 April 2011 £000	Year ended 31 March 2011 £000	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
NHS receivables-revenue	1,864	2,691	1,636		
Other receivables with related parties	236	64	63		
Accrued Income	1,176	395	395		
Provision for the impairment of receivables	(112)	(128)	(128)		
Prepayments	838	973	888	2,365	1,835
PDC Receivable	71	48	48		
VAT	349	260	260		
Other receivables	1,954	515	515	5	966
<b>Total</b>	<b>6,376</b>	<b>4,818</b>	<b>3,677</b>	<b>2,370</b>	<b>2,801</b>

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.

The figures for 1st April 2011 have been adjusted to include the TCS opening balances from NHS North Yorkshire and York - NHS Receivables £1,055k; Prepayments £85k and Other Receivables £1k.

### 17.1 Receivables past their due date but not impaired

	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
By up to three months	2,163	647
By three to six months	79	34
<b>Total</b>	<b>2,242</b>	<b>681</b>

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 2012 £000	Year ended 31 March 2011 £000
<b>Balance at 1 April</b>	<b>128</b>	<b>152</b>
Amount written off during the year		(20)
Amount recovered during the year		(1)
Increase/(decrease) in receivables impaired	(16)	(3)
<b>Balance at 31 March</b>	<b>112</b>	<b>128</b>

The increase in the amount provided for in the year ended 2011/12 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 2012	Year ended 31 March 2011
	£000	£000
Balance at 1 April	21,888	17,444
Net change in year	1,609	4,444
<b>Balance at 31 March</b>	<b>23,497</b>	<b>21,888</b>
<b>Made up of</b>		
Cash with Government Banking Service	23,362	21,702
Commercial banks and cash in hand	135	186
<b>Cash and cash equivalents as in statement of financial position</b>	<b>23,497</b>	<b>21,888</b>
<b>Cash and cash equivalents as in statement of cash flows</b>	<b>23,497</b>	<b>21,888</b>

## 19 Non-current assets held for sale

	Property, plant and equipment	Total
	£000	£000
Balance brought forward 1 April 2011		
Plus assets classified as available for sale in the year	1,207	1,207
Less Impairment of assets held for sale	(542)	(542)
Less assets sold in the year		
Balance carried forward 31 Mar 2012	665	665
Balance brought forward 1 April 2010	337	
Less assets sold in the year	(337)	
Balance carried forward 31 Mar 2011	-	-

The assets held for sale are Peel Court and 36/38 Otley Old Road.

# Annual Accounts

## 20 Trade and other payables

	Current		
	Year ended 31 March 2012 £000	As at 1 April 2011 £000	Year ended 31 March 2011 £000
NHS payables-revenue	4,501	3,228	2,760
Amounts due to other related parties		26	4
Non NHS trade payables - capital	907	1,554	1,554
Accruals	4,492	3,982	3,879
Other	5,195	3,187	2,913
<b>Total</b>	<b>15,095</b>	<b>11,977</b>	<b>11,110</b>

The figures for 1st April 2011 have been adjusted to include the TCS opening balances from North Yorkshire and York PCT - NHS Payables £468k; Amounts due to Related Parties £22k, Other Payables £274k and Accruals £103k

## 21 Borrowings

	Current		Non-current	
	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
PFI liabilities	1,074	991	30,021	31,095
Finance lease liabilities	179	149	2,208	2,387
<b>Total</b>	<b>1,253</b>	<b>1,140</b>	<b>32,229</b>	<b>33,482</b>

The Trust has a prudential borrowing limit of £34,600k in 2011/12 (£35,700k in 2010/11). The Trust has actually borrowed £0 in 2011/12 (£0 in 2010/11). The Trust has Monitor approval to seek a working capital facility of £0.0m (£8.5m in 2010/11).

The Trust has not breached the Prudential Borrowing Code (PBC).

Financial ratio	2011/12		2010/11	
	Actual ratios	Approved PBL ratios	Actual ratios	Approved PBL ratios
Minimum dividend cover	26x	>1x	26x	>1x
Minimum interest cover	3x	>2x	3x	>2x
Minimum debt service cover	2.3x	>1.5x	2.2x	>1.5x
Maximum debt service to revenue	3.7%	<10%	4%	<10%

Leeds and York Partnership 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		
	Year ended 31 March 2012 £000	As at 1 April 2011 £000	Year ended 31 March 2011 £000
Deferred Income	2,957	5,623	5,349
<b>Total</b>	<b>2,957</b>	<b>5,623</b>	<b>5,349</b>

The figures for 1st April 2011 have been adjusted to include the TCS opening balances from North Yorkshire and York PCT £274k

## 23 Finance lease obligations

Amounts payable under finance leases	Minimum lease payments		Present value of minimum lease payments	
	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Within one year	512	469	496	455
Between one and five years	2,180	2,064	1,826	1,576
After five years	1,423	1,946	989	1,223
Less future finance charges	(1,728)	(1,943)		
Present value of minimum lease payments	2,387	2,536	3,311	3,254
Included in:				
Current borrowings	179	149	496	455
Non-current borrowings	2,208	2,387	2,815	2,799
	2,387	2,536	3,311	3,254

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 £3,311k (£3,254k 2010/11) is calculated from the minimum lease payments figures at £2,387k (£2,536k 2010/11) with the future finance charges at £1,728k (£1,943k 2010/11) added back. This figure is discounted at 0.49% (6.00% per annum) for 89 months (101 months 2010/11) 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 £43,778k (2010/11 £43,778k). The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028. The Trust has the right to purchase the units at market value at the end of the contract.

More detail is provided in the PFI accounting policy in note 1.

### Minimum amounts payable under the contract:

#### Asset financing component

	Gross Payments		Present values of payments	
	Year ended 31 March 2012	Year ended 31 March 2011	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000	£000	£000
Not later than one year	4,807	4,584	4,627	4,413
Later than one year, not later than five years	19,226	18,335	15,560	14,839
Later than five years	49,667	51,951	24,687	25,037
Sub total	73,700	74,870	44,874	44,289
Less: finance cost attributable to future periods	(42,605)	(42,784)	(13,779)	(12,203)
<b>Total</b>	<b>31,095</b>	<b>32,086</b>	<b>31,095</b>	<b>32,086</b>

#### Services component

	Gross Payments	
	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000
Not later than one year	5,657	5,395
Later than one year, not later than five years	22,629	21,581
Later than five years	58,459	61,146
<b>Total</b>	<b>86,745</b>	<b>88,122</b>

The future services amounts due as at 31 March 2012 reflect an adjustment for the RPI indexation of the Unitary Payment applied during 2011/12.

The amount charged to operating expenses during the year in respect of services was £5,393 (2010/11 £5,280).

# Annual Accounts

## 25 Provisions

	Current		Non-current	
	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000	Year ended 31 March 2012 £000	Year ended 31 March 2011 £000
Pensions relating to other staff	133	128	1,502	1,468
Legal claims	55	121		
Other (specify)	118	109		
<b>Total</b>	<b>306</b>	<b>358</b>	<b>1,502</b>	<b>1,468</b>
	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
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
At 1 April 2011	1,596	121	109	1,826
Arising during the year	116	68	100	284
Change in discount rate	12			12
Used during the year	(134)	(102)	(6)	(242)
Reversed unused	(1)	(32)	(85)	(118)
Unwinding of discount	46			46
<b>At 31 March 2012</b>	<b>1,635</b>	<b>55</b>	<b>118</b>	<b>1,808</b>
<b>Expected timing of cash flows:</b>				
In the remainder of the spending review period to 31 March 2013	133	55	118	306
Between 1 April 2013 and 31 March 2018	532			532
Thereafter	970			970
<b>TOTAL</b>	<b>1,635</b>	<b>55</b>	<b>118</b>	<b>1,808</b>

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 equal pay claims (£18k 2011/12; £109k 2010/11) and redundancy (£100k 2011/12; £nil 2010/11). 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.

£30k is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011 £42k).

Leeds and York Partnership 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 2012	Year ended 31 March 2011
	£000	£000
Other (specify)	28	59
<b>Total</b>	<b>28</b>	<b>59</b>

Contingent liabilities represent excess payments not provided for on legal cases being dealt with by NHSLA, on the 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 and York Partnership 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 and York Partnership NHS Foundation Trust undertakes active financial risk management to manage its exposure to risk, particularly credit risk and treasury risk. Similar to general risk management, financial risk management requires identifying its sources, measuring it, and implementing plans to address them.

### 27.1 Financial assets - carrying amount

	Loans and receivables
	£000
Receivables	3,447
Cash at bank and in hand	21,888
<b>Total at 31 March 2011</b>	<b>25,335</b>
Receivables	5,123
Cash at bank and in hand	23,497
<b>Total at 31 March 2012</b>	<b>28,620</b>
<b>Ageing of over due receivables included in Financial Assets</b>	
Receivables overdue by:	
1-30 days	2,021
31-60 days	73
61-90 days	69
91-180 days	79
	<b>2,242</b>



# Annual Accounts

## 27.2 Financial liabilities - carrying amount

	Total
	£000
Payables	9,091
PFI and finance lease obligations	34,622
Provisions under contract	1,826
<b>Total at 31 March 2011</b>	<b>45,539</b>
Payables	<b>13,141</b>
PFI and finance lease obligations	<b>33,482</b>
Provisions under contract	<b>1,808</b>
<b>Total at 31 March 2012</b>	<b>48,431</b>

## 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 and York Partnership 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 and York 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 2012 are in receivables from customers, as disclosed in the Trade and other receivables note.

Leeds and York Partnership NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investors. Trust treasury activity is subject to review by the Trust's internal auditors.

# Annual Accounts

## 27.4 Financial risk management (cont)

### Liquidity Risk

Leeds and York Partnership 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 and York Partnership 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).

Leeds and York Partnership NHS Foundation Trust's main long term liability is its PFI obligation, with the contract ending in 2028. Further information on the commitments under this contract are provided in note 24.

### Market risk

Market risk comprises three elements: Foreign currency risk, Interest rate risk and Price risk.

### Foreign currency risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure, consequently exposure to currency risk is not significant.

### Interest rate risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities e.g. borrowing and financial assets. However a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds and York Partnership NHS Foundation Trust is not, therefore, exposed to significant interest rate risk.

### Price risk

As explained in note 24, Leeds and York Partnership NHS Foundation Trusts annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard. The annual adjustments are reflected in Finance Costs (contingent rent), Operating Expenses and Property Plant and Equipment Additions respectively.

For 2011/12 the percentage increase in the unitary payment was 4.86%, equalling to a monetary increase of £511,768. (4.4% £500,840 in 2010/11)

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%

2011/12 Uplift in Unitary Payment	Actual uplift at 4.86% £000	Uplift at 3.7% £000	Uplift at 5.5% £000
Recognised in Finance Costs	146	93	176
Recognised in Operating Expenses	278	212	315
Recognised in Surplus/deficit	424	305	491
Recognised in Property, plant and Equipment Additions			
	424	305	491
<b>Net impact of sensitivities on Surplus/(Deficit)</b>		<b>119</b>	<b>(67)</b>
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
<b>Net impact of sensitivities on Surplus/(Deficit)</b>		<b>126</b>	<b>(51)</b>

# Annual Accounts

## 28 Related party transactions

Leeds and York Partnership NHS Foundation Trust is a body corporate authorised by Monitor, the Independent Regulator of NHS Foundation Trusts in exercise of the powers conferred by the National Health Service Act 2006.

### 28.1 Related party transactions - members of the Board of Directors

During the period Leeds and York Partnership NHS Foundation Trust had the following material transactions with entities which are considered related parties to members of the Board of Directors of the Trust.

	Payments to Related Parties £000	Receipts from Related Parties £000	Amounts owed to Related Parties £000	Amounts due from Related Parties £000
<b>Leeds Mind</b>				
2010-11	127	-	-	-
2011-12	26	-	-	-
<b>Dearden Consultancy</b>				
2010-11	68	-	-	-
2011-12				

In 2011/12 the Trust had £8k of related party transactions with its charitable funds (2010/11 £15k).

# Annual Accounts

## 28.2 Related party transactions - UK Government ultimate parent

During the period Leeds and York Partnership NHS Foundation Trust had a significant number of material transactions with entities for which the UK Government is the ultimate parent, and so has control of. These entities are listed below:

	Income		Expenditure	
	Year ended 31 March 2012	Year ended 31 March 2011	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000	£000	£000
<b>Department of Heath as immediate parent</b>				
Yorkshire and Humber Strategic Health Authority	6,311	7,241	40	91
North Yorkshire and York Primary Care Trust	35,333	1,312	2,626	38
Leeds Primary Care Trust	112,713	101,573	216	390
Leeds Teaching Hospitals NHS Trust	479	375	2,817	3,067
South West Yorkshire Partnerships NHS Foundation Trust	1,311	1,228	301	108
Barnsley PCT	1,942	1,898	655	15
<b>Local Government</b>				
Leeds City Council	1,018	1,043	1,460	1,314
<b>Central Government</b>				
Department of Heath	410	70	596	30
<b>Total</b>	<b>159,517</b>	<b>114,740</b>	<b>8,711</b>	<b>5,053</b>

	Debtors		Creditors	
	Year ended 31 March 2012	Year ended 31 March 2011	Year ended 31 March 2012	Year ended 31 March 2011
	£000	£000	£000	£000
<b>Department of Heath as immediate parent</b>				
Yorkshire and Humber Strategic Health Authority	297	585	37	3
North Yorkshire and York Primary Care Trust	680	329	2,362	19
Leeds Primary Care Trust	118	135	86	123
Leeds Teaching Hospitals NHS Trust	115	78	655	512
South West Yorkshire Partnerships NHS Foundation Trust	113	79	92	43
Barnsley PCT	35		131	25
NHS Business Services Authority			233	234
York Hospitals NHS Foundation Trust	44	1	301	
<b>Local Government</b>				
Leeds City Council	135	64		
<b>Central Government</b>				
NHS Pension Scheme (Own staff employers and employees contributions)			1,527	1,208
<b>Total</b>	<b>1,537</b>	<b>1,271</b>	<b>5,424</b>	<b>2,167</b>



# Annual Accounts

## 28.3 Related party commitments (year ended 31/03/2013)

	Income
	£000
NHS Leeds	95,236
North Yorkshire and York Primary Care Trust	34,267
Barnsley Primary Care Trust	7,970
	<b>137,473</b>

The Trust has no expenditure commitments with related parties for the year ended 31 March 2013.

## 29 Third party assets

The Trust held £343k cash and cash equivalents at 31 March 2012 (2011: £153k) 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	519		2,002	
Balances with Local Authorities	1,874		2,498	
Balances with NHS Trusts and Foundation Trusts	1,121		1,889	
Intra Government balances	<b>3,514</b>	-	<b>6,389</b>	-
Balances with bodies external to Government	2,862	2,370	8,706	
<b>At 31 March 2012</b>	<b>6,376</b>	<b>2,370</b>	<b>15,095</b>	-
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	-

## 31 Losses and special payments

There were 24 (15 in 2010/11) cases of losses and 39 (32 in 2010/11) special payments totalling £113k (£58k in 2010/11) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

## 32 Events after the reporting period

There have been no material post balance sheet events.

# 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 ڈائورسٹی ٹیم سے 0113 2954413 پر یا ای میل [diversity@leedspft.nhs.uk](mailto: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](mailto:diversity@leedspft.nhs.uk)

## Bengali

যদি আপনি বাৎসরিক রিপোর্ট ট্যাব, a ডিও টেস, a বা ভাষায় a থবা a বা কোন ফর্ম্যাটে পেতে চান, a নমুনা করে ডা ডারসিটি টিমের সাথে যোগাযোগ করুন 0113 2954413 নম্বরে a থবা i -মেলে [diversity@leedspft.nhs.uk](mailto:diversity@leedspft.nhs.uk)

## Gujarati

જો તમને આ વાર્ષિક અહેવાલ બ્રેઇલ, ઓડીઓ ટેપ, કોઇ અન્ય ભાષામાં અથવા કોઇ પણ અન્ય ફોર્મેટમાં જોઇતો હોય, તો કૃપા કરી 0113 2954413 ઉપર કોલ કરી અથવા ઇમેઇલ કરી [diversity@leedspft.nhs.uk](mailto:diversity@leedspft.nhs.uk) પર ઇમેઇલ કરો

## Punjabi

ਜੇਕਰ ਤੁਸੀਂ ਇਹ ਸਲਾਨਾ ਰਿਪੋਰਟ ਬ੍ਰੇਲ 'ਚ, ਆਡੀਓ 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](mailto:diversity@leedspft.nhs.uk) 'ਤੇ ਈਮੇਲ ਕਰੋ।

## Kurdish

ئەگەر دەتەوێت ئەم راپۆرتە سالاڤە بە دێزێ برەیل، شریتی دەنگ، یان بە زمان یان فۆرماتێکی دیکە بۆ تۆ نەمادە بکەین تەکنیە لە زینگی ژمارە تەلەفۆنی 0113 2954413 یان ئیمیلێ [diversity@leedspft.nhs.uk](mailto:diversity@leedspft.nhs.uk) لێکەڵ تێمی جۆراوجۆری Diversity Team پەڕێنێ.

## Vietnamese:


Nếu quý vị muốn có bản báo cáo thường niên này bằng chữ Brail, hoặc bằng âm thanh, bằng một ngôn ngữ khác hoặc bất kỳ định dạng nào khác, vui lòng liên hệ với nhóm Diversity Team ở số 0113 2954413 hoặc thư điện tử [diversity@leedspft.nhs.uk](mailto:diversity@leedspft.nhs.uk).

## Russian

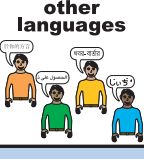
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## Polish


Jeśli chciał(a)by Pan(i) otrzymać sprawozdanie roczne pisane braille, 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](mailto:diversity@leedspft.nhs.uk)




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Please contact the Diversity Team by telephone; 0113 2954413 or by email; [diversity.lypft@nhs.net](mailto:diversity.lypft@nhs.net)



# Contact us

## Leeds and York Partnership NHS Foundation Trust

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Web: [www.leedsandyorkpft.nhs.uk](http://www.leedsandyorkpft.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](mailto: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.lypft@nhs.net](mailto:pals.lypft@nhs.net)

## Membership

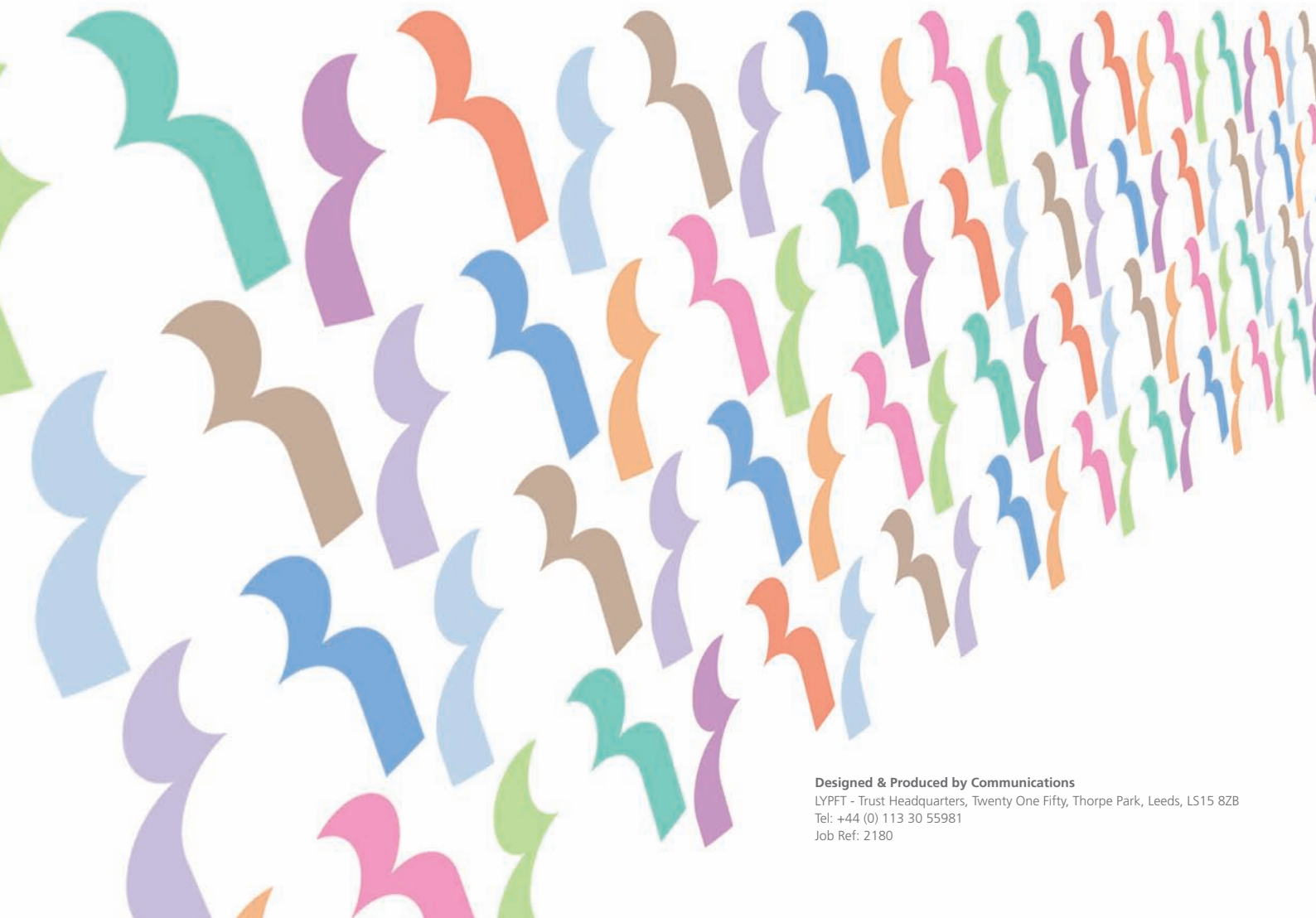
If you are interested in becoming a member of Leeds and York Partnership NHS Foundation Trust please contact:  
The Membership Office  
Tel: 0113 30 55900  
Email: [ftmembership.lypft@nhs.net](mailto:ftmembership.lypft@nhs.net)  
Web: [www.leedsandyorkpft.nhs.uk/membership](http://www.leedsandyorkpft.nhs.uk/membership)

## Communications

If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:  
The Communications Team  
Tel: 0113 30 55977  
Email: [communications.lypft@nhs.net](mailto:communications.lypft@nhs.net)

## Members of the Board of Directors and Council of Governors

Can be contacted by email at the addresses shown on our website at  
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