Leeds and York Partnership NHS
NHS Foundation Trust

Annual Report and Accounts

1 April 2012 to 31 March 2013

improving health, improving lives

Leeds and York Partnership NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS
1 April 2012 to 31 March 2013

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

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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, learning disability and substance misuse 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.

Bootham Park, York

Get me?

Get a better understanding of learning disabilities

Get me? campaign

Directors' Report

2.1 THE CHAIR'S ADDRESS

I am proud to lead a Board of Directors with a strong executive team and a diverse and challenging group of non-executive directors (NEDs) who engage directly with the daily work of our Trust and apply their unique blend of knowledge, skills and experience. Our Board is supported and challenged by a Council of Governors comprising 34 members covering 'all the bases', so to speak, across each aspect of our work. Their support to me has been invaluable and I was pleased to be re-appointed for a second three-year term from 1 April 2013.

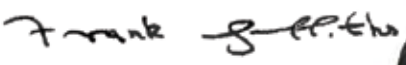
There have been significant changes to the Board's membership. Two of our NEDs, Linda Phipps and Niccola Swan, retired in January, and our current chair of the Audit of Assurance Committee, Allan Valks, will be retiring at the end of May 2013. I am grateful for their contribution to the Board and to the Trust as a whole. Two new NEDs have been appointed. Julie Tankard will be taking over the chairmanship of the Audit and Assurance Committee and joins us a senior executive at BT. Steven Wrigley-Howe joined the Board in February and comes from a private business and consulting background. We are currently in the process of appointing a third non-executive whose role will focus upon service user quality of care, a focus now highly significant in the post-Francis era.

The Executive Team has also undergone major change. Our Chief Financial Officer, Guy Musson, left to work in the private sector and was replaced by Dawn Hanwell. Michele Moran who was both Chief Nurse and Chief Operating Officer took up the position of Chief Executive at Manchester Mental Health and Social Care NHS Trust last November and we recently welcomed Beverley Murphy as Chief Nurse and Director of Quality Assurance. Dr Jim Isherwood joined the Board on the 1 September 2012. The changes in the executive team have allowed the Chief Executive to re-align the portfolios of directors this is described further in Part A Section 6 of this report.

Over the last 12 months the Board has concentrated on a number of themes. These include the consolidation of the integration of service between Leeds and York and parts of North Yorkshire; a major refresh of our corporate strategy and progress on key supporting strategies including estates, information governance and technology, and not least our workforce and organisational development strategy. The Board has also intensified its scrutiny of performance and we shall be implementing key aspects of the Francis Report's recommendations in coming months. We will also be strengthening our reporting systems covering both serious incidents and complaints.

An era of radical change in the NHS has commenced with the passing of the Health and Social Care Act. We have to be responsive to the changes clearly spelt out in the legislation and to the effect of their implementation. In addition there will inevitably be some 'unintended consequences' – not least regarding the role of competition and the significance of the 'any qualified provider' doctrine. Before the Act was given royal assent we implemented the open governance principles and both our Board of Directors and Council of Governors have been meeting in public for well over a year. Moreover before each meeting I engage directly with those members of the public present about the agenda and now regularly receive requests about what they would like to be considered within the meeting. We also utilise social network technology before, during and after meetings and receive both comments and questions via Twitter. Further innovations will follow over the coming year.

It is a truism to say that change is a constant but nonetheless it represents a major challenge to the NHS. We are determined not to be distracted in our core task of providing the best possible quality of care to our service users and support for those who care for them. We aim to be both financially strong and to be regarded by all who come into contact with us as a Trust which sets out to improve health and thereby improve lives. On that basis we look forward to the coming year.



Frank Griffiths

Frank Griffiths

Directors' Report

2.2 f trust

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

Our NHS

As I write this review the NHS is four days into its largest reorganisation in recent memory in terms of how it both commissions and provides services. Primary care trusts have been abolished with clinical commissioning groups coming into being. Strategic Health Authorities have been abolished, area teams have been established which are, in turn, part of the regional structure of NHS England.

Our Trust now relates to two area teams: North Yorkshire and the Humber, and West Yorkshire; and four CCGs, three in Leeds (with the Leeds North CCG taking the lead on mental health and learning disability services) and the Vale of York CCG. Broadly speaking 90% of our work will be commissioned by clinical commissioning groups with 10% being commissioned by NHS England.

Alongside this are new partnership structures, such as Health and Wellbeing Boards. Each of our local authority partners is taking a different approach to establishing their boards. In York we are a full member of the Health and Wellbeing Board; in Leeds the Health and Wellbeing Board's NHS representation is vested in the clinical commissioning groups.

At the same time Health Education England has come into existence. This organisation is responsible for commissioning from universities the under and post-graduate training of NHS staff and it has set up a number of Local Education and Training Boards (LETB) across England to oversee this. I am a member of the Yorkshire and Humber LETB and have been asked to chair the West Yorkshire Partnership Council, which will include all providers of NHS services in this particular area to inform the work of the bigger LETB.

The shape of research and development in the NHS is also changing. As part of its response to Innovation Health and Wealth the Department of Health is in the process of setting up Academic Health Science Networks across England. In Yorkshire and the Humber I am a member of a steering group involved in setting up our network. At the time of writing this we have submitted a business plan to the Department of Health which states three goals improving the health of the population; transforming health care and wealth creation. By the time this report is published we will know if our bid has been successful.

Why do I refer to this and what does it mean for us? My view is that if you are not involved in trying to shape any new system you really cannot complain later about how things work in practice and the impact this has on service users and carers. I see it as my task to ensure that the need to improve the health and lives of service users with mental health problems and learning disabilities and their carers is not lost in the middle of all the structural changes.

Our Trust

In my last report I referred to how 1 February 2012 marked the emergence of the new Leeds and York Partnership NHS Foundation Trust. As well as providing services in Leeds we also became 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. We also extended the range and scope of some of our tertiary services, such as Forensic Psychiatry.

You may recall that this was not a crude 'take-over' of these services. Our intention was to ensure that service users and carers did not experience any disruption to the provision of services. We would also adopt and spread what worked well for people and change what needed to be improved. I am pleased to say that the first objective was largely achieved. With regard to learning from each other and improving what we do it is hardly surprising that, given the complexity of our work across multiple service locations this is still work in progress.

Given all this change, and in the context of having to save 4 - 5%, year-on-year, it is hardly surprising that staff in the NHS are feeling strained. We are not immune from this. Our last staff survey showed that those who responded feel stressed at work and disconnected from the Trust as an organisation. Despite this, my colleagues' professionalism continues to ensure that thousands of service users and carers get the help and support they need each and every day. I am personally very proud and humbled to be associated with such dedication and commitment. Having reflected on the feedback from staff I have decided to take a fresh view of the evidence base of those things that make a positive impact on staff morale and their sense of affiliation to their employer.

At the same time I am working with my colleagues to change the style and tone of leadership and management; in short I think

Directors' Report

we need to do more listening and less telling. We need to work harder at respecting the commitment and expertise of our staff. This takes time, energy and a commitment to be different in our dealing with each other. Though times are hard in the NHS, because of our success as a 'business' we do have the space to do this – though there is no doubt that we are in an ever tightening financial environment.

Our plan for the future

During 2012/13 working with our governors and partners, we have looked again at our organisation's strategy. This will be formally launched later in 2013/14. There will be some changes to points of detail; however, our purpose remains unchanged. This places health and wellbeing at the heart of what we do and is stated as:

Improving health, improving lives

Linked to this is our ambition statement which is also unchanged and is:

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

This reflects our sustained commitment to enable people who use our services to achieve to the fullest extent possible the good things they wish for themselves. We know that we can only make this possible by working in partnership with others. Our ability to work effectively in a new and different landscape of stakeholders is therefore vital for service users and carers.

Our strategy summarises this as our three goals which are:

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

These infer that the Trust always needs to balance intervening in people's lives while always knowing that this is no more than a means by which we help people achieve their own broader aspirations of living life to the full.

As an organisation we aspire to provide high quality services. During 2012/13 we have looked at the implications of the two Francis reports, and shared some initial thoughts with the Council of Governors and Board of Directors. Our view is that both these reports have implications not only for acute hospitals but for every part of the NHS including our Trust. During 2013/14 we will develop a new supporting strategy with regard to quality. This will encompass a considered response to the Francis reports and will sit alongside other supporting strategies such as workforce, estates and facilities.

We have also looked at the recommendations to come out of the Winterbourne View Hospital Report into learning disabilities. We have considered how we will respond to each recommendation to ensure that our services are safe for the vulnerable adults who access them. This has included partnership working across health and social care in Leeds; undertaking internal inspections of our own services and providing assurance through our established professional forums.

Earlier in this report, I mentioned the need to save 4-5% every year. More money is coming into the NHS but, regrettably, this simply does not cover the increased cost of providing a service year-on-year. We remain firmly committed to continuing to improve the services we provide but at the same time we must also increase productivity whilst reducing costs. This is a big ask for everyone and is putting people under pressure, but we will do this in close collaboration with our staff, service users, carers and partners.

With our governors, we will also continue to challenge the stigma and discrimination faced by people with mental health problems and learning disabilities. We will continue to do this though media work actively campaigning against discrimination by taking our positive, yet challenging, message onto the streets of our cities and towns.

In summary we are here to:

- **Provide excellent quality, evidence-based, safe care that promotes recovery and inclusion**
- **Work with partner organisations to improve health and lives**
- **Value and develop our workforce and those supporting us**
- **Provide efficient and sustainable services**
- **Govern our Trust effectively and meet our regulatory**

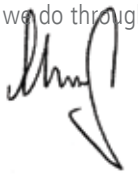
Directors' Report

requirement.

This has never been an easy thing to do and in some respects it gets harder each year. But we cannot run away from reality and experience shows that there are always ways in which we can improve. Whatever happens, we must continue to put quality at the heart of everything we do. We will always be a 'people organisation' and in this context we will demonstrate our shared commitment to the people who use our services, their families and carers, and to each other, by continuing to do our best to adhere to the NHS values:

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

In concluding I again want to take a moment to sincerely thank the staff, governors, and the members of the Board of Directors of the Trust for their professionalism and deep commitment to our work. We only do what we do through our common endeavour.



Chris Butler
chief executive

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 goals.

At the end of 2012/13 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, Julie Tankard, Dr Gill Taylor, Allan Valks, Keith Woodhouse and Steven Wrigley-Howe.

The Executive Team

- Chris Butler (Chief Executive), Jill Copeland (Director of Strategy and Partnerships), Dawn Hanwell (Chief Financial Officer), Dr Jim Isherwood (Medical Director), Lynn Parkinson (Acting Chief Operating Officer/Chief Nurse), and Susan Tyler (Director of Workforce Development).

During 2012/13 the following people also held positions on the Board of Directors:

- Guy Musson, Chief Financial Officer (resigned on 31 May 2012)
- Carole Greaves, Acting Chief Financial Officer (between 1 June 2012 and 31 July 2012)
- Dr Douglas Fraser, Medical Director (left the post on 31 August 2012)
- Michele Moran, Chief Operating Officer / Chief Nurse (resigned on 30 November 2012)
- Linda Phipps, Non-executive Director (came to the end of appointment on 31 January 2013)
- Niccola Swan, Non-executive Director (came to the end of appointment on 31 January 2013)

Further and more detailed information about the Board of Directors and its members can be found in Part A, 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.

We have used the Equality Delivery System (EDS), a framework developed through the NHS, to help us to assess our equality performance and to identify our equality priorities in 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 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

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'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 the consultation the following four-year equality objectives have been identified and are embedded within our business planning and performance monitoring processes:

- **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 / 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 while giving service users the opportunity to reach their full potential.

2.5.1 Disability and employment

Our recruitment and selection procedures take full account of the requirements of the Equality Act and associated public sector equality duties. We have committed to the Mindful Employer charter and through our annual health and wellbeing action plan we implement activities to further develop our Trust as a mentally healthy workplace. We are also a 'Disability ✓✓' employer, which demonstrates commitment to supporting people with disabilities to successfully attain and retain employment within the Trust.

We have recently established a Lived Experience Network for staff who have a lived experience of mental health problems. The network offers peer support for its members and is a way of consulting on the development and implementation of policies and activities that affect people with a disability.

We have supportive employment practices in place not only for those that we employ with a disability, but for those who may become disabled while they are working for us. These include a support package within the Employee Wellbeing and 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

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account of individuals' needs. Currently 4.5% of our staff have a declared disability based on a voluntary notification.

Our attendance procedures take account of individual needs related to disability and provide for disability leave as a reasonable adjustment to support people to remain in work. We have made reasonable adjustments to working environments through the purchase of specialised equipment and have made necessary alterations to premises in respect of access to buildings. In addition to this, our diversity training package aims to raise awareness of a wide range of diversity issues, including disability, to minimise discrimination in all aspects of employment. Diversity training is mandatory for all staff and is required to be undertaken every three years. This ensures that our workforce is aware of current legislative and organisational requirements and best practice. While 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 Part C of the document. Details of senior employees' remuneration can be found in the Remuneration Report in Part A Section 8.

2.9 OUR AUDITORS

2.9.1 External audit services

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.

All members of the PwC 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 Account. The cost of independent audits during 2012/13 is detailed in the table below:

Table 2A

Cost of statutory audits	
Annual Accounts	£45,889
Quality Account	£8,755

The Trust also requested PwC to carry out non-audit work in respect of other operational areas at a total cost of £44,979 during 2012/13.

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.

2.9.2 Internal audit services

Internal audit and counter-fraud services are provided by RSM Tenon for a period of three years

Directors' Report

until 31 May 2014. This contract was secured through a competitive tender process.

2.10 COMPLIANCE WITH THE CODE OF GOVERNANCE

The Board of Directors considers that, except where mentioned below, throughout 2012/13 the Trust has met the requirements of the Code of Governance. Non-compliance or limited compliance is reported below.

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 come to 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 E.2.2: - *"The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of 'senior management' for this purpose should be determined by the board but should normally include the first layer of management below Board level".* The Board has determined that the definition of 'senior management' should be limited to members of the Board of Directors only. All other staff remuneration is covered by the NHS Agenda for Change pay structure. In addition to this the Remuneration Committee does not agree the pension rights for executive directors as this is determined by the NHS pension scheme.

Code Provision G.1.6: - *"The Board of Directors should monitor how representative the NHS Foundation Trust's membership is and the level and effectiveness of member engagement. This information should be used to review the Trust's membership strategy, taking into account any emerging best practice from the sector".* This function is primarily carried out by the 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 the Leeds and York Partnership NHS Foundation Trust to make any such payments.

Our Strategy

3.1 OUR STRATEGY

In 2010 we launched our Trust strategy Improving health, improving lives. This was our five-year strategy which described what we want to achieve and how we planned to get there. The strategy is designed around the three key elements of quality: effective outcomes, safe care and positive service user and carer experience.

In 2012 we decided to refresh our strategy in response to the many changes which have happened both within our organisation and in the wider world around us. In particular, we wanted to make sure our strategy is relevant to the new communities we serve following our integration with mental health and learning disability services in York and North Yorkshire on 1 February 2012 and the formation of the Leeds and York Partnership NHS Foundation Trust.

Our strategy has at its heart the people who use our services, their families and carers. Development of our refreshed strategy has been led by our governors, with the support of people who use our services, carers, staff, our main commissioners and partner organisations. Our refreshed strategy was agreed by the Board of Directors on 28 March 2013 and will be formally launched at our Annual Members Day in September 2013.

A summary of our new strategy for 2013 - 2018 can be found on page 17.

We have three goals that very simply describe the outcomes to which we aspire for everyone who uses our services. They are the three things we believe will help us achieve our purpose and which we are passionate about realising. We have deliberately kept them simple so all our staff can keep a clear focus on them every day and in everything they do. For each goal we have criteria that we can measure, so that we will know when we have supported people to achieve their desired outcomes.

Our strategic objectives describe what we need to do to achieve our goals. They are the means by which we will achieve our goals. We are proud of the achievements we have made over the last few years; we know we have much more to do. Underpinning each strategic objective are the priority actions we will undertake to achieve our ambition and goals over the next five years.

For each objective we have set ourselves some measures of success: standards we want to achieve by 2017/18, and milestones to track our progress. Included are some new measures that reflect the breadth of services we now provide. We have also removed some measures included in our last strategy that are already reported as part of our regulatory regime, to organisations like Care Quality Commission and Monitor. All our measures will continue to be tracked through our governance framework to make sure we are on course in achieving them.

3.2 OUR VALUES

The values set out in the NHS Constitution underpin our strategy and the way we work with people every day. Our staff provide compassionate, high quality care that focuses on improving people's lives; they treat people with respect and dignity; they make sure that everyone counts by supporting people to achieve their individual goals; and our staff know the importance of working together with our partner organisations to make sure people get the best package of care and support to meet their needs. When occasionally we get this wrong, we do our best to address any individual complaints quickly and to learn from our mistakes.

We are already doing lots of things to embed the values in everything that we do. For example, we include the values in our annual performance review for every member of staff.

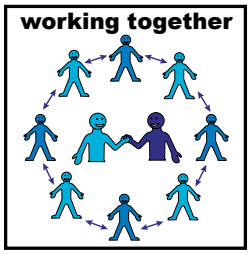
Garden of Tranquillity at the Mount

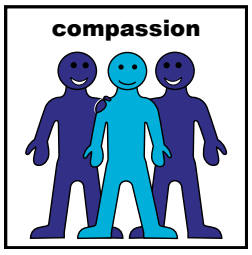
Our Strategy

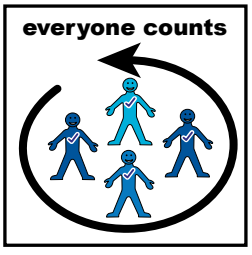
We also recognise those staff and volunteers, who demonstrate the values in their day-to-day work through a reward scheme called STAR. When we recruit new staff in our learning disabilities services, we ask them to show us how they will live the values in their role. We ask people to demonstrate how they live the NHS values in their annual appraisal. We continually seek new ways to further embed our values in the day-to-day life of our organisation, to celebrate our successes and learn from our mistakes.

Purpose	Improving health, improving lives					
Values	Respect and dignity	Commitment to quality of care	Working together	Improving lives	Compassion	Everyone counts
Ambition	Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives					
Goals	**1** People achieve their agreed goals for improving health and improving lives		**2** People experience safe care		**3** People have a positive experience of their care and support	

Strategic objective 1	**Quality and outcomes**	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	• Measuring and improving outcomes • Ensuring we meet people's needs through effective care planning • Implementing new approaches to support recovery and wellbeing • Developing new and existing services to meet people's needs • Making services better, simpler and more efficient • Improving services through research
Strategic objective 2	**Partnerships**	We work with partners and local communities to improve health and lives	• Building and maintaining successful partnerships • Campaigning against stigma and discrimination • Involving people in shaping their services
Strategic objective 3	**Workforce**	We value and develop our workforce and those supporting us	• Promoting a healthy culture and the NHS values • Developing our staff • Ensuring a healthy work environment
Strategic objective 4	**Efficiency and sustainability**	We provide efficient and sustainable services	• Delivering cost effective services and maintaining financial stability • Making best use of modern technology • Providing services from fit-for-purpose, cost-effective buildings • Implementing payment by results
Strategic objective 5	**Governance and compliance**	We govern our Trust effectively and meet our regulatory requirements	• Responding to national governance and compliance requirements • Developing our Board of Directors and Council of Governors
Measures of success	Measures of success for all goals and strategic objectives can be found on our Trust website		







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."

improving health, improving lives

Frank Griffiths
chair

Chris Butler
chief executive

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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. This is borne out in our strategy. Our principal activity is the provision of free healthcare to eligible service users and this section shows what we have done in respect of the services we provide.

4.1.1 The transformation programme

The aim of the transformation programme is to redesign 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 clinical and clinical-related services provided by our Trust.

Transformation is following an innovative approach using Lean Six Sigma methodologies. This determines 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 integrated care pathways that provide an evidence-based approach to the delivery of care to service users.

Integrated care pathway design puts the experience of service users and carers 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 improving the technology available to clinical staff. In addition we will use a range of methodologies to ensure processes used by staff are effective and efficient releasing more time to care for the service user.

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. In April 2012 Leeds mental health adult social care workers were integrated into the Trust. Joint working with Leeds City Council adult social care staff continues with the aim of implementing the principles of self-directed care and the use of personal budgets.

The transformation programme will deliver redesigned clinical services which do not discriminate in respect of age, gender, race, religion or disability. These will be based around integrated care pathways which will describe a logical and evidence-based standard of care that service users should expect to receive. Core and three needs-based integrated care pathways have now been developed and approved by our clinical governance processes. These will be integrated into the Trust's electronic clinical information system.

4.1.1.1 Community and alternative to hospital services

In June 2012 following analysis and redesign, a range of new services for adults of all ages were implemented. They included:

- **A single point of access for all referrals into the Trust**
- **Crisis Assessment Services for referrals that need responding to within four hours**
- **Three localities: south, west and east each including:**
  - **An intensive community service providing both home and building-based treatment**

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- A community mental health team
- A community learning disability team.

- City-wide services including:
  - A memory service including the Younger People with Dementia Team
  - Assertive Outreach Team
  - Community Forensic Team.

A review of the changes was conducted after three months resulting in a number of recommendations being made for areas where further work was needed. In addition a formal external evaluation has been commissioned and is now underway.

4.1.1.2 Inpatient services

All inpatient services across Leeds and York have been process mapped and analysed. This work has led to a number of projects being set up to redesign inpatient services. This work will take place between April 2013 and March 2014 with the aim of implementing changes from April 2014.

4.1.1.3 York and North Yorkshire

Following the formation of the Leeds and York Partnership NHS Foundation Trust on 1 February 2012, the transformation approach has also helped to review community and alternative to hospital services in York and North Yorkshire. This work is now being used to redesign those services.

Mapping of inpatient services has included York and North Yorkshire services along with Leeds services. All new projects will consider services across Leeds, York and North Yorkshire.

4.1.1.4 Managing risks

Transformation is a significant programme of work for the Trust which impacts on service users, carers and staff. It is important therefore that the programme identifies, assesses and manages risks and that actions are put in place to reduce or eliminate risks that could result in a negative impact on service users, carers and staff. The table below highlights examples of risks that have been identified and how the Trust is managing them.

Table 4A

Identified risk	Identified risk
One or more project objectives do not meet expected timescales.	Projects are monitored regularly and any delays identified at an early stage. Alternative ways to achieve the same outcome are developed.
Project outcomes are dependent on partners outside the Trust.	Project managers identify key stakeholders at an early stage and ensure they are involved in developing the project plan and can be signed up to the project's objectives.
Staff delivering new service models need support through the process of change and to acquire new skills.	Project managers are supported by Human Resources and Staff Development expertise to identify current skills and any new skills required; and to put in place skills development programmes.

4.1.2 Principal activities of the Trust

The Care Services Directorate includes those services that provide direct clinical services to our service users in Leeds, York and North Yorkshire. The directorate is made up of four clinical directorates:

- Adult Mental Health and Older People's Mental Health Services in Leeds
- Specialist Services in Leeds
- York and North Yorkshire Services
- Learning Disabilities.

Since the merger of services in Leeds, York and North Yorkshire in February 2012 we have reviewed our service structures to ensure these make best use of clinical expertise and management across both former organisations. This has resulted in four changes to the way our services are organised in that:

- Learning Disability Services are managed as a single service across Leeds, York and North Yorkshire

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- **Forensic Services are now managed as a single service across the organisation**
- **York Child and Adolescent Mental Health Services (CAMHS) has been integrated into the Specialist Services Directorate**
- **Formation of a single Adult Mental Health and Older People's Directorate in Leeds.**

We will continue to review our service structures to ensure these are delivered with lower overheads including management costs and estates costs. We will also ensure that the maximum available resources are given to the direct delivery of care to service users and support to their carers.

We understand that service users get most benefit from having direct contact with those people providing their care. We will therefore continue to harness opportunities to increase the time that clinical staff have to directly deliver care. We have been working closely with colleagues in our information department to improve the Trust's clinical information system (PARIS) to make this simpler for staff to use and less time consuming. We will also be taking advantage of the benefits of new technologies which will make mobile working a greater reality for staff. This will ensure our staff have the information they need to deliver high quality and safe care to service users at the time it is needed.

All the clinical directorates understand that we are one of many partner organisations who come together to provide care and services to service users. Having and maintaining strong relationships between these organisations will, we believe, deliver benefits for our service users. We will therefore continue to work collaboratively with both the newly formed clinical commissioning groups and other partners to plan and deliver joined up, effective and safe services which are recovery focused and deliver positive outcomes for our service users.

We are committed to developing our staff and ensuring they have the necessary skills, expertise and knowledge to continue to deliver high quality care. We know that for staff to work at their best they must have clear personal, professional and organisational goals and that appraisals are important to achieving this. In the last year we have increased the number of staff with a personal development plan and who have attended training. This is important to help them continue to provide effective and safe care, and we will continue to monitor and improve our position in this area.

It is critical that service users achieve their agreed goals for improving health and improving lives. In order to evidence that this is the case we will be further developing and introducing outcome measures for our services. These will be completed both by clinical staff and service users. We recognise that across the range of service we provide service users will need different measures. We will therefore introduce those measures which best meet the needs of our service users.

4.1.2.1 Adult Mental Health and Older People's Directorate

In the last year our adult and older people's services have come together to form a single directorate where services are delivered based on need rather than age. We have more work to do with some of our services to make sure they meet the service users' full range of needs and will continue to develop and refine these services. We will be continuing to review our Community Locality Teams and Intensive Community Services over the next year to make sure they are responsive to service users and provide high quality and safe community services focused on recovery.

The single point of access has been introduced to make sure that people can contact our services using a single telephone number. We believe that this has made receiving a service from us simpler and getting a response more immediate. Our aim to treat people within the community means that we will be looking again at providing a wider range of services to support people to be treated out of hospital and when they need to be admitted to hospital help people return home as soon as possible.

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 Assessment Services**
- **Intensive Community Services including the Mental Health Intermediate Care Team**
- **Younger People with Dementia Team**
- **Psychological Therapies**
- **Assertive Outreach Team**
- **Older People's Liaison**

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Mental Health Service (based at St James's Hospital)

- **Mental Health Inpatient Service**
- **Dementia Inpatient Service**
- **Rehabilitation and Recovery Services**
- **Healthy Living Service.**

Key achievements for the Adult Mental Health and Older People's Directorate during 2012/13

During 2012/13 the Working Age Adult Mental Health Directorate and Older People's directorate have come together to offer a full range of services based on service user need rather than age. In doing this we have worked hard to improve the services we provide and to enhance the service user experience. Some of these achievements are listed below.

- We have opened a new 17-bed rehabilitation unit at the Newsam Centre on the Seacroft Hospital site to provide a range of services for people who historically had to receive treatment outside of Leeds. The ward opened in June 2012 and we have gradually returned service users to Leeds over the year

- In recognition that people who used our services at The Mount and their carers had told us that they would like better access to an outside space we have developed sensory and therapeutic gardens for service users

- Over the last year we have merged the adult and older people's psychological therapies services into one service with a single service manager thus reducing management costs. The service will continue to operate more specialist services across the city while integrating most of the services provided with locality teams. A key aim remains to build psychological skills within community mental health teams including supervision and consultation

- We have continued to develop the skills of our staff working within dementia services including the use of the dementia mapping and roll-out of the Stirling University based training programme. This is a long-term commitment for the services and will continue throughout 2013/14

- Over the last year there has been much change within crisis resolution and intermediate care services with the formation of a single Crisis Assessment Service and the merger of mental health intermediate care teams, acute community services and home based treatment to form the Intensive Community Service. As well as this the Accident and Emergency Liaison Service and Self-harm Team have been devolved to form part of wider liaison service. We are committed to continuing to offer a wide range of alternatives to hospital admission and will continue to develop options for these services in 2013/14

- We have completed our work to centralise inpatient services for older people at The Mount to create a centre of excellence where we can build skills, knowledge and expertise in the care and treatment of older people. We will continue to develop our services in this central location in line with Trust values.

Some of the key priorities for the future for the Adult Mental Health and Older People's Directorate

There has been much work undertaken within the Adult Mental Health and Older People's Directorate to transform and improve the experience of service users across the care pathways. We are committed to an ongoing review of these changes to ensure they continue to meet the needs of service users and are sustainable. In the next year we will be working to form better defined teams within the existing localities to ensure that we are responsive to the needs of local communities. This review has begun and we are currently consulting with clinical staff across a range of professions to gather opinions on how best to do this.

During 2012/13 the use of out of area treatment beds has increased compared with 2011/12. We recognise this provides a less than ideal experience for service users and that remaining in Leeds provides benefits relating to continuity of care plans and maintaining support structures with carers, family and friends during a time of acute illness. We remain committed to ensuring that service users receive the right level of care at the right time in the right place. However, we believe that we should not admit people to hospital unless this is absolutely necessary.

We will be working hard over the next year to ensure that all our capacity across the acute parts of our services is best used and that people remain in hospital for as short a time as is clinically right for them. We have appointed a new clinical post to concentrate on working with wards and alternatives to admission services to make sure these fit together to best meet the needs of service users. We will also be reviewing accommodation services for people in hospital to make sure service users continue to have appropriate housing on discharge and that this is provided in a timely way.

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During 2012/13 much work has been undertaken to develop evidence based integrated care pathways (ICP) covering core elements of care, common mental health problems, psychosis and cognitive impairment. Over the next year we will introduce these pathways to ensure that fundamental standards of care are consistently delivered. The care pathways will allow bespoke packages of care to be developed for individual service users and will link to the care plan. It is important that we take time to ensure clinical teams and service users understand the benefits of the ICP approach and it is forecast that this will take a number of months to implement.

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 while 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 with which service users are comfortable.

Over the next year the directorate will work closely with key partners including the new clinical commissioning groups to influence the development of services. We believe that we will have a key role in delivering, for example, the Leeds Dementia Strategy and city-wide work on how services are provided for people with other long-term conditions.

4.1.22 Specialist Services Directorate

The Specialist Services Directorate is a collection of ten 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 2012/13 the directorate has continued to develop outcome measures and has undertaken a review of the Clinical Outcomes in Routine Evaluation (CORE) to help us make improvements in clinical practice. 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 for the Specialist Services Directorate during 2012/13

During 2012/13 the key achievements for the Specialist Services Directorate are:

- The completion of a full review of the Chronic Fatigue Service (CFS/ME) model and costing structure using Lean Six Sigma principles engaging with stakeholders and service users throughout the process. Service user feedback strongly supported the need for general medical input into the service and the recruitment of appropriate medical input is being pursued. The staffing skill mix was reviewed and new staff members recruited

- To ensure service users have stable and appropriate housing which is an important aspect to maintaining good mental health and recovery. The Prison In-reach Service has, over the last year, undertaken evaluation of the effectiveness of a dedicated intervention to support housing needs. The findings from this evaluation have been very positive with widespread support for continuation and potential expansion of the service

- The Gender Identity Service has worked in partnership with the service user volunteer initiative to develop the service user support group and the one-to-one support sessions provided by volunteers. This support is now available both in face-to-face sessions and through telephone support. A new 12-month strategy has been agreed and guest speakers have been identified for future groups

- The introduction of a community service for young people with learning disabilities and severe challenging behaviour by the CAMHS service in York. This has been highly successful in terms of keeping young people at home thereby avoiding disruptive, unsatisfactory and expensive out of area admissions for service users. Based on these outcomes the local authority and PCT agreed to fund this service for a further five years

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■ The Personality Disorder Clinical Network has been selected as the preferred partner for four Yorkshire and Humber Probation Trusts to support the requirements of the new offender personality disorder strategy. This represents not only a significant new source of investment for the service but also re-emphasises the innovative nature of the work of the network

■ The Clinical Support Unit provides a range of support functions to help our clinical teams deliver services. In the last year we have completed and implemented a redesign of administration services that work with and support our clinical teams. The service has also supported the development of new technology to improve communication with key partners.

Some of the key priorities for the future for the Specialist Services Directorate

The directorate will continue its drive to establish and promote outcome measures as a quality indicator for service delivery developing these for all services. Services will continue to grow to meet the needs of our new commissioners and recognise the changing requirements of service users and the skills of staff. The growth will include:

- **Development of an integrated service model to support the partnership bid with Carer Leeds**
- **Work with commissioners in the north of England to discuss the current waiting list for Gender Identity Services and future commissioning intentions**
- **Secure funding for a Community Alcohol Service**
- **Aim to open a sixth bed within the Perinatal Service**
- **Improve the bed occupancy in the Yorkshire Centre for Eating Disorders (YCED) by developing relationships with key stakeholders and creating a seamless care pathway between the YCED and North Yorkshire Eating Disorder Services.**

Directorate staff will be fully engaged in the principles of transformation and all services are being process mapped and evaluated to ensure that the best quality of care is delivered within the best staffing structures. A key change which occurred last year in the organisation of liaison services in the acute Trust's Accident and Emergency Department will continue to be reviewed to ensure that this service meets its key performance indicators.

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 clinical commissioning groups potentially reducing their out of area placement funding and non-urgent treatment approvals. The directorate needs to ensure it can evidence positive outcomes of treatment and effective marketing and promotion of services.

4.123 York and North Yorkshire Directorate

The York and North Yorkshire Directorate delivers community and inpatient services to adults of all ages. It also provides substance misuse service in the York, Selby, Tadcaster and Easingwold areas. Forensic community services and low-secure inpatient services are provided to adults in Leeds, York and North Yorkshire and to the Yorkshire and Humber region. All services will continue to strive to provide the highest quality safe care focused on achieving effective and positive outcomes for all service users. We will be actively continuing our review of how we can best organise and deliver these services taking into account the local needs of our service user populations.

Key achievements for the York and North Yorkshire Directorate during 2012/13

■ In the last year we have achieved the safe transfer of York and North Yorkshire services within the Trust

■ The directorate has actively engaged in the work required to bring it into a position of readiness for future Payment by Results commissioning for mental health. Staff have been trained in the completion of the mental health clustering tool and super-users have been identified in service areas and teams

■ We have, with support from the Transformation Team, undertaken a review of our community, Intensive Home Treatment and Inpatient Services. Work is ongoing following this review to develop models of care which support care pathways and take account of the needs of local populations. The review focused on ensuring that we have the right levels of capacity in the right place to meet

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demand and need ensuring rapid access for service users

- In November 2012 we received final agreement for the funding required to develop a new inpatient women's low-secure mental health service to enhance the care pathway for women within the low-secure service. We are now actively engaging in project plans to ensure that we can begin to provide this new service with a forecast start date in 2014

- We have undertaken a full review of the directorate skill mix within the last year to ensure that services which are delivered represent best value. As part of this review we have looked at administration support services, management costs and team skill mix including senior clinical posts. All reviews are either complete or are on track to complete by the end of the financial year

- Building on our successful work with the Kings Fund Enhancing the Healing Environment we will continue to review the effectiveness of our estates

- Ward 2 at Bootham Park Hospital successfully qualified for the Full Monty Award in March 2012. The award is given to wards that have implemented 75 star wards ideas, which provide practical ideas for improving the daily experience and treatment outcomes of acute mental health inpatients

- The Recovery Unit at Acomb Garth has commenced working towards accreditation for acute inpatient mental health services rehabilitation with the Royal College of Psychiatrists.

Some of the key priorities for the future for the York and North Yorkshire Directorate

The key strategic issue for York and North Yorkshire services is to ensure that we continue to deliver cost effective and service user-focused services that are well designed to implement care pathways. We will continue to work towards delivering our services focusing on the needs of local people while harnessing the opportunities available through foundation trust status. We will continue to work with commissioners to focus on ensuring that, where possible, money is spent within the local health economy, reducing the need for service users to access care outside of York and North Yorkshire.

- Having unified forensic services across Leeds, York and North Yorkshre within a single management structure, over the next year we will continue to work with the Specialist Commissioning Group to maximise the benefits of this increased critical mass to all forensic mental health service users

- By combining a number of support functions such as mandatory training, risk management performance management and complaints management we will endeavour to reduce our overheads. This will ensure that the maximum resource is made available to support the delivery of frontline clinical services

- There are benefits to the delivery of service user care in having efficient and effective clinical information systems available to clinical teams. The directorate recognises that this is an area where improvement is possible. However, there are also benefits to having a shared information system across primary and secondary care. As well as the need for a new system there is also a need to upgrade the existing equipment available to staff and we will be putting together a plan of how to achieve this. It is intended that this approach will realise the benefits available through mobile working for staff

- Over the next year, we will be developing a detailed proposal for the redesign of the Counselling and Psychotherapy Service ensuring a robust personality disorder pathway is in place. The new service will demonstrate clinical and cost effectiveness ensuring equity of provision based on need. We will consult widely on these proposals before submitting a final plan for implementation

- Maintaining people in their own homes and preventing unnecessary admission to hospital are key aims of our services. We are currently recruiting for posts to form a Care Homes Team in order to help us achieve this aim. The Care Homes Team will work with service users in care homes to work with and educate staff on how best to support service users with mental health needs. The team will also provide intensive support during periods of acute illness to prevent admission.

There are a number of risks and uncertainties that face the directorate in the next year. The first key risk relates to the achievement of the estates plan to support the delivery of quality, safe and local services for service users in York and North Yorkshire services. Secondly, we recognise that the current clinical information system will need to be significantly improved to meet the delivery of effective care. Without this the reporting requirements necessary to demonstrate the quality of services to commissioners and other key stakeholders of the quality of services could be compromised.

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The third risk related to the ability to modernise and improve service delivery structures in the year. This will require a wider cultural shift, and it is crucial that we design robust and sustainable service structures to meet the needs of our service users. The changes which it is anticipated will be implemented in the next year are a significant opportunity but also a potential risk. To minimise the risk we will continue to build a consensus amongst service users, staff and local partners to ensure that we have fully understood the full range of needs which services must meet.

4124 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 service is jointly managed across Leeds, York and North Yorkshire.

The directorate provides a range of health and social care services including community, 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 the Trust's single point of referral. Services are strategically driven by local and national policies and initiatives reflecting best clinical practice.

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.

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 for the Learning Disability Services Directorate during 2012/13

Our key objective during 2012/13 is one which is simply summed as 'to improve the Learning Disability Service' and we believe we have ensured that during the last year we have continued a successful cycle of service improvement. This improvement can be demonstrated through the following:

- Achievement of 'excellent' accreditation for our inpatient services

- Improvements in working relationships between Leeds and York services with shared learning between the services and the development of stronger working relationships with key partners in York and North Yorkshire through attendance at partnership boards

- Introduction of person-centred planning training across teams in York and North Yorkshire building key skills for staff

- Successful introduction of the learning disabilities clustering tool in preparation for future changes to commissioning arrangements.

We have also achieved the following:

- No service users have been transferred out of area within the last year within York and North Yorkshire. Our aim last year was to use Oakrise to return female service users from out of area placements to local services and within the last year we have supported our first admission to Oakrise with successful support

- Development of the White Horse View site at Easingwold has begun. We remain committed to offering a flexible, value for money service in the local area which is responsive to the needs of people with autism and those service users currently placed out of area. We will continue to engage the multi-disciplinary teams and local partners in the ongoing development of these plans

- A commitment to ensuring that all developments within the service lead to service improvements which can be outcome-measured in terms of benefits. We have commenced the process for the implementation of the productive community series to engage frontline teams in improving quality and productivity. The introduction was delayed while the service changes associated with the transformation programme were implemented. However, we have now reinvigorated the process and collaborative work with other regional services has been established

- Ensuring that service user involvement drives our development and have worked with Adult Social Care partners in developing the 'easy on the i' brand as the symbolic language system used exclusively in Leeds

- We have developed our workforce ensuring they are skilled and competent to meet the needs of service users. Two associate practitioners are now in post at Parkside Lodge and identification of interested parties for further intakes have been completed for next year. Our current rate of staff appraisal is at 87% and is one of the highest within the Trust. We are working with partners from Huddersfield and York Universities to offer

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placements for their undergraduate students in learning disability nursing.

Some of the key priorities for the future for the Learning Disability Services Directorate

- During 2012/13 we have been undertaking a full strategic review of our learning disability services to ensure these are well positioned to meet future challenges and opportunities. The review will be completed by April 2013 along with recommendations and an implementation plan. Implementation of these improvements and the necessary consultation that will be required will form a major part of the work of the directorate over the coming year

- We believe there is significant potential to use the integration of services between York and North Yorkshire and Leeds as a driver for improvement. Over the next year we will concentrate on embedding shared practice through a single clinical governance meeting and use this to improve outcomes for patients across all areas

- There are currently unused buildings on the site at Easingwold which can be developed to improve services for people with learning disabilities. Over the next year we will develop a clear understanding of the opportunities available and the work required to make these buildings fit for purpose. We recognise that this will require a clear commitment including clinical input which will be vital to the success of this service.

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. We believe that having strong and robust relationships with the new clinical commissioning groups across both areas will be crucial to delivering improved services and maximising best value and we will work to build these relationships. While making any changes within our services we will work with service users and carers to make sure that these are managed and happen at a pace with which the service users are comfortable.

4.2 HOW WE ARE USING OUR FOUNDATION TRUST STATUS TO IMPROVE CARE

We were authorised as a foundation trust (FT) in August 2007. Since this time we have made good use of the benefits of our foundation trust status, maintaining a strong financial position while making full use of our financial strength to improve services.

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 2012/13 we have used the benefits of being an FT in the following ways:

- Members and governors have continued to help develop the shape and direction of our services in York and North Yorkshire, especially around future scoping and planning of priorities

- We have developed a range of events run as 'Knowledge Cafes', which enable members and governors to have creative conversations about our future priorities

- 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. This year we have showcased our addictions service, The Yorkshire Centre for Eating Disorders, and our gender re-assignment service

- At the Annual Members' Day, in September 2012, we brought together our What's your goal? campaign with a key speech from Frank Bruno talking about stigma and mental health in sport. We were also able to introduce ideas for our new campaign Sharing Stories. Our members gave lots of feedback about our performance and had the opportunity to ask many wide-ranging questions

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

- Two of our governors have become ambassadors of our Get Me? learning disability anti-stigma campaign. The launch was accompanied by a short film that has been screened in a number of prestigious locations this year, and featured at the Leeds Film Festival

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

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

- Governors have been involved in the Patient Environment Action Team (PEAT) inspections, and have taken part in the pilot of the new scheme (PLACE)

- The Council of Governors has exercised its statutory duty and appointed two new non-executive directors and re-appointed the Chair of the Trust with effect from 1 April 2013.

4.3 SERVICE USER AND CARER EXPERIENCE

4.3.1 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 are in the process of implementing a standardised approach to receiving service user and carer feedback. This survey will allow people to comment on the care they have received and is to be fully implemented in 2013/14.

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 community survey and will be reporting the results in 2013/14.

The 2012 community survey was sent to 850 service users in Leeds, York and North Yorkshire. The response rate for both surveys was around the national average (38%) and included service users whose care is co-ordinated and planned using the Care Programme Approach (CPA).

The 2012 community survey showed that overall 62% 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, having an out of hours telephone number to call; and, when calling the number, getting the help needed. York and North Yorkshire services demonstrated a statistically better experience reported by service users and, as a result, a great deal has been learnt over the last year to improve the overall experience of people who use our services.

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 Account. Each of our service directorates has an action plan in place in response to the survey findings; 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 service user surveys:

- **Work with service users to gain their opinion about what makes a care plan understandable in terms of language and format**
- **Provide training for care coordinators in how to write in 'plain English'**
- **Provide an information leaflet for service users and carers outlining the purpose of a Care Programme Approach (CPA) review including the use of care planning to discuss more general progress**
- **Ensure all services have access to 'crisis cards' that can be given to service users with information on how to contact services out of hours**
- **Ensure all correspondence meets minimum requirements discussing medication and side effects**
- **Update our website to include information on medication.**

4.3.2 Public and patient involvement

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

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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:

- **Published a new magazine called Our Stories, offering hope to people who are experiencing a sense of despair**
- **Re-launched our service user network meetings**
- **Participated in a wide range of community events to challenge stigma and raise awareness around our campaigns.**

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 understanding of the service user experience, and a similar one for carers to complete. This will help us to form an accurate picture of the way in which our services are both perceived and understood by those who use them the most.

The development of the Involvement Leaders' Forum this year has led to a review of involvement, a workshop around stages of development, and a new approach to involving people at many different levels. Good practice in involvement has continued to be shared providing an opportunity to share this across York and North Yorkshire-based services.

4.3.3 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 the Advocacy and the Complaints Team and will make referrals to these services when appropriate.

During the period 1 April 2012 to 31 March 2013 the PALS Team handled 795 cases from across the organisation, compared with 783 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.

4.3.4 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. We aim to ensure that individual concerns are addressed and appropriate actions are implemented to learn lessons, to improve services and to help ensure there is not a recurrence of similar events in the future.

During the period 1 April 2012 to 31 March 2013 the Trust received 73 formal complaints including those from York and North Yorkshire services, compared with 56 formal complaints received in the corresponding period last year from Leeds services. 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**

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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.**

4.4 PARTNER RELATIONS

4.4.1 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.

4.4.2 Ambition works

We are committed to supporting our service users to access and retain 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 project within our adult community mental health services aims to embed vocational support within clinical teams through partnership working. Employment specialists from Leeds Mind are co-located within our three Community Locality Teams and actively support people with mental health difficulties to access appropriate training, voluntary work and paid employment
- In partnership with Leeds Mind, job retention specialists provide specialist support and guidance to ensure that people accessing our inpatient and community mental health services can retain their paid employment
- Our own Voluntary Services provide our service users with access to volunteering opportunities both within and external to the Trust.

4.4.3 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 Human Resources Department work in partnership with NHS Airedale, Bradford and Leeds, and Leeds City Council to support them in developing positive human resources practice in relation to Mindful Employer®
- The Carers Connections training programme that sits within the Leeds 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, Carer 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
- Football for Me: is entering into a third year of partnership with Leeds United Foudndation to increase access to community football for people using our services. Coaches run sessions in three localities within Leeds aimed at people with mental health difficulties. They are then supported to participate in either local community football clubs or the LUFC Ability Counts programme. Mental health awareness training is being provided for coaches and clubs. The programme will be fully integrated within Ability Counts
- The 2013 anti-stigma campaign, Sharing Stories has been established to raise awareness and reduce prejudice around mental health and learning disabilities. Partnerships have been made throughout Leeds, York and North

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Yorkshire to endorse the campaign messages. Partners include: Waterstones in Leeds and York, City of York Council, Leeds City Council, Selby Libraries, schools and universities and many more

- The Communications and Engagement Team has been working closely with Converge and St John's University to create a Love Arts Festival in York. Similar to the festival in Leeds, the programme of events will help raise awareness and encourage understanding around mental health and learning disabilities through art and creativity

- The Diversity Team has developed relationships with York Teaching Hospital NHS Foundation Trust in a bid to tackle health inequalities and encourage engagement

- The Volunteer Service has developed relationships with York University and St John's University to help encourage students to become volunteers and ultimately encourage understanding around mental health and learning disabilities.

4.5 CORPORATE SOCIAL RESPONSIBILITY

4.5.1 Engaging employers

We have worked with a variety of employers in a number of ways to support employers to increase their knowledge and awareness of mental health and learning disabilities and to promote anti-stigma work within their organisations. Below are examples of this work during 2012/13:

- We worked in partnership with Lloyds Banking Group to facilitate a day of volunteering within our services as part of their annual corporate social responsibility Give and Gain Day. Twenty staff volunteered within our older adults and dementia wards and feedback from the volunteers, our staff and people using our services was very positive. Briefing sessions were undertaken with Lloyds Banking Group staff prior to the event to increase their knowledge of dementia and the needs of older adults and how to apply best practice in their work. A number of the volunteers have stayed in contact with our services and regularly volunteer

- We have promoted our learning disability and mental health anti-stigma campaign messages to members of the Leeds City Region and York and North Yorkshire Chamber of Commerce.

4.5.2 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 2012/13:

- Our second Love Arts Festival (www.loveartsleeds.co.uk) took place last autumn with over 50 events during five weeks. The festival's aim is to raise public awareness of mental health and learning disability and contribute to a reduction of stigma and discrimination. We developed partnerships with 66 arts organisations and recruited 17 volunteers who supported our events. We made direct contact with an estimated 121,353 people over the course of the festival and reached an estimated 6,468,830 people through our media profile during that time. The festival was marketed heavily using social media – it has 900 Twitter followers and 2,625 friends on Facebook. We won a Health Service Journal Communicating Efficiency award for innovation and the wide range of people we reached thorough the festival. We are currently planning our 2013 festival with sister events taking place in the York area

- We were successful in our bid to the Arts Council to fund bespoke arts projects within forensic services at the Newsam Centre and learning disability services at Parkside Lodge. Our arts partners Pyramid of Arts and Artlink ran these very successfully and have secured funds to enable some of this work to continue

- We were successful in our bid to Leeds Inspired to enable our members to create new films and poetry. These were showcased at the Love Arts Festival and at the Leeds International Film Festival.

- Arts and Minds has expanded partnerships with a range of education providers to stimulate improved take-up of education. Following a successful partnership bid with us, Swarthmore Education Centre appointed an education outreach worker to provide in-reach taster courses into a wide range of our services. Leeds Art College has also provided four bespoke 10-week art and design courses in community venues for groups including women only and people with dementia. In September these courses were taken over by East Street Arts and Swarthmore Centre and continue to run successfully

- Arts and Minds has expanded the opportunities for individuals to display or perform their art. Our annual members' exhibition at The Light included 3D work for the first time; and we co-ordinated ten further exhibitions during the summer and throughout the Love Arts Festival. We have also started a new monthly 'Instrumental' event that gives our members the opportunity

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to perform music and songs. The funds raised from this are paying for monthly song-writing workshops and music sessions at the Newsam Centre. Our current membership has increased by 209 to a total of 890 members. We have engaged with 682 service users, 122 staff, and 140 members of the public through a range of creative networking events, training workshops, and presentations.

4.5.3 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 volunteer co-ordinator post is the first of its kind in the country. The role, which is jointly funded by the Trust and NHS Airedale, Bradford and Leeds, co-ordinates volunteers who take our anti-stigma messages to public events and festivals throughout the year.

In 2013 the Time to Change volunteer co-ordinator will be based in our organisation and will continue to develop initiatives such as the 'living library' as well as our web-based and social media presence. We are also developing a stronger focus on younger people, with a Time to Change project being run in partnership with Carr Manor Community School and Space 2 in the summer term.

In 2012 we ran an Olympics and Paralympics Games-inspired campaign, entitled What's your Goal? This explored the relationships between physical health and mental wellbeing. We attended events and festivals throughout the year to promote our campaign. We encouraged members of the public to set a goal for themselves and then represent their goal on a piece of bunting. We connected all the pieces of bunting together to create one collective goal, which broke the Guinness World Record for the longest line of bunting. We achieved this in December 2012 and showcased our achievement at a home game at Leeds United's Elland Road ground.

4.6 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 2013 we employed 3,330 staff, 459 bank staff and 250 volunteers.

4.6.1 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.

We have 250 volunteers within our services and during 2012/13 recruited over 50 volunteers from York.

We proactively request volunteer experience feedback through an annual questionnaire to inform the development of the service. Areas which have been implemented include mental health and learning disabilities awareness training for volunteers and a volunteer forum to exchange ideas and best practice to further improve the service.

In response to feedback from people using our services we have developed a partnership with the Leeds College of Music and recruited music student volunteers to share their talents across our services.

Volunteers continue to support a variety of services within the Trust including our Addiction Service, the Time to Change project and our Supported Living Services. Our volunteers have supported 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 way they contribute to improving the health and lives of the people who use our services.

4.6.2 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.

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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 merger with the York and North Yorkshire mental health and learning disability services has established Staffside input across the Trust.

Staffside has continuing involvement in Trust strategy development and workforce issues through involvement in the Workforce and Development Standing Group. Additionally we are successfully working 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. We also continue to support staff who are redeployed, in order to minimise any redundancies.

In January 2013 Staffside implemented a 'Bright Ideas' initiative which is an engagement opportunity for staff to give opinions and ideas about improvement and voice their views on their workplace.

Staffside also provide information and advice to staff through the development of an internal intranet page. They can be contacted by emailing staffside.lypft@nhs.net .

4.6.3 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 through internal communications. We are currently reviewing and updating our system to make it easier to use and more accessible

- '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 it

- 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

- We have 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

- 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 roadshows have informed staff of the change process. In addition, weekly communication briefings ask 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 this period of significant 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.

4.6.4 Our staff survey

4.6.4.1 Results from the NHS staff survey 2012

This is the tenth annual staff survey in which we have participated. For the 2012 survey the response rate was 46%. This is the first survey following integration with York and North

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Annual members day, 2012

Yorkshire services.
Table 4B, below, shows our performance in respect of response rate, and Table 4C shows the top and bottom four ranking scores as presented in the findings by the Care Quality Commission.

Table 4B

2011/12		2012/13		
Trust %	National average %	Trust %	National average %	Trust improvement/ deterioration (increase or decrease in % points)
53	54.5	46	51	-7

For the first this year we attempted to increase the response rate through the use of an incentive scheme for staff who completed the survey using a random selection process. We also encouraged staff to complete the survey using regular communications and team briefs via managers. However, neither of these methods proved successful as the response rate was lower than last year.

Some of the explanation for this is likely to be a combination of factors. These include being in the midst of significant change and service re-design across most of our clinical services while also implementing challenging financial cost reductions, both of which have had an unsettling effect on staff. We are also looking at how we feedback on the actions and work that comes out of the staff survey to ensure that staff value providing information via this channel.

We are improving how we engage with staff from board level to first-line managers and have started some work with an external organisation to assess our capacity and capability around organisational development and cultural change. Work will start in 2013/14. We are also re-launching engagement forums to allow managers to meet with senior managers and discuss key priorities and hot issues across the Trust. We are working in partnership with Staffside on a 'bright ideas' initiative and staff feedback which should improve communication. We are hopeful that through this work and other engagement activities both our response rate and scores will start to improve.

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Table 4C

	2011/12		2012/13		
	Trust %	National average %	Trust %	National average %	Trust improvement/ deterioration (Increase/ decrease in % points)
Top four ranking scores (we are in the best 20% of Trusts)					
Percentage of staff reporting errors, near misses or incidents witnessed in the last month (The higher the score the better)	97	97	96	93	-1%
Percentage of staff able to contribute towards improvements at work (The higher the score the better)	66	66	75	71	+9%
Percentage of staff feeling pressure in last 3 months to attend work when feeling unwell (The lower the score the better)	23	20	19	22	-4%
Support from immediate managers (The higher the score the better)	3.83	3.79	3.82	3.77	-0.01%
Percentage of staff agreeing that their role makes a difference to patients (The higher the score the better)	90	90	85	90	-5%
Percentage of staff suffering work-related stress in last 12 months (The lower the score the better)	32	33	48	41	+16%
Percentage of staff reporting good communication between senior management and staff (The higher the score the better)	24	29	25	30	+1%
Percentage of staff experiencing physical violence from patients, relatives or the public in the last 12 months (The lower the score the better)	18	12	25	20	+7%

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4.6.4.2 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 when refreshing the staff survey action plan for 2013/14.

The Trust's response to the 2012 staff survey is to focus on the four areas where the Trust has scored in the lowest 20% compared with other mental health and learning disability trusts. These are:

- **% agreeing that their role makes a difference to patients**
- **% suffering work related stress in the last 12 months**
- **% reporting good communication between senior management and staff**
- **% experiencing physical violence from patients, relatives or the public in last 12 months.**

Although the overall staff survey results for 2012 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. These include the changing national landscape of the NHS, local transformation, the impact of the integration of services from York and North Yorkshire and the wider general economic climate. All of these may account for some of the less positive outcomes of the survey. Work will continue within the Trust to address the areas where responses were poor and to seek to improve Trust performance in the 2013 survey.

Rather than develop further action plans the intention is to relate the results to some work underway to assess the Trust's capacity and capability around organisational development and cultural change.

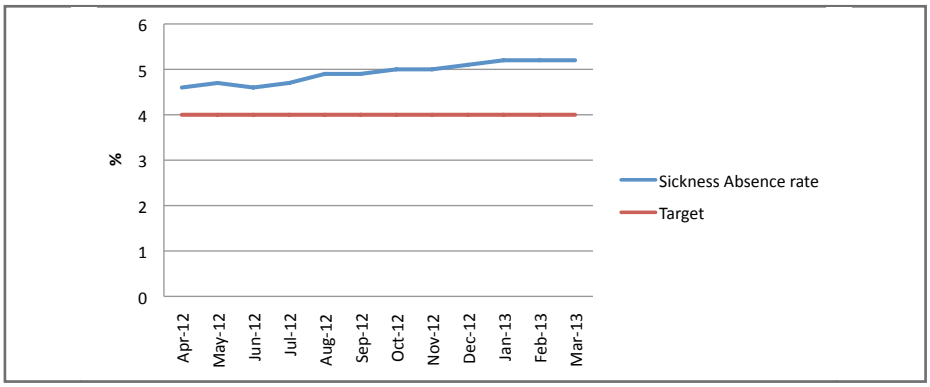
4.6.4.3 Future priorities and targets

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

- **Progress outstanding actions in the 2011/12 staff survey action plan, refresh the existing plan as necessary, monitor progress against the plan and ensure the outcome of the survey is communicated to all staff via a payslip mail shot**
- **Focus on those four key findings which fall in the lowest 20% of scores alongside any actions or outcomes which arise from the pilot organisational diagnostic work**
- **Gauge progress throughout the year by continuing to use barometer polls for key issues affecting our workforce.**

4.6.5 Sickness absence

Table 4D – Trust sickness absence Mar 12 - Mar 13



At the end of March 2013 the sickness absence rate was 5.2%, although our target was 4%. Compared with other trusts across the country our sickness absence rate is similar, but we are striving to improve attendance and to reduce costs wherever possible.

We have developed a new Employee Wellbeing and Managing Attendance Procedure which will be implemented on 1 April 2013. We have delivered a number of briefing sessions for managers to support the implementation of the new procedure. Our Health and Wellbeing Standing Support Group has been refreshed this year and we have undertaken an employee

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health needs assessment which will assist with the review of our health and wellbeing action plan. We are also planning employee engagement events early in 2013/14.

We introduced an Absence Case Review Group to focus on activity relating to attendance management and to ensure that staff are receiving the appropriate support and management when absent from work.

We also introduced an Attendance Management Task and Finish Group including service managers and Staffside representatives to consider and implement further action to support the management of attendance. Other proactive 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.

4.6.6 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, learning disability and community services trust. The team now provides occupational health services for 8,500 employees in the region and continues to operate service level agreements for external contracts.

During 2012/13 the main achievements included:

- **Introduction of a 'choose and book service' to reduce postage costs and did-not-attend rates**
- **Update of the management referral form to reflect the choose and book process and assist managers in asking questions relevant to specific cases**
- **Remote hosting of the occupational health database which allows access to occupational health records from all satellite clinics**
- **Introduction of digital dictation**
- **Integration of York and North Yorkshire employees**
- **Introduction of a one-year physiotherapy pilot from January 2013**
- **Rebranding of the Occupational Health Services**
- **Tuberculosis testing services brought in-house with the introduction of T-Spot testing, saving occupational health and employee time**
- **Integration of SWYPFT counselling services into occupational health**
- **Service level agreements and customer satisfaction maintained following increase in workload.**

4.6.7 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 2012 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.

This year saw us winning a bid to support the development of the organisational effectiveness and change management programme. This programme has been developed to support staff through change and transformation. There are several key interventions some of which are listed below:

- **Several e-learning products have been developed to include; resilience, team development, coaching skills and service improvement**
- **Increasing capability and capacity around coaching to support individuals, teams and managers**
- **Developing service improvement capability across care services**
- **Accredited leadership and management development programmes for staff bands 4-7**
- **Bespoke leadership programme for senior clinical managers affected by transformation**

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- **Customer service skills**
- **Dealing with change and personal transition.**

This year we have launched our Vocational Learning Hub. This demonstrates our commitment 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 help them provide 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 introduced apprenticeship contracts to new employees, supporting individuals to gain workplace experience and achieve nationally-recognised qualifications, while enabling us to support our workforce plan and the local population. We currently have a group of six staff who are working in our Specialist Supported Living Services. The pilot is being evaluated and consideration being given to a second group. We are also considering a group in customer service/ administration functions. Recently we won a Strategic Health Authority award for Apprentice Supporter of the Year; were highly commended in second place for Mental Health Service Employer of the Year; and shortlisted for a Leeds City Council award for the work we do to support our apprentices.

Our in-house training provider, the Andrew Simms 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. This year the centre has supported the medical revalidation and appraisal work by running a series of workshops.

4.7 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 (CTO)**
- **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 CTO.**

Prior to the transfer of services from York and North Yorkshire a 'task and finish' group was set up to ensure the MHA manager function was integrated across the Trust. As a result we made a number of changes in relation to the governance of MHA managers. A Mental Health Act Managers Governance Group met for the first time on 26 November 2012, chaired by Aqila Choudhry (non-executive director), giving a direct link to the Board of Directors. Other changes included:

- **An agreement to recruit further MHA managers to address diversity within the group**
- **An agreement on the term of office for MHA managers to align them with those for non-executive directors**
- **The approval of the terms of reference for the MHA Managers' Governance Group**
- **An agreement to carry out appraisals annually**
- **The harmonisation of remuneration across the organisation**
- **A review of the protocol for the conduct of Mental Health Act tribunal hearings across the Trust**
- **The establishment of training plans to ensure MHA managers are fully trained and competent for the role.**

Further work is planned on protocols for renewals of detention and extension of CTOs and the standard for hearings, which will conclude the harmonisation process of this group.

This year the MHA managers produced a report for the Board of Directors highlighting their activity in respect of managers' hearings and reviews for 2011/12. The report covering 2012/13 will be presented to the Board of Director during 2013/14.

There was an excellent response to the

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recruitment drive in the autumn of 2012 resulting in the appointment of 13 new MHA managers on 31 January 2013. They are currently in the process of being trained in the role. It is planned to hold a further recruitment drive towards the end of 2013.

We are appreciative of the time and commitment that MHA managers and non-executive directors acting as MHA managers have given this year, particularly during a time of significant change to the organisation. Once again we wish to thank our MHA managers for their dedication and the skill they apply when undertaking this vital role. In particular we would like to thank Robert Seymour, Chair of the MHA Managers' Committee for many years, for his support to the service and would like to wish him well on his retirement from the role on 30 April 2013.

The table below shows those people who have been MHA managers during 2012/13. This year has seen a number of changes in our managers and we would like to record our particular thanks to Kate Kershaw for her long commitment and dedication as a MHA manager and welcome the 13 new MHA mangers detailed in the table below.

Table 4E

Mental Health Act managers during the period 1 April 2012 to 31 March 2013	
Maggie Archer	Bernard Marsden
Enid Atkinson	Roger Mattingly
Chris Collins	Tom McGuffog
Brian Councell	Jennifer Patrick
Lindsay Councell	Anesh Pema
Kathleen Fenwick	Anne Rice
Roger Helm	Jenny Roper
K. Wendy Henry	Angela Senior
Jill Hetherton	Robert Seymour
Nancy Hill	Pat Varley
Ian Hughes	David Walkden
Brian Kemp	Mike Wash
Kate Kershaw *	Keith Wood
Heather Limbach	Michael Yates
Andrew Marran	
Non-executive directors also acting as Mental Health Act managers during the period 1 April 2012 to 31 March 2013	
Aqila Choudhry	Linda Phipps **
Niccola Swan **	Keith Woodhouse
New Mental Health Act managers appointed on 31 January 2013	
Kashif Ahmed	James Meehan
Nasar Ahmed	James Morgan
Judith Devine	Claire Morris
Pauline English	Sarah Roberts
Alison Herbert	Nicolas Smith
Lorna James	Thomas White
Peter Jones	

* Retired in December 2012
** Niccola Swan and Linda Phipps ceased to be non-executive directors on 31 January 2013 but continued to be appointed as Mental Health Act Managers

4.8 THE NHS CONSTITUTION

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

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:

- **Monitor requires 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 the 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.

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This is how we have done this:

Table 4F

Our strategy	NHS Constitution
Strategic objective 1 **We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing**	• **Access to health services** • **Quality of care and environment** • **Nationally-approved treatments, drugs and programmes** • **Respect, consent and confidentiality** • **Informed choice** • **Involvement in your healthcare and in the NHS complaint and redress.**
Strategic objective 3 **We value and develop our workforce and those supporting us**	• **Staff legal rights, pledges and duties** • **Staff expectations – how staff should play their part in ensuring the success of the NHS and delivering high quality care.**

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 in Part A Section 3.

During 2012/13 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
- Recognising those staff, including volunteers, who demonstrate the values in their day-to-day work through a reward scheme called STAR
- Held workshops for clinical staff to understand what the values mean to them and their work
- Our new appraisal and development scheme encompasses 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
- 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 2012
- Regularly reviewing service user experience feedback to understand whether they experience values-based behaviour from our staff.

4.9 SUSTAINABILITY

4.9.1 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.

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Table 4G

Area	Type	Non-financial information	Financial information
Greenhouse gas emissions	Direct greenhouse gas emissions	In **2012/13**[1] the Trust's Leeds sites consumed **13,244,042 kWh of gas,** which equates to **2,432 tonnes of CO2e**[3]**.**	In **2012/13**[1] the Trust spent **£244,890** purchasing gas[2].
	Indirect energy emissions	In **2012/13**[1] the Trust's Leeds sites consumed **5,402,333 kWh** of **electricity,** which equates to **2,834 tonnes of CO2e**[3]**.**	In **2012/13** the Trust spent **£231,166** purchasing electricity[2].
	Official business travel emissions	**Grey fleet**[4]**:** In **2012/13** mileage travelled by the grey fleet amounted to **2,416,880 miles.** This is a 100% increase on the previous year and reflects the merger of Leeds and York services into a single trust and the more rural distances covered across a segment of North Yorkshire. **Lease cars:** In **2012/13** there were **183 lease** cars: **Petrol: 83** cars contracted for **347,000** miles **Diesel: 97** cars contracted for **469,200** miles There is also **1 electric car** 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.	**Grey fleet:** In **2012/13** the Trust spent **£942,554** on mileage for the Grey Fleet. **Lease cars:** In **2012/13** the Trust spent **£113,046** on mileage for lease cars: **Petrol = £52,050** **Diesel = £69,996**
Waste minimisation and management	**Commercial waste**[5]**:** For **2012/13** the figures for commercial waste are as follows: • Total waste arising approx.: **141,000 kg** • **3,373,560 m3** of waste services were procured (**17%** less than 2011/12) • Waste recycled: **54% = 1,815,312 m3** of procured services • Waste to landfill or RDF6: **46% = 1,558,247 m3** of procured services • Waste incinerated: **0 kg**		**Commercial waste:** In **2012/13** the cost of disposing of commercial waste was **£22,479 - 26% less** than 2011/12
Finite resources	**Healthcare Waste:** For **2012/13** the figures for healthcare waste are as follows: • Total bulk waste: **75,450 kg.** This figure includes York properties. Of this: • **Waste landfilled** (offensive 18.01.04): **59,450kg = 78.9%** (2011/12 = 65%) • **Waste autoclaved** (infectious 18.01.03): **15,140kg = 20.1%** (2011/12 =34%) • **Waste incinerated** (sharps and pharmaceutical 18.01.03/09): **810kg (1.1%)** (2011/12 = 1%)		**Healthcare Waste:** In **2012/13** the cost of disposing of all healthcare waste was **£33,422.** The above figure includes all bulk and non-bulk collections and represents a 10% reduction in overall costs for HCW compared with the 2011/12 and also the inclusion of 8 new sites in York.
	In **2012/13*** The Trust consumed **30,450m3** of water and sent away **28,928m3** in the form of sewage.		In **2012/13*** the total water and sewerage cost was **£83,570**

1 These are the final figures for 2012/13, but include estimates for gas for the final month (March 2013) in lieu of bills from the various gas suppliers. The figures include Trust-managed and leased sites as well as eight PFI sites from which we operate. Leeds sites only are included.
2 Financial figures for gas and electricity do not include six PFI sites where the cost for procuring utilities sits with the SPV and is not recharged to the Trust. The Trust has not been supplied with PFI utilities costs this year.
3 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.
4 Grey fleet = employee-owned vehicles used for Trust business purposes (home visits, meetings, conferences, etc).
5 Because of the neighbourhood collection vehicle nature of commercial waste collections it has not been possible until very recently to accurately estimate weights for recycling report purposes. Therefore the recycling % is based upon volume in m3 procured for each site, based on assumptions that bins are generally full when they are serviced.
6 From October 2012 all trust waste classified as 'general waste to landfill' has undergone a mechanical separation whereby cardboard, paper and plastics incorrectly disposed of have been further removed for recycling. The remaining waste is then bailed and sent to Denmark for incineration in approved waste to energy plants. The waste is now therefore classified as RDF (refuse derived fuel) and not as landfill waste.

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4.9.2 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. The past 12 months have seen considerable effort put into monitoring the impact of changes in waste handling and disposal made over the previous 12 months. The impact of recent initiatives aimed at influencing staff travel behaviour to and from our sites has also been the subject of increasing focus. A number of site-based travel plans have been submitted in support of planning applications. More recent plans commit the Trust to implementing more ambitious initiatives aimed at reducing single-occupancy car journeys to many of our sites. This improvement in monitoring our results will allow us to measure 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 estates strategy is an evolving document and has undergone significant revision over the course of the last 12 months. Any plans to make changes to the Trust's estates portfolio will be reflected in the Trust's Carbon Management Plan. This also states the requirement to ensure that any new buildings are commissioned to a high environmental standard. In addition, the Trust is working hard to maximise the value of its PFI buildings, enabling more services to be located at these sites and so allow an assessment made in respect of older and less efficient buildings across Leeds.

The incorporation of the mental health services element from sites previously managed by NHS North Yorkshire and York into the merged Trust in February 2012 led to a number of opportunities for operational improvements in waste handling at York sites. These have already (or will shortly) realise savings that can be achieved in a relatively short space of time. As an example, improvements in healthcare waste segregation, handling and disposal were implemented in York in 2012. Allied to further improvements in Leeds, as a result the Trust has been able to absorb the cost of disposal of healthcare waste from eight new sites in York without any increase in overall costs. Segregation and recycling are also to be introduced in the coming two months into York sites, with a commercial waste service which it is expected will reduce waste costs by over 30%.

It is hoped that 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. However, much of this is dependent upon as yet unknown developments as a result of the creation of NHS Property Services and the transfer of the buildings in York to our Trust.

In 2013/14 we anticipate seeing good environmental and financial returns from a number of initiatives which continue to be implemented now and 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. This started in 2012/13 and is continuing into the coming financial year**
- **Continuing the implementation of travel plan initiatives for St Mary's Hospital, Aire Court and the redeveloped Asket Croft, many of which will benefit staff across the Trust. For example, the cycle loan and carshare schemes will complement the already existing public transport discount scheme. The Trust is investigating the feasibility of piloting a fleet of electric bikes, supported by low-carbon pool cars at one of its sites as an initiative aimed at reducing the need for staff to bring their own car to the site. The success of this, if implemented, will be carefully monitored**
- **100% implementation of Trust-wide recycling to include PFI third party-managed sites. Three large PFI sites still do not have effective recycling in place and discussions continue into how this can be implemented to the satisfaction of all parties**
- **Opportunities from within the transformation programme for estates efficiencies and further potential rationalisation, in particular getting more out of the buildings already occupied.**

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4.10 CONFIDENTIALITY OF INFORMATION

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

4.10.1 Monitor reportable incidents

In line with reporting requirements the Board of Directors is satisfied that an analysis of our information governance incident reporting records for 2012/13 contains no incidents which have either a volume or severity that would classify them as a serious incident, reportable to Monitor and the Information Commissioner's Office.

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

Table 4H – Summary of other personal data related incidents in 2012/3

Category	Nature of incident	Total
I	Loss of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	2
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	9
V	Other	0

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).

4.11 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, while we endeavour to provide a welcoming friendly environment for both service users and staff. We have a nominated non-executive director for security management. 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 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

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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.

4.12 COUNTER FRAUD

The Local Counter-Fraud Specialist (LCFS) service in 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 has a large integrated team with accredited and experienced LCFS personnel.

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 2012/13

4.13 FINANCIAL PERFORMANCE

The Trust's financial performance during 2012/13 was strong. It was set to be a challenging year as the Trust planned to maintain its good track record of generating a reasonable level of surplus to support future investment requirements. This was in the context of the increasing financial pressure on organisations recognising the scale and pace of change that would be required. The outturn position was better than was anticipated, with a surplus of £4.269 million being delivered against a plan of £3.2 million. This is a consistent year-on-year achievement (prior year surplus being £4.475 million),

Overall financial management performance and assessment of financial risk is measured by Monitor the independent regulator of foundation trusts. A range of key indicators are used and each is scored and aggregated on a scale of 1 to 5 (1 representing very poor financial performance and a high risk organisation and 5 representing the best performance and lowest risk). As a sign of good financial health Monitor expect foundation trusts to remain a minimum risk rating of 3. The Trust maintained its good record of achieving an overall financial risk rating of 4 for 2012/13 in line with the financial plan.

Table 4I below show the calculated risk rating. The two individual metrics which were much better than we planned were the surplus margin and liquidity. The surplus margin is better than expected predominantly because during the year we received more income for our services than we planned and we controlled our costs well. We also reduced our capital expenditure plan during the year. Both of these factors contributed to the cash and overall liquidity being higher at the close of the financial year.

Table 4I

	Metrics		Rating	
	Plan	**Actual**	**Plan**	**Actual**
Achievement of plan: EBITDA	100%	116.6%	5	5
Underlying performance: EBITDA margin	6.4%	7.2%	3	3
Financial efficiency: return on assets	4.4%	7.4%	5	5
Financial efficiency: surplus margin	1.8%	2.9%	3	4
Liquidity	20 days	34 days	3	4
Overall rating			**4**	**4**

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4.13.1 Income from activities

Table 4J

Revenue from patient care activities	Year ended 31 March 2013		Year ended 31 March 2012		Movement
	£000	%	£000	%	£000
Leeds PCT	96,423	62%	111,619	69%	(15,196)
NYY PCT	31,185	20%	34,365	21%	(3,180)
Yorkshire & Humber Specialist Commissioning	14,481	9%	1,060	1%	13,420
Other PCT's	2,493	2%	3,926	2%	(1,433)
Leeds City Council	993	1%	1,008	1%	(15)
Income for Social Care Clients	7,410	5%	7,230	4%	179
Other Commissioners	2,029	1%	3,079	2%	(1,049)
Total revenue from patient care activities	**155,014**	**100%**	**162,287**	**100%**	**(7,273)**

The table above shows the income we received for our patient care activities, split between commissioners, with the prior year for comparison. Overall the income decreased by £7.3 million (around 4%) year-on-year (taking into account that the prior year comparator included full year figures for services that transferred into the Trust on 1 February 2012).

This reduction reflects a combination of factors including the effect of the national negative inflationary adjustment to contracts of 1.8 %, and that 89% of our income in 2012/13 was from block contracts (the level of income is fixed whether the volume of activity varies during the year). In 2012/13 some of the services we provide transferred from our main local commissioner's responsibility to the responsibility of Yorkshire and Humber specialised commissioners. These were Perinatal, Eating Disorders, Forensic Low Secure, Child and Adolescent Mental Health Services (CAHMS) and explains the increase in-year.

In addition there was a change in responsibility for Forensic Low Secure out of area treatments where the commissioners took back responsibility for this service which reduced the income to the Trust by £4 million. This had a corresponding impact on expenditure (see note 5 in Part C 'Purchase of healthcare from non-NHS bodies').

In 2012/13 the Trust also received a total non-recurrent investment of £5.7 million from NHS Leeds (in the previous year it had received around £4 million). This was primarily to support the transformation programme, transition linked to repatriation of locked rehabilitation services, and some IT investment. 2.5% of our overall patient care income is dependent on delivering CQUINs (Commissioning for Innovation and Quality). At the start of the year we agreed a number of stretch targets in areas of service which demonstrate continuing improvement (referenced in the Quality Account in Part B of this report). We achieved all these indicators and £2.3 million was paid to us in relation to these from our various commissioners.

Other operating income

The Trust also receives other sources of income for a range of functions and services linked to but not directly attributable to patient care. These include primarily education and training, research and development, some services to other NHS bodies and a number of non-clinical activities for example income linked to hosting the North of England Collaborative Procurement Consortium. Broadly, this type of income is matched by an equal amount of cost, so any increase in income during the year has a similar amount of expenditure.

Over the year the most significant increase was in research and development. This is partly attributable to the integration of York and North Yorkshire services, and also ongoing success in attracting funds for the wide range of projects we undertake.

There was a non-recurrent amount of £2.1m reported within the income figures resulting from the revaluation of estate, due to reversal of previous impairments.

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4.13.2 Expenditure

Year-on-year expenditure (our operating costs) remained reasonably stable overall, with a marginal net decrease of approximately 0.5%. There were some individual material items and variances within this, but the key expenditure categories were kept under strong control reflecting the good financial management of the organisation and the continuing drive for productivity and efficiency.

Pay

There was no national pay award in 2012/13. The overall pay bill stayed reasonably static year-on-year, showing a very small decrease (less than 0.5 %) after taking account of £5.3 million cost improvements linked to transformation and other efficiencies, offset by agreed developments and pressures.

The agency spend for the year was £2.2 million which was consistent with the previous year. The Trust is consistently trying to reduce this spend. A significant in-house recruitment exercise to increase the availability of bank staff will positively impact on agency usage going forward.

During the year the Trust ran a Mutually Agreed Resignation Scheme (MARS), which is a nationally agreed scheme. The impact of this has been to enable ongoing staff cost efficiencies of over £0.5 million recurrently. There were also some staff-related one-off costs linked to redundancies (shown separately in the accounts) of £0.9 million which were agreed as a consequence of the service transfers from York and North Yorkshire.

Non-pay and other expenditure

Overall expenditure was reasonably static year-on-year. The main changes were linked to corresponding variances in income, predominantly the most significant of which was research and development costs £1.2 million.

The other major year-on-year change was linked to the revaluation of the estate. There was a significant impairment of £2.9 million included in non-pay. This was predominantly offset by £2.1 million reversal of impairment (as noted in other operating income).

Efficiency targets

The NHS as a whole is set annually challenging efficiency targets due to the need to meet year-on-year increases in demand which outstrips the resources available. The national target is approximately 4% every year but is variable for individual trusts. The efficiency target for this Trust in 2012/13, in order to meet its overall financial plans was 4%, equating to £6.7 million. Overall the Trust over achieved this target delivering £6.9 million, predominantly through service transformation in Leeds community based services which delivered slightly ahead of plan. The balance of cost savings were generated from a wide range of other pay related efficiencies linked to different ways of working.

4.13.3 Capital expenditure

At the beginning of the year we had a significant capital investment programme estimated at approximately £7 million. However, during the year we undertook two significant strategy reviews around our estate and use of technology, in response to emerging issues, linked to the wider Trust strategy and direction. This has delayed some expenditure intentionally and without detriment to our services. It has also meant that some expenditure will not proceed as previously planned and we will be able to use the resources differently. The actual capital expenditure was £2.1 million, and the main categories of this investment are shown in the table below.

Table 4K

	£ million
Estates	0.32
PFI	0.35
IT	0.67
Service strategy	0.81
Other	0.02
Total	**2.17**

The estates spend during the year was in relation to operational and statutory requirements for back-log maintenance, fire health and safety. A large proportion of the information technology spend was in relation to the computer replacement programme and rolling out of mobile devices and Wifi to support the transforming services and new ways of working.

The main change to our plans in year was the decision to review the large single development on the Seacroft site, and instead review separately the individual service needs. This was also partly because after discussions with commissioners it became clear that more time was required to specify in greater detail the requirements for inpatient learning disability services in Leeds. Due to these changes a small proportion of the capital expenditure incurred in the year was subsequently impaired as the scheme as previously planned was not progressed. The largest scheme which was delayed by this process but which is proceeding in 2013/14 is the Yorkshire

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Centre for Psychological Medicine, currently an 8 bedded unit which we intend to expand to a 14-bed service. Some of the slippage in information technology was linked to the review of the clinical information system requirements which again will be proceeding in 2013/14.

4.13.4 Cash

At 31 March 2013 the Trust held a £31.7 million cash balance, which was an overall increase of £8.2 million on the previous year. As a foundation trust, we recognise the importance and emphasis on our overall liquidity, so that we can meet our financial obligations on a day-to-day basis. This is also a key measure for our regulator and is one of the metrics that they use to assess financial risk. The Trust has the ability to meet its commitments in the short term and does not utilise a working capital (overdraft) facility to support its liquidity rating. Building up cash reserves is important as it allows the Trust to develop new services and invest in the estate and technology without the need for borrowing.

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 in low risk deposit accounts with either United Kingdom commercial clearing banks or the HM National Loans Fund.

4.13.5 Outlook for the future

The national economic situation, the increasing demands on NHS and other public services generally linked primarily to the aging population and other demographics, is undoubtedly challenging. There are other external drivers linked to the reforms in the Health and Social Care Act 2012; the impact on commissioning landscape; the competition and integration agenda (commissioner landscape, competition and integration); increased regulation and the requirement to evidence and demonstrate quality and outcomes for service users. These factors are all impacting on how the Trust sets its strategic direction and its financial strategy for sustainability and business development, going forward.

For 2013/14 despite the significant change in the commissioning landscape and responsibility, the Trust has negotiated and signed all its main contracts. Therefore we have a high degree of certainty on income, of which 94% is tied to block contracts. The overall financial plan for the year is robust. Resources have been aligned to need and cost pressures and incremental drift fully funded. The cost improvement plan is challenging at £7.2 million but there are clear plans in place to deliver this. In addition a contingency reserve has been set aside to manage in-year risk. The capital programme for 2013/14 reflects the operational and strategic requirements for the year. It is realistic and affordable within existing resources.

Beyond 2013/14, not uncommon with other NHS organisations, the financial planning is increasingly difficult. The current working assumptions of contract deflation and cost pressures generate an ongoing requirement to meet 4% efficiencies. Plans are in place for the two years beyond 2013/14 but the certainty of how some of these will be delivered is less formed at this stage. Predominantly the Trust is driving transformation, workforce changes, better use of its estate and increasingly the enabling use of technology to underpin its plans. Anticipated investment in estate and technology going forward should be achievable as the Trust has a strong cash reserve. However, we also understand the increasing emphasis on liquidity in measuring financial risk and the level of fixed cost debt that is tied into PFI contracts. This is an area of risk and opportunity the Trust is exploring.

In addition to the known financial challenges the Trust also faces the prospect of significant changes to the method of contracting through the introduction of payment by results in mental health services. There have already been delays nationally with this implementation and there are clearly a number of issues and risks associated with this. However fundamentally the Trust supports this general direction of travel as it aligns resources to need along an integrated care pathway and is linked to outcomes supporting the service transformation work with which the Trust is involved. There is some risk also attached to the information requirements that support such a change, but the Trust is working actively on this and is reviewing its information strategy.

The Trust also recognises that it is unlikely to meet the financial challenges ahead without working closely with partner organisations both in the public and independent sector. This is a key strategic theme.

4.13.6 Exposure of the Trust to financial risks

Price risk - The Trust has relatively low exposure to price risk. This is for three main

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reasons. Firstly, salary costs are the single biggest component of our costs. Staff will receive a maximum 1% on average inflationary pay award for 2013/14. This also applies to senior managers pay. For 2014/15 and 2015/16 our financial plans assume a stable pay award of 1%. With regard to non-pay our plans assume a similar level to the rate of increase in the consumer price index. Secondly, income assumptions are set out each year through the business and planning arrangements for the NHS mandated 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 1.5% per annum have been factored into our plans after 2013/14. 2013/14 already includes a 1.3% deflator.

Finally, most income is received on a block contract basis rather than 'pay as you go' and it is unlikely, for the significant part of our income that this will change quickly. As noted there have been national delays in the implementation of a tariff system for mental health. When this does actually come in it will need to be managed carefully due to unintended risk for commissioners and providers.

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 clinical commissioning groups and NHS England, which in turn are financed from money received from parliament. Assumptions about future income have been revised to take into account 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 Trust has modified its capital expenditure plans, and has a robust approach to investment appraisal including risk issues.

4.13.7 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 Part C of this Annual Report.

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Income disclosure

The Trust is required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012) to ensure that income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has met this requirement in 2012/13. The Board of Directors therefore declares that there has been no material income other than from the provision of goods and services for the purposes of the health service in England. Any benefit is re-invested in the provision of those services.

4.13.8 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 by the Executive Team and the Board of Directors to ensure there is an understanding of the key assumptions being made and the impact on the Trust's financial risk ratings.

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

The Board of Directors and the Council of Governors receive regular information regarding financial performance; the Board of Directors on a monthly basis and the Council of Governors five times a year. A monthly performance report which highlights performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives the information and is provided with an explanation to give assurance on the financial position and that the Board of Directors is meeting its terms of authorisation (soon to be the licence).

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. We provide bespoke training as and when required to budget managers.

4.14 REGULATORY PERFORMANCE

Information about our non-financial performance, our regulatory ratings and performance against national standards and targets can be found in the Quality Account in Part B of this Annual Report.

Jonathan Butler, service user governor

Tricia Thorpe, Time to Change volunteer co-ordinator

Council of Governors

5.1 COMPOSITION OF THE COUNCIL 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 28 March 2013 Monitor authorised a change in our Constitution. One of the ways in which the Constitution changed was in respect of the composition of our membership constituencies, and therefore the seats on the Council of Governors. We also took the decision to reduce overall the number of seats on the Council. The tables below show the composition of the Council from how it looked at the start of 2012/13 to the new makeup as at the 28 March 2013. We made interim arrangements in our Constitution to ensure that there was as little impact as possible on the individual governors in post at the time of the change and no elected governor had to step down as a result of these changes.

Table 5A Establishment as at 1 April 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 Local Medical Committee	1
York Local Medical Committee	1
Leeds City Council	1
City of York Council	1
North Yorkshire County Council	1
TOTAL	**47**

Table 5B – Establishment from 28 March 2013

Constituency name	No of seats
Public: Leeds	6
Public: York and North Yorkshire	3
Public: Rest of England and Wales	1
Service User: Leeds	4
Service User: York and North Yorkshire	2
Carer: Leeds	3
Carer: York and North Yorkshire	1
Service User and Carer: Rest of the UK	1
Clinical Staff: Leeds and York and North Yorkshire	4
Non-clinical Staff: Leeds and York and North Yorkshire	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
TOTAL	**36***

* With effect from 1 April 2013, due to the commencement orders in the Health and Social Care Act 2012 these seats will be removed from the Council of Governors which will reduce the number of seats overall to 34.

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 5C and 5D list those governors that have served on the Council of Governors during 2012/13. Please note that for those governors who were not still in office at 31 March 2013 the name of the constituency in which they served is shown. For all other governors the name of the constituency shown is as of 28 March 2013.

Table 5C – Elected governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends/ended
Amit Bhagwat	Public: Leeds	3 years	12.4.12	11.4.15
Alec Hudson **	Public: Morley and Rothwell	3 years	17.8.09	16.8.12
Grace Mangwanya	Public: Leeds	3 years	17.8.10	16.8.13
Andrew Marran	Public: Leeds	3 years	17.8.10	16.8.13
Sharron Plews ***	Public: Leeds West	3 years	17.8.10	15.5.12
Graham Purdy	Public: York and North Yorkshire	3 years	12.4.12	11.4.15
Colin Rhodes *	Public: Selby and Ainsty	3 years	12.4.12	16.3.13
Jenny Roper	Public: Leeds	3 years	16.7.09	15.7.12
	(Re-elected)	3 years	1.11.12	31.10.15
Barry Tebb	Public: Rest of England and Wales	3 years	12.4.12	11.4.15
Keith Wilson	Public: Leeds	3 years	9.5.11	8.5.14
Jonathan Butler	Service User: Leeds	3 years	17.8.10	16.8.13
Pamela Dolan	Service User: Leeds	3 years	17.8.10	16.8.13
Roy Goddard	Service User: York and North Yorkshire	3 years	12.4.12	11.4.15
Janette Howlett	Service User: Leeds	3 years	17.8.10	16.8.13
Andy Parker **	Service User: Leeds	3 years	17.8.09	16.8.12
Ann Shuter	Service User: Leeds	3 years	12.4.12	11.4.15
Tricia Thorpe	Service User: Leeds	3 years	17.8.09	16.8.12
	(Re-elected)	3 years	1.11.12	31.10.15
Maria Trainer	Service User: Leeds	3 years	17.8.10	16.8.13
Fiona Walker *	Service User: York and Selby	3 years	12.4.12	7.1.13
Bill Boland *	Carer: Leeds	3 years	24.3.11	15.9.12
Andy Bottomley	Carer: Leeds	3 years	17.4.11	16.4.14
Annie Dransfield	Carer: Leeds	3 years	24.3.11	23.3.14
Julia Raven	Carer: York and North Yorkshire	3 years	12.4.12	11.4.15
Jackie Worthington *	Carer: Leeds	3 years	17.8.09	31.5.12
Paul Cockcroft	Staff Non Clinical: Leeds and York & North Yorkshire	3 years	12.4.12	11.4.15
Mahesh Jayaram	Staff Clinical: Leeds and York & North Yorkshire	3 years	17.8.10	16.8.13
Jonathan King	Staff Clinical: Leeds and York & North Yorkshire	3 years	24.3.11	23.3.14
Pamela Morris	Staff Non Clinical: Leeds and York & North Yorkshire	3 years	12.4.12	11.4.15
Heather Simpson *	Staff Clinical: Leeds	3 years	17.8.10	31.1.13
Mark Willis	Staff Clinical: Leeds and York & North Yorkshire	3 years	12.4.12	11.4.15
Stephen Wright	Staff Clinical: Leeds and York & North Yorkshire	3 years	17.8.10	16.8.13

* Indicates those governors that stepped during 2012/13 before the end of their term of office

** Indicates those governors that came to the end of their term during 2012/13 and either did not stand for re-election or were not re-elected

*** Indicates those governors that were removed from office by the Council of Governors during 2012/13

Council of Governors

Table 5D – Appointed governors

Name	Appointing Organisation	Term of Office (years)	Date appointed from	Date Term of office ends/ended
Julie Bolus*	NHS North Yorkshire and York	3 years	20.3.12	30.11.12
Colin Clark	Equitix	3 years	14.2.11	13.2.14
John Dossey	Tenfold	3 years	5.9.12	4.9.15
Cllr Helen Douglas	City of York Council	1 year	29.10.12	28.10.13
Pip Goff	Volition	3 years	17.8.09	16.8.12
	(Re-appointed)	3 years	17.8.12	16.8.15
June Goodson-Moore *	NHS Airedale, Bradford and Leeds	3 years	15.10.09	31.5.12
Nigel Gray **	NHS Airedale, Bradford and Leeds	3 years	25.10.12	31.3.13
Kate Langan *	Leeds Voluntary Sector Learning Disability Forum	3 years	15.2.10	4.9.12
Cllr Christine Macniven	Leeds City Council	1 year	4.7.12	3.7.13
Cllr Lucinda Yeadon *	Leeds City Council	3 years	21.7.13	4.7.12
Cllr Tracy Simpson-Laing *	City of York Council	3 years	14.6.12	16.9.12

* Indicates those governors that stepped down during 2012/13 before the end of their term of office.
** Indicationg those governors that had to stepdown during 2012/13 due to change in constitution.

5.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2012/13 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 2012/13 we concluded two rounds of elections. The first round concluded in April 2012 and the second in October 2012.

5.2.1.1 Elections that concluded in April 2012

Following the successful transfer of services from NHS 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 elections to the new seats and vacancies in existing seats commenced. This election was concluded on 12 April 2012 and we were successful in filling seats as follows:

Table 5E – Elected unopposed:

Name	Constituency elected to:	Constituency now called *:
Amit Bhagwat	Public: Leeds Central	Public: Leeds
Barry Tebb	Public: Rest of England and Wales	Public: Rest of England and Wales
Julia Raven	Carer: York and Selby	Carer: York and North Yorkshire
Roy Goddard	Service User: York and Selby	Service User: York and North Yorkshire
Fiona Walker	Service User: York and Selby	Service User: York and North Yorkshire
Mark Willis	Clinical staff: North Yorkshire and York	Clinical staff: Leeds and York & North Yorkshire

* Some of the names of our constituencies changed on 28 March 2013 as per our new Constitution

Heather Simpson, staff governor

Council of Governors

Table 5F – Elected by ballot:

Name	Constituency elected to:	Constituency now called *:	Percentage turnout
Colin Rhodes	Public: Selby and Ainsty	Public: York and North Yorkshire	14.7%
Graham Purdy	Public: York Outer	Public: York and North Yorkshire	28.1%
Ann Shuter	Service User: Leeds (Learning Disability)	Service User: Leeds	26.3%
Paul Cockcroft	Non-clinical staff: Leeds and North Yorkshire and York	Non-clinical staff: Leeds and North Yorkshire and York	23.9%
Pamela Morris	Non-clinical staff: Leeds and North Yorkshire and York	Non-clinical staff: Leeds and North Yorkshire and York	

* Some of the names of our constituencies changed on 28 March 2013 as per our new Constitution

52.12 Elections that concluded in October 2012

With a number of governors coming to the end of their term of office and long standing vacancies it was felt necessary to hold a second round of elections. This round concluded in October 2012. Whilst we were successful in filling two seats, it was disappointing to have the other nine seats in the election remain unfilled.

Following the outcome of the October round of elections there was an intention to run a third round of elections commencing in early spring 2013. However, the Council of Governors agreed that due to the impending change in the composition of the Council that this round of elections would be postponed until the final effect of the change in constituencies was known.

There were no governors elected unopposed. The table below shows those elected by ballot

Table 5F – Elected by ballot:

Name	Constituency elected to:	Constituency now called *:	Percentage turnout
Jenny Roper	Public: Leeds North West	Public: Leeds	5.5%
Tricia Thorpe	Service User: Leeds	Service User: Leeds	15.0%

* Some of the names of our constituencies changed on 28 March 2013 as per our new Constitution

During 2012/13 there were two elected governors who came to the end of their term of office and were either not re-elected or did not choose to stand for re-election. These were Andy Parker (Service User: Leeds) and Alec Hudson (Public: Morley and Rothwell). There were also five governors who stood down before their term of office came to an end. These were Bill Boland (Carer: Leeds), Heather Simpson (Staff Clinical: Leeds), Fiona Walker (Service User: York and Selby), Colin Rhodes (Public: Selby and Ainsty) and Jackie Worthington (Carer: Leeds).

The Board of Directors would like to thank the elected governors it has worked with through the year for all their hard work and support to the development of the services we provide.

Council of Governors

During 2012/13 the Council of Governors also found it necessary to use the powers vested in it under the Constitution to remove one governor from office for failing to attend Council of Governors' meetings and therefore carry out their duties.

5.2.2 Appointed governors

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

During 2012/13 there were a number of changes to our appointed governors. Five appointed governors stepped down before the end of their term of office. These were Julie Bolus (NHS North Yorkshire and York), June Goodson-Moore (NHS Airedale, Bradford and Leeds), Kate Langan (Leeds Voluntary Sector Learning Disability Forum), Cllr Tracy Simpson-Laing (City of York Council), and Cllr Lucinda Yeadon (Leeds City Council). With the commencement orders of the final parts of the Health and Social Care Act 2012 which came into effect on 1 April 2013 this removed the need to have a representative from the PCT. The result of this was that Nigel Gray from NHS Airedale, Bradford and Leeds came to the end of his term of office on 31 March 2013, and the vacant seat for NHS North Yorkshire and York was removed.

We also welcomed three new appointed governors; John Dossey (Tenfold), Cllr Christine Macniven (Leeds City Council) and Cllr Helen Douglas (City of York Council). In addition to this we were pleased to welcome back Pip Goff (Volition) who was re-appointed for a third term of office.

The Board of Directors would like to thank all the appointed governors it has worked with through the year for all their hard work and support to the development of the services we provide.

5.3 MEETINGS OF THE COUNCIL OF GOVERNORS

During 2012/13 the Council of Governors met formally six times, five scheduled meetings and one extraordinary meeting in November 2012. All Council of Governors' meetings are open to members of the Trust and members of the public although any matters which are deemed to be of a confidential nature will be taken in a private session.

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

The table below details the number of meetings attended by each governor during 2012/13. This is shown out of a maximum of six meetings unless a governor has either resigned from, or joined the Council of Governors part-way through the financial year.

Annual Members Day 2012

Council of Governors

Table 5H – Number of meetings attended by each governor

Name	Appointed or elected	Number of meetings eligible to attend	Number of meetings attended
Amit Bhagwat	E	6	6
Bill Boland **	E	3	2
Julie Bolus **	A	5	3
Andrew Bottomley	E	6	4
Jonathan Butler	E	6	6
Colin Clark	A	6	6
Paul Cockcroft ***	E	6	5
Pamela Dolan ***	E	6	1
John Dossey *	A	3	2
Helen Douglas *	A	1	1
Annie Dransfield	E	6	5
Roy Goddard	E	6	6
Pip Goff	A	6	6
June Goodson-Moore **	A	1	0
Nigel Gray *	A	3	0
Janette Howlett ***	E	6	5
Alec Hudson **	E	2	0
Mahesh Jayaram ***	E	6	4
Jonathan King ***	E	6	2
Kate Langan **	A	2	0
Cllr Christine Macniven *	A	3	3

Name	Appointed or elected	Number of meetings eligible to attend	Number of meetings attended
Grace Mangwanya	E	6	4
Andrew Marran	E	6	6
Pamela Morris	E	6	5
Andy Parker **	E	2	2
Sharon Plews **	E	1	0
Graham Purdy	E	6	6
Julia Raven	E	6	6
Colin Rhodes	E	6	6
Jenny Roper *	E	5	4
Ann Shuter ***	E	6	2
Heather Simpson **	E	5	5
Cllr Tracey Simpson-Laing **	A	2	1
Barry Tebb	E	6	0
Tricia Thorpe *	E	5	5
Maria Trainer ***	E	6	5
Fiona Walker **	E	5	2
Mark Willis ***	E	6	4
Keith Wilson	E	6	5
Jackie Worthington **	E	1	1
Dr Stephen Wright	E	6	5
Cllr Lucinda Yeadon **	A	1	0

* Indicates those governors that were elected or appointed part-way through 2012/13 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 2012/13 and may not have had the opportunity to attend all meetings.
*** Indicates those governors who were unable to attend the extraordinary Council meeting called at short notice

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. In addition to this there are a number of key statutory tasks the Council of Governors must carry out. These include:

- **Advising the Board of Directors on strategic direction**
- **Ensuring the Board of Directors does not breach the Trust's terms of authorisation as set by Monitor**
- **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.**

In June 2012 the Health and Social Care Act received Royal Ascent. On 1 April 2013 many of the new duties for governors will come into force and this will see the role of governors change to include:

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

To help governors carry out their role, the Board of Directors will also have a number of statutory duties placed on it including:

- **Sending a copy of the agenda to governors before each meeting and copies of minutes of meetings as soon as practicable after the meeting**
- **Ensuring that governors have the skills and knowledge they require to undertaken their role.**

We will continue to work closely with our governors over the coming months to ensure that structures and processes are in place and that they are equipped with the skills and knowledge that they need to carry out their enhanced role.

Further information about how governors have contributed to the development of services can be found in Part A, Section 4.2.

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 members of the Board of Directors to attend 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. This can inform their input to the Board of Directors and other areas of their work.

We continue to have facilitated discussion sessions in the formal Council of Governors' meetings. This is to ensure that, for key strategic papers 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 are able to take account of the views of all governors in a formal way.

To ensure that the non-executive directors

Council of Governors

(NEDs) understand the views of governors and members, they are invited to attend each Council of Governors' meeting. There is also an informal session before each Council meeting where NEDs and governors can meet informally and discuss those issues that are important to governors. In the coming financial year we will be having a NED formally attend each meeting to take questions about performance. This will ensure there is greater engagement between NEDs and governors, and that governors can hold them to account for the performance of the Board.

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 recommendations to the Council of Governors regarding the appointments process for vacant posts within the non-executive director team, and also sets the level of remuneration made to members of the non-executive team. Further information about the work of this committee in 2012/13 can be found in the Remuneration Report in Part A, 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. Each year governors will complete a new Declaration of Interest form to ensure the most up to date position is declared.

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 chill29@nhs.net.

Frank Bruno, Annual Members Day 2012

Get me?

Get a better understanding of learning disabilities

Get me? campaign

Board of Directors

6.1 INTRODUCTION

The Board of Directors is the legally responsible body for the day-to-day management of the organisation and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of our strategy. It does this by:

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

The 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 for the Board. 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 necessary, the views of the governors are taken into account.

While 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.

6.2 COMPOSITION OF THE BOARD OF DIRECTORS

6.2.1 Non-executive directors

There have been a number of changes to the non-executive director team during 2012/13. Firstly, Linda Phipps and Niccola Swan came to the end of their terms of office on 31 January 2013. Because both Linda and Niccola had already served two terms of office they were ineligible to be considered for re-appointment. However, both have maintained contact with the Trust and have continued as Mental Health Act managers.

The Council of Governors made two new appointments to the non-executive director team, those of Steven Wrigley-Howe who took up his appointment on 6 February 2013, and Julie Tankard who started with the Trust on 1 March 2013.

We would like to thank Linda and Niccola for the very valuable contribution they have made to the work of the Trust during their time as non-executive directors (not least most recently in the transition of mental health and learning disability services from NHS North Yorkshire and York), and also welcome Steven and Julie to the Board of Directors.

6.2.2 Executive directors

There have also been a number of changes in the executive director team during 2012/13.

On 31 May 2012 Mr Guy Musson, who was the Chief Financial Officer resigned from the Trust to take up a role as an independent contractor. On 1 August 2012 Dawn Hanwell was appointed into the vacant post, and brings with her a number of years experience as the Director of Finance at the Barnsley Hospital NHS Foundation Trust.

During 2012/13 there was a also a change in Medical Director. On 31 August 2012 Dr Douglas Fraser came to the end of his period of secondment into the role and on 1 September 2012 Dr Jim Isherwood took up the post substantively; he had previously been the Medical Director with the York and Selby PCT.

The third change to the team was the resignation of Michele Moran as Chief Nurse / Chief Operating Officer on 30 November 2012. Michele left to take up the position of Chief Executive of the Manchester Mental Health and Social Care NHS Trust. Until such time as a substantive appointment was made Lynn Parkinson was seconded into the post.

Changes to the executive team, in particular the resignation of Michele Moran, allowed the Chief Executive to look at each of the executive directors' portfolios. While some duties were re-assigned to directors during 2012/13, from 1 April 2013 the executive team roles will be as listed below, which is also when Beverley Murphy will join the team as Chief Nurse / Director of Quality Assurance. Information about our executive team from 1 April 2013 can be found on our website.

- **Chief Executive - Chris Butler**
- **Chief Financial Officer - Dawn Hanwell**
- **Chief Nurse / Director of Quality Assurance - Beverley Murphy**
- **Medical Director - Jim Isherwood**
- **Chief Operating Officer - Jill Copeland**
- **Director of Workforce Development - Susan Tyler**

Board of Directors

The Board wishes to thank Guy Musson, Dr Douglas Fraser and Michele Moran for their 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 Dawn Hanwell and Jim Isherwood to the team and also thank Lynn Parkinson for stepping in as the Chief Nurse / Chief Operating Officer until Beverly Murphy joins the Trust as the new Chief Nurse / Director of Quality Assurance on 1 April 2013.

6.2.3 Members of the Board of Directors

At the end of 2012/13 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).

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 (re-appointed with effect from 1.4.13)**
Aqila Choudhry	**Non-executive Director (Deputy Chair from 1 January 2013)**	**3 year appointment from 18.10.10**
Julie Tankard	**Non-executive Director**	**3 year appointment from 1.3.13**
Dr Gill Taylor	**Non-executive Director (Deputy Chair until 31 December 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**	**3 year appointment from 18.10.10**
Steven Wrigley-Howe	**Non-executive Director**	**3 year appointment from 6.2.13**
Executive Team		
Chris Butler	**Chief Executive**	
Jill Copeland	**Director of Strategy and Partnerships**	
Dawn Hanwell	**Chief Financial Officer**	
Dr Jim Isherwood	**Medical Director**	
Lynn Parkinson	**Acting Chief Operating Officer/Chief Nurse**	
Susan Tyler	**Director of Workforce Development**	

*extended by the Council of Governors until 31 May 2013

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.

Non-executive directors, including the Chair of the Trust are appointed by the Council of Governors. Should it be necessary to remove either the Chair of the Trust or any of the other non-executive directors this will also be done by the Council of Governors. A decision to remove the Chair of the Trust or another non-executive director must be done in accordance with the Trust's Constitution and only if three quarters of the total number of governors appointed or elected at the time vote to remove an individual.

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-Committees namely the Nominations Committee; and the Remuneration Committees. Frank also chairs the Council of Governors and its sub-committees 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 £1 million 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 (Deputy Chair of the Trust from 1 January 2013)

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, providing there is no conflict of interest. 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; she is their diversity champion for Yorkshire and the Humber.

Julie Tankard, Non-executive Director

Julie was appointed on 1 March 2012 for a period of three years. It is intended that Julie will chair the Audit and Assurance Committee, when Allan Valks comes to the end of his term of office in May 2013. Julie is a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required,providing there is no conflict of interest.

She is a Fellow of the Chartered Institute of Management Accountants and qualified as an accountant 20 years ago. She has experience in finance and commercial roles and is currently working as the vice president of commercial finance for BT Global Services, a division of BT plc.

Julie runs a large global team and has worked in an international environment for most of her career; consequently she is used to working across different cultures and values diversity. She is very experienced in procurement processes and contract negotiations and is currently responsible for the new business generated by BT Global Services. Her key skills lie in risk management, financial evaluation, investment appraisal and governance. She has a high degree of personal integrity. She is excited by the challenge of bringing her commercial skills from a corporate environment to the Trust and hopes that she can bring a benefit to the service users.

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Dr Gill Taylor, Non-executive Director (Deputy Chair of the Trust until 31 December 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 Audit and Assurance Committee, the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required, provided there is no conflict of interest. As part of her portfolio Gill takes a special interest in change management and organisational growth.

Gill is Principal Advisor of the Local Government Association which helps improve the performance of local government, shares good practice and supports councils at risk through the facilitation of their improvement programmes. Gill has responsibility for councils in the North West region and has the national lead role for the transition of health functions into local government.

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 for the Homes and Communities Agency; and was a government policy advisor on sustainable communities and community cohesion. She is also a board member of Manningham Housing Association in Bradford, and has a particular interest in housing and partnership working to support individuals and communities.

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 until 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, and providing there is no conflict of interest. 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 (FCA) currently working as a director within the Public Sector Team at BDO Stoy Hayward LLP, a position to which he was appointed in 2005.

Keith Woodhouse, Non-executive Director

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, providing there is no conflict of interest. Keith also sits on 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 ten 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 the Child Maintenance Service. This included the overall management of the change programme, control of budgets in excess of £100 million 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.

Steven Wrigley-Howe, Non-executive Director

Steven was appointed as a non-executive director on 6 February 2013. Steven is a member of the Remuneration Committee and is entitled to be a member of the Nominations Committee as and when required, providing there is no conflict of interest.

Board of Directors

Steven is currently a trustee for York Mind. Prior to joining the Trust he also worked with national Mind on a number of projects including ways of engaging service users in the implementation of Mind's new strategy.

He has over 20 years' experience within healthcare in various management and executive roles including ten years running a healthcare consultancy with both public sector and independent sector clients including NHS trusts, primary care trusts, BUPA hospitals, and Nuffield Health.

Steven has also been appointed as the security management specialist for the Trust and will work with the security management function to fulfil this role.

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 authorisation as an NHS Foundation Trust in 2007. Chris successfully steered the incorporation into the Trust of services in York and parts of North Yorkshire, with the Leeds and York Partnership NHS Foundation Trust coming into being in February 2012.

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

Chris is a member of the Yorkshire and Humber Local Education and Training Board (LETB) and is the Chair of the LETB's Partnership Council for West Yorkshire. He is also a member of the NHS Regional Leadership Council for Yorkshire and the Humber and is a member of the Health Education England 'Better Training, Better Care' junior doctor taskforce. Chris is involved in the work of the Royal College of Nursing Nurses in Management and Leadership Forum which is concerned with the professional development of aspirant and established leaders in nursing.

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 joined the Trust in October 2009 as Director of Strategy and Partnerships. In this role, she was responsible for strategy; integration of services from York and North Yorkshire; partnerships and social inclusion; communications; campaigning; governor and member engagement; equality and diversity; and board and governor development. Previously, Jill was executive director of strategic development at NHS Leeds, where she led on strategy; partnerships; commissioning for priority groups, including mental health and learning disability services; organisational development through World Class Commissioning; and estates.

Jill has worked in healthcare for almost 25 years, and her experience includes policy development and implementation at the Department of Health. Jill graduated in philosophy and holds a masters in business administration from Manchester Business School.

Dawn Hanwell, Chief Financial Officer

Dawn was appointed as Chief Financial Officer from 1 August 2012. She started work in the NHS in 1986 as a financial management trainee in Rotherham where she went on to gain her CIPFA qualification in 1990.

Prior to joining the Trust Dawn was the Director of Finance in Barnsley NHS Foundation Trust. She has worked across the NHS, predominantly in mental health and for a short while in a primary care trust. She has worked in Sheffield, Wakefield Derby and Leeds; including being the Deputy Director of Finance of our predecessor organisation, Leeds Partnerships NHS Foundation Trust, when she was part of the team that led on securing our foundation trust status.

Dr Jim Isherwood, Medical Director

Jim was appointed to the substantive post of Medical Director on 1 September 2012.

He trained at the University of Leeds Medical

Board of Directors

School and after graduation worked in hospitals in West Yorkshire before undertaking the North Yorkshire rotational training scheme in psychiatry. He then worked in Wessex as Senior Registrar for four years before taking up a consultant post to develop forensic psychiatry services in North Yorkshire in 1996. In 2004 he became Medical Director of the Selby and York PCT, a position he maintained until services transferred to the Trust in February 2012.

Lynn Parkinson, Acting Chief Operating Officer/ Chief Nurse

Lynn was appointed as the Acting Chief Nurse and Chief Operating Officer on the 1 December 2012.

She qualified as a nurse in 1989 and has spent all of her career working in mental health. Lynn has a wealth of experience of the Trust's services having started with the Trust since qualifying as a registered mental health nurse and working in a wide variety of clinical services including acute inpatients, community and a number of years with the Eating Disorder Service, finally being appointed to the substantive position of Deputy Director of Care Services in 2012.

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 healthcare 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 ahead of the changes in the Health and Social Care Act, which will come into force on 1 April 2013, has held 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 2012/13 the Board of Directors met on 13 occasions, and the table below show directors' attendance at those meetings.

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	11	Jill Copeland	13	13
Linda Phipps *	11	10	Dr Douglas Fraser *	6	6
Niccola Swan *	11	9	Dawn Hanwell **	8	8
Julie Tankard **	1	0	Carol Greaves * **	2	1
Dr Gill Taylor	13	13	Dr Jim Isherwood **	7	7
Allan Valks	13	13	Michele Moran *	9	9
Keith Woodhouse	13	12	Guy Musson *	3	2
Steven Wrigley-Howe **	2	2	Lynn Parkinson * **	4	4
			Susan Tyler	13	13

* Indicates directors who left the Trust / post during 2012/13.

** Indicates directors who joined the Trust / post during 2012/13.

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

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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, and make an annual declaration of interest to ensure declarations remain up to date.

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 chill29@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 autumn of 2012 the Board of Directors undertook a 360-degree evaluation of its effectiveness, working with the Real World Group. Feedback was requested from Board members themselves, governors and staff and in December 2012 representatives from Real World Group fed back the findings to the Board. A session was also undertaken with the Senior Leader's Forum which was given the opportunity to provide views on the outcome. Since the review there have been a number of changes to the membership of the Board of Directors at both executive and non-executive director level, which will inevitably change the way in which the Board interacts both internally and externally. The 360-degree review will provide a baseline for further Board development.

6.7 SUB-COMMITTEES OF THE BOARD OF DIRECTORS

The sub-committees of the Board of Directors comprise the Audit and Assurance Committee, the Remuneration Committee, and the Nominations Committee. (Information about the work of the Remuneration Committee and the Nominations Committee can be found in Part A Section 8.)

6.8 THE AUDIT AND ASSURANCE COMMITTEE

The Audit and Assurance Committee is the primary governance and assurance committee. 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 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.

The substantive membership of the Audit and Assurance Committee is made up of four non-executive directors. During 2012/13 these were Allan Valks, Aqila Choudhry, Linda Phipps and Dr Gill Taylor. However, the other non-executive directors are invited attend on an ad-hoc basis as and when they feel it appropriate. Allan Valks is the current chair of the committee, but this will pass to Julie Tankard when Allan leaves the Trust on 31 May 2013 at the end of his term of appointment as a non-executive director.

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, our internal auditors 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 and also other members of the non-executive director team during 2012/13.

Board of Directors

Table 6C

Name	Number of meetings eligible to attend	Number of meetings attended	Name	Number of meetings eligible to attend	Number of meetings attended
CORE MEMBERS OF THE COMMITTEE					
Allan Valks (Chair of the committee)	7	6	Linda Phipps ** (Deputy Chair of the committee up to 31.1.13)	6	5
Aqila Choudhry	7	6			
Julie Tankard ***	1	1	Dr Gill Taylor *	7	5
NON-EXECUTIVE DIRECTORS WHO CHOSE TO ATTEND MEETINGS					
Niccola Swan		5	Keith Woodhouse		1
Steven Wrigley-Howe		1			

* The meeting held on 23 January 2013 was re-arranged at short notice and Dr Taylor was unable to attend

** Left the organisation part way through during 2012/13

*** Commenced with the organisation part way though 2012/13

During 2012/13 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 Board Assurance Framework. As part of its statutory duty it has reviewed the Annual Accounts, the Board statements for the Annual Plan and the Quality Account 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.

Further information about the sufficiency of our internal control processes can also be found in the Annual Governance Statement in Part A Section 10.

Love Arts Festival 2012, Vintage Tea Party

Annual Members Day, 2012

Membership

7.1 THE CONSTITUENCIES AND ELIGIBILITY TO JOIN

We have three membership constituencies:

- Public
- Service user and carer
- Staff

Up until Monitor authorised changes to the Constitution on 28 March 2013 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 28 March 2013 the number of constituencies changed from nine to three; all the Leeds constituencies were rolled into one, as were the York and North Yorkshire constituencies, with the rest of England and Wales areas for local government elections being captured into one constituency. If a person wants to join the public constituency the class they are put into will be determined by the address they live at.

Until 28 March 2013 the service user and carer constituencies were divided into nine categories, however the change in the constitution has amalgamated these constituencies into five. Again these constituencies follow the local government electoral 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 which class they join.

The Staff Constituency is divided into two categories: Staff: Clinical; and Staff: Non-clinical. Any individual who is employed by us under a contract of employment will automatically 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. Whether a person joins the clinical or the non-clinical class will be determined by national occupation codes.

More details on our membership constituencies can be obtained from our Membership Office (contact details are on the back page of this Annual Report).

The table below shows the membership constituencies and classes.

Table 7A – Membership constituency

Public Constituency	Service User and Carer Constituency	Staff Constituency
Public: Leeds Public: York and North Yorkshire Public: Rest of England and Wales	Service User: Leeds Service User: York and North Yorkshire Carer: Leeds Carer: York and North Yorkshire Service user and Carer: Rest of the UK	Clinical Staff: Leeds and York and North Yorkshire Non-clinical Staff: Leeds and North Yorkshire and York

7.2 NUMBER OF MEMBERS

Membership has grown steadily to the current figure of 17,151. Table 7B illustrates the breakdown, by constituency, of the total number of members as at 31 March 2013.

Table 7B – Total membership by constituency

Public Constituency	Number of Members
Public: Leeds	9424
Public: York and North Yorkshire	824
Public: Rest of England and Wales	1737
Total public members	**11985**

Service User and Carer Constituency	Number of Members
Service User: Leeds	599
Service User: York and North Yorkshire	56
Carer: Leeds	399
Carer: York and North Yorkshire	41
Service User and Carer: Rest of UK	99
Total service user and carer members	**1194**

Staff Constituency	Number of Members
Clinical staff: Leeds and York & North Yorkshire	3145
Non-clinical staff: Leeds and York & North Yorkshire	894
Total staff members	**4039**

7.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, with no significant deficits. During the past 12 months, we have undertaken activities with gender, ethnicity and age-specific groups to ensure that the membership continues to be representative. We have also started to collect

Membership

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.

As part of our expanding work in York and North Yorkshire and our work to continue to develop both the membership and the Council of Governors, we will build on our positive programme of involving and engaging our members and offering individual support and a comprehensive training package for our governors. We have recently revisited our Trust's Constitution and the role of our governors to create a clear picture of what they do, and help create a Council of Governors that is confident to work together at the heart of the organisation. We believe that this will help strengthen our recruitment of governors and also support our current governors in their new roles in line with the Health and Social Care Act 2012. We believe that this will help us to support our governors, who in turn will promote membership and involvement to the general public, service users, carers, staff and stakeholders.

We see our members as having an important role in helping to combat the stigma experienced by people with learning disabilities and mental health problems; and we will continue to attract a committed and involved membership who will act as ambassadors for the Trust.

7.4 MEMBERSHIP RECRUITMENT AND ENGAGEMENT

We will continue to recruit members through our well established channels. However, there are a number of new strands that we need to develop, particularly to increase our membership in York and North Yorkshire. These new opportunities include:

- **A better use of outpatient appointment letters**
- **Circulation of membership forms to York and North Yorkshire libraries, linked in to the Sharing Stories campaign**
- **Continued development of links with York universities and colleges**
- **Development of a Love Arts programme across York and North Yorkshire**
- **Development of anti-stigma campaigns across York and North Yorkshire**
- **Encouraging present members to share the membership magazine Imagine with their families and friends and thereby introduce new members.**

In addition, the membership team is reviewing the programme of public events to book stalls and maintain a presence at. The team is also keen to establish a recruitment target for governors, with membership recruitment becoming a core activity for all governors.

We will continue to maintain our membership recruitment activities in Leeds, York and North Yorkshire particularly through our Time to Change campaigns, the Love Arts Festival and seasonal activities.

Annual Members Day, 2012

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.

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 2012/12. 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 determining their respective salaries and remuneration.

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

8.2 THE APPOINTMENTS AND REMUNERATION COMMITTEE (a sub-committee of the Council 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 role in the appointment of non-executive directors.

The committee meets as required and is made up of four elected governors, two appointed governors. It is chaired by the Chair of the Trust and is supported by the Director of Workforce Development and the Head of Corporate Governance.

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 2012/13

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 2012/13 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 by the Remuneration Committee in respect of executive directors for the period 2012/13.

8.2.3 Appointment of non-executive directors in 2012/13

During 2012/13 there were three rounds of appointments for non-executive directors completed and one commenced:

- On 29 November 2012 the Council of Governors made an appointment to a non-executive post due to become vacant on 1 December 2012. However, the successful candidate withdrew on being offered the post

To ensure there was no unnecessary vacancy within the non-executive director team the Council of Governors extended the term of appointment for Niccola Swan by two months from 1 December 2012 to 31 January 2013 until the next round of NED appointments were completed on 5 February 2013

- On the 5 February 2013 the appointment of two non-executive directors was concluded with Steven Wrigley-Howe being appointed for a period of three year from 6 February 2013 and Julie Tankard being appointed also for a period of three years with effect from 1 March 2013

- On 5 February 2013 Frank Griffiths was re-appointed as the Chair of the Trust for a further period of three years commencing 1 April 2013

- Also on 5 February 2013 the Council of Governors approved the process for the appointment of one non-executive director who will be appointed to fill the vacancy created when Allan Valks

Remuneration Report

comes to the end of his term of office on 31 May 2013. This process of appointment will be concluded during 2013/14

Details of the non-executive director team as at the end of March 2013 are shown in the table below.

Table 8A

Name	Date Appointed	Period	Date Appointment Ends
Frank Griffiths (Chair of the Trust)	1 April 2010	3 years	31 March 2013 *
Aqila Choudhry	18 October 2010	3 years	17 October 2013
Julie Tankard	1 March 2013	3 years	29 February 2016
Dr. Gill Taylor	2 January 2011	3 years	1 January 2014
Allan Valks	1 December 2010	2 years	31 May 2013 **
Keith Woodhouse	18 October 2010	3 years	17 October 2013
Steven Wrigley-Howe	6 February 2013	3 years	5 February 2016

* In 2012/13 the Council of Governors re-appointed Frank Griffiths as Chair of the Trust for a further three years with effect from 1 April 2013

** The appointment of Allan Valks was extended in 2011/12 by the Council of Governors from ending on 30 November 2012 to ending on 31 May 2013

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

On 5 February 2013 the Council of Governors ratified the appointment of Steven Wrigley-Howe and Julie Tankard both for a period of three years. The first step in this process was for the Nominations Committee (a sub-committee of the Board of Directors) to define the skills and experience required on the Board and to draft a role profile and person specification. The Appointments and Remuneration Committee (a sub-committee of Council of Governors) received the role profile and person specification against which the appointments were made, and agreed the process and timetable for the appointment process. The process and timetable was then signed off by the Council of Governors. A panel consisting of a majority of governors headed by the Chair of the Trust drew up a shortlist of candidates from the applicants. An interview panel was formed, which again included a majority of governors (four governors in total), the Chair of the Trust and an independent assessor. The panel then conducted the interviews and chose the preferred candidates based on merit. Once the panel had made its choice a recommendation was made to the Council of Governors which ratified the appointments.

Our process for the appointment of non-executive directors would normally allow incumbent NEDs to be considered for re-appointment if they met the skills required. However in this round, there were no incumbent non-executive directors eligible to apply for the posts as Linda Phipps and Niccola Swan were coming to the end of their term of office having already served two terms of up to three years. They were therefore ineligible to be considered for re-appointment.

The re-appointment of Frank Griffiths as Chair of the Trust was ratified by the Council of Governors on 5 February 2013 following a robust process which included: an application being made by Mr Griffiths to demonstrate how he matched the skills and experience set out in the role description agreed by the Nominations Committee; a presentation of his personal statement to a group of governors where he set out his vision for the coming three years; a 360-degree appraisal involving governors and members of the Board of Directors; and an interview with a panel made up of a majority of governors, the Senior Independent Director and an independent assessor.

8.2.5 Meetings of the Appointments and Remuneration Committee

There were four formal meetings of the committee on 4 July, 13 September, 4 October and 5 November 2012. On 29 November 2012 revised Terms of Reference for the committee were ratified by the Council of Governors, including a change to the membership of the committee. This meant that it was not quorate to meet and consider the process for the NED appointments due to start in February 2013. Therefore, on 5 February 2013 the Council of Governors considered and agreed that appointment process and documentation.

Remuneration Report


Alan Valks

Table 8B – Appointments and Remuneration

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 of committee)	4	4	Allan Valks *	N/A	1
			Pamela Morris	4	4
Colin Clark	4	4			
Jenny Roper **	1	1			

* Allan Valks chaired the meeting of 5 November when the process for the appointment of Chair of the Trust was being discussed
** Indicates governors who stepped down from the committee part way through 2012/13

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 provide the agreed skills and experience required to 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 (who will attend those meetings where no conflict of interest exists). The committee is supported by the Head of Corporate Governance.

During the year the committee has led on the process for the appointment of one executive director vacancy that of the Chief Nurse / Director of Quality Assurance (the committee was involved in the initial work for the posts of Medical Director and the Chief Financial Officer commenced in 2011/12, although the appointments were subsequently made in 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 of committee)	4	4	Chris Butler	4	4
			Niccola Swan *	4	3
Aqila Choudhry *	4	1	Susan Tyler	4	4
Dr Gill Taylor *	4	3			
Allan Valks *	4	3			

* 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.

Remuneration Report

8.3.1 Appointment of executive directors in 2012/13

In 2012/13 there were two new appointments to the executive director team: the Chief Financial Officer on 1 August 2012 and the Medical Director on 1 September 2012. Both these appointment processes were initiated by the Nominations Committee in 2011/12 and the appointments were made by a panel made up of non-executive directors, including the Chair of the Trust and the Chief Executive.

In 2012/13 the Nominations Committee also considered the job description and person specification for the post of Chief Nurse / Director of Quality Assurance. This post was appointed to through open advertisement and Beverley Murphy will take up the post on 1 April 2013.

In each of these appointment processes governors were invited to be included.

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

The Remuneration Committee sets the remuneration for the executive directors. This is a sub-committee of the Board of Directors, and is made up of all the non-executive directors and is chaired by the 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 ('cost of living awards') 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 has been 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 Susan Tyler, the Director of Workforce Development. The Head of Corporate Governance provides secretariat support and advice on matters of governance.

In 2012/13 there were six formal meetings of the committee held on 26 April, 31 May, 29 June, 27 July, 31 August and 30 November 2012. The table below shows the number of Remuneration Committee meetings that were attended by each member.

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 of committee)	6	6	Aqila Choudhry	6	5
			Niccola Swan	6	5
Linda Phipps	6	5	Allan Valks	6	5
Dr Gill Taylor	6	5			
Keith Woodhouse	6	4			

Table 8D – The Remuneration Committee

There is no performance-related pay in any director's current contract of employment. Where a salary requires review, a benchmarking exercise may be requested to make comparison against other similar NHS organisations. All contracts for executive directors are permanent and therefore open-ended. The period of notice for each member of the executive team is set out in their contracts, and is normally three months. There has been no requirement to make a provision for compensation in respect of the early termination of any contract pertaining to any executive director.

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

Name	Title	Period
Chris Butler	Chief Executive	1 January 2005
Jill Copeland	Director of Strategy and Partnerships	1 April 2011
Dawn Hanwell	Chief Financial Officer	1 August 2012
Dr Jim Isherwood	Medical Director	1 September 2012
Lynn Parkinson	Chief Operating Officer/Chief Nurse (secondment)	1 December 2012
Susan Tyler	Director of Workforce Development	1 January 2012

Remuneration Report

8.5 PERFORMANCE AND APPRAISALS

While 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 other member of staff within the organisation.

During 2012/13 a new appraisal process for non-executive directors was devised this was agreed by the Council of Governors and will be implemented in 2013/14 with the first round of appraisals concluded in-year and reported back to the Council.

8.6 OFF-PAYROLL ENGAGEMENTS

The following table relates to a Department of Health review of tax arrangements for public sector employees.

Table 8F – Off-payroll engagements at a cost of over £58,200 per annum that were in place as of 31 January 2012

Number in place on 31 January 2012	4
Of which: Number that have since come onto the Trust's payroll	0
Of which: Number that have since been re-negotiated/re-engaged to include contractual clauses allowing the department to seek assurance as to their tax obligations	0
Number that have not been successfully re-negotiated, and therefore continue without contractual clauses allowing the department to seek assurance as to their tax obligations	2
Number that have come to an end	2
Total	4

The requirement to include contractual clauses allowing the Trust to seek assurance as to their tax obligations has been noted and will be addressed as Service Level Agreements are renewed.

Table 8G – All new off-payroll engagements between 23 August 2012 and 31 March 2013, for more than £220 per day and more than six months

Number of new engagements *	4
Of which: The number of new engagements which include contractual clauses giving the department the right to request assurance in relation to income tax an National Insurance obligations	0
Of which: The number for whom assurance has been requested and received	0
The number for who assurance has been requested but not received	0
The number that have been terminated as a result of assurance not being received	0
Total	0

* The contract for two of the above new engagements ended prior to 31 March 2013.

The requirement to include contractual clauses allowing the Trust to seek assurance as to their tax obligations has been noted and will be addressed as Service Level Agreements are renewed.

Remuneration Report

8.7 DIRECTORS' AND GOVERNORS' EXPENSES

The following table sets out the total paid to directors (executive and non-executive) and governors for out-of-pocket expenses resulting from incurring costs of travel and substance during 2012/13.

Table 8H

Executive directors	£7494.72
Non-executive directors	£6297.49
Governors	£1323.42

8.8 SENIOR EMPLOYEES PENSION ENTITLEMENTS, REMUNERATION AND BENEFITS IN KIND

Accounting policies for pensions and other retirement benefits are set out in the notes to the Annual Accounts, see Part C of this Annual Report. 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 Part A Section 8.8.1 is consistent with the financial statements.

8.8.1 Pension entitlements for senior employees

Table 8I – 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
Chris Butler - Chief Executive	2.5 - 3.0	7.5 - 10.0	15 - 20	50 - 55	289	354	65	45	0
Guy Musson - Chief Financial Officer	(10.0) - (7.5)	(27.5) - (25.0)	0	0	1,035	0	(173)	(121)	0
Carol Greaves - Acting Chief Financial Officer	2.5 - 5.0	12.5 - 15.0	25 - 30	75 - 80	0	464	78	54	0
Dawn Hanwell - Chief Financial Officer	22.5 - 25.0	67.5 - 70.0	30 - 36	100 - 105	0	596	397	278	0
Dr Douglas Fraser - Medical Director	0 - 2.5	50 - 7.5	30 - 35	95 - 100	476	558	35	24	0
Dr Jim Isherwood - Medical Director	27.5 - 30.0	87.5 - 90.0	50 - 55	150 - 155	0	884	514	360	0
Michele Moran - Chief Operating Officer and Chief Nurse	5.0 - 7.5	17.5 - 20.0	45 - 50	145 - 150	649	838	127	89	0
Lynn Parkinson - Acting Chief Operating Officer and Chief Nurse	10.0 - 12.5	30.0 - 32.5	30 - 36	90 - 95	0	500	166	116	0
Susan Tyler - Director of Workforce Development	5.0 - 7.5	17.5 - 20.0	40 - 45	120 - 125	668	803	136	95	0
Jill Copeland - Director of Strategy and Partnerships	0 - 2.5	12.5 - 15	30 - 35	100 - 105	562	603	41	29	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
- Dawn Hanwell started as Chief Financial Officer on 1 August 2012 and Dr Jim Isherwood started as Medical Director 1 September 2012
- Guy Musson opted out of the pension scheme from 1 April 2012
- Carol Greaves was Acting Chief Financial Officer between 1 June 2012 and 31 July 2012
- Lynn Parkinson was Acting Chief Operating Officer/Chief Nurse from 1 December 2012 until 31 March 2013.

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 8J – Remuneration and benefits in kind for senior staff (subject to audit)

Name and Title	2012 - 13			2011 - 12		
	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Benefits in kind Rounded up to the nearest £100	Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	
Chris Butler - Chief Executive	150 - 155	0	0	145 - 150	5 -10	
Guy Musson - Chief Financial Officer	15 - 20	0	0	105 - 110	0 - 5	
Carol Greaves - Acting Chief Financial Officer	15 - 20	0	0	0	0	
Dawn Hanwell Chief Financial Officer	70 - 75	0	0	0	0	
Dr Douglas Fraser Medical Director	35 - 40	10 - 15	17	85 - 90	25 - 30	
Dr Jim Isherwood Medical Director	55 - 60	40 - 45	1	0	0	
Michele Moran - Chief Operating Officer and Chief Nurse	80 - 85	0	1	105 - 110	0 - 5	
Lynn Parkinson Chief Operating Officer and Chief Nurse	30 - 35	0	0	40 - 45	0 - 5	
Susan Tyler - Director of Workforce Development	95 - 100	0	2	20 - 25	0	
Jill Copeland - Director of Strategy and Partnerships	110 - 115	0	0	110 - 115	0	
Frank Griffiths - Chairman	40 - 45	0	2	40 - 45	0	
Linda Phipps - Non Executive Director	5 - 10	0	1	10 - 15	0	
Nicola Swan - Non Executive Director	5 - 10	0	0	10 - 15	0	
Allan Valks - Non Executive Director	10 - 15	0	0	10 - 15	0	
Keith Woodhouse Non Executive Director	10 - 15	0	16	10 - 15	0	
Aqila Choudhry Non Executive Director	10 - 15	0	0	10 - 15	0	
Gillian Taylor Non Executive Director	10 - 15	0	4	10 - 15	0	

It should be noted that:

- Dawn Hanwell started as Chief Financial Officer on 1 August 2012 replacing Guy Musson who left the Trust 31 May 2012. Carol Greaves acted up to this position in the interim
- Michele Moran resigned as Chief Operating Officer/Chief Nurse on 30 November 2012. Lynn Parkinson acted up into this position from 1 December 2012 to 31 March 2013
- Dr Jim Isherwood started as Medical Director on 1 September 2012 replacing Dr Douglas Fraser who was seconded into this post
- The "Other Remuneration" amount paid to Dr Jim Isherwood relates to a Clinical Excellence award and the proportion of his salary paid to him for the clinical work he carries out. The amount paid to Dr Douglas Fraser relates to the proportion of his salary paid to him for the clinical work he carried out during the time he was seconded into the post
- In previous years some executive directors received a car allowance under this heading. This is no longer paid to executive directors
- 'Benefits in Kind' in respect of the Chair of the Trust and the other non-executive directors relates to the profit element on all travel and reimbursed expenses through payroll and is the amount over and above the HMRC allowable rates.

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.)

Table 8G

	Highest earner (a)	Median salary (b)	Ratio (a versus b)
2011/12	181,585	26,071	6.97
2012/13	181,585	26,247	6.92

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 31 March 2013 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 31 March 2013. The agency fee was identified and removed based on invoices previously paid.

24 May 2013, Chris Butler, Chief Executive, Leeds and York Partnership NHS Foundation Trust

The Mount garden

Statements

9.1 STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including responsibility for the propriety and regularity of public finance for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS foundation trusts (Monitor).

Under the NHS Act 2006, Monitor has directed Leeds 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.

Chris Butler
chief executive

Date: 24 May 2013

Chris Butler, chief executive

Niccola Swan, non executive director for LYPFT
Leeds Mind 40th anniversary celebrations

Annual Governance Statement

10.1 THE ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place by the Trust to identify and manage risk.

10.1.1 Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, while 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 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.

10.1.2 The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2013 and up to the date of approval of the Annual Report and Accounts.

10.1.3 Capacity to handle risk

The Board of Directors is responsible for the overall governance of the Trust, and its members have appropriate skills and experience to carry out this function effectively. The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The Chief Nurse/Chief Operating Officer has delegated responsibility for the development and implementation of organisational risk management, including Local Security Management. With effect from 1 April 2013 this responsibility will pass to the Chief Nurse and Director of Quality Assurance. The Chief Financial Officer (CFO) has delegated responsibility for managing the development and implementation of financial risk management (including counter-fraud). The CFO also has the role of Senior Information Risk Officer (SIRO). The SIRO has delegated responsibility for managing the strategic development and implementation of information risk management. The responsibility for risk management is also clearly communicated to all staff and is included within job descriptions.

The organisation provides compulsory and statutory training that all staff must complete. The composition of compulsory training programmes for different groups of staff has been risk assessed to ensure these are targeted and appropriate packages of training are in place. The current completion rate for compulsory training is 68%. The Trust has in place systems for monitoring the uptake of training including a report to the Board of Directors on progress.

Risk management training and awareness is included in the compulsory health and safety training supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust including to the Board of Directors. This was provided to the Board in a workshop session during the financial year and included: the seven steps of risk assessment; how we manage risk; roles and responsibilities of management of risk across the organisation; and the risk assessment and register process.

The Trust was assessed against the NHS Litigation Authority Risk Management Standards for NHS Trusts 2012/13 Providing Mental Health and Learning Disability Services in February 2013. The Trust gained compliance against Level 1 of the standards.

The Trust seeks to learn from good practice through a range of mechanisms including benchmarking; clinical supervision and reflective practice; individual and peer reviews; performance management; continuing professional development programmes; clinical audit and the application of evidence-based practice and reviewing compliance with risk management standards. There are formal mechanisms in place to ensure that external changes to best practice, such as those issued by the National Institute for Health and Care Excellence, are incorporated into policies and procedures, where appropriate.

10.1.4 The risk and control framework

The Trust has in place a comprehensive Risk

Annual Governance Statement

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

All risks are assessed using an electronic system / database for recording and managing risk assessments, which is available on Staffnet. This system /database is used by staff to assess and record risk assessments, scoring risks being extreme, high, medium or low using a 5x5 assessment of likelihood and impact. The Trust also has a process for tiering risks at tier 1, tier 2 and tier 3. Any tier 1 extreme risks are reported monthly to the Board of Directors in the performance report.

Clinical risk management continues to be supported by a standardised approach to risk assessment, underpinned by the Care Programme Approach; FACE (Functional Analysis of Care Environment) Risk Assessments (for Leeds services), and SAMP (Safety Assessment and Management Plan) Risk Assessment (for York and North Yorkshire services).

The Board Assurance Framework (BAF) is the key proactive risk identification tool for the Trust. It contains the principal risks to the achievement of the organisation's objectives as identified by the Board of Directors. The BAF enables the Board to monitor the effectiveness of the controls required to minimise the principal risks that threaten the achievement of the Trust's objectives and therefore provides the evidence to support this Annual Governance Statement. The BAF is formally reviewed by the Board and also the Audit and Assurance Committee at least twice a year. The Executive Team reviews the BAF on a regular basis to ensure that it is complete and appropriate. The BAF also details the tier 1 extreme risks and maps the controls and assurances against these.

The Data Quality Policy provides a framework for data quality assurance, highlighting the importance of accurate data and clarifying the responsibilities of staff, management and committees. This supports the organisation in meeting its legislative and regulatory requirements, as well as meeting requirements from the Department of Health for organisations to manage the security of their information, as defined within the Connecting for Health Information Governance Toolkit.

Risks to data security are managed by ensuring that all staff with access to patient-identifiable data have the requisite access permissions and have completed their compulsory information governance training. The Trust has an Information and Knowledge Manager whose role it is to advise on data security. There is also an Information Governance Standing Support group whose role it is to ensure compliance with information governance standards and to raise the profile of data security risks and develop mitigations, especially through staff training and awareness.

The Trust made a self-assessment against the Information Governance Toolkit of 'not satisfactory' as at 31 March 2013. This is because a perceived weakness in the access controls for systems used in York services. A remedial action plan is in place linked to the clinical system evaluation which will lead to those services being moved from this application. This assessment has led the Trust to review overall compliance with CQC essential standards outcome 21, and declare yellow (outcome mostly met). All other CQC essential standards are fully met.

An analysis of our information governance incident reporting records for 2012/13 contains no incidents which have either a volume or severity that would classify them as a serious incident reportable to Monitor and the Information Commissioner's Office.

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter Fraud Specialist in accordance with the NHS Secretary of State's Directions to NHS Bodies on Counter Fraud Measures that were re-issued in November 2004.

All staff are responsible for managing risks within the scope of their role and responsibilities as employees of the Trust. There are structured processes in place for incident reporting and the investigation of Serious Incidents. The Board of Directors, through the Risk Management Policy and the procedure for the Management of Incidents and Serious Incidents, promotes open and honest reporting of incidents, risks and hazards. The Trust has a positive culture of reporting incidents. The Board also receives and reviews reports in respect of Serious Incidents.

Annual Governance Statement

Incident reporting is encouraged within the Trust and a comprehensive programme of investigation and follow up of all incidents is in place. The Trust Incident Review Group (TIRG), which includes non-executive director representation and more recently governor representation, has responsibility for reviewing all serious incidents. Objective investigations are carried out for each case and a root cause analysis is undertaken. Both the Board of Directors and Council of Governors receive information regarding incidents unexpected deaths, 'Trigger to Board' and 'Never Events', should they occur.

The Risk Management team also produces a quarterly integrated report which brings together information about serious incidents (SIs), complaints, claims and PALS enquiries. This is presented to TIRG, Means Goal Standing Group 1&2, and the Audit and Assurance Committee. Procedures are in place to review processes and to learn any lessons that might be highlighted by incidents, complaints, claims and PALS enquires. In addition to learning lessons from the integrated report, the Trust also highlights learning through review of the individual incident reporting form; the Directorate Risk forum; data analysis; 12-hour fact find; thematic reviews, and analysis of latent and causational factors highlighted in root cause analysis investigations.

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with. Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Those concerned with the development of procedural documents 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 procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents and the Equality Impact Assessment Guidance.

Compliance with the Care Quality Commission (CQC) essential standards of quality and safety are one of the elements of the organisation's risk management process. The Trust is registered with the CQC without conditions, and is fully compliant with its registration requirements.

To manage any risk of being non-compliant with the CQC registration standards detailed assessments of compliance are undertaken on a quarterly basis. These are 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 is carried out. These mirror the format of inspections undertaken by the CQC and provide an in-depth look at individual ward compliance with the registration requirements. A full report of findings is produced along with action plans to address any identified areas for improvement.

During the year the CQC made two visits to the Trust and confirmed that the services visited are fully compliant with the outcomes inspected, as described below.

The CQC carried out a visit to Ward 3 Newsam Centre on the 1 May 2012 to follow up compliance actions from a previous review at the ward in December 2011. The CQC confirmed that significant improvements had been made to all areas identified in the previous review and the Trust was found to be compliant with both the outcomes assessed. The concerns were removed.

The CQC carried out a routine review of the Becklin Centre on 21 August 2012 as part of their schedule of planned reviews. The review focused on five outcomes; Outcome 1: Respecting and involving people who use services; Outcome 5: Meeting nutritional needs; Outcome 7: Safeguarding people who use services from abuse; Outcome 13: Staffing ,and Outcome 21: Records. The CQC found the Becklin Centre to be fully compliant with all outcomes reviewed, with positive comments received and no areas of concern or improvement identified.

Where compliance actions or improvement actions have been received as a result of an inspection, robust action plans have been implemented with progress reported to the Executive Team and the Board of Directors through the monthly performance report. The Trust has a proven track record of addressing compliance actions in a timely and effective manner with these being removed by the CQC at the follow-up visits.

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

Key stakeholders, including service users and carers, are consulted and involved with the

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management of those risks that impact upon them. This is achieved through a variety of mechanisms including public consultation, involvement with service planning and modernisation, individual care planning, the Council of Governors, Patient Advice and Liaison Services (PALS), Health and Overview Scrutiny Committees and joint working arrangements with key partners in the local areas.

The Trust has undertaken risk assessments, and carbon reduction delivery plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that the Trust's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

10.1.5 Key Risks for the Organisation

With regard to the immediate / in-year risks, those that are showing as tier 1 extreme risks on the risk register include:

- The need for the Yorkshire Centre for Psychological Medicine to vacate their current premises

The risk of not finding suitable accommodation located close to acute hospital services will mean that the service may not be able to operate effectively. To mitigate this risk, senior officers in the organisation are actively exploring alternative options for accommodation including those in both Leeds and York, along with evaluating other potential solutions.

- The lack of a robust data reporting system in place for the York and North Yorkshire services to support the recording of appropriate regulatory information

The risk of this is that the Trust is unable to gain satisfactory assurance on performance, and the collection of information in respect of the Mental Health Minimum Data Set and to support Payment by Results. To mitigate this risk work has been undertaken to look at how the patient information system might be enhanced to obtain the necessary reports. Where no computerised patient data system is in place manual reporting systems have been established until such time as the Trust can implement a standardised system across the organisation.

Some of the future risks facing the organisation include:

- The implementation of Payment by Results (PbR)

Changes to contract currencies, including specialist commissioning, could potentially affect the profile of income for the Trust, particularly if tariffs are mandated that are below the Trust's local prices and activity recording is not robust to support a payment currency. To mitigate this risk there is a robust system of project management in place to support PbR implementation in the Trust.

- Loss of contracts for the provision of clinical services

As a consequence of the commissioner landscape changing and an increasing drive to tender / market test services this may lead to a loss of current commissioner contracts. To mitigate this risk the Trust is seeking to establish good working relationships with all commissioners, to maintain service quality and demonstrate ongoing value for money.

10.1.6 Review of economy, efficiency and effectiveness of the use of resources

The Trust has a comprehensive system that sets strategic and business objectives. The Board of Directors sets these objectives with regard to the economic, efficient and effective use of resources. The objectives that are set reflect national and local performance targets for standards of service user care and financial targets to deliver this care within available resources. Within these targets, the Trust includes specific Cash Releasing Efficiency Savings (CRES) plans. The Trust has a track record of delivery against CRES plans demonstrating sustainability and improvements in economy and efficiency.

The Trust has a robust monitoring system to ensure that it delivers the objectives it identifies. Ultimate responsibility lies with the Board of Directors which monitors performance through reports to its meetings on a monthly basis. Underpinning this is a system of reports on financial and operational information to the Executive Team, and the operational means goal groups.

Clinical services in the Trust are currently undergoing a major transformation to ensure that recovery-focused, person-centred care continues to be delivered along appropriate care pathways in a cost effective way. Comprehensive programme management arrangements have been put in place. This transformation is the key part of the sustainable CRES plans that will be needed over the medium term and is supported by Lean Six Sigma methodology. All staff are required to undergo regular appraisal, part of which is to identify training and development needs to

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ensure that the clinical workforce remains fit for purpose. Changes to care pathways are quality assured by our Professional Advisory Forum (PAF).

The Trust operates within a governance framework which includes Standing Orders, Standing Financial Instructions, a Scheme of Delegation and Matters Reserved to the Board of Directors. This framework includes explicit arrangements for:

- **Setting and monitoring financial budgets**
- **Delegation of authority**
- **Performance management**
- **Achieving value for money.**

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

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

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

- The Board of Directors which receives an update on any significant events or matters that affect the Trust. The Board also receives regular reports on the significant risks as identified in the risk register, the Board Assurance Framework, minutes from its sub-committees including the Audit and Assurance Committee.

- Internal Audit (RSM Tenon) provides an independent and objective opinion on the degree to which risk management, control and governance support the achievement of the Trust's objectives. The audit plan is derived from an assessment of risk areas within the Trust and includes all areas where Internal Audit is named in the Board Assurance Framework as a provider of assurance on the effectiveness of key controls. Internal audit reported no major concerns arising from their work during the period of this report. A small number of reviews provided only limited assurance and action plans are in place to address the weaknesses identified.

Internal audit reported that both the Board Assurance Framework and risk management processes operated effectively during the year. The Head of Internal Audit in his opinion stated "My overall opinion is that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and / or inconsistent application of controls put the achievement of particular objectives at risk".

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

- The Audit and Assurance Committee is a sub-committee of the Board of Directors and reports directly to it. The committee has responsibility for being assured in respect of risk management, and for overseeing the activities of internal and external audit and the local counter-fraud services.

The committee executes this role by approving the annual plans for internal, external, clinical audit and counter-fraud; receiving reports and updates against those plans; reviewing risks and the Board Assurance Framework; carrying out deep-dives into any area where further assurance is required on an area of risk.

10.1.7 Annual Quality Report

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

Our top three priorities for quality improvement, which have been set out in our previous Quality Account, have been consistent with our three strategic end goals. It has been reported in our previous Quality Account that the Trust envisaged that these three priorities will remain our Quality Account priorities until 2015, in line with our Trust Strategy. Following the refresh of the Trust Strategy these three priorities will remain in place within our

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Quality Account until 2017.

Our strategy has at its heart the people who use our services, their families and carers. Development of our strategy was led by our governors, with the support of people who use our services, carers, staff, our main commissioners and partner organisations. 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 previous Quality Account measures were in line with the strategic direction of the Trust and local quality schemes, a review of our Quality Account measures took place to ensure that these were aligned with our strategy measures and local Commissioning for Quality and Innovation (CQUIN) measures. A shortlist of our strategy measures was circulated to our Council of Governors which was asked to vote on the measures they wanted including in our 2010/11 Quality Account.

With the planned refresh of the Trust Strategy, our governor's Performance Group and our Executive Team agreed that the strategy measures included within our 2011/12 Quality Account would remain in place for our 2012/13 Quality Account to enable consistency and to allow progress to be demonstrated.

A full consultation of the Trust Strategy commenced in April 2012 to ascertain whether key stakeholders were satisfied that our strategy measures were still in keeping with the local and national direction of travel. This work has continued to ensure we have a set of measures within our strategy which are meaningful to all. This is also reflected in our Annual Plan.

Our final measures are set out under each priority within our Quality Account. The source of the measure demonstrates whether this is one of our strategy measures or one of our 2012/13 CQUIN (Commissioning for Quality and Innovation) measures.

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. The findings are used as assurance of the quality of clinical care provided by the Trust, and actions being taken to address areas for improvement.

The performance information included in the Quality Account is in line with the performance information 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 the Board of Directors, which set out performance against external requirements including Monitor targets, CQC Registration Regulations and our contractual requirements with our main commissioner
- Quarterly performance reports to the 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 Care Quality Commission Registration Regulations
- Quarterly submissions to the Board of Directors for sign-off on our performance against Monitor targets.

Performance information is obtained from the Trust's PARIS (Leeds services) and CPD (York and North Yorkshire services) service user administration and clinical information systems.

To manage the risk of there being incorrect performance information, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into the patient records' systems. 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 warehouse is used 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 information analysts work closely with

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the Performance Team to ensure appropriate performance reports are provided. The Performance Team works closely with directorates to ensure information required for the reporting of measures of performance is collected appropriately and included in performance reports. These reports are reviewed on a regular basis to ensure new items are included, such as CQUIN and Monitor updates.

Information is supplied within a real-time framework allowing, for example, the April Board meeting to review data for March. Data quality reports are used to ensure data is collected appropriately and reviewed on a regular basis. Performance measures are reported using the appropriate constructs and the information and Performance Teams work closely to ensure any changes to these constructs are taken into consideration. Areas of concern in the collection of data are reported to the appropriate governance group for resolution with appropriate directorates / teams.

Progress against our 2012/13 Quality Account initiatives and measures were reported to the Board of Directors through the monthly performance report. Each key priority was reported upon on a quarterly basis.

10.1.8 Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee and the Executive Team and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The processes, procedures and reports that I used to maintain and review effectiveness include:

- The development, review and challenge of the Board Assurance Framework (BAF) by the Audit and Assurance Committee. The BAF is compiled by the Head of Corporate Governance in conjunction with the relevant executive directors and senior managers
- A review of the effectiveness of committees within the governance structure including the Board of Directors and the Council of Governors, with any weakness being the subject of action plans for each group
- Challenge from the Audit and Assurance Committee which receives assurances on the sufficiency of the internal controls from various aspects of the organisation
- The completion of the Clinical Audit plan for which a progress report is provided to the Audit and Assurance Committee to ensure appropriate progress is being made and assurance on any actions to address any slippage
- Internal Audit reports on internal controls to provide assurance that they remain effective, with reports being made to the Audit and Assurance Committee, and a satisfactory Head of Internal Audit Opinion being provided for the financial year
- A performance report on the key internal and external targets and standards is presented at each Board of Directors' meetings with challenges made to executive directors as to how any under-performance is being managed
- The achievement of Level 1 NHSLA assessment with only minimal action necessary to further improve performance.

With regard to the governance structure in place in 2013/14 there will be review of the lines of reporting and the committees / groups required to ensure that the structure remains effective and responsive to the needs of the organisation.

10.1.9 Conclusion

Over the last year I have overseen actions to ensure that we continue to improve the systems of control we operate. My review confirms that the Leeds and York Partnership NHS Foundation Trust has no significant internal control issues and a generally sound system of internal control that supports the achievement of its policies, aims and objectives.

Signed by order of the Board

Chris Butler
Chief Executive, Leeds and York Partnership NHS Foundation Trust

Date: 24 May 2013

Part B
Quality Account

Content

Chief Executive's Statement

1.1 The Chief Executive's statement

There has been a lot of change in the NHS during 2012/13. We have seen the new structures of the NHS evolve over the past 12 months which will culminate in the abolition of the Primary Care Trusts and Strategic Health Authorities on 31 March 2013, to be succeeded by the new Clinical Commissioning Groups and NHS England. This is in the context of the February 2013 publication of the second Francis Report into the work of the Mid Staffordshire NHS Foundation Trust http://www.midstaffspublicinquiry.com

There are 290 recommendations in the report and the Government has published its response. I do not intend to address all of the issues raised in the report in this statement, but I want to alight on those which I believe are salient to our Trust and to this Quality Account. This is in the context of our Trust's strategy which is a strategy for quality with service users, their families, and their carers at the heart of all that we do.

Governance and Trust Boards

Francis alighted on a need for Boards of Directors (the Board), also Councils of Governors (the Council) to keep the quality of service provision clearly in their sight along with being responsive to problems.

We do our best to ensure that both the Board and the Council discharge their responsibilities in this area. Currently our corporate performance report, which is considered every month by the Board and quarterly by the Council, covers much more than financial performance. The bulk of the report covers non-financial issues, such as our compliance with the standards of the Care Quality Commission (CQC); nationally defined "never events"; along with our locally agreed "trigger to board" events, which are matters giving cause for concern which the Board and the Council are automatically alerted to. Hard data is also supplemented by other activities such as quality walk-arounds and service user stories to the Board.

Along with a range of other mechanisms, such as the risk register, the assurance framework, and the work of our Trust Incident Review Group, it is our intention to continue keeping quality permanently on the agenda of the Board and the Council. However, we never assume that everything is covered. This coming year is an opportunity to use the Francis Report, and the government's response, to take a fresh view of our existing arrangements consistent with the government's intention that all NHS hospitals (we are interpreting this as including mental health and learning disability services) will set out how they intend to respond to the inquiry's conclusions before the end of 2013.

Fundamental and enhanced standards of quality

Francis described the need for a system of standards to ensure patient safety. He envisages the development of fundamental standards established through legislation and enforced by the regulator of health and social care. This, he suggests, should be aligned to a zero tolerance approach to sub-standard care connected, in some instances, to criminal sanctions in the event of patient death or serious harm from poor quality of service provision. In its response the Government has said that it will ask the CQC to draw up a new set of simpler fundamental standards.

With regard to standards of care, there is a lot being done in this area. A quick snapshot of these within our Trust include:

- Therapy Outcome Measures **http://ahp.dh.gov.uk/2012/08/31/toms-supporting-learning-disability-ahps-to-show-how-they-improve-health-and-lives/**;
- CORE outcome measures in psychological therapies **http://www.coreims.co.uk/index.htm http://ahp.dh.gov.uk/2012/08/31/toms-supporting-learning-disability-ahps-to-show-how-they-improve-health-and-lives/l**
- Our development work in recovery **http://www.centreformentalhealth.org.uk/recovery/what_is_recovery.aspx,**
- The Department of Health's Essence of Care **http://www.dh.gov.uk/en/Publicationsandstatistics/Bulletins/Chiefnursingofficerbulletin/October2010/DH_120939** and,
- Some of our inpatient units being successful in the Royal College of Psychiatrists Accreditation for Inpatient Mental Health Services (AIMS) **http://www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement/qualityandaccreditation/psychiatricwards/aims.aspx**

However during 2013/14 there is work to do to ensure that these great initiatives are better linked together into a coherent framework which is more explicitly linked to outcomes.

With regard to zero tolerance, it would, I suggest, be entirely unrealistic of any mental health or learning disability service to have an overly zealous approach to this. I know from my own clinical practice that, consistent with helping service users achieve their goals for improving their health and their lives, there are and will be occasions where risks will need to be taken. A simple example

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will be agreeing a period of leave for a person detained under the Mental Health Act as they recover from an acute episode of illness. What will always need to be evidenced is the rationale for a decision in the context of a coherent plan for a person's care. However, it follows that it is conceivable that there will be times when there is an adverse outcome for a service user but for the right reason.

Duty of candour, complaints and clinical risk

The Francis Report found that there were organisational and structural impediments to staff reporting episodes of poor quality care, which meant that patients and their families were not able to find out about it and obtain closure. To combat this, Francis recommended, among other things, a "duty of candour", again with related criminal and regulatory penalties for non-compliance.

How open are we as a Trust?

We do our level best to never make a misleading statement to anyone about our work.

Ahead of being compelled to do so, our Board has been meeting in public for some time. Our simple view is that as a Public Benefit Corporation it was simply the right thing to do. At the start of every meeting, the Chair invites questions and comments from those attending and re-engages with the same people at the end of the meeting. At the same time we use Twitter throughout the course of the meeting to let a wider audience know about what we are discussing and agreeing. I mentioned earlier in this statement how we use our corporate performance report which is publically available.

When things go wrong in our services we do our best to directly engage with those who are effected by events, though we cannot always reach agreement between family members and the professionals involved, particularly in what can be very difficult circumstances.

With regard to staff reporting concerns, like all other NHS organisations we have a whistleblowing policy. Alongside this we try to find other ways to enable staff to express their opinions about a number of issues both face to face and by using technology by conducting ad-hoc polls on issues.

We do our best to offer information to service users and, when appropriate, carers through, for example, offering service users a copy of their care plans.

We encourage people to express views about our services and we do our best to positively respond. For example, the website Patient Opinion has cited us a Trust that works positively and well with them https://www.patientopinion.org.uk/. Concerns raised about our services through Patient Opinion, and our responses, are fully public.

With regard to patient safety and serious incidents (SI), we are still among the Trusts which frequently report a large number of incidents to the NHS Commissioning Board (prior to this the National Patient Safety Agency). Much of what we report causes no harm but we know that we need to ensure that we capture information about high frequency, low impact incidents. For SIs we always do a root cause analysis, and there are times when we commission independent reviews of events even if we have a vague suspicion that something may be going wrong. Following an SI we do our best to prevent a recurrence of a similar event.

Enhancements to provision of information, inspection and monitoring

Our activities in this area is covered elsewhere within this statement.

Workforce issues

Francis has called for a more rigorous approach to the management of difficult personnel issues sometimes by the NHS. This will include giving contractual force to duties around NHS values and the NHS Constitution http://www.dh.gov.uk/health/category/policy-areas/nhs/constitution/, and requiring senior managers to comply with a code of conduct and standards. The report also recommends that fitness to practise procedures on the part of, for example, the General Medical Council or the Nursing and Midwifery Council, should not delay actions of providers and that employment disciplinary proceedings may need to be reviewed to enable this.

With regard to values, our Trust has adopted the NHS values in the NHS Constitution, which are:

Respect and 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.

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.

Working together

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

Chief Executive's Statement

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.

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

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.

These values are easy to write down but difficult to put into practice in a consistent way every day. We use the NHS values in recruitment and discuss these in staff appraisals.

Connecting these to the experience of service users and carers show us that 39% (Leeds) and 53% (York and North Yorkshire) of service users see us as having a positive experience in helping them meet their goals for improving health and lives[1]. There is clearly more work to do in this area.

With regard to staff, we try to strike the right balance between being clear about expectations, whilst being sensitive to the fact that our colleagues work with people who are experiencing difficulties which require specialist interventions by expert professionals. There are times when things will go wrong and there are times when we take formal disciplinary action, but that is not the only thing that we do. There are many occasions when, rather going down the disciplinary route, we will work with a person who "owns up" to a situation and takes personal responsibility and agree with them what improvements and changes need to happen through a shared "personal responsibility plan" (PRP). During 2012/13 there were 44 instances of disciplinary action being taken ranging from a verbal warning to dismissal whilst 42 were dealt with via a PRP.

Like every organisation across the NHS we need to increase our efficiency and reduce our costs. We do our best to assess the impact of any changes to the numbers of staff resulting from any changes we put in place. It will never be possible to eliminate each and every risk associated with this but, given our relative financial strength as a Trust, we always have plans ready to mitigate any unexpected risks we encounter.

Commissioning for quality

Francis emphasises that commissioners should also have a primary responsibility for ensuring quality and, if needed, commission services from an alternative provider.

Over the past 12 months we have worked hard with our commissioners to both familiarise each other with our respective work, also for us to understand their future requirements. Most of our work is commissioned from four clinical commissioning groups with 10% being commissioned by NHS England.

We have always met the requirements of our commissioners in order for us to earn our Commissioning for Quality and Innovation (CQUIN) funding.

We always keep our commissioners connected to any SIs and how they are being managed.

The role for the regulators

The Francis Report's comments are largely concerned with national issues, however we work hard at aligning our work with the intentions and actions of the General Medical Council (GMC) and the Nursing and Midwifery Council (NMC). Examples include local work with our university partners with regard to shaping the undergraduate nursing curricula. For doctors, we are also ready for the implementation of medical revalidation. Relevant to the role of Health Support Workers we have, with the University of Leeds, developed a Mental Health Associate Practitioner programme. Finally, all of our managers already have the Code of Conduct for NHS Managers

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005410
and, for managers who are registrants, they are at the same time also bound by their professional codes (GMC, NMC).

Winterbourne View Hospital review

Along with the Francis Report, in May 2011, the BBC's Panorama programme disclosed horrific levels of abuse at Winterbourne View, a private sector assessment and treatment hospital near Bristol for people with learning disabilities.

Since the abuse was discovered both our Learning Disability service and, the Trust as a whole, has undertaken work to ensure that our services are safe for the vulnerable adults who access them.

[1]Results from the 2012 National NHS Community Mental Health service user survey

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All the ensuing reports from the scandal at Winterbourne View have been reviewed through our learning disability service's governance processes including the recommendations of:-

- Dr Margaret Flynn's Serious Case Review http://hosted.southglos.gov.uk/wv/report.pdf
- The response of national government http://www.gov.uk/government/publications/winterbourne-view-hospital-department-of-health-review-and-response
- The results of the national inspection of the Care Quality Commission (CQC) http://www.cqc.org.uk/public/our-action-winterbourne-view. This work was subject to the oversight of the Trust's governance arrangements.

We have worked with Leeds Safeguarding Adults Partnership Board, together with The Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare NHS Trust, and City of Leeds Adult Social Services Directorate to provide assurance to the Safeguarding Adults Partnership Board that we are compliant with the recommendations from the Serious Case Review.

As part of the initial response, prior to formal visits by the CQC as part of their national inspection, mock CQC inspections were conducted in the Leeds and York Learning Disability service. Full CQC inspections were conducted at Parkside Lodge, White Horse View, Woodland Square and the Newsam Centre. We have worked to ensure compliance with the essential standards of quality and safety.

Our Learning Disability services at Oak Rise and Parkside Lodge have also been subject to the national programme of Mental Health Act inspections focussing on restrictive practices, where positive feedback was received.

The events at Winterbourne View were also reviewed and discussed at the professional forums across the Trust, including the Learning Disability Nurse Forum, and in team meetings in both Leeds and York.

From our assurance work following Winterbourne View we have developed a Trust wide programme of mock CQC Inspections, which we have implemented in a number of services throughout the Trust.

Work continues within Learning Disability services, through a Winterbourne View Task and Finish Group, which will monitor progress against the concordant of action, which was published by the Department of Health in 2013

Conclusion

As is evident, regardless of the government's response to the Francis Report and Winterbourne View, and what we already have in place, we do have work to do to take forward the spirit if not the letter of both of these inquiries. Specifically, this Quality Account illustrates some of the key points on our journey of being the best we can be in this context.

In concluding I also want to take a moment to thank all of the staff of Leeds and York Partnership NHS Foundation Trust for their professionalism and the deep commitment they show to their work 24 hours a day, 7 days a week. We only do what we do through the work of our people and everybody working in our Trust, either directly or indirectly contributes to creating a better future for service users and carers. I am proud to be associated with the people who everyday display such expertise and professionalism.

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

Chris Butler
chief executive

Leeds and York Partnership NHS Foundation Trust
April 2013

Our Trust Strategy and Trust Values

2.1 Our Trust strategy and Trust values

Our Quality Account is fully aligned with our five-year strategy, which describes what we want to achieve over the next five years and how we plan to get there. The strategy is designed around the three key elements of quality: effective outcomes, safe care, and positive service user and carer experience.

We produced our first strategy in 2010 and decided to refresh it in 2012 in response to the many changes which have happened both within our organisation and in the wider world around us. In particular, we wanted to make sure our strategy is relevant to the new communities we serve following our integration with mental health and learning disability services in York and North Yorkshire on 1 February 2012 to form the Leeds and York Partnership NHS Foundation Trust.

A summary of our new strategy for 2013 – 2018

Purpose	Improving health, improving lives		
Values	Respect and dignity	Commitment to quality of care	Working together	Improving lives	Compassion	Everyone counts
Ambition	Working in partnerships, we aspire to provide excellent mental health and learning disability care that supports people to achieve their goals for improving health and improving lives.		
Goals	**1** People achieve their agreed goals for improving health and improving lives	**2** People experience safe care	**3** People have a positive experience of their care and support	
Strategic objective 1	**Quality and outcomes**	We provide excellent quality, evidence-based, safe care that involves people and promotes recovery and wellbeing	• Measuring and improving outcomes • Ensuring we meet people's needs through effective care planning • Implementing new approaches to support recovery and wellbeing • Developing new and existing services to meet people's needs • Making services better, simpler and more efficient • Improving services through research
Strategic objective 2	**Partnerships**	We work with partners and local communities to improve health and lives	• Building and maintaining successful partnerships • Campaigning against stigma and discrimination • Involving people in shaping their services
Strategic objective 3	**Workforce**	We value and develop our workforce and those supporting us	• Promoting a healthy culture and the NHS values • Developing our staff • Ensuring a healthy work environment
Strategic objective 4	**Efficiency and sustainability**	We provide efficient and sustainable services	• Delivering cost effective services and maintaining financial stability • Making best use of modern technology • Providing services from fit-for-purpose, cost-effective buildings • Implementing payment by results
Strategic objective 5	**Governance and compliance**	We govern our Trust effectively and meet our regulatory requirements	• Responding to national governance and compliance requirements • Developing our Board of Directors and Council of Governors
Measures of success	Measures of success for all goals and strategic objectives can be found on our Trust website		

Our Trust Strategy and Trust Values

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

We have three **goals** that very simply describe the outcomes we aspire to for everyone who uses our services. They are the three things we believe will help us achieve our purpose and which we are passionate about realising. We have deliberately kept them simple so all our staff can keep a clear focus on them every day and in everything they do. For each goal we have criteria that we can measure so that we will know when we have supported people to achieve their desired outcomes.

Our **strategic objectives** describe what we need to do to achieve our goals. They are the means by which we will achieve our goals. We are proud of the achievements we have made over the last few years; and we know we have much more to do. Underpinning each strategic objective are the priority actions we will undertake to achieve our ambition and goals over the next five years.

For each objective we have set ourselves some measures of success: standards we want to achieve by 2017/18, and milestones to track our progress. Included are some new measures that reflect the breadth of services we now provide. We have also removed some measures included in our last strategy that are already reported as part of our regulatory regime, with organisations like Care Quality Commission and Monitor. All our measures will continue to be tracked through our governance framework to make sure we are on course in achieving them.

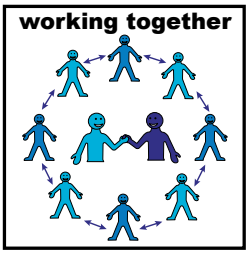
Our Trust Values

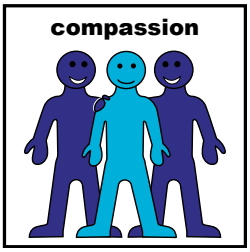
The values set out in the NHS Constitution underpin our strategy and the way we work with people every day. Our staff provide compassionate, high quality care that focuses on improving people's lives; they treat people with respect and dignity; they make sure that everyone counts by supporting people to achieve their individual goals; and our staff know the importance of working together with our partner organisations to make sure people get the best package of care and support to meet their needs. When, occasionally, we get this wrong, we do our best to address any individual complaints quickly; and also to learn from our mistakes.

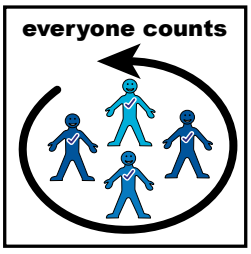
We are already doing lots of things to embed the values in everything that we do. For example, we include the values in our annual performance review for each and every member of staff. We also recognise those staff, including volunteers, who demonstrate the values in their day-to-day work through a reward scheme called STAR. When we recruit new staff in our learning disabilities services, we ask them to show us how they will live the values in their role. We ask people to demonstrate how they live the NHS values in their annual appraisals. We are continually seeking new ways to further embed our values in the day-to-day life of our organisation, to celebrate our successes and learn from our mistakes.

Our Charter of Values is shown on the opposite page.

Matthew Armitage receiving his Star Scheme award







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."

Frank Griffiths
chair

Chris Butler
chief executive

improving health, improving lives

Overview

2.2 Overview of organisational effectiveness initiatives

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

Integrated organisation

Since the creation of Leeds and York Partnership NHS Foundation Trust in February 2012 we have continued to work to bring 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. We now have integrated management arrangements for Leeds and York forensic services; and are seeking to identify improvements in forensic pathways which we can deliver as a result. Similarly our learning disability services are now integrated, and services for children and adolescents are managed as part of our Specialist Services. This is the beginning of full service integration; to deliver the quality benefits of our Better Together project

What's your Goal?

Throughout 2012, our What's your Goal? campaign shared the simple messages about mental health and wellbeing with 10,000,000 people. We raised £24,000 in funds for healthy living activities and broke a world record for the longest line of bunting. We have entered our campaign for a CIPR award (a prestigious PR awards ceremony).

World record attempt, longest line of bunting

Love Arts

Last year the Love Arts festival was awarded a Health Service Journal Communicating Efficiency award. We expect this year's festival to be even bigger and better. We plan to have over 40 different events taking place throughout the city of Leeds. There are also plans afoot to develop a micro-festival in York too. This year's festival will have a strong storytelling theme that will link to our Sharing Stories campaign.

Adult Social Care awards – Partner of the Year

The Learning Disability Service User Involvement Team was nominated and shortlisted in the 'Partner of the Year' category, at the Adult Social Care Awards for Excellence (September 2012.)

Adult Social Care Head of Service Andy Rawnsley, who nominated the team, said:

"The Service User Team specialise in involving people with learning disabilities in taking control of their lives and making information accessible to people with a wide range of needs.

They have gone that extra mile to support a wide range of initiatives across sectors in both this and previous years. The quality of their input is always excellent and I would particularly like to note their contribution to Learning Disability Week and the Safe Places scheme - for which they quite literally not only wore, but designed the T-shirt!"

Overview

Your Health Matters resource centre

The Your Health Matters resource centre was launched in May 2012. It provides focussed day service alternatives for up to five people with learning disabilities a day. The service is directly commissioned by Adult Social Care and is part of the day service modernisation programme. The service enables participants to undertake focussed activities which explore their own health and wellbeing as well as producing resources and materials for use by people with learning disabilities and provider organisations right across Leeds.

AIMS Learning Disabilities at Parkside Lodge

The incremental accreditation process is progressing to stage 2 at Parkside Lodge. This second stage follows successful accreditation at Stage 1 in October 2011.

A project team led by our Consultant Psychiatrist within the service has been initiated in order to monitor and gather evidence to support the self review which is taking place from 1st January 2013 to 29th April 2013. Upon completion of the Self Review there will be an external assessment to ascertain the level of compliance against the standards for accreditation.

Apprentices in the Specialised Supported Living Service

During 2012/13, the Specialised Supported Living Service worked closely with Human Resources and the Development Team throughout 2012 to introduce apprentice support workers to the service. In addition this programme has been a partnership with Leeds City College who will provide the educational/academic input into each apprentice placement

Seven apprentices commenced in December 2012. The service will be looking to undertake a further campaign in 2013.

Apprenticeship Pilot Awards

We have won two awards at the Yorkshire and Humber Strategic Health Authority Apprenticeship Awards.

The service manager of the Learning Disabilities Supported Living Team was the winner of the 'NHS Apprenticeship Supporter of the Year' Award acknowledging her tireless work to introduce apprenticeships for new recruits into the Supported Living Service.

Our Trust's work on this Apprenticeship Pilot and apprenticeship opportunities for Trust employees was 'Highly Commended' in the 'NHS Apprenticeship Employer of the Year' category.

Lisa Baker, pharmacy technician, St Mary's Hospital

Overview

Structured activity

Significant work has evolved across all the wards at the Mount to increase the amount of structured activity offered to service users. This piece of work has focussed on providing needs-led activity which is available during the day, evenings and at weekends. The activities provided are regularly reviewed taking into account service user feedback on effectiveness and also levels of attendance. Work has also been undertaken to explore the use of volunteers and a particularly memorable day was when employees from Lloyds Banking Group offered their services for a day to help provide some planned activities across the dementia wards.

Garden of Well-being – The Mount dementia inpatient services

As part of a carers event in 2011 for our inpatients with dementia at The Mount, access to fresh air and outside space was seen as one of their top three priorities. As a result of this a project group was initiated using evidence based practice and a garden was designed specifically for this group to replace the existing area that was currently not meeting our service users' needs. This project eventually culminated in a sensory garden being developed and opened in July 2012.

Garden of Tranquillity:-

Simple landscaping for quiet reflection and space for service users, carers and staff to spend therapeutic time together.

Potter's Corner – The Mount mental health wards:-

Potter's Corner is essentially a working garden designed to provide therapeutic occupation for older people who enjoy gardening. This garden was specifically designed to cater for older people (raised beds, accessible walkways etc) and it is hoped that the service users will be able to spend significant time off the ward area to enjoy this space.

Garden of Tranquillity at the Mount

Priority 1

2.3 How we have prioritised our quality improvement initiatives

Our top three priorities for quality improvement, which have been set out in our previous Quality Account have been consistent with our three strategic goals. With the refresh of our Trust strategy these three priorities will remain in place within our Quality Account until 2018. We have taken the opportunity to go back to people who use our services, carers, staff and partners to check that our goals and strategic objectives are still the right ones for the next five years; and to help us develop a list of priorities for action. We have done this through conversations, workshops and a survey which we sent out widely to get the views of our many stakeholders.

Therefore, our three top priorities for quality improvement remain as:

Priority 1:
(clinical effectiveness): **People achieve their agreed goals for improving health and improving lives**

Priority 2:
(patient safety): **People experience safe care**

Priority 3:
(patient experience): **People have a positive experience of their care and support**

Each of these priorities, along with our initiatives for 2013/14, are set out on the following pages.

Progress against our priorities set out in our 2011/12 Quality Account are reported on the following pages and have been reported to our Board of Directors and Council of Governors through our corporate performance report, with each key priority reported upon on a quarterly basis. These are publicly available documents and can be viewed on our website www.leedspft.nhs.uk/about_us/performance

Progress against our priorities set out in this year's Quality Account will continue to be reported to our Board of Directors and Council of Governors through our corporate performance report.

P1 Priority 1 (clinical effectiveness) - People achieve their agreed goals for improving health and improving lives

Progress against 2012/13 initiatives:

a) 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 Trust-wide transformation programme.

The customised reports from the Leading to Quality project have been issued directly to the relevant teams. Funding is secured to resource the evaluation of our Trust-wide transformation programme which involves collaborative work with both universities of York (via the Collaboration for Leadership in Applied Health Research and Care and Translating Research into Practice – Leeds and Bradford theme) and Leeds, as well as the Leading to Quality team.

Additionally, the Academic Health Science Network in Yorkshire and the Humber will come into being from 1st April 2013. We intend to be a partner organisation and have been involved in the successful bid that will result in £10m per year for a five year period. The intention is to create a step improvement in the health of the region's population and transform the quality and efficiency of healthcare by: generating evidence, testing and delivering new service models and accelerating the translation, adoption and spread of innovation and research, creating a workforce trained for new ways of working, and partnering with industry. Specific to our Trust, this incorporates prioritising areas for service development that reflect the NHS Outcomes Framework and research strengths including mental health, dementia, depression, self-harm and patient safety. A key goal is to promote independence, self-management and care for people with current, emerging and complex long-term conditions through the implementation of evidence-based innovation in assistive technologies, telehealth, new drugs and therapies, including a full economic assessment of new systems.

b) 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

Priority 1

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 (CORE)
- Health of the National Outcome Scales (HoNOS)
- Therapy Outcome Measures (TOMs)

Initial work has demonstrated that our Trust is helping people improve their wellbeing on these measures, and the next step will be to implement this work systematically across the organisations.

Work is being scoped to have clinical outcome information presented on the client care summary in PARIS, including TOM, CORE-OM and HoNOS.

Utilisation of CORE-OM across our Trust will be re-assessed to determine its usage across the organisation and in specific service areas. The Psychological Therapy Service is focusing on increasing the use of routine clinical outcome measurement, and in taking forward the case tracking work.

HoNOS reports are provided weekly to clinicians which include the numbers of service users who have been clustered and those without a cluster. Those with a cluster allocated or reviewed within the last 12 months and therefore meet the HoNOS requirement can be drawn from that report and managed to improve performance. Training continues in the use of the Mental Health Clustering tool which includes training in HoNOS. There are now plans in place to make clustering compatible in line with the Department of Health guidelines 2013/14. This will enable clinicians to use the CROM (Clinician Rated Outcome Measure) with service users and our Trust to assess performance with our commissioners and assessment to be made in comparison with other providers.

Further areas of development have been identified by the Learning Disability Service to ensure that TOMs is used to drive forward the quality of services that are provided. The aim is to develop a TOMs carer information leaflet that will be available alongside the TOMs service user information which is in use within the service. An evaluation process has already commenced with clinicians, however, now that the report is regularly used in practice, the service aims to work alongside the service user Involvement Team to work with service user and carers to review and develop the tool using their feedback and input.

c) 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 implementation of the Shared Pathway, which is a national requirement for all secure services.

The tracking system continues to be piloted on paper within multi-disciplinary teams to ensure its relevance and effectiveness for teams and service users. The team are currently utilising anonymised paper summaries to complete the audit of service users progressing through their pathway. Options are being explored in translating the system to an electronic version.

d) 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

The What's your Goal? campaign drew to a fantastic finale at Leeds United Football Club in December 2012. The bunting was measured by independent witnesses and an announcement was made within the stadium that the record had been broken. Leeds United Football Club included an article in their match programme. Our Trust also received an array of media coverage.

After the event, the bunting was displayed at the St John's Shopping Centre and is currently on display at Monks Cross Shopping Centre and Coppergate, York. The bunting is displayed alongside posters as a reminder of what the campaign was about and to again encourage people to talk about mental health

e) 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

Priority 2

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 partners organisations in this exciting project.

A current project plan for recovery strategies within our Trust for 2012/13 has been submitted for approval.

A successful proposal from our Trust and Adult Social Care has been approved with agreement for six posts for peer support workers and two social work posts within the community hubs. This project will focus on raising awareness of recovery focussed practices and develop more self-directed assessments to enable service users to develop their own care packages.

A lived experience network has been set up for staff who work within our services to determine how we can better support our staff. A conference is planned for late 2013 in conjunction with the voluntary sector and the Andrew Simms centre.

The recovery module continues to be accredited by Leeds Metropolitan University and sessions are run in house at St Mary's Hospital – this forms the start of the Recovery Education Centre and runs on a yearly basis for staff, service users and carers. Recovery sessions for all staff within our Trust continue on a monthly basis and will be focussed on the community hubs in 2013.

Initiatives to be implemented in 2013/14:

- Sharing Stories is our 2013 campaign to help raise awareness around mental health and learning disabilities. The campaign, which launched in January 2013, is using the power of storytelling, sharing stories and harnessing the power of the written word to encourage understanding around mental health and wellbeing. We have developed partnerships with Waterstones and the council libraries in both Leeds and York. Each of the locations will endorse the 'book of the month' and the campaign more generally.
- The Health Commissioner's review of Health and Social Care Services for people with learning disabilities in Leeds is due for completion in April 2013. The recommendations from this report are due for implementation in the forthcoming year. This will help to develop an overarching vision and strategy for learning disability services across our Trust.
- Integrated Care Pathways (ICPs) will ensure that evidence based clinical interventions will be delivered by the right staff with the right skills at the right time and in the right order all benefitting service users. In 2013/14 we will concentrate on fuller testing of the pathways to ensure they are clinically appropriate in the settings they will be used in and how they will be best implemented by teams. We will be engaging fully with teams within our Trust, service users and carers and other partners to ensure that we will realise the full benefits that ICPs can bring.
- The Recovery Unit inpatient rehabilitation team have responded to service user needs and identified scope to improve the use of recovery principles in collaborative assessment, care planning and progress reviews. Having considered best practice examples the team have produced My Recovery Pathway, three booklets guiding service users and staff through assessing strengths and needs (Starting from here), goals (Where I want to be) and collaborative care planning and reviews (Making plans). Currently being introduced on the unit initial feedback from service users and staff is positive and evaluation of the resources will be carried out later in the year. The initiative has been presented to the Focus on Recovery Group and the intention is to extend its use across our Trust following evaluation.

P2 Priority 2 (patient safety) - People experience safe care

Progress against 2012/13 Initiatives

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

Infection control

The infection prevention and control environmental audit and performance monitoring framework is fully established across our services. The audits and framework support a continual process of improvement across all areas leading to improved service user experience. Outbreaks have been controlled, monitoring of trends occurs and advice is provided where infection control input will minimise risks to service users, staff

Priority 2

and visitors. Policy and training are now fully integrated across our services.

Safeguarding

A specific safeguarding section is now within PARIS which requires staff to give a précis of incidents which may relate to a service user or their family. Guidance is in place for staff to ensure full completion of this section.

Record keeping is a priority and work has taken place to improve safeguarding information and consideration of the children of service users on PARIS, including information on the children and information on the care pathway/holistic assessment specific to children

The Safeguarding Board in Leeds is continuing to undergo a review with a view to merging Safeguarding Board and protocols for the West Yorkshire region. Consideration is also being taken for the upcoming Care and Support Bill currently progressing through Parliament. An audit of quality commissioned by the performance and quality sub group (LSAB) has been carried out and work is being undertaken to build this into the work of the Adult Safeguarding Team (Leeds) on a quarterly basis.

Essence of Care

A Trust-wide audit took place in November 2012 in all inpatient areas of our Trust and data is currently being analysed. Initial findings demonstrate further improvements when compared with 2011 audit results. This is the first time services in York and North Yorkshire have participated in the audit and as a result will inform the development of initial actions plans to address areas for further improvement, as well as to support the sustainability of good practice. Full reports relating to the audit findings will be shared with the clinical governance fora to inform further developments.

Medicines management

The biennial support framework for the Safe Administration of Medicines continues to be a requirement of all registered nurses within our Trust. Work is being progressed by the directorate lead nurses to ensure all nurses within their respective areas have completed and updated the framework as required. Compliance is monitored through the Professional Nurse Advisory Forum's performance report, highlighting areas that may require additional support. The online medicines calculation test has recently been reviewed and updated and is now available via e-learning.

Medicines Talks for Nurses continue to be delivered by the lead nurses in collaboration with pharmacy colleagues to support the on-going developments in medicines management. Bespoke training has been delivered within services that have highlighted a need for further support and both the nursing and pharmacy teams continue to provide advice and support to teams when required.

b) 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.

Given the changes to our Trust's Single Point of Access, previous plans for the Section 136 suite have had to be revisited to ensure the whole of the expansion is fit for purpose.

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

Since the Quality Walk-arounds began in September 2011, 11 visits have taken place across a variety of Leeds clinical services. Quality Walk-arounds now include the York and North Yorkshire clinical services. All of the Quality Walk-arounds are open to all non-executive directors and executive directors to participate in.

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

A new Patient Safety Champion from Doctors in Training for 2012/13 was appointed in

Priority 3

October 2012. They are currently working closely with the Patient Safety Manager and the Associate Medical Director for Doctors in Training in the introduction of a communication tool, SBAR (Situation Background Assessment Recommendation), to aid clinical decision making processes for out of hours teams. This communication tool is currently being rolled out across 16 inpatient units across the Leeds sites, with plans to roll out across community and York and North Yorkshire settings throughout 2013/14.

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

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

- NPSA 'How do you compare to your peers' national and regional statistics of patient safety incidents.
- Incorporation of the extended NPSA 'Never Events' into Board reporting.
- Continuation of monthly reporting of our Trust's 'Trigger to Board' events.

The York and North Yorkshire services data sets are currently being integrated into our Trust's benchmarking.

f) Continued expansion of proactive patient safety initiatives across our Trust.

Patient safety remains a top priority within our 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, our 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 2013/14:

- The Leeds Gender Identity Service is currently developing a medicines management resource pack for nurses within the team. The resource pack is an addition to the mandatory biennial support framework for the safe administrations of medicines and is bespoke to gender identity. This initiative aims to be educational for both the client and the clinician so that nursing clinicians can discuss physical care issues and promote safe self-care where appropriate. In instances where physical educational support may not be appropriate, clinicians will be encouraged to liaise and coordinate care with the appropriate specialists, such as the GP's and surgeons involved.

- We are looking to develop a partnership with Topman. As part of their corporate social responsibility work, Topman support CALM, the Campaign Against Living Miserably, which aims to prevent suicides in the UK for males under 35.

- The whole of the learning disability service in York and North Yorkshire will be reviewed with the clinical team and commissioners to create a service that responds to the Winterbourne View review (Department of Health December 2012). This development will further improve access to local services bringing service users back to their area and support people, where possible, in their own locality.

- In 2013/14 we are beginning the construction of a new low secure unit for women, on the site of Clifton House, York. There are no women's forensic low secure services provided in this locality currently and so service users are often placed some distance away. This development will provide a sub-regional service for Yorkshire and Humberside.

- We are working with commissioners to develop plans for a Section 136 service in York. This proposed service development will create a facility for those detained under Section 136 of the Mental Health Act who present with apparent mental health problems and who can be safely managed in this facility. This facility will improve the experience for service users who may be in distress, who will be assessed in a more suitable environment that protects their safety and security whilst caring for their mental health needs.

Priority 3

P3

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

Progress against 2012/13 Initiatives

a) 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.

A new model for community and alternative to hospital services was implemented through the Transformation Programme in June 2012. Referrals into Leeds services are through a Single Point of Access. Community and alternative to hospital services are delivered through three locality Community Mental Health teams and three Intensive Community Services. They provide services that are accessible to service users of all ages. Care and treatment for our service users is based on their individual needs and not limited by the age of those using our services.

Performance data continues to show that all referrals are being handled through the single point of access. Response times to telephone contact and subsequent assessments are meeting our local target (which is in line with the national target for GPs). Work is planned as part of the CQUIN measures to review satisfaction of referrers with the Single Point of Access and Crisis Assessment Service, this will provide both qualitative and quantitative data.

An initial review of these changes has been undertaken and a range of recommendations have been made to the Trust's Transformation Programme Board for further refinements to the new model. Operational managers and corporate services continue to support community teams in addressing local training and capacity requirements to ensure that the model continues to deliver safe and effective care. Examples of work taking place to address these issues include:

- Additional work to improve the holistic assessment tool
- A review of team sizes with plans to set up new sub-teams in locality CMHTs
- Improvements to the process of allocating routine referrals to workers
- Appointment of additional staff to address capacity issues
- Further work to clarify the function of the Intensive Community Service and how it fits within the acute pathway.

Work is now underway to redesign Mental Health Inpatient Services. It is anticipated that these changes will be implemented from 1 April 2014.

b) 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.

Positive responses have been received from carers with regards to repatriation of their family members back to Leeds as they can now have more contact with them. The ward has established a lead for carers issues and for the monthly carers group.

There is now a daily community meeting which is held on the ward at 9:30 am as well as a group programme offering at least two groups a day (including weekends). The ward holds a weekly 'Your Views' meeting where any issues relating to the running of the ward can be discussed. This is complimented by a "your views" book where service users can log any comments about the ward.

Service users have access to individual sessions from their primary care team and care planning is enhanced by a weekly multi-disciplinary team case formulation meeting, which will include access to psychological therapies on the ward.

Some of the therapeutic activities available on the ward are linked into community based activities and resources to promote integration into the community and plan the pathway for therapeutic activity once discharged from the ward.

c) 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.

Service users have continued to enjoy time in the working garden with staff despite the onset of the cold and wet weather. Winter vegetables have been harvested which the team have then utilised in a cooking group to create healthy meals. Weeding and raking has also allowed interested service users to get involved in the garden.

Priority 3

A more structured return to the garden will be made in the spring and it is hoped that all service users, carers and staff will be able to fully utilise and enjoy the gardens.

d) Through the implementation of our equality objectives we aim to further develop our equality performance:-

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

Analysis of our results from the national community mental health service user survey by protected characteristics has been completed. This data has been triangulated with responses from our service user 'Your Views' pilot survey results.

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

We are one of five Trusts within the region signed up to the Innov8 NHS programme which aims to reshape how senior leaders appreciate and develop diverse talent in NHS organisations in the Yorkshire and the Humber region. A joint workforce research study between NHS Airedale, Bradford and Leeds, the Yorkshire and the Humber Strategic Health Authority and ourselves was undertaken and the research report was disseminated in November 2012. A national conference based on the findings from the research took place in the early part of 2013.

iii. 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.

Work to improve engagement with protected groups and our local interests is on-going. Examples of work over the last quarter includes:-

- Extending further the membership of the Leeds NHS Equality Advisory Panel comprised of organisations representing the interests of protected groups. A review meeting was held in January 2013 to review our 2012 equality performance and to agree equality priorities for 2013/14.
- Formal links with the newly established equality and diversity leads within the new clinical commissioning group structures in Leeds, York and North Yorkshire have been established.
- Partnership work with voluntary sector refugee and asylum seeker support organisations in Leeds has been undertaken to improve mental health care pathways. Training has been delivered to clinical staff and evaluation indicated an increased understanding of the refugee and asylum seeker process, of best practice with regards to assessment and of support agencies within Leeds.
- Engagement through the Diversity and Inclusion Forum held in February 2013 to increase staff, service user, carer and third sector awareness of pilot work focused on dignity and respect within mental health inpatient services through the 15 Steps Challenge and to encourage involvement in undertaking site visits in future.

iv. 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.

Partnership work to improve access, experience and choice for service users from black and minority ethnic (BME) communities within our Leeds services is on-going.

e) 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.

An active programme is currently underway on the dementia inpatient areas to enhance the environment. Best practice and evidence has been utilised from a wide range of sources and corridors and communal areas are being up-dated to develop these environments therapeutically and increase safety. To help support this project a bid has been submitted to the Department of Health Improving the Environment of Care for People with Dementia for a substantial capital investment. The dementia wards are also participating in a number of innovative practices including book therapy as well as piloting a reminiscence daily newspaper called the Daily Sparkle which outlines events in history that occurred that day. Book therapy involves using a number of books specifically designed for service users with dementia which are predominantly pictorial and, similar to the Daily Sparkle, help staff and carers to effectively communicate with our service users.

Our mental health wards continue to develop

Priority 3

structured activity programmes and have reviewed and introduced a number of new groups since November 2012. These include a sleep hygiene group, singing group and a music group. There has also been additional recruitment into the therapy team to allow increased weekend activity programmes. Work has also commenced to explore the use of volunteers to further assist in the delivery of groups both during the day, evenings and at weekends.

Initiatives to be implemented in 2013/14

- We are currently developing a young people strand of the Time to Change campaign. We have been working closely with partners including Young Minds, NHS Airedale, Bradford and Leeds, Space 2 and Leeds Mind. We are working closely with a group of young people with experience of mental ill-health; and we are working towards creating school projects to get children thinking and talking about mental health.

- During 2013, the 'Your Health Matters' initiative will become online. This new animated website, highlighting four themes (Eat Well, Be Active, Get Checked Out and Stay Well) will promote those resources and give people new tools for taking control of their health. The site is due to launch during Leeds Learning Disability week in June 2013.

- Over the coming year we will further increase the amount of time that clinical staff are able to spend in direct contact with service users by improving access to mobile technology. Over the last year we have undertaken work with clinical teams to understand what will make a difference to them and we will be investing in technology to support this. This will be linked to a review of our Trust clinical information system to make the recording of information simpler and more efficient.

- In order to ensure that there is sufficient capacity within the memory service to provide an early diagnosis of dementia we will work with partners in primary care to develop 'shared care' guidelines. These guidelines will support GP's to be more involved in the care of people with dementia and will free our memory services to provide this specialist diagnosis and needs-led support for people and families.

Statement of Assurance

2.4 Statement of assurance

During 2012/13 Leeds & York Partnership NHS Foundation Trust provided six relevant health services which were:

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

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

The income generated by the relevant health services reviewed in 2012/13 represents 100% of the total income generated from the provision of relevant health services by Leeds and York Partnership NHS Foundation Trust for 2012/13.

Annex B provides a signed statement from our directors in respect of the Quality Account.

2.5 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. Our Trust therefore uses an annual plan to prioritise topics for audit, with the topics being recommended for prioritisation using the criteria developed by the Healthcare Quality Improvement Partnership (HQIP). The projects proposed for inclusion on our Trust's priority plan are then discussed by a multi-disciplinary group and the plan is subsequently recommended for approval through our Trust's clinical governance structure. Clinical audit activity and findings, from both the priority plan and locally agreed projects, are reported through the clinical governance structure – reaching from ward to board, and across care services – so that knowledge is shared, and the implementation of change is monitored. In this way we are provided with assurance that service users and staff benefit from this activity.

During 2012/13 four national clinical audits and one national confidential enquiry covered relevant health services that Leeds and York Partnership NHS Foundation Trust provides.

During 2012/13 Leeds and York Partnership NHS Foundation Trust participated in 100% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Leeds and York Partnership NHS Foundation Trust was eligible to participate in during 2012/13 are shown in Table 1.

The national clinical audit and national confidential enquiries that Leeds and York Partnership NHS Foundation Trust participated in, and for which data collection was completed during 2012/13 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:

Sharing Stories Launch

Clinical Audits

Table 1 - National audit participation

Audit or enquiry	Participation (Yes/No)	Number of cases required	Number of cases submitted
POMH-UK Topic 12 Personality disorder	Yes	No set number required	82
POMH-UK Topic 2 Side effects of antipsychotics (AOT services only)	Yes	No set number required	54
POMH-UK Topic 11 Antipsychotic prescribing in dementia	Yes	No set number required	131
POMH-UK Topic 13 ADHD prescribing	Yes	No set number required	Data collection in progress
National Confidential Enquiry into Suicide and Homicide by People with Mental Illness	Yes	No set number required	100% of cases identified

The reports of two national clinical audits were reviewed by the provider in 2012/13 and Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided (see Table 2).

Table 2 - National audit findings review

Audit or enquiry	Status	Quality improvement actions
POMH-UK Topic 12 Personality disorder	Review in progress	Action plan in process of agreement
POMH-UK Topic 2 Side effects of antipsychotics (AOT services only)	Review in progress	Action plan in process of agreement
POMH-UK Topic 13 ADHD prescribing	Data collection in progress	Findings for review in 2013/14

Our Trust supports clinical audit activity undertaken either as part of a Trust-wide priority plan or as part of a directorate/service plan.

The reports of 21 local clinical audits (six Trust-wide priority plan projects, and 15 directorate/services plan audits) were reviewed by the provider in 2012/13 and Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided. Of these reports, 13 had action plans for quality improvement, and the remainder had action plans in development. Table 3, provides examples of the plans for improving clinical practice/care in these areas.

Clinical Audits

Table 3 - Local audit findings review

Audit	Quality improvement actions
The content and timing of inpatient discharge summaries	• Doctors to ensure they follow trust guidelines on timing of discharge summaries • Doctors to ensure they follow trust guidelines on content of discharge summaries • Doctors to ensure they fill in details of key worker on discharge summary.
Copying correspondence to service users	• Raise awareness of the Department of Health guidelines and our Trust policy with junior doctors.
Completion of the MHA 5(2) form	• Provide training on the use of Mental Health Act Section (5) and Mental Capacity Act • Clarify the Section 5(2) in hospital procedure to trainees • Record in PARIS section 5(2) undertaken and outcome.
Medical teaching	• Encourage consideration of teaching in job planning and supporting activities • Peer review of teaching.
Management of depression and cardiovascular disease in the elderly population	• Doctors regularly check physical health status • Doctors be aware of NICE guidelines Clinical Guideline 91 • Provision of medication leaflets in out-patient settings • Reinforcement of need for full and clear notes at educational meetings.
Methadone use and ECGs	• Design a standard letter to communicate with the GP: – Whether client is prescribed high dose Methadone – Confirmation of clients' previous medical history if any concern that client unable to provide this him/herself • Establish routine testing of electrolytes.
Lithium monitoring in pregnant women	• To design lithium monitoring care plan pro-forma to be completed during their pregnancy for each pregnant woman on Lithium • Time table of required blood tests for serum lithium levels to be shared with patient as well as GP/phlebotomist and obstetrician.
NICE Guideline-Violence	• Links to be made between the FACE risk assessment, management plan, and the behaviour plan • PMVA team to review the recording form for physical restraint (body map) to consider inclusion of monitoring vital signs and lead clinician for physical restraint • Care pathway documentation is to be reviewed in connection with service user access to information in a suitable format.

Clinical Audits

Table 3 - Local Audit Findings Review (continued)

Audit	Quality improvement actions
Record keeping	• To ensure that all service users have the opportunity to develop advanced statements • Ensure that repeat risk assessments and other relevant assessments are completed within the agreed time frame • Emphasise the importance of discharge planning (and documentation thereof) as early as possible in service user's stay • All staff to ensure that consent to disclose information is clearly documented • Disclosure of information to be added to admission checklist • Team members to have access to remote technology to achieve standard of same day entries in the electronic record.
Clinical supervision	• All staff to have a clinical supervision contract • Management team structures used to demonstrate and promote the need for clinical supervision • Ensure that each member of staff has a supervisor identified and an understanding of what clinical supervision entails • Supervisors to review supervision every six months • Communicate to staff the minimum frequency/duration for clinical supervision, and amend contracts to reflect this • Remind staff of their professional recommendations to engage in clinical supervision. • Each clinician to maintain a record of attendance that is signed by themselves and their supervisor.
NICE Guideline-borderline personality disorder	• Teams to establish systems for ensuring that the quality of crisis plans is regularly reviewed, such as through clinical lead line management caseload review, CPA meeting • A Personality Disorder ICP developed to include these standards at Assessment and Review.
MHA Section 132	• Produce a single pack that contains all information leaflets • Amend the review notes template used in multi-professional ward reviews to document that those rights are reinforced in such a review • Staff to be reminded to record in service user records involvement of an interpreter.
Outpatient clinics	• The new outpatients/ medical new ways of working project should consider how clinicians can be helped to provide documentary evidence about why certain aspects of an outpatient clinic have not been carried out • Repeat the questionnaire in June 2013 following changes to outpatients' clinics and compare June 2013 results to the baseline.

Clinical Audits

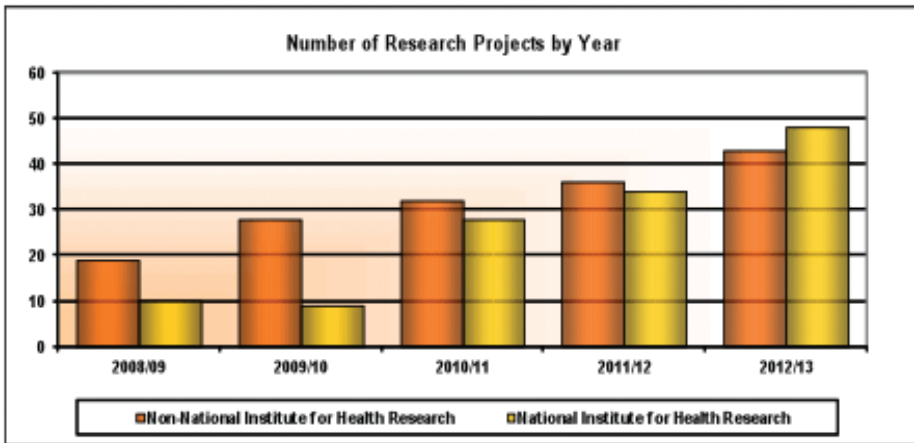
2.6 Participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Leeds and York Partnership NHS Foundation Trust in 2012/13, that were recruited during that period to participate in research approved by a Research Ethics Committee was 610.

Total recruitment was made up of:

- **372 service user recruited to National Institute of Health Research adopted studies**
- **80 recruited to non-National Institute of Health Research adopted studies i.e. local and student.**
- **158 recruited to Collaboration for Leadership in Applied Health Research and Care (CLAHRC) funded studies**

Leeds and York Partnership NHS Foundation Trust was involved in conducting 91 clinical research studies in mental health and learning disabilities in 2012/13. Of these, 48 were National Institute for Health Research (NIHR) adopted studies. This compares favourably with the 70 (34 NIHR) in 2011/12, 60 (28 NIHR) in 2010/11 and 37 (9 NIHR) in 2009/10 illustrated in the graph. 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 possible treatment possibilities and active participation in research leads to successful service user outcomes. This figure does not include all research undertaken in our Trust; due to changes in the requirements for review by a Research Ethics Committee (Governance arrangements for Research Ethics Committees, DH 2011) certain categories of research no longer require Research Ethics Committee review but still require local NHS permission.

We host 13 research posts funded by two Comprehensive Local Research Networks (West Yorkshire and North East Yorkshire and North Lincolnshire) to work on NIHR projects in mental health and learning disabilities. These posts have facilitated an important link with the Mental Health Research Network (MHRN) hub in Newcastle, and provided access and support to Trust staff wishing to engage with MHRN and NIHR supported studies. These developments provide a significant opportunity to increase the level of NIHR portfolio activity within Leeds and York Partnership NHS Foundation Trust, previously outside MHRN's activity.

We continue to develop our profile in learning, research and innovation. 97 clinical staff were involved in conducting research within our Trust during 2012/13. These staff participated in mental health and learning disability research.

We continue to engage service users in research design, identifying research priorities, interview panels for research staff, participating in research projects and research governance during 2012/13.

In the last three years, 23 publications have resulted from our involvement in NIHR research, which show our commitment to transparency and desire to improve service user outcomes and experiences across the NHS.

Our engagement with a range of clinical research as the lead site for five National Institute for Health Research funded projects also demonstrates our commitment to testing and offering the latest medical treatments and techniques. These projects include a new self-harm intervention; systematic review of an early parenting intervention for families with young children showing severe attachment problems; computerised cognitive behavioural therapy

Quality and Innovation

for depression in adolescents; translation of the Strengths and Difficulties Questionnaire into British Sign Language and the use of social stories for autism spectrum disorders.

We are working in partnership with the universities of York and Leeds as part of the Leeds, York and Bradford Collaboration for Leadership in Applied Health Research and Care (CLAHRC) on eight research projects looking at various aspects of addiction and to implement the National Institute for Health and Clinical Excellence's (NICE) guideline on core interventions in the treatment and management of schizophrenia to ensure patients experience safe care. The CLAHRC is also providing funding to support the evaluation of our Trust's Transformation Programme which started in 2012 and will continue into 2013/14.

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.

2.7 Commissioning for quality and innovation

A proportion of Leeds and York Partnership NHS Foundation Trust's income in 2012/13 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 relevant health services, through the Commissioning for Quality and Innovation payment framework. Further details of the agreed goals for 2012/13 and for the following 12 month period are available online at

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

For Leeds and York Partnership NHS Foundation Trust, the monetary total for the amount of income conditional upon achieving quality improvement and innovation goals was £2,265.206 (Leeds Services), £514,000 (York and North Yorkshire Services) and £370,626 (Specialist Commissioning Group). The monetary total for the associated payment in 2012/13 was £3,149,832.

In 2012/13 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 and Council of Governors on a quarterly basis through our performance report which can be found on our website at www.leedspft.nhs.uk. Any risks to performance were identified within the reports and actions in place to improve performance were documented.

In 2013/14 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 Services**
- **Low Secure Services**
- **Perinatal Services**
- **Gender Services**
- **Eating Disorder Services**
- **Personality Disorder Services.**

Details of our 2013/14 Commissioning for Quality and Innovation indicators and our performance against these will be reported to our Board of Directors and Council of Governors on a quarterly basis and will be available publicly through our corporate performance report which is available on our website at www.leedspft.nhs.uk.

Plans are in place to ensure that we meet our 2013/14 Commissioning for Quality and Innovation indicators and continue to further improve the quality of care for people who use our services.

Care Quality Commission

2.8 Care Quality Commission

Registration status

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

The CQC has not taken enforcement action against Leeds and York Partnership NHS Foundation Trust during 2012/13.

Detailed assessments of compliance are undertaken on a quarterly basis, with sign off from leads and lead directors within our Trust. Assessments of compliance are reported on a quarterly basis to our Board of Directors and Council of Governors via our corporate 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 have been carried out across services during 2012/13. These will continue throughout 2013/14.

We will continue to ensure that compliance against each registration requirement is monitored and maintained. It should be noted that the Trust self-assessment against the Information Governance Toolkit was 'not satisfactory' as at 31 March 2013. This is due to an issue that has been identified with the York and North Yorkshire system. A remedial action plan is in place linked to the clinical system evaluation which will lead to those services being moved from this application. This assessment has led the Trust to review overall compliance with CQC essential standards outcome 21, and declare yellow (outcome mostly met). All other CQC essential standards are fully met.

Care Quality Commission reviews

Leeds and York Partnership NHS Foundation Trust has participated in two special reviews by the Care Quality Commission relating to the following areas during 2012/13:-

Ward 3, Newsam Centre (Leeds)

The Care Quality Commission carried out a visit to ward 3 Newsam Centre on the 1 May 2012 to follow up compliance actions made following the previous review of compliance at ward 3 Newsam Centre in December 2011.

The Care Quality Commission confirmed that significant improvements had been made to all areas identified and we were found to be compliant with both Outcome 4 and Outcome 7.

The Becklin Centre (Leeds)

The Care Quality Commission carried out a routine review to The Becklin Centre on the 21 August 2012 as part of their schedule of planned reviews. The review focused on five outcomes; Outcome 1: Respecting and involving people who use services, Outcome 5: Meeting nutritional needs, Outcome 7: Safeguarding people who use services from abuse, Outcome 13: Staffing and Outcome 21: Records. The Care Quality Commission found The Becklin Centre to be fully compliant with all outcomes reviewed, with positive comments received and no areas of concern or improvement identified.

As a result, no actions arose from these two reviews. Leeds and York Partnership NHS Foundation Trusts has made the following progress by 31 March 2013 in taking such action; all CQC reports have been analysed internally and appropriate actions have been taken. A system of internal mock unannounced CQC inspections are now in place to provide further assurance around compliance with CQC requirements.

Quality of Data

2.9 Information on the quality of data

NHS number and General Medical Practice code validity

Leeds and York Partnership NHS Foundation Trust submitted 2,952 records during 2012/13 (April to February 2013) 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 99.6% for admitted patient care, 99.9% for outpatient care and 99.6% 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 99.1% 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 2012/13 was 70.4% and was graded 'Not Satisfactory' (red).

Despite maintenance of satisfactory performance (i.e. level 2 or better) on 42/44 requirements (the requirement relating to offshore data processing is not required), our acquisition of York and North Yorkshire services has reduced two requirements to sub-optimal performance, both with remedial action plans:-

- **305:** An issue has been identified with the York and North Yorkshire system. Our action plan to remedy this will be enacted within current Trust projects to re-provision clinical systems. Level 1 performance achieved.

- **514:** Clinical coding in York has been carried out by clinicians rather than a trained clinical coder. Our first annual audit cycle since acquisition has reported errors in both primary and secondary diagnosis coding. Remedial action commenced in November, with our Leeds-based coder now working across the wider Trust to improve Finished Consultant Episode coding, with a permanent solution being sought via the recruitment of a York-based clinical coder. Level 1 performance achieved.

Our Trust has an on-going programme of information governance training which is now refreshed annually. Our Trust has now delivered first-time or refresher information governance training to 86% of all substantive staff in the last 12 months. Annual refresher training is being actively pursued and has shown an upward trajectory all year.

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 York and North Yorkshire services for which we have data controller status from 1 February 2012.

Our commitment to providing a quality service on Freedom of Information Act has resulted in all incoming requests being processed within the statutory timescales. 2012/13 has seen a marked increase in overall Freedom of Information Act requests over the year in comparison to 2011/12 and has seen the highest number of requests per year to date, 20% up on the previous year.

Statement on data quality

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

- Improving awareness of data quality issues amongst Trust staff based in York and North Yorkshire
- Extension of Data Quality Improvement Group membership to include clinicians
- Maintaining the data quality assurance processes that are in place Trustwide.

Leeds and York Partnership NHS Foundation Trust will be taking the following actions to improve data quality during 2013/14:

- Continued awareness raising in both Leeds and York
- Improving data collection in restructured services
- Reviewing coding systems to ensure that they are fit to purpose.

Clinical coding error rate

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

Quality of Data

Additional mandatory quality indicator sets to be included in the 2012/13 Quality Account

For 2012/13 all Trusts are required to report against a core set of indicators, for at least the last two reporting periods. These additional quality indicators are listed below with our performance against each one.

<table>
<tr>
<td>The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to:-

(a) The value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and
(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</td>
<td>This indicator is not applicable to a mental health Trust.</td>
</tr>
<tr>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period.

Annex C describes the construction of how this target has been calculated.</td>
<td>
<table>
<tr><th></th><th>Qtr 1 2012/13</th><th>Qtr 2 2012/13</th><th>Qtr 3 2012/13</th><th>Qtr 4 2012/13</th></tr>
<tr><td>LYPFT</td><td>97.0%</td><td>96.5%</td><td>96.3%</td><td>95.6%</td></tr>
<tr><td>Nat.Av</td><td>97.5%</td><td>97.2%</td><td>97.6%</td><td>TBC</td></tr>
</table>
Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

• Performance is monitored on a weekly basis to minimise the risk of any breaches and actions are put in place where necessary.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.
</td>
</tr>
<tr>
<td>The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period.

Annex C describes the construction of how this target has been calculated.</td>
<td>
<table>
<tr><th></th><th>Qtr 1 2012/13</th><th>Qtr 2 2012/13</th><th>Qtr 3 2012/13</th><th>Qtr 4 2012/13</th></tr>
<tr><td>LYPFT</td><td>97.1%</td><td>98.4%</td><td>95.3%</td><td>95.9%</td></tr>
<tr><td>Nat.Av</td><td>98.0%</td><td>98.1%</td><td>98.4%</td><td>TBC</td></tr>
</table>
Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

• Performance is continually monitored to minimise the risk of any breaches.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.
</td>
</tr>
</table>

Quality of Data

The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care information Centre with regard to the Trust's patient reported outcome measures scores for:- (i) Groin hernia surgery (ii) Varicose vein surgery (iii) Hip replacement surgery, and (iv) Knee replacement surgery during the reporting period.	This indicator is not applicable to a mental health Trust.
The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of patients aged:- (i) 0 to 14; and (ii) 15 or over readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.	**Service Users 0 to 14:** We have not received any readmissions for this age group during 2012/13. **Service Users 15 or over:** These figures (cumulative) are based on Trust services with a 710 speciality code which includes adult mental health service users (excluding service users allocated to Forensic Services in line with national codes)

Apr-12	May-12	Jun-12	Jul-12
3.55%	5.56%	6.72%	7.14%

Aug-12	Sep-12	Oct-12	Nov-12
6.38%	6.92%	6.43%	4.72%

Dec-12	Jan-13	Feb-13	Mar-13
4.62%	4.11%	5.98%	3.45%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Each readmission is flagged with the appropriate clinical teams and consultants to fully understand the cause of the readmission and implement any necessary actions as required.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

Quality of Data

The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the Trust's Commissioning for Quality and Innovation indicator score with regard to its responsiveness to the personal needs of its patients during the reporting period.

Patient Safety Thermometer (National CQUIN)

The data below highlights the number of service users recorded as having 'harm free' care. It should be noted that throughout quarter 1 we embedded a reporting process within the eligible services. Therefore, data was reported to the Information Centre from quarter 2 onwards.

Qtr 2 - 2012/13					
July		August		September	
LYPFT	Nat.Av	LYPFT	Nat.Av	LYPFT	Nat.Av
97.42%	91.11%	98.68%	91.22%	98.54%	91.78%

Qtr 3 - 2012/13					
October		November		December	
LYPFT	Nat.Av	LYPFT	Nat.Av	LYPFT	Nat.Av
97.85%	91.99%	98.38%	92.27%	99.04%	92.41%

Qtr 4 - 2012/13					
January		February		March	
LYPFT	Nat.Av	LYPFT	Nat.Av	LYPFT	Nat.Av
99.46%	92.3%	98.37%	92.19%	98.79%	92.49%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Processes have been put in place across all relevant services to enable the capture and reporting of this data.

Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve this percentage, and so the quality of its services, by continually monitoring as described above.

Quality of Data

The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

The results from the 2012 National NHS Staff Survey show that 3.43 staff would recommend our Trust as a place to work or receive treatment. This is compared to the national average for mental health/learning disability trusts of 3.54 and against 4.06 of best 2012 score for mental health/learning disability trusts. This is based on 380 staff at Leeds and York Partnership NHS Foundation Trust who took part in the survey.

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Survey obtained directly from the National NHS Staff Survey Co-ordination Centre.

Leeds & York Partnership NHS Foundation Trust intends to take the following actions to improve this percentage, and so the quality of its services, by:-

- The survey results have been analysed and an action plan has been developed to deal with those areas of concern and priority areas.
- Focussing on improving internal communications, staff engagement and staff recognition through a number of new initiatives.

The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the Trust's "Patient experience of community mental health services" indicator score with regard to a patient's experience of contact with a health or social care worker during the reporting period.

Apr-12	Leeds services	North Yorkshire & York services	Nat. Av.
Did this person listen carefully to you?	76%	86%	78%
Did this person take your views into account?	70%	80%	72%
Did you have trust and confidence in this person?	67%	83%	71%
Did this person treat you with respect and dignity?	85%	93%	87%
Were you given enough time to discuss your condition and treatment?	69%	79%	72%

Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:-

- Survey obtained directly from Quality Health.

Leeds and York Partnership NHS Foundation Trust intends to take the following actions to improve these percentages, and so the quality of its services, by:-

- The survey results have been analysed and an action plan has been developed to deal with those areas of concern and priority areas.

Quality of Data

The data made available to the NHS Trust or NHS Foundation Trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents that occurred within the Trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Annex C describes the construction of how this target has been calculated.

For the period 1 April 2012 to 30 September 2012 (latest comparative reporting rate summary provided by NPSA):-

- The number of patient safety incidents that occurred within our Trust and reported to the NPSA was 2,241.
- Of those incidents, the number and percentage of such patient safety incidents that resulted in severe harm (severity 3 & 4) or death (severity 5) were:-

Severity 3	64	2.86%
Severity 5	9	0.4%

National Average for Severity 3 7.9%
National Average for Severity 5 0.8%

The Trust's internal data for this period is as follows:-

2,241 total incidents		
Severity 3	64	2.86%
Severity 4	-	
Severity 5	9	0.4%

For the period 1 October 2012 to 31 March 2013 (comparable data is currently unavailable from the NPSA)

- The number of patient safety incidents that occurred within our Trust and reported to the NPSA was 2,541.
- Of those incidents, the number and percentage of such patient safety incidents that resulted in severe harm (severity3 & 4) or death (severity 5) were:-

Severity 3	83	3.3%
Severity 4	3	0.1%
Severity 5	43	1.7%

Quality of Data

Continued	The Trust's internal data for this period is as follows*:- 2,458 total incidents Severity 3 77 3.13% Severity 4 3 0.1% Severity 5 40 1.63% * Internal data differs slightly to the NPSA data due to late submissions of IR1 forms into our Risk Management Team. In relation to identifying severity data for York and North Yorkshire, this is not included. This is because from February 2012 to March 2013, the York and North Yorkshire incidents were recorded on a separate system. From March 2013, the Trust now operates a singular, uniform and centrally administered incident reporting system, centrally managed within our Risk Management Department. Due to the roll out of a singular reporting and analysis systems, York and North Yorkshire data will be included in all subsequent reports. Leeds and York Partnership NHS Foundation Trust considers that this data is as described for the following reasons:- • Serious incidents are investigated using Root Cause Analysis methodology, with reports presented to our incident review group. • Standardisation of risk management serious incident documentation with guidance notes to aid completion. Leeds and York Partnership NHS Foundation Trust has taken the following actions to improve these numbers/percentages, and so the quality of its services, by continually monitoring as described above.
Where the necessary data is made available by the Health and Social care Information Centre, a comparison of the numbers, percentages, values, scores or rates of the trust (as applicable) in the items above with:- (a) The national average for the same; and (b) With those NHS Trusts and NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.	National average has been shown for:- • Care Programme Approach who were followed up within 7 days after discharge from psychiatric in-patient care during the reporting period • Percentage of admissions to acute wards for which the Crisis Resolution Home Treatment Team acted as a gatekeeper during the reporting period • National Patient Safety Thermometer • 2012 National NHS Staff Survey • 2012 National NHS Community Mental Health Service User Survey • National Patient Safety Incidents.

Our selected measures

3.1 Our selected measures

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

A full consultation of our Trust strategy commenced in April 2012 to ascertain whether key stakeholders were satisfied that our strategy measures were still in keeping with the local and national direction of travel. This work has continued to date to ensure we have a set of measures within our strategy which are meaningful to all. This is also reflected in our strategic Plan for Monitor.

With the refresh of our Trust strategy in 2012, these three priorities will remain in place within our Quality Account until 2018.

Our strategy measures set out in Priority 1 and Priority 3 of our 2011/12 Quality Account remain in place in our refreshed strategy. Therefore, it was agreed that these measures remain in place within our 2012/13 Quality Account to ensure our Quality Account remains aligned with our Trust strategy, to enable historical data to be shown within our Quality Account, to demonstrate consistency with our measures and to continue to allow progress to be demonstrated.

With regard to Priority 2: People experience safe care; the following measures included within our previous Quality Account are no longer included within the refreshed Trust strategy:-

- Staff views of the fairness and effectiveness of incident reporting procedures
- Evidence that we meet national guidelines for clinical care and treatment relevant to our Trust within two years of publication.

To ensure continued alignment with our Trust strategy it was therefore agreed that these measures will not be included within our 2012/13 Quality Account and that they will be replaced with the following measure, which remains in our Trust's refreshed strategy. This measure is also a staff pledge set out in the NHS Constitution:-

- Staff Pledge 3: To provide support and opportunities for staff to maintain their health, wellbeing and safety: Perceptions of effective action from employer towards violence and harassment

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 2013/14 local Commissioning for Quality and Innovation measures.

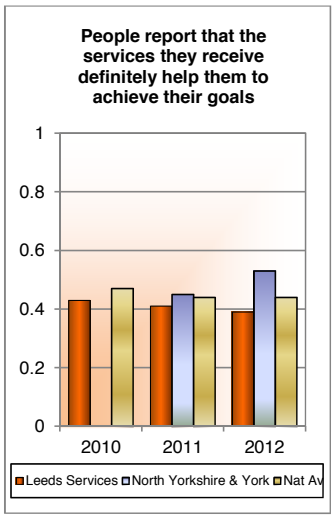
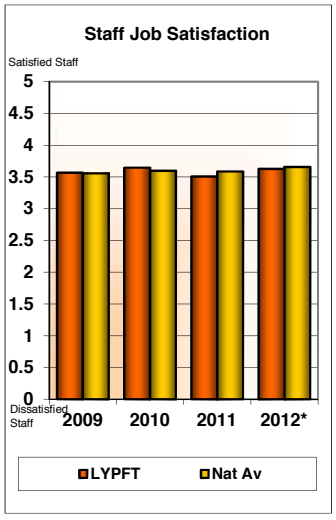
Progress against our measures set out in our 2011/12 Quality Account was reported to our Board of Directors through the corporate performance report and to our Council of Governors, with each measure reported upon on a quarterly basis. These are publicly available documents and can be viewed on our website http://www.leedspft.nhs.uk/about_us/performance

Progress against measures set out in our 2012/13 Quality Account will continue to be reported to our Board of Directors through the corporate performance report and to our Council of Governors on a quarterly basis. These measures also form part of our Service Directorate and Corporate Directorate Performance Reviews.


Get Me? campaign

Priority 1

P1 **Priority 1 (clinical effectiveness): People achieve their agreed goals for improving health and improving lives**
Performance of Trust against selected measures:

Measure	Source	Performance	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	 250 service users from our Leeds services responded to the 2012 National Community Service User Survey 263 service users from our York and North Yorkshire services responded to the 2012 National Community Service User Survey	We are currently working to integrate the Care Plan documentation with integrated care pathways (ICP). Integrated care pathways provide a means of ensuring that consistent standards of care are delivered to service users which are evidence based. The care plans will continue to be goal based and will be augmented with ICPs by recording which interventions have been delivered, by whom and when. In the next year we will be implementing these care pathways with teams and providing training for clinical staff to ensure that they are smoothly and consistently implemented. An action plan has also been developed across our Trust building on the existing work of the Planning Care Standing Support Group to better understand how we can improve the service user experience and measure this on a continual basis.
2. Staff job satisfaction	Strategy measure from the National NHS Staff Survey	 Trust score is based on 380 staff who took part in the 2012 National NHS Staff Survey (* 2012 incorporates the combined Trust)	The staff survey results have been analysed and the existing action plan has been updated and refreshed to build on those areas of concern and priority areas. The Trust is also focussing on improving internal communications, appraisal and performance review, health and well-being and staff engagement. To support and improve employee engagement the Trust is working in partnership with NMK partners using an organisational development diagnostic and capability assessment tool that will give us a good understanding of our current organisational development capability but that will also add value in its own right by starting an organisational conversation about what needs to improve.

Priority 1

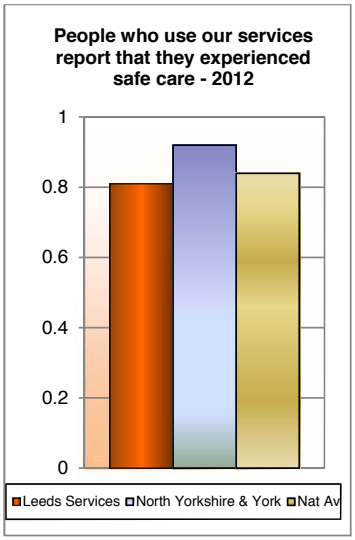
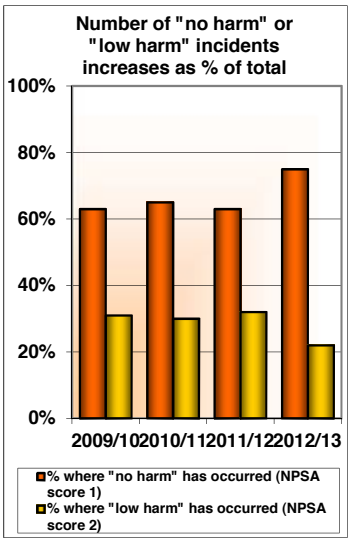
Priority 1 - Continued

Measure	Source	Performance	Comments
3. Carers report that their own health needs are recognised and they are supported to maintain their physical, mental and emotional health and well-being	Strategy measure	As part of the pilot with Psychological Therapies Services, a total of 550 carers questionnaires were issued (27 returned, 4.9% response rate) via the automated postal survey system generated from the PARIS information system.	Following evaluation of the pilot, the questionnaire and method of collection have been reviewed, due to the low response rate. A revised easy read questionnaire and web-based data collection process are being developed.
4. Older people who are inpatients will have their clinical outcomes measured by a validated outcome measures tool to improve patient care and 95% of those eligible for a TOMs assessment will have an accessible version to keep in their record.	Commissioning for Quality and Innovation measure	2013/14 will be the baseline year where the Therapy Outcome Measures (TOMs) tool will be implemented within our Older People's Inpatient Unit.	In 2011/12 and 2012/13, the focus of the Therapy Outcome Measure (TOM) tool was in our Learning Disability Services. In 2013/14 we will further develop this measure to focus on capturing and reporting outcomes for service users within our Older People's Inpatient Services. The indicator will measure the numbers of new referrals eligible who have a received a TOMs assessment, develop an on-going programme of training for staff and to implement a pilot to capture the outcomes for service users within older people inpatient units.
5. To improve patient pathways on transition from secondary care to primary, third sector and other statutory providers. A standardised summary will be provided to all receivers on discharge and a copy to the service user	Commissioning for Quality and Innovation measure	2013/14 will be the baseline year in order to develop a plan to undertake the CQUIN involving GP's, other referrers, service users, carers and service managers.	The overall objective will be to devise a discharge template to be in operation by the start of quarter 4 2013/14.
6. Measures will be in place to assess the health and wellbeing of carers of people with a learning disability and increase access to support.	Commissioning for Quality and Innovation measure	2013/14 will be the baseline year where a programme of innovative methods and events will be developed.	In 2013/14 an innovative method of engagement with carers, including design of tools to measure the impact of health and wellbeing interventions will be devised. This will include a Therapy Outcome Measures review data as well as before and after experience snapshots to collage carers feedback. In conjunction with carers, a programme of health and wellbeing events, aimed at carers, will be planned for 2013/14.

Priority 2

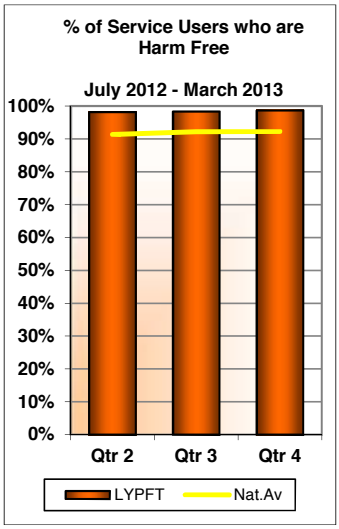
P2 **Priority 2 (patient safety): People experience safe care**

Performance of Trust against selected measures:

Measure	Source	Performance	Comments
1. People who use our services report that they experienced safe care	Strategy measure	 (Results from the 2012 Mental Health Inpatient Service User Survey)	The pilot phase of the local survey has now been completed and feasibility work is currently being undertaken to identify data collection options for roll-out across all services. These services will also include those without access to PARIS in York and North Yorkshire services.
2. Number of 'no harm' or 'low harm' incidents increases as % of total: • % where 'no harm' has occurred (National Patient Safety Agency score 1). • % where 'low harm' has occurred (National Patient Safety Agency score 2).	Strategy measure	 (All service user incidents – inpatient & community)	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.

Priority 2

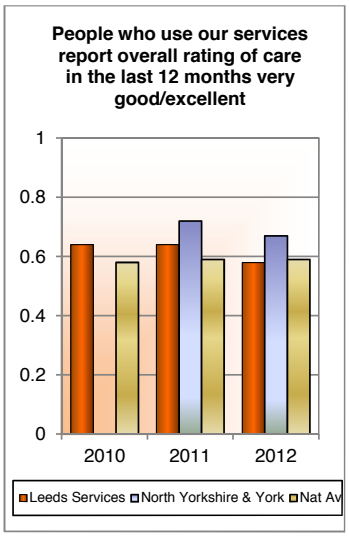
Priority 2 - **Continued**

Measure	Source	Performance	Comments
3. 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	The data below highlights the number of service users recorded as having 'no harm'. It should be noted that throughout quarter 1 we embedded a reporting process within its eligible services. Therefore, data was reported to the Information Centre from quarter 2 onwards.  	Processes have been put in place across all relevant services to enable the capture and reporting of this data. Quarter 4 data has been submitted to the Information Centre in line with the CQUIN requirements. Data will continue to be collected on a monthly basis and submitted to the Information Centre every quarter. Analysis of data is presented to our Means Goal 1 and 2 Standing Group through the Means Goal 1 and 2 performance report.
4. To provide support and opportunities for staff to maintain their health, wellbeing and safety: Perceptions of effective action from employer towards violence and harassment	Strategy measure from the National NHS Staff Survey	2013/14 will be the baseline year	The Trust continues to implement the Health and Wellbeing Action Plan and has implemented from 1 April a new Employee Wellbeing and Managing Attendance Procedure which aims to both support employee health and well-being and manage attendance at work. To identify our priorities to support health and wellbeing for staff a health needs assessment has been carried out and a staff event planned for April/May to agree the next year's priorities. We are identifying teams and areas where stress related absence is high and are focussing on supporting those teams through targeted support through HR and Occupational Health.

Priority 3

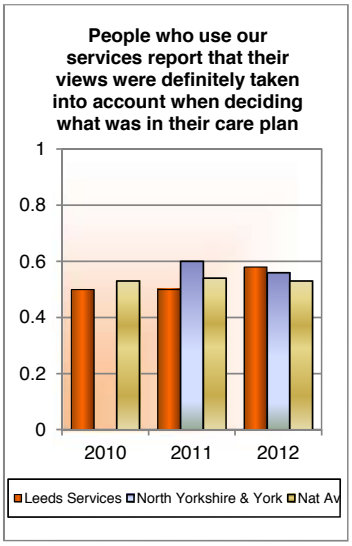
P3 **Priority 3 (patient experience): People have a positive experience of their care and support**

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	 250 service users from our Leeds services responded to the 2012 national community user survey 263 service users from our York and North Yorkshire services responded to the 2012 national community user survey	The 2013 National Community Service User Survey (NCSUS) data collection process has commenced and the results will be known in late spring. We are currently exploring an alternative solution for the collection of local experience data, which includes the introduction of a values/behaviours based service user questionnaire which is applicable to all our services and that also fits with the NCSUS strategy measures. The Clinical Guidelines & Clinical Outcome Standing Support Group recently approved a revised and shortened 'Your Views' and carers surveys. The surveys will initially be web based and plans (including costings) are being developed.

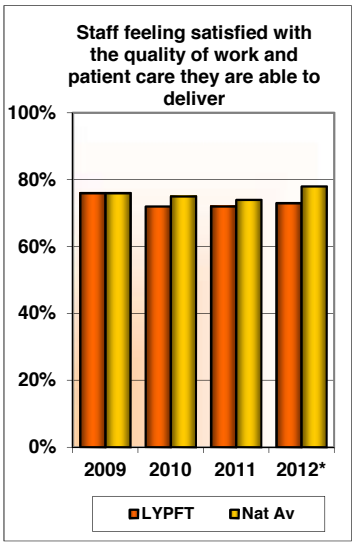
Priority 3

Priority 3 - **Continued**

Measure	Source	Performance	Comments
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	 250 service users from our Leeds services responded to the 2012 national community user survey 263 service users from our York and North Yorkshire services responded to the 2012 national community user survey	Service user involvement in planning their care is fundamental to good CPA and a person's recovery. These are core components of training available to staff Trust-wide. An e-learning package incorporating CPA and recovery is now available. This provides a 'foundation' level of awareness and knowledge aimed particularly at staff new to the organisation, mental health or learning disability or clinicians new to care co-ordination. Classroom based CPA training is aimed at more experienced staff and is based around two modules, one focusing on the CPA process and the other on meeting individual need through CPA. The first module is now available Trust wide, the other is being developed and will be available next quarter. Training evaluation and effectiveness are monitored through the Planning Care Standing Support Group. The Recovery and Social Inclusion Team (RASI) have delivered sessions to community staff to support a service user focus to care planning and to embed recovery approaches.

Priority 3

Priority 3 - Continued

Measure	Source	Performance	Comments
3. Staff feeling satisfied with the quality of work and patient care they are able to deliver	Strategy measure / National NHS Staff Survey	 Trust score is based on 380 staff who took part in the 2012 National NHS Staff Survey (* 2012 incorporates the combined Trust)	We are in the process of launching the refreshed Appraisal and Performance Review Procedure following a pilot in three of our teams which takes account of the new national changes to pay progression which focuses on both performance and development needs. Through the implementation of the transformation programme and new ways of working for staff aimed at improving the service user journey, integrated care pathways and eliminating non valuing activity will further improve service user care. A review of the first two tranches of the transformation programme has been completed which looked at service user and staff feedback. This review has led to improvements and changes in process, a review of team sizes, understanding of workloads, and IT processes. A full programme of organisational, team and individual training and learning opportunities are being delivered to those staff in the first tranches. Learning is also being applied to further transformation and change programmes.
4. Measures to be in place to monitor the numbers of referrals to crisis and the response times with particular emphasis upon, referrer involvement, service improvement and customer satisfaction	Commissioning for Quality and Innovation measure	2013/14 will be the baseline year.	In 2013/14 a methodology will be established in order to gain the experience of referrers, service users and carers of referring to and being assessed by the crisis assessment service. A tool will be devised with agreement for distribution and method.
5. Inpatients will have access to debt and financial advice to reduce levels of anxiety, reduce inequity and improve outcomes.	Commissioning for Quality and Innovation measure	Results from the 2012 Community Service User Survey highlight that 30% (32% in 2011) of service users definitely received support from anyone in the NHS mental health services in getting help with financial advice or benefits.	In 2013/14 we will liaise with CAB mental health outreach service to provide guidance on what frontline clinical staff should be providing. Service user interviews will be conducted that will establish a baseline of service user experience of support with financial issues.

Performance

3.2 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 our Board of Directors, through the corporate 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 http://www.leedspft.nhs.uk/about_us/performance

As part of our 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 refreshed strategy sets out our Trust goals, our strategic objectives and our stretch quality measures for quality improvement. Progress against the strategy action plan and performance against milestones and measures is reported to our Board of Directors and Council of Governors through the corporate 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.

Our Council of Governors receive our corporate 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 2012

We continue to be in a period of major change through the implementation of the transformation programme which is changing how it provides services and, following the acquisition of York and North Yorkshire services both of which are affecting staff and together with changes more wider in the NHS we are expected to find that people's views are less positive.

The survey results have been analysed and an action plan has been developed to deal with those areas of concern and priority areas. We are also focussing on improving internal communications, staff engagement and staff recognition through a number of new initiatives. The 'STAR' scheme launched in April 2012 recognises staff achievement each month. The appraisal scheme is currently being reviewed which includes a development scheme to make it more user friendly and targeted at developing staff and improving performance. This has been piloted across our services in Leeds and York from October 2012 for a three month period and is currently being evaluated.

We are implementing the Health and Wellbeing Action Plan as well as developing a new Employee Wellbeing and Managing Attendance Procedure which aims to both support employee health and well-being and manage attendance at work to be effective from 1 April 2013. To identify our priorities to support health and well-being for staff a health needs assessment has been carried out and a staff event planned for April/May 2013 to agree the next year's priorities.

Medical revalidation

On 3 December 2012, medical revalidation was formally launched by the General Medical Council (GMC). It is the process by which all doctors with a licence to practise in the UK will need to satisfy the GMC, at regular intervals, that they are fit to practise and should retain their licence. The information presented below is correct as of 28 February 2013.

The first cycle of revalidation will take until 2017 to complete. Doctors with a prescribed connection with our Trust are currently scheduled as follows;

Performance

Year zero	January 2013 to March 2013	1 doctor to be submitted by 28.3.13
Year one	April 2013 to March 2014	18 doctors
Year two	April 2014 to March 2015	45 doctors
Year three	April 2015 to March 2016	45 doctors
Year four	April 2016 to March 2017	5 doctors

In Year zero, our Responsible Officer has made no deferment requests or non-engagement reports to the GMC.

During 2012/13, our Responsible Officer has made no deferment requests or non-engagement reports to the GMC.

The doctors for which we have responsibility in terms of making recommendations about revalidation to the GMC is determined by national policy. These doctors must have a prescribed connection to our Trust. Each month, the Head of Quality updates GMC Connect (secure partner portal to maintain doctors' prescribed connections) regarding these doctors (including leavers and starters and changes from training contracts).

Infection prevention and control

We are fully registered with the Care Quality Commission (CQC) across our health and social care services for Regulation 12: Cleanliness and Infection Control. The Infection Prevention Control Team provides assurance that we have robust and effective prevention and control services in place and is compliant with the Code of Practice for Health and Adult Social Care on the prevention and control of infections and the CQC essential standards outcome 8.

Our Infection Prevention Control Team continues to facilitate an increased focus on practice, improving education and assessment standards, as well as a continuing improvement of environmental cleaning. Policies and procedures have been fully harmonised across our Trust.

Our 2012/13 clostridium difficile infection threshold agreed with our main commissioner is not to exceed eight new cases of clostridium difficile infections during the year for Leeds services. The table overleaf demonstrates that Leeds services performed well below the threshold with no cases of clostridium difficile GDH+ infection reported during 2012/13. The figures also demonstrate an improvement since 2009/10. 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 2012/13 within York and North Yorkshire 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 our Trust and reduce further the likelihood of such infections occurring. The roll out of 'Essential Steps' monitoring across York and North Yorkshire commenced in March 2012.

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 Infection Prevention Control Team 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. Our Infection Prevention Control Team works closely with our pharmacy department to ensure that the treatment is completed in order to further reduce the risk of MRSA in all of our inpatient areas.

Performance

Leeds healthcare associated infections	2009-10	2010-11	2011-12	2012-13
Number of cases of MRSA bacteraemia	0	0	0	0
Number of new cases of clostridium difficile	5	2	1	0

York and North Yorkshire healthcare associated infections	2011-12	2012-13
Number of cases of MRSA bacteraemia	0	0
Number of new cases of clostridium difficile	0	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 York and North Yorkshire 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 2012/13 with the Monitor targets, admission to inpatient services having access to Crisis Resolution and access to healthcare for people with a learning disability.

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.

A unified data base has been developed to capture both alerts and referrals within our Trust.

We are actively involved in a number of board sub-groups including policy development/ quality/training.

We have developed pathways for dealing with safeguarding alerts between Adult Social Care and ourselves, our aim is to access the Adult Social Care recording systems (ESCR) to enable us to access information and better respond to patterns of abuse across the system.

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. The Safeguarding Team have also provided bespoke sessions to inpatient units and health support workers to strengthen awareness of safeguarding amongst non-qualified staff.

We continue to develop a depth of safeguarding adult specialism within our Trust. Our safeguarding adult coordinators are encouraged to access the Local Safeguarding Adults Board specialist training and have access to supervision and development led by the lead and manager within our own Safeguarding Team.

Our integrated Trust incorporates a geographical area embracing three Safeguarding Adults Boards upon which we have representation.

We are in the process of scoping a single point of referral for all safeguarding adult referrals (including Leeds and York and North Yorkshire).

Safeguarding children

Recent work completed has involved

Performance

contributing to three section 11 audits for the separate safeguarding boards of Leeds, North Yorkshire and City of York and a completed York and North Yorkshire Competency Framework. Our named nurse sits on the training and development sub-group of the Leeds Local Safeguarding Children's Board and contributes to the pan-Leeds training pool. It is planned that the safeguarding children coordinators within our trust will also contribute to training provision. A review of e-learning has taken place and two new updated courses planned to replace the current one giving practitioners the opportunity to refresh at level 2 online.

A safeguarding section has been developed for recording of specific information within PARIS to improve information sharing and ease of access to information regarding children and adults.

The safeguarding governance structure has now integrated with Safeguarding Adults to form the Safeguarding Standing Support Group.

All serious case reviews, learning lessons reviews and root cause analyses have been reported through our Trust Incident Review Group and actions completed on time and monitored through Safeguarding Children Operational Committee.

The Safeguarding Team have continued to contribute to the quarterly declarations for Care Quality Commission and Leeds Community Healthcare via reports. The OFSTED inspection conducted within Leeds was categorised as 'satisfactory with good capacity to improve' and our Trust are supporting the Local Safeguarding Children's Board with implementing recommendations for example: promotion of the Common Assessment Framework which is now incorporated into Care Programme Approach updates. We are awaiting the publication of 'Working together' (HM Government) which will influence all safeguarding work and be incorporated into the work programme of the Safeguarding Team as we progress throughout 2013/14.

A safeguarding children care pathway has been designed within transformation procedures to aid clinical decision making for staff working with parents or carers.

A domestic violence policy is progressing for ratification which will help move the organisation towards the level 2 quality mark for domestic violence services.

Eliminating mixed sex accommodation

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

On 1 February 2012 we gained additional 15 inpatient services in York and North Yorkshire. As a result all mixed sex accommodation was reviewed and a number of actions agreed to ensure all units were compliant with Eliminating Mixed Sex Accommodation (EMSA).

All facilities providing mixed sex accommodation ensure a female only lounge is available on the ward/unit and that this is clearly signed. Toilets are designated single sex and where possible bathroom facilities also. There are, however, occasions where clinical need requires bathroom facilities to be accessible by both genders, for example where service users need specialist equipment such as in our learning disabilities or older people's services.

In areas where bathroom facilities may be used by both genders, bathrooms only accommodate one service user at a time and may be locked by the individual using the facilities (with an external override). Clear signs are in place when bathrooms are allocated for a specific gender and where required, service users are assisted by staff with their personal care needs. Specific work is currently planned within three of the older people's units in York and North Yorkshire to ensure bathroom facilities are improved to meet EMSA guidance. An action plan has been developed in collaboration with commissioners and work will commence shortly.

Success in this area will continue to be measured by patient experience/satisfaction surveys, Patient Led Assessments of Care Environments, 15 Step Challenge visits, Essence of Care Benchmark Audits, clinical governance groups, Board Reports and, the Care Quality Commission inpatient survey. 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 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 below show our 2010, 2011 and 2012 Patient Environment Action Team Assessment scores.

Following the inspections for 2012, we have produced 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 our governance framework and reported to our Board of Directors.

Performance

Leeds Services

2012			
Site Name	**Environment score**	**Food score**	**Privacy & dignity score**
The Mount	Excellent	Excellent	Excellent
Asket Croft	Excellent	Excellent	Excellent
St. Mary's Hospital PCT Unit	Excellent	Excellent	Excellent
1-5 Woodland Square	Excellent	Excellent	Excellent
Towngate House	Excellent	Excellent	Excellent
Millside CUE	Excellent	Good	Excellent
Newsam Centre	Good	Excellent	Excellent
Asket House	Excellent	Excellent	Excellent
Becklin Centre	Good	Excellent	Excellent
Parkside Lodge	Good	Excellent	Excellent

2011			
Site Name	**Environment score**	**Food score**	**Privacy & 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 in-patients		
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 & dignity score**
Aire Court	Excellent	Excellent	Excellent
The Mount	Good	Good	Excellent
Asket Croft	Good	Good	Excellent
St. Mary's Hospital PCT Unit	Excellent	Excellent	Excellent
Peel Court	Good	Good	Excellent
1-5 Woodland Square	Good	Good	Excellent
Towngate House	Unit closed to in-patients		
Millside CUE	Excellent	Good	Excellent
Newsam Centre	Good	Good	Excellent
Asket House	Good	Good	Excellent
Becklin Centre	Good	Good	Excellent
Parkside Lodge	Excellent	Good	Excellent

Performance

York and North Yorkshire Services

2012			
Site name	**Environment score**	**Food score**	**Privacy and dignity score**
Bootham Park Hospital	Acceptable	Good	Good
Clifton House	Good	Excellent	Good
Worsley Court	Acceptable	Good	Excellent
Limetrees	Good	Acceptable	Poor
Meadowfields CUE	Good	Acceptable	Good
Mill Lodge CUE	Good	Acceptable	Good
Peppermill Court	Good	Good	Excellent
Acomb Garth	Acceptable	Good	Good

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

Performance

Service user and carer involvement

This year we have refreshed our strategy to take account of the changing needs around us and the integration of our work with those services in York and North Yorkshire that we now provide. Whilst refreshing our strategy we have retained the central element of involving the people who use our services, their families and friends. They are our reason for doing what we do, and we are committed to our working together in partnership. We have made the commitment to improve health and improve lives, and this can only be done through working together. 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 vital partners with us in helping to influence the provision of services, and as a commitment to carers we have ensured that carers have broad representation on our council of governors. 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 have also developed the way in which we use social media so that people who are familiar with using Facebook and Twitter can keep in touch with us and get involved. By live tweeting from public events, people who are not able to attend can still raise questions or make a contribution.

Below are a few examples of the ways in which we involve people who use our services and carers in our Trust:

- Our Board of Directors invites people who use our services, or who care for those who use our services to attend a private session of their meeting and share their experiences. Over the last twelve months the Board have heard from a wide range of people including staff who use our services, this is an important piece of engagement work as the Board hear for themselves what it is really like to access services

- As a foundation trust we have continued to transform our services to ensure that they are both effective and efficient. This programme has provided regular feedback on its developments and clarified its ideas by discussion, consultation, and engagement with both those who use our services and their families or carers. This has significantly influenced the different elements of the project moving forward into the future

- Inpatient ward areas continue to hold regular 'Your Views' meetings, and these provide a rich source of views and ideas for service improvement. Daily activities and patient facilities are reviewed in these meetings and any changes which take place are fed back at each meeting

- Live tweeting from Council of Governor meetings, Board meetings, and involvement activities has enabled people, who are not able to attend, to contribute both their opinions and raise questions with positive feedback being received

- Developing our services into North Yorkshire and York has provided a new range of forums for involvement. Working with the City of York Council and the Vale of York Clinical Commissioning Group we have led a series of involvement activities where we have encouraged people to share creative conversations and we have listened to people's hopes for the future shape of services. This was then fed back to the commissioners

- Our regular corporate involvement events 'Building Your Trust' and 'Everything you need to know about...' have been re-branded as 'knowledge Cafes' with the emphasis on listening to what people have to say about our services. These events are also being delivered into York and North Yorkshire

- The Service User Network meetings have been re-branded and refreshed with a new venue and a new approach; there is regular good attendance in Leeds with people inviting speakers from within our organisation and strategic partners, as well providing a useful forum to sound out future developments. Plans are in place to roll this out within York and North Yorkshire over the next few months.

NHS Litigation Authority Risk Management Standards

We were assessed against level 1 Risk Management Standards on 12 February 2013 and passed with a score 48/50. An action plan to ensure any further recommendations are completed will be developed by the Risk Management Department which will be agreed and monitored by our Means Goal 7 Standing Group.

The key findings that were noted from the assessor showed that there were some good

Monitor Targets

concepts identified during the assessment which are worth a special note. Firstly, the use of action hot lists, which have been developed to alert staff immediately to outstanding actions on action plans; and secondly, the establishment of the directorate risk and clinical governance meetings, within which risk could be owned and managed locally.

Serious incidents

Serious incidents are investigated using root cause analysis methodology, with reports presented to our Trust Incident Review Group.

Systems and processes have been introduced by the Risk Management Team through 2012/13 which have resulted in an improved communication process with the Coroner's office and with NHS Airedale, Bradford and Leeds. This has enabled enhanced working practice and culminated in us demonstrating due process of investigation in order to assist us in meeting agreed 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
- Standardisation of risk management serious incident documentation with guidance notes to aid completion.

NHS Airedale, Bradford and Leeds timescales

- Incidents are scheduled into our Trust Incident Review Group agenda once Trust 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 our Trust Incident Review Group for monitoring purposes.

We 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 our Board of Directors and the Council of Governors following each meeting of our Trust Incident Review Group which provides an overview of the incidents, investigation and any lessons learnt.

Monitor assessments

Monitor is the independent regulator of foundation trusts. Using its assessment framework our overall 2012/13 performance is shown below along with our previous performance.

Prior to 2010/11 for both annual risk assessment and in-year monitoring, Monitor assigned a risk rating in three areas; finance; governance; and mandatory goods and services. From 2010 onwards the provision of mandatory goods and services is included in the governance risk rating.

Monitor uses these risk ratings to guide the intensity of its monitoring and to signal to the Trust its degree of concern with the specific issues identified and evaluated.

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

Monitor Targets

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

Risk ratings	Annual Plan 2012-13	Quarter 1 2012-13	Quarter 2 2012-13	Quarter 3 2012-13	Quarter 4 2012-13
Financial	4	4	4	4	4
Governance	Green	Green	Green	Green	Green

We currently have 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. We have addressed each compliance action in a timely and effective manner.

Monitor Targets

Monitor Targets

The table below shows our performance against Monitor targets. Progress against each of Monitor's targets are presented within our monthly performance report to the Board of Directors.

<table>
<tr><th>Monitor Target</th><th>2012/13</th><th>Threshold</th></tr>
<tr><td>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.</td><td>We have maintained a position of compliance throughout 2012/13, with performance above the threshold at 95.6%</td><td>95%</td></tr>
<tr><td>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.</td><td>We have maintained a position of compliance throughout 2012/13. Quarter 4 figures demonstrate performance remains at the threshold at 96.4%.</td><td>95%</td></tr>
<tr><td>Minimising delayed transfers of care: We must achieve no more than 7.5% of delays across the year. Monitor includes delays attributable to social care.

Annex C describes the construction of how this target has been calculated.</td><td>We have maintained a position of compliance throughout 2012/13. The annual performance below the threshold at 4.49%
<table><tr><th>Qtr 1 2012/13</th><th>Qtr 2 2012/13</th><th>Qtr 3 2012/13</th><th>Qtr 4 2012/13</th></tr><tr><td>5.32%</td><td>5.62%</td><td>4.14%</td><td>2.88%</td></tr></table></td><td>No more than 7.5%</td></tr>
<tr><td>Access to Crisis Resolution: We must achieve 95% 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.</td><td>We have maintained a position of compliance throughout 2012/13 with a yearly performance at 96.7%</td><td>95%</td></tr>
<tr><td>Data Completeness: Identifiers: We must ensure that 97% 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.</td><td>We have maintained a position of compliance throughout 2012/13.

Quarter 4 figures demonstrate performance at 99.8%.</td><td>97%</td></tr>
<tr><td>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.</td><td>We have maintained a position of compliance throughout 2012/13.

Quarter 4 figures demonstrate performance at 57.9%.</td><td>50%</td></tr>
<tr><td>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)</td><td>For the 6 recommendations 4 have been assessed as a level '4' (the highest rating) and 2 at a level '3'.</td><td>Not Applicable as set out in the Compliance Framework 2012/13</td></tr>
<tr><td>Meeting Commitment to Serve New Psychosis Cases by Early Intervention Teams. This target is only applicable to York and North Yorkshire services as Early Intervention is provided by Aspire within Leeds.</td><td>Data provided for year end 2012/13 demonstrates we have exceeded the contract target, with 62 new cases of psychosis supported by the Early Intervention Team.</td><td>95% of contract value (contract value is 34 new cases)</td></tr>
</table>

Annex A

A Annex A: Third Party Statements

Leeds North Clinical Commissioning Group statement for Leeds and York Partnership NHS Foundation Trust's Quality Account 2012/13

Leeds North Clinical Commissioning Group

Thank you for inviting us to comment on your draft quality account for 2012-13. We have reviewed the account and would like to offer the following comment:

"Leeds North Clinical Commissioning Group (CCG) welcomes the opportunity to comment on Leeds & York Partnerships Foundation Trust's Quality Account for 2012-13. Following the formation of new commissioning bodies, Leeds North Clinical Commissioning group is providing this narrative on behalf of all local Commissioning Groups.

We have reviewed the Account and we believe that the information published in this Quality Account, that is also provided to as part of the contractual agreement, is accurate.

We have continued to work collaboratively and positively with the Trust, building on successes in previous years, and we continue to support the Trust's three priorities for quality improvement.

The publication of Sir Robert Francis's inquiry into the events at Mid-Staffordshire Hospital has had far- and wide-reaching consequences, and makes a number of recommendations for providers and commissioners of healthcare. We are pleased to note therefore, that the Trust has adopted the NHS Values as outlined in the NHS constitution, and note the use of these values in staff appraisals and recruitment.

We commend the Trust on their continued work in communicating with the public and service users, and offer our congratulations in their breaking of a world record in support of their campaign to improve mental health and wellbeing, and for their Health Service Journal Award for their 'Love Arts' festival.

We note the Priority 1 update regarding outcome measures in use within Trust services (CORE, HONOS and TOMs), and we are particularly impressed with the progress made in the implementation of TOMS in Learning Disability services as part of last year's Commissioning for Quality and Innovation scheme. However, we also note that there is no mention of the recovery star measures introduced across some areas last year, and that there appears to be lack of clarity on how outcome reports will be shared with commissioners and how information will be used to influence service development, which we believe to be a crucial factor in using outcomes measures.

We note the progress made with regards to Priority 2 and support the Trust in its continued drive to improve patient safety. We note the work in ensuring that all registered nurses within the Trust have completed the support framework for the safe administration of medicines. We are pleased to note the continuing programme of Quality Walkrounds, and following discussion with the newly appointed Director of Nursing, look forward to commissioners being invited into the Trust to either be included in the programme or to arrange separate, regular visits.

Whilst we note the progress made on the transformation project as part of the Priority 3 update it is not clear as to the level of stakeholder involvement in the review of transformation. We believe that involving stakeholders is important in supporting their understanding of the impact of transformation on the mental health system in Leeds.

We commend the opening of the new secure rehabilitation facility as outlined in Priority 3 update (b). We are also mindful that there have been some challenges in relation to absconsions and the challenging behaviour of some of the service users. We believe that it would have been helpful for the Trust to recognise this and make clear proposals as to how these challenges will be addressed, although we do note the introduction of the 'your views' book and related meeting.

We note that there is no mention of progress against NICE Quality Standards, particularly in relation to Dementia. We are aware that with the introduction of community teams there are some challenges in ensuring that all staff have received appropriate training in dementia care, but that work is underway to address this. A statement to this effect would help readers of the Account understand the Trust's position on this element of the quality standard. We believe that it is important to publicly recognise where standards are not as expected and include the actions being taken to address shortfalls. This demonstrates an open, honest and responsive culture.

The Account makes reference to a bid having been submitted to the Department of Health to support improvement of corridors and communal environments, but we feel that it would be helpful to note that the bid was unsuccessful. We would like to see some commitment by the

Annex A

Trust to identify alternate means of investment to improve these areas.

We are pleased to note the actions proposed with regard to supporting staff, particularly in light of some of the findings reported in the national staff survey. However, we feel that this work should include proposals on addressing the areas of low satisfaction such as percentage of staff suffering work-related stress, experiencing physical violence and communication between senior management and staff.

We believe that we have a highly positive relationship with the Trust, and we look forward to further developing this in the pursuit of high quality mental health services for the people of Leeds. We will continue to work with the Trust in the monitoring of progress against the priorities outlined in this Account."

Overview and Scrutiny Committee (Yorkshire and the Humber) statement for Leeds & York Partnership NHS Foundation Trust's Quality Account 2012/13

Comments were requested from the Overview and Scrutiny Committee but unfortunately no formal comments were received within the required timescales for inclusion within the Quality Account.

Healthwatch Leeds statement for Leeds & York Partnership NHS Foundation Trust's Quality Account 2012/13

healthwatch Leeds

Healthwatch Leeds (HWL) is very pleased to provide a comment on this year's Quality Accounts (QA). As the champion of the voice of local people in Leeds, we are particularly interested in how you have used the process of listening to the voices of patients and citizens in Leeds, and how this has influenced how you have commissioned or provided services and the quality of services. We are pleased to see your reflections on the Francis Report and the way in which LYPFT hope to learn the lessons from the investigation into Mid Staffordshire NHS Trust (p4).

We were particularly impressed by LYPFT's attempts to involve HWL in commenting these accounts - ahead of every other Trust in Leeds. We hope next year's comments will be solicited at a similarly early stage - to ensure we are able to involve a wider range of voices in forming our comments and feedback. Meanwhile may we submit the following comments for inclusion in your Quality Account (QA) page 66 (draft version).

We welcome your clear strategy, linked to your charter of values. We think this is a good way of knowing how you plan to achieve your overall aims, and the criteria you wished to be judged against. Although we agree that the respect and dignity of everyone is paramount, it is less clear how the Trust plans to measure and achieve equality of experience and outcomes for people using the Trust. Although Everyone Counts, we think it is important that the Trust explicitly uses the 2011 Census to work out which groups of people are over/under-represented in Trust Services, and is clear about how it has achieved greater equality of outcomes over time. We would welcome a clearer link between the involvement or engagement activities undertaken with service users and carers and those groups who currently experience greatest mental health inequalities. We can help with this.

We are pleased to note an increased emphasis on wellbeing work in this year's QA following on from the LINKS comments last year - and the importance of social and non-medical support in recovery.

We welcome your clear commitment to the involvement of people who use your services in deciding how these services are delivered and evaluated. We would recommend that this engagement (and evaluation) takes place in parallel with those of clinicians - to ensure their role is more than offering an opinion on what clinicians have already decided (pp16/17). We welcome the employment of peer workers as a way of demonstrating your commitment to valuing experience from all quarters, and the Trust's commitment to recovery-oriented models of treatment. Similarly we commend the way you are championing patient stories and experiences as a way of explaining the process of recovery and the Trusts role in facilitating this. We would recommend other Trusts in Leeds learn from this excellent practice to enhance their existing methods of survey (p18e).

We would like to better understand the methods being used to increase levels of engagement with patients and carers, and how the low response rate of both carers (<5%, p41) and wider engagement activities where staff opinions outnumbered those of patients and people who use your services (pp40-44). HWL would like to extend the offer made by LINK in last year's QA feedback to support improvements in this area. We would like to help LYPFT adopt more effective methods of engaging with people who use LYPFT's

Annex A

services, as well as the people who provide informal care and support for them.

There is clearly plenty of effort being put into patient engagement, and service user involvement, but there is a lack of clarity or detail about what this achieves, or how it continues to influence the way in which the Trust plans delivers and evaluates treatment options. In the coming year, we would like to explore ways in which such feedback can help you further to improve quality and service design, and to be "part of the solution".

We feel it is unclear to what extent your annual quality priorities are derived from patient and public priorities. Over the coming year, HWL will seek to discuss with you how we can support and enable local people to contribute to your consideration of quality priorities for 2014-15. In next year's accounts we would like a clearer account of the formal mechanisms by which patients and carers' opinions feed into the strategic decision making processes within the Trust.

We hope these comments are useful and look forward to a future dialogue in relation to the QA for 2013-14.

Healthwatch York statement for Leeds & York Partnership NHS Foundation Trust's Quality Account 2012/13

Healthwatch York welcomed the opportunity to review this quality account and found it to be very comprehensive and well laid out. It was pleasing to see the inclusion of information about services in York and we look forward to seeing more of this in the future. We particularly look forward to the Service User Network meetings being rolled out in York.

Healthwatch York regards the development of plans for a Section 136 service in York as an urgent priority for 2013/14 and hope a solution will be agreed and implemented as soon as possible.

We welcome the development of services for people who are currently assessed and treated out of area and look forward to seeing the plans for improvement. The construction of the new women's unit at Clifton House is a very positive development for patients in York.

It is good to see that the Trust acknowledges the importance of carers and is taking their needs into account when planning service improvements.

Healthwatch North Yorkshire statement for Leeds & York Partnership NHS Foundation Trust's Quality Account 2012/13

Healthwatch North Yorkshire would like to thank Leeds and York Partnership NHS Foundation Trust for the opportunity to comment on their Quality Accounts for the year 2012-2013.

Comments from Healthwatch North Yorkshire[2]

A clear concise Quality Account.

Pleased that the Trust are addressing the recommendations of the second Francis Report and will continue to do so in the following year.

Recommend the inclusion of an Acronym and Jargon buster.
Highlight more clearly, especially where staff training and process development are concerned, the benefit to patients and carers. Clarification needed of the measurement process.

Graphical representation of the priorities shows a difference between North Yorkshire and Leeds satisfaction. This is not discussed in the QA. How will the Trust address this?

Disappointed that Priority 1 does not include the measure "timely". There is a need to address the provision of the IAPT service within North Yorkshire in future QAs.

[2]Comments received from Healthwatch North Yorkshire in relation to spellcheck/grammar have been removed from the above statement. However, these have been actioned within the Quality Account.

Annex B

B Annex B: 2012/13 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 to prepare a Quality Account for each financial year.

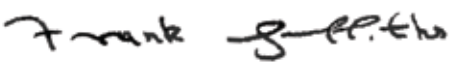
Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality report (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the quality report.

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 2012/13;
- 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 2012 to March 2013;
  - Papers relating to quality reported to the Board over the period April 2012 to March 2013;
  - Feedback from the commissioners dated dated 9 May 2013;
  - Feedback from the governors dated April 2012
  - Feedback from Local Healthwatch organisations dated 30/04/2013 and 01/05/2013
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated April 2012 – May 2013;
  - The latest national patient survey 2012
  - The latest national staff survey 2012
  - The Head of Internal Audit's Opinion over the Trust's control environment dated 22 May 2013;
  - CQC quality and risk profiles dated April 2012 – March 2013
- 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 Account regulations) (published at www.monitor-nhsft.gov.uk/annualreportingmanual) as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

By order of the Board



31 May 2013

Frank Griffiths - chair of the trust

31 May 2013

Chris Butler - chief executive

Annex C

C Annex C: Mandatory Performance Indicator Definitions

In regard to the mandatory performance indicators, definitions for each indicator are as follows.

100% enhanced Care Programme Approach (CPA) patients receive follow up contact within seven days of discharge from hospital

Detailed descriptor
The proportion of those patients on Care Programme Approach (CPA) discharged from inpatient care who are followed up within 7 days.

Data definition
All patients discharged to their place of residence, care home, residential accommodation, or to non-psychiatric care must be followed up within seven days of discharge. All avenues need to be exploited to ensure patients are followed up within seven days of discharge[3]. Where a patient has been discharged to prison, contact should be made via the prison in-reach team.

Exemption:
- Patients who die within seven days of discharge may be excluded.
- Where legal precedence has forced the removal of the patient from the country.
- Patients transferred to NHS psychiatric inpatient ward.
- CAMHS (children and adolescent mental health services) are not included.

The seven day period should be measured in days not hours and should start on the day after discharge.

Accountability
Achieving at least 95% rate of patients followed up after discharge each quarter.

[3]Follow up may be face-to-face or telephone contact, this excludes text or phone messages.

Minimising delayed transfers of care[4]

Detailed descriptor
The number of Delayed Transfers of Care per 100,000 population (all adults – aged 18 plus).

Data Definition
Commissioner numerator_01: Number of Delayed Transfers of Care of acute and non-acute adult patients (aged 18+ years).

Commissioner denominator_02: Current ONS resident population projection for the relevant year aged 18 years or more.

Provider numerator_03: Number of patients (acute and non-acute, aged 18 and over) whose transfer of care was delayed, averaged over the quarter. The average of the three monthly sitrep figures[5] is used as the numerator.

Provider denominator_04: Average number of occupied beds[6].

A delayed transfer of care occurs when a patient is ready for transfer from a hospital bed, but is still occupying such a bed.

A patient is ready for transfer when:
a) A clinical decision has been made that the patient is ready for transfer AND
b) A multi-disciplinary team decision has been made that the patient is ready for transfer AND
c) The patient is safe to discharge/transfer.

To be effective, the measure must apply to acute beds, and to non-acute and mental health beds. If one category of beds is excluded, the risk is that patients will be relocated to one of the 'excluded' beds rather than be discharged.

Accountability
The ambition is to maintain the lowest possible rate of delayed transfers of care. Good performance is demonstrated by a consistently low rate over time, and/or by a decreasing rate. Poor performance is characterised by a high rate, and/or by an increase in rate.

[4]This definition was provided to Monitor by the Mental Health and Disability Division of the Department of Health
[5]From the monthly delayed transfers of care sitrep return, see guidance at http://transparency.dh.gov.uk/2012/06/21/dtoc-information/
[6]In the quarter open overnight

Admissions to inpatient services had access to crisis resolution home treatment teams[7]

Detailed descriptor
The proportion of inpatient admissions gatekept by the crisis resolution home treatment teams.

Annex C

Data definition

Gatekeeping:
In order to prevent hospital admission and given support to informal carers CR/HT are required to gatekeep all admission to psychiatric inpatient wards and facilitate early discharge of service users. An admission has been gatekept by a crisis resolution team if they have assessed the service user before admission and if the Crisis Resolution Team was involved in the decision making-process, which resulted in an admission.

Total exemption from CR/HT Gatekeeping:-

- Patients recalled on Community Treatment Order
- Patients transferred from another NHS hospital for psychiatric treatment.
- Internal transfers of service users between wards in the Trust for psychiatry treatment
- Patients on leave under Section 17 of the Mental Health Act
- Planned admission for psychiatric care from specialist units such as eating disorder unit are excluded.

Partial exemption:

- Admissions from out of the Trust's area 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. Crisis Resolution Team should assure themselves that gatekeeping was carried out. This can be recorded as gatekept by Crisis Resolution Teams.

[7]This indicator applies to patients in the age bracket 16-65 years and only applies to CAMHS patients where they have been admitted to an adult ward.

[8]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 should be face-to-face and only by telephone where face-to-face is not appropriate or possible.

Patient safety incidents reported

Indicator description
Patient safety incidents reported to the National Reporting and Learning Service (NRLS)[9].

Indicator construction
The number of incidents as described above.

A patient safety incident (PSI) is defined as "any unintended or unexpected incident(s) that could or did lead to harm for one of more person(s) receiving NHS funded healthcare".

Indicator format
Whole number.

[9]Monitor has removed the requirement to report this as a rate of 100,000 population.

Safety incidents involving severe harm or death

Indicator description
Patient safety incidents reported to the National Reporting and Learning Service (NRLS), where degree of harm is recorded as severe harm or death, as a percentage of all patient safety incidents reported[10].

Indicator construction

Numerator: The number of patient safety incidents recorded as causing severe harm/death as described above.

The degree of harm for PSIs is defined as follows:-

'Severe' – the patient has been permanently harmed as a result of the PSI, and
'Death' – the PSI has resulted in the death of the patient

Denominator: The number of patient safety incidents reported to the National Reporting and Learning Service (NRLS).

Indicator format: Standard percentag

[10]Monitor has replaced the requirement to report this as a rate per 100,000 population with the requirement to report such incidents as a percentage of all PSIs reported by the trust.

Independent Auditor's Report

Independent Auditor's Limited Assurance Report to the Council of Governors of Leeds and York Partnership NHS Foundation Trust on the Annual Quality Report

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 and York Partnership NHS Foundation Trust's Quality Report for the year ended 31 March 2013 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2013 in the Quality Report that have been subject to limited assurance consist of the following national priority indicators as mandated by Monitor:

1. Admissions to inpatients services had access to crisis resolution home treatment teams
2. Minimising delayed transfers of care

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 assessment criteria for the indicators specified above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The 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 not consistent in all material respects 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 the following documents:

- Board minutes for the period April 2012 to the date of signing this limited assurance report (the period);
- Papers relating to Quality reported to the Board over the period April 2012 to the date of signing this limited assurance report;
- Feedback from the Commissioners, Leeds North Clinical Commissioning Group dated 09/05/2013;
- Feedback from Governors;
- Feedback from local Healthwatch organisations, Healthwatch York dated April 2013;
- The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 13/01/2013, 12/07/2012, 12/10/2012;
- The latest national staff survey: "2012 National NHS staff survey" published 28/02/2013;
- The latest national patient survey: "2012 National NHS community mental health service users survey" published 13/09/2013;
- Care Quality Commission quality and risk profiles dated 01/04/2012-31/03/2013; and
- The Head of Internal Audit's annual opinion over the trust's control environment dated 22/05/2013.

We consider the implications for our report if we become 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, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2013, 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 accept or assume responsibility to anyone other than the Council of Governors as a body and Leeds and York

Independent Auditor's Report

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 Standard 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 specified indicators back to supporting documentation.
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report.
- 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 materially different measurements and 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 out in the FT ARM and the Directors' interpretation of the Criteria specified in the Quality Report.

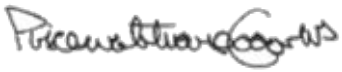
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

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 for the year ended 31 March 2013,

- 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 not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria.



PricewaterhouseCoopers LLP Chartered Accountants
Leeds
Date: 29/5/13

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 indicators or criteria since they were initially presented on the website.

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Content

Notes to the accounts

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1.1 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.

Chris Butler - chief executive
24 May 2013

Dawn Hanwell - chief financial officer
24 May 2013

1.2 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 2013 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2012/13 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Directors' Responsibilities Statement the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2012/13. Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service 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.

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 misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. 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

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of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on financial statements

In our opinion the financial statements:

- give a true and fair view, of the state of the NHS Foundation Trust's affairs as at 31 March 2013 and of its income and expenditure and cash flows for the year then ended 31 March 2013; and
- have been prepared in accordance with the NHS Foundation Trusts Annual Reporting Manual 2012/13.

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

In our opinion

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trusts Annual Reporting Manual 2012/13; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

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

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS \ Foundation Trust Annual Reporting Manual 2012/13 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, on any aspect, our opinion on 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 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Ian Looker (Senior Statutory Auditor)
For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds

29 May 2013

Notes:

(a) The maintenance and integrity of the Leeds and York Partnership NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

1.3 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 2013 £000	Year ended 31 March 2012 £000
Operating income	3 & 4	180,170	181,166
Operating expenses	5	(171,804)	(172,516)
OPERATING SURPLUS		**8,366**	8,650
FINANCE COSTS			
Finance income	10	501	343
Finance expense - financial liabilities	12	(4,248)	(4,160)
Finance expense - unwinding of discount on provisions	25	(46)	(46)
PDC Dividends payable		(304)	(312)
NET FINANCE COSTS		**(4,097)**	(4,175)
Surplus from operations		4,269	4,475
Surplus/(deficit) of discontinued operations and the gain/(loss) on disposal of discontinued operations			
SURPLUS FOR THE YEAR		**4,269**	4,475
Other comprehensive income			
Revaluation gains and impairment losses on intangible assets		53	68
Revaluation gains and impairment losses property, plant and equipment		399	557
Public Dividend Capital repaid			(390)
TOTAL COMPREHENSIVE INCOME / (EXPENSE) FOR THE YEAR		**4,721**	4,710

The notes on pages 159 to 195 form part of this account.

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STATEMENT OF FINANCIAL POSITION AS AT 31 March 2013	NOTE	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Non-current assets			
Intangible assets	13.1	282	356
Property, plant and equipment	14.1	51,775	53,927
Trade and other receivables	17	2,677	2,370
Total non-current assets		54,734	56,653
Current assets			
Inventories	16	72	73
Trade and other receivables	17	5,855	6,376
Non-current assets for sale	19	729	665
Cash and cash equivalents	18	31,716	23,497
Total current assets		38,372	30,611
Current liabilities			
Trade and other payables	20	(16,838)	(15,095)
Borrowings	21	(1,377)	(1,253)
Provisions	25	(1,220)	(306)
Other liabilities	22	(2,627)	(2,957)
Total current liabilities		(22,062)	(19,611)
Total assets less current liabilities		**71,044**	67,653
Non-current liabilities			
Borrowings	21	**(30,852)**	(32,229)
Provisions	25	(1,549)	(1,502)
Other liabilities	22		
Total non-current liabilities		**(32,401)**	(33,731)
Total assets employed		**38,643**	33,922
Financed by (Taxpayers' Equity)			
Public Dividend Capital		19,119	19,119
Revaluation reserve		6,948	6,549
Other reserves		(651)	(651)
Income and expenditure reserve		13,227	8,905
Total taxpayers' equity		**38,643**	33,922

The notes on pages 159 to 195 form part of this account.

The financial statements on pages 154 to 195 were approved by the Board on 24 May 2013 and signed on its behalf by:

Signed: ..... (Chief Executive)

Date: **24 May 2013**

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STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2012	19,119	6,549	(651)	8,905	33,922
Surplus for the year				4,269	4,269
Revaluation gains and impairment losses on intangible assets		53			53
Revaluation gains and impairment losses property, plant and equipment		399			399
Public Dividend Capital repaid					
Transfers to the income and expenditure account in respect of assets disposed of		(43)		43	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(10)		10	
Movement in year subtotal		**399**		**4,322**	**4,721**
Taxpayers' Equity at 31 March 2013	19,119	6,948	(651)	13,227	38,643

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital	Revaluation Reserve	Other Reserves	Income and Expenditure Reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2011	19,509	6,644	(651)	3,710	29,212
Surplus/(deficit) for the year				4,475	4,475
Revaluation gains and impairment losses on intangible assets		68			68
Revaluation 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**
Taxpayers' Equity at 31 March 2012	19,119	6,549	(651)	8,905	33,922

Description of Reserves:

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

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

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

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

The notes on pages 159 to 195 form part of this account.

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STATEMENT OF CASH FLOWS	NOTE	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Cash flows from operating activities			
Operating surplus from continuing operations		8,366	8,650
Operating surplus		**8,366**	8,650
Non-cash income and expense			
Depreciation and amortisation	5	3,672	3,372
Impairments and reversals	14.3	870	899
(Increase)/decrease in trade and other receivables	17	264	(1,090)
(Increase)/decrease in inventories	16	1	7
Increase/(decrease) in trade and other payables	20	1,853	3,765
Increase/(decrease) in other liabilities	22	(330)	(2,666)
Increase/(decrease) in provisions	25	915	(64)
(Increase)/decrease in other assets	19		
Other movements in operating cash flows		1	153
Net cash generated from operations		**15,612**	13,026
Cash flows from investing activities			
Interest received	10	470	330
Purchase of intangible assets	13.1	(4)	(85)
Purchase of property, plant and equipment	14	(2,289)	(6,027)
Sales of property, plant and equipment		238	390
Net cash used in investing activities		**(1,585)**	(5,392)
Cash flows from financing activities			
Public dividend capital repaid			(390)
Capital element of finance lease rental payments	21	**(177)**	(149)
Capital element of private finance initiative obligations	21	**(1,066)**	(991)
Interest element of finance lease	12	**(334)**	(345)
Interest element of private finance initiative obligations	12	**(3,907)**	(3,815)
PDC dividend paid		**(323)**	(335)
Cash flows from (used in) other financing activities			
Net cash used in financing activities		**(5,807)**	(6,025)
Increase/(decrease) in cash and cash equivalents		8,220	1,609
Cash and cash equivalents at 1 April		23,497	21,888
Cash and cash equivalents at 31 March		**31,716**	23,497

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Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
(Increase)/decrease in receivables as per SOFP	214	(1,127)
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		
- Financing transactions	50	37
(Increase)/decrease in receivables adjusted for non-I&E items	264	(1,090)
Increase/(decrease) in payables per SOFP	1,743	3,118
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	124	647
- Financing transactions	(14)	
Increase/(decrease) in payables adjusted for non-I&E items	1,853	3,765
Increase/(decrease) in other liabilities per SOFP	330	(2,666)
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	330	(2,666)
Increase/(decrease) in provisions per SOFP	961	(18)
Adjustments for provisions movements:		
- Adjustments for EU ETS on surrender of allowances		
- Unwinding of discount on provisions	(46)	(46)
Increase/(decrease) in provisions for non I&E items	915	(64)
Opening capital receivables		
Closing capital receivables		
Change in capital receivables in-year		
Opening capital payables	(907)	(1,554)
Closing capital payables	(783)	(907)
Change in capital payables in-year	**124**	647

The notes on pages 159 to 195 form part of this account.

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Notes to the accounts

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

1 Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012/2013 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 (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently, other than where new policies have been adopted, in dealing with items considered material in relation to the accounts.

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

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

1.1 Accounting convention

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

1.2 Segmental reporting

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

1.3 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for Leeds and York Partnership NHS Foundation Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.4 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 are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would allow NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

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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 under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

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 with the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. Employers and employee contribution rates may be varied from time to time, on the advice of the scheme actuary, to reflect changes in the scheme's liabilities. In 2012/13 employee contributions ranged from 5% to 10.9% and from 1 April 2013 contributions will range from 5% to 13.3% with plans to carry out further consultation on employee contribution rises in 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 2013, is based on detailed membership data as at 31 March 2010 (the latest midpoint) updated to 31 March 2013 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 2012-13 the NHS Pension Scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

Annual pensions

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

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

Pensions indexation

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

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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 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.

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1.6.2 Measurement & valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust's purposes are stated in the Statement of Financial Position at their revalued amounts being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. In accordance with IFRS and NHS policy, a full revaluation is performed at least every five years, with an interim revaluation in the third year after the full revaluation 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 are determined as follows:

- **Land and non-specialised buildings – market value for existing use**
- **Specialised buildings – depreciated replacement cost based on providing a modern equivalent asset**
- **Non-operational land and buildings – fair value based on alternative use.**

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. A valuation was last undertaken as at 31 March 2013 and in the current year the assets were reviewed for impairment using the Modern Equivalent Asset method as appropriate.

Plant and equipment assets were last indexed using the latest available Consumer Price Indices, being for February 2013, 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 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

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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 potential from it. This period is specific to the foundation trust and may be shorter than the physical life of the asset itself.

Assets held under finance leases (including leased land) are depreciated over the shorter of their estimated useful economic lives or the lease period. Where the Trust will, or is reasonably certain to, acquire 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 aa prospective basis.

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

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

1.6.5 Revaluation and impairment

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

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

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

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

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

1.6.6 Non-current assets held for sale

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

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- **the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales**
- **the sale must be highly probable i.e. management are committed to a plan to sell the asset; an active programme has begun to find a buyer and complete the sale; the asset is being actively marketed at a reasonable price; the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.**

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

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

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

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

1.7 Private finance initiative (PFI) transactions

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

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

b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to "fair value" by the District Valuer in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to "finance costs" within the Statement of Comprehensive Income. Contingent rent due to inflationary increases in the unitary payment is also included in the finance cost.

The minimum lease payments of the finance lease component are split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each year is then calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in 'finance costs' in the Statement of Comprehensive Income.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as part of the PFI Operating Expenses in the Statement of Comprehensive Income.

c) Operating lease for the land

The land that the PFI Building is built on, is classified as an operating lease in accordance with IAS 17.

Assets contributed by the Trust to the operator for use in the scheme

Assets contributed for use in the scheme continue to be recognised as items of property, plant and equipment in the Trusts Statement of Financial Position.

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

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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 of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. The Trust holds software licences as Intangible assets. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 5 and 10 years depending on the software licence.

1.8.2 Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- **the project is technically feasible to the point of completion and will result in an Internally generated intangible asset for sale or use**
- **the Trust intends to complete the asset and sell or use it**
- **the Trust has the ability to sell or use the asset**
- **how the intangible asset will generate probable future economic or service delivery benefits 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.**

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 present legal or constructive obligations that are of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate in real terms. The discount rate for early retirement and injury benefit provisions (both use the HM Treasury's pension discount rate) is 2.35% (2.8% in 2011/12) in real terms. The discount rate for other provisions from 2012/13 varies depending on the timing of the liability from -1.8% (up to 5 years), -1.0% (6 - 10 years) and 2.2% over 10 years (in 2011/12 the rate was 2.5%).

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 (NHSLA) took over the full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the Trust.

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Leeds and York Partnership NHS Foundation Trust does not include any amounts in its accounts relating to these cases. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

Non-clinical risk pooling

Leeds and York Partnership NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises and these are the only amounts included in the accounts of the Leeds and York Partnership NHS Foundation Trust.

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is possible. Otherwise, they are not recognised, but are disclosed in Note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- **possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or**
- **present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.**

1.13 Value added tax (VAT)

Most of the activities of Leeds and York Partnership NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation tax

Leeds and York Partnership NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is

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potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disapplied, the foundation trust has no corporation tax liability.

1.15 Foreign exchange

The functional and presentation 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. Gains and losses that result are taken to the Statement of Comprehensive Income.

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 FReM.

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 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.

1.18 Public dividend capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS Trust.

HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by Leeds and York Partnership NHS Foundation Trust, is paid over as PDC dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General, the Government Banking Service and PDC receivable/payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

In accordance with the requirements laid down by the Secretary of State (as the issuer of PDC) the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the financial statements. The dividend is not revised should any adjustment to net assets occur as a result of the audit of the financial statements.

1.19 Losses and special payments

Losses and Special Payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore

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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 (with the exception of provisions for future losses).

1.20 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase and sale of non-financial items (such as goods or services), which are entered into in accordance with Leeds and York Partnership NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policies for leases.

All other financial assets and financial liabilities are recognised when the foundation 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 which 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, the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, Leeds and York Partnership NHS Foundation Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

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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 in the FT ARM.

IAS 1, 'Financial statement presentation' regarding other comprehensive income.

The main change resulting from these amendments is a requirement for entities to group items presented in 'other comprehensive income' (OCI) on the basis of whether they are potentially reclassifiable to profit or loss subsequently (reclassification adjustments). The amendments do not address which items are presented in OCI. Effective date of 2013/14 but not yet adopted by the EU.

IFRS 13 'Fair value measurement'

This standard aims to improve consistency and reduce complexity by providing a precise definition of fair value and a single source of fair value measurement and disclosure requirements for use across IFRSs. Effective date of 2013/14 but not yet adopted by the EU.

IAS 19, 'Employee benefits', was amended in June 2011.

These amendments eliminate the corridor approach and calculate finance costs on a net funding basis. Effective date of 2013/14.

IFRS 9, 'Financial instruments'

IFRS 9 was issued in November 2009 and October 2012. It replaces the parts of IAS 39 that relate to the classification and measurement of financial instruments. IFRS 9 requires financial assets to be classified into two measurement categories: those measured as at fair value and those measured at amortised cost. The basis of classification depends on the entity's business model and the contractual cash flow characteristics of the financial asset. Standard has not yet been adopted by the EU.

IFRS 10, 'Consolidated financial statements'

The standard builds on existing principals by identifying the concept of control as the determining factor in whether an entity should be included within the consolidated financial statements of the parent company. The standard provides additional guidance to assist in the determination of control where this is difficult. Effective date of 2014/15 but not yet adopted by the EU.

IFRS 11, 'Joint arrangements'

IFRS 11 is a more realistic reflection of joint arrangements by focusing on the rights and obligations of the parties to the arrangement rather than its legal form. There are two types of joint arrangement: joint operations and joint ventures. Joint operations arise where a joint operator has rights to the assets and obligations relating to the arrangement and therefore accounts for its share of assets, liabilities, revenue, and expenses. Joint ventures arise where the joint venture has rights to the net assets of the arrangement and therefore equity accounts for its interest. Proportional consolidation of joint ventures is no longer allowed. Effective date of 2014/15 but not yet adopted by the EU.

IFRS 12, 'Disclosures of interests in other entities'

This standard includes the disclosure requirements for all forms of interests in other entities, including joint arrangements, associates, special purpose vehicles and other off balance sheet vehicles. Effective date of 2014/15 but not yet adopted by the EU.

IAS 27 (revised 2011), 'Separate financial statements'

This standard includes the requirements relating to separate financial statements. Effective date of 2014/15 but not yet adopted by the EU. The impact on Leeds and York Partnership NHS Foundation Trust is the requirement to consolidate Charitable Funds into the Trusts accounts from 2013/14 (as per Note 1.25 and Note 33).

IAS 28 (revised 2011), 'Associates and joint ventures'

This standard includes the requirements for associates and joint ventures that have to be equity accounted following the issue of IFRS 11. Effective date of 2014/15 but not yet adopted by the EU.

Amendment to IAS 32, 'Financial instruments: Presentation'

These amendments are to the application guidance in IAS 32 and clarify some of the requirements for offsetting financial assets and financial liabilities on the Statement of Financial Position.

Amendment to IFRS 7, 'Financial instruments: Disclosures'

This amendment includes new disclosures to

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facilitate comparison between those entities that prepare IFRS financial statements to those that prepare financial statements in accordance with US GAAP. Effective date of 2013/14 but not yet 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.

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, expenditure, assets, liabilities and reserves on consolidation. Income and expenditure between the Trust and the charitable fund will be eliminated on consolidation.

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 2012/13.

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.

1.24 Private patient income cap

Previously, NHS Foundation Trusts were required to disclose private patient income where this exceeded the amount specified in the FT ARM. This disclosure is no longer required.

1.25 Charitable funds

Under IAS 27 (revised) Leeds and York Partnership NHS Foundation Trust is required to consolidate any Charitable Funds that meet the definition of subsidiary contained in the standard. HM Treasury has granted dispensation to NHS FT organisations in this respect for 2011/12 and 2012/13. This dispensation ends in 2013/14 and therefore the Trust will be required to consolidate Charitable Funds within the main Trust accounts where it continues to meet the criteria within the standard.

IAS 27 (revised) also requires specific disclosures to be included in the accounts. The dispensation granted does not include the requirement for appropriate disclosure and consequently Note 33 - Charitable Funds, is included in the Trusts accounts in compliance with these disclosure requirements.

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 for 54% of its income (62% in 2011/12) and NHS North Yorkshire & York for 19% of its income. The Trust also had contracts with the Yorkshire & Humber Specialised Commissioning Group, 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.

Six operating segments are reported below. The operating segments include the five core service directorates; Adult & Older Mental Health Services, Specialist Services, Learning Disability Services (LD), Specialised Supported Living (SSL) and North Yorkshire & York (NYY) Services. There is also an additional hosted services segment which includes the Commercial Procurement Collaborative (CPC), National Research Ethics Society, Research & Development, the Care Pathways & Packages Project and the Northern School of Child & Adolescent Psychotherapy. Adult & Older Mental Health Services were reported as two separate segments in 2011/12; they have

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been combined in 2012/13 in order to reflect the restructuring of services as a result of the Transformation Programme.

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.

Poet, Lemn Sissay speaking at the Northern School of Child & Adolescent Psychotherapy

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	Adult & Older		Specialist		LD		SSL		NYY		Hosted Service		Total	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Income by segment														
Income from activities	**83,233**	91,539	**15,695**	14,287	**11,210**	11,377	**7,735**	7,536	**37,141**	37,545		1	**155,013**	162,287
Other operating income	**8,734**	5,754	**2,758**	2,816	**1,159**	751	**342**	369	**2,655**	1,720	**7,444**	5,609	**23,093**	17,020
TOTAL INCOME	**91,967**	97,294	**18,453**	17,103	**12,370**	12,128	**8,078**	7,906	**39,796**	39,265	**7,444**	5,611	**178,106**	179,306
TOTAL EXPENDITURE	**(82,342)**	(88,079)	**(15,541)**	(14,462)	**(11,829)**	(11,229)	**(9,181)**	(8,815)	**(38,669)**	(39,447)	**(7,636)**	(5,953)	**(165,198)**	(167,985)
EBITDA	**9,625**	9,215	**2,912**	2,641	**541**	899	**(1,104)**	(910)	**1,127**	(182)	**(193)**	(342)	**12,908**	11,321
Non operating income and expenditure total	**(7,426)**	(5,885)	**(608)**	(482)	**(599)**	(475)	**27**	22			**(33)**	(26)	**(8,639)**	(6,846)
Surplus/(deficit) from continuing operations	**2,199**	3,330	**2,304**	2,159	**(58)**	424	**(1,076)**	(888)	**1,127**	(182)	**(226)**	(368)	**4,269**	4,475

a) Income includes £167m from NHS organisations (primarily £100m from NHS Leeds and £33m from NHS NYY).

b) Expenditure includes:	**£'000 2012/13**	**£'000 2011/12**
Employee Expenses	£126,695	£127,351
Premises	£7,012	£7,793
Depreciation & Amortisation	£3,672	£3,372
Establishment	£5,515	£5,093

c) Depreciation and non-current asset impairment (£6,599k 12/13, £4,379k 11/12) is included in operating expenses in the accounts, but non operating expenses in service line reports.

d) 12/13 includes £8k and 11/12 includes £153k for profit/loss on disposal which is included in operating expenses in the accounts, but non operating expenses in service line reports.

e) 12/13 includes £2,057k reversal of impairment and £7k profit on disposal (11/12 - £107k reversal of impairment and £1,753k other payments) which are included in operating income in the accounts but in non operating income in service line reports.

f) The expenditure figure for NYY above includes an allocation of central overhead costs.

g) In the figures above the following amounts have been allocated across segments; depreciation £3,591k; amortisation £81k; finance income £501k and finance expense £4,248k

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 2013 £000	Year Ended 31 March 2012 £000
NHS Trusts	16	17
Primary Care Trusts	144,581	151,650
Foundation Trusts	201	390
Strategic Health Authorities	1,496	1,520
Local Authorities	1,283	1,515
NHS other	13	
Non-NHS:		
Income for Social Care Clients	7,410	7,195
Other	13	
Total Revenue from patient care activities	**155,013**	162,287

Leeds and York Partnership NHS Foundation Trust participates in a pooled budget arrangement with NHS Leeds and Leeds City Council as a provider of services.

As a provider of healthcare services, Leeds 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.

All income from patient care activities is mandatory

4 Other operating revenue

	Year Ended 31 March 2013 £000	Year Ended 31 March 2012 £000
Research and Development	**2,111**	844
Education and Training	**3,909**	3,587
Non-patient care services to other bodies	**4,722**	3,761
Other Income:		
Inter NHS Foundation Trust	**1,985**	2,057
Inter NHS Trust	**1,728**	1,622
Inter RAB	**6,071**	4,816
Inter Other WGA Bodies	**35**	24
Other (Outside WGA)	**2,109**	1,750
Gain on disposal of assets held for sale	**7**	
Reversal of impairments of property, plant and equipment	**2,057**	105
Reversal of impairments of intangible assets		2
Income in respect of staff costs where accounted on gross basis	**423**	311
Total Other Operating Revenue	**25,157**	18,879

Susan Hanley, Get me? campaign

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5 Operating expenses

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Services from Foundation Trusts	682	1,396
Services from other NHS Trusts	719	746
Services from PCT's	736	975
Services from other NHS bodies	13	2
Purchase of healthcare from non NHS bodies	4,115	8,045
Employee expenses - Executive Directors	809	838
Employee expenses - Non Executive Directors' costs	178	176
Employee expenses - Staff	125,886	126,513
Drugs costs	2,477	2,766
Supplies and services - clinical (excluding drugs)	1,908	1,297
Supplies and services - general	1,427	1,341
Establishment	5,515	5,093
Research and development	1,939	743
Transport	1,064	918
Premises	7,012	7,793
Increase/(decrease) in provision for impairment of receivables	20	(16)
Rentals under operating leases - minimum lease payments	2,715	
Depreciation on property, plant and equipment	3,591	3,282
Amortisation of intangible assets	81	90
Impairments of property, plant and equipment	2,858	458
Impairments of intangible assets	16	7
Impairments of assets held for sale	53	542
Audit fees - statutory audit and regulatory reporting	66	68
Other audit fees	45	
Clinical negligence	228	340
Loss on disposal of intangible fixed assets	2	153
Loss on disposal of other property plant and Equipment	6	
Consultancy services	541	650
Patient's travel	42	42
Redundancy	906	449
Early retirement	63	46
Insurance	109	122
Losses, ex-gratia and special payments	5	2
Other	5,977	7,639
Total operating expenses	**171,804**	172,516

Rentals under operating leases are disclosed separately in 2012/13. These were previously included as establishment, supplies and services or premises costs.

£4,115k of expenditure categorised as purchase of healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£8,045k 2011/12). In 2011/12 the budget for low secure and rehabilitation out of area treatments (OATs) transferred to Leeds and York Partnership NHS Foundation Trust from NHS Leeds.

Other expenditure and rentals under operating leases includes £6,113k (5,763k and 350k respectively) in relation to PFI costs (£5,717k in 2011/12). 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 auditors liability.

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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 1 June 2009. The statutory and regulatory audit fees were £57k (2011/12 £67k) excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011.

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Financial Audit	46	55
Charitable Funds Independent Examination/Audit	3	4
Quality Accounts	9	9
Other non-audit services	45	
Total	**102**	67

6 Operating leases

6.1 As lessee

35% (by value) of the leasing arrangements are made up of rental of the land under the PFI Schemes/finance leases. The contract end dates for 'Equitix' and 'Revival' properties are July 2028 and August 2019 respectively. Other leases are for buildings, vehicles and other equipment.

The Revival properties are for the land at two community units, Millside and Towngate House, for inpatient and day care for older people with severe mental illness together with a base for a community mental health team. The scheme started in September 1998 and is contracted to end in September 2019. At the end of the contract the Trust has an option to renew for 10 years.

The Equitix contract is for the seven mental health units, Becklin, Newsam, The Mount, Asket Croft, Asket House, Parkside Lodge and Woodhouse Hall, providing a comprehensive range of mental health services. The first unit opened in December 2001 and the last unit opened in February 2003. The contract end date is July 2028.

Other building leases include a 15 year lease on Trust headquarters at Thorpe Park and other non specialised properties used for clinical purposes. Vehicle leases are for cars supplied to qualifying staff under a vehicle lease scheme. Other equipment leases are mainly for photocopy equipment in the various Trust properties.

Payments recognised as an expense	**Year ended 31 March 2013** £000	Year ended 31 March 2012 £000
Minimum lease payments	2,715	3,122
Total	**2,715**	3,122

Total future minimum lease payments	**Year ended 31 March 2013** £000	Year ended 31 March 2012 £000
Payable:		
Not later than one year	2,643	3,091
Between one and five years	5,081	7,341
After 5 years	4,347	5,360
Total	**12,071**	15,792

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7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**101,672**	**95,394**	**6,278**	102,700	97,994	4,706
Social Security costs	**7,726**	**7,726**		7,800	7,800	
Employer contributions to NHS Pension scheme	**12,311**	**12,311**		12,462	12,462	
Termination Benefits				495	495	
Agency/Contract Staff	**5,208**		**5,208**	4,630		4,630
Employee expense	**126,917**	**115,431**	**11,486**	128,087	118,751	9,336

There were no employee benefits paid in the year ended 2012/13 (£nil in 2011/12)

In addition to the above:		
Charged to capital		
Recharged income	**(222)**	(241)
Total employee costs	**126,695**	127,846

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.

Directors remuneration	**Year ended 31 March 2013** **£000**	Year ended 31 March 2012 £000
Aggregate Emoluments to Executive Directors	**727**	679
Remuneration of Non-Executive Directors	**168**	176
Pension Cost	**95**	159
	990	1,014

Directors' emoluments include basic salary, other payments and benefits in kind.
Remuneration of Non-Executives include MH Act Managers £53k (£48k in 2011/12).

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7.2 Average number of people employed (wte)

	Year Ended 31 March 2013			Year Ended 31 March 2012		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**218**	**213**	**5**	226	220	6
Administration and estates	**619**	**607**	**12**	633	623	10
Healthcare assistants and other support staff	**284**	**284**		306	305	1
Nursing, midwifery and health visiting staff	**1,437**	**1,437**		1,522	1,498	24
Scientific, therapeutic and technical staff	**404**	**377**	**27**	427	402	25
Social care staff	**15**		**15**	15	4	11
Other	**254**		**254**	252		252
Total	**3,231**	**2,918**	**313**	3,381	3,052	329

7.3 Staff exit packages

Exit package cost band	**Number of redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band**
Less than £10,0000	2 (2)	4 (0)	6 (2)
£10,001 - £25,000	4 (1)	4 (0)	8 (1)
£25,001 - £50,000	4 (4)	2 (0)	6 (4)
£50,001 - £100,000	6 (1)	6 (0)	12 (1)
£100,001 - £150,000	2 (0)	0 (0)	2 (0)
£150,001 - £200,000	0 (1)	0 (0)	0 (1)
Total number of exit packages by type	**18 (9)**	**16(0)**	**34 (9)**
Total resource cost (£000)	**906 (449)**	**557 (0)**	**1,463 (449)**

Figures in brackets relate to 2011/12.

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 Board members can be found in the Directors Remuneration Report. There were no exit packages for Board members in 2012/13 (0 in 2011/12).

8 Retirements due to ill-health

During 2012/13 there were 6 (2011/12 = 1) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £518k (2011/12: £329k). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

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9 Better payment practice code

	Year Ended 31 March 2013		Year Ended 31 March 2012	
	Number	£000	Number	£000
Total Non-NHS trade invoices paid in the period	22,217	40,363	19,792	44,445
Total Non-NHS trade invoices paid within target	20,204	36,333	17,206	39,948
Percentage of Non-NHS trade invoices paid within target	91%	90%	87%	90%
Total NHS trade invoices paid in the period	1,321	11,541	900	7,057
Total NHS trade invoices paid within target	1,066	11,256	707	4,275
Percentage of NHS trade invoices paid within target	81%	98%	79%	61%

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 2013 £000	Year ended 31 March 2012 £000
Bank accounts	501	343
Total	501	343

This figure includes accrued interest of £38k (2011/12 £32k)

11 Other gains and losses

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Gain/(loss) on disposal of intangible assets	(2)	(153)
Gain/(loss) on disposal of property, plant and equipment	1	
Total	(1)	(153)

12 Finance costs

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Interest on obligations under finance leases	333	345
Interest on obligations under PFI contracts:		
- main finance cost	2,462	2,544
- contingent finance cost	1,453	1,271
Total	4,248	4,160

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13 Intangible assets - current year

2012/13:	Computer software purchased £000
Gross valuation at 1 April 2012	384
Additions purchased	4
Disposals other than by sale	(8)
Reclassifications	
Revaluation/indexation	(46)
Gross valuation at 31 March 2013	**334**
Accumulated amortisation at 1 April 2012	28
Disposals other than by sale	(6)
Revaluation	(67)
Impairments	16
Charged during the year	81
Accumulated amortisation at 31 March 2013	**52**
Net book value	
Purchased	282
Total at 31 March 2013	**282**

Intangible assets - prior year:

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
Gross valuation at 31 March 2012	384
Accumulated amortisation at 1 April 2011	
Disposals other than by sale	(23)
Revaluation	(44)
Impairments	5
Charged during the year	90
Accumulated amortisation at 31 March 2012	**28**
Net book value	
Purchased	356
Total at 31 March 2012	356

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5k is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 3 and 10 years depending on the software licence. The remaining economic life is assessed each year.

Quotations were sought in 2012/13 for the software licences and this led to an impairment of £16k (£5k in 2011/12).

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14 Property, plant and equipment - current year

2012/13:	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 2012	3,700	54,848	1,765	864	434	4,222	1,229	67,062
Additions purchased			1,469	34		662		2,165
Reclassifications		2,597	(2,676)			13	66	
Reclassified as held for sale	(350)							(350)
Disposals				(62)	(10)	(102)	(397)	(571)
Revaluation/indexation (losses)/gains	(70)	(10,982)		(2)	(1)		22	(11,033)
Impairments	(25)	(356)						(381)
At 31 March 2013	**3,255**	**46,107**	**558**	**834**	**423**	**4,795**	**920**	**56,892**
Accumulated depreciation at 1 April 2012	2	8,620	40	565	268	2,624	1,016	13,135
Disposals				(56)	(10)	(102)	(397)	(565)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains	(100)	(11,760)		(1)	(1)		17	(11,845)
Impairments	100	2,549	209					2,858
Reversal of impairment		(2,057)						(2,057)
Charged during the year	16	2,860		67	44	531	73	3,591
Accumulated depreciation at 31 March 2013	**18**	**212**	**249**	**575**	**301**	**3,053**	**709**	**5,117**
Net book value								
Total at 31 March 2013	**3,237**	**45,895**	**309**	**259**	**122**	**1,742**	**211**	**51,775**
Asset financing								
Owned	3,205	23,768	309	259	122	1,742	211	**29,616**
Finance Lease	32	912						**944**
PFI		21,192						**21,192**
Donated		23						**23**
Total at 31 March 2013	**3,237**	**45,895**	**309**	**259**	**122**	**1,742**	**211**	**51,775**
NBV Protected Assets at 31 March 2013	2,657	45,050						47,707
NBV Unprotected Assets at 31 March 2013	580	845	309	259	122	1,742	211	4,068
NBV Total at 31 March 2013	**3,237**	**45,895**	**309**	**259**	**122**	**1,742**	**211**	**51,775**

The latest revaluation of Land and Buildings was carried out by the Valuation Office with an effective date of 1 April 2013.

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

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

The Foundation Trust's property, plant and equipment are held for service delivery, rather than for cash generating purposes. Consequently, in accordance with the 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'.

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14.2 Property, plant and equipment - prior year

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 (losses)/gains		107		15	(1)		52	173
Impairments	(65)	(32)						(97)
At 31 March 2012	**3,700**	**54,848**	**1,765**	**864**	**434**	**4,222**	**1,229**	**67,062**
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 (losses)/gains		(533)		10	(1)		43	(481)
Impairments		353						353
Charged during the year	1	2,585		72	47	493	84	3,282
Accumulated depreciation at 31 March 2012	**2**	**8,620**	**40**	**565**	**268**	**2,624**	**1,016**	**13,135**
Net book value								
Total at 31 March 2012	**3,698**	**46,228**	**1,725**	**299**	**166**	**1,598**	**213**	**53,927**
Asset financing								
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**
Total at 31 March 2012	**3,698**	**46,228**	**1,725**	**299**	**166**	**1,598**	**213**	**53,927**
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
NBV Total at 31 March 2012	**3,698**	**46,228**	**1,725**	**299**	**166**	**1,598**	**213**	**53,927**

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14.3 Classification of impairments for parliamentary budgeting purposes

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Abandonment of assets in course of construction	209	
Changes in Market Place	3,131	1,104
Reversals of impairments	(2,057)	(107)
At 31 March	**1,283**	997

15 Capital commitments

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

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Property, plant and equipment	**45**	457
Total	**45**	457

16 Inventories

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Consumables and work in progress	**72**	73
Total	**72**	73
Of which held at net realisable value:	**72**	73

16.1 Inventories recognised in expenses

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Inventories recognised as an expense in the period	**16**	38
Total	**16**	38

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17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
NHS receivables-revenue	**2,141**	1,864		
Other receivables with related parties	**237**	236		
Accrued Income	**701**	1,176		
Provision for the impairment of receivables	**(132)**	(112)		
Prepayments	**777**	838	**2,677**	2,365
PDC Receivable	**90**	71		
VAT	**310**	349		
Other receivables	**1,731**	1,954		5
Total	**5,855**	6,376	**2,677**	2,370

The 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

17.1 Receivables past their due date but not impaired

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
By up to three months	**1,451**	2,163
By three to six months	**83**	79
Total	**1,534**	2,242

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 2013 £000	Year ended 31 March 2012 £000
Balance at 1 April	**112**	128
Amount written off during the year		
Amount recovered during the year		
Increase/(decrease) in receivables impaired	**20**	(16)
Balance at 31 March	**132**	112

The increase in the provision for the year ended 31 March 2013 has been provided for after taking all factors into consideration regarding the potential for recovery.

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18 Cash and cash equivalents

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Balance at 1 April	23,497	21,888
Net change in year	8,219	1,609
Balance at 31 March	31,716	23,497
Made up of		
Cash with Government Banking Service	31,568	23,362
Commercial banks and cash in hand	148	135
Cash and cash equivalents as in statement of financial position	31,716	23,497
Cash and cash equivalents as in statement of cash flows	31,716	23,497

19 Non-current assets held for sale

	Property, plant and equipment £000
Balance brought forward 1 April 2012	665
Plus assets classified as available for sale in the year	350
Less Impairment of assets held for sale	(53)
Less assets sold in the year	(233)
Balance carried forward 31 Mar 2013	729
Balance brought forward 1 April 2011	1,207
Less Impairment of assets held for sale	(542)
Less assets sold in the year	
Balance carried forward 31 Mar 2012	665

The assets held for sale are East Ardsley Health Centre, Peel Court and 36, Otley Old Road.

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20 Trade and other payables

	Current	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
NHS payables-revenue	**4,346**	4,501
Amounts due to other related parties	**1,683**	1,528
Non NHS trade payables - capital	**783**	907
Accruals	**6,319**	4,492
Other	**3,707**	3,667
Total	**16,838**	15,095

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
PFI liabilities	**1,163**	1,074	**28,858**	30,021
Finance lease liabilities	**214**	179	**1,994**	2,208
Total	**1,377**	1,253	**30,852**	32,229

The Trust has a prudential borrowing limit of £33,200k in 2012/13 (£34,600k in 2011/12). There were no borrowings in 2012/13 (0 in 2011/12).

The Trust has not breached the Prudential Borrowing Code (PBC).

	2012/13		2011/12	
Financial ratio	**Actual ratios**	**Approved PBL ratios**	**Actual ratios**	**Approved PBL ratios**
Minimum dividend cover	30x	>1x	26x	>1x
Minimum interest cover	3x	>2x	3x	>2x
Minimum debt service cover	2.4x	>1.5x	2.3x	>1.5x
Maximum debt service to revenue	3.1%	<10%	3.7%	<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.

Annual Accounts

22 Other liabilities

	Current	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Deferred Income	**2,627**	2,957
Total	**2,627**	2,957

23 Finance lease obligations

	Minimum lease payments		Present value of minimum lease payments	
Amounts payable under finance leases	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
Within one year	**526**	512	**509**	496
Between one and five years	**2,237**	2,180	**1,875**	1,826
After five years	**845**	1,423	**605**	989
Less future finance charges	**(1,400)**	(1,728)		
Present value of minimum lease payments	**2,208**	2,387	**2,989**	3,311
Included in:				
Current borrowings	**214**	179	**509**	496
Non-current borrowings	**1,994**	2,208	**2,480**	2,815
	2,208	2,387	**2,989**	3,311

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 £4,916k. 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 is £2,989k (£3,311k 2011/12), calculated from the minimum lease payments figures of £2,208k (£2,387k 2011/12) with the future finance charges at £1,400k (£1,728k 2011/12) added back. This figure is discounted at 0.49% per month (6.00% per annum) for 77 months (89 months 2011/12) which is the remaining life of the agreement.

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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. 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 2013	Year ended 31 March 2012	**Year ended 31 March 2013**	Year ended 31 March 2012
	£000	£000	**£000**	£000
Not later than one year	**4,989**	4,807	**4,802**	4,627
Later than one year, not later than five years	**19,954**	19,226	**16,150**	15,560
Later than five years	**46,560**	49,667	**23,878**	24,687
Sub total	**71,503**	73,700	**44,830**	44,874
Less: finance cost attributable to future periods	**(41,482)**	(42,605)	**(14,809)**	(13,779)
Total	**30,021**	31,095	**30,021**	31,095

Services component

	Gross Payments	
	Year ended 31 March 2013	Year ended 31 March 2012
	£000	£000
Not later than one year	**5,872**	5,657
Later than one year, not later than five years	**23,487**	22,629
Later than five years	**54,802**	58,459
Total	**84,161**	86,745

The future services amounts due as at 31 March 2013 reflect an adjustment for the RPI indexation of the unitary payment applied during 2012/13.

The amount charged to operating expenses during the year in respect of services was £5,763 (2011/12 £5,393).

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25 Provisions

	Current		Non-current	
	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000	**Year ended 31 March 2013 £000**	Year ended 31 March 2012 £000
Pensions relating to other staff	**139**	133	**1,549**	1,502
Legal claims	**85**	55		
Redundancy	**308**			
Other	**688**	118		
Total	**1,220**	306	**1,549**	1,502

	Pensions relating to other staff £000	Legal claims £000	Redundancy £000	Other £000	Total £000
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
At 31 March 2012	1,635	55	100	18	**1,808**
At 1 April 2012	1,635	55	100	18	1,808
Arising during the year	106	79	556	688	1,429
Change in discount rate	54				54
Used during the year	(140)	(28)	(348)	(7)	(523)
Reversed unused	(13)	(21)		(11)	(45)
Unwinding of discount	46				46
At 31 March 2013	1,688	85	308	688	**2,769**
Expected timing of cash flows:					
In the remainder of the spending review period to 31 March 2014	139	85	308	688	1,220
Between 1 April 2014 and 31 March 2018	556				556
Thereafter	993				993
TOTAL	1,688	85	308	688	**2,769**

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 the commitment placed on the Trust in ensuring it meets its obligations in respect of the Working Time Directive (£677k) and in respect of staff claims to be regraded under agenda for change (£11k).

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.

£39k is included in the provisions of the NHS Litigation Authority at 31 March 2013 in respect of clinical negligence liabilities of the Trust (31 March 2012 £30k).

Leeds and York Partnership NHS Foundation Trust has no expected reimbursements for any class of provision made.

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26 Contingencies

26.1 Contingent liabilities

	Year ended 31 March 2013 £000	Year ended 31 March 2012 £000
Other	31	28
Total	31	28

Contingent liabilities represent excess payments not provided for on legal cases being dealt with by NHSLA, on the Trust's behalf, (primarily in respect of employer's liability - £31k in 2012/13 and £28k in 2011/12). 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	5,123
Cash at bank and in hand	23,497
Total at 31 March 2012	28,620
Receivables	4,678
Cash at bank and in hand	31,716
Total at 31 March 2013	36,394
Ageing of over due receivables included in Financial Assets	
Receivables overdue by:	
1-30 days	1,195
31-60 days	132
61-90 days	124
91-180 days	83
	1,534

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27.2 Financial liabilities - carrying amount

	Total £000
Embedded derivatives	
Payables	13,141
PFI and finance lease obligations	33,482
Other borrowings	
Provisions under contract	1,808
Other financial liabilities	
Total at 31 March 2012	48,431
Embedded derivatives	
Payables	**14,336**
PFI and finance lease obligations	**32,229**
Other borrowings	
Provisions under contract	**2,769**
Other financial liabilities	
Total at 31 March 2013	**49,334**

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. The majority of the Trust's income comes from contracts with other public sector bodies, however, and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 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.

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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, the Trust is not considered to be exposed to significant liquidity risks (the inability of paying financial liabilities).

Leeds and York Partnership NHS Foundation Trust's main long term liability is its PFI obligation, with the contract ending in 2028. Further information on the commitments under this contract are provided in note 24.

Market risk

Market risk comprises three elements: foreign currency risk, interest rate risk and price risk.

Foreign currency risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure. Consequently, exposure to currency risk is not significant.

Interest rate risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities e.g. borrowing and financial assets. However a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds and York Partnership NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Price risk

As explained in note 24, Leeds and York Partnership NHS Foundation Trusts' annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard. The annual adjustments are reflected in finance costs (contingent rent), operating expenses and property, plant and equipment additions respectively.

For 2012/13 the percentage increase in the unitary payment was 3.79%, equalling a monetary increase of £419k (4.86%, £512k in 2011/12)

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%.

2012/13 Uplift in Unitary Payment	Actual uplift at 3.79% £000	Uplift at 3.7% £000	Uplift at 5.5% £000
Recognised in finance costs	99	95	182
Recognised in operating expenses	227	222	330
Recognised in surplus/deficit	326	317	512
Recognised in property, plant and equipment additions			
	326	317	512
Net impact of sensitivities on surplus/(deficit)		**9**	**(186)**
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
Net impact of sensitivities on surplus/(deficit)		**119**	**(67)**

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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. There have been no material transactions which are considered related parties to senior employees (in posts of influence) of the Trust.

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
Leeds Mind				
2011-12	26			
2012-13	**7**		**12**	

The related party with Leeds Mind left the Trust on 31 January 2013. In addition, there are 2 other entities which will be considered related parties, ie York Mind and BT Global respectively (these are both in relation to recent Non-Executive appointments to the LYPFT Board).

In 2012/13, the Trust had £6k of related party transactions with its charitable funds (2011/12 £8k)

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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 2013	Year ended 31 March 2012	**Year ended 31 March 2013**	Year ended 31 March 2012
	£000	£000	**£000**	£000
Department of Heath as immediate parent				
Yorkshire and Humber Strategic Health Authority	**6,567**	6,311	**33**	40
Bradford and Airedale PCT	**522**	799		
North Yorkshire and York Primary Care Trust	**32,503**	35,333	**2,962**	2,626
Leeds Community Healthcare	**2,470**	1,986		
NHS Leeds	**100,259**	112,713	**242**	216
Leeds Teaching Hospitals NHS Trust	**748**	479	**2,990**	2,817
London Strategic Health Authority	**1,496**	1,532		
South West Yorkshire Partnerships NHS Foundation Trust	**1,146**	1,311	**318**	301
Barnsley PCT	**15,313**	1,942	**72**	655
Kirklees PCT	**659**	962		
Local Government				
Leeds City Council	**998**	1,018	**1,443**	1,460
Central Government				
Department of Heath	**994**	410	**406**	596
Total	**163,675**	164,796	**8,466**	8,711

	Receivables		Payables	
	Year ended 31 March 2013	Year ended 31 March 2012	**Year ended 31 March 2013**	Year ended 31 March 2012
	£000	£000	**£000**	£000
Department of Heath as immediate parent				
Yorkshire and Humber Strategic Health Authority	**104**	297	**346**	37
North Yorkshire and York Primary Care Trust	**361**	680	**2,957**	2,362
NHS Leeds	**537**	118	**2**	86
Leeds Teaching Hospitals NHS Trust	**134**	115	**741**	655
South West Yorkshire Partnerships NHS Foundation Trust	**67**	113	**82**	92
Barnsley PCT	**176**	35	**347**	131
York Hospitals NHS Foundation Trust	**20**	44	**286**	301
Local Government				
Leeds City Council	**155**	135	**389**	
Central Government				
NHS Pension Scheme (Own staff employers and employees contributions)			**1,602**	1,527
Total	**1,554**	1,537	**6,752**	5,191

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28.3 Related party transactions commitments (year ended 31/3/2014)

	Income £000
Leeds Clincal Commissioning Groups	91,475
York Clinical Commissioning Groups	31,467
NHS England	16,765
	139,707

The Trust has no expenditure commitments with related parties for the year ended 31 March 2014.

29 Third party assets

The Trust held £395k cash and cash equivalents at 31 March 2013 (£343k 2011/12) which relates to monies held 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	310		4,104	
Balances with Local Authorities	237		495	
Balances with NHS Trusts and Foundation Trusts	2,584		4,482	
Intra Government balances	**3,131**		**9,081**	-
Balances with bodies external to Government	2,634	2,677	7,887	
At 31 March 2013	**5,765**	**2,677**	**16,968**	-
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	**3,514**	-	6,389	-
Balances with bodies external to Government	2,862	2,365	8,706	
At 31 March 2012	**6,376**	**2,365**	**15,095**	-

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31 Losses and special payments

There were 9 cases of losses totalling £57k (24 in 2011/12 totalling £19k) and 23 special payments totalling £32k (39 in 2011/12 totalling £113k) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

32 Events after the reporting period

The structure of the NHS has changed from 1 April 2013 with overall responsibility for commissioning now with NHS England. Services previously commissioned by the Specialist Commissioning Groups (SCGs) will also be commissioned by NHS England via the Local Area Teams (LATs). Clinical Commissioning Groups (CCGs) have replaced Primary Care Trusts (PCTs) and Local Area Teams (LATs) have effectively replaced Strategic Health Authorities (SHAs). The Trust's main commissioners in 2013/14 are now NHS Leeds North CCG (lead commissioner for mental health), NHS Leeds South & East CCG, NHS Leeds West CCG along with Vale of York CCG (lead for mental health services), NHS Hambleton, Richmondshire and Whitby CCG, NHS Harrogate and Rural District, NHS Scarborough and Ryedale CCG and South Yorkshire & Bassetlaw Local Area Team.

On 1 April 2013 IT assets transferred to Leeds and York Partnership NHS Foundation Trust from NYY PCT as a result of these changes. This asset transfer will be at carrying value, currently estimated to be £157k. The Trust is currently working with NYY PCT to agree this value.

There were no events after the reporting period that had an impact on the Trust's 2012/13 financial statements.

33 Charitable funds

	Year ended 31 March 2013	Year ended 31 March 2012
	£000	£000
Income	**180**	10
Expenditure	**(15)**	(18)
Transfer of fixed assets	**(164)**	
Net movement in funds	**1**	(8)
Current assets	**238**	235
Current liabilities	**(13)**	(11)
Total Charitable Funds	**225**	224

Income and expenditure in 2012/13 includes the transfer of resources from NYY PCT under TCS and the transfer of a fixed asset to Leeds Community NHS Trust.

The 2012/13 Charitable Funds accounts have not yet been subject to audit. The audit fee in 2011/12 was £4k and the agreed fee for 2012/13 is £3k. The difference is due to an independent examination rather than a full audit being requested for 2012/13.

About this Annual Report

Urdu

اگر آپ اس سالانہ رپورٹ کا ترجمہ بریل، آڈیو ٹیپ، کسی دیگر زبان یا کسی دیگر شکل میں چاہتے ہیں براہ کرم ڈائیورسٹی ٹیم سے **0113 2954413** پر یا ای میل diversity@leedspft.nhs.uk پر رابطہ کریں۔

Chinese:

如需本年度报告的磁带、录音带或者其他语言或其他格式，请联系 **Diversity Team**，电话：**0113 2954413**，或电子邮件：diversity@leedspft.nhs.uk

Bengali

যদি আপনি বাৎসরিক রিপোর্ট ব্রেল, a ডিও টেপ, a ন্য ভাষায় a থবা a ন্য কোন ফর্মাটে পেতে চান, a নুগ্রহ করে ডা: ভারসিটি টিমের সাথে যোগাযোগ করুন 0113 2954413 নম্বরে a থবা i -মেলে diversity@leedspft.nhs.uk

Gujarati

જો તમને આ વાર્ષિક અહેવાલ બ્રેઇલ, ઑડીઓ ટેપ, કોઇ અન્ય ભાષામાં અથવા કોઇ પણ અન્ય ફોર્મેટમાં જોઈતો હોય, તો કૃપા કરી ૦૧૧૩૨૯૫૪૪૧૩ ઉપર ડાઈવર્સીટી ટીમનો સંપર્ક કરો અથવા diversity@leedspft.nhs.uk ઉપર ઈ-મેલ કરો

Punjabi

ਜੇਕਰ ਤੁਸੀਂ ਇਹ ਸਲਾਨਾ ਰਿਪੋਰਟ ਬ੍ਰੇਲ 'ਚ, ਆਂਡਿਓ ਟੇਪ 'ਤੇ, ਕਿਸੇ ਹੋਰ ਭਾਸ਼ਾ ਜਾਂ ਰੂਪ 'ਚ ਚਾਹੁੰਦੇ ਹੋ ਤਾਂ ਕਿਰਪਾ ਕਰਕੇ 0113 2954413 'ਤੇ ਡਾਇਵਰਸਿਟੀ ਟੀਮ ਨਾਲ ਸੰਪਰਕ ਕਰੋ ਜਾਂ diversity@leedspft.nhs.uk 'ਤੇ ਈਮੇਲ ਕਰੋ।

Kurdish

ئەگەر دەتەوێت ئەم ڕاپۆرتی ساڵانە بە دۆری بریل، شریتی دەنگ، یان بە زمان یان فۆرماتێکی دیکە بۆ تۆ ئامادە بکەین تکایە لە ڕێگەی ژمارە تەلەفۆنی **0113 2954413** یان ئیمەیڵی **diversity@leedspft.nhs.uk** لەگەڵ تیمی جۆراوجۆریی **Diversity Team** پەیوەندیی بکە.

Vietnamese:

Nếu quý vị muốn có bản báo cáo thường niên này bằng chữ Brail, hoặc băng âm thanh, bằng một ngôn ngữ khác hoặc bất kỳ định dạng nào khác, vui lòng liên hệ với nhóm Diversity Team ở số 0113 2954413 hoặc thư điện tử diversity@leedspft.nhs.uk.

Russian

Если Вы хотите получить информацию по данному годовому отчету в шрифте Брайля, на аудио кассете, или на другом языке или в другом формате, пожалуйста, позвоните в отдел культурного разнообразия, по номеру: 0113 2954413 или на электронный адрес diversity@leedspft.nhs.uk.

Polish

Jeśli chciał(a)by Pan(i) otrzymać sprawozdanie roczne pisane brajlem, w formie nagrania dźwiękowego, w innym języku lub jeszcze w innej formie, proszę się skontaktować z Diversity Team pod numerem 0113 2954413 lub napisać e-mail na adres: diversity@leedspft.nhs.uk

Notes

Contact us

Leeds and York Partnership NHS Foundation Trust

Trust Headquarters
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB
Tel: 0113 30 55000
Web: 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

Patient Advice and Liaison Services (PALS)

If you need any help or advice about our services, please contact:
Tel: 0800 0525 790 (freephone)
Email: pals.lypft@nhs.net

Membership

If you are interested in becoming a member of Leeds and York Partnership NHS Foundation Trust please contact:
The Membership Office
Tel: 0113 30 55900
Email: ftmembership.lypft@nhs.net
Web: www.leedsandyorkpft.nhs.uk/membership

Communications

If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:
The Communications Team
Tel: 0113 30 55977
Email: 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
Web: www.leedsandyorkpft.nhs.uk alternatively please contact
The Communications Team
Tel: 0113 30 55977
Email: communications.lypft@nhs.net

Designed & Produced by Communications
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Job Ref: 2484