Leeds and York Partnership
NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS
(Including the Quality Report)

1 April 2018
to
31 March 2019

Leeds and York Partnership NHS Foundation Trust

ANNUAL REPORT AND ACCOUNTS
(Including the Quality Report)
1 April 2018 to 31 March 2019

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

PART A
ANNUAL REPORT
2018/19

CONTENTS

PART A – ANNUAL REPORT

SECTION 1.1 – THE PERFORMANCE REPORT (Overview)

The purpose of the Overview Section is to provide a short summary setting out our purpose, key risks to the achievement of our objectives and how we have performed during the year.

1.1.1 A MESSAGE FROM OUR CHAIR

In this 70th anniversary year for the NHS, I continue to be humbled and inspired by so many of our staff, volunteers and service users by their day-to-day commitment to the values underpinning the NHS. Every day, acts of kindness and compassion, along with professional knowledge, sharing expertise and commitment to team working take place across our services. Sometimes these are tested by pressures in the system, sometimes by unforeseen crises such as the fire last May at the Becklin Centre. Our Trust values are Integrity, Simplicity and Caring, and are despite such difficulties, demonstrated in abundance.

We start every Board meeting with an opportunity to hear about the experience of service users, carers or members of staff. This discussion reminds us of the purpose of this organisation and of the reality of the day-to-day challenges we all face in trying to deliver services to the best of our ability within our financial limitations.

This year we have heard some powerful and challenging accounts from service users and carers. Some were very moving, eloquent descriptions of how it feels to live with a mental illness and be served by an imperfect system. Others have been more positive accounts of the life changing impact of our services on individuals and their families. Each story has been full of opportunities to learn, to improve and to strengthen our services for the better. I am hugely grateful for the candour, courage and willingness to share by all those who have come along to our Board meetings.

This year the Board agreed our strategic vision and a number of detailed underpinning plans. The plans cover workforce, estates, information technology, clinical services and quality. They represent a huge amount of work, detailed planning and a creative ambition for the future provision of services for people with mental illness and learning disabilities in Leeds and York. The plans have provided a focus for the Board during 2018/19, the first year for implementing these three-year plans.

We welcomed the development of new services for Veterans in the armed services, and also for those who experience gambling addiction. Both these services were developed with partner agencies (Combat Stress, and GamCare respectively) and we look forward to their continued development over the coming year.

We await our next visit from the CQC which is expected in July 2019. Since our last inspection, a huge amount of work has taken place across all our services to address the matters raised by the inspectors and we will welcome the inspection team back later in 2019 to review our services once more.

In January, the NHS published its Long Term Plan. We welcome the much stronger focus on mental health and learning disability services and look forward to more detailed guidance on really making a difference to addressing the parity of esteem of these services in future. The Long Term Plan also emphasises the importance of partnership working. We already work closely with many partners in delivering mental health and learning disability services to people in Leeds and York. We also take an active role in the wider collaborative systems across West Yorkshire and Harrogate, working with other mental health and learning disability providers to improve services. I would like to take this opportunity to thank our all of our partners within the NHS, local authorities, third sector and education sector. We look forward to continuing this work to deliver sustainable improvements in the coming year.

I am extremely grateful to the Council of Governors for their commitment and continued work in the Trust. This year has seen a number of changes in welcoming new governors and saying goodbye and thanks to a number of long-serving governors too. Our lead governor Steve Howarth stepped down from this role after his two-year tenure. Steve has been a great support in the role and generous in sharing his knowledge and insights after a long career in mental health nursing. I look forward to working with his successor in due course. Governors have such an important role in holding the non-executives to

account, and in representing the views of the public, staff, service users and carers. We have done some important work to strengthen their contribution and to enable them to carry out their roles effectively.

The Board has seen some changes this year, and we welcomed one new non-executive director Andrew Marran, and a new executive director, Claire Holmes. I would like to take the opportunity of thanking their predecessors, Steven Wrigley-Howe and Susan Tyler for all their dedication and support to the Trust in recent years.

In the media, the NHS often generates negative headlines which tell of unprecedented demands and pressures, especially during the winter months. In our services, the pressure extends beyond winter and is commonplace throughout the year. This year was no exception and the Board has been hugely impressed by the dedication and resilience of our staff. Staff across our services worked hard to provide support and care for so many of our service users and their families, and we are very grateful for their efforts.

In 2018/19 we celebrated the 70th anniversary of the NHS and there were many events and activities across the trust to mark this significant year. We have some truly impressive and unique activity in this Trust which recognises the value of supporting positive mental health and tackling the stigma of mental illness. The event in the city centre last July to celebrate the progress in the provision of services for adults with learning disabilities over the last 70 years was a powerful illustration of radical positive change. The annual Leeds Love Arts festival in October was once again, a wonderful celebration of the role of art, creativity, learning and mental health, and provided a great stage to give an authentic voice for service users, partners and colleagues in the city.

As we look to next year, we will no doubt continue to face pressures across our services, but we have strong foundations in place, and are proud to have staff who live and demonstrate our values every day. We are focused on continuing to improve and to develop our services to ensure excellence for all our service users and their families.

Prof Sue Proctor
Chair of the Trust

1.1.2 A MESSAGE FROM OUR CHIEF EXECUTIVE

It is with great pleasure that I present our annual report and accounts for 2018/19. The following pages provide a summary of the important work the Trust has done over the last 12 months.

We have continued to work hard to implement our strategy throughout the year, and have kept our values - we have integrity, we keep it simple, we are caring – at the heart of everything we do.

Our leadership and governance arrangements are now embedded and the executive team has been fully appointed to. Every member of our Trust Board routinely visits all our services to make sure that we keep connected to what matters to our staff and the work they do day in and day out to support our service users and carers.

Our continued focus on staff engagement is having a positive impact, and this was clear in the results of the 2018 Staff Survey. The results show significant improvements this year, with notable progress in relation to staff feeling valued, recommending our organisation as a place to work and patient care being seen as our organisational priority. We do know however, that there is much more we need to do to support health and wellbeing and ensure equal opportunities for all; these areas for improvement will form the foundation of our efforts over the coming months.

Patient experience, involvement and engagement has been a big focus for us this year. We knew from our last Care Quality Commission (CQC) inspection and feedback from our service users and carers that we weren't always getting it right. One of the first things our Director of Nursing, Professions and Quality, Cathy Woffendin, did when she joined the Trust in March 2108 was to commission an external review. The review made a number of recommendations to the Trust Board early in 2019, and Cathy and her team are now working to strengthen our approach to involving people and listening to their experiences. This work will ensure that that our services, activities and policies are shaped by the people best placed to know what works – our service users and those closest to them.

We have delivered some significant changes in our clinical services, such as the expansion of our community perinatal and liaison psychiatry services, and significant improvements in our forensic services. We're also leading on a new model of care for eating disorders for West Yorkshire, which has eliminated out-of-area placements. The eating disorders team was honoured at the national Positive Practice in Mental Health Awards in October, alongside colleagues from the personality disorder service. Our Rainbow Alliance, a network of staff, service users and carers committed to enhancing the quality of services the Trust delivers to the LGBT+ community, was a very worthy runner up.

Following a huge three year project, we launched a range of new community mental health services in March. This includes new dedicated community teams for both younger and older adults, a new 24/7 mental health crisis service and an intensive home treatment team. During 2018 the Trust involved thousands of staff, service users, carers and partners in shaping the services and lots of their suggestions have been implemented in the new service models. The information and data generated from this work has helped us work with our commissioners in Leeds to identify where more investment is needed, which in the long run will reduce the need for patients to have to go 'out of area' for inpatient care.

We have been successful in the work we have led for West Yorkshire on rehabilitation, and have secured over £11million of capital money to invest over the next two years. Our York-based forensic services have developed an expanded outreach service and a new rehabilitation pathway to support more people to move out of hospital. Part of this work involved reopening Rose Ward at Clifton House as a new male rehabilitation ward following its temporary closure in 2017.

We remain very much committed to partnership working with Bradford District Care NHS Foundation Trust, Leeds Community Healthcare NHS Trust and South West Yorkshire Partnership NHS Foundation Trust as the lead providers of mental health and learning disability services in West Yorkshire and Harrogate. It was with pleasure that I took on the lead for this programme of work during 2018 and the publication of the NHS Long Term Plan has provided us with a very strong mandate to develop our five year strategy.

Despite the increased and ongoing risks to our financial position, we have delivered on the control total set by our regulator, NHS Improvement, and have maintained the best score possible for our financial

performance. We have made some significant financial transactions this year, including disposing of old and inadequate buildings and refinancing our PFI estate. These transactions have resulted in some additional money for the Trust, which will be used to support some significant investments in the coming years. The first of these investments is our new electronic patient record system, CareDirector.

Our estates and facilities team have overseen the refurbishment of a number of premises as we continue to modernise and streamline our use of estate. We are also working closely with our colleagues at Leeds Community Healthcare NHS Trust to support the build of a brand new Tier 4 Child and Adolescent Mental Health Service (CAMHS) unit for West Yorkshire on our St Mary's Hospital site.

I cannot finish a statement about the last twelve months without mentioning the fire we had at The Becklin Centre. As an 'on call' director, being alerted to a fire on an inpatient ward is one of your biggest fears, but that's exactly what happened in May 2018. Thankfully nobody was injured, and staff worked hard to keep our patients safe and calm as the incident unfolded. Thanks to the incredible work from our clinical, facilities, estates and Interserve staff, and our wonderful partners at Bradford District Care NHS Trust, we had a new ward up and running within 24 hours. Ward 5 has since reopened and we've shared the learning from the incident across all our inpatient services, including best practice on environment safety, storage and security of patient possessions, improving the training we provide to staff and changing how we monitor and learn from incidents. Our approach to learning, especially from serious incidents, has significantly improved, and our culture of openness and speaking up to promote safety has really benefited from the hard work of our Freedom to Speak up Guardian, John Verity.

I wish I had the space here to write about each and every one of our teams and services. As Chief Executive, what I am most proud of every day is the staff I meet across our organisation who do the most amazing job. They work hard, they live our values and they genuinely care about what they do. The job we do is hard and demanding, but it is also hugely satisfying. We don't always get it right but that is never about lack of intent and we are committed to continuing to develop and improve.

Thank you for all your commitment over the last twelve months, and the continued faith you put in me, the executive team and the Board to provide you with the support, resources and recognition you deserve to do your jobs.

Dr Sara Munro
Chief Executive

1.1.3 ABOUT OUR TRUST – A BRIEF HISTORY AND STATUTORY BACKGROUND

As part of the NHS and Community Care Act (1990) the Leeds Community and Mental Health Services Teaching NHS Trust was formed on 1 February 1993. This was a self-governing trust providing community, mental health and learning disability services within the Leeds metropolitan area. In 2002 the community services previously provided by the NHS Trust transferred to the PCTs in Leeds, and the Trust was renamed the Leeds Mental Health Teaching NHS Trust; providing only mental health and learning disability services.

On 1 August 2007 NHS Improvement (formally Monitor) authorised us as a foundation trust, and we were formed as the Leeds Partnerships NHS Foundation Trust under the NHS Act 2006. As a foundation trust we provide mental health and learning disability services and have freedoms to act which NHS trusts don't.

A further development for our Trust was the acquisition of mental health, learning disability and substance misuse services from NHS North Yorkshire and York and NHS England on 1 February 2012. To reflect the new geographical area in which services were provided we became the Leeds and York Partnership NHS Foundation Trust. However, the services commissioned by NHS North Yorkshire and York transferred to Tees, Esk and Wear Valleys NHS Foundation Trust on 1 October 2015. The Trust still provides Tier 4 and deaf CAMHS, and low secure forensic services in York which serve a regional population base and are commissioned by NHS England.

1.1.4 STATEMENT OF PURPOSE AND ACTIVITIES OF THE TRUST

We are a provider of specialist mental health and learning disability services. As a teaching trust with strong links to local universities we have a reputation as a centre of excellence for teaching, research and development, partly attributable to the national profiles of a number of our clinicians.

Leeds and York Partnership NHS Foundation Trust is the main provider of specialist mental health and learning disability services in Leeds. We also provide specialist services across York, the Yorkshire and Humber region, and some highly specialised national services. We have developed robust relationships with service users, carers and our partners in the NHS, Local Authorities and third sectors.

We provide services to approximately 781,000 adults in the Leeds areas and specialist services and accept referrals from across the UK. We operate from 123 dispersed sites and employ approximately 2,500 staff and nearly 500 bank staff.

Clinical services are currently delivered across two service directorates:

Leeds Care Group	Providing adult services, commissioned by the Leeds Clinical Commissioning Group (CCG)
Specialist and Learning Disabilities Care Group	Providing mainly NHS England specialist services but with some CCG and Local Authority commissioned services such as learning disabilities

The Care Quality Commission (CQC) asks us to list our services within a set of pre-determined categories. Using these categories the regulated activities that we are registered to provide are as follows:

- Treatment of disease, disorder or injury
- Nursing care
- Assessment or medical treatment for persons detained under the Mental Health Act
- Diagnostic and screening procedures
- Personal care.

More information about the work of the care directorates can be found in Part A section 2.2.1 of this Annual Report.

1.1.5 OUR STRATEGY

In November 2017 we launched our reimagined Trust Strategy *Improving health, improving lives*, which describes what we want to achieve over the next five years (to 2023) and how we plan to get there. The strategy is designed around the three key elements of delivering great care; a rewarding and supportive workplace; and effective and sustainable services.

Our strategic intent is set out in our Trust Strategy (2018 to 2023) and one-year Operational Plan (2019-2020). This has been fully aligned with the key themes within national and local strategies and the challenges and opportunities we see ahead over the next one to five years. We have continued to work alongside commissioners and providers, both locally and regionally, to develop integrated strategic objectives and plans.

1.1.5.1 Our goals, strategic objectives and priorities

Our strategy used a crowdsourcing approach to reimagine our vision, values and strategic objectives. Through extensive staff, governor and member engagement the organisation developed and agreed its vision and ambition; three simple objectives that describe the outcomes we aspire to; and the values we will work to. The outcome of the crowdsourcing exercise was communicated to the Board by our Chief Executive. Our objectives are the three things we believe will help us achieve our vision and which we are passionate about realising. We have deliberately kept them simple so all our staff can keep a clear focus on them every day and in everything they do.

For each objective we have a series of priorities for action for achievement by 2022/23. All our priorities will be tracked through our governance framework to make sure we are on course to achieve them.

A headline summary of our strategy can be found below.

Table 1.1A – Our Trust strategy

Purpose	Improving health, Improving lives	
Vision	To provide outstanding mental health and learning disability services as an employer of choice	
Ambition	We support our service users and carers, our staff and the communities we serve to live healthy and fulfilling lives. We want to achieve our personal and professional goals; to live our lives free from stigma and discrimination; and to improve the lives of people with a learning disability and mental ill health	
Our values		
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	**We keep it simple** We make it easy for the communities we serve and the people who work here to achieve their goals.	**We are caring** We always show empathy and support those in need.
Our strategic objectives		
1. We deliver great care that is high quality and improves lives.	2. We provide a rewarding and supportive place to work.	3. We use our resources to deliver effective and sustainable services.

1.1.5.2 Our strategic plans

To support the delivery of our overarching strategy our Board agreed five 3-year strategic plans. These are for: Workforce and Organisational Development; Quality; Clinical Services; Health Informatics; and Estates. These were signed off by our Board and priorities to support delivery of the plans are agreed by the Board each year. More information about the strategic plans can be found on our website www.leedsandyorkpft.nhs.uk .

1.1.6 OUR VALUES AND BEHAVIOURS

Our values and behaviours describe what attitudes and behaviours we believe are important in achieving our purpose. A key part of our strategy redevelopment has focused on the values and behaviours our staff are committed to deliver. Our charter of values is set out below.

Table 1.1B – Our values and behaviours

Our values	Behaviours that uphold our values
We have integrity We treat everyone with respect and dignity, honour our commitments and do our best for our service users and colleagues.	• We are committed to continuously improving what we do because we want the best for our service users. • We consider the feelings, needs and rights of others. • We give positive feedback as a norm and constructively challenge unacceptable behaviour. • We are open about the actions we take and the decisions we make, working transparently and as one team with service users, colleagues and relevant partner organisations.
We are caring We always show empathy and support those in need.	• We make sure people feel we have time for them when they need it. • We listen and act upon what people have to say. • We communicate with compassion and kindness.
We keep it simple We make it easy for the communities we serve and the people who work here to achieve their goals.	• We make processes as simple as possible. • We avoid jargon and make sure we are understood. • We are clear what our goals are and help others to achieve their goals.

1.1.7 PRINCIPAL RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the strategic risk register which are also set out in our Board Assurance Framework (BAF). In summary these described as follows:

- SR1 - Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- SR2 - We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- SR3 - Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- SR4 - We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- SR5 - If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services
- SR6 - We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services
- SR7 - As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- SR8 - A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- SR9 - Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff

- SR10 - As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

Each of these risks has an identified executive director and management lead. These risks will are managed through the risk management, risk register and operational planning processes. They are reported to the Executive Risk Management Group, Board sub-committees and the Board through the BAF.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations.

1.1.8 GOING CONCERN STATEMENT

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.

SECTION 1.2 – THE PERFORMANCE REPORT (Performance Analysis)

1.2.1 MEASURING PERFORMANCE

We have NHS Improvement targets, NHS Standard contract requirements, national and local Commissioning for Quality and Innovation (CQUIN) measures and locally agreed performance and quality measures with our commissioners (referred to in this section as targets and measures).

Each month, we produce a Combined Quality and Performance Report (CQPR) that brings together performance, activity, quality, workforce and financial measures into one report for our Board meetings. This includes the requirements for monitoring performance through NHS Improvement's Single Oversight Framework as well as contractual and local metrics. Relevant sections of this report are shared with and discussed by our Board sub-committees to provide further challenge, insight and assurance. By bringing all these aspects of our organisation and care into one place, links can be made and risks identified which might impact on service user experience and our performance.

Our Governance, Accountability, Assurance and Performance Framework (GAAP), sets out our performance reporting process across the whole of the organisation from ward to Board and vice versa. This layered approach includes monthly team level dashboards, bi-monthly service line dashboards, monthly Trust level reports (including the CQPR) and Commissioning for Quality and Innovation (CQUIN) reports produced in accordance with the Standard Contract reporting timescales.

We have in place a performance framework that delivers reporting for our team and service managers as well as the high level CQPR reporting to Board. Dashboards and reports are used to promote discussion and challenge in team and service quality and performance meetings, operational delivery groups and at the monthly Performance, Information and Data Quality Group (PIDQG) meetings.

PIDQG also focuses on the definitions that sit behind the measures and whether reporting is being affected by data quality or completeness providing assurance to the organisation about the robustness of the data being used for analysis and decision making. During 2018/19, this group began a monthly audit process for a metric looking at accuracy and completeness followed by kite-marking the data quality of the metric.

There are identified service based leads for each target and measure and they are responsible for ensuring reports are submitted on time and that all relevant actions are completed to achieve performance. Where agreed targets are not met exception reports are produced by the relevant lead or service explaining how they will address the issue and move towards achievement. Where required contractually, Remedial Action Plans are also produced for the commissioners.

We also have regular dialogue with our commissioners and have a reporting schedule to submit performance and quality information to them. We meet on a regular basis (bi-monthly and quarterly) and have a set agenda which addresses all aspects of performance and quality.

1.2.1.1 Areas of focus

Month-on-month we continue to perform well against our contractual and local targets. The table below sets out our performance during 2018/19.

Table 1.2A – Our contractual and local targets

Our contractual and local targets					
LEEDS CLINICAL COMMISSIONING GROUP					
	Target	**2018/19 Q1**	**2018/19 Q2**	**2018/19 Q3**	**2018/19 Q4**
Timely commencement of a MH assessment by the ALPs team in the LTHT Emergency Department (1 hour)	90% (March)	34.1%	40.8%	70.9%	74.8%
Timely access to a mental health assessment by the LYPFT liaison Psychiatry In-reach Service (24 hours)	90% (March)	69.4%	67.5%	80.3%	86.3%
Timely access to MH assessment under S136; % within 3 hours	No target	29.8%	29.3%	19.7%	25.8%
Proportion of In Scope patients assigned to a Cluster	90.0%	90.8%	89.8%	89.7%	89.4%
Referral and Receipt of a Diagnosis within LADs Service within 26 weeks	80.0%	45.0%	12.1%	26.0%	36.9%
Waiting times Access to Memory Services; Referral to first face to face contact within 8 weeks	90.0%	91.6%	91.4%	90.0%	91.0%
Memory Services – Time from Referral to Diagnosis within 12 weeks	50.0%	73.2%	65.2%	72.8%	64.2%
Waiting times for Community Mental Health Teams first contact within 15 days	80.0%	83.0%	85.0%	82.5%	80.0%
Incidents Reported within 48 hrs from Incident identified as Serious	100.0%	100.0%	100.0%	100.0%	100.0%
Bed Occupancy rates for Acute Adult Inpatient Services	No target	99.9%	100.5%	99.3%	100.7%
Crisis Plan within 24 Hours	95.0%	97.0%	95.8%	97.9%	96.8%
NHS ENGLAND					
	Target	**2018/2019 Q1**	**2018/2019 Q2**	**2018/2019 Q3**	**2018/2019 Q4**
HCR20 within 3 months of Admission	95.0%	85.7%	100.0%	100.0%	90.9%
HCR20 & HoNOS Secure (service users with LOS > 9 months)	95.0%	100.0%	100.0%	97.1%	93.5%
CAMHS use on Admission of HoNOSca and CGAS as effective tools for improving outcomes	95.0%	100.0%	100.0%	100.0%	100.0%
CAMHS use on Discharge of HoNOSca and CGAS as effective tools for improving outcomes	95.0%	100.0%	100.0%	100.0%	100.0%
Gender Identity Service Average Waiting Time To First Offered Appointment (days)	No target	346	473	475	441
Gender Identity Service Waiting List	No target	1,070	1,217	1,281	1,414

OTHER REPORTED INDICATORS					
	Target	2018/2019 Q1	2018/2019 Q2	2018/2019 Q3	2018/2019 Q4
Appraisals	85.0%	69.0%	74.3%	76.9%	85.3%
Clinical Supervision	85.0%	44.0%	58.1%	61.0%	81.5%
Sickness Absence Rate	4.6%	4.6%	4.7%	4.8%	4.8%
Staff Turnover	10.0%	10.8%	10.1%	10.3%	10.0%
Healthcare Associated Infections – C.difficile	0	1	0	0	0
Healthcare Associated Infections – MRSA	0	0	0	0	0
Delayed Transfers of Care	7.5%	11.0%	13.7%	13.8%	13.9%
SINGLE OVERSIGHT FRAMEWORK AND STANDARD NHS CONTRACT					
	Target	2018/2019 Q1	2018/2019 Q2	2018/2019 Q3	2018/2019 Q4
7 Day Follow Up	95.0%	93.8%	95.6%	96.1%	95.4%
Data Quality Maturity Index (MHSDS)	95.0%	97.3%	97.4%	97.3%	97.2%
Data Completeness - Ethnicity (All referrals)	90.0%	85.1%	85.2%	85.0%	84.3%
Dataset Completeness - NHS Number	99.0%	99.8%	99.4%	99.4%	99.3%
Percentage of service users in Employment	No target	12.8%	14.7%	15.0%	15.9%
Percentage of service users in Settled Accommodation	No target	59.0%	78.4%	80.0%	81.5%
Number of Incidents	No target	3,115	2,743	2,811	2,890
Communication with GPs within 7 days (CPA care plans)	No target	-	21.6%	34.2%	35.3%
Cardio Metabolic Assessment (SMI community caseload)	No target	-	-	60.4%	44.9%
Cardio Metabolic Assessment (current SMI inpatients)	No target	-	-	72.1%	69.2%
Risky Behaviours screening of admissions	No target	-	-	84.0%	84.8%
Never Events	0	0	0	0	0
NHS Safety Thermometer Harm Free Care	95.0%	99.2%	98.1%	98.4%	99.3%
Inappropriate out-of-area placements for adult mental health services (number of bed days)	720 (Q4)	663	1,750	1,566	982

The Trust meets regularly with its commissioners to review performance against the key metrics and action plans are put in place for any metric falling below standard. The reasons for underperforming are discussed and challenged both internally and with commissioners to ensure that all possible steps are being taken to improve. Factors outside of our control such as the higher than commissioned referral numbers in the Gender Identity service are taken into account alongside reasons that can be more easily influenced such as real time data entry into clinical systems or differing performance across similar teams within the organisation to ensure that a rounded picture of performance is achieved.

1.2.2 FINANCIAL PERFORMANCE

1.2.2.1 Overview

The Trust's overall financial performance in 2018/19 was very strong, and the Trust continued its good track record of delivering all its financial targets, as set within the national NHS financial framework. The way the framework operated during 2018/19 enabled the Trust to deliver an exceptionally high income and expenditure surplus which is described below. The underlying performance of the Trust remained stable with a range of challenges and pressures experienced which were not dissimilar to those being experienced across the NHS and within the mental health sector, namely on going workforce challenges and inpatient bed occupancy linked to patient flow between hospital and community settings. These issues continue into the new financial year, with a range of actions and measures in place to improve.

The Trust's plan and actual performance is highlighted in the table below, showing the key areas against which we measure and assess our overall financial performance. The table demonstrates overall a very solid financial performance by the Trust, building on good performances in previous years helping to maintain an underlying stable position.

Table 1.2B

Plan		**Outturn**	
Income and expenditure surplus	£28.0m	Income and expenditure surplus	£32.4m
Capital expenditure	£4.6m	Capital expenditure	£4.4m
Cost improvement / efficiency	£2.9m	Cost improvement / efficiency	£2.9m
Agency ceiling	£5.0m	Agency ceiling	£5.1m
Use of resources score	1	Use of resources score	1

The use of resources score is the overall assessment used by NHS Improvement, our regulator. It is based on five key financial metrics which are shown in the table below;

Table 1.2C – Use of Resources Metric

Year ending 31 March 2019	**Score**	**Risk rating category**	**Weighting**
Capital service capacity	6.70	1	0.2
Liquidity	184 days	1	0.2
Income and expenditure margin	18.4%	1	0.2
Variance in income and expenditure margin	2.6%	1	0.2
Agency spend	3.6%	2	0.4
Use of resource metric score		**1**	**1.2**

An overall score ranging from 1 (highest performance / lowest risk) to 4 (lowest performance / highest risk) is calculated based on these five metrics.

Capital service capacity
This metric measures our ability to service long-term debt. This is important for the Trust as we have high levels of debt linked to our Private Finance Initiative (PFI) assets.

Liquidity
This measures the number of days the Trust can operate and pay day-to-day expenses, after accounting for all outstanding current liabilities. The Trust is in a strong position with this metric currently being at 184 days (the prior year was 111 days). This is mainly due to the level of cash balances.

Income and expenditure margin
This measures the overall surplus as a percentage of operating income. A good minimum surplus is around 1-2% in order to generate cash for reinvestment. The Trust's overall level of

income and expenditure surplus was higher than planned, mainly as a consequence of additional non-recurrent income that was received through the incentive Provider Sustainability Fund (PSF). A technical adjustment based on the downward revaluation of our assets (an impairment) reduced the net surplus to £32.4m as shown in the table below.

Table 1.2D

Year ending 31 March 2019	Plan £m	Actual £m	Variance £m
Surplus (pre PSF)	9.616	12.361	2.745
Provider Sustainability Fund	18.427	21.957	3.530
Surplus (pre impairments)	**28.043**	**34.318**	**6.275**
Impairments	0	(1.915)	(1.915)
Reported surplus	**28.043**	**32.403**	**4.360**

Income and expenditure variance
This measures the gap between the planned margin and the actual margin. The Trust over-achieved on the plan so this equates to a good performance.

Agency ceiling
This metric was introduced in 2017/18 to provide a focus on reducing the excessive cost burden of spending on agency staff nationally. The Trust increased spending on agency from £4.5m (2017/18) to £5.1m in 2018/19. The Trust marginally exceeded the maximum ceiling (target maximum spend) of £5m.

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

The statement of comprehensive income shows a surplus of £32.4 million for the year ended 31 March 2019 (compared to £3.8m in the previous year). This exceptionally high performance was mainly as a consequence of non- recurrent measures which enabled the Trust to access significant PSF as shown above (total £21.9m). The key specific non recurrent actions which increased our income position were the refinancing the PFI contract and asset disposals which generated profit.

Operating income
Our income for the year increased to £186.1 million (£156.5 million in 2017/18), which reflects movements in tariff inflation and the impact of recurrent and non-recurrent funding changes across the years. Income received in respect of service user care activities is predominantly received on a fixed block basis.

Operating expenses
The total operating expenses for the year was £158.4 million (£146.6 million in 2017/18), which is a net increase of just under 2%. Staff costs are our single largest operating expense and this increased by 5.3% in the year. Expenditure on the purchase of healthcare from non-NHS bodies increased to £8.2 million during the year (£6.6 million in 2017/18) mainly as a consequence of increasing numbers of Out of Area placements. Following the revaluation of our estate we incurred an impairment charge to operation expenses, due to the downward valuation linked mainly to a reduction in the location factor. The total impairment was £1.9m , but this is excluded from the financial performance assessment for purposes of control total targets and sustainability funding.

Cost Improvement Plans (CIPs)
Each year we are required to meet a level of efficiency savings through the cost improvement programme. Combined cost savings delivered £2.9m (around 1.9% of operating expenses less PFI costs) in the year.

1.2.2.3 Capital expenditure

The Trust originally planned to spend £9.1m on capital improvements in 2018/19. However during the year, the plan was scaled back as it became clear that the initial plans would not be fully delivered, due mainly to slippage on the plans linked to the West Yorkshire CAMHS Tier 4 Unit. Overall we delivered a

level of investment of £4.4m, which was significantly higher than the previous year (£1.7m). The key strategic investments linked to our Community services redesign and the provision of a new clinical hub at St Marys House (South Wing) and the phased implementation of our new Electronic Patient Record system.

1.2.2.4 The statement of financial position

The summary of the Trust's overall value shows a net increase in taxpayers' equity of £31.1 million to £98.4 million as at 31 March 2019. This reflects the impact of the surplus generated in the year and the net impact of asset disposals and revaluations. Working capital (current assets less current liabilities) has increased by £32.7million, of which, the net cash increase was £17 million. The surplus cash held at the end of the year was deposited with the Government Banking Service (GBS). It is our policy to deposit any temporary surpluses in cash in low-risk deposit accounts with either United Kingdom commercial clearing banks or the HM National Loans Fund, when interest rates are more beneficial the GBS. .

1.2.2.5 Future financial outlook and risks

The Trust has prepared an operational financial plan for 2019/20, which supports the delivery of the objectives for the year. Due to the significant financial pressure that the NHS provider sector, in aggregate, remains under, individual organisations have again been asked by the regulatory bodies to deliver specific financial positions in the context of their underlying positions. This Trust has been set a breakeven position but with receipt of further PSF funding plans to achieve a £1.3m surplus as required. The plan requires an overall cost improvement plan of around 1.7% (£3m), of which £1.1m remains unidentified at the start of the financial year.

Recognising the wider financial challenges of the NHS and social care, the Trust's financial strategy remains focused on supporting the organisation to achieve its goals and maintain a strong stable position, which minimises financial risk. We fully recognise the balance between financial sustainability, service quality and improvement, with the emphasis being to work more collaboratively to ensure system-wide sustainability. The Trust is well placed to support the broader agenda and is in a stable financial position.

1.2.2.6 Our exposure to financial risks

Price risk
We have a relatively low exposure to price risk. This is for three main reasons. Firstly, salary costs are the single biggest component of our costs and for 2018/19 our financial plans reflect the nationally agreed pay award. With regard to non-pay our plans assume a similar level to the projected rate of increase in the consumer price index.

Secondly, income assumptions are set out each year through the business and planning arrangements for the NHS, as mandated by the Department of Health and Social Care. Assumptions made regarding inflationary / deflationary changes have been assumed to be extremely challenging in the future. Finally, most income is received on a block contract' basis rather than 'pay as you go' and it is unlikely for the significant part of our income that this will change quickly.

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

Liquidity risk
Liquidity risk is felt to be low. This is because operating costs are incurred primarily through legally-binding contracts for services provided to clinical commissioning groups and NHS England, which in turn are financed from money received from parliament. Assumptions about future income have been revised to take into account the new market conditions.

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

loan facility because we have sufficient working capital. The Trust has modified its capital expenditure plans and has a robust approach to investment appraisal including risk issues.

Our performance information is shared with our Council of Governors and performance dashboards have been created at team, service and care group level, in order that we can share performance information with our staff.

2.5.7.1 Financial Performance

Financial plans are set in the context of an annual planning process. We are required to complete a one year Operational Plan produced in the context of our overarching strategy. 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 our use of resources rating.

Finance managers are integrated within the Care Groups, 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 within the Combined Quality and Performance Report. The performance report highlights financial performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives a report on performance (including financial performance) which allows the Council to hold the non-executive directors to account for the performance of the Board (including financial performance) and to understand how they have challenged the executive directors in respect of any areas of poor performance or risks to performance.

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.

1.2.3 CORPORATE SOCIAL RESPONSIBILITY

1.2.3.1 Human rights

Our Trust respects and abides by all human rights legislation. The human rights principles of fairness, respect, equality, dignity and autonomy are detailed within our organisational values. They underpin our strategic objectives and our policies and procedures. Minimum standards are set out within our Equality, Diversity and Human Rights procedure and adherence to these standards and principles is monitored through our governance structure.

1.2.3.2 Sustainability report

1.2.3.2.1 Introduction

As an NHS organisation, and a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met and is the right thing to do for our communities.

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a baseline set in 1990) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to meet this target by reducing our carbon emissions 28% by 2020/21 using 2007/08 as a baseline year.

1.2.3.2.2 Awards

This year the Trust was awarded the excellence in sustainability reporting certificate for the work it has achieved on improving our reporting outputs over the past year. The Sustainable Development Unit (SDU) conducted an analysis of all provider and Clinical Commissioning Groups (CCGs) annual reports to evaluate sustainability content. 55 trusts and 42 CCGs (around 22%) were selected for recognition out of 432 organisations across England.

1.2.3.2.3 Policies

One of the ways in which an organisation can embed sustainability is through the use of a Sustainable Development Management Plan (SDMP). In January 2018 year our SDMP was approved by the Board of Directors.

The SDMP is a Board-approved, strategic organisational plan which sets out the Trust's ambitions for its sustainable development over the next five years. A live sustainable development action plan is included as part of the SDMP. The action plan details projects and related activities. This shows our continual improvement in sustainability performance and demonstrates our understanding, and commitment to meeting our responsibilities in relation to the sustainability agenda.

Within our SDMP We have adopted the following vision for our Sustainable Development:

> ***"We recognise that Sustainable Development is a critical factor in realising our ambition to become an outstanding healthcare provider. We are therefore dedicated to ensuring we create and embed sustainable models of care throughout our operations and to ensuring our activities, and our estate, are as efficient, sustainable and resilient as they possibly can be".***

We have included an action on Our SDMP action plan to incorporate Sustainability section in standard Business Case templates to ensure sustainability is a key area of consideration in future plans.

Climate change brings new challenges to our business both in the direct effects to the healthcare estate, but also to service user health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. Our plans address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events. Our SDMP action plan includes working with our business continuity experts to produce a Climate Change Adaptation Plan.

1.2.3.2.4 Sustainable Development Assessment Tool (SDAT) Score

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT). This year we measured our performance for the first time using the new tool and achieved a score of 35%. The results of this benchmarking assessment (see below) have been used to further identify areas of improvement for inclusion in our Sustainable Development Action Plan and we have committed to performing this exercise annually and achieving a year-on-year increase in our scored performance.

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST Latest assessment score **35%**	**MODULE**	**SCORE**
	Corporate approach	26.92%
	Asset Management and utilities	36.36%
	Travel and logistics	17.71%
	Adaption	34.62%
	Capital projects	71.43%
	Green space and biodiversity	36.51%
	Sustainable care models	38.46%
	Our people	47.31%
	Sustainable use of resources	33.33%
	Carbon / GHGs	30.63%

1.2.3.2.5 Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. As a provider, evidence of this commitment will be provided in part through contracting mechanisms.

Strategic partnerships are already established and we are currently in the process of implementing our Sustainability Management Group to help us achieve our ambitions contained in our SDMP Action Plan. The group includes representation from each of the following strategic partner organisations: Leeds Teaching Hospitals NHS Foundation Trust, Leeds Community Health NHS Foundation Trust, North of England Commercial Procurement Collaborative, Leeds City Council, Equitix (PFI Partners) & NHS Property Services.

1.2.3.2.6 Performance

a) Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

	2015/16	2016/17	2017/18	2018/19
Total gross internal floor space	105,692	59,632	59.632	58,902
Total no. staff employed	2,436	2,375	2,543	2,411

The 2014 to 2020 Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. We have supported this ambition and the results are set out in the sections below.

b) Energy

Overall our total energy consumption has reduced again for the fourth year running. This year we have realised a total 5% reduction compared to last year's figures (see table below). The Estates Strategic Plan (ESP) is the key contributor to these reductions in the Trust's energy performance and continues to drive improvements in the flexibility, utilisation, performance, cost and long-term sustainability of our current estate and organisational carbon footprint by focusing on the one public sector estate, and divestment of properties not deemed fit for purpose. Future ESP projects are incorporated into our sustainable development action plan.

Successful projects delivered this year include:

- Disposal of four owned sites (The Cottage St Mary's House, Malham House, Springfield House and Southfield House) where design, flexibility, performance and long-term sustainability had been assessed as poor.

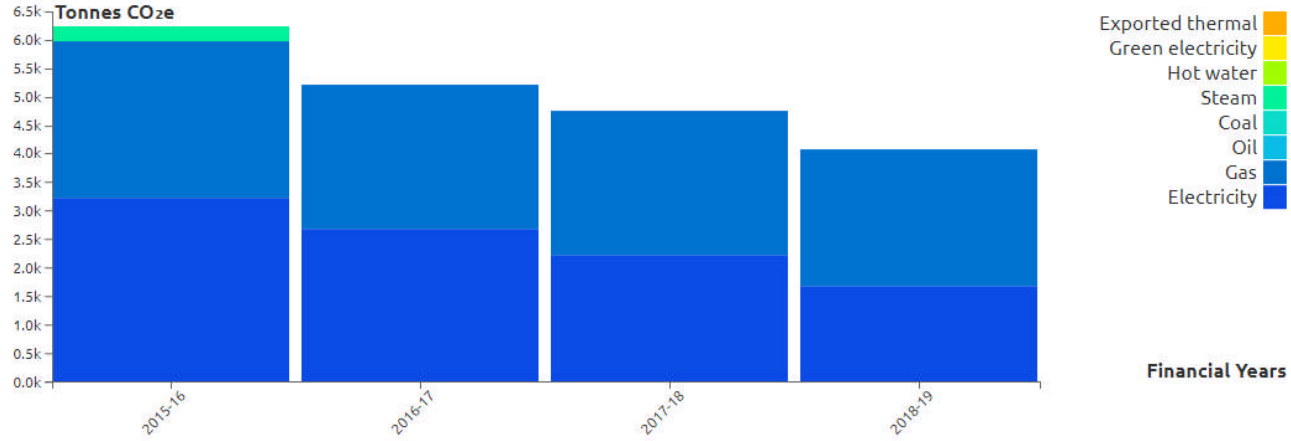
- Re-provision and extensive upgrading of two sites including South Wing at St Mary's House site with: upgrades to LED lighting; installation of energy efficient heating ventilation and air conditioning systems (HVAC); and the utilisation of technology to deliver improved performance such as kettle taps. A number of our PFI sites have also undergone lighting upgrades.

% Change from previous year (Total electricity and gas 2017/18)		
Ownership	**kWh**	**£**
TOTAL	**-827,564**	**-5.14%**
LYPFT	-1,097,869	-21.05%
NHSPS	193,414	-11.39%
PFI	523,198	5.90%
PRIVATE	-59,479	-18.82%

Total energy used (energy consumption in kWh)

	2015/16	2016/17	2017/18	2018/19
Electricity Consumed	5,605,299	5,179,717	5,000,289	4,768,420
Gas Consumed	13,135,153	12,179,328	11,919,676	11,312,409
Oil Consumed	0	0	0	0
Coal Consumed	0	0	0	0
Steam Consumed	1,143,587	0	0	0
Hot Water Consumed	0	0	0	0
Green electricity	0	0	0	0
Total	19,884,039	17,359,045	16,919,965	16,080,829

Carbon emissions resulting



CO2 Emissions (tCO2e)

	2015/16	2016/17	2017/18	2018/19
Electricity	3,223	2,677	2,229	1,682
Gas	2,749	2,545	2,527	2,403
Oil	0	0	0	0
Coal	0	0	0	0
Steam	256	0	0	0
Hot water	0	0	0	0
Green electricity	0	0	0	0
Exported thermal	0	0	0	0
Total	6,227	5,222	4,756	4,085

c) Paper

The movement to a Paperless NHS is supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper. We are aiming to become a “paper light” organisation. This includes a project aimed at digitalising medical records, which will also provide savings in terms of Transportation (taxi use), space utilisation and energy.

We have already achieved successes by changing the type of paper the Trust now procures. From this year we only procure a product that is manufactured from 100% recovered waste and processed without any environmental harmful bleaching agents (chlorine, chlorine-dioxide or other halogenated bleaching agents).

Paper consumed

	2015/16	2016/17	2017/18	2018/19
Paper spend (£)	0	0	0	23,270
Paper products used (tonnes)	0	0	0	4,242

d) Travel

We recognise that a Healthy Transport Plan is a foundation of our Travel Policy and we will be putting that in place as soon as possible.

We support a culture for active travel with schemes such as “cycle to Work” and are working to increase the uptake over the coming year with a number of roadshows taking place and promotional work targeting both new and existing employees.

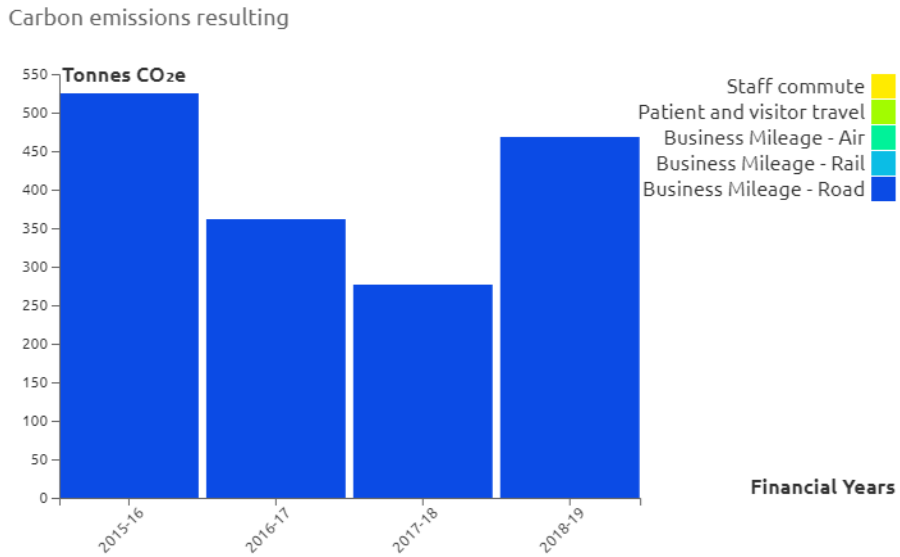
We also offer a Metro card scheme to promote the use of affordable public transport; again we plan to increase the uptake of this scheme in the coming year.

Our SDMP action plan includes a project to work on our reporting metrics, particularly regarding service user / visitor travel and staff commutes so we can report and track our progress more completely.

Our most exciting potential project within our SDMP is to provide electric pool vehicles for our community teams and install a charging infrastructure to reduce the emissions associated with community hub business travel. Our Transport department is currently trialling several vehicles to find the one most appropriate for our needs. The charging infrastructures introduced as part of these projects will also allow our staff to use their owned / leased electric vehicles for commuting and business travel which would see considerable reductions in business travel emissions, particularly given that the latest figures suggest around 20% of our employees own an electric or hybrid vehicle.

Travel undertaken (travel shown in miles)

	2015/16	2016/17	2017/18	2018/19
Patient and visitor travel	0	0	0	0
Business travel and fleet	1,452,496	1,001,318	777,441	1,272,035
Staff commute	0	0	0	0
Total	1,452,496	1,001,318	777,441	1,272,035



The increase in business mileage in 2018/19 was due in part to the Trust taking on a number of new community services, and services being temporarily relocated in Bradford due to the fire at the Becklin Centre.

CO2 Emissions (tCO2e)

	2015/16	2016/17	2017/18	2018/19
Business Mileage - Road	525	362	277	469
Business Mileage - Rail	0	0	0	0
Business Mileage - Air	0	0	0	0
Patient and visitor travel	0	0	0	0
Staff commute	0	0	0	0
Total	525	362	277	469

e) Waste

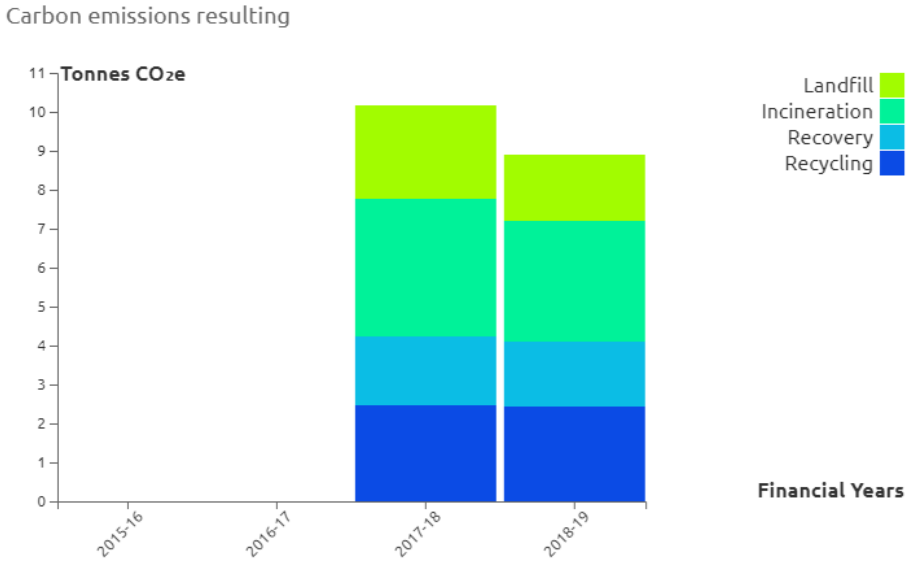
A change of waste contracts and the widening capture of reporting data over the past two years is why we have chosen to only report from 2017/18.

This coming year we are continuing with our waste segregation awareness work which includes full site audits of all waste streams across our estate, in addition to targeting new employees during the induction market place events.

Our SDMP action plan also includes a project to stop the procurement and use of single use catering items across the estate, with a particular focus on the reduction of plastic waste. This will include items like single use plastic cups and individual pods of milk.

Waste produced (in tonnes)

	2015/16	2016/17	2017/18	2018/19
Waste recycling weight	0		113	114
Other recovery weight	0		82	78
Incineration disposal weight	0		16	14
Landfill disposal weight	0		7	5
Total	0		218	211



CO_2 Emissions (tCO_2e)

	2015/16	2016/17	2017/18	2018/19
Recycling	0	0	2.46	2.44
Recovery	0	0	1.78	1.67
Incineration	0	0	3.52	3.08
Landfill	0	0	2.41	1.72
Total	0	0	10.2	8.91

We are about to launch our warp-It asset re-use scheme and have already achieved the following carbon, waste and procurement savings.

Savings you have made LEEDS AND YORK PARTNERSHIP NHS FOUNDATION

CO2 (KG) SAVED	CARS OFF THE ROAD	WASTE AVOIDED (KG)	TREES EQUIVALENT	TOTAL SAVINGS (£)
0000440	0000000	0000125	0000000	000 1072

CO2E (KG) SAVED

Carbon and other Greenhouse Gases are given off in the manufacture of products. Every item transferred using WARPit saves on carbon emissions because a new item does not have to be manufactured, transported and purchased. Using standard conversion factors we are able to work out the estimated carbon dioxide equivalent. The conversion factors are calculated by Centre for Sustainability Accounting (CenSA), York, based on previous calculations by Stockholm Environment Institute (SEI), University of York

CARS OFF THE ROAD FOR ONE YEAR

Using the total CO2 saved on each transaction we can work out what the equivalent would be for taking a car off the road for one year. Based on a Ford Focus 1.6TDCi which emits 115g/KM (Source: Ford Motor Company). Assuming an average mileage of 12,000miles per year, a single vehicle would emit 2,300 KG of CO2 per year.

WASTE (KG) DIVERTED

This is a measure of waste being diverted into reuse rather than disposal. Each item that is transferred using WARPit is given an approximate average weight value (KG) based on a sector leading bulky waste guide. If the KG information for an item is not included in the reference document an average weight of the item is estimated using company specification data.

EQUIVALENT TREES PLANTED

Native broadleaf trees provide sustainable habitat for wildlife and enhance the natural landscape. These are therefore commonly used for Carbon offsetting projects. Over the course of its lifetime a broadleaf tree absorbs on average 730KG. Please note this is trees equivalent, we do not actually plant trees www.carbonfootprint.com

MONEY SAVED (£)

Each item transferred on WARPit is given a replacement purchasing value. This is the cost of purchasing a new item. The value is derived from public sector priced catalogues. Each item is also given waste disposal financial value related to it's weight and volume. The total cost (£) saving is made up from internal trades, external inward trades, waste cost savings. This figure may also include the value (£) of time saved by staff, from avoiding the normal quote, purchase order, invoice process.

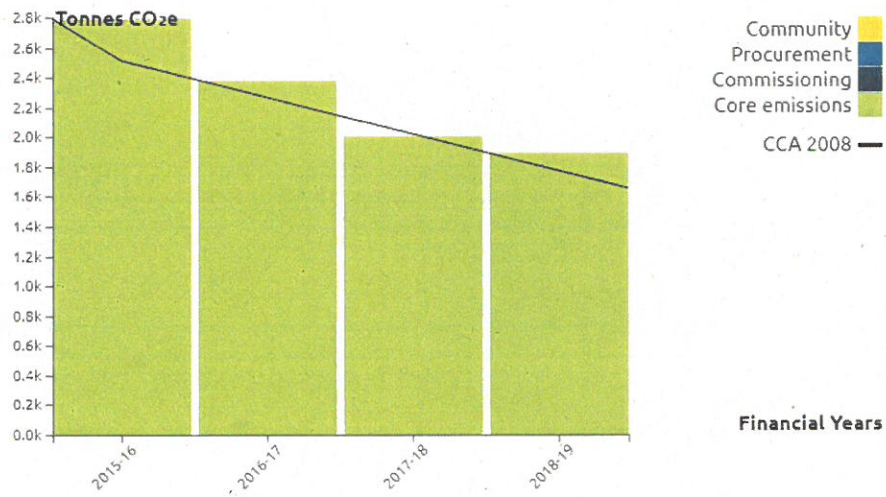
f) Overall progress

CO_2 Emissions (tCO_2e)

	2015/16	2016/17	2017/18	2018/19
Scope 1	2,749	2,545	2,527	2,403
Scope 2	3,478	2,677	2,229	1,682
Scope 3	575	421	287	478
Total	6,803	5,643	5,043	4,563

g) Benchmarking by number of staff (tCO2e / WTE)

Benchmarking our core emissions against the number of whole time equivalent (WTE) staff the Trust continues to realise reductions in its carbon footprint.



	2015/16	2016/17	2017/18	2018/19
Core emissions	42.5	39.2	34.8	28.8
Commissioning	0	0	0	0
Procurement	0	0	0	0
Community	0	0	0	0
Total	42.5	39.2	34.8	28.8

1.2.4 ANTI-BRIBERY CULTURE

We have a zero tolerance to bribery and the Board has in place an Anti-Bribery and Fraud Policy which is available to staff on Staffnet. Staff are reminded of their responsibilities under the procedure and how to access this on a regular basis. Counter-fraud services are provided by NHS Audit Yorkshire who carry out proactive and, where necessary, reactive work in relation to bribery. They will make a report to each meeting of the Audit Committee to provide on progress with their work. In 2018/19 there were no instances of bribery identified within the Trust.

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Performance Report (made up of sections 1.1 and 1.2 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Date: 23 May 2019

Dr Sara Munro
Chief Executive

SECTION 2.1 – THE ACCOUNTABILITY REPORT (Directors' Report)

The directors are responsible for keeping proper accounting records, which disclose with reasonable accuracy at any time the financial position of the Trust and enable them to ensure that the accounts comply with the requirements outlined in the direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors consider that to the best of their knowledge and belief they consider the Annual Report and Accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for service users, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

2.1.1 MEMBERS OF THE BOARD OF DIRECTORS

At the end of 2018/19 the Board of Directors was made up of seven non-executive directors (including the Chair of the Trust) and six executive directors (including the Chief Executive). The table below lists members of the Board of Directors on 31 March 2019. It shows the name of the Chair of the Trust and Deputy Chair; the Senior Independent Director; the Chief Executive and the Deputy Chief Executive.

Table 2.1A – Members of the Board of Directors on 31 March 2019

NON-EXECUTIVE TEAM	
Prof Sue Proctor	Chair of the Trust
Prof John Baker	Non-executive Director
Helen Grantham	Non-executive Director
Andrew Marran	Non-executive Director
Margaret Sentamu	Non-executive Director
Sue White	Non-executive Director (Deputy Chair of the Trust)
Martin Wright	Non-executive Director (Senior Independent Director)
EXECUTIVE TEAM	
Dr Sara Munro	Chief Executive
Joanna Forster Adams	Chief Operating Officer
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)
Claire Holmes	Director for OD and Workforce
Dr Claire Kenwood	Medical Director
Cathy Woffendin	Director of Nursing, Professions and Quality

Non-executive directors (NEDs), including the Chair of the Trust, are appointed by the Council of Governors. Where there is a vacancy this would be filled through a full open advertisement process. Where there is an incumbent NED who is eligible for re-appointment by virtue of the number of years they have served and where they wish to be considered for re-appointment, this would be done based on a satisfactory appraisal and approval by the Council of Governors. Should it be necessary to remove either the Chair of the Trust or any of the other non-executive directors this would be done by the Council of Governors. A decision to remove the Chair of the Trust or another non-executive director must be done in accordance with our constitution and only if three quarters of the total number of governors appointed or elected at the time, vote to remove the individual.

The Board of Directors considers that it is balanced, complete and appropriate and this can be seen in the biographical details of Board members as set out in Part A section 3.3 of this Annual Report. All the non-executive directors are considered to be independent in both judgement and character, and the Board has confirmed there are no relationships or circumstances which are likely to affect, or could appear to affect, judgment in this respect.

It is also reported that Prof Sue Proctor, the Chair of the Trust, had no other significant commitments during the year 2018/19 that affected her ability to carry out her duties to the full, and she has been able to allow sufficient time to undertake these duties.

Further information about the Board of Directors can be found in Part A sections 2.4 and 3 of this Annual Report.

2.1.2 REGISTER OF DIRECTORS' INTERESTS

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

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

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

The register of interests is maintained by the Associate Director for Corporate Governance and is available for inspection on the Trust's website. The associate Director for Corporate Governance can be contacted by telephone 0113 8555930 or by email chill29@nhs.net.

2.1.3 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.

2.1.4 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. There has also been no interest paid under the Late Payment of Commercial Debts (Interest) Act 1998.

2.1.5 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 2018/19. The Board of Directors, therefore, declares that there has been no material income other than from the provision of goods and services for the purposes of the health service in England. Any benefit is re-invested in the provision of those services.

2.1.6 COST ALLOCATION AND CHARGING

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

2.1.7 POLITICAL AND CHARITABLE DONATIONS

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

2.1.8 NHS IMPROVEMENT'S WELL-LED FRAMEWORK

In January 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the NHS Improvement well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice and the requirements of the well-led framework.

The first phase of the review looked at sub-Board level structures and processes i.e. structures and processes at executive director (corporate) through to directorate (care service) level. Phase 2 of the review looked at Board and committee effectiveness.

This review against the well-led framework strengthened our existing internal governance arrangements and our systems of internal control. It made clear to staff where decisions are taken and where risks or issues are escalated to; where accountability sits and what assurance looks like. It provided us with a comprehensive system of monitoring, evaluating and reporting on performance. The changes also ensured that we are clear about the performance measures we need to report against and where these are reported to. We reviewed and refreshed the Board Assurance Framework and strengthened our quality governance reporting.

The key arrangements that are in place to ensure we are well-led are:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board and Senior Leadership Team has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understood them in relation to their daily roles
- The newly developed trust strategy is directly linked to the vision and values of the trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery the strategy.
- Senior leaders visit all parts of the trust and feed back to the board to inform the discuss in relation to the challenges staff and the services face
- We are actively engaged in and leading on collaborative work with external partners including NHS partners, primary care, Local Authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that included data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators (KPIs) and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation.

In January 2018 we received an inspection from the CQC. The report was issued and said staff were "caring and compassionate during their interactions with patients" and that "feedback from patients confirmed that staff treated them well and with kindness, compassion and respect." It also said that "patients were positive about the care and treatment they received and felt involved in the decision-making" and that "staff involved carers and others close to patients in decisions about the care and

treatment provided by the service."

The report showed that 85% of the Trust's services are now rated as either good or outstanding. However; the inspection found that there were a number of issues to resolve including three services rated as 'Requires Improvement' alongside some actions the Trust needs to take centrally. As such the Trust was rated 'Requires Improvement' overall.

The Trust was given the following overall ratings by the CQC. Well-led was also rated good.

Table 2.1B

Are services safe?	Are services effective?	Are services caring?	Are services responsive?	Are services well-led	Overall
Requires improvement	Requires improvement	Good	Good	Good	**Requires improvement**

Over 2018/19 our improvement approach has been to address and complete our "must do" actions from the January 2018 CQC Inspection and continue to address and complete the "should do" actions. Monthly CQC Steering Group meetings chaired by our Director of Nursing, Professions and Quality, seeks assurance from all services and corporate areas that the actions from the last inspection are progressing and being implemented. In addition, all peer reviews are reported to the steering group and any areas of concern, themes or trends are discussed and plans put in place to address and mitigate future risks. Quarterly updates are provided to the Board.

Over the course of 2018/19 we have been conducting peer reviews (against the CQC KLOEs) on a scheduled basis. This is an opportunity to share best practice and improvement plans as well as using feedback to continuously improve the process of review within our organisation. We are in regular contact with the CQC and are part of the 'Moving to Good Programme' (North) with NHSI. In the medium term we are:

- Learning from other comparable Trust's presenting best practice and gaining assurance of our own practices (organisational culture, staff engagement, medical engagement and quality improvement).
- Learning first-hand about what 'good' looks and feels like from being paired with an 'outstanding' Trust with planned visits for 2019.

In the longer term we will continue to involve staff from different services to review colleagues' services across the Trust and report on these at service level. Themes and learning from peer reviews are now being collected and reported on through the Trust's governance meetings. In addition, the CQC Steering Group meetings will continue with further quality improvement work planning and preparing for successful future inspections.

More information on the arrangements in place to ensure services are Well-led can be found in the Annual Governance Statement in Section 2.9 of this Annual Report.

2.1.9 EU EXIT PREPARATIONS

Through the latter part of 2018/19 the Board received progress reports on the plans the Trust was making to respond to a potential 'no-deal' exit of Britain from the EU. This was to assure the Board that any potential impact of leaving the EU without national arrangements being in place were managed and reduce any impact on our ability to provide services. NHS England's Emergency Preparedness, Resilience and Response function took a lead on coordinating plans at a local, regional and national level, which the Trust was linked into. Internal governance arrangements were put in place to oversee the arrangements and regular reports were made to the Board and key support functions in the Trust which could be affected by a 'no-deal; were included in proactive contingency planning. . Through 2019/20 we will continue to review the national position in relation to exiting the EU; work with our support functions and respond to any central requests for a coordinated and managed approach to Britain's exit from the EU

SECTION 2.2 – ACCOUNTABILITY REPORT (Service User Care)

2.2.1 SERVICE USER CARE

We put the health, safety and wellbeing of our service users and carers at the heart of everything we do. This is borne out in our Trust Strategy and our five strategic plans. Our principal activity is to provide excellent quality mental health and learning disability care that supports people to achieve the very best they can for their health and learning disability care the supports people to achieve the very best they can for their health and wellbeing. We work together with our partners to offer service users a choice of interventions and to ensure that our services provide a joined-up pathway of care.

2.2.1.1 Principal activities of our care groups

The Care Services Directorate includes those services that provides direct clinical care to our service users in Leeds and across Yorkshire and the Humber.

The directorate is made up of two care groups, these are:

- Leeds Mental Health Care Group
- Specialist Services and Learning Disabilities Care Group.

This arrangement of services: strengthens clinical leadership and ensures that the care we provide for service users is safe and effective; matches the delivery of our care to the local commissioning groups and specialist commissioners who ask us to provide care and services; and makes sure that our services are grouped together to deliver pathways and packages of care to our service users which reduce delays and are joined up to give people the right care at the right time from the right service.

Leeds Mental Health Care Group

The Leeds Mental Health Care Group provides a range of acute and community-based services to service users over the age of 18. The services we provide in the care group are commissioned by Leeds Clinical Commissioning Group and include:

- Community Mental Health Teams
- Care Home Team
- Memory Service
- Crisis Assessment Services
- Intensive Community Services including the Home-Based Treatment Team
- Younger People with Dementia Team
- Psychological and Psychotherapy Services
- Assertive Outreach Team
- Older People's Liaison Mental Health Service (based at St James's Hospital)
- Mental Health Inpatient Services
- Dementia Inpatient Service
- Rehabilitation and Recovery Services
- Healthy Living Service.

Specialist Services and Learning Disability Care Group

The Specialist Services and Learning Disability Care Group is made up of a range of specialist services operating on a local, regional and national basis. These services are:

- Forensic Services
- CAMHS Tier 4 Inpatient Services
- Learning Disability Services
- Eating Disorders Services
- Gender Identity Services
- Liaison Psychiatry

- National Deaf Children and Families Service
- Northern School of Child and Adolescent Psychotherapy (NSCAP) Clinical Services
- Perinatal Services
- Personality Disorder Services
- Veterans Service
- Gambling Addiction Service.

Our services are delivered across a range of settings in Yorkshire and the Humber and our Deaf CAMHS service operates from Manchester and Newcastle. They are commissioned by a range of commissioners, including national specialised commissioning (NHS England), local CCGs, the Local Authority and Public Health. A number of our services are also delivered through formal partnerships with other agencies.

Key achievements of the care groups during 2018/19

- **Completed the work on redesigning our community services:** our new community mental health service pathway was launched in March 2019. This provides a new community and crisis model for older and working age adults. We will mobilise this model of care through 2019/20

- **The development and implementation of the new community forensic model:** a clinical model provides staff and service users with a shared framework in which to develop an understanding of our service users' difficulties and provide pathways for recovery

- **Implementation of the new model of care for Eating Disorders – Connect:** the expansion and changes to existing eating disorders services to significantly reshape both inpatient and community care for adults with eating disorders across regional footprint

- **Implementation of a Veterans health service across the North of England:** providing care and support with the mental health needs of veterans from the armed forces

- **Street Triage: collaboration and improvement:** reviewed and improved the support provided to people in crisis who are admitted to a place of safety under Section 136 of the Mental Health Act

- **Nursing Child Assessment Satellite Training– Parent Child Interaction Scales:** this will allow staff to be competent in assessing mother-infant interaction in a structured manner be used routinely as a quality outcome measure (upon admission to the service and prior to discharge); and provide Structured assessments to improve the standard of documentation and improve the quality of reports for child protection conferences

More detailed information on these key achievements can be found in the Quality Report in Section B of this Annual Report

Future priorities for the care groups in 2019/20

The key priorities for the care groups are stated within the Clinical Services Strategic Plan which is a three-year plan for 2018 to 2020. A number of priorities have been identified as being key to the delivery of the Plan these include:

- Delivery of an enhanced Care Homes Service that offers intensive assessment and support to newly placed care home residents and reduces admission to inpatient services.
- Mobilisation of the new community and crisis model for older and working age adults
- Integrating the specialist liaison outpatient model with Leeds Teaching Hospitals NHS Trust and identify growth opportunities in non-acute outpatient care
- Ensue the achievement of an agreed out of area placement trajectory for acute and PICU with the underpinning assumption of core mental health investment to provide out of hospital alternatives to admission
- Develop new models of inpatient rehabilitation provision involving third sector partners in Leeds
- Implement the Acute Care Excellence programme of work to address clinical variation and in particular length of stay across our acute wards

- Working in collaboration with the other providers across West Yorkshire develop a standard future model for Learning Disability assessment and treatment inpatient care, as a networked service working to the same standards.
- Develop an intensive community support offer for people with a learning disability.

The priorities will be delivered by staff in the care groups, with Project Management Office support and regular reports on progress to our Board, its sub-committees and to our operational groups.

Risks and challenges for the care groups in 2019/20

We continue to operate in a complex national picture; with uncertainties around commissioning intentions, recruitment and retention challenges, and financial pressures.

We need to balance the delivery of high quality care with our cost improvement plans and overall our regulatory control total. Those working in our services strive to look at ways in which care can be delivered differently without compromising quality or the service users' experience. We have an ambitious plan for 2018/19 and the things we want to do, but we are only able to deliver our priorities if we have the capacity in our services. We, like all other NHS organisations, face risks around filling our vacancies and ensuring we have the right clinical staff to provide the care our service users expect from us; and the right management structure in place to oversee the delivery of the priorities. To help support us in this the Board has agreed a Workforce and Organisational Development Plan. This sets out how we will achieve the workforce we need to deliver these priorities.

We also need to ensure that the premises from which we provide our services are fit for purpose and provide the right therapeutic environment. This means that we will need to make some changes to where services are provided and we will work with our staff and service users to ensure we get this right and involve people in the changes. These changes are set out in our Estates Strategic Plan; progress on this is reported to the Finance and Performance Committee.

Our IT systems also need to support the delivery of high quality care. In 2018/19 we procured a new electronic patient records system, CareDirector. Changing such a large IT system presents a number of risks to our day to day business. These will be managed through the project Board overseeing this and staff in the care groups will be involved in the implementation and changes.

We also need to work with our commissioners and partners in the health and care sectors within which we provide services to ensure that we are able to meet the needs of our service users not just when they are in our services, but when they are cared for by our partners. This means that we will need to continue to develop our partner relationships and look at ways of working differently to provide the care needed.

2.2.2 SERVICE USER EXPERIENCE

2.2.2.1 Feedback from people who use our services (our service user survey)

We gather feedback from people who use our services and their carers through a broad range of methods including both local and national surveys. Every NHS service provider must run a national service user survey each year for community services and the CQC will use the results from this survey in the regulation, monitoring and inspection of NHS trusts in England. The National inpatient survey is voluntary. Both surveys are managed by an independent company (Quality Health) on our behalf, which sends a questionnaire to a sample of representative community service users and inpatients. They then work with the answers given to produce result 'scorecards' that can be compared with other mental health trusts and community interest companies that deliver mental health services. This helps us to benchmark our performance in regard to service user experience on at least an annual basis.

2.2.2.1.1 The 2018 Survey of people who use community mental health services

We were one of 56 providers of mental health services in England that took part in the 2018 survey for people who use community mental health services. For most of the scores we were placed in the middle 60% across all trusts nationally. Two scores were in the top 20% and one of our scores being the highest score nationally. This was as a direct result of our improvement actions taken last year,

although our commitment to try to improve the uptake of the survey from the 2017 response rate was not realised. However, in the context of significant changes in the community services maintaining a response rate of 26% (212 useable responses) was a positive achievement.

In the 2018 survey service users were asked to give feedback on their experience of the staff who cared for them. The results showed that there was evidence that staff listened carefully to them and understood how their mental health needs affected other areas of life. Service users said they were given enough time to discuss their needs and treatment.

A pledge identified in the 2017 community services survey was to take action to improve service user involvement in decisions about the medicine they received. Positively, our feedback from the 2018 survey evidenced achievement of this improvement, with our results being in the top 20% of trusts nationally. The Trust also achieved the highest score nationally in 2018 for *supporting service users in accessing community activities and addressing wider social and vocational needs*.

The Trust's score for *involving service users in a formal meeting with someone from mental health services to discuss how their care is working in the last 12 months* showed a slight decline this year, although this was still maintained in the middle 60% of scores for trusts nationally. Service user involvement in recovery focused care planning, and delivery of CPA processes has been identified as a key focus of quality improvement within community services, with improvement actions developed within clinical teams, and progress monitored though local governance processes and with service users using a "you said we did " approach.

2.2.2.1.2 The 2018 National Mental Health Inpatient Survey

We were one of 18 Mental Health Trusts that voluntary undertook the National Mental Health Inpatient Survey and although we only had a response rate of 20% it remains important that we work to ensure this feedback is triangulated with feedback from other sources.

All but one of the scores were in either the top 20% or middle 60%, when compared to the organisations surveyed by Quality Health. Four of the best overall scores were for having enough time with a psychiatrist to discuss a condition and treatment; always having confidence and trust in the psychiatrist; being involved in decisions about care and treatment; and being contacted by the mental health team since discharge.

Just one score was in the bottom 20% of Trusts, and this related to the cleanliness of toilets and bathrooms. This issue has been taken to the Clinical Environments Group and we will review the cleaning contract. It has also been agreed to introduce clinical environment checks on inpatient wards. This requires all areas to be checked by the shift co-coordinator three times per day (at shift change over) and any issues escalated as required for action.

Some of the Care and treatment scores from 2017 declined in 2018. The inpatient services have responded to this by making pledges in the following improvement areas:

- **Make sure that our service users develop their care plan with their mental health and social care professionals and are given a hard copy with an agreed date to review it**. Practice development staff are working with ward managers and teams to improve individualised and meaningful care plans written collaboratively with service users. Care planning groups are helping teams to come together and think in a more psychologically informed way to produce evidenced based care plans which are discussed with service users. Safety plans are also being progressed as a means of collaboratively written care plans which will remain with the service user throughout their recovery and care pathway.

- **Investigate reasons for service users feeling unfairly treated while in hospital** – The service will focus on themes of complaints and any feedback from 'your views' meetings as a way of looking at data because the survey only offers limited information. The outcomes will be fed through operational meetings and clinical improvement forums to identify themes and learning that can be shared with the team and improve the service.

- **Take further action to make service users feel safer while in hospital –** We need more in-depth information in this area and will discuss this with service users in the 'your views'

meetings. The service is in the process of embedding the 10 Safewards interventions across all of the inpatient wards and we have spent time focusing on sustainability to bring in cultural change. The implementation of safety huddles also supports the approach to improving safety and each ward will focus on a specific harm / risk to reduce in the first instance.

Our 2018 service user feedback results in the community and inpatient services demonstrate that whilst we have made a number of improvements across service delivery and care and treatment, we still have further work to do to improve the experience of those using our services.

2.2.2.2 Dealing with concerns – our complaints and PALS service

The Trust's Complaints and PALS function operates as a gateway for concerns and complaints, ensuring they are managed in accordance with regulatory requirements. The team strives to ensure that they deliver an accessible, robust complaints service driven by the rights of the patient as set out within the NHS Constitution.

Complaints are seen by the Trust as a valuable source of feedback which can be used to inform service improvements, enabling us to provide high quality services for our service users and carers. They present an opportunity to review both the care provided and our services, whilst examining the way we interact and provide information to our service users.

The Trust recognises the importance of learning from complaints and the value of sharing this learning across the organisation. Once a complaint has been investigated, the complainant is informed of any action that will be taken to ensure the events leading to their experience, are put right. Often this involves individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study.

Overdue complaints are continually monitored by the Legal Services and Complaints Lead with any areas of concern being raised with the responsible directors. The Complaints Team regularly prompt investigators and the Associate Director for progress updates on all complaints; but there are still occasions when capacity issues delay the final approval stage. We are working on ways to reduce any delays and have a clear escalation process when required. During 2018/19 the Complaints and PALS team has enhanced the existing good practice in a number of areas resulting in significant improvements in the completion and quality of complaint responses.

Learning from complaints is disseminated through the CLIP (Complaints, Compliments, Litigation, Incidents and PALS) report via Clinical Governance Councils. Learning is also shared through Lessons Learnt bulletins, or through Ward Managers and Community Managers' Forums or the Consultants Committee, as appropriate.

Staff often receive compliments verbally or by letter and card. They are thanked for treatment, care and support, or complimented on the environment of the ward. As a result, there is now a formal process in place for recording compliments as a key measure of service user experience. During 2018/19 there were 434 compliments formally recorded, which is an increase of 27% from those recorded in 2017/18.

The PALS team received 1607 enquires during 2018/19. The PALS team is supported by one social work student from Leeds Beckett University who commenced a 90-day placement as part of their MA in social work. This has created more capacity for promoting the service and increasing activity. As a result, the PALS team continues to visit our inpatient units (Becklin Centre; Newsam Centre; The Mount; Clifton House; and Mill Lodge); these have been very positively received.

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

We were authorised as a foundation trust in August 2007. Since this time we have made good use of the benefits of our foundation trust status.

Our ambition is simple. We want to support our service users, carers, our staff, and the communities we serve to live healthy and fulfilling lives. We use various initiatives to help us achieve this ambition. One of which is that we remain 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. This enables

us to achieve our ambition whilst ensuring engagement with service users and carers remains at the centre of our work.

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; people who are passionate about mental health and learning disability services. From this 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 2018/19 we have used the benefits of being a foundation trust in the following ways:

- Members and governors continued to help develop the shape and direction of our services in Leeds, York and North Yorkshire, especially around future scoping and planning of priorities through the strategic planning process.
- The Board agreed to use additional money received from the refinancing of the PFI contract to build a new unit on the St James's Hospital site. Work to progress this will continue through 2019/20.

- At the Annual Members' Meeting in September 2018 attendees were invited to join a conversation about what person centred care means to them and what we can do better. The feedback was captured and a summary of how it has been integrated within the Trust will be presented at the 2019 Annual Members' Meeting.

- Part of the Annual Members' Meeting was made up of our public meeting where members of the Board of Directors and Council of Governors made reports to members and the public on the work and performance over the previous financial year.

- Governors attended a West Yorkshire Mental Health Services Collaborative Engagement Event, which was run in partnership with three other trusts, two of which are foundation trusts. These organisations provide the region's NHS mental health services. Governors provided feedback on the joint priorities for mental health service provision.

- Governors were invited to be part of the NHS 70 Project Group, looking at initiatives to recognise and celebrate 70 years of the NHS.

- One new non-executive director (Andrew Marran) was appointed by our Council of Governors for a three-year period.

- Governors continued to form part of the service visits that the non-executive directors undertake. These visits provide an opportunity to find out more about the services that the Trust provides. It also provides the governors with a chance to see the role that non-executive directors undertake in staff engagement; providing an independent view on the Trust's services and holding the executive directors to account.

- We continued to invite governors to observe a number of Board sub-committees, this included the: Quality Committee, Mental Health Legislation Committee, and the Finance and Performance Committee. This provides an opportunity for governors to get a better understanding of the work of the Trust and to observe non-executive directors appropriately challenging the executive directors for the operational performance of the Trust.

- We held one round of elections for vacant seats on the Council of Governors. Members had the opportunity to become further engaged with the work of the Trust by standing to become a governor within the elections, and be part of any ballot that takes place. The composition of the Council of Governors continues to remain a priority for the Trust to ensure it is representative of the members and people we provide services to.

- Governors were invited to provide feedback on the performance of the seven non-executive directors, including the Chair of the Trust. This anonymous feedback contributed to a 360 degree feedback approach used as part of the appraisal process for each of the non-executive directors. Alongside the Chair, our Lead Governor took part in the appraisal meetings for the NEDs.

2.2.4 REGULATORY RATINGS AND PERFORMANCE

Information about our performance against key healthcare targets, our performance against national standards and targets, and actions resulting from Care Quality Commission inspections can be found in Part A section 2.7 and the Quality Report in Part B of this Annual Report.

For locally agreed targets these are reported in the Combined Quality and Performance Report (CQPR) and are shared with the Board of Directors, Board sub-committees and the Council of Governors. We also have quarterly Quality and Performance meetings with the commissioners and progress against targets and measures is discussed and where necessary remedial action plans are agreed.

2.2.5 RESULTS OF THE 2018/19 NHS EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE ASSURANCE PROCESS

The Trust is required to carry out an annual assessment of its compliance with NHS England's core standards for Emergency Preparedness, Resilience and Response (EPRR). This assessment is considered by our EPRR group and is then approved by the Board of Directors. The standards were increased in 2018 to include additional items and the attainment level to record compliant with each standard was also made more challenging. The Trust's overall assessment was of partial compliance; 46 of the 54 standards were assessed as being fully complied with; seven as partial and one as non-compliant.

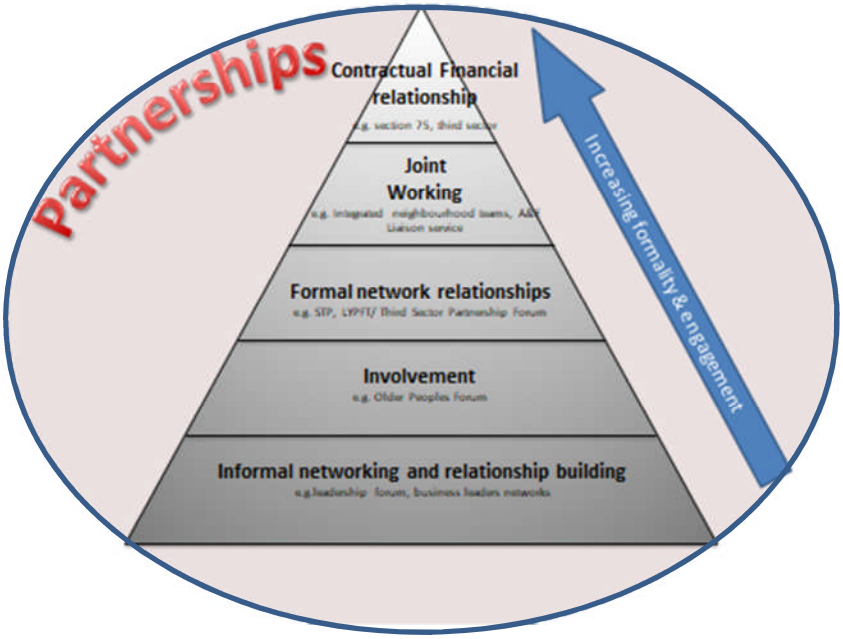
SECTION 2.3 – ACCOUNTABILITY REPORT (Stakeholders)

2.3.1 PARTNER AND STAKEHOLDER RELATIONS

2.3.1.1 Working in partnership

The trust has focused on strengthening relationships and delivering system-wide improvements to services with a range of partners. The Trust values working in partnership and recognises the positive impact this has on service users' experience of clinical services. This ethos underpins the strategic clinical plan. Consequently we have seen an increase in the number of partners with which we engage and collaborate.

We have strengthened our approach through the development of a framework and approach to partnership working which is illustrated below.



This framework has clarified the approach taken and is leading to improvements to the contractual arrangements in place with our partners. In light of this we have commenced a systematic review of those arrangements. And work will continue on this review through 2019/20.

The main benefit of working in partnership is those that impact on the delivery of clinical services. Over the last year we have made significant achievements some of which are captured in the table below.

Table 2.3A – Partnership arrangements

Partnership	Achievement
Humber Coast and Vale Health and Care Partnership (HC&V HCP)	The development and implementation of the new community forensic model
West Yorkshire and Harrogate Health and Care Partnership	Implementation of the new model of care for Eating Disorders - Connect
Consortium with LTHT, LCH and LYPFT	Implementation of a new weight management service
Consortium led by Wakefield Council	Expansion of Liaison and Diversion Services
Partnership with Combat Stress	Implementation of a veterans health service across the North of England.

We recognise the importance of third sector providers in supporting our service users and equally value working in partnership with them. We have instigated a forum to bring together third sector partners on a quarterly basis to undertake in-depth reviews into different service areas to improve the care provided across all providers.

In addition to the partnership working at a service level, the Trust has formal partnership arrangements with other NHS organisations in Leeds and the wider West Yorkshire and Harrogate Integrated Care System footprint. These are described in the sections below.

2.3.1.2 West Yorkshire Mental Health Services Collaborative

This Trust, along with Bradford District Care Foundation Trust, South West Yorkshire Partnership Foundation Trust and Leeds Community Healthcare, came together to form the West Yorkshire Mental Health Services Collaborative. This brings together collective expertise from the region's providers of mental health services.

The focus of the collaborative is to work together to improve acute and specialist mental health services for our local communities and deliver the Mental Health Five Year Forward View for people in West Yorkshire. A number of priorities have been agreed and work streams established to ensure delivery of the priorities. Executive directors and senior managers from within the Trust are part of these work streams which feed into the key priorities and day-to-day operation of the Trust.

In 2018 the respective Boards agreed the governance arrangements including the agreement of a Memorandum of Understanding and the establishment of a Committees in Common. Representation from each Trust on this committee is the Chair and Chief Executive. This arrangement ensures there are mechanisms in place to review progress and the delivery of our shared agenda.

During 2018/19 the Committees in Common met in three formal meetings to review progress against its agreed priorities. It also held a non-executive / governor engagement event which looked in greater detail at aspects of these priorities.

2.3.1.3 West Yorkshire and Harrogate Integrated Care System (WY&H ICS)

The Trust continues to participate as a key partner in the West Yorkshire and Harrogate ICS, formally the STP, with our Chief Executive being the Senior Responsible Officer. The focus of the partnership is to set out the vision, ambitions and priorities for the future of health and care in the West Yorkshire region. We have been an active participant in the development of the partnership with our executive team members taking an active role in the development of plans and governance arrangements.

For the WY&H ICS a Memorandum of Understanding has been established and agreed by the each of the partner Boards and governing bodies. This sets out the governance and accountability arrangements for the partnership. The development of the governance arrangements is expected to continue into 2019/20. Representation on the WY&H HCP comes from our executive team and senior leaders in the organisation as the focus of the work feeds into our key priorities and day-to-day operation of the Trust.

2.3.1.4 Leeds Providers' Integrated Committees in Common

The Leeds Providers' Integrated Committees in Common (LPICC) is made up of the Chair and Chief Executive from this Trust, Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals Trust and the GP Confederation. It has been established to facilitate joint working and decision making to improve the ability for organisations to deliver changes within Leeds.

In 2018/19 a Memorandum of Understanding was agreed by each of the partner Boards and it has met through the year to establish priorities and align work plans with these priorities. The Board of Directors of the Trust receive regular updates and reports to its meetings.

2.3.2 PUBLIC AND SERVICE USER INVOLVEMENT

2.3.2.1 Consultations

We have not carried out any formal consultations during 2018/19. However, we ran a large scale public and staff engagement exercise in May and June 2018 on our proposals to redesign our community mental health services. Working with our third sector partners, Forum Central, we did this through two public events, a series of face-to-face meetings with key partners, surveys, digital communications and direct mailings to service users and members.

The headline results from the public engagement were that:

- The majority of public respondents felt our proposals would improve services.
- 74% felt that our proposals will either make big or some improvements to our community mental health services overall.
- 75% felt our proposals will either make big or some improvements to older people's services
- 69% felt our proposals will either make big or some improvements to working age adult services.

A number of suggestions from our engagement exercise were incorporated into the final services models and we are extremely grateful for all the contributions we received. The new look community mental health service was launched in March 2019.

2.3.2.2 Public involvement activities

NHS 70 celebrations

We took the opportunity to celebrate the 70th birthday of the NHS with a range of activities and initiatives. Examples included:

- The NHS Big 7 Tea which involved staff hosting tea parties with service users and carers. Evaluation showed around 1,000 people took part in our Big 7 Tea event.

- Our Child and Adolescent Mental Health Service staff in York opened their new and improved sensory garden. The garden was prepared with help from local partners, companies and volunteers.

- 'Looking Back, Looking Forward: 70 years of Learning Disability Services in Leeds' was a very special event organised by our Anti-Stigma Co-ordinator Tricia Thorpe. Held at Leeds City Museum, it reflected on the last 70 years of learning disability services in the city, recognising how far we have come. Tricia also curated an exhibition of archive material through the years with a particular focus on Meanwood Park Hospital, which closed in 1996. The event was attended by staff past and present as well as service users, carers and dignitaries including the Lord Mayor of Leeds.

Membership Communications

We published two editions of our membership magazine Imagine during 2018/19. The content and editorial of both continued to follow the insight and feedback we received from our membership in 2017, including features on specific conditions, treatments and services.

Our website

Our website is our primary external communications channel. In 2018/19 it received 524,592 views (an average of over 1,400 views per day) from 415,116 individual people (an average of over 1,100 per day).

Engaging the public on social media

The Trust engages with the public through four social media channels including: Twitter; Facebook; LinkedIn; and YouTube.

Our Twitter channel reached 6,000 followers during 2018/19. Our engagement rate is exceptionally high at around 1.2% is considered to be high by industry standards).

Our Facebook channel continues to grow in popularity, reaching around 2,500 followers by the end of 2018/19. We have used it successfully to recruit staff and to promote activities such as our mental health drop-in events, which received over 10,000 views.

Our LinkedIn channel has grown steadily throughout the year, reaching 2,600 followers at year end. This has proven to be an effective way of reaching a more professional audience in higher social demographic categories.

We revamped our YouTube channel in 2018, including the removal of old content and organising remaining content into category playlists. The channel is used to host a range of Trust videos from service specific to training-related. During 2018/19 videos on this channel received over 12,000 views and the total watch time of these videos exceeded 25,000 minutes.

2.3.2.3 Service user involvement activities

The 'You said, we did'' service user community meetings remain a key activity to keep service users and carers up to date with local events and plans for our wards and services. The meetings are an opportunity for the people who use our services to give feedback and share ideas, alongside receiving timely responses about any issues of concerns. In June 2018 the Patient Experience Team (PET) carried out a mapping/scoping of 'Your Views' and highlighted good practice areas within the Trust that were listening and learning from the patient's own journey / experience and this allowed the wards to improve communications and make any reasonable adjustments after they had received feedback.

We have a well-established service user network (SUN) and the Patient Experience Team continues to support service users to attend the monthly meetings. This is an opportunity for service users, carers and staff to get together to share their experiences of Trust services, as well as providing a platform to support the shaping and influencing of service provision and development. At the request of members guest speakers are invited where issues have been identified or raised within the network and we now have a co-production model in place whereby staff / guest speakers facilitate workshops at SUN and engage with service users on their project / programme and any developments. The feedback gained at the SUN workshops is then considered and acted upon by the staff member and the following SUN meeting, delegates get to hear about the impact and outcomes of their feedback in a 'You Said We Did' or 'We are doing' format. Members have been involved in the community re-design evaluations, recruitment of medical consultants, co-facilitating and delivering training and also have been members of interview panels for key jobs within the Trust.

Public / Patient engagement: our values based approach to service user and carer engagement / involvement has now evolved into a more co-productive model which brings together service users, carers and staff. The Patient Experience Team are now supporting services with their engagement activities via focus groups, workshops, listening events, carers coffee mornings and supporting listening to people in a way that responds to their needs and concerns and compliments about services.

April 2018 to March 2019 saw a rise in the number of SUN attendees with over 400 people taking part in the activities of the group. The PET team are proud that they have been able to improve upon the diverse range of people currently attending but are continuing with promotional work that aims to increase the membership of those from harder to reach communities even further. SUNRAYS has also been instrumental in providing a platform for staff and service users in the community localities to come together and discuss local service and access related issues which is then fed back to SUN and other governance groups across the Trust. Our York based services have also set up Patient Panels using the 'You Said We Did' approach.

Volunteers have been recruited to the Patient Experience Team and have supported involvement activity, surveys, events and other work streams. A key activity of this partnership has enabled the team to be supported with the collection of Friends and family cards and analysing the data.

A key area for the Patient Experience Team is to ensure that we have a fit for purpose patient experience and involvement strategy and model. An external review has now been completed. The report has been shared with the Board of Directors and the recommendations were the focus of a patient experience and involvement and carer's workshop in March 2019. As an outcome of the feedback the Director of Nursing, Professions and Quality will lead a strategic governance committee for patient experience, involvement and carers. The committee will be responsible for setting clear priorities for experience, involvement and carers.

SECTION 2.4 – ACCOUNTABILITY REPORT (Remuneration Report)

2.4.1 INTRODUCTION

In company law, senior managers are defined as 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the foundation trust'. For the purpose of this Remuneration Report, the description 'senior managers' refers to the executive and non-executive directors holding positions on the Board of Directors.

This Remuneration Report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2018/19) as required by NHS Improvement's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager during 2018/19.

The information in sections 2.4.2 to 2.4.5 below is not subject to audit by our external auditors, KPMG; however, they will read the narrative to ensure it is consistent with their knowledge of our Trust.

2.4.2 ANNUAL STATEMENT ON REMUNERATION

The information provided in Sections 2.4.2 to 2.4.4 forms the annual report from the chair of the committees that are responsible for the remuneration of the executive and non-executive directors, which is the Chair of the Trust.

Remuneration for senior managers is determined by two committees: the Remuneration Committee (a sub-committee of the Board of Directors made up of all the non-executive directors), which is responsible for the remuneration for the executive directors; and the Appointments and Remuneration Committee (a sub-committee of the Council of Governors made up of a majority of governors), which is responsible for the remuneration for the non-executive directors.

2.4.2.1 Remuneration Committee – executive directors' remuneration

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

Further information about the work of the Remuneration Committee during 2018/19 can be found in section 2.4.4.2 below.

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

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

Further information about the work of the Appointments and Remuneration Committee during 2018/19 can be found in section 2.4.4.3 below.

2.4.3 SENIOR MANAGERS' REMUNERATION POLICY

2.4.3.1 Future policy tables

This section describes the policy narrative relating to the components of the remuneration packages for executive and non-executive directors. Each of the components detailed in these tables supports the Trust's Strategic Objective 2: we provide a rewarding and supportive place to work (putting in place a benchmarked remuneration package to fairly remunerate our Board; recognising the liability and responsibility they carry; attracting an appropriately skilled and qualified senior team to lead the organisation).

Table 2.4A – Remuneration policy for executive directors

Element	Policy
Salary	The overarching policy of the Remuneration Committee is to: use benchmarked figures to ensure they are in line with other organisations; ensure equity within the executive team pay structure, taking account of levels of experience; and reference the Department of Health guidance on Very Senior Managers (VSM) salaries. A further consideration when determining the overall level of remuneration is the differential between the amount paid to an executive director and their direct reports. There are no annual increments associated with executive directors' salaries. A time-limited additional payment of up to 10% of salary may be payable for the undertaking of Senior Responsible Officer roles within the Integrated Care System.
Taxable benefits	This will, in the main, be any mileage rates paid which are over and above the HMRC threshold or any other benefit in kind applicable at the time of remuneration.
Annual performance related bonuses	The Trust does not pay any annual performance-related bonuses to executive directors. (Section 2.4.3.2 below sets out the process for performance appraisals (not linked to pay)).
Long-term performance-related benefits	The Trust does not pay long-term performance related bonuses to executive directors. (Section 2.4.3.2 below sets out the process for performance appraisals (not linked to pay)).
Pension-related benefits	Pension rights for executive directors are determined by the NHS Pension Scheme, and the maximum payable (by the employee and the employer) is determined by the NHS Pension Scheme.
Percentage uplift (cost of living increase)	The Remuneration Committee will decide if the executive directors are to be awarded a percentage uplift ('cost of living' increase) for each financial year and what level this will be. In doing this the committee is mindful of the national advisory rate for VSM and the uplift awarded to staff on Agenda for Change pay bandings.
Other remuneration (e.g. relocation expenses)	Any other expenses paid to executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to executive directors. Relocation expenses are available to new executive directors under the Trust's Relocation Procedure

It should be noted that paragraph 7.2 of the executive directors' contract allows the Trust to recover any monies owed at any time via deductions from salary.

Table 2.4B – Remuneration policy for non-executive directors

Element	Policy
Fee payable	The overarching policy for the remuneration of the non-executive directors (NEDs) is to award levels in line with other comparable NHS foundation trusts using benchmarked figures. The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors. There are no annual increments associated with non-executive directors' remuneration.
Additional fees for any other duties	The remuneration for the Chair of the Trust recognises the specialist role and extra time commitment over and above that of the other NEDs. The Chair of the Audit Committee is also remunerated differently in recognition of the specific skills and responsibility this role requires.

Element	Policy
	All other non-executive directors are remunerated equally; however, for those NEDs who chair a Board sub-committee (excluding the Audit Committee, which attracts a separate level of remuneration) there is an honorarium of £1,000 per annum (paid pro-rata). This honorarium is in recognition of the added workload and responsibility that comes with chairing a Board sub-committee The maximum amount that can be paid will be determined by the Appointments and Remuneration Committee and ratified by the Council of Governors.
Percentage uplift (cost of living increase)	The Appointments and Remuneration Committee will decide if the non-executive directors will be awarded a percentage uplift ('cost of living' increase) and what level this will be. In doing this the committee is mindful of the uplift awarded to staff on Agenda for Change pay bandings and any percentage uplifts awarded to the executive directors.
Travel	Travel costs will be reimbursed through the payroll and will be supported by a completed travel claim form supported by appropriate receipts. Costs incurred will be reimbursed on a like-for-like basis with mileage being paid at a fixed pence per mile.
Pension contributions	No pension deductions are made from non-executive directors' remuneration and no contribution is made to a pension fund in respect of any non-executive director.
Other remuneration	Any other expenses paid to non-executive directors would be paid in accordance with the relevant Trust policy. There are no items of other expenditure which are applicable only to non-executive directors. An honorarium of £1000 per annum is paid to chairs of Board sub-committees (excluding the Chair of the Audit Committee).

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

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

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

2.4.3.2 Performance and appraisals

2.4.3.2.1 Overview

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

The Board of Directors is committed to continuous improvement and it undertakes an evaluation of its performance as part of its meetings. We also have in place a 360-degree evaluation process for members of the Board with information from this being fed into the appraisals of individual members.

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

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

2.4.3.2.2 Executive Directors

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

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

2.4.3.2.3 Non-executive Directors

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

The NEDs have their objectives agreed with the Chair; the Chair agrees their objectives in conjunction with the Lead Governor. Appraisals of the non-executive directors are carried out by the Chair of the Trust with the Lead Governor in attendance. The Senior Independent Director conducts the appraisal of the Chair of the Trust again in conjunction with the Lead Governor. Governors and members of the Board are invited to provide feedback on each of the NEDs and the Chair which informs the appraisal discussion. The Council of Governors will receive assurance that the process is in place and has been completed effectively.

Any areas of concern about the performance of any non-executive director will be reported to the Appointments and Remuneration Committee with an assurance on the proposed remedial action.

2.4.3.3 Policy on payment for loss of office and notice periods

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

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

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

2.4.4 ANNUAL REPORT ON REMUNERATION

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

- The Remuneration Committee (a sub-committee of the Board of Directors) which is made up of all the non-executive directors and is chaired by the Chair of the Trust
- The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) which is made up of a majority of governors and is chaired by the Chair of the Trust
- The Nominations Committee (a sub-committee of the Board of Directors) which is made up of a mix of executive and non-executive directors (NEDs) and is chaired by the Chair of the Trust.

2.4.4.1 Directors' contracts

Details of the contract start date for the Chief Executive and other members of the Executive Team who have served during 2018/19 are set out in the table below.

Table 2.4C – Executive directors who have served during 2018/19

Name	Title	Date appointment effective from	Date left the Board position
Dr Sara Munro	Chief Executive	5 September 2016	N/A
Joanna Forster Adams	Chief Operating Officer	3 July 2017	N/A
Dawn Hanwell	Chief Financial Officer (Deputy Chief Executive)	1 August 2012	N/A
Claire Holmes	Director of OD and Workforce	1 October 2018	N/A
Lindsay Jensen	Interim Director of Workforce Development	1 June 2018	30 September 2018
Dr Claire Kenwood	Medical Director	1 March 2017	N/A
Susan Tyler	Director of Workforce Development	1 January 2012	31 May 2018
Cathy Woffendin	Director of Nursing, Professions and Quality	1 March 2018	N/A

Details of the non-executive directors who have served during 2018/19 are shown in the table below along with details of their terms of appointment.

Table 2.4D – Non-executive directors that have served during 2018/19

Name	Date appointment effective from	Term	Date appointment ends or ended	Number of the term of office
Prof Sue Proctor (Chair of the Trust)	1 April 2017	3 years	1 April 2020	First
Prof John Baker	1 September 2016	3 years	31 August 2019	First
Helen Grantham	15 November 2017	3 years	14 November 2020	First
Andrew Marran	17 February 2019	3 years	16 February 2022	First
Margaret Sentamu	31 July 2017	3 years	30 July 2020	Second
Sue White	7 November 2016	3 years	6 November 2019	First
Martin Wright	20 January 2018	3 years	19 January 2021	First
Steven Wrigley-Howe	17 February 2016	3 years	16 February 2019	Second

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

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

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

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2018/19 the committee took advice from the following officers of the Trust: Dr Sara Munro, Chief Executive who provided information in regard to the remuneration for executive directors; Susan Tyler, the Director of Workforce Development in relation to employment matters (up to 31 May 2018); Lindsay

Jensen, Interim Director for Workforce Development (between 1 June and 30 September 2018); Claire Holmes, the Director for OD and Workforce (from 1 October 2018) and Cath Hill, the Associate Director for Corporate Governance, who provided secretariat support and advice on matters of governance. In taking this advice the committee was mindful of any potential conflicts of interest and has dealt with these appropriately as evidenced in the minutes.

The Remuneration Committee has a key role regarding the recruitment and retention of appropriately qualified and experienced executive directors. It does this by agreeing appropriate reward packages. It exercises scrutiny of the remuneration of executive directors in regard to both salary and other areas of reward and has a core responsibility to ensure compliance with all legal obligations and regulations in respect of the employment and remuneration of executive directors.

During 2018/19 the committee met on five occasions (with one meeting being held virtually by email) with membership being made up of the Chair of the Trust and six non-executive directors. Its main areas of business were discussions in regard to:

- Agreeing 'cost of living' uplift of 2% for the executive directors with effect from 1 April 2018
- Receiving a summary of the appraisals for the executive directors
- Considering and agreeing the payment of an Additional Responsibility Allowance for the Chief Executive in light of added responsibilities as the Senior Responsible Officer within the West Yorkshire and Harrogate ICS
- Reviewing the secondment arrangements for the previous Director of Nursing, Professions and Quality (who left the Trust on 24 September 2017)
- Agreeing the remuneration for the substantive post of Director of OD and Workforce
- Reviewing and Agreeing the Trust's VSM Pay Policy for executive directors.

The membership of the Remuneration Committee is all the NEDs plus the Chair of the Trust. The table below shows the Remuneration Committee meetings that each member attended. The shaded boxes relate to those meetings that individuals were not eligible to attend due to their appointment date.

Table 2.4E – The Remuneration Committee

Name	28 June 2018	5 September 2018	25 September 2018 (virtually by email)	25 January 2018	22 February 2018
Prof Sue Proctor (chair of the committee)	✓	✓	✓	✓	✓
Prof John Baker	✓	✓	-	✓	✓
Helen Grantham	✓	✓	✓	✓	✓
Andrew Marran					✓
Margaret Sentamu	✓	✓	✓	✓	✓
Sue White	✓	✓	✓	✓	✓
Martin Wright	✓	-	✓	✓	✓
Steven Wrigley-Howe	✓	✓	✓	✓	

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

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

The Appointments and Remuneration Committee is a sub-committee of the Council of Governors. It is established in accordance with the NHS Act 2006 and operates in accordance with the principles of NHS Improvement's Code of Governance for Foundation Trusts. It sets the remuneration and terms of

service for the non-executive directors and it also plays a role in the appointment of non-executive directors, particularly in respect of the interview panels which are made up of members of the Committee.

The Committee meets as required and is made up of governors chosen by ballot by members of the Council to represent them. It is chaired by the Chair of the Trust and is supported by the Director of OD and Workforce and the Associate Director for Corporate Governance. At the end of 2018/19 its membership was Steven Howarth, Niccola Swan, Les France, Ivan Nip and Peter Webster; all of whom are elected governors.

Where the Committee is discussing the remuneration for the Chair of the Trust these agenda items will be chaired by the Lead Governor.

In 2018/19 there was one formal meeting of the Appointments and Remuneration Committee. The table below shows the attendance of members at that meeting.

Table 2.4F – The Appointments and Remuneration Committee

Name	14 February 2019
Prof Sue Proctor (chair of the committee)	✓
Les France	✓
Steve Howarth (Lead Governor)	✓
Ivan Nip	✓
Niccola Swan	✓
Peter Webster	✓

In 2018/19 the main areas of work for the committee were:

- Forming an interview panel for a non-executive director appointment and making a recommendation to the Council of Governors to appoint Andrew Marran
- Agreeing a 'cost of living' uplift of 2% for the non-executive directors with effect from 1 April 2018. This level of uplift was recommended to the Council of Governors for ratification.

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

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

Competitive interview process

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

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

Re-appointment process

Where there is a re-appointment process carried out, the Chair will conduct a 360 degree appraisal taking views from members of the Board and Council on the NEDs performance. An appraisal will then be carried out by the Chair which will include the Lead Governor. A report will be made to the Council of Governors by the Chair who will advise if the appraisal has been satisfactory. The Council of Governors will then be asked to ratify their re-appointment. If the Council has evidence that this it is not appropriate to re-appoint the individual then a competitive interview process will be carried out and the individual's appointment as a NED will come to an end.

Appointment / re-appointment of non-executive directors in 2018/19

In 2018/19 there was one appointment made by the Council of Governors. This was in respect of Andrew Marran who was appointed for a period of three years with effect from 17 February 2019. This appointment was through a competitive interview process.

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

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

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

Where the vacant post is for a non-executive director, the Nominations Committee will provide the Council of Governors' Appointments and Remuneration Committee with details of the agreed skills and experience required. Where the vacant post is for an executive director a panel, constituted in accordance with the NHS Act 2006, made up of a majority of non-executive directors, will lead on the appointment process to appoint to the agreed skill-set by a process agreed by the Nominations Committee

The Nominations Committee meets as required. It is chaired by the Chair of the Trust and its membership is made up of the Chief Executive, the Director of OD and Workforce and two non-executive directors. The choice of which NED will be at any given meeting will depend on them not having a conflict of interest in any matter under discussion at that meeting. The committee is supported by the Associate Director for Corporate Governance who provides secretariat support and advice on governance matters.

During 2018/19 the committee met on two occasions. The table below shows the number of meetings each member took part in.

Table 2.4G – The Nominations Committee

Name	25 May 2018	28 June 2018
Prof Sue Proctor (Chair of the Committee)	✓	✓
Helen Grantham (Non-executive Director)	✓	✓

Name	25 May 2018	28 June 2018
Lindsay Jensen (Interim Director of Workforce Development)		✓
Dr Sara Munro (Chief Executive)	✓	✓
Margaret Sentamu (Non-executive Director)	✓	✓
Susan Tyler (Director of Workforce Development)	-	

During the year its main areas of work were:

- Agreeing the role description for a vacant non-executive director position, which was determined to be: commercial experience, such as might be found in the new business sector or gained through experience of innovation and change, entrepreneurial / commercial acumen, and being a creative thinker
- Agreeing the role description and appointment process for the substantive post of Director of OD and Workforce.

Appointment of executive directors in 2018/19

In 2018/19 one executive director joined the Board; Claire Holmes who was appointed as the Director for OD and Workforce with effect from 1 October 2018.

There was also an interim appointment; Lindsay Jensen was appointed as the Interim Director of Workforce Development. Lindsay was appointed between 1 June and 30 September 2018 following the retirement of Susan Tyler and prior to the substantive appointment of Claire Holmes.

Information in sections 2.4.5 to 2.4.7 is subject to audit by our external auditors, KPMG.

2.4.5 DIRECTORS AND GOVERNORS' EXPENSES

The following table sets out the total paid to directors (executive and non-executive) and governors for out-of-pocket expenses for travel and subsistence during 2018/19.

Table 2.4H – Directors and governors' expenses

	2018/18			2017/18
	Number in office throughout the reporting period	Number receiving expenses in the reporting period	The aggregate sum paid in the reporting period £'00	The aggregate sum paid in the reporting period £'00
Executive directors	8	6	9	7
Non-executive directors	8	6	18	11
Governors *[1]	17	3	2	13

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

Please note that expenses relating to executive and non-executive directors are shown in more detail in the expenses payments column in table 2.4J below.

2.4.6 SENIOR EMPLOYEES PENSION ENTITLEMENTS, REMUNERATION AND BENEFITS IN KIND

Accounting policies for pensions and other retirement benefits are set out in the notes to the annual accounts; see Part C of this Annual Report.

The disclosure on senior employees' remuneration and pension entitlements is subject to audit by our external auditors, KPMG.

Information about pension entitlements, remuneration and benefits in kind are set out in table 2.4I and 2.4J below.

Table 2.4l – Pension entitlement for senior employees (executive directors)

Name and title	Real increase in pension at age (Bands of £2500) £'000	Real increase in pension lump sum at age (Bands of £2500) £'000	Total accrued pension at age 60 as at 31 March 2019 (Bands of £5000) £'000	Lump sum at age related to accrued pension at 31 March 2019 (Bands of £5000) £'000	Cash equivalent transfer value at 31 March 2018 £'000	Real increase in cash equivalent transfer value £'000	Cash equivalent transfer value at 31 March 2019 £'000	Employer's contribution to stakeholder pension To nearest £100
Dr Sara Munro (Chief Executive)	0 – 2.5	0	35 - 40	80 - 85	440	101	554	0
Joanna Forster Adams (Chief Operating Officer)	2.5 – 5	0 – 2.5	40 - 45	105 - 110	694	127	841	0
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	17.5 – 20	55 – 57.5	65 - 70	205 - 210	1,008	526	1,565	0
Claire Holmes (Director of OD and Workforce)	0 – 2.5	0	0 - 5	0	0	4	8	0
Lindsay Jensen (Interim Director of Workforce Development)	12.5 – 15	42.5 – 45	40 - 45	125 - 130	0	333	997	0
Dr Claire Kenwood (Medical Director)	0 – 2.5	5 – 7.5	50 - 55	155 - 160	985	149	1,163	0
Susan Tyler (Director of Workforce Development)	0	0	50 - 55	155 - 160	1,174	0	0	0
Cathy Woffendin (Director of Nursing and Professions)	7.5 – 10	17.5 – 20	35 - 40	85 - 90	471	210	695	0

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

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

Non-executive directors do not receive pensionable remuneration and consequently there are no entries for them in this report
Susan Tyler let the Director of Workforce role on 31 May 2018
Lindsay Jensen was appointed Interim Director of Workforce from 1 June 2018 – 30 September 2018
Claire Holmes was appointed Director of OD and Workforce on 1 October 2018
Real increase figures have been allocated pro-rata for directors starting during the year
There are no directors with additional duties

Table 2.4J – Remuneration and benefits in kind for senior staff

Name and title	2017/18							2017/18						
	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000	Salary (bands of £5000) £'000	Expenses payments (taxable) (rounded to nearest £100) £'	Performance pay and bonuses (bands of £5000) £'000	Long-term performance pay and bonuses (bands of £5000) £'000	All pension related benefits (bands of £2,500) £'000	Other remuneration (bands of £5,000) £'000	Total (bands of £5000) £'000
Dr Sara Munro (Chief Executive)	150 - 155	300	0	0	25 – 27.5	0	175 – 180	145-150	300	0	0	255.5 – 257.5	0	405 - 410
Dawn Hanwell (Chief Financial Officer and Deputy CEO)	130 - 135	100	0	0	415 – 417.5	0	550 - 555	125 - 130	100	0	0	130.0 – 132.5	0	255 - 260
Joanna Forster Adams (Chief Operating Officer)	115 - 120	100	0	0	35 – 37.5	0	150 - 155	80 - 85	0	0	0	912.5 – 915.0	0	995 - 1000
Cathy Woffendin (Director of Nursing and Professions)	105 - 110	0	0	0	160 – 162.5	0	265 - 270	5 - 10	0	0	0	595.0 – 597.5	0	600 - 605
Dr Claire Kenwood (Medical Director)	150 - 155	200	0	0	22.5 - 25	0	175 - 180	135 - 140	0	0	0	1145.0– 1147.5	0	1280-1285
Lindsay Jensen (Interim Director of Workforce Development)	30 - 35	0	0	0	315 – 317.5	0	350 - 355	0	0	0	0	0	0	0
Susan Tyler (Director of Workforce Development)	15 - 20	100	0	0	0	0	15 - 20	100 - 105	100	0	0	70.0 – 72.5	0	175 - 180
Claire Holmes (Director of OD and Workforce)	45 - 50	100	0	0	0 – 2.5	0	45 - 50	0	0	0	0	0	0	0
Prof Sue Proctor (Chair of the Trust)	45 - 50	100	0	0	0	0	45- 50	45 - 50	100	0	0	0	0	45 - 50
Helen Grantham (Non-execute Director)	10 - 15	300	0	0	0	0	10 - 15	0 - 5	100	0	0	0	0	0 - 5
Andrew Marran (Non-executive Director)	0 - 5	0	0	0	0	0	0 - 5	0 - 5	100	0	0	0	0	0 - 5
Steven Wrigley-Howe (Non-executive Director)	10 - 15	600	0	0	0	0	10 - 15	10 - 15	400	0	0	0	0	10 - 15
Margaret Sentamu (Non-executive Director)	10 - 15	100	0	0	0	0	10 - 15	10 - 15	200	0	0	0	0	10 - 15
Martin Wright (Non-executive Director)	10 - 15	400	0	0	0	0	15 - 20	0	0	0	0	0	0	0
Prof John Baker (Non-executive Director)	10 - 15	300	0	0	0	0	10 - 15	10 - 15	100	0	0	0	0	10 - 15
Sue White (Non-executive Director)	10 - 15	0	0	0	0	0	10 - 15	10 - 15	0	0	0	0	0	10 - 15

Susan Tyler was Director of Workforce until 31st May 2018
Lindsay Jensen was Interim Director of Workforce between 1st June 2018 and 30th September 2018
Claire Holmes was appointed Director of Workforce from 1st October 2018

2.4.7 FAIR PAY MULTIPLE

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

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

Table 2.4K – Median remuneration

	2018/19	2017/18
Band of highest paid directors' total remuneration (£'000)	150 – 155	140 – 150
Median Salary (£)	28,050	28,746
Ratio	5.44	5.13

The banded remuneration of the highest-paid director in the Trust in the financial year was £150,847 (2017/18, £148,512). Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The ratio was 5.44 times (2017/18, 5.13 times) the median remuneration of the workforce, which was £28,050 (2017/18, £28,746). The ratio has increased partly due to the highest paid director this year being paid higher than the previous year's highest paid director and partly due to there being less lower paid staff (administrators and support workers) than last year.

In 2018/19, 3 substantive employees (2017/18, 7) received remuneration in excess of the highest-paid director. Remuneration for these employees ranged from £152,909 to £207,194 (2017/18, £148,545 to £175,384).

The median salary is calculated based on data that is generated from our payroll system. All staff that were employed by the Trust on 31 March 2019 are included in the calculation.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

2.4.8 ACCOUNTING POLICIES

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

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Remuneration Report (made up of sections 2.4.1 to 2.4.8 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed  Date: 23 May 2019

Dr Sara Munro
Chief Executive

SECTION 2.5 – ACCOUNTABILITY REPORT (Staff Report)

2.5.1 EQUALITY REPORTING

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 for our service users and staff.

Everyone who comes into contact with our organisation can expect to be treated with respect and dignity. We are committed to eliminating discrimination and to the fair treatment of everyone, taking into account all 'protected characteristics' under the Equality Act 2010. If unfair discrimination occurs it will be taken seriously and it may result in formal action being taken against individual members of staff, including disciplinary action.

We undertake an annual assessment to review equality progress across the organisation using the NHS Equality Delivery System framework and identify priority areas for action through this process. Progress is monitored through our Equality and Inclusion Group and membership includes staff, and service users to ensure there are wide ranging contributions to the development and implementation of the strategic equalities agenda.

During the last year a variety of work was undertaken including the continued delivery of Diversity and Inclusion CPD (Continuing Professional Development) events to over 300 staff, aimed at supporting cultural competence and inclusive practice. There was participation from staff within a wide variety of roles and occupational areas and included members of our flexible workforce; our bank staff and volunteers.

The work of our Rainbow Alliance Network has further developed, aimed at increasing the inclusivity of our services and processes for people who are LGBT+ (lesbian, gay, bisexual or transgender). Membership of our WREN (Workforce Race Equality Network) has increased to over 90 members of staff, which aims to strengthen access to development and support opportunities for staff from Black and Minority Ethnic communities.

We also aim to ensure that we employ and develop a 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 so we are able to deliver high quality care and services whilst giving service users the opportunity to reach their full potential.

2.5.2 DISABILITY AND EMPLOYMENT

Our recruitment and selection procedures take full account of the requirements of the Equality Act 2010 and the associated public sector equality duties. This includes giving full and fair consideration to applicants with a disability or long-term health condition. We have committed to the Mindful Employer Charter and through our annual health and wellbeing action plan we implement activities to further develop our Trust as a healthy workplace in respect of mental health. We are also a Disability Confident employer at Level 2. This demonstrates we are positive about people with disabilities and support them to successfully attain and retain employment within our Trust.

We have supportive employment practices in place not only for those that we employ who have a disability, but for those who may become disabled whilst working for us. These include a support package within the Employee Wellbeing and Managing Attendance Procedure; a process for the management of work-related stress including a stress pathway tool-kit; an Employee Assistance programme (EAP) providing counselling and other support to staff; flexible working arrangements; and a bespoke Occupational Health Service. These procedures and services support the employment and retention of disabled employees and the implementation of reasonable adjustments to take account of individual needs.

Our attendance procedures also take account of individual needs related to disability and provides for disability leave as a reasonable adjustment, to support people to remain in work. 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 in order to minimise discrimination in all aspects of employment. Diversity training is compulsory for all staff and is required to be undertaken every three years. This ensures that our workforce is aware of current legislative and organisational requirements and best practice. We have developed an annual programme of development sessions to provide our staff with the knowledge and expertise they require when working with our service users and staff from diverse communities.

2.5.3 VALUING OUR WORKFORCE

Our workforce is our most valuable asset and we recognise this by making a commitment to ensure they are well trained, well informed and are given every opportunity to contribute not only to the delivery of services but also to the development of these and other new services.

2.5.3.1 Volunteers

As a Trust we value the contributions that our volunteers make to the experience of people accessing our services. Our volunteers have a variety of skills and experiences, including volunteers with personal lived experience. This is invaluable to providing inclusive, recovery-focused activities for our service users.

Our Voluntary Services department continues to provide a high quality service across our sites; working in partnership with volunteers, staff, service users and external voluntary organisations. We have achieved the Leeds Volunteering kite mark recognition by Leeds City Council and Voluntary Action Leeds that the Trust manages a volunteering programme where volunteers receive a high quality, positive volunteering experience.

We actively support our volunteers to build on their skills and confidence and volunteering with our Trust continues to be a route into paid employment or full-time / part-time education. During the last year we developed new areas of volunteering whilst continuing to support existing schemes and their volunteers. This included the development of gardening activities within our younger people's mental health services.

We continue to maintain and raise the profile of the value of volunteers both within our Trust and the communities we serve. We are extremely grateful for all the good work undertaken by volunteers and the feedback they provide as well as the difference they make to the lives of our service users, carers and staff.

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

Staffside is the elected body of the representative trade unions in our Trust. Staffside meets at least monthly to discuss and question, on behalf of the wider union membership, any issues raised by the individual trade unions or by the Trust. This committee enables the trade unions to negotiate with one voice. The JNCC (Joint Negotiation and Consultation Committee) is the place where all issues raised at Staffside meetings are brought to the attention of management.

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

During the past year Staffside has contributed to the strategic agenda by continuing to have involvement in service redesign and management restructuring, and also in communication and engagement with staff. Staffside has:

- Actively encouraged staff to complete the annual staff survey which has resulted in an increased response rate
- Continued involvement in the development of our strategy and in workforce issues through regular dialogue with the Director of Workforce Development and senior operational managers
- Successfully worked in partnership with the Workforce Development Directorate and its managers to support staff going through significant change
- Contributed to the job evaluation process under Agenda for Change to ensure fairness and equity in pay banding
- Continued to support staff who are redeployed in order to minimise any redundancies
- Contributed to feedback and action planning for teams to improve employee relations and learn lessons
- Contributed to the review and development of employment procedures.

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

The following tables show the Trade Union facility time which is required to be reported under the Trade Union (Facility Time Publication Requirements) Regulations 2017.

Table 2.5A – Relevant union officials – The total number of employees who were relevant union officials during 2018/19

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
5	5.0

Table 2.5B – Percentage of time spent on facility time – The number of employees who were relevant union officials employed during 2018/19 and the percentage time of their working hours spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	5
51%-99%	0
100%	0

Table 2.5C – Percentage of pay bill spent on facility time during 2018/19

Total cost of facility time	£36,565
Total pay bill	£113,684k
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.032%

Table 2.5D – Paid trade union activities during 2018/19

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100	4.91%

2.5.4 STAFF ENGAGEMENT

Engaging with staff and their representatives, to ensure they have the opportunity to share their views and receive regular information on decisions that may affect their interests is aligned with our Trust's value of Integrity. The aim is to be open about actions taken and decisions made, to work as transparently as possible.

In 2018 we continued with our Your Voice Counts campaign to engage with staff via a series of staff engagement events throughout the summer. These involved the Senior Leadership Team visiting sites across the Trust for a series of events to discuss the Trust's priorities with staff and consider how we can work together Trust-wide to deliver these.

A key element of our internal communications in 2018/19 has been improving our staff intranet, Staffnet. Examples include:

- Significant work to improve important content (such as recruitment, IT, Quality resources, NICE guidance etc.) as well as reducing unnecessary and old content
- Regular internal blogs and briefings from senior leaders on matters of significant importance e.g. the Bricks and Mortar blog series on estates changes
- Training and development of our super-user network to enable and empower subject matter experts to take control of their own information i.e. policies and procedures library
- Regular reporting which has shown a steady increase in the usage and engagement of the intranet
- Approval of a business case to secure investment and development for the next two years.

A series of regular blogs and briefings from the Chief Executive and Chair have been used to target staff and wider stakeholders on front-line staff engagement, the business of the Board of Directors, projects, wider system developments and celebrating success. These are shared internally via our twice weekly e-bulletin and externally via the website and social media channels, on which our staff are highly active.

The Communications Team supported work in respect of staff health and wellbeing. Examples include:

- Flu vaccine campaign, which had a record uptake in 2018
- Staff health and wellbeing roadshows
- Launch of the financial support scheme Neyber.

A key staff engagement focus during 2018/19 has been the on-going redesign of our Community Services, which culminated in the launch of the redesigned services on 25 March 2019. Holding a comprehensive series of engagement, listening and feedback events have been essential over the last 12 months to ensure that staff have been kept up to date with regards to the progress of the project; providing them with regular opportunities to input into the formation of the plans.

As part of the engagement process for the Community Redesign we ran an extended Your Voice Counts campaign using our online crowdsourcing platform alongside a series of face-to-face engagement events open to all staff at our Trust. In total we received 2574 contributions from these

conversations, which have provided us with a real opportunity to engage in a dialogue with our staff and hear their ideas and feedback.

We have also produced a series of blog updates around the Community Redesign from a number of different perspectives such as staffing, estate changes, and from our CEO. In early 2019 we ran a series of 'Show and Tell' Workshops to which all affected community based staff where invited; this provided them with the opportunity to receive and discuss more detailed information about the day-to-day activities of our proposed new service prior to its launch.

2.5.5 OUR STAFF SURVEY

Staff engagement is fundamental to the successful implementation of our strategic objectives and continues to be a key component of the Trust's organisational development approach. .

We conduct the national NHS Staff Survey annually and throughout the year conduct Staff Friends and Family Tests which provide us with valuable feedback from staff on a variety of key areas across the Trust.

This year we have taken an even more transparent approach to our Staff Survey and, for the first time, made our results available in their entirety to everyone across the Trust. We have broken down the results by directorate, service, care group and team, allowing staff to see the fullest picture possible at both local and Trust level.

2.5.5.1 Results from the NHS staff survey 2017

The NHS staff survey is conducted annually and in 2018 we continued to adopt a full census approach to the survey.

The response rate to the 2018 survey among trust staff was 58.1% (2017: 56.3%).

Table 2.5E – Staff survey response rate

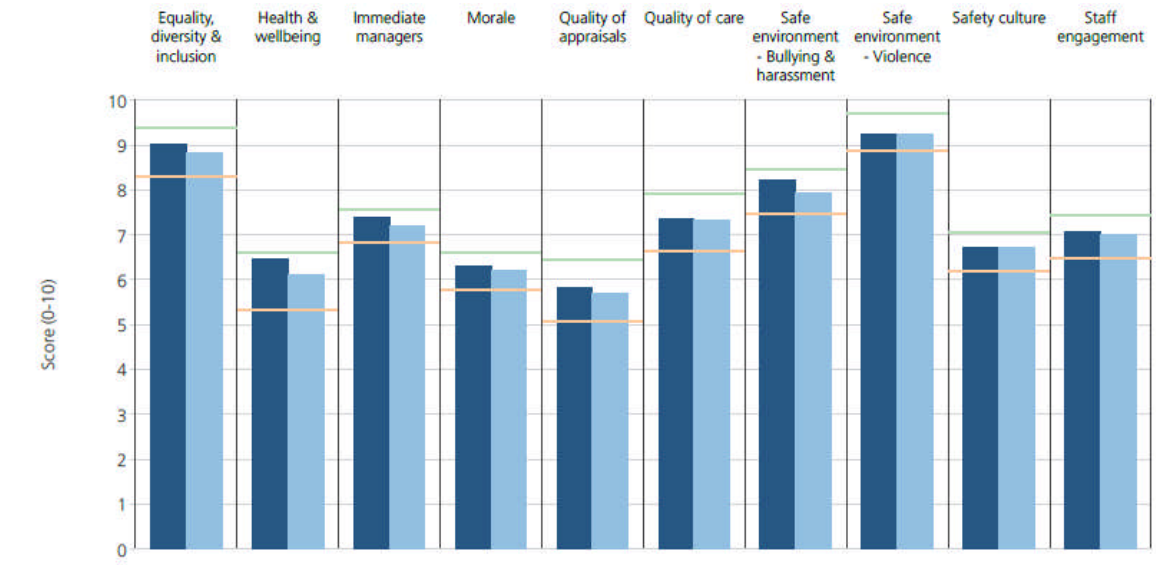
2018 Survey		2017 Survey		
Trust	National average	Trust	National average	Trust movement 2017-2018
58.1%	54%	56.3%	52%	+1.8%

This year we transitioned more staff to completing the survey via the online method (approx. 72% in 2018, up from 55% in 2017). Of the responses, 409 were paper copies and 1006 submitted online. This equates to approximately 58% of the 689 paper copies being completed. Paper surveys continued to be provided to those teams where accessing the online survey would present a barrier to them participating.

We also maintained the approach taken in previous years to increase participation, which included a collation of dedicated staff, managers and Staffside representatives, who came together to steer delivery of the survey and encourage participation by staff at a local level. This year's response rate increased to 58.1% and is 4.1% above the national average for all mental health and learning disability trusts in England.

From 2018 onwards, the results from questions are grouped to give scores in ten themes (indicators). The 2018 results show significant improvements in three of the ten key themes compared to the 2017 scores (which showed two significant improvements from 32 Key Findings), including the Quality of Appraisals, Safety Culture and Staff Engagement. Graph 2.5B shows the Trust's scores for each of the ten key themes benchmarked against our comparison group:

Table 2.5F – Theme scores against benchmark group



	Equality, diversity & inclusion	Health & wellbeing	Immediate managers	Morale	Quality of appraisals	Quality of care	Safe environment - Bullying & harassment	Safe environment - Violence	Safety culture	Staff engagement
Best	9.4	6.6	7.5	6.6	6.4	7.9	8.4	9.7	7.0	7.4
Your org	9.0	6.4	7.4	6.3	5.8	7.3	8.2	9.2	6.7	7.1
Average	8.8	6.1	7.2	6.2	5.7	7.3	7.9	9.3	6.7	7.0
Worst	8.3	5.3	6.8	5.8	5.1	6.6	7.5	8.9	6.2	6.5

We are therefore performing better than the national average for mental health and learning disability trusts in England across seven of the ten Key Themes, with two of the remaining three themes being equal to the benchmark group average. The theme where we were below the benchmark average was Safe Environment – Violence. Our score of 9.2 was 0.1 less than the 9.3 average.

Table 2.5C shows that all but one of the ten Key Theme scores have remained static or improved for 2018 compared to 2017. The remaining theme is Equality, Diversity and Inclusion which has declined by 0.1 to 9.0 for 2018, but is still above the sector average of 8.8.

Table 2.5G – Theme scores over last two years

	2018 Survey		2017 Survey	
Theme	Trust	Benchmark	Trust	Benchmark
Equality, Diversity and Inclusion	9.0	8.8	9.1	9.0
Health & Wellbeing	6.4	6.1	6.4	6.2
Immediate Managers	7.4	7.2	7.3	7.2
Morale	6.4	6.2	New theme for 2018	
Quality of Appraisals	5.8	5.7	5.4	5.5
Quality of Care	7.3	7.3	7.2	7.3
Safe Environment - Bullying and Harassment	8.2	7.9	8.2	8.0
Safe Environment - Violence	9.2	9.3	9.1	9.2
Safety Culture	6.7	6.7	6.5	6.7
Staff Engagement	7.1	7.0	6.9	7.0

Following the results of the survey in 2017 we commenced specific programmes of work to address some of the key themes and areas for improvement, and the 2018 results show that staff are reporting improvements in these areas. Some of the ways in which we have addressed staff concerns are set out below.

- We have increased our focus on appraisals, both from a quality and compliance perspective, to ensure staff are receiving their appraisal on time but also that the appraisal taking place is of value. Appraisal guidance is readily available and training sessions take place across the Trust so staff feel confident in using our iLearn online system to record their appraisal and help keep our compliance statistics up to date. These initiatives have seen the scores for all questions in the 'Quality of Appraisals' theme increase. Work is currently underway to refresh the Trust's Appraisal and Performance Review Policy and a framework to develop and monitor the quality of appraisals will be included in this refresh.

- We took steps to address bullying and harassment within the Trust. The policy and procedures around bullying and harassment were reviewed and we also commissioned ACAS, who are independent and impartial, to coordinate a series of focus groups and talk to staff about their experiences. ACAS reported back the key themes, these were discussed by the Senior Leadership Team and future plans include the creation of a Culture Club which is to be led by our Chief Executive and will work with staff on initiatives to change and improve the culture of the Trust.

- We continue to focus on health and wellbeing as a Trust. Following their success in 2017, we ran a series of Health and Wellbeing Roadshows again in 2018 which allowed us to engage with staff across the Trust and share the resources available to help promote their health and wellbeing. We have also launched a Workplace Wellbeing Scheme which is designed to promote positive health and wellbeing in the workplace through peer support and signposting. The scheme is facilitated by a team of 'Workplace Wellbeing Advisers', who are trained staff volunteers with a passion for promoting a positive and inclusive culture.

The tables below show a comparison between our scores and that of the sector average; specifically the top five and bottom five differences in scores. The questions in italics indicate where a lower percentage score is more favourable and therefore a negative percentage difference for these questions is also more favourable.

Table 2.5H – Top five ranking scores

	Trust Score 2017	Trust Score 2018	National Average* 2018	Positive difference against national average*
On average, how many additional UNPAID hours do you work per week for this organisation, over and above your contracted hours?	**55%**	**54%**	**63%**	**-9%**
Does your organisation take positive action on health and well-being?	**34%**	**36%**	**29%**	**+7%**
I have adequate materials, supplies and equipment to do my work.	**63%**	**65%**	**58%**	**+7%**
My manager supported me to receive this training, learning or development.	**63%**	**67%**	**60%**	**+7%**
In the last three months have you ever come to work despite not feeling well enough to perform your duties?	**53%**	**51%**	**57%**	**-6%**

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

Table 2.5l – Bottom five ranking scores

	Trust Score 2017	Trust Score 2018	National Average* 2018	Negative difference against national average*
I receive regular updates on patient / service user experience feedback in my directorate / department (e.g. via line managers or communications teams).	51%	51%	60%	-9%
Is patient / service user experience feedback collected within your directorate / department? (e.g. Friends and Family Test, patient surveys etc.)	86%	86%	94%	-8%
I have unrealistic time pressures.	N/A	29%	23%	+6%
Time passes quickly when I am working.	74%	72%	78%	-5%
On average, how many additional PAID hours do you work per week for this organisation, over and above your contracted hours?	30%	30%	25%	+5%

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

2.5.5.2 Addressing areas of concern

An analysis of our Staff Survey results provides us with a basis for determining the main areas to focus on when developing our key areas for action in 2019. The Trust will continue to use the *Your Voice Counts* Crowdsourcing platform, as well as face-to-face listening events to engage with staff on strategic issues from the national staff survey key findings.

As with previous years, teams are in the process of creating their own local action plans based on their team level results.

2.5.5.3 Future priorities and targets

In 2019 we will be working with teams on local action planning to focus on local priorities arising from the staff survey. In early March 2019, teams were provided with their local level data and local action planning has commenced and will be reported back centrally before the end of April 2019.

Monitoring of local action planning will be via our Workforce and Organisational Development Group.

2.5.6 HOW WE INVOLVE OUR STAFF IN UNDERSTANDING PERFORMANCE

Our performance information is shared with our Council of Governors and performance dashboards have been created at team, service and care group level, in order that we can share performance information with our staff.

2.5.6.1 Financial Performance

Financial plans are set in the context of an annual planning process. We are required to complete an Operational Plan, produced in the context of our overarching strategy. Key assumptions to be used

are discussed by the Executive Management Team and the Board of Directors to ensure there is an understanding of the key assumptions being made and the impact on our use of resources rating.

Finance managers are integrated within the Care Groups, 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 within the Combined Quality and Performance Report. The performance report highlights financial performance against plan; any significant variances; how these have occurred; and what action is required, if any. The Council of Governors receives a report on performance (including financial performance) which allows the Council to hold the non-executive directors to account for the performance of the Board and to understand how they have challenged the executive directors in respect of any areas of poor performance or risks to performance.

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.

2.5.6.2 Contractual and regulatory performance

There has been a great deal of work again this year to further develop existing and create new dashboards for service managers to access. These dashboards provide the Key Performance Indicator (KPI) data that services need in order to better manage the performance of their services. The bi-monthly Quality, Delivery and Performance Meetings with each service line also give the opportunity for a range of staff in each area (including service managers and clinical leads) to discuss performance across a range of topics including improved service delivery and quality improvement plans.

Overall performance against our contracts is monitored by the Finance and Performance Committee and it has been assured of performance against contracts and any risks that have been identified.

We have reinstated a series of Quality Reviews, whereby staff visit services and assess them using the Key Lines of Enquiry template used by the CQC. The emphasis is on highlighting good practice and high quality care as well as recognising areas for improvement. As part of the reviews, ongoing progress and compliance against the CQC standards for that specific area is also reviewed.

The main aim of this approach is to engage all staff in the quality agenda and build up a body of knowledge through the organisation on what good quality looks like. The visiting team will be clinicians from other teams supported by staff from corporate services such as safeguarding, mental health act legislation and medicines management.

2.5.7 MENTAL HEALTH ACT MANAGERS

Mental Health Act Managers (MHAMs) are members of the public, appointed by the Board of Directors, together with a number of non-executive directors who act in this role. Their key responsibilities are to:

- Review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO)
- Discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

The Board of Directors has established a Mental Health Legislation Committee as a sub-committee of the Board. During 2018/19 this committee was chaired by a non-executive director. It provides a mechanism for assurance on the robustness of arrangements in place for the Trust to meet its duties in respect of the Mental Health Act 1983. Providing information to the committee is the Mental Health

Act Managers' Forum. This seeks to provide a forum for communication between the Mental Health Act Managers and officers of the Trust. The forum is also chaired by a non-executive director to ensure a direct link to the Board of Directors in accordance with the Mental Health Act Code of Practice and has as its deputy chair one of the MHAMs.

The recruitment of further MHAMs continued during 2018/19 and ten new MHAMs were appointed. Regular recruitment ensures diversity is addressed within the group and that the organisation retains sufficient panel members to review detentions and CTOs, in accordance with the Trust's own standard.

We are committed to ensuring that our MHAMs are appropriately trained for their role and that all new managers attend a one-day induction, followed by a period of observation with support from experienced MHAMs. On-going training is provided at forum meetings and during 2018/19 the MHAMs Forum identified a need to focus on training around recording reasons for decisions, the training was positively received. A joint training session with clinicians was held in September 2018. This was positively received by those in attendance and there are plans to run this session on an annual basis.

In 2018/19 there were 65 appeal hearings, of which 53 were heard within our standard of 10 days. The MHAMs reviewed 301 renewals / extensions of detention and CTOs. A total of 11 nearest relative barring orders were heard. The Mental Health Legislation Committee monitors hearing data at its quarterly meetings and seeks assurance as to how processes can be made more effective.

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

We currently have 44 acting Mental Health Act Managers and the table below shows those people who have acted in this capacity during 2018/19.

Table 2.5J – Mental Health Act Managers during 2018/19

Mental Health Act Managers during the period 1 April 2018 to 31 March 2019		
Bernadette Addyman	Nasar Ali	Janis Bottomley
Marilyn Bryan	Deborah Byatt	Rebecca Casson
Aqila Choudhry	Judith Devine	John Devine
Michael Hartlebury	Ian Hughes	Mohammed Hussain
Lorna James	Peter Jones	Trevor Jones
Andrea Kirkbride	Harold Kolwole	Nicolle Levine
Andrew Marran	Graham Martin	David Mayes
Claire Morris	Susan Mosley	Gillian Nelson
Lynsey Nicholson	John O'Hara	Harold Oluwaseun
Ismail Patel	Debra Pearlman	Shamailia Qureshi
Andrea Robinson	Alex Sangster	Sarah Smith
Susan Smith	Elisabeth Sunley	Niccola Swan
Jennifer Taylor	Jeffery Tee	Claire Turvill
Viv Uttley	Thomas White	Janice Wilson
Michael Yates	Paul Yeomans	Keith Woodhouse*
* retried during 2018/19		
Non-executive directors also acting as Mental Health Act Managers during 2018/19 Margaret Sentamu Andrew Marran (in his capacity of a non-executive director with effect from 17 February 2019)		

2.5.8 SICKNESS ABSENCE

At the end of March 2019 our absence rate increased to 4.88% from a position of 4.77% as at 31 March 2018. Whilst our overall absence is consistently lower for each corresponding period than the previous year, it is evident that between November 2018 and March 2019 a 5 month consecutive increase in sickness is being reported.

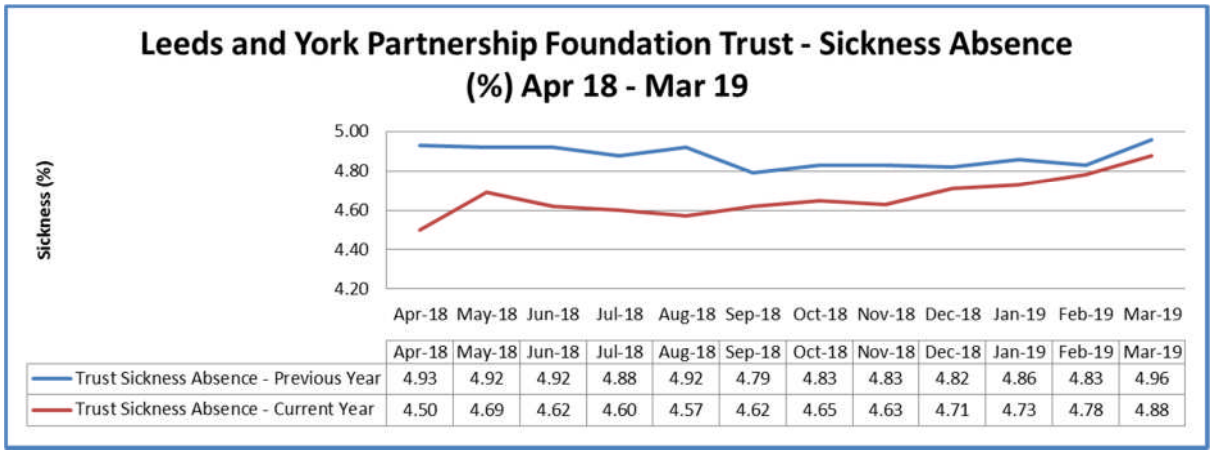
During this period a significant redesign of our community services has taken place and it is not surprising to see that the community services are registering as having the highest number of sickness episodes due to stress related illness over the financial year.

The latest figures available from the NHS Digital show that staff sickness absence between July 2018 and September 2018 for mental and learning disability services was 4.72% and for the NHS in England was 4.08%.

Our top reasons for sickness absence continue to be mental health related absences and muscular-skeletal (MSK) related absence. There are similar national trends in these areas and this is where we are focusing our efforts to support staff and improve attendance.

The tables below show our sickness absence rate during 2018/19 and also present some statistics around the number of days lost due to sickness absence.

Table 2.5K – Sickness absence (percentage for 2018/19)



	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
Trust Sickness Absence - Previous Year	4.93	4.92	4.92	4.88	4.92	4.79	4.83	4.83	4.82	4.86	4.83	4.96
Trust Sickness Absence - Current Year	4.50	4.69	4.62	4.60	4.57	4.62	4.65	4.63	4.71	4.73	4.78	4.88

Table 2.5L – Number of days lost during 2018/19

Table 2.5J – Sickness absence as reported in the FTCs	2018 (calendar year) Number
Total days lost	24,418
Total staff years	2,286
Average days lost	11

To improve efficiency we have changed our system for reporting, recording and managing absence, ending our contract with our provider FirstCare, with all absence management now conducted internally using the Health Roster system. We continue to have fast-track access to Occupational Health Services and consistent return to work and reporting processes.

We continue to provide a 24/7 Employee Assistance Programme to support staff both from a work and personal perspective which includes counselling support. All staff members can access Personal Resilience Workshops looking at skills, strategies and insights that help their resilience develop. Our stress pathway online toolkit is available as a useful source of information and support for staff and Managers. We also have a dedicated Well-being Practitioner supporting staff and managers to prevent and manage work-related stress.

Our physiotherapy service is well established and we are seeing a decrease in MSK absences. We have physiotherapy clinics and continue to provide education and advice to prevent injury / absence where possible. We offer a telemedicine model to triage symptoms and offer first-line advice and support. We offer physical health checks for blood pressure, blood sugar, cholesterol, and body composition along with a lifestyle questionnaire with advice being offered and onward referral to GPs where appropriate. We run well-being events across the Trust where we promote our wellbeing services and these are well received by staff. We also deliver an annual physical health challenge. There has been an increase each year, in the number of staff who have responded positively regarding the organisation taking positive action on health and welling.

We have launched a new Workplace Wellbeing Adviser Scheme this year with a team of staff volunteers who have a passion for promoting a positive and inclusive culture. Their role is to promote positive health and wellbeing in the workplace through peer support, signposting and helping staff if they are experiencing any difficulties at work.

We have introduced Neyber as a provider of employee financial well-being solutions. Neyber offers flexible options of loans with repayments directly from salary and access to an educational site and helpline. This scheme was supported in response to the evidence-based links between mental health and financial wellbeing.

Our strategic approach to health and wellbeing is led by the Trust's Health and Wellbeing Group which implements and monitors the Health and Wellbeing Action Plan. Our Action Plan for 2019/20 will continue to embed our services, will have a focus on prevention and early intervention and will set out our staff mental health and wellbeing plan in line with the Thriving at Work (2017) report recommendations. We are working collaboratively with other partners on mental health first aid training and promote national campaigns such as smoking cessation, Dry January, World Mental Health Day, National Stress Awareness Day, Work Out at Work Day, Back Care Awareness Week and the seasonal flu campaign. We continue to engage with staff to evaluate and influence Trust-wide initiatives through local Health and Wellbeing Forums which provide a voice from the frontline.

2.5.9 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. The team now provides an overall occupational health service for 13,000 employees in the region and continues to operate service level agreements for external contracts.

During 2018/19 the main achievements include:

- Integration of the Bradford District Care Trust contract
- Introduction of on line modules for work health assessments and management referrals
- Continuation of fast track appointments for work related stress and MSK issues
- Stress prevention workshop developed.

2.5.10 HEALTH AND SAFETY

In October 2018 the Trust had a Health and Safety Executive (HSE) inspection. The HSE inspection was targeted at two specific occupational issues, musculoskeletal disorders (MSKs) and violence and aggression. The inspection did not find any material breaches, but did prompt the Trust to commission an external review of the overall health and safety management arrangements.

The HSE inspection generated an action plan related to the 26 contraventions that were identified. The action plan has been reviewed by the Executive Risk Management Group to confirm director level engagement and ownership and was been returned to the HSE at the end of March. We have been notified that the HSE will return to the Trust in autumn 2019 to review progress.

The Trust also commissioned an external review of the governance arrangements for Health and Safety. This highlighted the need to design a Safety Management System which is owned at Board level and embedded across the organisation. Arrangements have been put in place to address the key findings from the external review.

2.5.11 COUNTER-FRAUD

During 2018/19 the Local Counter Fraud Specialist Service (LCFS) was provided by NHS Audit Yorkshire. Audit Yorkshire specialises in all aspects of internal audit and counter fraud work, primarily across the NHS but also the public, corporate and not for profit sectors. Audit Yorkshire has a team of accredited and experienced LCFS personnel.

Our LCFS has conducted work across all areas of counter-fraud activity, placing emphasis on the continued development of fraud awareness within the Trust and the prevention of fraud. The LCFS regularly attends the 'Trust Welcome Event' to meet with staff to raise fraud awareness and to advise them on how to report fraud. Furthermore they have delivered presentations with selected groups of staff, particular with departments where the risk of fraud is greater. The LCFS has continued to be proactive in their work and has liaised with staff regarding potential fraud risks and has provided advice accordingly.

They regularly attend the Employment Procedures Group and has provided advice from a counter fraud perspective on policies and procedures where necessary.

They have liaised with the NHS Counter Fraud Authority and disseminated all relevant prevention guidance, intelligence bulletins and alerts issued by them, following any relevant instructions provided.

During 2018/19 the LCFS has received allegations regarding possible fraudulent behaviour and has investigated the matters accordingly whilst working in conjunction with the relevant departments throughout the Trust where appropriate. As a result of the investigations the LCFS undertook, no criminal action was taken in any of the reported matters.

2.5.12 AVERAGE STAFF NUMBERS

Table 2.5M – Average staff numbers for 2018/19

Average number of employees (Whole Time Equivalent basis)	Permanent (Number)	Other (Number)	Total Number (2018/19)	Total Number (2017/18)
Medical and dental	182	11	193	195
Administration and estates	573	53	626	610
Healthcare assistants and other support staff	565	247	812	786
Nursing, midwifery and health visiting staff	695	43	738	736
Scientific, therapeutic and technical staff	322	5	327	307
Social care staff	6	0	6	1
Total average numbers	**2,343**	**359**	**2,702**	**2,634**
Of which: Number of employees (WTE) engaged on capital projects	0	0	0	0

2.5.13 GENDER PROFILE OF OUR TRUST

Table 2.5N – Gender profile

Group	Number male	Number female
Directors	3	10
Senior managers (Band 8 and above)	85	160
Employees	774	2002

Information in section 2.5.15 is subject to audit by our external auditors, KPMG LLP.

2.5.14 ANALYSIS OF STAFF COSTS

Table 2.5O – Analysis of staff costs for 2018/19

Average number of employees (Whole Time Equivalent basis)	Permanent (£000)	Other (£000)	Total £000 (2017/18)	Total £000 (2016/17)
Salaries and wages	76,446	9,994	89,440	84,993
Social security costs	8,578	0	8,578	8,265
Employer's contributions to NHS pensions	11,069	0	11,069	10,535
Temporary staff	0	5,138	5,138	4,470
Total gross staff costs	**99,093**	**15,132**	**114,225**	**108,263**
Recoveries in respect of seconded staff	0	0	(563)	(523)
Of which: Costs capitalised as part of assets	0	0	(194)	0
Total staff costs	**99,093**	**15,132**	**113,468**	**107,740**

2.5.15 OFF-PAYROLL ENGAGEMENTS

The Trust's policy in relation to off-payroll engagements is as follows:

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

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

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

In all circumstances appropriate contracts and/or framework agreements should be in place between the Trust and either the individual, agency or personal service company. All contracts and/or framework

agreements should include a clause giving the Trust the right to seek assurance in relation to income tax and national insurance.

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

The following table sets out all off-payroll engagements as at 31 March 2019 where the individual is paid more than £245 per day and where the engagement lasts for longer than six months.

Table 2.5P

Number of existing engagements as of 31 March 2019	14
Of which:	
The number that have existed for less than one year at the time of reporting	9
The number that have existed for between two and three years at time of reporting.	5

The following table relates to all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, where the individual was paid more than £245 per day and where the engagement lasted for longer than six months.

Table 2.5Q

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	9
Number assessed as within the scope of IR35	7
Number assessed as not within the scope of IR35	2
Of which:	
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

All of the above were sourced through employment agencies. Those identified as not within the scope of IR35 are not operating through a PSC and are on the agency payroll. Those operating through a PSC have been identified and confirmation sought that these engagements are compliant with the legislation.

The following table shows any off-payroll engagements of Board members and/or senior officials with significant financial responsibility between 1 April 2018 and 31 March 2019.

Table 2.5R

No. of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year	0
No. of individuals that have been deemed "board members and/or senior officials with significant financial responsibility" during the financial year. This figure should include both off-payroll and on-payroll engagements.	16

2.5.16 STAFF EXIT PACKAGES

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

Exit packages for Board members are included above with further detail in the Directors' Remuneration Report. There were no exit packages relating to Board members in 2018/19 (0 in 2017/18).

Table 2.5S

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Less than £10,000	0 (0)	4 (3)	4 (3)
£10,001 - £25,000	0 (2)	2 (4)	2 (6)
£25,001 - £50,000	1 (4)	0 (4)	1 (8)
£50,001 - £100,000	0 (2)	0 (0)	0 (2)
£100,001 - £150,000	0 (1)	0 (0)	0 (1)
£150,001 - £200,000	0 (0)	0 (0)	0 (0)
Greater then £200,000	0 (0)	0 (0)	0 (0)
Total number of exit packages by type	**1 (9)**	**6 (13)**	**7 (22)**
Total resource cost (£000)	**27 (449)**	**52 (332)**	**79 (781)**
Note: Figures in brackets relate to 2017/18			

2.5.17 NON-COMPULSORY / OTHER DEPARTURES AGREED

Table 2.5T

	Agreements (Number)	Total value of agreements (£000)
Voluntary redundancies including early retirement contractual costs	0 (0)	
Mutually agreed resignations (MARS) contractual costs	1 (9)	18 (296)
Early retirements in the efficiency of the service - contractual costs	0 (0)	
Contractual payments in lieu of notice	5 (4)	34 (36)
Exit payments following Employment Tribunals or court orders	0 (0)	
Non-contractual payments requiring HMT approval	0 (0)	0 (0(
Total	**6 (13)**	**52 (332)**
Of which: Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0 (0)	0 (0)
Figures in brackets relate to 2017/18		

As a single exit package can be made up of several components, each of which will be counted separately in this note, the total number above may not necessarily match the total numbers in Table 2.5S (staff exit packages), which will be the number of individuals.

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

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

2.5.18 EXPENDITURE ON CONSULTANCY

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

SECTION 2.6 – ACCOUNTABILITY REPORT (Disclosures required in the Annual Report)

2.6.1 COMPLIANCE WITH THE CODE OF GOVERNANCE

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

2.6.1.1 Comply or explain

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

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

Table 2.6A – Areas of non-compliance or limited compliance with the provisions of the Code of Governance

Code provision	Requirement	Explanation
D.2.2	The Remuneration Committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management.	The Remuneration Committee sets the pay for executive directors both at the point of advertising for a vacancy and then periodically if required to do so. The Remuneration Committee has also agreed that the pension rights for executive directors are determined by the NHS pension scheme not by itself.

2.6.2 DISCLOSURE STATEMENTS TO BE MADE IN THE ANNUAL REPORT

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

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

Table 2.6B – How we have complied with the disclosures we are required to report on in the Annual Report

Code provision	Requirement	Section in Annual Report / explanatory statement
A.1.1	The schedule of matters reserved for the Board of Directors should include a clear statement detailing the roles and responsibilities of the Council of Governors. This statement should also describe how any disagreements between the Council of Governors and the Board of Directors will be resolved. The Annual Report should include this schedule of matters or a summary statement of how the Board of Directors and the Council of Governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the Board of Directors.	• Section 3.1 (Board of Directors) • Section 4.4 (Council of Governors)
A.1.2	The Annual Report should identify the: • Chairperson and the deputy chairperson (where there is one) • Chief Executive • Senior Independent Director • Chairperson and members of the Nominations Committee and the number of meetings and attendance by directors • Chairperson and members of the Audit Committee and the number of the meeting and attendance by directors • Chairperson and members of the Remuneration Committee and the number of the meeting and attendance by directors • Number of meetings of the Board and individual attendance by directors.	• Section 2.1.1 • Section 2.1.1 • Section 2.1.1 • Section 2.4.4.4 • Section 3.6 • Section 2.4.4.2 • Section 3.4
A.5.3	The Annual Report should identify: • The members of the Council of Governors • A description of the constituency or organisation that governors represent, whether they were elected or appointed, and the duration of their appointments • The nominated lead governor.	• Tables 4B and 4C in Section 4.1 • Table 4B and 4C in Section 4.1 • Section 4.1
Annual Reporting Manual additional disclosure	The Annual Report should include a statement about the number of meetings of the Council of Governors and individual attendance by governors and directors.	• Table 4G in Section 4.3 and table 4H in Section 4.5
B.1.1	The Board of Directors should identify in the Annual Report each non-executive director it considers to be independent, with reasons if necessary.	• Section 2.1.1
B.1.4	The Board of Directors should include in its Annual Report a description of each director's skills, expertise and experience. Alongside this, in the Annual Report, the Board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	• Section 3.3 • Section 2.1.1
Annual Reporting Manual additional disclosure	The Annual Report should include a brief description of the length of appointments of the non-executive directors, and how they might be terminated.	• Section 2.1.1
B.2.8	The Annual Report should describe the process followed by the Council of Governors in relation to appointments of the chairperson and non-executive directors.	• Section.2.4.4.3

Code provision	Requirement	Section in Annual Report / explanatory statement
B.2.10	A separate section of the Annual Report should describe the work of the Nominations Committee(s), including the process it has used in relation to Board appointments.	• Section 2.4.4.3 (Appointments and Remuneration Committee) • Section 2.4.4.4 (Nominations Committee)
Annual Reporting Manual additional disclosure	The disclosure on the work of the Nominations Committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of the chair or non-executive director.	Not applicable, open advertising and external search companies are used in new NED recruitment campaign.
B.3.1	A chairperson's other significant commitments should be disclosed to the Council of Governors before appointment and included in the Annual Report. Changes to such commitments should be reported to the Council of Governors as they arise, and included in the next Annual Report.	• Section 2.1.1 and 3.3
B.5.6	Governors should canvass the opinion of the Trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the Board of Directors. The Annual Report should contain a statement as to how this requirement has been undertaken and satisfied.	• Section 1.1.5.1
Annual Reporting Manual additional disclosure	If during the financial year the governors have exercised their power under paragraph 10c of Schedule 7 of the NHS Act 2006 then information on this must be included in the Annual Report (power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance).	This power has not been exercised during the course of the financial year
B.6.1	The Board of Directors should state in the Annual Report how performance evaluation of the • Board • Board committees • Directors including the chairperson, has been conducted.	• Section 2.4.3.2 • Section 3.5.2 • Section 2.4.3.2
B.6.2	Where there has been external evaluation of the board and or governance of the Trust, the external facilitator should be identified in the Annual Report and a statement made as to whether they have any other connection to the trust.	• Section 2.1.8
C.1.1	The directors should explain in the Annual Report their responsibility for preparing the Annual Report and accounts, and state that they consider the Annual Report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	• Section 2.1
C.1.1	Directors should also explain their approach to quality governance in the Annual Governance Statement (within the Annual Report).	• Section 2.9

Code provision	Requirement	Section in Annual Report / explanatory statement
C.2.1	The Annual Report should contain a statement that the Board has conducted a review of the effectiveness of its system of internal controls.	• Section 2.9 (Annual Governance Statement)
C.2.2	The trust should disclose in the Annual Report if it has an internal audit function, how the function is structured and what role it performs.	• Section 6.2
C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, re-appointment or removal of an external auditor, the Board of Directors should include in the Annual Report a statement from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable there was no appointment of the auditors made during 2018/19
C.3.9	A separate section of the Annual Report should describe the work of the Audit Committee in discharging its responsibilities. The report should include: • The significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed • An explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted • If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	• Section 3.6
D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the Annual Report should include a statement of whether or not the director will retain such earnings.	Not applicable
E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the Annual Report.	• For governors, section 5.5 • For directors section 3.3
E.1.5	The Board of Directors should state in the Annual Report the steps they have taken to ensure that the members of the Board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the Council of Governors, direct face-to-face contact, surveys of members' opinions and consultations.	• Section 4.5
E.1.6	The Board of Directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the Annual Report.	• Sections 5.3 and 5.4

Code provision	Requirement	Section in Annual Report / explanatory statement
Annual Reporting Manual additional disclosure	The Annual Report should include: • A brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • Information on the number of members and the number of members in each constituency • A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	• Section 5.1 • Section 5.2 • Section 5.3 and 5.4
Annual Reporting Manual additional disclosure	The Annual Report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the Annual Report to simply state how members of the public can gain access to the registers instead of listing all the interests in the Annual Report.	• Governors = Section 4.7 • Directors = Section 2.1.2

2.6.3 DISCLOSURES AS PER SCHEDULE 7 OF THE LARGE AND MEDIUM SIZED COMPANIES AND GROUPS REGULATIONS 2008

This section sets out those disclosures required as per Schedule 7 of the Large and Medium Sized Companies and Groups Regulations 2008 and where these have been reported.

Table 2.6C – Disclosures and where they are reported in the Annual Report

Disclosure requirement	Statutory reference	Section in which reported
Any important events since the end of the financial year affecting the NHS foundation trust	7(1) (a) Schedule 7	Not applicable
An indication of likely future developments	7(1) (b) Schedule 7	• Section 2.2.1
An indication of any significant activities in the field of research and development	7(1) (c) Schedule 7	• See the Quality Report
An indication of the existence of branches outside the UK	7(1) (d) Schedule 7	Not applicable, no disclosure required
Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities	10(3) (a) Schedule 7	• Section 2.5.2
Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period	10(3) (b) Schedule 7	• Section 2.5.2
Policies applied during the financial year for the training career development and promotion of disabled employees	10(3) (c) Schedule 7	• Section 2.5.2
Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees	11(3) (a) Schedule 7	• Section 2.5.4 • Section 2.5.6

Disclosure requirement	Statutory reference	Section in which reported
Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests	11(3) (b) Schedule 7	• Section 2.5.4
Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance	11(3) (c) Schedule 7	• Section 2.5.4 and 2.5.6
Actions taken in the financial year to achieve a common awareness on the part of all employees of the financial and economic factors affecting the performance of the NHS foundation trust	11(3) (d) Schedule 7	• Section 2.5.6
In relation to the use of financial instruments, an indication of the financial risk management objectives and policies of the NHS foundation trust and the exposure of the entity to price risk, credit risk, liquidity risk and cash-flow risk, unless such information is not material for the assessment of the assets, liabilities, financial position and results of the entity	6 Schedule 7	• Section 1.2.2

2.6.4 OTHER DISCLOSURES AS REQUIRED BY THE NHS FOUNDATION TRUST ANNUAL REPORTING MANUAL 2018/19 AS DETERMINED BY NHS IMPROVEMENT

The Annual Reporting Manual for 2018/19 requires a number of disclosures to be made in the Annual Report and to state where these have been reported on. The following table sets out where these disclosures have been made.

Table 2.6D – Disclosures and where they are reported in the Annual Report

Disclosure requirement	Section in which reported
Any new or significantly revised services	• Section 2.2.1
Service improvements following staff or patient surveys	• Section 2.2.2.1 (for service users) • Section 2.5.5.1 (for staff)
Improvements in patient / carer information	• Section 2.2.2.1
Information on complaints	• Section 2.2.2.2
Descriptions of significant partnerships and alliances entered into by the NHS foundation trust to facilitate the delivery of improved healthcare	• Section 2.3.1
Development of services involving other local services/agencies and involvement in local initiatives	• Section 2.3.1 and 2.3.2

SECTION 2.7 – ACCOUNTABILITY REPORT (NHS Improvement Single Oversight Framework)

2.7.1 OUR PERFORMANCE

The following tables show our regulatory performance as reported to NHS Improvement for 2018/19.

Table 2.7A – Regulatory performance

Target / Measure	At Q1 2018/19	At Q2 2018/19	At Q3 2018/19	At Q4 2018/19
Finance and Use of Resources score	1	1	1	1
Governance	Green	Green	Green	Green
SOF name and % target	Actual performance %	Actual performance %	Actual performance %	Actual performance %
Mental health scores from Friends and Family Test – % positive Target: No target	80.0% (16/20)	70.5% (91/129)	78.7% (111/141)	75.8% (88/116)
Admissions to adult facilities of patients under 16 years old Target: No target	0	0	0	0
Care programme approach (CPA) follow up – proportion of discharges from hospital followed up within seven days – Mental Health Services Data Set Target: 95%	93.8%	95.6%	96.1%	95.4%
% clients in settled accommodation Target: No target *	59.0%	78.4%	80.0%	81.5%
% clients in employment Target: No target	12.8%	14.7%	15.0%	15.9%
Data Quality Maturity Index (DQMI) – MHSDS dataset score Target: 95%	97.3%	97.4%	97.3%	97.2%

*Definition amended in August 2018

2.7.2 COMMENTARY ON THE TRUST'S PERFORMANCE

In relation to the financial and use of resources score the Trust has been rated as '1'. The financial commentary is in Section 1.2.2 of Part A of this Annual Report.

The Trust has been placed in Segment 2. This segmentation information is the Trust's position as at end March 2019. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

During 2018/19, there have been some areas of strong performance, for example, there were no admissions of people under 16 to adult wards and the Data Quality Maturity Index target was met. This maturity index encompasses a number of data recording metrics including NHS number and ethnicity.

During the year, the Trust has put considerable resource into raising the profile of follow up of inpatients within 7 days of discharge and has also monitored the performance of teams in achieving 3 days. A new guidance document has been produced for staff and performance is monitored every week with any breach of 7 days investigated. It is worth noting that in some instances, follow up does not occur at the request of the service user or their family.

The Trust continues to look at new ways to improve the way in which the organisation collects and encourages participation in the Friends and Family Test. The recent externally commissioned review of our patient experience and involvement processes has resulted in the development of a strategic steering group whose key priority is to develop a patient experience, carer and involvement strategy.

2.7.2.1 Segmentation

The Trust was placed in Segment 2 through the Single Oversight Framework by NHS Improvement. We continue to have robust measures in place to monitor performance and address areas of concern. Each care group management team meets with individual services to review performance against key national, contractual and local targets on a regular basis. This is supported by joint operational meetings and reviews of performance at Executive Team and Trust Board level monthly.

CONFIRMATION FROM THE CHIEF EXECUTIVE

As Chief Executive I confirm that the information in this Accountability Report (made up of sections 2.1 to 2.7 of this Annual Report) is accurate to the best of my knowledge and that I have properly discharged the responsibilities set out in the NHS Foundation Trust Accounting Officer Memorandum.

Signed

Date: 23 May 2019

Dr Sara Munro
Chief Executive

SECTION 2.8 – STATEMENTS

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Leeds and York Partnership NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Leeds and York Partnership NHS Foundation Trust and of its income and expenditure, 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 Department of Health and Social Care Group Accounting Manual:

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- Prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed  Date: 23 May 2019

Dr Sara Munro
Chief Executive

SECTION 2.9 – ANNUAL GOVERNANCE STATEMENT

This statement seeks to make assurances about the framework of internal controls put in place to identify and manage risk for the period 1 April 2018 to 31 March 2019.

2.9.1 SCOPE OF RESPONSIBILITY

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

2.9.2 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds and York Partnership NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Leeds and York Partnership NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the Annual Report and Accounts.

2.9.3 CAPACITY TO HANDLE RISK

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

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

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

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

2.9.3.1 Staff training

The organisation provides compulsory training for all staff to complete in order to comply with internal, legislative and regulatory standards. The composition of compulsory training programmes for different groups of staff have been risk assessed to ensure these are targeted, and that appropriate packages of training are in place. We have a process for monitoring the uptake of compulsory training through a system called iLearn. The Workforce and Organisational Development Group oversees performance, and assurance reports are made to the Quality Committee and to the Board of Directors on performance against our target measures.

Risk management training and awareness is included in the compulsory health and safety training and is supported by local induction. The Trust's risk management team delivers specific risk management training at all levels across the Trust. The role of individual staff in managing risk is supported by a framework of policies and procedures that promotes learning from experiences and sharing good practice.

The Board also receives training on risk through bespoke training sessions which address their legal responsibilities as a Board member.

2.9.3.2 Incident reporting and capacity to learn

The Trust actively encourages an open and honest culture of reporting incidents, risks and hazards. It uses all such reports as an opportunity to learn and improve.

Incidents of severity 3 and above are now being reviewed on a weekly basis, with support offered to the relevant teams and any learning established including good practice.

The Learning from Incidents and Mortality Meeting (LIMM) reviews all deaths and codes them in accordance with the Mazar tool. The group decides the required level of investigation and monitors its progress through the relevant forums in the Trust's governance structure.

The work of LIMM identifies themes and trends and where appropriate will provide more depth to the mortality review process and reduce variation in reviews. LIMM is a sub-committee to the Trust Incident Review Group (TIRG) and reports to it accordingly.

The Trust Incident Review Group (TIRG) has responsibility for reviewing in detail all incidents reported as serious, for agreeing that the recommendations and actions are appropriate.

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

2.9.3.3 NHS Litigation Authority risk management standards

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

- Clinical negligence claims are covered by the NHS Resolution Clinical Negligence Scheme for Trusts (CNST). The CNST handles all clinical negligence claims against the Trust. The Trust is the legal defendant, however, the NHSR takes over full responsibility for handling the claim and meeting the associated costs
- Employer liability claims are covered by the NHS Resolution Risk Pooling Scheme for Trusts (RPST) and Liability to Third Parties Scheme (LTPS). LTPS covers employers' liability claims,

from straightforward slips and trips in the workplace to serious manual handling, bullying and stress claims. In addition LTPS covers public and products liability claims, from personal injury sustained by visitors to NHS premises to claims arising from breaches of the Human Rights Act, the Data Protection Act and the Defective Premises Act
- Public liability claims are handled as above
- Claims in respect of loss or damage to Trust property are covered by the NHS Resolution RPST Property Expenses Scheme (PES).

2.9.3.4 Work performed to assess Well-led

In 2017 the Board asked Deloitte LLP to carry out an independent review of our governance arrangements against the well-led framework. The Board decided to do this so it had assurance that the Trust met the standards of good practice. This looked at both Board and sub-Board level structures and processes i.e. ward to Board structures and processes.

This review made a number of recommendations as to how the governance structures and arrangements could be strengthened. These were accepted by the Board and then implemented. To ensure the organisation is 'well-led' the following key arrangements are in place:

- An experienced leadership team with the skills, abilities, and commitment to provide high-quality services. We recognise the training needs of managers at all levels, including those of the leadership team, and provide development opportunities for the future of the organisation
- The Board has set a clear vision and values that are at the heart of all the work within the organisation and we ensure staff at all levels understand them in relation to their daily roles
- The Trust strategy is directly linked to the vision and values of the Trust and we have involved stakeholders in the development of the strategy. We also have five strategic plans which have been aligned to each other and to the delivery of the strategy.
- Senior leaders visit all parts of the Trust and feed back to the Board to inform the discussion in relation to the challenges staff and the services face
- The Board has a sharing stories session at the beginning of each public meeting which allows service users to come and share their experience of our services
- We are actively engaged in collaborative work with external partners including NHS partners, primary care, local authorities, the voluntary sector, and the local transformation plans
- The Board has sight of the most significant risks and mitigating actions through the Board Assurance Framework
- Appropriate governance arrangements are in place in relation to Mental Health Act administration and compliance
- We have a structured and systematic approach to staff engagement
- The Board reviews performance reports that include data about the services. We also have an Executive Performance Overview Group which allows executive directors and service managers and staff to be sighted on their key performance indicators and any issues to delivery
- We are committed to improving services by learning from when things go well and when they go wrong; we also promote research and innovation
- We monitor the quality of our services at all levels of our organisation with our governance structure providing clear lines of accountability and ward to Board reporting.

2.9.4 THE RISK AND CONTROL FRAMEWORK

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

Clinical risk management is based on a structured clinical assessment model under-pinned by CPA and supported by decision-making aids.

Business, financial and service delivery risks are derived from organisational objectives through the business planning process. Clinical and non-clinical risks are identified through a well-defined process of assessment and reporting.

2.9.4.1 The Board Assurance Framework

The Board Assurance Framework (BAF) is one of the key risk assurance tools for the Board. It contains the principal risks to the achievement of the organisation's strategic objectives, which are taken from the strategic risk register. It also sets out the Board's risk appetite in relation to those risks. The BAF enables the Board, primarily through its Board sub-committee structure, to monitor the effectiveness of the controls required to minimise the principal risks to the achievement of the Trust's objectives and therefore provides evidence to support this Annual Governance Statement.

The BAF is formally reviewed by the Board on a quarterly basis and the Audit Committee at least twice a year. The relevant sections of the BAF are also reviewed by the Board sub-committees on a quarterly basis for those risks where they are named as assurance receivers. The BAF has been audited in-year and found to be fit-for-purpose with 'significant assurance' being given to its governance process.

2.9.4.2 Quality governance arrangements

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

The framework describes how the Trust will use improved information management, alongside clear governance and accountability in order to deliver better performance. This will be achieved through the introduction of a tiered performance management process which demonstrates rigour, support, challenge, timely escalation and a consistent approach to clinical governance and performance management at all levels of the organisation. It uses the approach set out in the Single Oversight Framework from NHS Improvement (November 2017).

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

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

To manage any risk of non-compliance with the CQC registration the Trust has established a CQC Project Group which meets monthly to monitor progress against the CQC action plan and to identify any risks which require immediate action. All actions and supporting evidence would have previously been agreed and signed off in the relevant Clinical Governance Forum. The Trust has a Quality Review process to support all areas to attain a rating of 'good' or 'outstanding'. There are also monthly discussions between the Nursing Leadership Team and the CQC link officers and a quarterly meeting between the Director of Nursing, Professions and Quality and the CQC officers linked with the Trust.

We will take a Trustwide view of the themes from our CQC inspections and take a holistic approach to resolving these issues and reducing risks of non-conformity across the Trust. We ensure that the programme of activities and projects are working together and that benefits and improvements are brought to all core services.

The Trust has a bespoke electronic activity tracker which is a tool to monitor deadlines, record evidence of actions and evidences in which governance meeting the action was signed off. This provides an audit trail and assurance for the CQC Group who then make assurance reports to the Quality Committee and in turn the Board.

The Trust has a programme of Peer Reviews throughout the year to improve, share and embed best practice around the Trust. The Peer Reviews are based around the CQC Key Lines of Enquiry (KLoE). Membership of the Peer Review teams changes and is shared between core services to ensure transparency and to spread the learning amongst staff. During these reviews we identify risks to service delivery and use the evidence to make processes and procedures easier to comply with.

2.9.4.3 Fraud, corruption and bribery

The Trust has procedures in place that reduce the likelihood of fraud, corruption and bribery occurring. These include an Anti-fraud and Bribery Procedure, Standing Orders, Standing Financial Instructions, documented procedures, a system of internal control (including internal and external audit) and a system of risk assessment. In addition, the Trust seeks to ensure that a comprehensive anti-fraud, corruption and bribery culture exists throughout the Trust via the appointment of a dedicated Local Counter-fraud Specialist (LCFS) in accordance with the standards set out in the provider contracts.

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

2.9.4.4 Principal risks to compliance with licence Condition 4.2 of FT4 (FT Governance)

The Trust has put in place measures to ensure that the Board is able to confirm compliance with Licence Condition 4.2 of FT4 (FT Governance) i.e. that we apply systems and standards of good corporate governance expected of a supplier of health services. Our arrangements include a governance structure with four locally-determined Board sub-committees, over and above those required in statute (the Quality Committee, the Finance and Performance Committee, the Mental Health Legislation Committee and the Strategic Investment and Development Committee). This ensures that members of the Board (particularly non-executive directors) are more closely involved in the governance of the organisation and assurance on the quality of services (clinical and non-clinical). There is also a structure beneath the Executive Management Team to support executive directors in delivering their individual portfolios to support the Chief Executive in carrying out their duties as Accounting Officer.

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

On a monthly basis the Board receives a Combined Quality and Performance Report that details compliance with, and achievement of, all regulatory, contractual and local targets and also provides financial information. The Board and its sub-committees receive timely and accurate information to the meetings, and in accordance with their scheduled cycles of business. Performance data relating to their areas of responsibility will be scrutinised. Performance is also reported to the Council of

Governors and governors are provided with an opportunity of holding the non-executive directors to account for the performance of the Board.

2.9.4.5 Corporate Governance Statement

The Corporate Governance Statement (CGS) has been prepared in accordance with the guidance issued by NHS Improvement; its completion in 2018/19 was co-ordinated by the Associate Director for Corporate Governance. Evidence of compliance or risks to compliance with each of the standards in the CGS was provided by a lead senior manager (identified for each condition). This was then approved by an identified director before the entire document was submitted to the executive directors for consideration and to the Audit Committee for assurance about the process.

2.9.4.6 Stakeholders and partners

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

- Working in partnership to develop system-wide plans with stakeholders across Leeds and West Yorkshire through the Integrated Care System (ICS) process.
- Participating within the citywide strategic partnership group for mental health (West Yorkshire Mental Health Services Collaborative and the Committees in Common)
- Working with partners in health and social services in developing and considering business and service change. The Trust has a framework for managing change to services agreed as part of its contracts with its main commissioners. The Trust also has good relationships with Overview and Scrutiny Committees
- Active relationships with Healthwatch and service user and carer groups, working with these groups on the management of service risks and change
- Active engagement with governors on strategic, service, and quality risks and changes including active engagement in the preparation of the Quality Report and the setting of strategic priorities.

2.9.4.7 NHS Pension Scheme control measures

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

2.9.4.8 Equality, diversity and human rights control measures

Control measures are in place to ensure that the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Board has arrangements in place to ensure that the Foundation Trust complies with the Equality Act 2010. It has approved equality objectives for 2018 to 2020 and an annual equality progress assessment is undertaken using the Equality Delivery System framework.

We have in place systems for monitoring equality progress and compliance against our objectives through the Workforce and Organisational Development Group. This includes reporting to the Quality Committee and to the Board of Directors on performance against our target measures and the publication of an annual Equality and Diversity and Human Rights Report.

Evidence that issues specific to equality and diversity have been considered is required before policy decisions are made. Equality analysis screening is required for all papers presented to governance meetings and for all new and revised procedural documents as detailed in the Trust's Procedure for the Development and Management of Procedural Documents.

2.9.4.9 Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

2.9.4.10 Workforce

Our Workforce and OD Strategic Plan 2018-2021 sets out our longer term vision and ambitions as well as the annual priorities and deliverables. 2018/19 was the first year of implementation and our deliverables are aligned to the plan. We have undertaken an active role in the NHS Improvement Retention cohort with the objective of reducing our turnover, and improving our recruitment processes, career pathways and career development for nurses and Allied Health Professionals. Since commencing this work we have seen a reduction in our turnover from 11.26% to 9.53%. We have also revised a number of our practices to improve access to substantive opportunities including implementing a guaranteed job scheme for our student nurses, a more flexible Retire and Return policy, and implementation of a fast track bank to substantive recruitment process. Part of our Workforce and OD Strategic Plan is to increase the quality and grow our internal bank to reduce reliance on agency staff. In 2018/19 we have achieved a growth rate of 20%. Our workforce requirements and performance are effectively managed through the executive-led Workforce and OD Committee, supported by a range of focused operational groups including our safer staffing and workforce planning groups which identify short and long term workforce requirements, solutions to meet immediate, and undertake long term job planning in relation to the development of new roles. The performance of workforce is held to account directly by the Board of Directors and specific performance indicators monitored through the CQPR report and the Quality Committee.

We recognise that some of our wider workforce challenges are best met by working in partnership. We are already working collaboratively within both Leeds and in the West Yorkshire and Harrogate ICS on shared leadership and development programmes; workforce planning; coaching and mediation services; and promotional recruitment materials to promote working in the NHS and in shortage occupations. We are also active partners in the development and leadership of the new Health and Social care Academy in Leeds and are part of the West Yorkshire Mental Health Workforce Collaborative.

2.9.4.11 Registers of Interests

The Trust has published an up-to-date register of interests for the decision-making staff within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS.

2.9.5 KEY RISKS FOR THE ORGANISATION

Key risks for the organisation are those that have been identified as strategic risks on the Strategic Risk Register. In summary these are:

- Due to an inability to align our workforce capacity to planned models of care, there is a risk that we are unable to deliver high quality, evidence based, person centred care
- We are unable to maintain compliance with regulatory requirements relating to the quality and safety of our services due to a failure to provide care in line with national standards and best practice.
- Due to inadequate systems to support continuous learning, improvement and innovation, there is a risk that our services deliver poor outcomes for service users
- We are unable to maintain effective, productive relationships with key external stakeholders, with the result that we are unable to work successfully with partners to support innovative care and exceptional outcomes for service users
- If we cannot produce and effectively use information about our services to support the operation of our governance structures, there is a risk that there will be a lack of confidence in our management information and that we will be unable to ensure the safety of our services

- We are unable to deliver an effective and attractive programme of training and development opportunities for our staff due to inadequate capability and capacity, corporately and within care services
- As a result of a culture of blame which does not foster a psychologically safe environment for our staff we are unable to reduce patient harms or provide a positive experience for our service users
- A lack of financial sustainability results in us having insufficient funds to sustain and develop our services and invest in high quality outcomes for our service users
- Due to inadequate, inflexible or poorly maintained estates and facilities we are unable to provide a safe and positive environment for service users and staff
- As a result of insecure, inadequate or unstable information technology systems and infrastructure, the quality and continuity of our services is compromised.

Each of these risks has an identified executive director and management lead. These risks will be managed through the risk management and risk register processes and reported to the Executive Risk Management Group, the Board and the relevant Board sub-committee through the Board Assurance Framework.

Behind each risk is a detailed risk assessment which sets out the controls and mitigations. The strategic risk register is reviewed by the Executive Risk Management Group via the Board Assurance Framework.

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

We published our refreshed Trust Strategy for 2018 to 2023 in November 2017. This sets out our ambitions and plans for the next five years. In refreshing our strategy we wanted to make sure it is relevant and fully aligned with the key themes within national and local strategies that are relevant to people using our services, carers, our staff and our organisation as a whole. Of particular note is the NHS Five Year Forward View and the Mental Health Five Year Forward View. All these plans have been translated into local actions through the sustainability and transformation plans, the local Leeds plan and the Transforming Care programme for learning disability services.

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

Refreshing our strategy has given us the opportunity to go back to people who use our services, carers, staff and partners to determine what our key strategic objectives should be for the next five years and to help us develop a list of priorities for action.

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

The financial strategy for the coming year is set out in the Trust's one-year Operational Plan. This shows on a projected basis what the expected financial performance for the coming year is to be. There is in place a comprehensive process for developing the plan with there being consultation with the Council of Governors and sign-off by the Board of Directors prior to submission to NHS Improvement. To be assured of progress against the plan (both financial and operational) the Board receives a quarterly update.

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

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

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

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

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

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

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

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

- **Internal Audit** (Audit Yorkshire) 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.

  In 2018/19 the Internal Audit reports issued in the year have generated an overall opinion of 'Significant assurance' as detailed in the Head of Internal Audit Opinion.

  Whist an overall opinion of 'significant assurance' has been provided; attention is drawn to the fact that there have been two reports issued in 2018/19 with a 'limited assurance' opinion which are detailed below.

  - **LY06/2019 Appraisal System**

    The audit identified areas where further improvement was required to increase the number and quality of appraisals undertaken at the Trust. The Trust had identified many of the issues and was already in the process of taking actions to improve the process, including a detailed management deep dive review.

The key issue identified in the audit was the validity of the data used for monitoring the Trust's Key Performance Indicator for appraisals. The Trustwide Appraisals Report included significantly overdue appraisals which were unlikely to be correct. There were also members of staff whose appraisals were last conducted over three years ago but may have had appraisals which have not been recorded. An appraisals report obtained for October 2018 found that a number of employees had a PDR Expiry Date of 2020, with one having an expiry date of 2021. Since the issue of the audit report the Trust has been undertaking an exercise to cleanse the data.

Additional points identified related to the quality of appraisal completed., the robustness of the procedure, procedures to support escalation of non-compliance and a review of the appropriate number of appraisals to be allocated to reviewing managers so that the process is manageable. An action plan has been agreed with management to address these points. Further audit work is planned in 2019/20 to review the design of the new procedures with further work planned in 2020/21 to evaluate its implementation

- **LY12/2019 GDPR Implementation**

  The review found that the Trust had built upon its established data protection arrangements, amending its systems and processes where required to achieve compliance with GDPR. However, some weaknesses were identified in both design and implementation of those refinements.

  Whilst the Trust's GDPR action plan was based on guidance from the Information Commissioner, local interpretation of that guidance was inconsistent in parts and no gap analysis had been carried out against subsequent NHS-specific advice from the Information Governance Alliance.

  There was some indication of over-reliance on the Information and Knowledge Manager, particularly as the role combines the monitoring and advisory functions of Data Protection Officer. The review highlighted some weaknesses in oversight and scrutiny of the work programme, which led to the overall opinion of Limited Assurance. An action plan has been with management and will be monitored during 2019/20.

All the above areas will be audited again in 2019/20 to ensure the sufficiency of the actions taken to address areas of weakness identified by our internal auditors.

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

  Our audit team will carry out the audit of the 2018/19 annual accounts and will provide a report on their findings (ISA 260 Report) to the Audit Committee which is the body 'charged with governance' in the Trust.

- **The Audit Committee** is a sub-committee of the Board of Directors, the membership of which is made up of non-executive directors. It reports directly to the Board. The committee has responsibility for being assured in respect of the Trust's internal controls, including risk management, and for overseeing the activities of internal audit, external audit and the local counter-fraud services.

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

- **Board sub-committee structure** is made up of three locally determined committees; the Quality Committee, the Mental Health Legislation Committee and the Finance and Performance Committee; each of which has responsibility for assurance in areas of clinical and financial performance and compliance. The Board also has two further statutory committees: the Nominations Committee and the Remuneration Committee. Each of the Board sub-committees is chaired by a non-executive director, with the Remuneration Committee being made up wholly of non-executive directors.

2.9.7 INFORMATION GOVERNANCE

2.9.7.1 Incidents relating to information governance

Below is an analysis of our information governance incident reporting records for 2018/19. This shows 3 incidents that have sensitivity factors that classify them as a Serious Incident Requiring Investigation (SIRI), which have been reported via the national online tool.

Aligned to General Data Protection Regulation (GDPR) / Data Protection Act (2018) a new approach to incident grading has been devised by NHS Digital. This method of grading takes a different approach to previous iterations, and uses a 5 x 5 likelihood vs impact approach, assessing both the likelihood and severity of harm caused. Serious incidents are still escalated to the Information Commissioners' Office (ICO), but only the most serious or large-scale are further escalated to the Department for Health and Social Care (DHSC). This new approach to incident grading came into effect on 25 May 2018.

Incidents are now graded as follows:-

- Non-Reportable
- ICO Reportable
- ICO Reportable and DHSC Notified

The 3 incidents reported below occurred under the older, pre 25 May reporting regime, and there have been no reportable incidents that have occurred under the new reporting thresholds.

Table 2.9A – Summary of incidents involving personal data as reported to the Information Commissioner's Office in 2018/19

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
March 18 (reported in current year)	Disclosed in error	Patient found in possession of data relating to fellow patient.	1	DH / ICO notification via NHS Digital website
April 18	Disclosed in error	E-mail sent to wrong & inappropriate non-care e-mail address.	1	DH / ICO notification via NHS Digital website
April 18	Disclosed in error	Appointment letter sent to wrong address.	1	DH / ICO notification via NHS Digital website
Further action taken	A local senior management fact-find has been undertaken in relation to each incident and process improvements and / or disciplinary actions have been actioned, where appropriate, to prevent recurrence. Although no regulatory action has been taken by the ICO in respect of the above incidents, we have enacted recommendations where appropriate including communications to Trust staff via e-mail broadcast. We will continue to monitor and assess information governance breaches. When weaknesses			

Date of incident (month)	Nature of incident	Nature of data involved	Number of people potentially affected	Notification steps
	in systems or processes are identified there will be interventions undertaken. Low-level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support information governance training via the national e-learning tool. All staff to undertake annual refresher training as a reminder of their information governance obligations.			

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

The group monitors IG breach incidents, triggering appropriate responses to clusters or themes of low-level non-SIRI incidents and those incidents which would have been reportable under the old reporting regime.

2.9.7.2 Data security

The Trust recognises that our approach to information security requires both a technical and organisational approach as described in the 6th Data Protection Principle (DPA 2018).

The Trust has a highly developed and mature approach to information governance, which includes high compliance with staff IG training and a comprehensive suite of IG-related procedural documents, giving instruction and regulation to our staff. The Trust deploys the mandatory public sector safeguards recommended by the HM Government Cabinet Office "Data Handling Procedures in Government"; including the operation of secure network storage, port control and the provision of encrypted digital media, and the encryption of high-risk portable computing resources.

The Trust continues to use NHSmail, facilitating secure digital communications with other NHS partners and the wider public sector via the Government Secure Intranet (GSi), and to local partner organisations operating e-mail services with Transport Level Security.

Senior managers in ICT receive the NHS Digital "CareCERT" broadcasts, to maintain an awareness of current information security threats so that timely and appropriate action can be taken where necessary. We have embedded the use of a CareCERT action tracking solution, with all CareCERT-reported threats recorded, assessed for exposure and potential impact, with solutions tracked, implemented and reported monthly to the IG Group.

The Trust continues to use the national NHS IG Training offering, *Data Security Awareness Level 1*, which contains both refreshed content on IG in a healthcare context and entirely new content on the user aspects of information / cyber security. Course content was refreshed again in November 2018.

We have a robust approach to business continuity (BC) / disaster recovery (DR) within ICT, with senior management taking ownership of developing BC/DR plans for their services. Work is continuing to align ICT BC/DR with clinical service system criticality. Review cycles of current plans are undertaken in response to any actual or near-miss BC/DR events.

The Trust made a self-assessment against the NHS Digital Data Security and Protection Toolkit of 'Standards Met' at 31 March 2019, meeting the required evidential standard for all compulsory Assertions. This was supported by an internal audit appraisal of a sample of 14 of the 32 compulsory Assertions, with an outcome of "Significant Assurance". Requirements were included from across all ten of the National Data Guardian's core data security standards.

2.9.8 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 Quality Accounts for each financial year. NHS Improvement (in exercising the powers conferred on 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.

The Director of Nursing, Professions and Quality is the executive director with the responsibility for the Quality Report. We have compiled our Quality Report in accordance with the guidance issued by NHS Improvement. The Quality Report is then published alongside our Annual Report and Accounts to ensure it contributes to a balanced view of the quality of the care provided by the Trust.

Our Council of Governors is made up of the public, service users, carers and staff and they have been involved in agreeing the indicators within the Quality Report. Public and easy read version of the Quality Report will be made available and the full report will be accessible on the Trust's website.

The following steps have been put in place to assure the Board that the Quality Report presents a balanced view and that there are appropriate arrangements in place to ensure the quality and accuracy of performance information.

- Performance reports to the Board of Directors, which set out performance against external requirements including NHS Improvement targets, the Single Oversight Framework and our contractual requirements with our main commissioners
- Assurance regarding maintaining CQC registration requirements is managed through the monthly CQC Project Group with assurances being made to the Quality Committee
- Performance reports to the Council of Governors
- The Executive Performance Overview Group seeks to supportively challenge performance within directorates.

There are systems and processes in place for the collection, recording, analysis and reporting of data which will ensure this is accurate, valid, reliable, timely, relevant and complete.

To manage the risk of there being incorrect data, the Trust has a Data Quality Policy which clearly identifies roles and responsibilities for the collection and input of service user information into patient records' systems. The Data Quality Team deals with erroneous entries and there are systems and processes in place to alert relevant managers of any issues in order to ensure that data presented in the Quality Report is both accurate and reliable. A data quality warehouse is used to ensure that data quality issues are dealt with proactively and quickly to maintain data integrity.

2.9.9 REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit, and the executive managers and clinical leads within the Leeds and York Partnership NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 Committee, the Quality Committee, the Finance and Performance Committee, and the Mental Health Act Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

I have drawn on the content of the performance information available to me. My review is also informed by comments made by the external auditors in their opinion; the Head of Internal Audit Opinion other audit reports. I have been advised on the effectiveness of the systems of internal controls by: the Board of Directors; the Audit Committee; the Quality Committee; the Finance and

Performance Committee; the Mental Health Legislation Committee; the Board Assurance Framework; and internal audit reports. I have also been advised by leadership from the executive directors with regard to risk reporting (clinical and non-clinical), implementing learning, and plans to address weaknesses and ensure continuous improvement of the systems in place.

2.9.10 CONCLUSION

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

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

Signed

Date: 23 May 2019

Dr Sara Munro
Chief Executive

SECTION 3 – THE BOARD OF DIRECTORS (further information)

3.1 INTRODUCTION

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

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

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

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

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

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

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

3.2 COMPOSITION OF THE BOARD OF DIRECTORS

3.2.1 Non-executive directors

Our non-executive director (NED) team is made up of seven non-executive directors including a non-executive Chair. During 2018/19 there was one new NED appointment: Andrew Marran who was appointed with effect from 17 February 2019. More detailed information about our non-executive directors is set out in the Remuneration Report in Part A section 2.4 of this Annual Report.

3.2.2 Executive directors

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

Chief Executive	Medical Director
Chief Financial Officer and Deputy Chief Executive	Director of Nursing, Professions and Quality
Chief Operating Officer	Director of OD and Workforce

There have been a number of changes in the executive director team during 2018/19.

On 31 May 2018 Susan Tyler retired from the Trust. She had been the Director for Workforce Development since 2012. Following Susan's retirement, Lindsay Jensen (the Deputy Director for Workforce Development) was appointed as the Interim Director for Workforce Development. Lindsay was in this position between 1 June and 30 September 2018, until a substantive appointment was made. Then on 1 October 2018, Claire Holmes was appointed through a competitive process as the Director for OD and Workforce.

3.2.3 Members of the Board of Directors

Information about who our members of our Board of Directors were on 31 March 2019 can be found in Part A section 2.1.1 of this Annual Report.

3.3 PROFILE OF MEMBERS OF THE BOARD OF DIRECTORS

Prof Sue Proctor, Chair of the Trust

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

Sue has expertise in leadership development, corporate and clinical governance, safeguarding, strategic planning and delivery. She has a passion for improving services for service users and carers by working in partnership with them.

Sue has over 35 years of experience in health care; qualifying as a nurse in 1987 and a midwife in 1990. She has extensive leadership experience in the NHS, including seven years as an executive director, and four years as a non-executive director. From 2010 to 2013 she was Chief Officer at the Diocese of Ripon and Leeds.

She currently runs a management consultancy working with charity and faith-based organisations. She has strong links with higher education as a former member of the University of Leeds Council and a Visiting Professor at Leeds Beckett University. Currently, she is Chair of the Strategic Safeguarding Group for the Diocese of York, Independent Chair of the North Yorkshire Safeguarding Adults Board, a member of the Lord Chancellors Advisory Committee for North & West Yorkshire, and a lay member of the Veterinary Nursing Council at the Royal College of Veterinary Surgeons.

In the last few years, she has led a number of extensive and complicated investigations into allegations of historical sexual abuse. From 2013 to 2014, she chaired the independent investigation into matters relating to Jimmy Savile at Leeds Teaching Hospitals NHS Trust and then led the national NHS Savile Legacy Unit overseeing 16 subsequent Savile-related NHS investigations.

From August 2013 to March 2017 Sue was Vice Chair of Harrogate and District NHS Foundation Trust; she was a member of their Audit Committee and the Quality Committee, as well as being the non-executive lead for research and development within the Trust.

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

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

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

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

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

Helen Grantham, Non-executive Director

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

She contributes to improving the experience of staff and service users and carers by having a particular focus on workforce related matters and the Trust's aim of being an 'Employer of Choice'. By having skilled and engaged employees demonstrating the values of the Trust in the work they do, then service users and carers should have improved experiences. In addition to this she is the champion NED for Health and Safety and the nominated lead for Emergency Preparedness, Resilience and Response (EPRR).

She brings 30 years of leadership experience, with the last 17 years having been in Local Government. Until October 2017, she was the Assistant Chief Executive at Wakefield Council with responsibility for HR, ICT, Communications, Customer Services, Policy and Performance.

She has recently become freelance as director / owner of Entwyne Ltd, providing HR and Organisational Development consultancy and in April was appointed as the Interim Director of HR and OD at Manchester City Council.

Andrew Marran, Non-executive Director

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

An Institute of Directors qualified director, Andrew's skills and expertise lie in leading sustainable growth in organisations, helping to develop long-term, sustainable partnerships and commercial relationships with other organisations; in particular establishing high quality , successful growth opportunities in the healthcare sector.

Andrew is a Mental Health Act Manager and non-executive board Director on a range of university spin-out and subsidiary companies at Leeds Beckett University. He manages a team of Business Development Managers who support the transfer of university ideas and research into tackling real world problems and innovations. He has 12 years' experience as a corporate management consultant and is currently the Chairman of Leeds Student Residences; a charity established to help students in accommodation hardship.

Margaret Sentamu, Non-executive Director (Chair of the Mental Health Legislation Committee)

Margaret's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is a member of the Audit Committee and the Chair of the Mental Health Legislation Committee. She also actively carries out the role of Mental Health Act Manager.

By holding the executive directors to account Margaret is able to be assured that services are provided in the most effective and efficient way. As a member of the Audit Committee she can be assured that the Trust is well governed and that we have effective processes and procedures in place. As the Chair of the Mental Health Legislation Committee and a practising Mental Health Act Manager she can make sure that we correctly apply the mental health legislation and ensure that we correctly review the detention of service users who are either detained under the Mental Health Act or who have been placed on Community Treatment Orders (CTO), and discharge those service users who no longer meet the criteria to be detained or are subject to a Community Treatment Order.

Margaret's background is in recruitment and selection in the private, public and the third sectors. More recently she has focused on helping organisations to embed diversity practices in the workplace by challenging unconscious bias in the areas of recruitment, retention and people development.

Her portfolio career includes regulating solicitors who breach the code of conduct for the Solicitors Regulatory Authority; and accountants, who are members of the Chartered Institute of Public Finance and Accountancy (CIPFA) who breach the by-laws. Margaret is a trustee and patron of a number of charities in the areas of health, education and poverty and is keen to strengthen partnerships between the mental health sector and the third sector and help fight stigma and discrimination.

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

Sue's role on the Board is to hold the Chief Executive and her executive team to account for the delivery of the organisation's strategic aims and objectives. She is the Chair of the Finance and Performance Committee, a member of the Mental Health Legislation Committee and the NED champion for sustainability.

By holding the executive directors to account Sue is able to be assured that services are provided in the most effective and efficient way. As Chair of the Finance and Performance Committee she is able to make sure that we are in a strong position to use the money we receive in the best way we can to benefit our service users and their carers, and that we take opportunities to build a sustainable organisation able to continue to provide high quality services. Sue has a passion for ensuring that the services our Trust provides are of a high quality and that service users are at the heart of everything we do.

Previously Sue was the Chief Executive and Company Secretary for Voluntary Action Sheffield (VAS) where she had responsibility for strategic and operational leadership and for the leadership and representation of the voluntary and community sector in the city. Before this she worked for Sheffield Teaching Hospitals NHS Trust as the Business Development and External Affairs Director and also worked for the Department of Health as Head of Social Enterprise Unit. Sue brings to the Board experience of working in the complex environment of health and social care and in building partnerships at local, regional, national and international level.

Martin Wright, Non-executive Director (Chair of the Audit Committee and Senior Independent Director)

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

He has also been appointed by the Board as the Senior Independent Director. This role means that he is available to members of the Trust and to governors in instances where they have concerns which have been raised through the usual channels of Chair, Chief Executive, Chief Financial Officer or Trust Board Secretary and these have failed to resolve the issue. He is also available where it would be inappropriate to use such channels. He is also the NED champion for speaking up and whistleblowing.

Part of his role is to make sure that services are being provided in the most effective and efficient way and as the Chair of the Audit Committee he ensures that the committee looks closely at the Trust's budgets and spending; making sure that the Trust is getting best value from the money it spends and is using its resources wisely to offer the highest quality services possible.

He was the Deputy Chief Finance Officer for DLA Piper International, one of the largest global law firms, where he was responsible for all aspects of financial reporting and control, including treasury, taxation and financial planning. He managed an international team of finance staff which provided support for more than 4,000 lawyers operating in more than 30 countries around the world.

Dr Sara Munro, Chief Executive

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

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

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

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

Joanna Forster Adams, Chief Operating Officer

As Chief Operating Officer Joanna works with the Trust's managers, clinical leads and staff to lead and support all our care services. She focuses on developing and improving service delivery, often working alongside our health and social care partners. Joanna is also responsible for major service change and supporting people to make these changes positively, and is responsible for making sure we can respond to an emergency or crisis situation and provide continuity for our service users and support for the wider public as needed.

Joanna contributes to improving the experience of service users and carers by reporting on what we're doing well and where we don't meet the standards of care, access or delivery which provides high quality care for our service users. She ensures that at a glance 'dashboard' is available to make the information easier to understand. She, and her team, will pay particular attention to the problems that directly affect service users and their carers and look for ways to improve the quality of what we do.

Joanna joined the Trust in July 2017. She was previously Executive Director of Operations for Mental Health and Community Services in the north west of England. She has worked in the NHS since 1984 and has experience of clinical and corporate services in hospitals, community and mental health organisations in the north east. She gained a Master's in Business Administration from Durham University and is a graduate of the NHS Leadership Academy Nye Bevan programme.

Her motivation is drawn from the passion and determination shown by staff, stakeholders, service users and carers to drive improvement in mental health care. During her 20 years as a senior NHS manager she has been keen to help staff be the best that they can be through personal and professional development.

Dawn Hanwell, Chief Financial Officer and Deputy Chief Executive

Dawn leads a number of departments which include finance and contracting, information management and technology (including mHabitat), estates and facilities and procurement (including the North of England Commercial Procurement Collaborative).

The functions she oversees make a significant contribution to the work of our Trust's frontline staff, in order to support them to focus on working directly with service users and carers. These functions contribute by:

- Looking after the finances and advising on what we can spend our resources on, including how to buy goods and services within the limits which we are set
- Dealing with our commissioners to get the best possible income settlement to provide the services we deliver
- Maintaining the estate to the best possible standard for delivering safe care and providing a good environment for staff
- Maintaining and continuously improving the technology, tools and infrastructure which support our work on a daily basis.

Dawn was appointed to this post on 1 August 2012, having previously worked at our Trust as the Deputy Director of Finance between 2003 and 2007. Her previous role was as Director of Finance and Information at Barnsley Hospital NHS Foundation Trust. She started her career in the NHS as a financial management trainee many years ago and has worked across a number of NHS organisations, mainly on the provider side but also briefly in commissioning and at the Department of Health. She has a wide range of experience mostly in finance but more recently managing estate and information.

Her first degree is in Theology and Religious Studies and she qualified as an accountant with the Chartered Institute of Public Finance Accountancy (CIPFA) in 1990.

Claire Holmes, Director of OD and Workforce

Claire Holmes is the Director for Organisational Development & Workforce and was appointed on 1 October 2018. She leads the Human Resources (HR), Organisational Development (OD) and Communications teams. Her role is to ensure we provide a positive working environment where our staff are, and feel valued, developed, and engaged.

Part of her role is to listen to staff and service user feedback and use it to influence the direction of the HR & OD strategy. Her aim is to make sure we give people development opportunities at work to help create a skilled workforce which is able to deliver quality specialist mental health and LD services.

Claire is a Fellow of the Chartered Institute of Personnel and Development. She was formerly the Group HR Director of the NPS Group, a national multi-disciplinary property design and consultancy company wholly owned by Norfolk County Council. She has worked across a variety of sectors including professional services, financial services, retail and the NHS.

From University, she joined Aviva (then Norwich Union Insurance) on its fast track HR graduate programme based in Norwich. Then having gained a master's in Strategic HR Management, she took a permanent role delivering major change programmes nationally for Aviva and a host of its subsidiary companies including the RAC, Auto Windscreens and car checking service HPI.

She then left Aviva to become Strategic HR Business Partner for Cambridgeshire and Peterborough Mental Health Trust and was part of a team that supported its successful journey to Foundation Trust status.

Dr Claire Kenwood, Medical Director

Dr Claire Kenwood was appointed as our Medical Director on 1 March 2017 and is responsible for applying the best medical practice and the highest quality of care for our service users.

Claire studied medicine at Birmingham University and qualified in 1988. She began her career in mental health in 1989 and completed her training in a variety of placements and specialties in Birmingham and Southampton, becoming consultant in assertive outreach in 1999.

After a period of work in Trafford as a consultant in assertive outreach and rehabilitation she moved to Scotland and spent 10 years working in Livingston, initially as a consultant and then as Clinical Director. Here she developed an interest in clinical leadership, initially completing a post graduate certificate in front line leadership and management and becoming a member of the chartered institute of managers. After this she completed a master's degree in clinical leadership at Glasgow University and then a master's degree in advanced leadership practice with Edinburgh Napier and Harvard Executive Education. The focus of these studies was on clinical, quality and safety and in particular research interests in relationships and leadership required for good service user outcomes.

In 2014 Claire took up a post in Cumbria Partnership NHS Foundation Trust as Associate Medical Director for Quality, also clinically supporting and leading the development of a new inpatient rehabilitation service for men. During this time she was successful in becoming part of the first cohort of the Q initiative and also a non-executive director of the Quality Improvement Organisation AQuA.

Cathy Woffendin, Director of Nursing, Professions and Quality

Cathy leads on the professional development and standards of staff within the Trust which covers Nursing, Allied Health Professionals and Psychology. Her particular focus is to ensure that quality is of a high standard across the organisation and she works closely with Claire Kenwood our Medical Director, to oversee the current quality and delivery of our services and shape these to best meet future needs.

Cathy contributes to improving the experience of service users and carers in many ways but in particular by leading a team which works directly with service users to gather and share their insight and feedback about their experience whilst in our care. This feedback is a vital tool for us as it shows us where we're getting things right and where there is still work to be done to improve our services.

Cathy is a qualified nurse and has worked in a variety of organisations in the NHS and private sector for over 30 years. She did some further training and gained a degree in Public Health Nursing and then worked as a health visitor developing a child health and safeguarding specialism. She moved into management in 2005 and has undertaken further study at Master's level in Management and leadership. Cathy has worked in a mental health and learning disability setting for the last eight years and was appointed as our Director of Nursing, Professions and Quality on 1 March 2018.

Anyone wanting to contact our directors can find their contact details on our website www.leedsandyorkpft.nhs.uk.

3.4 MEETINGS OF THE BOARD OF DIRECTORS

Our Board meets monthly with the exclusion of August and December, although in 2018/19 the Board held an extraordinary private meeting in December for the approval of a business case. All meetings are held in public but items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session.

In 2018/19 the Board of Directors met on 11 occasions. The table below shows directors' attendance at those meetings. Attendance at Board meetings is also reported to the Council of Governors at each of its meetings.

Table 3A – Attendance at Board of Directors' meetings during 2018/19

Name	Meetings eligible to attend	26 April 2018	24 May 2018	28 June 2018	26 July 2018	27 September 2018	25 October 2018	29 November 2018	18 December 2018 (ExtraOrdinary)	31 January 2019	28 February 2019	28 March 2019
Non-executive directors												
Prof Sue Proctor (Chair)	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
John Baker	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Helen Grantham	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Andrew Marran	2										✓	✓
Margaret Sentamu	11	✓	✓	✓	✓	✓	-	✓	✓	✓	✓	✓
Sue White	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Martin Wright	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Steven Wrigley-Howe	9	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Executive directors												
Sara Munro	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Joanna Forster Adams	11	✓	✓	-	✓	✓	✓	✓	✓	✓	✓	✓
Dawn Hanwell	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Claire Holmes	6						✓	✓	✓	✓	✓	✓
Lindsay Jensen	3			✓	✓	✓						
Claire Kenwood	11	✓	✓	✓	✓	✓	✓	-	✓	✓	-	✓
Susan Tyler	2	✓	✓									
Cathy Woffendin	11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

3.5 EVALUATION OF THE BOARD OF DIRECTORS

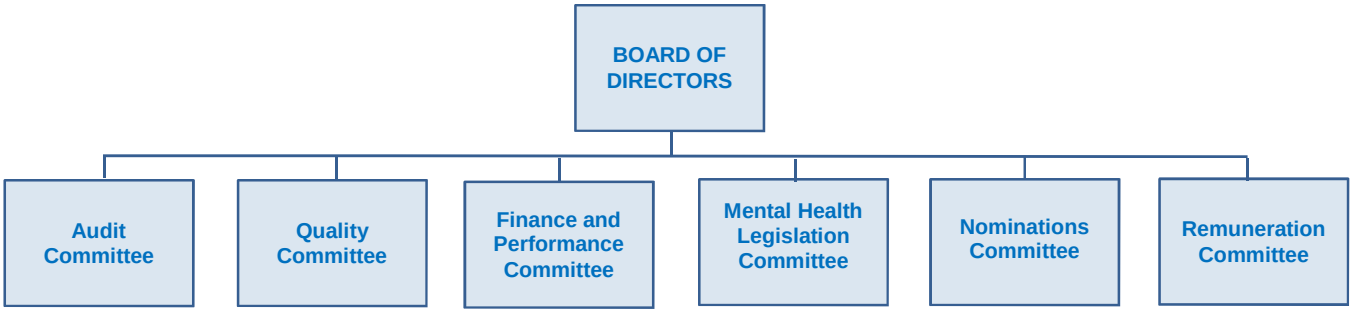
3.5.1 The Board of Directors and members of the Board

Details relating to the evaluation of the members of the Board of Directors can be found in Part A section 2.4.3.2 of this Annual Report.

3.5.2 Board sub-committees

The Board's sub-committee structure is made up of the: Audit Committee, Quality Committee, Finance and Performance Committee, Mental Health Legislation Committee, Remuneration

Committee, and Nominations Committee. Each of these committees receives secretariat support from the Corporate Governance Team, except in the case of the Mental Health Legislation Committee which is supported by the Mental Health Legislation Team.



Evaluation of the Board sub-committees is carried out using an internal evaluation questionnaire. The outcome is reviewed by the committee and a report on any proposed changes that may be required is made to the Board of Directors by the chair of the committee. If required the Terms of Reference would be changed and ratified by the Board.

3.6 THE AUDIT COMMITTEE

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

The Audit Committee seeks high-level assurance and provides an independent and objective review on the effectiveness of our governance (corporate and clinical) and risk management processes and it assures the Board of Directors in respect of internal controls. It receives assurance from executive directors and other areas of the organisation through reports, both regular and bespoke. It validates the information it receives through the work of Internal Audit and External Audit, again through reports and attendance by key personnel at its meetings to present papers on specific matters. Assurance is also brought to the committee through the knowledge that non-executive directors gain from other areas of their work, not least their own specialist areas of expertise, visiting services, and talking to staff and governors.

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

The substantive membership of the Audit Committee is made up at any one time of three non-executive directors. During 2018/19 the following members served on the committee as substantive members: Martin Wright, who was the chair of the committee, Helen Grantham and Margaret Sentamu. The other non-executive directors are invited to attend on an ad-hoc basis as and when they feel it is appropriate, with the Chair of the Trust and the Chief Executive being invited to attend the Audit Committee on an annual basis; in 2018/19 Prof Sue Proctor attended the meeting in October 2018 and Sara Munro attended the meeting in May 2018.

In regular attendance at committee meetings are the Chief Financial Officer, and the Associate Director for Corporate Governance. There is also representation from our external auditors KPMG and NHS Audit Yorkshire for audit and counter-fraud services.

The table below shows the number of Audit Committee meetings in 2018/19 and attendance by each non-executive director member.

Table 3B – Attendance at Audit Committee meetings in 2018/19

Name	17 April 2018	21 May 2018	17 July 2018	20 November 2018	22 January 2019
Substantive non-executive director members					
Martin Wright (chair of the committee)	✓	✓	✓	✓	✓
Helen Grantham	✓	✓	✓	✓	✓
Margaret Sentamu	✓	✓	✓	-	✓

During 2018/19 the Audit Committee fulfilled the role of the primary governance and assurance committee and carried out its role primarily through:

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

At its May 2018 meeting the committee reviewed the Annual Report, Annual Accounts, the Quality Report, the Annual Governance Statement and the Head of Internal Audit Statement for 2017/18. It was assured in relation to each of these documents and recommended to the Board that they should be adopted.

A separate annual report for the Audit Committee is produced and submitted to the Board of Directors for assurance and is also submitted to the Council of Governors for information. This can be found on our website at www.leedsandyorkpft.nhs.uk.

Further information about the sufficiency of our internal control processes can be found in the Annual Governance Statement in Part A section 2.9 of this Annual Report.

SECTION 4 – THE COUNCIL OF GOVERNORS

4.1 COMPOSITION OF THE COUNCIL OF GOVERNORS

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

NHS Improvement requires each foundation trust to have a Lead Governor. Steven Howarth was our Lead Governor throughout 2018/19 and he stepped down in February 2019. We then ran an election process to find a governor from amongst our current Council membership and in April we confirmed Peter Webster as our new Lead Governor. We would like to thank Steven for his dedication to the role of Lead Governor during his time of appointment and welcome Peter to the role.

The main duties of the Lead Governor are to: be a point of contact for governors; make a presentation at the Annual Members' Meeting accounting for the work of the Council over the past year; and to be involved in the appraisal of the Chair of the Trust (with the Senior Independent Director) and the other non-executive directors (with the Chair of the Trust).

During the 2018/19 there was no change to the composition of seats within our Council of Governors. The composition ensures the Council is representative of our members and the public. Table 4A shows the composition of seats within our Council of Governors.

Table 4A – Composition of our Council of Governors

	Constituency name	Number of seats
ELECTED	Public: Leeds	6
	Public: York and North Yorkshire	1
	Public: Rest of England and Wales	1
	Service User: Leeds	4
	Service User: York and North Yorkshire	1
	Carer: Leeds	3
	Carer: York and North Yorkshire	1
	Service user and Carer: Rest of the UK	1
	Clinical Staff: Leeds and York & North Yorkshire	4
	Non-clinical Staff: Leeds and York & North Yorkshire	2
APPOINTED	Equitix Ltd (our PFI partner)	1
	Volition (third sector mental health network)	1
	Tenfold (third sector learning disabilities network)	1
	York Council for Voluntary Services	1
	Leeds City Council	1
	City of York Council	1
	TOTAL	**30**

Governors are either elected or appointed to seats on the Council of Governors for a period of up to three years. Elected governors consist of public, service user, carer, and staff (clinical and non-clinical) governors. Appointed governors are nominated individuals from partner organisations. Elected governors can stand to be re-elected for three terms of office holding a seat for up to a maximum of nine-years. Elections are carried out in accordance with the election rules in Annex 5 of our Constitution. Further details about the elections we have held during 2018/19 can be found below in section 4.2.1.

Appointed governors can also be on our Council for a maximum of nine years. This period is made up of three terms each of up to three years.

Tables 4B and 4C list those governors that have been members on the Council of Governors during 2018/19.

Table 4B – Elected governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of terms served
Marc Pierre Anderson	Service User: Leeds	3 years	25.09.17	24.09.20	1st
Sarah Chilvers *	Staff: Non-clinical	3 years	21.03.17	31.03.19	1st
Les France	Public: Leeds	3 years	22.08.16	21.08.19	1st
Gill Galea	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Jo Goode *	Staff: Clinical	3 years	21.03.17	12.12.18	1st
Christopher Hobbs *	Carer: Leeds	3 years	25.09.17	09.11.18	1st
Steve Howarth	Public: Leeds	3 years	22.08.16	21.08.19	2nd
Andrew Johnson	Staff: Clinical	3 years	21.03.17	20.03.20	2nd
Sarah Layton **	Staff: Non-clinical	3 years	30.04.18	29.04.21	1st
Jessica Lintin * **	Service User: Leeds	3 years	30.04.18	15.05.18	1st
Kirsty Lee	Public: Leeds	3 years	25.09.17	24.09.20	1st
Ellie Palmer *	Service User: Rest of UK	3 years	21.03.17	22.03.19	1st
Ivan Nip **	Public: Leeds	3 years	30.04.18	29.04.21	1st
Sally Rawcliffe-Foo	Staff: Clinical	3 years	25.09.17	24.09.20	1st
Ann Shuter **	Service User: Leeds	3 years	30.04.18	29.04.21	3rd
Niccola Swan	Public: Rest of England and Wales	3 years	22.08.16	21.08.19	2nd
Peter Webster	Public Leeds	3 years	22.08.16	21.08.19	1st

* Indicates those governors who stepped down early during 2018/19, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2018/19

Table 4C – Appointed governors

Name	Constituency	Maximum term of office elected for	Date appointed from	Date term of office ends / ended	Number of Terms served
Sarah Armstrong *	York Council for Voluntary Services	3 years	17.10.17	31.07.18	1st
Councillor Jenny Brooks	City of York Council	3 years	23.08.17	22.08.20	1st
Councillor Neil Dawson *	Leeds City Council	3 years	15.02.17	15.05.18	1st
Helen Kemp	Volition	3 years	08.11.17	07.11.20	1st
Councillor Keith Wakefield **	Leeds City Council	3 years	25.07.18	24.07.21	1st

* Indicates those governors who stepped down early during 2018/19, before the end of their term of office
** Indicates those governors who were newly elected or re-elected part-way through 2018/19

4.2 CHANGES TO THE COUNCIL OF GOVERNORS

During 2018/19 there were a number of changes to the individuals holding the position of governor on our Council of Governors. The Board of Directors would like to thank all those who either stepped down early from office or came to the end of their term of office and note the valuable contribution they made to the work of the Council. These are: Sarah Chilvers, Jo Goode, Christopher Hobbs, Jess Lintin, and Ellie Palmer.

4.2.1 Elected governors

Elections are carried out in accordance with the election rules as set out in Annex 5 of the Trust's Constitution (elected governors are in the constituencies set out in Table 4A). To be eligible to stand for election you must be a member of our Trust. Where a vacancy occurs in a constituency and the Trust agrees to hold an election, members in that constituency are invited to nominate themselves, and where there are more people standing for election than there are seats available it will be necessary to hold a ballot which is held on a first-past-the-post system of voting. In 2018/19 we held one round of elections one in spring 2018.

4.2.1.1 Elections held in spring 2018

During spring 2018 an election was held to the Council of Governors. This was due to there being a number of vacant seats already on the Council caused either by governors stepping down early or because the seats had been vacant for some time. The following seats were included in the election:

Table 4D – Seats included in the spring 2018 election

Constituency	Name of constituency	Number of seats included in the election
Public	Leeds	1
Public	York and North Yorkshire	1
Carer	Leeds	1
Carer	York and North Yorkshire	1
Service User	Leeds	3
	York and North Yorkshire	1
Staff Non-Clinical	Leeds and York and North Yorkshire	1

This round of elections commenced 1 March and concluded on 30 April 2018. We were successful in filling seats as follows:

Table 4E – Elected unopposed

Name	Constituency elected to:
Ivan Nip	Public: Leeds
Ann Shuter	Service user: Leeds
Jess Lintin	Service user: Leeds

For the Staff Non-clinical constituency we had more people stand than seats available and so we had to hold a ballot. The following governor was elected by ballot and turnout was 21.17%.

Table 4F – Elected by ballot

Name	Constituency elected to:
Sarah Layton	Staff: Non-clinical

At the end of the election we still had vacancies in the constituencies of Public: York and North Yorkshire (1 seat), Carer: Leeds (1 seat), Carer: York and North Yorkshire (1 seat), Service User: Leeds (1 seat), and Service User: York and North Yorkshire (1 seat). These will go into the next round of elections in summer 2019.

4.2.2 Appointed governors

Appointed governors are nominated by those organisations we have identified as our partner organisations, for the purpose of the Council of Governors, and are set out in table 4A.

During 2018/19 there were three changes to our appointed governors. Sarah Armstrong (York Council for Voluntary Services) and Cllr Neil Dawson (Leeds City Council) both stepped down during their first term of office. Councillor Keith Wakefield (Leeds City Council0 commenced his first term of office as an appointed governors on the Council of Governors.

The Board of Directors would like to thank all the appointed governors it has worked with through the year for all their hard work, supporting the development of the services we provide, and we would like to welcome those newly appointed to our Council.

4.3 MEETINGS OF THE COUNCIL OF GOVERNORS

During 2018/19 the Council of Governors had four business meetings. All general Council meetings are held in public, although items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session. The table below shows attendance at those four meetings.

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

The governors also hold an Annual Members' Meeting. This was held in July 2018. This is a public meeting and members are encouraged to attend to hear more about the work of the Trust and the Council of Governors. Table 4G shows those governors who attended the Annual Members' Meeting.

The table below details the number of meetings attended by each governor during 2018/19. This is shown out of a maximum of four meetings. If a governor has either resigned from, or joined the Council of Governors part-way through the financial year, the number of meetings they were eligible to attend has been amended to reflect this (those meeting dates which have been blanked out in the table indicate that a governor was not eligible to attend to the meeting).

Table 4G – Number of meetings attended by each governor

			COUNCIL BUSINESS MEETINGS ATTENDED				ATTENDANCE AT THE ANNUAL MEMBERS MEETING
Name	**Appointed (A) or elected (E)**	**Number of business meetings eligible to attend**	**15 May 2018**	**3 July 2018**	**8 November 2018**	**5 February 2019**	**31 July 2018**
Marc Pierre Anderson	E		-	-	-	✓	✓
Sarah Armstrong *	A		✓	✓			✓
Councillor Jenny Brooks	A		✓	-	✓	✓	✓
Sarah Chilvers *	E		✓	✓	✓	✓	✓
Councillor Neil Dawson *	A		✓				
Les France	E		-	-	✓	✓	✓
Gill Galea	E		✓	✓	-	-	✓
Jo Goode *	E		-	✓	✓		✓
Christopher Hobbs *	E		-	-	-		-
Steve Howarth	E		✓	✓	✓	✓	✓
Andrew Johnson	E		✓	✓	✓	✓	✓
Helen Kemp	A		✓	✓	✓	✓	-
Sarah Layton **	E		✓	✓	✓	✓	✓
Jessica Lintin * **	E		✓				
Kirsty Lee	E		-	✓	-	-	✓
Ellie Palmer *	E		-	✓	-	-	-
Ivan Nip **	E		✓	✓	✓	✓	✓
Sally Rawcliffe-Foo	E		✓	-	✓	✓	✓
Ann Shuter **	E		✓	✓	-	✓	✓
Niccola Swan	E		✓	✓	✓	-	✓
Councillor Keith Wakefield **	A				-	✓	-
Peter Webster	E		✓	✓	✓	✓	✓

* Indicates those governors who stepped down during 2018/19, before the end of their term of office and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)

** Indicates those governors who were newly elected or appointed during 2018/19 and as such may not have been eligible to attend all meetings (any meetings not eligible to attend are shaded out)

4.4 DUTIES OF THE COUNCIL OF GOVERNORS

The overarching role of the Council of Governors is to make our Trust publically accountable for the services it provides. It does this by representing the interests of members as a whole and those of the public. It informs our forward plans, and holds the non-executive directors (NEDs) to account, individually and collectively, for the performance of the Board. Governors are not directors and the duty of holding the NEDs to account does not mean governors are responsible for the decisions taken by the Board of Directors (members of the Board of Directors (both executive and non-executive directors collectively) share corporate responsibility and liability for those decisions).

Further information about the work of the Board of Directors can be found in Part A section 3 of this Annual Report.

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

- Appointing (and if necessary removing) the Chair of the Trust and non-executive directors
- Approving the appointment of the Chief Executive
- Appointing (and if necessary removing) the external auditor
- Receiving the Annual Report and Accounts, and the auditor's report on these
- Approving amendments to the constitution
- Taking decisions on significant transactions and also on any changes to non-NHS income.

If during the course of the Board of Directors and the Council of Governors carrying out their respective duties, it becomes apparent that there is a dispute between the Council and the Board there is a formal dispute resolution process which is set out in the Constitution at Annex 7 paragraph 10.

To help governors carry out their role, the Board of Directors also has a number of statutory duties placed on it including: sending a copy of the agenda of Board meetings to governors before each meeting and copies of minutes of meetings as soon as practicable after the meeting; and ensuring that governors have the skills and knowledge they require to undertake their role.

4.5 WORKING TOGETHER

The work of the Board of Directors and of the Council of Governors is closely aligned. The Chair of the Trust, supported by the Associate Director for Corporate Governance, provides a formal link between the two bodies and it is the Chair's responsibility to ensure an appropriate flow of information.

The Council of Governors has a primary relationship with the non-executive directors (NEDs) who are encouraged wherever possible to attend Council meetings to get to know the governors better and to hear first-hand their views and those of members. One way in which this is further supported is through the annual Board to Council meeting. This private meeting includes a number of the Trust's key strategic areas of focus on the agenda. This meeting further enhances the relationship between the Council and the NEDs and provides an opportunity for the governors to work more closely with NEDs and other members of the Board. Governors are also invited to a number of the Board sub-committee meetings and are encouraged to attend at least one public Board of Directors' meeting each year. This provides further opportunity for the governors to witness the NEDs holding the executive directors to account for the performance of the Trust.

The following table shows those Council meetings that were attended by members of the Board.

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

Name	15 May 2018	3 July 2018	8 November 2018	5 February 2019
Non-executive directors				
Prof Sue Proctor	✓	✓	✓	✓
Prof John Baker	✓	✓	-	-
Helen Grantham	✓	✓	✓	✓
Margaret Sentamu	-	-	✓	-
Sue White	✓	✓	✓	✓
Martin Wright	✓	✓	-	-
Steven Wrigley-Howe	-	-	✓	-

4.6 SUB-COMMITTEES OF THE COUNCIL OF GOVERNORS

The Council of Governors may not delegate any of its responsibilities; however, it can choose to carry out its duties either through individual governors or through groups and committees. In light of this, the Council of Governors has formed the Appointments and Remuneration Committee (a committee required in statute). This committee reports formally to the Council of Governors.

- **The Appointments and Remuneration Committee** – this committee reviews and makes recommendations to the Council of Governors regarding the appointments process for vacant posts within the non-executive director team, and also sets the level of remuneration for NEDs. Further information about the work of this committee during 2017/18 can be found in the Remuneration Report in Part A section 2.4 of this Annual Report.

4.7 THE REGISTER OF GOVERNORS' INTERESTS

Under the provisions of the Constitution and as described in the provider license, we are required to have a register of interests to formally record declarations of interests of members of the Council of Governors. The register will include details of all directorships and other relevant material interests which have been declared. It also asks governors to declare that they are of sound character and background to hold a position in public office.

On appointment and annually thereafter, members of the Council of Governors must declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interest and those arising from their membership of the Council of Governors. Members of the Council of Governors are also required to declare any conflict or pecuniary interests that arise in the course of conducting business at each meeting. Each year governors will complete a new declaration of interest form to ensure the most up-to-date position is declared. These annual declarations are also reported to the Council of Governors.

The Register of Interests is maintained by the Associate Director for Corporate Governance and is available for inspection on the Trust's website. The Associate Director for Corporate Governance can be contacted by telephone on 0113 8555930 or by email at chill29@nhs.net.

SECTION 5 – MEMBERSHIP

5.1 OUR CONSTITUENCIES AND ELIGIBILITY TO JOIN

As at 31 March 2019 the membership was 15,379. This has been steadily maintained throughout the year. The tables below illustrate the breakdown, by constituency, of the total number of members.

We have three membership constituencies: public; service user and carer; and staff. A breakdown of these is shown at table 5A.

There are three public constituencies: Leeds; York and North Yorkshire and Rest of England and Wales. These constituencies are made up of a number of local government electoral areas. This is in accordance with the NHS Act 2006. If a person wants to join a public constituency the relevant one will be determined by the address at which they live.

The Service User and Carer Constituency is divided into five constituencies for the geographical areas of: Leeds; York and North Yorkshire and the rest of England and Wales. Again these constituencies follow the local government electoral boundaries. Anyone who has used our services in the last 10 years or cares for someone who has used our services can join the Service User and Carer Constituency. An individual's home address will determine which constituency they join.

The Staff Constituency is divided into two categories: Staff: Clinical and Staff: Non-clinical. Any individual who is employed by the Trust under a contract of employment will automatically become a member unless they opt out. In addition to those individuals directly employed by the Trust, people who exercise a function for the Trust may also choose to be a member of the Staff Constituency. Whether a person joins the clinical or the non-clinical class will be determined by national occupation codes.

Table 5A – Membership constituencies

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

5.2 NUMBER OF MEMBERS

Table 5B – Total membership by constituency as at 31 March 2019

Public constituency	Number of members
Public: Leeds	8198
Public: York and North Yorkshire	1579
Public: Rest of England and Wales	1932
Total public members (including 35 members outside England and Wales)	11741

Service User and Carer constituency	Number of members
Service user: Leeds	547
Service user: York and North Yorkshire	93
Carer: Leeds	337
Carer: York and North Yorkshire	41
Service User and Carer: Rest of UK	104
Total service user and carer members	1122

Staff constituency	Number of members
Clinical staff: Leeds and York & North Yorkshire	1874
Non-clinical staff: Leeds and York & North Yorkshire	618
Total staff members (including 10 unspecified)	2516

Membership has maintained steady at 15,379 as at 31 March 2019. These tables illustrate the breakdown, by constituency, of the total number of members.

5.3 DEVELOPING A REPRESENTATIVE MEMBERSHIP

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

A review of membership has been undertaken by the Trust and results from this confirmed that membership numbers remain high and representative. It was felt that further work should be undertaken to develop meaningful engagement with members whilst maintaining the total number. Work has taken place to review what meaningful engagement could look like for our members. It was decided the basis of this would include:

- Improving member engagement
- Communicating better with members
- Maintaining a representative membership.

Work has also been underway to create a clear branding for membership that is consistent with the Trust's brand and its wider strategy. The Trust has reached a strong solid membership number; now the focus will be on developing a programme of engagement for members.

5.4 MEMBERSHIP RECRUITMENT AND ENGAGEMENT

We value the contribution of our membership and our focus will be on qualitative rather than quantitative membership levels and engagement. The Council of Governors support planned development work of the membership database alongside the creation of an ongoing engagement programme. Work to develop these areas of work is on-going.

A focused approach to membership engagement and recruitment is supported by the development of the membership database. This allows for recruitment and engagement campaigns to maintain a representative membership. Engagement with members is enhanced through improved communication tools using the database, and a structured membership engagement plan that is supported by the Trust's Communications Team.

We have a varied approach to facilitating engagement between governor, members and the wider public. In particular, each year we hold our Annual Members Meeting. This not only incorporates the statutory annual meeting where the Council accounts for how it has carried out its duties on behalf of members, it also has an opportunity for a 'Big Conversation'. This is where members and the public can talk about their experience of our services both good and not so good which informs their role on the Council. Governors get the opportunity to meet with, talk to and hear from their constituents and the wider public. In 2019/20 we will continue to ensure that our governors are central to this event which allows them to engage with a diverse group of people.

5.5 THE MEMBERSHIP OFFICE

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

SECTION 6 – OUR AUDITORS

6.1 EXTERNAL AUDIT SERVICES

Our external audit service is provided by KPMG. They were appointed by our Council of Governors with effect from 1 October 2017 following a full tender process.

All members of the KPMG audit team are independent of the Board of Directors and of staff members. Each year the audit team provides a statement in support of the requirements for their objectivity and independence to the Audit Committee. The auditors provide audit services in accordance with the Code of Audit Practice. This covers the opinion on the annual accounts, financial aspects of corporate governance, the use of resources, the Annual Report and the Quality Report.

The cost of independent audits during 2018/19 is detailed in the table below:

Table 6A – Cost of statutory audits

The Annual Accounts	£47,000
The Quality Report	£8,100
Total	£55,100

6.2 INTERNAL AUDIT SERVICES

Our internal audit and counter fraud services are provided by Audit Yorkshire. This is a specialist provider of internal audit services to the NHS. Audit Yorkshire was formed on 1 July 2016 from a merger of West Yorkshire Audit Consortium (WYAC) and North Yorkshire Audit Services (NYAS). WYAC and NYAS previously worked in partnership to provide our internal audit service and had signed a Memorandum of Understanding to support this.

The Internal Audit Team is led by Helen Kemp-Taylor who is the Managing Director and Head of Internal Audit. She is supported by Sharron Blackburn (CPFA) as Client Manager. Sharron is the Deputy Head of Internal Audit. The remaining team of auditors and specialists is drawn from across Audit Yorkshire.

The scope of the work of internal audit is to review and evaluate the risk management, control and governance arrangements that we have in place, focusing in particular on how these arrangements help it to achieve our objectives. The audit opinion may be used by the Accounting Officer to support the Annual Governance Statement. This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee. Internal Audit is only one source of assurance and it works closely with other assurance providers, such as external audit and Local Counter-fraud Services, to ensure that duplication is minimised and a suitable breadth of assurance obtained.

In 2018/19 the Trust took the decision to become a formal member of Audit Yorkshire rather than a client. This will provide both a direct cost benefit, in terms of a reduced day rate. It also has the benefit of ‘buy-in’ and ownership with the ability to shape coverage and direction of the service, and will contribute to the consolidation of back office functions which is in line with the Lord Carter and NHS Improvement recommendations. The membership of Audit Yorkshire will commence on 1 June 2019 when the current client contract ends.

PART B
THE QUALITY REPORT
2018/19

CONTENTS

PART B – QUALITY REPORT

SECTION 1 STATEMENT ON QUALITY FROM THE CHIEF EXECUTIVE

On behalf Leeds and York Partnership NHS Foundation Trust (LYPFT) I am pleased to present our Quality Report and Account for 2018/19.

This document shares with you a range of data, information and stories to assure you about the quality of our services. This report also provides statements of assurance on the quality of services and describes some of the quality improvements and developments we have made during 2018/19. It reviews the Quality Improvement Priorities (QIPs) we made a commitment to in 2018/19; and reports on the positive progress against those to date. We have also set out the quality priorities we have identified for the forthcoming year (2019/20), how these have been developed and how we will measure and report on them going forward.

This year's report has been co-produced using service user and carer feedback and engagement; in consultation with our staff and Clinical Care Groups; and using lots of intelligence available to us through our electronic systems, reports and governance meetings. Many of the stories regarding the development and quality improvement of our services have been written by service leads; and those who work hard to ensure we provide the best possible service to our service users and those that care for them. A service user story is also featured.

We have also included statutory information statements that all NHS Trusts are required to include in accordance with National Regulations and NHS Improvement (NHSI) requirements. These are mainly contained within Section 3.

We hope that this document clearly demonstrates our commitment to our Values and Behaviours:

- **We have integrity**
- **We are caring**
- **We keep it simple**

as well as evidencing that our services are safe and effective.

We recognise the value of working in partnership with other healthcare providers to achieve the maximum benefits and improve clinical outcomes for service users. We have been actively involved in the Integrated Care System (ICS) Mental Health & Learning Disability Programme for West Yorkshire and Harrogate; a programme that I chair. ICS's take the lead in planning and commissioning (funding) care; and providing joined up leadership for their populations. They bring together NHS care providers and commissioners and local authorities to work in partnership in improving health and care in their area.

In the last year we have led on a number of the work streams in the programme, including the review of inpatient assessment and treatment provision for people with a learning disability across West Yorkshire, which we hope will lead to improvements in the year ahead. We have also been involved in other work streams relating to acute & urgent care and suicide prevention. LYPFT has led the development and delivery of a new West Yorkshire service for the care and treatment of adults with an eating disorder, as one of the national New Care Model initiatives. This has resulted in us no longer having any out of area admissions to hospital, as well as a significant increase in the availability of community treatment packages.

This document describes many of the things we are proud of as a provider of Mental Health and Learning Disability Services; as well as identifying our challenges and how we might address these.

Further examples of areas to celebrate include our new service: the Veterans' Mental Health Complex Treatment Service (VMH CTS) for former armed forces personnel who have been diagnosed with complex mental health illness. We have also developed our Clinical Model in the Forensic Service with great success. The development of Leeds's first Recovery College began in 2018 and is a multi-

agency, citywide venture which seeks to provide educational and learning opportunities for service users, their families and staff from across Leeds. You can read more about these examples, and many other service developments and improvements, throughout the document.

Over the past year, the people who work for the Trust have made a real difference, by providing high quality mental health and learning disability services to those in need of our support. It is vital that we celebrate these achievements and acknowledge the resilience and determination that our staff have demonstrated in the face of some notable challenges. Our monthly STAR Award recognises staff, teams and volunteers who display positive behaviours in keeping with the Trust's values. The STAR Awards provide us with an opportunity to celebrate the valuable contributions made by our employees and teams. We also hold an annual awards ceremony. We received a record-breaking 188 nominations for our 2018 Trust Awards, which is a testament to the fantastic people we have on our team.

Whilst we have much to celebrate, we are mindful that there are many challenges ahead for us. Like many NHS organisations we continue to meet the challenge of improving the quality of care in a time of constrained resources and increased demand for our services. We have managed our resources well to remain in a positive position financially whilst undertaking to transform, develop and ultimately improve our services. Our challenge will be to sustain this position in parallel with making future cost improvement savings and ensuring our estate is fit for purpose.

We also share the experience of our partner organisations in the challenge to maintain our workforce numbers, particularly in the fields of nursing, medicine and allied health professions. Recruiting and retaining staff remains a high priority for us and you can read more about our strategies for this in the document, as well as the ways we are working to grow our workforce and leadership within the organisation. The wellbeing of our staff is paramount and we are continually exploring ways to minimise working time lost through illness, including mental health illness, within LYPFT.

Patient safety and quality of clinical care is at the heart of everything we do and reducing avoidable harm is everybody's business. Embedding safety within our service Care Groups is a high priority for us. Our Services have well established and robust safety and clinical governance arrangements in place, which are embedded through operational teams and services. During the last 12 months the oversight of risk and incident management reporting, for example, has been strengthened within both of our Care Groups. These developments have given staff the opportunity to understand where things have gone well and to identify opportunities for learning and development; as well as share this with other services.

We have made, and are still making, continuous improvements to our clinical governance structures and processes to ensure they are robust and facilitate learning and improvement. Our clinical governance processes will be further embedded during the next 12 months as we move to a more cohesive and integrated operational care services model. You will see this reflected within this document as well as our Quality Improvement Priorities for 2019/20, alongside a commitment to progress our suicide prevention work.

Over the last year we have developed a partnership forum with third sector providers with the aim of improving the services we jointly deliver and strengthening relationships. Our established joint operational and governance meetings with Leeds Teaching Hospitals NHS Trust, Leeds Community Healthcare and Adult Social Care are proving to be invaluable. We have also entered into new partnership to provide a Liaison and Diversion service.

Following the CQC inspection in January 2018, we have continued to address the actions we identified as necessary to move to being a 'good' organisation, as assessed by the CQC's Key Lines of Enquiry (KLOE). All of these actions are now complete; or on track for completion by the required

timescale. We regularly meet and closely engage with our CQC inspection team and are currently preparing for our next inspection.

I am happy to state that, to the best of my knowledge, the information included in our Quality Report is accurate. We very much hope you enjoy reading about the progress we have made over the last year; and our plans for 2019/20.

Dr Sara Munro
Chief Executive

Statement of Directors' responsibilities in respect of the Quality Report and Account

The directors are required under the Health Act 2009 to prepare a Quality Account for each financial year. The Department of Health issues guidance on the format and content of Quality Accounts, which incorporates the legal requirements in the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010, as amended by the National Health Service (Quality Accounts) Amendment Regulations 2011.

NHS Improvement (NHSI) has issued guidance to NHS Foundation Trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the report meets the requirements set out in the NHS foundation Trust annual reporting manual 2017/18 and supporting guidance
- 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 2018 to 23 May 2019
  - papers relating to quality reported to the board over the period April 2018 to date
  - feedback from commissioners received 25 April 2019
  - feedback from governors received through consultation in January and April 2019
  - feedback from the local Healthwatch received 26 April 2019

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

By order of the Board

Date 23 May 2019 **Chair** 

Date 23 May 2019 **Chief Executive**

SECTION 2

REVIEW OF OUR QUALITY IMPROVEMENT PRIORITIES 2018/19

In addition to the regulated statements regarding the quality of our services, a set of Quality Improvement Priorities (QIPs) should be developed, which describe our plans for quality improvement within the organisation. They are informed using intelligence identified through for example: patient, public, carer, and staff engagement; performance information and data; learning from incidents; feedback from concerns and complaints; CQC recommendations; and feedback from our stakeholders. You can read more about how we have done this for our 2019/20 QIPs in Section 4.

The Quality Account Toolkit 2010/11 recommends that Trusts have a manageable number of QIPs to set out within the document. This is often a challenge amidst all the work we set out to achieve over the year. As recommended, we continue to link our QIPs to the following three domains of quality:

Review of 2018/19 Quality Improvement Priorities

For 2018/19 we identified twenty Quality Improvement Priorities (QIPs) in total that we committed to review as part of our requirements for this report. These priorities were also the Trust's operational priorities, which are part of 3-year strategic (long term) plans. They have been monitored over the year as part of the Trust's Operational Plan and via the governance groups included with each priority as follow in the small tables included throughout this section. These QIPs are also monitored on a quarterly basis by our Executive Management Team and twice each year by our Trust Board.

All currently applicable QIPs are either **complete or progressing** towards the completion date. Some of them have been grouped together where they are part of broader plans to improve our services. You will find them within the boxes identified throughout this section.

One QIP is currently pending: in partnership with Leeds Community Healthcare NHS Trust (LCH) as the main community provider, the Leeds GP Confederation as the main primary care service provider and third sector providers we have recently collaborated on a partnership tender bid to provide a primary care mental health service (incorporating Improving Access to Psychological Therapies [IAPT] and primary care mental health) across Leeds. The outcome of this process will not be known until later in the year.

We will not be 'retiring' any of the 2018/19 priorities where they are still in progress. We will continue to monitor those priorities through the forums described within this section, to ensure they remain on track against the proposed completion dates.

The following 2018/19 QIPS continue in a new way into the QIPs for 2019/20:

- Review of the Patient Experience Service and team structure
- Community Mental Health Services Redesign
- Implementation of a model for Quality Improvement to be used across the whole Trust

You can read about how these will continue in Section 4.

Patient Experience Service Review

In May 2018 our Executive Director of Nursing Professions and Quality commissioned an external review of our current systems and processes in relation to patient and carer experience and public involvement.

It is important that LYPFT is able to clearly describe through a strategy 'how we obtain service users' and carers' experience and feedback'; and how we continue to involve them in our planning and improvement of services. Whilst we have historically had a small centrally based team carrying out this service, we recognised that there was need to work towards ensuring that quality patient experience and involvement was not limited to a small group of staff; and to ensure that patient experience and involvement is everybody's business.

The review was led by Professor Gamsu from Leeds Beckett University. The outcome of the review in January 2019 formed the basis for ensuring that LYPFT has a structured, systematic and fully inclusive approach to patient, carer and public engagement.

Projected QIP 2018/19	Time frame	Progress achieved
Review of the Patient Experience Service	*March 2020*	**On track to be achieved.** We have completed a formal independent review of the way we provide our Patient Experience Service. Improvements have been identified as part of our review; these are to be fully implemented during 2019/20.

Community and Crisis Redesign

Projected QIP 2018/19	Time frame	Progress achieved
Community Mental Health Services redesign	*March 2019*	**Scheme achieved.** Our new service model for community mental health services officially went live on Monday 25 March 2019. Extensive engagement conducted as part of our new service model design process (see narratives that follow) Monitored through the Service Development Group. Plan in place to evaluate our new service model which has been agreed through a process involving service users, carers and our commissioners.

Community and Crisis Redesign: Engagement

In October 2017 we began to review the options for how we provide community services for older people. A series of consultation events with service users, carers and staff provided feedback that our 'ageless service' did not reach the standards of care that we aspire to provide to our older service users. This included concerns that older people's needs were not sufficiently recognised and that there was decreasing expertise in older people's care. It became clear that we needed to re-establish specialist older people's mental health services in the community in a way that would lead to improved outcomes and higher quality care.

As the work progressed we could see that plans to move staff into a dedicated older people's service would also impact on the services for adults of working age; and that community mental health services for working age adults were experiencing significant challenges within their own existing care model. Therefore, in December 2017 we undertook to review both working age and older people's community mental health services together.

Our proposed model for community services and the basis for our engagement included:

- Development and delivery of a dedicated service and pathway for older people
- Establishment of two Crisis Resolution Intensive Support Services (for working age and older people) providing 24 hour per day, 7 days per week, intensive support to people, gatekeeping all acute admissions to hospital and providing crisis assessment and intensive support to people at home
- Separation of the Single Point of Access (SPA) function from the Crisis team
- The working age adult community mental health teams providing a clear and consistent assessment and formulation period for all patients; and prioritising those with greatest need for on-going interventions
- Changes to the Memory Service pathway, with an increased focus on early diagnostic activity
- Integration of the stand-alone Care Homes team into other community services for older people
- Realigning our geographical boundaries across the city
- Developing in partnership with our Social Care colleagues, an offer of structured therapeutic interventions to be provided from Stocks Hill, Vale Circles and Lovell Park

Engaging with all….

Our eight week programme of engagement began on 1 May 2018, building upon the engagement activities and views already captured as part of the development of the older people's community model, which began in October 2015. The engagement programme featured a number of activities and mechanisms that have allowed service users, carers, staff, partners and members of the public to hear the proposed plans for our community mental health services and allowed us to understand people's views, opinions and experiences in relation to this. We identified the following people and groups as being the most important to the success of our engagement programme:

- Staff working in the affected services
- Staff across the Trust
- Community mental health service users
- Carers
- Our Leeds-based foundation trust membership
- Forum Central – collective voice for the third sector in Leeds
- Third sector partners
- Voluntary sector organisations
- Groups representing service users and carers e.g. Healthwatch Leeds, Age UK, Leeds MIND
- Representatives from relevant local authority departments e.g. Adult Social Care
- GPs and primary care health professionals
- Local NHS commissioners
- Local NHS partners e.g. Leeds Community Health NHS Trust
- Leeds City Council Scrutiny Board for Adults, Health & Active Lifestyles

The core elements of our public engagement included:

- A suite of communications materials, including three public facing leaflets specific to our proposed plans for working age adults, older people and a general overview.
- A survey designed to be as short and accessible as possible to facilitate maximum return. This was produced in paper copy and hosted online via the Survey Monkey website.
- A dedicated page on our website hosting all the relevant information, a link to the survey, details of our engagement events and how to contact us about the engagement and proposed service changes. See www.leedsandyorkpft.nhs.uk/get-involved/community-mental-health

- A series of face to face public events and meetings with the key groups and individuals referenced above.
- Two mass mailings: one to current service users and one to our Leeds-based membership database.
- Partnership working to deliver our engagement programme with Forum Central - a collective voice for the health and care third sector in Leeds representing a membership of around 300 organisations.

In total we engaged with **17,850** service users, carers, staff, partners and the general public about our proposed plans. We had an overwhelming response to our engagement campaign, with 74% of our public respondents feeling our proposals would improve services. Our full engagement report can be found at:
https://www.leedsandyorkpft.nhs.uk/get-involved/wp-content/uploads/sites/11/2018/10/CMHS-Engagement-Summary-Report.pdf

We would like to thank our colleagues at Healthwatch Leeds who carried out their own engagement with older people to gain further independent feedback. Their findings very much reflected what we learned from our own engagement and strengthened our rationale for change. The Healthwatch report is available alongside the suite of engagement documents available on our website.

In 2019/20 we will evaluate the change we have made to assess the impact and outcome in relation to the experience our patients have received. We have identified this work as one of our Quality Account Quality Improvement Priorities for 2019/20.

New mental health service for armed forces veterans

The Veterans' Mental Health Complex Treatment Service (VMH CTS) is for former armed forces personnel who have been diagnosed with complex mental illness. Many will have been affected by trauma and all will be facing challenges as a direct result of their military service. The service was launched in April, and offers trauma-focused therapies and other support to veterans, including help with substance misuse, physical health, employment, accommodation, relationships and finances.

The service became 'live' on 1 April 2018 and throughout its first year has established a service across the North of England working in partnership and collaboration with:

- *Combat Stress* an organisation that provides our substance misuse and peer support services)
- *Transition Intervention and Liaison services (TILs)* provided by Northumberland Tyne & Wear Trust who refer into the CTS

The number of people accessing the service has steadily grown over the year with over 100 veterans receiving all or part of a phased period of treatment from stabilisation and trauma focussed therapy, concluding with reintegration; enabling veterans with military related trauma to receive evidence based treatment and support.

Bases in each of the three hubs; Sunderland, Salford and Leeds have now been sourced to enable the team to be supported to deliver treatment across the whole geographical area. Effective networks have been established with other NHS providers and military charities; predominantly signed up to the Armed Forces Covenant; *"a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly",* to support veterans with complex mental health needs.

CONNECT: The West Yorkshire and Harrogate Adult Eating Disorders Service

Projected QIP 2018/19	Time frame	Progress achieved
Delivery of New Care Models for Eating Disorders	*April 2018*	**Scheme achieved.** Monitored through the Service Development Group. Project went live on 1 April 2018 with a graded implementation. Work conducted with partner Trusts to implement the service across the Sustainability and Transformation Partnership (STP: a group of local NHS organisations and councils that have drawn up proposals to improve health and care in the areas they serve). Funding has been agreed with NHS England. The service will be evaluated and monitored over the next 18 months as per the requirements of the pilot.

We are incredibly proud to be part of the new West Yorkshire and Harrogate Adult Eating Disorders Service. The service was developed through a 'New Care Models' initiative for Adult Eating Disorders as part of NHS England's 'Five Year Forward View for Mental Health', in partnership with Bradford District Care Foundation Trust (BDCFT) and South West Yorkshire Partnership NHS Foundation Trust (SWYFT).

This development has involved the expansion and changes to existing eating disorders services to reshape both inpatient and community care for adults with eating disorders across regional footprint shown below, with a population of 2.6 million people spread across a wide geographical area.

Management of Really Sick Patients with Anorexia Nervosa (MARSIPAN)

Eating disorders encompass physical, psychological and social elements that increase the risk for the patient. They cause significant psychiatric illness and the harmful physical consequences of dieting, weight loss and purging can sometimes prove fatal with anorexia nervosa being the highest cause of death of any psychiatric condition. In response to these concerns the Royal College of Psychiatrists published the "Management of Really Sick Patients with Anorexia Nervosa" (MARSIPAN) report (2014) which provides guidance on:

- standards of physical assessment for eating disorders
- criteria for admission to both medical units and specialist eating disorder units as well as non-specialist psychiatric units, and criteria for transfer between services
- Development of MARSIPAN pathways and a MARSIPAN expert working group for every hospital which admits patients with eating disorders
- the medical, nutritional and psychiatric management of patients with eating disorders in medical units, including the appropriate use of mental health legislation
- commissioning of services for MARSIPAN patients

Quality Improvement Plans and Strategy

One **aim** of the new CONNECT service was to deliver a consistent approach to MARSIPAN across the West Yorkshire and Harrogate region and to: *develop a safe and effective region wide MARSIPAN hub and spoke model covering West Yorkshire and Harrogate.* We set out our plans to standardise MARSIPAN pathways and expert working groups across all of the acute NHS Trusts within the region, as well as ensuring local care pathways were based on service user and local community needs.

We implemented the following changes:

- engagement with stakeholders from the 4 regional MARSIPAN spoke sites and the central MARSIPAN hub site in Leeds
- development of a MARSIPAN care pathway and expert working group within each of the 4 spoke sites
- Monitoring of MARSIPAN performance through audit and stakeholder feedback

We also identified the following ways to monitor and measure the changes we made:

- MARSIPAN care pathway documents for each of the MARSIPAN hub and spokes sites
- MARSIPAN expert working group meeting minutes

Outcome and Impact on Quality of Care

Since April 2018 CONNECT has successfully developed MARSIPAN care pathways and expert working groups in four spoke sites (Bradford and Airedale, Harrogate, Wakefield and Dewsbury, Calderdale) with integrated partnership arrangements agreed with local mental health providers, primary care services and local acute hospital providers.

The CONNECT MARSIPAN hub and spoke model will be continuously evaluated as part of the annual CONNECT service evaluation. The NHSE Eating Disorders Reference Group and Royal College of Psychiatrists have included the CONNECT MARSIPAN hub and spoke model as part of their national service specification for adult eating disorders services.

Projected QIP 2018/19	Time frame	Progress achieved
Redesign of our low secure model at Clifton House, York	*December 2018*	**Scheme achieved.** Monitored through the Service Development Group. Local restructure is now completed and the wards are reconfigured. All staff are settled into their new roles.
Implement a new forensic community outreach model (including in-reach) that provides specialist community support and intervention for service users with on-going significant / complex mental health needs.	*December 2018*	**Scheme achieved.** Monitored through the Service Development Group. An expanded community forensic team has been recruited to and is fully operational from Clifton House.

Development of a Clinical Model in the Forensic Service

A clinical model provides staff and service users with a shared framework in which to develop an understanding of our service users' difficulties and provide pathways for recovery. It also provides us with opportunities to think and work collaboratively (together with others) and constructively when stuck. Research suggests that using a collective clinical model that underpins clinical practice, is essential to ensure consistent delivery of care.

An external review of our Forensic Service highlighted the absence of a clinical model within the service. Additionally, the requirement for a clinical model that "describes the purpose of the service and details the clinical approach in relation to key therapeutic outcomes" is a quality standard, as assessed by the Royal College of Psychiatrists Peer Review Quality Network.

Previous attempts to introduce a clinical model within the service had been unsuccessful for a number of reasons. To increase the chances of success when reattempting to introduce a clinical model, greater emphasis was placed on engaging the whole service; and the use of Organisational Development expert support.

The team set out to establish a model that was:

- structured to provided consistency and flexible enough for individual differences and ward variations

- owned across the service and different professional and staff groups
- developed and owned by the service
- evidence based and meaningful
- administratively efficient
- consistent with the service vision
- empowering for staff and developed and enhanced their skills

A cross cutting group of staff and professions across both our Forensic sites, Clifton House York and the Newsam centre Leeds engaged in three workshops to begin to work through the tasks required. These were facilitated externally by an expert in Organisational Development that had been working with the service on wider change. The working party shared their work with the wider leadership team to test its viability, effectiveness and meaningfulness; and to consider the next steps.

The process brought about widespread recognition that the service was dominated by certain legal frameworks which, whilst necessary, were experienced as limiting. We also needed to consider the richness, diversity and complexity of our service users; and the skills and professional knowledge of our staff as part of the model development.

"*Nurturing Safer Futures*": To further frame our model of care delivery we adopted the principles of 'trauma informed care'. These recognise that most of our service users have experienced multiple traumas and challenges in their lives; and how these experiences shape service users' choices, behaviours, thoughts, feelings and relationships as adults.

The clinical model was well received and embraced by the wider service; and over 2018/19 we moved from shaping the model to embedding the model, aligning existing practice to the new model rather than build in extra processes or paperwork. In 2019/20 we will continue to embed the model with a focus on both staff and service users; this will include the co-development of an information leaflet via our recovery college. We plan to evaluate the change to see how well the model is understood and utilised; and the impact of its introduction on patient care staff and staff wellbeing.

Street Triage: collaboration and improvement

Section 136 of the Mental Health Act 1983 provides for the police to remove a person from a public place when they appear to be suffering from a mental disorder; and transfer them to a place of safety with a view to preventing harm. Street Triage was first introduced in Leeds at the end of 2018 as one of nine pilot sites in the country. The service supports the police offering advice and/or face to face assessment prior to the use of a 136 detention; to ensure its use is appropriate.

Following the commencement of our pilot there was a 26% reduction in the use of Section 136 in the first year, with a further 2% reduction in the second year. The Section 136 annual referral rate has been relatively stable. More recently our Street Triage service noticed an increase in 136 referrals for people who were due to be released from custody and who presented with a mental health issue whilst in custody. When the team reviewed the available data they noted that a full mental health act assessment was likely to be unnecessary in most cases and service users could have been offered a less restrictive, informal method of assessment of their mental health.

It was a challenge for the police custody service to ensure that people being released from custody, who appear to have a mental health issue, were released in a safe way and received the right support for their mental health needs. The learned approach was to transfer the person being released from one place of safety (custody) to another (Becklin Centre) using section 136 of the Mental Health Act to facilitate this.

Through the review of many relevant cases we identified that our crisis services could have intervened earlier to provide the opportunity for an enhanced assessment of a person's mental state. The team involved unpicked the issues to providing this approach and found that two areas for improvement:

- communication at the point someone was taken to custody with a suspected mental health problem
- a lack of understanding of both services working processes were the key areas to improve on

Police custody inspectors visited the Becklin Centre to see how both the Crisis Team and Street Triage services are provided. This enabled staff in both services to get to know each other and understand how they could improve their partnership working. This year the Street Triage team will spend time in the police custody service to understand how the service operates; and to meet more of the staff they will be working with.

The Street Triage team has introduced a daily call to the custody suite with a view to building on the improved working relationships: to ensure people who need mental health support are brought to the attention of the team as early as possible; and to enable us to plan the most effective route of assessment.

Since this work, Section 136 cases arising directly from custody have reduced and working relationships remain strong between both services. Plans are in place to extend this approach to patrol police, as the next step to improving partnership working and the quality of mental health care within the footprint of the service we provide.

Enhanced Care Homes Team (ECHT)

Projected QIP 2018/2019	Time frame	Progress achieved
Development and delivery of the Winter Plan	*March 2019*	**Scheme achieved.** We have successfully implemented an Enhanced Care Homes service within the Trust and have received confirmation that this function will continue to be commissioned on a recurrent basis. This new service has been instrumental with improving the flow from our inpatient units and supporting people either into new or existing care home places. Monitored through the Service Development Group.

Our Care Homes Team works mostly with older people who live in care homes and have difficulties related to mental health problems or dementia. Over the last 3 years it has become apparent that a certain group of care home residents are particularly vulnerable to being admitted to hospital; and experience problems in finding another place to live if the care home is unable to provide them with accommodation on discharge from hospital.

This group of people often have complex behavioural and psychological symptoms of dementia that care homes can find a challenge to manage, such as physical aggression and sexually inappropriate behaviour. Whilst these behaviours are a symptom of the dementia, if they continue for a long time, the care homes can feel they are no longer able to care for the person safely.
In these circumstances, people are often admitted to Acute Inpatient Dementia wards. Once admitted it can prove difficult to find places where a person can live safely and with a good quality of life; hence their hospital stay can be longer than required. This is not the best place for that person or their family/carers because they are deprived of a normal living experience that a care home can provide compared to a hospital stay. It also means that other people who do need hospital care aren't able to access that service as quickly as they need.

We commenced a trial, using a new Enhanced Care Homes Team from July 2018. This piece of work provided an additional and alternative service to the existing Care Homes Team. The new team has focused on people in wards at Leeds Teaching Hospitals NHS Trust and on our own wards that have stayed in hospital longer than necessary. The team have worked proactively to identify suitable care homes willing to take these vulnerable residents and offer intensive support to the home to help establish the placement successfully. This intensive work included two or more visits per day where necessary to assist the resident to settle into their new home and support for care home staff to find ways to best support each individual.

The team also carried out preventative work, to avoid admission to hospital where it was not indicated as best for the patient's needs. This was achieved by offering rapid support to care homes when they felt they could no longer carry on supporting the person with dementia.

The Enhanced Care Home Team has to date achieved the following quality outcomes:

- Supporting 42 residents who have been 'stuck' in hospital to be discharged to suitable care homes
- Helped 5 residents avoid being admitted to hospital where it was not necessary
- Received feedback from care home providers and social workers that the team's input has made a significant difference to the care of people with complex needs

These outcomes are encouraging and the successes have gained support within Leeds for the service to continue in order to assess the level of impact the team can have over a longer period of time. This means there will be an improved and enhanced level of support to residents living in residential and nursing care homes when they need it most.

Safe staffing

Projected QIP 2018/19	Time frame	Progress achieved
Ensuring we have the right number of staff, with the right skills on our wards (safe staffing)	*March 2020*	**On track to be achieved.** Using a nationally recognised acuity tool we are completing a review of the level of staffing across our inpatient services, to help us understand if we have the right number of staff on our inpatient wards. Monitored through the Safer Staffing Steering Group and Financial Planning Group.

Safe staffing levels have historically been agreed according to a department's budget, relying on professional judgment, providing little evidence to rationalise using flexibility to meet the level of care service users need when this differs from the agreed numbers of staff. This can lead to unwarranted variation in staffing levels.

In order to address this, we have adopted the use of The Keith Hurst Optimal Staffing Tool across all of our inpatient services. This evidence-based tool helps us understand what our nursing and staffing levels should look like at ward level. The tool can analyse the needs of the service users present on the ward every day; it is recommended that we use it twice per year to check we have the right overall level of staffing. It also enables wards to gather data to predict ward activity and staffing levels and better prepare to meet the needs of its service users.

Benefits of the tool for service users:

- Places service users' needs at the heart of workforce planning and delivery.
- Allows reduced dependency on agency staff and service users experience the benefits of having a more consistent care team who are more familiar with each service user, their care plans and our Trust policy & procedures.
- Provides for better patient outcomes and reduce the length of stay people have on our wards.

Benefits for staff:

- Staffing levels are scientifically calculated and evidence based. This models how a safe ward looks. The tool provides the robust evidence for proposals to funding bodies for changes to services.
- The ward is staffed to optimum level, so levels of overtime and use of agency staff are minimised. Workload should be more consistent between wards and shifts.
- Colleagues have the experience and knowledge of service users and team members to efficiently and effectively provide a higher quality of service.

Our Estate

We are currently developing our estates upgrade programme to be implemented from 2019 to 2021 as outlined in our Estates Strategic Plan. This programme will include Life Cycle funded through the Private Finance Initiative (PFI) Contract; and we are working with external partners to develop an overarching plan for agreement with our clinical teams.

Projected QIP 2018/19	Time frame	Progress achieved
Redesigning our estate	*April 2020*	**On track to be achieved.** During 2018/19 we concluded the sale of four Trust properties: Malham House, Springfield Mount, Southfield House and The Cottage; and successfully concluded the re-financing of our Private Finance Initiative (PFI) arrangement. Staff engagement sessions are being held that will inform our future estate plans for the St Mary's Hospital site and our ward refurbishment programme at the Becklin Centre. Monitored through the Estates Steering Group.

In 2018-2019 our Estates team implemented the following quality improvement initiatives:

- The Estates Strategic Plan approved by the Board
- A Board approved Sustainability Plan
- Refurbishment of St Mary's House South wing providing 17 multi-purpose consultation rooms, bookable meeting rooms and agile working space and decorated to an autism friendly environment.
- Becklin Ward 5 refurbishment. Following a fire the ward was full upgraded to include bathrooms, shower rooms, toilets, bedrooms and therapy space and decorated to an autism friendly environment.
- Refurbishment of Willow House St Marys Hospital to modern office/meeting room accommodation for Clinical and Non Clinical Staff.
- Small Estates redevelopment works to facilitate the Community Redesign at Aire Court, St Mary's House, The Mount and St Mary's Hospital.
- Board approval of business case for Estates team's solution for National Inpatient Centre for Psychological Medicine (NICPM) and Eating Disorders

In 2019/20 the Estates team have planned:

- A PFI premises upgrade programme
- Redevelopment of St Mary's Hospital site for the new build West Yorkshire Community Adult Mental Health Service Unit
- St James envelopment for NICPM and Eating Disorders

The Environment

The general cleanliness of all areas is monitored through our Estates Officers in line with the contracts we have agreed with the providers of this service; or our internal standards where we deliver this service ourselves. In addition cleaning audits are undertaken across the estate and any changes identified through this are dealt with through the Joint Cleaning and Catering Group which meets monthly and is represented by clinical and estates staff. This group feeds directly into the monthly Clinical Environments Group, from where any concerns about the environment can be escalated to the Estates Strategy Group.

You said we did……
In 2018/19 our service users said the cleanliness of bathrooms could be improved

Patient Led Assessments of the Care Environment

PLACE is the annual inspection of inpatient units with 10 beds or above covering Cleanliness, Food, Privacy, Dignity and Wellbeing, Condition, Appearance and Maintenance, Dementia and Disability. The scores for each section are assessed and the results are returned from the NHS Digital Centre formerly known as (Health and Social Care Information Centre). Every Trust is therefore benchmarked and a scored performance obtained. This information is available to the public.

Our independent assessment results for this year's PLACE scores follow. Little Woodhouse Hall and Crisis Resolution Unit (CRU) are not included in our scores as the services within these buildings are operated by another Trust. However we do provide facilities services to these buildings hence the scores are shown. Parkside Lodge was not assessed this year as it is a unit with less than 10 beds.

Site	% cleanliness			% food and hydration			% privacy, dignity and wellbeing			% Environment			% Dementia			% Disability		
	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018	2016	2017	2018
Asket Croft	98.60%	99.91	99.76	92.92%	91.83	97.23	90.77%	92.45	90.83	97.54%	99.56	98.18	N/A		92.97		93.84	97.61
Asket House	99.40%	99.74	100	N/A	N/A	N/A	89.86%	92.45	97.66	97.54%	99.63	98.97	N/A		91.67		97.96	97.3
Becklin Centre	98.59%	99.83	99.93	89.62%	90.85	80.68	93.49%	94.64	92.96	95.57%	98.49	99.04	N/A		94.25		91.13	93.71
Clifton House	99.61%	99.81	98.37	91.42%	90.85	71.18	92.64%	93.47	85.56	97.42%	98.3	94.36	N/A		82.141		93.96	91.44
Mill Lodge Unit	98.84%	99.37	100	84.14%	90.85	70.77	87.38%	93.47	87.9	95.70%	98.3	98.87	N/A		90.48		93.96	94.1
National Inpatient Centre for Psychological Medicine (NICPM)	100%		92.86	95.82%		86.29	86.33%		89.9	90.00%		91.04	N/A		52.61			63.5
Newsam Centre	97.84%	98.7	98.82	93.35%	92.74	98.66	92.13%	95.27	94.92	95.49%	98.43	96.29	N/A		90.2		96.49	80.67
Parkside Lodge	N/A		NA	N/A		NA	N/A		NA	N/A		NA	N/A		NA	N/A		NA
The Mount	96.83%	99.49	99.89	90.54%	92.23	90.81	94.05%	95.4	95.43	98.56%	98.65	98.47	99.72	99.72	99.72		97.96	99.57
Woodland Square	99.62%	99.14	99.22	94.23%	92.44	86.11	89.73%	84.42	89.01	95.03%	96.16	91.04	N/A		51.04		91.37	66.4
Trust Average	**98.20%**	**99.37**	**99.31**	**91.28%**	**91.83**	**85.2**	**92.41%**	**93.96**	**93.41**	**96.48%**	**98.3**	**97.34**	**76.71**	**99.72**	**91.25**	**82.56**	**93.96**	**90.24**
National Average	**98.06%**	**98.38**	**98.5**	**88.24%**	**89.68**	**90.2**	**84.16%**	**83.68**	**84.2**	**93.37%**	**94.02**	**94.3**	**75.28**	**76.71**	**78.9**	**78.84**	**82.56**	**84.2**

National results 2018			
Category (with 2017 national average % shown)	National Average % Score 2018	Organisational Average % (extracted from HSCIS place report 2018)	Organisational and National Average % Discrepancies
Cleanliness 98.38	98.5	99.31	0.81
Food 89.68	90.2	85.2	-5
Privacy and Dignity 83.68	84.2	93.41	9.21
Environment 94.02	94.3	97.34	3.04
Dementia 76.71	78.9	91.25	12.35
Disability 82.56	84.2	90.24	6.04

Electronic Patient Record (EPR)

Projected QIP 2018/19	Time frame	Progress achieved
Upgrading to a new Electronic Patient Record (EPR) system	*June 2020*	**On track to be achieved.** EPR programme is progressing according to plan and within allocated resources. Workshops and staff engagement programmes are currently taking place. Monitored through the Informatics Services Strategy Group.

We have used our existing Electronic Patient Record (EPR) system called Paris for eight years and whilst it has performed its purpose, we have taken the opportunity to explore other systems available that could provide improvements to the benefit of our service users.

The Department of Health and Social Care (DHSC) published its vision for digital, data and technology in health and care in October 2018 providing a long term view on how technology will transform care. This builds on the vision provided by NHS England's *Five Year Forward View for Mental Health* https://www.england.nhs.uk/mental-health/taskforce/imp/ which highlighted the importance of electronic systems as a vehicle to improving patient care and outcomes.

A number of the recommendations within this depend on our ability to deliver 24 hour care in the community by 2020/21, for services such as:

- Crisis Resolution
- Home Treatment Team
- Assertive Outreach
- Rehabilitation
- Liaison services

To achieve this staff will need access to a service user's record in an agile and consistent way and the current system is not capable of achieving this. It does not provide remote access and is unwieldy. There is a need for us to be able to work collaboratively within our systems, across different care settings and with other organisations; in order to record and store fully transparent data. Deploying a new system provides the opportunity for us to structure it to deliver what is required from both a patient care and staff perspective; and achieve the national drive and mandate that requires us to phase out the use of paper. These themes are echoed in the strategy document '*No Health without*

Mental Health' - A Cross-Government Mental Health Outcomes Strategy for People of All Ages, published 2 Feb 2011.

The EPR upgrade programme supports our objective of ensuring the involvement of people in defining their care and the choices they have. We need to provide evidence-based treatments, monitor outcomes and be responsive through making adjustments to care. Therefore, we a need to have a robust recording and reporting solution from within the electronic patient record rather than using separate systems.

All of these objectives are enabled by the use of a robust, flexible electronic patient record (EPR).

We expect that in the future up to 5% of our income will be dependent on outcome measures. A new system will allow the Trust to set up the data recording and reporting to support the demands of evidence based allocation of resources (commissioning).

Our next steps are to:

- complete a series of workshops with front line clinicians to ensure that the configuration of the system is clinically led
- configure the system
- migrate key data from the old system to the new
- target go live for the new system in November 2019

Out of Area Placements

Projected QIP 2018/19	Time frame	Progress achieved
Achievement of our out of area placement target for our acute and Psychiatric Intensive Care Unit (PICU) services and reviewing our inpatient capacity	*April 2021*	At the end of quarter 4 2018/19 **we did not meet our agreed trajectory** to reduce the number of bed days its service users spent out of area. During 2019/20 we have sought agreement with our commissioners, NHS Leeds to revise our trajectory and look at alternative ways to support the reduction of out of area bed days in the immediate, short and longer term. A review of our inpatient services is also being considered for 2019/20 to support improvement linked with the previous work undertaken by Newton Europe and NICHE looking at our inpatient capacity. As part of our future plans, during 2019/20 we will develop new models of inpatient rehabilitation provision involving third sector partners in Leeds. Monitored through the Operational Delivery Group.

Progress against out of area trajectory: Number of inappropriate bed days in month*

	Q1 18/19	Q2 18/19	Q3 18/19	Q4 18/19
Trajectory	1,092	1,104	920	720
Actual bed days	663	1,752	1,566	982

**from April 2018*

Based on an externally commissioned and comprehensive citywide review of patient flow across the system, Leeds is regarded to have broadly the correct number of beds to service the acute inpatient mental health needs of its adult and older population. However due to wider system pressures and general demand fluctuations there is frequent need for additional beds that are not available in Leeds.

In the last year the Trust has introduced a number of initiatives to support the delivery of our agreed Out of Area acute placement trajectory. These have included the introduction of a nurse case manager, enhanced discharge facilitation arrangements in older people's services; and a revised framework of local and system-wide meetings to monitor and support a reduction in these placements. Unfortunately, we are yet to consistently meet the agreed level of reduction in Out of Area placements.

We have agreed a trajectory for reducing adult acute and PICU out of area placements to zero by March 202, in line with the Mental Health Five Year Forward View with our commissioners, Leeds CCG. A further range of initiatives to improve the system's ability to avoid unnecessary admission and to shorten inpatient stays has been agreed. These include the implementation of a new community model that will see improved access to crisis assessment, gatekeeping and intensive home treatment that will enable early step down from inpatient wards; and the introduction of telephone line support and a crisis cafe facility over extended hours.

Projected QIP 2018/19	Time frame	Progress achieved
Exploring the feasibility and viability of a female only Psychiatric Intensive Care Units (PICU)	*March 2020*	**On track to be achieved.** As part of the West Yorkshire Mental Health Programme we will complete a review of the acute/PICU pathway to fully understand capacity and demand impacts upon each organisation and how this can influence the future configuration of the bed base across West Yorkshire. Monitored through the Service Development Group.

Learning Disability (LD) Service

Projected QIP 2018/19	Time frame	Progress achieved
Exploring a reduction in inpatient care for people with a Learning Disability in line with the Transforming Care Plan	*March 2020*	**On track to be achieved.** Working in collaboration with other providers across West Yorkshire we are developing a standard future model for Learning Disability assessment and treatment inpatient care, as a networked service working to the same standards. Monitored through the Service Development Group.

Our Learning Disability Service provides multi-professional, specialist health services across 23 of our service sites for people over the age of 18 with a learning disability. This includes three care settings:

- ***Inpatient services***: acute assessment and treatment inpatient services, planned care/health respite services and nursing out of hours service.
- ***Community services***: two multi-disciplinary, Community Learning Disability Teams, Health Facilitation Team, Assessment and Referral Team, and Service User Involvement Team.
- ***Specialised Supported Living services*****:** a social care service that comprises of 16 dedicated support teams; enabling 94 adults with complex health and supports needs in addition to LD, to live in their own homes.

Through these services we provide a range of interventions that provide specialist, holistic, person health care for adults with a LD that have; behaviours that challenge services, mental health needs or complex physical and sensory health needs.

Three things the LD service is proud of:

☑ We are committed to the delivery of high quality, person centred, and holistic care. We actively engage in, and support, partnership working with other internal and external health partners, third sector and social care providers to ensure that the needs of people with LD that access our services are met in the most effective way possible. Through the work of the Health Facilitation Team, the development of service Clinical Pathways, Undergraduate training, student placements and the development of a range of resources and tools, the service also seeks to enable others to make the reasonable adjustments necessary to support people with LD to access wider services and care.

☑ The Specialised Supported Living service successfully achieved a CQC inspection rating of "good" overall and "outstanding" for being caring. The service was commended for its development of a Quality Assessment Framework (QAF) that it uses to assess, improve and monitor the quality of the care and services delivered. The QAF tool, and lesson learnt from the development of the tool were shared with our LD Inpatient and Community services and other services in our Specialist and LD Care Group.

☑ We continue to support a range of improvement work streams to ensure our services are fit for the future and are in the right place to be able to support system wide change. A significant focus of recent activities has been Transforming Care agenda seeking ways to prevent hospital admission, reducing length of stay and ensuring that care is delivered close to home.

Three things that the LD service is focusing on improving:

- ↑ Improving service user and carer involvement within LD governance activities and employing a person with a LD as a co-worker within the Service User Involvement Team.
- ↑ Ensuring that service are safe and effective through the development of multi-disciplinary (MDT) clinical pathways and the establishment of a MDT NICE Guidelines Working group.
- ↑ Driving forward system wide change and strategic development across the city of Leeds and the Yorkshire and Humber region in relation to the Transforming Care agenda.

Continual learning and improvement

Projected QIP 2018/19	Time frame	Progress achieved
Implementation of a model for Quality Improvement to be used across the whole Trust	*March 2021*	**On track to be achieved.** Monitored through the Quality Committee. Work continues to build an organisation-wide improvement framework and model based on the Institute for Healthcare Improvements (IHI) Model for Improvement who visited in March 2019. Continuous Improvement awareness sessions have taken place with more in-depth continuous improvement training being developed.

Continuous Improvement (CI) Team

The CI Team is based at The Mount site within the Trust. A team of five staff work with clinical and corporate teams to transform good ideas into sustainable workable solutions designed to improve and deliver quality for everyone using our services.

As a resource the team can be accessed by all staff across the Trust, either via an informal conversation or a formal request for support. The CI team's approach is to provide the space, time, tools and support to teams and individuals; as we know our staff have the ideas and the solutions for improvement.

During the past year the CI Team have supported a wide range of individuals and departments from across the organisation from our Estates and Human Resource Departments to Ward based and Community based teams. Below is an example of this work:

The Younger People with Dementia (YPWD) service asked the CI team for support in streamlining their referral management processes. Staff feedback showed that teams felt parts of the referrals process were inefficient, time consuming & prone to errors.

Specialist process improvement skills were required to harness the team's enthusiasm. A process map for the referral management procedure was produced; this provided a detailed view of each step of the process. Following on from this work, a series of 'activity follows' were performed which provided the team with a quantifiable view of the effort required to manage the referral process. This assessment showed blockages, issues & barriers that prevented the process operating smoothly. Additional information was collected from *Cognos* to support this work (a web based reporting and analytic tool that allows staff to look at specific data and produce reports to help make informed decisions).

The findings in summary were:

× **Referral Quality:** 40% of referrals received did not contain all the service user information clinicians required in order to offer an Initial Assessment Appointment. Handling poor referral quality consumed 6 hours of staff time per week & resulted in service users' referrals being 'postponed' for an average of 35 days until all the correct information was gathered.
× **Service Inconsistencies**: mechanisms for communicating with referrers were processed on a case by case basis. Individualised responses were provided to referrers consuming 2.5 hours of staff time per week. The timeliness of service communications was sporadic; an average of 9 days to process replies was recorded, detrimentally impacting on the service's ability to meet its performance targets.
× **Stakeholder Awareness:** stakeholders did not have a good understanding of the scope of the service & the referral quality requirements.

In an Away Day was held with the service, supported by the CI team who presented the Process Map and facilitated process improvement discussions. A number of action plans were created:
➢ **Referral Quality:** to create an YPWD referral form and a service inclusion/exclusion criteria document
➢ **Standardised Responses:** to create standard service responses to all common occurrences
➢ **Stakeholder awareness:** to develop and deploy a marketing and communications strategy

Process improvement work streams were managed through weekly improvement huddles. The creation of the services' improvement products were managed collaboratively with the CI Team providing oversight & support. Following a 4 month pilot of the improvements, a summary of the impact of these showed:

↑ **Referral Quality:** referrers provided the YPWD team with the right service user information using the new referral form & standardised letter response; a 12 day improvement
↑ **Standardised responses**: activity follows performed following the integration of standard letter templates reduced the referral management effort from 6 hours to 2 hours per week
↑ **Stakeholder awareness:** the Memory Service's webpage experienced a 52% increase in page visits during the pilot. Positive feedback was received from referrers during engagement events. The service experienced a 14% improvement in referrals being submitted with the correct information from the outset

In 2019/20 the CI team will continue to provide tailored support to individuals and teams based on their needs. The team is in the process of developing a plan that will outline how it will build its improvement capability across the Trust over the next 3 years. This work supports the delivery of the Trust's Quality Strategic Plan.

Primary Care Liaison

Since 2016 we have collaborated with NHS Leeds to try out new ways of working to improve Mental Health care in GP surgeries across the city.

It is recognised by NHS England that people with mental health problems do not have access to the same level of service as those with physical health problems, albeit they often have poor physical health and need extra support to stay physically well. We know that there is a 'gap' in mental health services for some groups of people with more complex needs or those who need more support after discharge from specialist services. We listened to people who told us:

- *that they had been "passed from pillar to post"*
- *services are confusing*
- *waiting times to see a mental health professional are too long*

We know that if we help people earlier they are less likely to become unwell. As part of the new way of working, mental health liaison practitioners from LYPFT have worked in approximately one third of Leeds' GP surgeries since early 2017. GPs are able to refer people directly to a Mental Health Practitioner. The practitioner might provide advice the GP or contact the patient to find out more about what is needed. Practitioners also offer a face to face appointment at the surgery to help the people identify their problem and explore possible solutions.
We aim to contact people within two weeks of referral; and see them within four weeks. We provide emotional support, mental health information and can make a referral to an appropriate service; or support a physical health need. We might need to see people more than once and if a person is very unwell, we will transfer their care to our colleagues in a specialist service; considering people's preferences, and those of their family and carers. Our aim is to offer a flexible service that responds quickly to people's needs.

We have collected the views of service users, GPs and other health professionals about the service to date:

> We want to make the services fit around the person, not make the person fit around the service!

> An overwhelming majority of people that we've come into contact with have found the service very useful and would recommend the service to other people

> GPs and other health professionals feel more confident and skilled in supporting people with their mental health

We report how many people we have had contact with, what kind of support was needed and what the outcome of the contact was, to NHS Leeds to help them make evidence-base decisions about the future of mental health services in the city. As a result of our work in GP surgeries, NHS Leeds intends to fund a primary care mental health service that is based locally in GP surgeries. We expect to commence in October 2019 and hope to contribute to an improvement in the quality of mental health care for the people of Leeds.

Nursing Child Assessment Satellite Training– Parent Child Interaction Scales

Parent-Child Relationship Programs have been used for many years within the Infant Mental Health field. These were founded by Dr Kathryn Barnard (Professor of Family and Child Nursing at the University of Washington) who developed assessment tools, widely known as the NCAST Feeding and Teaching Parent-Child Interaction scales (NCAST - PCI).

The NCAST-PCI is used widely in the USA. It gives professionals, parents and other care givers the knowledge and skills to provide nurturing environments for young children by developing and disseminating innovative evidence-based and research-based products and training programs. It aims to train staff in assessing mother infant interactions in a structured manner and use these as an outcome measure.

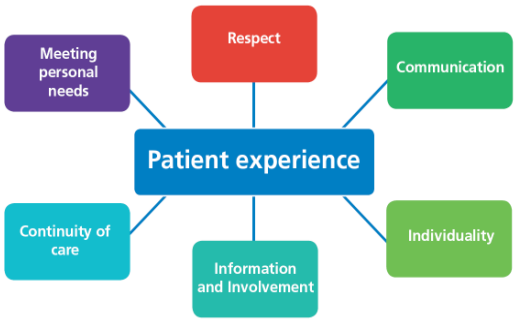
The Perinatal Service was successful in a bid for £51000.00 from NHS England's Perinatal Quality Improvement Fund and used part of this to train staff. Sue Ranger, a Consultant Clinical Psychologist for the Leeds Infant Mental Health Service, works with our mother and baby unit and is an accredited trainer in the NCAST-PCI.

In March 2018 eight staff members from our Specialist and Learning Disability Care Group undertook a 3-day training course for the teaching scale in and passed the reliability tests that are sent to and checked in the USA. Eight further staff were trained in November 2018. Staff members have started using the scale under supervision initially. This was commenced on our mother and baby inpatient unit and will be rolled out to our community patients in the forthcoming months. A further seven staff members will be trained in using the NCAST–PCI feeding scale (a shorter scale to be used in the community) in 2019.

Benefits of NCAST-PCI for our staff and patients:

- ✓ Staff will be competent in assessing mother-infant interaction in a structured manner
- ✓ NCAST will be used routinely as a quality outcome measure (upon admission to the service and prior to discharge)
- ✓ Structured assessments will improve the standard of documentation and improve the quality of reports for child protection conferences

Improving quality through the engagement and involvement of patients, carers and the public; our staff; and stakeholders



Patient Experience and Involvement

Patient experience and involvement begins at the moment people have first contact with our services and our staff.

"**We are all part of the patient experience**" and by that we mean that good care and treatment doesn't belong to a single team or function but should be embedded in everything we do as individuals; as colleagues; as teams; as an organisation and amongst a wide range of partners.
In the last year we have worked really hard to help us to understand further what good experience and involvement should look like and to help us with this, we commissioned Professor Mark Gamsu from

Leeds Beckett University. We will share the outcomes and recommendations from this report with service users, carers, families, staff and partners to agree our next steps in the forthcoming year.

We have excellent examples of inclusion and involvement across a number of services and we use a number of ways to capture those events and comments that tell us where we are doing well and where we need to do better.

Patient Stories at our Trust Board meetings

Patient and carer stories addressed to the Trust board are a monthly feature on the agenda. The stories help to inform the board's discussions about patient experience and bring a voice and perspective that is not always heard at this level. Personal stories are an important way to understand how our patients view the care and treatment received; view the organisation and can offer valuable insights into a whole, or several episodes, of care.

Stories are also a way of understanding how we demonstrate our three core values Integrity, Caring and Simplicity. Over the past year, the Patient experience team has supported many individuals before, during and after Trust board meetings to tell their powerful and moving stories:

Lorraine shared her concerns regarding her experiences from the perspective of a mother and carer. Trust board members offered their apologies to Lorraine with a commitment to make improvements and Lorraine has agreed to support this by sharing her story with other senior managers.

Natalka Mateszko's story

I was an inpatient The National Inpatient Centre for Psychological Medicine (NICPM) at the Leeds General Infirmary under LYPFT. My experience of my stay overall was amazing. I am happy to talk about all aspects of my stay from admission through to discharge.

My admission came with a few hiccups. Everything went through my partner as I was too ill to communicate. Paul was told a certain date for admission only to find out it was a week later (miscommunication). It was quite stressful for us both due to the extreme severity of my illness and the hardship it brought on us. Paul had also arranged transport which had to be rearranged along with his work commitments. Then a bed broke, which delayed the admission for a further week; adding to the stress. I am aware that this was out of the hands of the ward but it just felt like one thing after another at the start.

The journey to the ward was horrendous. I had to book an ambulance as I needed to be taken by a stretcher. It was an extremely old ambulance with an extremely hard suspension which felt like I was on a rickety rollercoaster. Being so severely ill it was a nightmare journey and I can only thank it was just over an hour for the journey although it seemed much longer than that.

When I got there I remembered being around people who genuinely cared. The first night though was awful. Due to procedures I had to be checked every 30mins. My room had to be light enough so they could see me. Consequently I didn't get much sleep which was causing anxiety. Luckily I got the situation resolved with the help of the medics.

An assessment was made of my needs however information wasn't passed over to staff efficiently. This caused stress and frustration which could have been avoided. The first three months of my admission was so hard and difficult, there was a lot of blood sweat and tears shed in order for progress to be made. Keep having to repeat myself over and over again as to what care was needed to help me could have been avoided if staff passed over information about me correctly. This is definitely an area that needs to be improved.

Apart from the hiccups at the start, the care support and it is dedication from staff was amazing. When I first saw Dr Trigwell it felt like he was reading my mind. He knew exactly all the worries, anxieties and concerns I was having and all the sorts of questions that I wanted to ask. It was so refreshing just to speak to someone who just got it. So much so I burst into tears I guess out of relief. Also the doctor there who lets us call her by her first name (Jini) said to me it was her job to take all the worries off me. Again I just burst into tears because no one had ever said that to me in the 13.5 years I had been ill. It was such a relief.
Over time I built up the trust with the team and their approach to dealing with the illness. It was only by listening to what they told me even though I didn't agree with most of it at the start is why I made such amazing progress.

My Joint sessions with my Occupational Therapist (OT) (Gemma at the start then Edward later on) and physio Linda we're challenging but I learnt so much about pacing, grading and how the body works and all sorts of things related which enabled me to make such good progress and to continue to make such good progress since leaving the ward.

My work done with Cognitive Behavioural Therapist (CBT) John also proved to be invaluable. We worked through my debilitating beliefs as other things that were getting in the way of recovery. Everything put together including the right medication saw my mental state and confidence come on leaps and bounds with my physical state alongside it. My key nurse was Heather who is an amazing lady and I had such a good relationship with her as well with the rest of the staff. I wasn't just getting good knowledgeable advice from key people like doctors, CBT's and OT's; it also came from nurses and health care assistants too. I felt comforted being in a place full of caring competent people.

Towards the end when my health was greatly improving it felt like I was in a kind of holiday camp. There were group activities which I was enjoying and I was able to go out into Leeds city centre every day and it was just amazing to be so much better than what I was when I first entered. Never in a million years did I think I would ever get as well as I did. For Paul and I it was like a miracle. I cannot thank everyone at NICPM enough.

When I was given the discharge date at first I felt a sense of panic. But it was given to me a month in advance so I still had time to prepare for my discharge home. I went home each weekend in the run up to my discharge which was absolutely crucial in preparing me to go home for good. It felt like all that could have been done was done. I am still continuing to making good progress and it's all down to NICPM.

The **Service User Network (SUN)** is one example of a well-established group which meets on the first Wednesday of every month. It provides a safe space on an independent site for service users and carers to work with staff; share their experiences of Trust services; contribute to service development; receive information; become involved in research projects and support the delivery of training. The success of SUN has been extended to include SUNRAYS which provides a similar platform in locality areas with the additional aim of engaging with hard to reach communities, working in partnership with other statutory, third-sector and voluntary organisations that contribute to the spirit of patient experience and involvement being everyone's responsibility. The groups have told us that they want to be able to demonstrate clearer outcomes in order to better evidence how the voice of the group has influenced change.

SUN annual **Question Time** was one of the highlights of the year. It was attended by 87 service users, carers, staff and stakeholders. The day's events were captured by a graphic artist who also provided a visual and easy read display of the questions to ensure everyone was able to participate. A clear outcome from this event is that planning is already underway to ensure that next year's event is co-facilitated by service users with the support of staff.

The involvement of families and carers can substantially improve a person's chances of recovery so it is really important that we ensure they are meaningfully involved in care and support planning. **Triangle of Care** offers key principles and resources to influence services and other people working with families and carers to be more effective in involving them within acute care. In April 2016 LYPFT became a member of the national *Triangle of Care* framework to help us improve the support we offer carers. A *Carers Involvement Group* was established, which worked over the next 12 months to ensure that the voices of carers were considered and included in the service improvements we were planning.

Our focus for the first year of our membership was to work with our community services, these included our Community Mental Health Teams (CMHTs), Intensive Community Services (ICS), Memory Services and other teams that supported people to remain and stay well in the community. Some of our key achievements in this year included;

- Developing a carer awareness training module of all LYPFT staff along with delivering 'face to face' training for our staff.
- Documents to support a greater understanding of the issues around confidentiality and information sharing.
- Identified different methods for gathering feedback and opportunities for co-production
- Undertook a service user record audit to identify carers views were being listened to and recorded
- Supported our Community Services to undertake a self-assessment (based on standards set out in the Triangle of Care framework.
- Set up forums for staff to meet to discuss and share good practice.

We were awarded our **Stage One** Kite Mark for the recognition of the work we did in Community Services and our commitment to improving carer's experiences in the future. The award was from the *Carers Trust* (who oversaw the membership of the Triangle of Care). We committed to our Stage 2 work, which is supporting all of our other services that we offer as a Trust to help reach the standards expected with the Triangle of Care framework.

We are working to ensure that every service has a nominated carers lead and have signed up to the 'Common Sense' confidentiality document as a way to support staff remove the myths regarding carers and information sharing. We are proud that this has been approved as good practice, as we know that not sharing basic information has historically been an area of clear frustration for carers and families and is not in keeping with our genuine commitment to including Carers in all aspects of our work.

The **Stage 2** application will be a challenge for the organisation as it is requires investment and resource. Whilst we can use some of the learning from the successful approach our community services took to achieve the Stage One membership award, we understand that sustainability of some of this work has been affected by the reorganisation of services through community redesign. In addition, there is work to do in terms of coordinating all other services including inpatient, crisis and

specialist services. This requires time, commitment and an agreed training plan to meet and sustain the standards of Stage 2 membership.

We will be required to start pulling our submission together in October 2019 with a final submission deadline of January 2020 which is under review on a monthly basis through the Triangle of caring steering group; however we will work with the Carers Trust to identify a way forward to ensure that the organisation is able to make a robust application.

We are committed to working with and improving our offer to carers; and progressing to Stage 2 within the Triangle of Care over the next 12 months. This is one of our Quality Improvement Priorities for 2019/2020 and has been chosen as a local indicator by our Council of Governors

The **Friends and Family Test** is compulsory for all NHS Providers and the Patient Experience Team have worked with a small team of volunteers to make these cards more accessible, to enable people using our services to tell us about the care and treatment they received. Positive feedback was received about staff attitude and behaviours; however we have heard that we need to improve on the availability of staff. Safe staffing requirements are being responded to in a number of transparent ways and have a number of successful recruitment events. We have also learnt from the feedback that we need to be better at letting families and people who use the services know what these are.

Some examples from our FFT feedback during 2018

Patient Reported Experience Measures (PREMs) and Clinician Rated Outcome Measures (CROMs)

Some of our service user feedback is collected through the use of Patient Reported Outcome Measures (PROMs) and staff reported feedback through Clinician Rated Outcome Measures (CROMs); much of the research states that the best measure of service user experience and satisfaction is from using PREMs. Some services analyse the data from the satisfaction surveys to help us focus on what is most important to the people who use the service.

The introduction of collaboratively developed **PREMs** is a focus for us this year. This work originated from the Trust-wide Clinical Outcomes Group which focuses on improving the quality of care and service provision through the use of outcome measures and quality standards/measures.

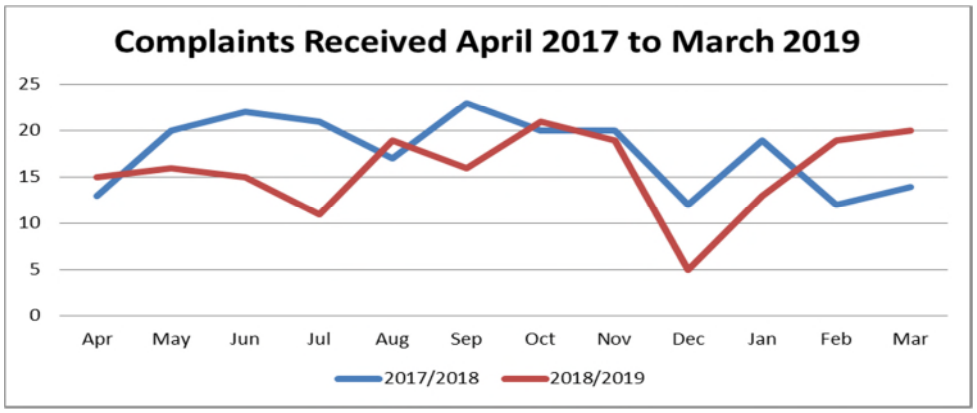
PALS and Complaints

We are committed to providing opportunity for any user of the organisation to seek advice, raise concerns or make a complaint about the services it provides. The Complaints and PALS Team provide a gateway to hear concerns and complaints; and ensure they are managed in accordance with regulatory requirements. The team strives to ensure that they deliver an accessible, robust complaints service driven by the rights of patients set out within the NHS Constitution.

We recognise that the formal complaints process is not always the best pathway for patients and families to receive a speedy resolution to a problem. We continue to promote a welcoming and positive culture for everyone making contact with the PALS and Complaints Team. Our PALS team are based at our Becklin Centre and are accessible for all users of our services. We have a dedicated

Freephone number to contact PALS and a direct line to the complaints team to ensure that quick access to the appropriate team is available.

During 2018/19 the Complaints and PALS teams have worked to ensure that the complainant is at the centre of the handling process with an increased emphasis placed on resolving concerns quickly and efficiently. To enhance the existing good practice, the Complaints and PALS team have identified areas for improvement for the forthcoming year with implementation already underway for a number of these including revised timescales, improvements to the DATIX system and obtaining stakeholder feedback on complaint responses. More information on our Quality Improvement Priority related to this can be found in Section 4.
During 2018/19, the Team have dealt with 1607 PALS enquiries/concerns and 189 complaints. The chart below shows the comparison of complaints received over the last two financial years:



We receive relatively small numbers of complaints, however they remain a valuable source of feedback and learning from complaints and the value of sharing this learning across the organisation is one of the most important aspects of our complaints process. Complaints present an opportunity for us to review care, our services; and the way in which we interact and provide information to our service users, from another perspective.

Once a complaint has been investigated, we inform the complainant is informed within the response where action will be taken to improve our service to prevent a recurrence of their experience. This might involve individual staff members reflecting on the way they have provided care, team discussions for wider group learning, staff training or use of the complaint as a case study; or a quality improvement change to the service.

In all cases complainants receive an apology for any instances of poor service or care.

A CLIP (Complaints, Litigation, Incidents & PALS) report is produced for each Care Group on a monthly basis and discussed within relevant forums. Actions from complaints and their progress are also discussed within Care Group Risk Forums.

The top three themes for **complaints** during 2018/19 are:

- Conduct of staff/attitude (63) 34%
- Poor General Care (61) 32%
- Admission, Discharge & Transfer (17) 9%

Themes of **concerns** tend to vary from formal complaints. Concerns are often problems that require immediate action such as meal options and environmental issues.

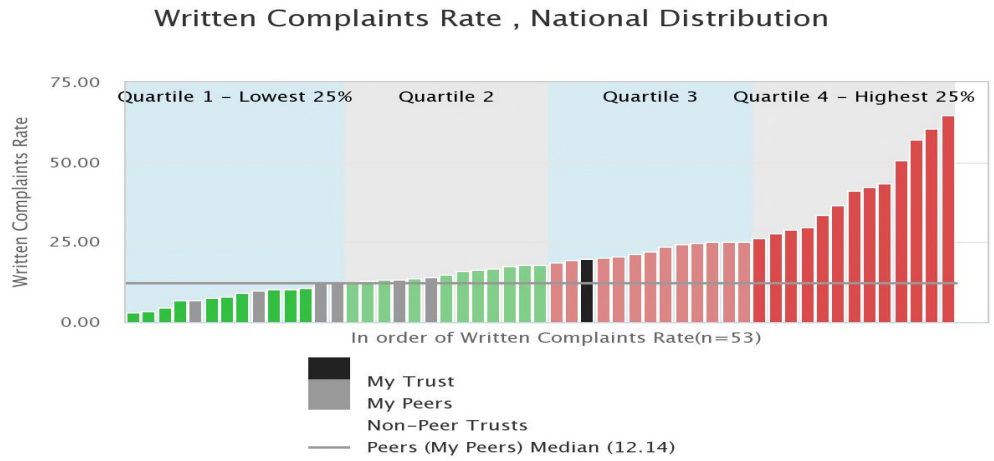
Statutory regulations require us to acknowledge complaints within 3 working days. This was achieved in 100% of cases in 2018/2019.

Of the complaints closed within the financial year 2018/19, five breached the statutory maximum response time of 180 working days. All cases were complex and had commenced historically, prior to us implementing improvement changes to the complaint handling process.
In all cases continuous liaison took place between the complaints handling team and complainant. However, we recognise that such delays are not helpful in bringing a complaint to a stage of resolution and as a result of these occurrences the following actions have been taken:

- Care Group leads and the executive team receive a weekly tracker of all open complaints including timescales for response, which highlight any delays in the process.
- The weekly trackers and additional reports are used at Care Group risk and governance meetings to prompt discussion and actions required to ensure timely response to complaints.
- The Complaints and PALS team have clear links and relationships with investigators to ensure regular contact.
- There is an established route through which to escalate any concerns regarding delays in complaint handling.

National Comparison

Benchmarking data from NHSI Model Hospital for Mental Health Trusts, positions LYPFT in the mid quartile for the rate of written complaints per 1,000 staff (whole time equivalent). We have a rate of 19.66 complaints per 1,000 whole time equivalent staff compared with the national median of 18.01 and the peer median at 12.14. This demonstrates our appetite to encourage service user feedback in all forms, including via complaints.



Compliments

Our teams and staff often receive compliments by letter or card, verbally or via a gift. Compliments are paid for treatment, care and support, or complimented on the environment, atmosphere, and cleanliness. Staff can record all compliments received (either written or verbal) as well as being able to attach any cards/letters to our DATIX system.

During 2018/19, the Trust received 406 compliments, this is an 18% increase compared to 2017/18 (343 recorded compliments). Compliments are a key measure of patient experience and we are keen to develop recording of compliments alongside our other methods of feedback in order to create a fuller picture of where we are doing well and where we might be able to further improve.

Our workforce

Projected QIP 2018/19	Time frame	Progress achieved
Delivery of Workforce Development Plans	*March 2019*	**On track for completion.** Monitored through the Workforce and Organisational Development Group. Delivery includes Mary Seacole leadership course cohorts, 2018 Shadow Board, Team coaching cohort, Affina Organisational Development model rolled out. Delivery of Year 1 Apprenticeship plan complete.

Our Medical workforce

This section describes the achievements and challenges for our medical workforce over the past year in the areas of medical education and training, medical staffing and medical leadership.

Medical Education and Training

Over the past two years there have been significant challenges for us in recruiting trainee psychiatrists; however, from 2017/8 the number of Core Trainees recruited to the Leeds and Wakefield Psychiatry Training Scheme increased. Many of these trainees were attracted by the opportunity to work in LYPFT.

Trainees are supported during their training by a group of enthusiastic Consultant College Tutors, ensuring excellent training and promoting the retention of promising trainees. This work is overseen by the Director of Medical Education, Dr Sharon Nightingale and Dr Abs Chakrabarti, Associate Medical Director for Doctors in Training.

In the year following their time with us, two of our trainee doctors in psychiatry received Health Education England (HEE) awards: HEE Yorkshire School of Psychiatry Core Trainee of the Year (Dr Karen Ball) and Higher Trainee of the Year (Dr Ben Alderson). Dr Zoe Goff (CT1) was awarded the Mohsen Nuguib prize in March 2019 for her research into the cardiac effects of medication for Alzheimer's dementia.

Medical Staffing

Within the Leeds Care Group there have been challenges in ensuring our acute inpatient areas have a full complement of medical staff. Our Consultants within the Senior Doctors' Forum are leading work which explores how these problems can be understood, minimised and improved upon.

Medical Leadership

Increasing and strengthening our medical leadership has been a priority focus this year, identified by the Senior Medical Council. Specific examples of medical leadership within service development for our Specialist and Learning Disability Care Group are:

- Dr Rhys Jones (Consultant at the Yorkshire Centre for Eating Disorders) developed the new model of care for Eating Disorders attracting a National innovation award
- Dr Peter Trigwell (Liaison Psychiatrist) led our bid to successfully secure NHSE funding for the National Inpatient Centre for Psychological Medicine
- Dr Lawrence Atkins (Specialty Doctor) played a key role in the launch of the new Veterans' Mental Health service for the North of England
- Dr Sophie Roberts (Deaf Child and Adolescent Mental Health Service Consultant) and Dr Liz Carmody (Learning Disability Consultant) both received the 'Health Service at 70' Trust awards

SECTION 3 STATEMENTS OF ASSURANCE FROM THE BOARD

This section has a pre-determined content and statements that provide assurance about the quality of our services in Leeds and York Partnership NHS Foundation Trust. The information provided is a combined content required by regulation (The National Health Service [Quality Account] Regulations 2010 and as amended); and taken from the NHS Improvement's (NHSI's) requirements for Quality Reports.

This information is provided in common across all Quality Reports/Accounts nationally, allowing for comparison of our services with other organisations. The statements evidence that we are measuring our clinical services, process and performance and that we are involved in work and initiatives that aims to improve quality.

Review of services

During 2018/19 LYPFT provided and/or sub-contracted 22 NHS services. LYPFT has reviewed all the data available to it on the quality of care in all of these NHS services.

We recognise that if we are to move towards more outcome-based reporting to evidence performance and quality, then complete, timely and accurate clinical record keeping in an agreed structured format that meets both clinical and analytical needs will be critical. However this is not an easy task and in order for accurate performance and outcomes data to be analysed, the information needs to be entered in a structured way onto the Trust's clinical systems. Trust standards require input of information to be completed ideally within 24 hours of occurrence but no later than 72 hours after the event. This serves the dual purpose of minimising clinical risk and ensuring high standards of data quality.

We have taken the following actions to further improve data quality during 2018/19:

- Embedded a clinical record keeping and data quality framework within the organisation underpinned by a dedicated group: the Performance, Information and Data Quality Group.
- Established a monthly audit cycle of data quality metrics to provide assurance to the organisation and ultimately our service users that the data we collect (and the performance information that it is based upon) is robust and accurate.
- Agreed a way to data quality "kitemark" our performance metrics based upon the outcome of a data quality audit, the presence of up to date operating procedures and the level of automation (removing the likelihood of errors from mistyping etc.).
- Strengthened routine reporting of data quality measures, backed up by completeness monitoring.
- Included data quality updates as a standing agenda item in the Trust's Operational Delivery Group attended by senior members of operational management.
- Undertaken a data cleansing exercise to support the transition of caseloads to newly created teams as part of the redesign of our community services.
- Continued to monitor and publish performance against national and contractual data quality metrics.

LYPFT will be taking the following actions to improve data quality during 2019/20:

- A move to a new clinical records system that will support more real-time monitoring of data quality to make it easier for staff to know when information is missing or required. This will have the added benefit of assuring that any metrics or outcomes measuring the quality of our services and care can be trusted for completeness and accuracy.
- Undertake a communications drive around the importance of clinical record keeping and data quality in support of the implementation of our new electronic patient record.

- Ensure the smooth migration of clinical records from our existing to our new clinical system.
- Continue to raise awareness throughout the organisation of key clinical record keeping processes that impact on data quality and performance.
- Maintain the programme of monthly local data quality audits as part of the new kite-marking process, publicising the findings internally and following up any recommendations to ensure that they are completed. These audits assist with understanding any discrepancies in the data, identifying whether any high standards of performance & quality or dips in performance, are real or as a result of data quality. This then enables the right decisions and actions to be taken to support the highest levels of care for our service users.

The income generated by the NHS services reviewed in 2018/19 represents 100% of the total income generated from the provision of NHS services by the LYPFT for 2018/19.

Transformation

Section 1 of this report includes a written piece on the organisation-wide service transformation process we have undertaken this year; evaluation of this process will take place in 2019/20 and in Section 4 we describe how we will evaluate this as part of our Quality Improvement Priorities for the next year. Other service examples are included within the report.

Participation in Clinical Audit

All clinical audits that are planned to be undertaken within LYPFT should be registered on the clinical audit and effectiveness registration database. The monitoring of each audit includes results, summary report and action plans.

National clinical audits

During 2018/19 six national clinical audits and two national confidential enquiries covered the NHS services that LYPFT provides. During that period LYPFT participated in 5 national clinical audits and 100% of 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 LYPFT was eligible to participate in during 2018/19 are as follows:

Eligible National Clinical Audits participated in
National Audit of Anxiety and Depression
National Audit of Care at the End of Life (NACEL)
Psychological Therapies Spotlight
POMH-UK: Topic 18a: Prescribing clozapine
POMH-UK: topic 7f: monitoring of patients prescribed lithium
POMH-UK: Topic 6d: Assessment of the side effects of depot antipsychotics
Eligible National Confidential Enquiries participated in
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Learning Disability Mortality Review Programme (LeDeR)

The national clinical audits and national confidential enquiries that LYPFT participated in during 2018/19 are as follows:

Eligible National Clinical Audits participated in
National Audit of Anxiety and Depression
National Audit of Care at the End of Life (NACEL)
Psychological Therapies Spotlight
POMH-UK: Topic 18a: Prescribing clozapine
POMH-UK: topic 7f: monitoring of patients prescribed lithium
Eligible National Confidential Enquiries participated in
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry into Suicide and Homicide by People with Mental Illness
Learning Disability Mortality Review Programme (LeDeR)

POMH-UK: Topic 6d: Assessment of the side effects of depot antipsychotics: LYPFT decided not to take part in this audit due to the re-design of the Community services (August 2018 via the Medicine Optimisation Group meeting). POMH-UK (Topic 6d) will be covered by two POMH-UK 111-17b (use of depo/LA antipsychotic injection for relapse prevention) and 111– 19a (prescribing for depressions in adult mental health).

The national clinical audits and national confidential enquiries that LYPFT participated in, and for which data collection was completed during 2018/19 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.

National Audit	Number of cases submitted	Percentage
National Audit of Anxiety and Depression	60	100%
Psychological Therapies Spotlight	115	100%
National Audit of Care at the End of Life (NACEL)	No cases to be submitted – organisational questionnaire	NA
POMH-UK: Topic 18a: Prescribing clozapine	No set number required – 81 cases	NA
POMH-UK: topic 7f: monitoring of patients prescribed lithium	No set number required - 57 cases	NA

National Confidential Enquiries	Number of cases submitted	Percentage
Mental Health Clinical Outcome Review Programme - National Confidential Inquiry (NCI) into Suicide and Homicide by People with Mental Illness	Not set number required	Currently unavailable
Learning Disability Mortality Review Programme (LeDeR)	Not set number required - 14	NA

The report of 4 national clinical audit(s) which was part of 2017/2018 quality accounts was published in 2018/2019. The findings were reviewed by the provider in 2018/19 and LYPFT intends to take the following actions to improve the quality of healthcare provided:

National Audit	LYPFT action 2018/19
National Clinical Audit of Psychosis (NCAP)	• Dissemination and discussion of the results in the consultants meeting and other relevant groups; • To make better use of the leaflets available on Choice of Medication website which is available through the- Important trust links; • Ongoing development of physical health monitoring clinics (i.e. adopting a monitoring month approach as currently used in East locality); • Quality indicators for the service have been chosen to include the standards of the NCAP audit, with additional indicators reflecting CVD risk assessment (Q-RISK2) and the conversion of referrals into contact and engagement.
POMH-UK: topic 16b: Rapid tranquillisation in the context of the pharmacological management of acutely-disturbed behaviour	• Lead practice nurses at Becklin and Newsam to perform weekly checks on inpatient wards checking that, when patients receive rapid tranquillisation, the required monitoring is being carried out; • Several training' sessions will be delivered by Pharmacy across the Trust and professional groups in order to improve awareness.
POMH-UK: topic 15b: Use of sodium valproate	• Early treatment and annual review to be highlighted at community care forum/ governance meeting; • Take to inpatient and community forums and governance groups to discuss the need for highly effective contraception.
POMH-UK: topic 17: The use of depot/long-acting injectable (LAI) antipsychotic medication for relapse prevention	• To include a patient specific plan for refusal or missed depot; • Update shared care guidelines: Responsibility of secondary care team to include plan for missed/refused depots

Other Audits:

Title	LYPFT actions and progress
Standard NHS contract Data sharing: NICE Guidance 138	Draft report with the project lead for feedback
CCG National Mental Health CQUINS - collaboration with GP – (Leeds Care Group) 2018/19	• A electronic communication system which should automatically send CPA care plans and inpatient discharge summaries to GPs within 48 hours; • The Physical Health Team to develop prompts for primary and secondary physical health diagnosis for staff in the new CPA care plan; • To develop a set of standards which will be used for community and inpatient discharge letter templates; • Medicine Awareness sessions for clinical staff to attend (first session delivered in January 2019 in Leeds and February in York). We plan for these to be held 6 monthly; • Prompts for cardio-metabolic symptoms to be included in the new CPA care plan

Title	LYPFT actions and progress
National Mental Health CQUINS: cardio metabolic screening (Trustwide) 2017/18	• Development of physical health monitoring clinics (i.e. annual monitoring for patients in clozapine clinic by adopting a monitoring month approach as currently used in East locality); • Quality indicators for the service have been chosen to include the standards of the National Clinical Audit of Psychosis, with additional indicators reflecting CVD risk assessment (Q-RISK2) and the conversion of referrals into contact and engagement.

Trust and Local Clinical Audit

This section is divided into two parts: Trustwide (part of the priority programme) and service/team clinical audits (local).

Number of clinical audits	Trustwide	Service/Team
Registered during 2018/2019	3	60
Completed during 2018/2019	5	37

Trustwide Clinical Audits

Trustwide clinical audits are part of the priority programme. They fulfil the criteria of high risk or high profile projects identified by Trust management or Trustwide Clinical Governance. The 5 completed Trustwide clinical audits are listed below alongside the actions to improve care:

Title	LYPFT action
CPA audit	• To ensure the service user voice is captured in their care plan; • To ensure the people who are most important to the service user are aware of any changes to their care; • To ensure the review is tailored to the wishes and preferences of the service user; • To promote empowerment and ensure the service user feels comfortable to express their views and wishes.
Antimicrobial prescribing	• Flow chart available on the policy to be sent around via Medical Education to all trainees and poster with flow chart to be put on the wards to increase awareness; • Trust policy to be reviewed to align with the rest of Leeds guidelines; • To reduce number of patients who had one or more missed dose: a) Monitoring and regular feedback (report) in place with management assessment (report sent directly to the ward manager for information and action); b) 2 months report to be sent to the Medicines Safety Committee.
Safeguarding advice/referral audit	• The safeguarding team to continue to support the EPR task and finish group to ensure the new clinical records have easy to follow safeguarding information and the details of children under 18 within families is mandatory; • Staff calling the team for advice is responsible for implementing the advice and should clearly document how this takes place or reasons why it is not progressed. This will be disseminated to clinical governance councils, sent out through Trustwide communications and added to level 3 training.
Prescription Charts	• Alert to be added for all patients for MH act status; • To improve Pharmacy 1 to 1 training; • Monitoring and regular feedback about missing doses (report) in place with management assessment (report sent directly to the ward manager for information and action).
Audit of falls	• For all new staff especially, to be made familiar with falls pathway and

Title	LYPFT action
in older people services	procedures and how to carry out falls risk assessments; • For all care plans to contain relevant falls prevention interventions; • Encourage Falls huddles to be implemented across all four inpatient services at The Mount; • Evaluate the use of Falls huddles; • To ask service users for their understanding of why they have sustained a fall; • To ensure that all clinical staff know how to conduct a lying and standing Blood Pressure.

The following 3 **Trust-wide** clinical audits are in progress:

- Mental Capacity Act – Best Interests audit - Data collection.- the audit is planned to be completed by the end of March 2019
- Compliance with MEWS within LYPFT Inpatient units - Data collection complete – reporting stage in progress – the audit is planned to be completed by April 2019.
- Documenting decisions, discussions and following up women of child bearing age who are prescribed valproate - Registered in January 2019. Data collection will start in February.

Service/Team Clinical Audits

The reports of 37 clinical audits were completed and reviewed by the provider in 2018/19 and LYPFT intends to take the following actions to improve the quality of healthcare provided:

Title	What are we going to do?
Offender Personality Disorder Pathway Quality Formulation Audit	• Amend the case consultation and formulation template to include a paragraph relating to the active collaboration of the document and to prompt for the prioritisation of recommendations; • Community Specification Team to consider the recommendations of their reports and how to prioritise these; • Amend the template, to include a section for any Offender Manager's comments on the report, or to provide feedback on the case.
Timely completion of discharge summaries at the Mount	• Implement a tool (e.g. Excel spreadsheet in shared folder) which will act as a log of, and a reminder of discharge summaries due to completed. • Allocate a patient to a junior doctor, so that it is clear who's responsible for completion of discharge summary e.g. Whiteboard with patient list and a box for junior doctor allocation.
YCED audit of safe handover of medications between day team and on call team using an electronic prescribing programme	• Further investigation into the reason as to why the comment box is not always utilized in daily practice; • Changes to the 'comment box' on ePMA for documentation of medication changes.

Title	What are we going to do?
Assessment of whether the standard operating procedure (SOP) for compliance aids is adhered to in relation to clozapine compliance aid prescriptions	• Raise awareness of healthcare professionals (HCP) that can request an MCA for a patient, that medicines placed into a compliance aid are unlicensed and that not every service user is suitable for a MCA; • Education and training of pharmacy staff on the compliance aid SOP; • To scan the request form and 6 month review paperwork onto the patient's notes on PARIS, as all pharmacy staff members can access this information; • To create a list of commonly prescribed medications in compliance aids and what colour status they have (taken from the SPS website) to assist pharmacists when assessing the stability of the prescribed medications and documenting an expiry date.
Completeness of MDT meeting report	• Primary nurse to review physical examination when completing the MDT note; • Change layout of the MDT report so that the Recovery Goal will be on the top of the form to focus the report; • Remind OT to input to the report, invite Carers to the MDT meeting well in advance of this actually happening; Medics to complete the medication section even when no changes to medication.
Monitoring of clerking in and physical health evaluation on admission CAU	• Educate new medics on best practise in CAU • Assessment is to be completed for each new admission to CAU • All admissions to CAU should have a physical health exam and routine investigations completed. If this is declined, the reason why should be documented.
Audit of Admission management plan for patient admitted to Acute IP services	• The admitting clinicians to develop a management plan (including observation level, Leave status, physical investigations, medication plan, risk and a statement of capacity) at the point of admission; • Discuss a proforma as a prompt to support staff to develop admission management plan.
An Audit of ECG and Haematological Investigations in South ICS in 2018	• Increase the number of staff members trained in taking blood and ECG. • Increase the number of clinical staff who are able to access LCR at the LCR Project Group so that more people have ownership of whether bloods have been done; • Create a method of recording the results that can be referred to and added to by all staff in the team. • Discuss physical observations/health screening results in MDT to facilitate planning and discussion on what is needed by which patient.
Advance care planning in Dementia (SSE Memory Service)	• Include advance care planning and end of life care discussions into the PDS proforma; • Incorporate into post diagnostic service proforma as a prompt for advance care planning/end of life discussion.
Community Treatment Order 11 and 12 consent to treatment and CPA audit	• Introduction of weekly checking of the systems has increased the compliance of consent to treatment forms with legal guidelines and this should therefore be continued. • CPA's will be monitored through individual management supervision, and it is anticipated that this system may replicate the improvements made be regular monitoring of the medication files.

Title	What are we going to do?
Flow of routine monitoring from Memory Services	• Develop a protocol on where and how to record the required information on PARIS; • Discuss technical issues around discharging service users from PARIS and implement local instructions on how to complete this process and when to notify other clinicians about a SU ready for transfer back to GP.
Leeds Autism Diagnostic Service Care Pathway	• Care pathway is explained and discussed with each service user, through updating the information pack and adding a checkbox to new initial assessment proforma re care pathway explanation; • Ensure every service user has a risk screen, the team will review risk questions in LADS registration form and include a risk screen section in the initial assessment proforma.
Learning Disability Services Violence Audit	• Post incident-debriefing of service will be done via the implementation of a protocol for debriefing service users after an incident; • Changes to paperwork will be done to show MEWS scores have been considered with details of why assessment of MEWS is not necessary.
Completion of Medicines Reconciliation on Admission	• Reinforce knowledge of both national guidance and the trust specific policy relating to medicines reconciliation within Pharmacy staff's members. • Improve recording of the medicines reconciliation tabs: to review and update reconciliation Standard Operating Policy (SOP).
SSLS Support Plan and Risk Assessment Audit	• Capacity statement to be added to the support plan. • Develop a generic assessment tool and guidance. • Develop a training pack.
Audit of time to therapy from initial assessment for psychoanalytic psychotherapy	• Record reasons for exceeding waiting time of eight weeks in patient records when this occurs. • Consider further work aimed at identifying reasons why some patients struggle to engage with the initial assessment process and identify ways in which engagement can be improved.
Physical Examination Audit in Becklin Centre	• Ensure that paper copies of the physical examination proforma are printed off and placed in the junior doctors' on-call room for easy accessibility. • Develop an electronic version of the proforma that can be accessed from any computer in the trust and put on PARIS.
Documentation of Pregnancy Testing and ECGs in an Acute adult Psychiatry Unit	• To raise pregnancy testing rates in eligible psychiatric inpatients (<55 years) to over 80%, by distributing the standards and audit findings, emphasising the need for pregnancy testing to staff teams through discussion with ward managers.
Management of pregnancy and women's health in psychiatric settings (CMHT SSE)	• Circulate via email the Standard of Documentations documents to the incoming juniors and on this email highlighting the need to discuss pregnancy and contraception with appropriate patients.
Management of challenging behaviour in LD	• Disseminate the information to the Consultant meeting and Clinical Governance in order to increase awareness of importance of a good record keeping; • The clinicians new to the team will be advised at the beginning of their job to clearly document in their clinic letters.
Audit on consent documentation for patients at The Mount undergoing	• Discuss having all the forms including legal documents like T4/T6 available electronically which would be very important to make sure that everyone is aware that ECT is being administered legally.

Title	What are we going to do?
electroconvulsive therapy (ECT) for the treatment of depression	
Documentation of contraceptive and Pregnancy information given to patients on antipsychotics on Becklin ward 1	• Add a 'pregnancy and contraception' heading to the plan section of the 'ward review template', thus acting as a weekly reminder to the MDT to consider these discussions; • The pharmacy team to engage in these discussions with patients prior to discharge, whenever possible; • Circulate proforma to guide discussion.
Assessment in CAMHS	• Checklist of standards to be completed for every child/young person seen for a FTA and placed in file. • Reasons for any non-adherence to standards to be documented on checklist form.
The monitoring and use of PRN psychotropic medication for people with learning disabilities on an inpatient ward	• Make staff aware of the NICE, Royal College of Psychiatrists and NHS England guidelines which emphasises the importance of discouraging the over-medication of people with learning disabilities. • Educate staff about the importance of completing the PRN Evaluation Tools every time any PRN medication is given to help us monitor the use of psychotropic medication in patients with learning disability. • Ensure that staffs are encouraged to review the PRN protocols, prescriptions and PRN monitoring charts, that they match the EPMA chart, and give any feedback about the indications and rationale for prescribing.
Audit of completion of MEWS assessment forms for perinatal in-patients	• Develop a system to storage the MEWS for current in-patients so that they are easily accessible. • The team will continue to use the new MEWS chart-now standard throughout the Trust and continue with 'MEWS day Tuesday' to ensure regular updated MEWS recorded-in ward diary each week for upcoming year.
Monitoring of patients on Antipsychotics/mood stabilizers medication in Rehabilitation & Recovery	• To raise awareness among staff on the need to document these parameters on PARIS or LCR as a way of monitoring compliance to antipsychotic and mood stabilisers; • To review of missing data of patients on LCR & Paris and discuss with team to identify possible reasons for not recording the information accordingly.
Audit of National Early Warning Score (NEWS) documentation at National Inpatient Centre for Psychological Medicine (NICPM)	• Documentation of NEWS at admission to be a criterion on the admission checklist and on the clerking checklist. • Prompt label on observations equipment to remind staff to record date and time. • Prompt on MDT chart and office patient whiteboard to update NEWS chart with change in frequency. • Where NEWS cannot be performed within six hours of admission, or medical review is needed, reasons should be documented on PARIS.
Front Door Safeguarding Hub - Audit of LYPFT process and actions	• The local working instruction for the Domestic Violence Meeting is revised to include more detailed instruction to safeguarding practitioners and clinicians in respect to processes and timescales, including greater clarity in regards communication, interpretation and storage of action plans, and increased clarity for the need for communication of completed allocated actions to the DVM.
Accuracy of	• All consultants will use the agreed template, but consultants can add one

Title	What are we going to do?
medication details in forensic service medical out-patients' letters	or two additional headings for any given patient, if felt to be appropriate. • Ensuring the medication is correct will be achieved by the following methods: – a) Check with the patient- this should already be being done and staff were reminded – b) With patient permission, check against the GP record through the NHS spine portal. Alternatively, if not on this record, then check with the pharmacy if they are directly prescribing, or the CPN can check the patient list of medication from the script summary.
Routine use of CT head scans in First Episode Psychosis	• The audit highlighted that practise within the inpatient wards at the Becklin centre were adherent to NICE guidance at the time of the audit.
Audit of Discharge Medicines Information Received by Primary Care from LYPFT	• Clarify and update Trust standards for discharge documentation. • Produce a Trust wide standardised discharge document containing all of the required standards. • Training for non-medics producing discharge documents: a) To design and distribute a poster to non-medics completing discharge documents; b) To produce and distribute case reports to highlight the impact of poor medicine information sharing at discharge.
Appropriate prescribing of rapid tranquilisation in informal patients at the Becklin	• Although the audit showed 100% adherence to the guidelines on this particular day, and therefore no actions are needed, it is important to recognise that this information still needs to be disseminated. It will be important to portray these results, and the local guidelines, so prescribers are aware of the current prescribing policies to continue to keep the high standards this audit has shown.
Audit On Healthy Living Education For Service Users High Risk Of Developing Diabetes and Cerebrovascular Diseases	• The introduction of compulsory discussion and initial advice on healthy living for any admission to the ward by the admitting doctor; • The introduction of compulsory referral for any admission to the Healthy Living Advisors following the initial health related risk assessment on admission; • The introduction of a structured advice/education tool in the form of a monthly workshop involving the healthy living advisors, dieticians, and clinicians to ensure effective preventative healthy living advice/education is provided by the service based on the BAP guideline. Any involvement of service users in the workshops should be documented appropriately according to the standards above.
MEWS at Clifton House	• Arrange staff training re-recording and responding to abnormal MEWS; • Print out PHOB for every patient and put in physical health file; • Disseminate via debrief meeting with follow-up email to all staff requiring re-receipt.
Audit of the “in team” joint working request referral protocol for Occupational Therapy	• New staff members are offered the opportunity to spend time with OT when they first join the team. • For an Occupational Therapist to be present during MDT to ask referrer and follow up questions regarding pathway and service user complexity.
The Assessment of Cardiac Status Before Prescribing Acetyl Cholinesterase Inhibitors for	• To make the Yorkshire and Humber Clinical Networks guideline “The assessment Cardiac Status before prescribing Acetyl Cholinesterase Inhibitors for dementia” especially the “Rowland algorithm” available during local induction for OPS staff.

Title	What are we going to do?
Dementia	
Nutritional screening, interventions and care plan in OPS (dementia and mental health units)	• SALT & Dietetics to arrange education groups and practical session for promoting a Food First approach. • AHP nutritional group to create new Nutritional monitoring chart and trial.

The following 55 local clinical audits are still ongoing. The projects are at different stages of audit cycle – planning, data collection, analysis and reporting:

Title	Service(s)
Audit of family and carer involvement in care on Acute inpatient wards at the Becklin centre	Acute (Adult & PICU)
Audit on documentation of key clinical discussions with family	Acute (Adult & PICU)
Calculation of QRISK and management with statins	Acute (Adult & PICU)
Monitoring of clerking in and physical health evaluation on admission to Ward 4 Becklin Centre	Acute (Adult & PICU)
Audit of reviewing bloods on admission	Acute (Adult & PICU)
Physical Examination Audit in Becklin Centre	Acute (Adult & PICU)
Clinical audit of patient medication treatment plans in the LYPT Women's acute inpatient	Acute (Adult & PICU)
Use of consent to treatment forms on acute working age adult wards	Acute (Adult & PICU)
VTE assessment and appropriate management if patients are identified as high risk of VTE whilst inpatients	Acute (Adult & PICU), Crisis Assessment & 136 Suite
Safeguarding at points of transition	Acute (Adult & PICU), ICS, Safeguarding Team
Baseline Prolactin level check for Inpatients on Antipsychotics	Acute (Older People)
Dental and oral health in people with first episode psychosis	Aspire
Audit of physical health monitoring on admission to Mill Lodge	CAMHS Inpts
The assessment of capacity or competence on young people in an inpatient child and adolescent psychiatry unit.	CAMHS Inpts
Annual Monitoring of Clozapine treatment in St Mary's House	CMHT Adult
Borderline personality disorder: management of comorbidities	CMHT Adult
An Audit of the Quality of Correspondence after Clinic Appointments in South Leeds Adult CMHT	CMHT Adult
Are we routinely providing appropriate information to patients on the medications we prescribe?	CMHT Adult
Audit of quality of clinic letters to GP	CMHT Adult
Older People's medical record Keeping audit (WNW)	CMHT OPS
Benzodiazepine use in old age psychiatry (Millfield House)	CMHT OPS
Vascular Dementia - ESREP	CMHT OPS
Audit of Regular Psychiatry Review in LD	Community (Learning disabilities)
Outcome measures in intellectual disability psychiatry	Community (Learning disabilities)
Safety and Effectiveness of Clinical Interview Rooms	Community (Learning disabilities)

Title	Service(s)
Formulation, reformulation and dissemination at SSE ICS	CRISS
Adherence to Prolactin screening, prescribing and communication of monitoring needs in South ICS	CRISS
Audit of Recording the Communication Profile	Deaf Children's Services
Letters in deaf CAMHS	Deaf Children's Services
Audit of language used in ADOS assessments for Deaf children	Deaf Children's Services
Clinical audit of implementation of structured clinical risk management through use of the HCR-20 and SAPROF in the York Forensic Psychiatry Service	Forensic Services
Metabolic Screening of Service Users Prescribed Anti-psychotic Medication within Clifton House and Newsam Centre	Forensic Services
An Audit into the Physical Health Investigations completed for patients on Ward 2, Women's' service	Forensic Services
Effective documentation of rationale for changing of RAG status during care under ENE ICS	ICS
Epilepsy Audit and Service Evaluation	Inpatients (Learning disabilities)
Audit of Positive Behaviour Support Framework	Learning disabilities (all services)
Accuracy of discharge data at the Dual Diagnosis team	Leeds Addictions Unit
Liver Function Testing in Buprenorphine Treatment	Leeds Addictions Unit
Liaison Psychiatry Pathway Audit	Liaison Psychiatry
Clinical record keeping by the Hospital Mental Health Team in LTHT	Liaison Psychiatry
An Audit of Face risk assessment in Liaison Psychiatry	Liaison Psychiatry
Compliance with Key Performance Indicators (KPIs) within the ENE Memory Service	Memory Services
Diagnosis Recording Audit	Memory Services
Audit of the assessment, diagnosis and management of depression according to NICE guidelines (CG90)	OPS Liaison Psychiatry
Review of cases from time of allocation to time of feedback	OPS Liaison Psychiatry
An audit to assess recommendations made by the old age liaison team regarding delirium management in inpatient older adults	OPS Liaison Psychiatry
An audit of record keeping within the PDCN	Personality Disorder Network
An Audit of FACE Risk assessment in the PDCN	Personality Disorder Network
Offender pathway record keeping clinical audit	Personality Disorder Network
Appropriateness of information given to patient on medication/treatment on admission and discharge	Pharmacy
Depot Audit in CMHTs	Pharmacy
Audit of Clozapine Plasma Level Monitoring	Pharmacy
Medical Psychotherapy Consultation Service - Standards Audit	Psychological Therapy Services
SSLS Support Plan and Risk Assessment Audit	Supported Living (Learning disabilities)
The use of Benzodiazepines on Ward 6, Inpatients Eating Disorders Services	Yorkshire Centre for Eating Disorders

NICE Guidance baseline assessment and compliance

During 2018/2019, NICE published 123 new and reviewed guidances. The Trust services reviewed 99 (73%) of guidance during April and December 2018. The remaining 24 guidance are under review.

The services identified 14 guidelines relevant to the Trust and 18 guidelines for information practice. Relevant guidelines are listed below:

Month	Reference	Title	Type
April	NG96	Care and support of people growing older with learning disabilities	Social Care guideline
April	CG192	Antenatal and postnatal mental health: clinical management and service guidance	Clinical guideline
April	CG185	Bipolar disorder: assessment and management	Clinical guideline
April	CG137	Epilepsies: diagnosis and management	Clinical guideline
April	CG90	Depression in adults: recognition and management	Clinical guideline
May	QS167	Promoting health and preventing premature mortality in black, Asian and other minority ethnic groups	Quality Standards
June	NG97	Dementia: assessment, management and support for people living with dementia and their carers	Clinical Guideline
June	TA217	Donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease	Technology appraisal guidance
July	QS33	Rheumatoid arthritis in over 16s	Quality Standards
August	NG103	Flu vaccination: increasing uptake	Public Health guidelines
September	QS175	Eating disorders	Quality Standards
September	NG105	Preventing suicide in community and custodial settings	Public Health guidelines
October	NG108	Decision-making and mental capacity	Social Care guideline
December	NG116	Post-traumatic stress disorder	Clinical guideline

LYPFT declared compliance with 11 guidelines during 2018/2019:

ID	Title
NG64	Drug misuse prevention: targeted interventions
NG10	Violence and aggression: short-term management in mental health, health and community settings
PH5	Smoking: workplace interventions
NG27	Transition between inpatient hospital settings and community or care home settings for adults with social care needs
CG137	Epilepsies: diagnosis and management
NG76	Child abuse and neglect
NG87	Attention deficit hyperactivity disorder: diagnosis and management
NG92	Stop smoking interventions and services
NG13	Flu vaccination: increasing uptake
NG53	Transition between inpatient mental health settings and community or care home settings
CG189	Obesity: identification, assessment and management

The following base line assessments are in progress:

ID	Title
NG32	Older people: independence and mental wellbeing*
NG54	Mental health problems in people with learning disabilities: prevention, assessment and management
NG58	Coexisting severe mental health illness and substance misuse: community health and social care
NG69	Eating disorders: recognition and treatment
NG93	Learning disabilities and behaviour that challenges: service design and delivery
NG97	Dementia: assessment, management and support for people living with dementia and their carers
NG105	Preventing suicide in community and custodial settings
NG108	Decision-making and mental capacity
NG116	Post-traumatic stress disorder

Two guidance working towards compliance; these guidance required an action plan to be fully compliance.

ID	Title
NG007	Preventing excess weight gain
NG43	Transition from children's to adults' services for young people using health or social care services

Service Evaluation

Evaluation is an integral part of quality improvement in healthcare. The Clinical Audit and Effectiveness team support staff with service evaluation to:

- place evidence at the heart of what they do
- guide clinical decision-making
- identify and disseminate good practice
- build knowledge
- assess service quality and outcomes
- demonstrate impact on areas of focus and patient groups

Good quality analysis and the ability to use information effectively is an essential element in any learning health care system. Analysis can help shape care for individual patients as well as informing decisions for services or across organisations and health systems.

Clinical research

The number of patients receiving NHS services provided or sub contracted by LYPFT in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1351. This figure is formed from a combination of service users, carers and staff.

Patient Research: Experience Survey feedback summary

This year we received overwhelmingly positive feedback from participants on their experience of taking part in our NHS research studies.

Of the 39 responses received to date:

- ☑ 92% recorded having had a positive experience of taking part in the study in which they were involved (one recorded negative experience appears to have been an error, as corresponding written feedback is positive)
- ☑ 94% of participants recorded that they had been given all the information they needed in relation to the study

Written feedback supports these positive findings with a significant number of participants describing the positive and professional manner in which the research team engaged with them:

"conducted the study in a friendly and professional manner."

"a kind, polite and helpful young woman. She answered questions fully and politely. It was a pleasure to talk to her and hope my contribution will help the study she took part in."

"The person leading the study was very genuine and caring."

"Sometimes great patience needed by the researcher, it was always there! Time given for answers, memory loss always considered."

"At the test I was made to feel comfortable …… they were relaxed and supportive. Taking any test can be stressful as you want to do your best and they made me feel that I was being encouraged and not judged. The whole process was positive."

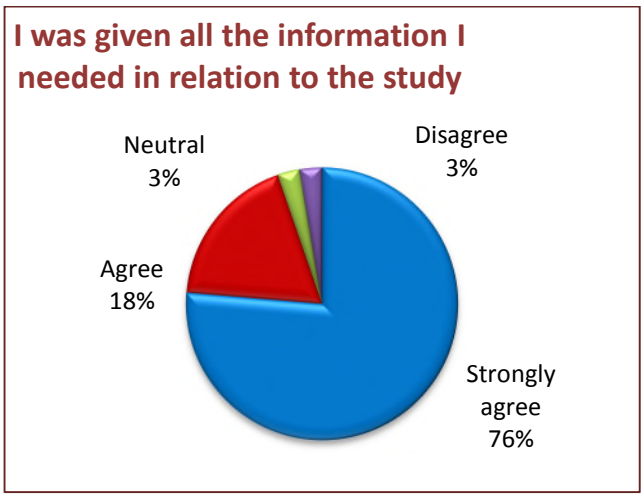
"I felt I was listened to, and my input was valued."

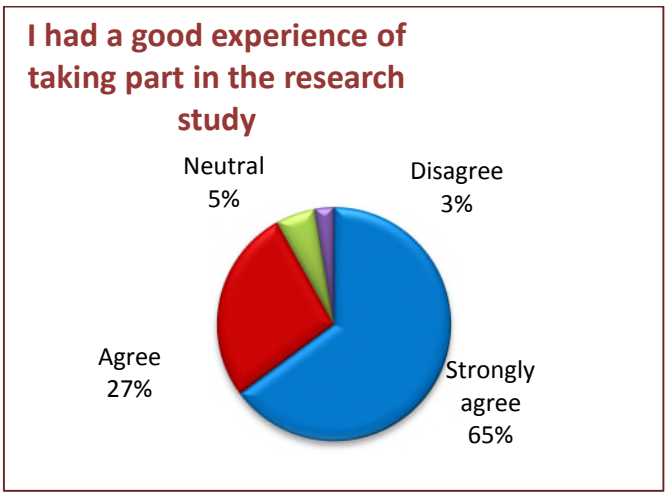
"Everything explained to me throughout the trial and made to feel comfortable at all times."

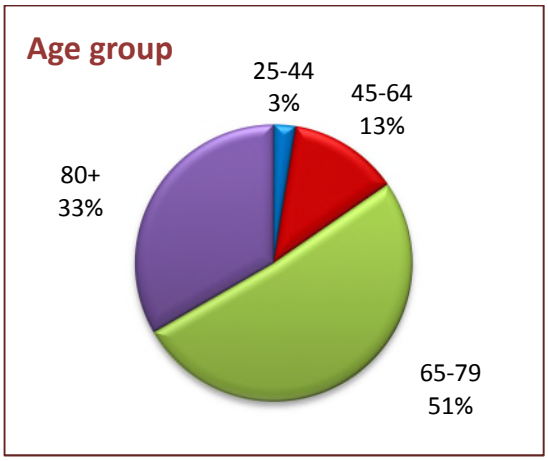
"I felt relaxed and it was an enjoyable experience. I was not embarrassed or worried about not being able to answer or complete the questions. I felt confident to ask questions before, during and after the test."
"Good explanation given by researcher e.g. purpose of study. The tests were undertaken in familiar surroundings. I felt quite at ease during the procedure and felt that my responses were meaningful and hopefully helpful to the research!"

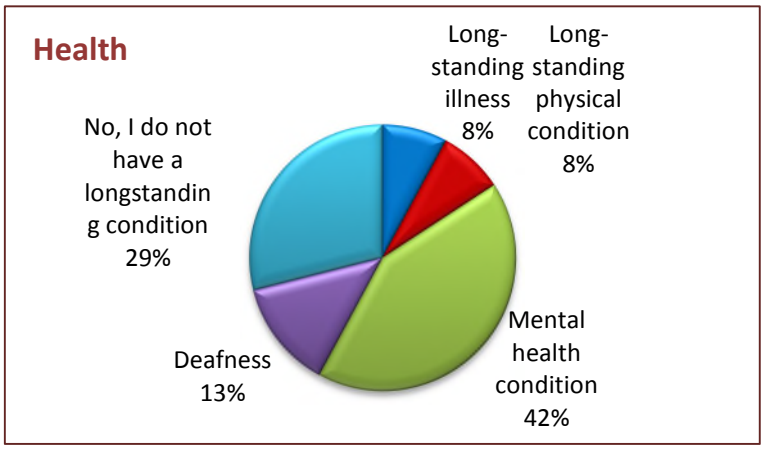
In two cases, respondents suggested that their partners, who had taken part in the research, may not have provided accurate answers due to their mental health conditions, whilst another participant suggested that service users should be more involved on the research side of the studies. Three participants noted that the research had not been relevant to them, but were pleased to have taken part for the wider success of the studies.

Responses:









Commissioning for quality and innovation (CQUIN)

A proportion of LYPFT income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between LYPFT and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. The achievement is based on our internal assessment and is subject to confirmation by commissioners.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available on request from emma.polhill@nhs.net

Commissioner	CQUIN	Description	Actual (YTD) Month 12
Leeds CCG	1a	Improvement of health and wellbeing of NHS staff	Not achieved
Leeds CCG	1b	Healthy food for NHS staff, visitors and patients	Full achievement
Leeds CCG	1c	Improving the uptake of flu vaccinations for frontline clinical staff	Full achievement
Leeds CCG	3a	Improving Physical healthcare to reduce premature mortality in people with SMI: Cardio Metabolic Assessment and treatment for Patients with Psychoses	Partial achievement expected for both community and inpatients (45% CQUIN value). This CQUIN is assessed on the national audit results, which are expected in June 2019.

Commissioner	CQUIN	Description	Actual (YTD) Month 12
Leeds CCG	3b	Improving Physical healthcare to reduce premature mortality in people with SMI: Collaboration with primary care clinicians	Partial achievement expected due to issues with sharing data with GPs (50% CQUIN value).
Leeds CCG	4	Improving services for people with mental health needs who present to A&E	Full achievement
Leeds CCG	5	Transitions out of Children and Young People's Mental Health Services (CYPMHS)	Full achievement
Leeds CCG	9a	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco screening	Partial achievement (75% CQUIN value)
Leeds CCG	9b	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco brief advice	Partial achievement (25% CQUIN value)
Leeds CCG	9c	Preventing ill health by risky behaviours - alcohol and tobacco: Tobacco referral and medication	Not achieved *
Leeds CCG	9d	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol screening	Full achievement
Leeds CCG	9e	Preventing ill health by risky behaviours - alcohol and tobacco: Alcohol brief advice or referral	Partial achievement (3% CQUIN value)
NHS England	Forensic Service	Adult Secure Mental Health Service Review and Recovery College	Full achievement
NHS England	Personality Disorder Services	Optimising care pathways	Full achievement
NHS England	CAMHS	CAMHS transitions	Full achievement
NHS England	Gender Identity Services	Peer support workers	Full achievement
NHS England	Eating Disorder Services	MH worker competencies, structure of the week, person centred care	Full achievement

** we have identified a problem with the ability to robustly record each referral for NRT/other medication; therefore this data may not be representative of the % of smokers offered this type of support.*

CQUIN Planned income and penalty incurred:

Planned Income	2018/19 £	2017/18 £	2016/17 £
Leeds CCGs	2,348,676	2,281	2,258
NHS England	605,409	600	577
Penalty Incurred			
Leeds CCGs	432,156 – estimated	120	350
NHS England	0	0	0

The percentage of patients on Care Programme Approach who were followed up within 7 days after discharge from psychiatric inpatient care during the reporting period

We currently have a **target of 95%** for patients on CPA to receive a follow up review within 7 days of discharge. Performance against this target has on average remained on target (average 95.21% for 2018/19).

Target of 95%	Q1	Q2	Q3	Q4
2018/19	93.81%	95.61%	96.06%	95.36%
2017/18	94.42%	96.68%	94.33%	95.33%

The LYPFT considers that this percentage is as described for the following reasons:
The Trust actively monitors performance and data quality for this metric 3 times per week to ensure that teams are able to fulfil the follow up target.
This metric gets audited annually by our external auditors and often our internal auditors.

The LYPFT intends to take/has taken the following actions to improve the percentage, and so the quality of its services:
- The Trust completed and issued a frequently asked questions document to ensure staff understand the requirements
- The Trust began monitoring performance for follow up in 3 days to ensure that the people are followed up as quickly as possible post discharge
- The Trust will continue the high level of scrutiny of performance and recording for this metric to ensure that service users are followed up appropriately

We have been working internally to achieve follow up within 72 hours; this will be a CQUIN for 2019/20 with a target of 80%.

The percentage of admissions to acute wards for which the crisis resolution home treatment team acted as a gatekeeper during the reporting period

Crisis Gatekeeping	2018/19					National comparison 2017/18
	Q1	Q2	Q3	Q4	Total	Total
Gate-kept Admissions	216	209	210	203		
Admissions	216	209	210	204		
Compliance	100.00%	100.00%	100.00%	99.51%	99.88%	99.1%

The Leeds and York Partnership NHS Foundation Trust considers that this percentage is as described for the following reasons: The data is produced according to the agreed specification and subject to monthly validation.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by:
One of the ambitions of the redesign of our community services is to improve the robustness of gatekeeping, routing service users to alternatives to admission where appropriate. The new Crisis and Intensive Support Service (CRISS) will lead on face to face gatekeeping, providing 24-hour intensive support to people seven days a week, 365 days a year. The service aims to prevent avoidable admissions and readmissions to hospital care. The assessment function of the service will work closely with colleagues across other services in order to gate-keep all acute admissions to hospital and provide intensive support at home.

The percentage of patients aged: (i) 0 to 15 and (ii) 16 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. *
as amended

Re-admissions	Q1			Q2			Q3			Q4		
	Discharges	Re-admissions in 28 Days	Re-admission Rate	Discharges	Re-admissions in 28 Days	Re-admission Rate	Discharges	Re-admissions in 28 Days	Re-admission Rate	Discharges	Re-admissions in 28 Days	Re-admission Rate
0-16	4	0	0.0%	6	0	0.0%	4	0	0.0%	3	1	33.3%
16+	407	18	4.4%	400	13	3.3%	419	16	3.8%	414	14	3.4%
Summary	**411**	**18**	**4.4%**	**406**	**13**	**3.2%**	**423**	**16**	**3.8%**	**417**	**15**	**3.6%**

The Leeds and York Partnership NHS Foundation Trust considers that this percentage is as described for the following reasons:
The data is produced routinely following the agreed specification.

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services:
As part of the Trust's plans to reduce out of area placements, the Trust is monitoring a suite of quality metrics for the acute wards to ensure that service users are not being discharged too early in support of repatriating someone from an out of area bed; or to avoid sending someone out of area at admission.

Readmissions are part of this suite of measures and any increase in the percentage would be flagged with the teams to review. This is likely to continue during the next year.

The percentage of patients under 16 years old admitted to adult facilities:
There were none during the reporting year.

Care Quality Committee (CQC) registration, Ratings and Improvement Plans

LYPFT is required to register with the Care Quality Commission (CQC) and its current registration status is full registration without condition. The current overall rating LYPFT achieved in April 2018 following inspection in January in 2018 is 'Requires Improvement'.

Since our last inspection we have worked to implement and address all 'must-do' actions identified by the CQC. This is resulting in improvements in practices, processes, patient safety and governance. Some examples of the work we have been achieving both across the Trust and within services are:

Care records
We have worked across the Trust to ensure that information in patient care records is accurate and up to date; and to improve the quality and consistency of those records. A Clinical Records Task & Finish group was set up, with clinical representation from all services, to address the following areas for improvement:

- Consistent recording of patient data across all services
- Consistent practice for downtime
- Accessibility of patient data to staff (including bank and agency)

An outcome of this work was the development of a Standard Operating Procedure which encompassed:

- A Local Working Instruction for when our electronic patient record system (PARIS) is unavailable
- Two guides for our Bank Staff regarding how to access and view patient records
- A business continuity plan

In addition the group created:

- a care plan audit tool (to measure the standard of patient care records)
- a schedule of audits and engagement with patients to cover the following year

Person centred care

✓ We have achieved progress in evidencing that our care is person centred by providing targeted training sessions, facilitating care planning groups and monitoring the quality of care plans weekly through Safewards. We've also carried out a trial of a hand held device on which plans can be recorded electronically whilst with the patient. We have a continuing drive to improve Mental Health Legislation training levels.

✓ We have employed a new Speech and Language Therapist within our Learning Disability team to ensure that service users' communication needs are fully met.

Safe Care

✓ We have made improvements for ensuring service users' physical health; including after rapid tranquilisation. This has included the recruitment of two additional members of staff to improve physical health care within our Trust.

✓ A new Physical Health Booklet has been introduced to ensure information is consistently recorded and easily located; and we monitor improvements to the recording of physical health of our service users.

✓ Our staff are being trained on administering medications and have evidenced a reduction in medicines errors.

✓ An Epilepsy risk assessment tool has been developed and a monthly check introduced to ensure the assessments are in place and are meaningful.

Staffing

✓ We have streamlined the method for recording clinical supervision ensuring clinical staff can quickly and easily make a timely record that this has taken place. We have also ensured that staff understand what constitutes supervision and all clinical areas have 'supervising trees' (which are a diagram-type family tree) that shows who staff can access for clinical supervision. This has led to an increase in recorded clinical supervision and all services are showing an improvement and sustained compliance with this essential requirement and means of support.

✓ In our Forensic services we have recruited additional staff and have worked to retain those staff. We opened our Westerdale ward and our supervision and appraisal rates have improved significantly in these services and continue to remain compliant.

LYPFT has participated in special reviews by the CQC during the reporting period. This was the Review of health services for Children Looked After and Safeguarding in Leeds (June 2018) and the Leeds Local system review (October 2018).

The CQC has not taken enforcement action against LYPFT during 2018/19.

Care Quality Commission (CQC) Standards: Peer Review process

Our Peer Review process assesses services to see how they would score against the CQC's quality assessment framework called Key Lines of Enquiry (KLOE), which the CQC use during their inspection of healthcare providers. The peer reviews include a day visit to a ward or service by a small team of staff who carry out the assessment. Each team member asks questions and makes observations against the KLOEs which are categorised under the CQC's headings (called domains): Safe, Effective, Responsive, Caring and Well-Led. The assessment includes talking with service users and staff, and examining patient care records.

Following the visit the Peer Review team summarise their findings and ask the service to create action plans for areas that are seen to 'require improvement'. The Peer Review process is a collaborative and supportive method of assessment, which allows teams to work across care groups to share best practice, as well as identify quality improvements.

The Peer Reviews have been well received by staff working within the services visited. Feedback tells us that the process helps to assure ourselves about what we are doing well and identify areas for improvement. Feedback from the Peer Review team has also been positive: it provides staff with an opportunity to review our services in real-time, see how others teams work and establish best practice. It also prompts staff to think about the good practice they carry out every day and how they can best demonstrate this during an inspection.

We have a continuous schedule of Peer Reviews and having carried out 15 assessments to date, we now have enough data to develop reports that look at the themes arising from the reviews to even better shape the quality improvements we need to make.

What are our Peer Reviews telling us?

- ✓ We found our staff to be caring, patient focused and professional in all areas. Staff work really well in teams and support each other
- ✓ Our staff are compassionate and live our values – caring, keeping it simple and showing integrity.
- ✓ We found that staff agreed that we are well-led

Other positive findings include:

- ☑ an improvement in mandatory training
- ☑ an improvement in clinical supervision
- ☑ an improvement in appraisal compliance
- ☑ more staff are aware of the Freedom to Speak Up Guardian (FTSUG) and the FTSUG posters are visible in more wards and services

However, there are some areas that we have identified as requiring improvement due to themes arising from our Peer Reviews. Being open about, and understanding, where we need to improve gives us the opportunity to put plans in place to address these areas.

Examples of areas for improvement include:

- × information on display in ward areas for service users, carers and families is sometimes missing or out of date (for example CQC ratings, Trust values, how to make a complaint)
- × cleaning contractors could be more responsive to our needs
- × improving our focus on quality improvement at ward level and to have this as a standing agenda item for team meetings and discussions
- × some of our patient care records could be more detailed, accurate and up-to-date; and evidence service user input

By conducting these reviews and rectifying the issues we come across, we are ensuring that our services are continuously improving and we are currently preparing ourselves in the best way for our next CQC inspection.

Secondary uses and hospital episode data

LYPFT submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

- that included the patients valid NHS Number was 99.6% for admitted care and was 100% for outpatient care
- that included the patient's valid General Medical Practice Code was 98.4% for admitted care and 98.9% for outpatient care

Information governance

The NHS Digital IG Toolkit has been superseded for 2018/2019 by the Data Security & Protection Toolkit, based largely on the National Data Guardian's Data Security Standards. The Trust made a self-assessment against the NHS Digital Data Security & Protection Toolkit of 'Standards Met' at 31 March 2019, meeting the required evidential standard for all compulsory Assertions. This was supported by an internal audit appraisal of a sample of 14 of the 32 compulsory Assertions, with an outcome of "Significant Assurance". Requirements were included from across all ten of the National Data Guardian's core data security standards.

Throughout the year the Trust has worked on several key Information Governance workstreams, including:

- General Data Protection Regulation (GDPR) readiness assessment and action planning across corporate departments, the re-authoring of policies and procedures aligned to GDPR, and the roll-out of new Privacy Notices
- Updating our Subject Access procedures to meet the new statutory 1 calendar month timescale, with compliance since enactment at >99%
- Maintaining our 100% record for statutory compliance with our Freedom of Information Act request processing
- Implementing revised NHS Digital Information Governance breach reporting standards, aligned to the GDPR, resulting in no reportable incidents since implementation
- Maintaining the highest levels of clinical coding accuracy for Finished Consultant Episodes, notably with 98% accuracy of primary diagnosis
- Maintaining the highest standards of medical records availability, with only 2 reports of records not located in the 12 months to date
- Implementing numerous data quality / data completeness work streams, aiming to improve data quality and completeness standards throughout the Trust

Payment by Results

LYPFT was not subject to the Payments by Results clinical coding audit during 2018/10 by the audit commission.

Seven day hospital services

The standards for seven day hospital services are not directly applicable for mental health and learning disability providers; and therefore LYPFT. However, we provide services outside of the normal core hours. We have recently redesigned the way we provide our community mental health services which sees our community services operating between 8am and 9pm, seven days a week and 365 days per year. Our crisis service also continue to operate over a 24 hour period, 365 days per year, seven days per week, with an enhanced provision between 8am – 9pm.

These small changes to the way we provide our community services make them even more accessible, ensuring that service users receive consistent high quality safe care every day of the week.

Patient experience of Community Mental Health Services

The information below summarises the LYPFT'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.

26% of service users accessing community mental health services in LYPFT during the reporting period responded to the Survey of people who use community mental health services 2018. This survey forms part of the Care Quality Commission's national NHS Patient Survey Programme, which benchmarks the Trust to assess whether performance is 'about the same', 'better' or 'worse' compared with most other trusts.

LYPFT scored 7.3 (with scores ranging from 5.9 to 7.7 across all Trusts) with regard to a service user's experience of contact with a health or social care worker. This score has been maintained from 2017, and places the Trust "about the same" as other Trusts in 2018. This is a significant achievement in maintaining quality in the context of an increasing demand and service redesign.

The LYPFT considers that this score is as described for the following reasons:

- Service user feedback of the direct experience of LYPFT staff in the survey highlighted evidence that the person they saw listened carefully to them, that the people they saw understood how their mental health needs affected other areas of life, and said they were given enough time to discuss their needs and treatment. LYPFT's results were significantly better than most Trusts for involving service users in making decisions about medication, and the Trust achieved the highest score nationally in 2018 for supporting service users in accessing community activities in addressing wider social and vocational needs.
- Our approach to audit of CPA practice has been revised to provide a focus on the quality aspects of care planning, to support improvement on person centred approaches. This has been evidenced through the last audit identifying increases in care plans reflecting service user defined goals.
- A Care Planning, Safety Planning and Recovery (CASPAR) working group has been established to drive improvement through sharing of best practice principles of care planning and effective care co-ordination; to develop collaborative practice with service users and their family/carers, and to embed recovery principles within services.
- Training delivered across the community teams to embed the principles of the Triangle of Care and improve involvement of carers.

The LYPFT intends to take/has taken the following actions to improve the score, and so the quality of its services by:

- Service user involvement in recovery focused care planning has been identified as a key focus of quality improvement within community services, with improvement actions identified within clinical teams, and progress monitored though local governance processes
- A local campaign in community teams supported by Trust Communications using the ''you said we did'' format to share the key messages of the survey with service users and carers, alongside "pledges" of the identified improvement actions, with progress monitored through our governance groups.

More information regarding these developments is available upon request by emailing: e.devine@nhs.net

Staff Satisfaction

The table below shows the percentage of staff employed by the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends, as reported on the NHS National Staff Survey**. This includes comparison with the previous three years.*

**current definition: "if a friend or relative needed treatment, I would be happy with the standard of care provided by this organisation"*
***definition has changed since Quality Account guidance was issued*

Year	Number of staff employed	% of those staff employed who recommend the trust to family or friends	National Average (Mental Health and LD Trusts)	Highest/Lowest
2018	2459	64%	61%	81% - 38%
2017	2419	59%	61%	87% - 42%
2016	2412	58%	60%	82% - 44%
2015	2670	57%	58%	84% - 36%

The LYPFT considers that this percentage is as described for the following reasons:
We are currently progressing through a significant change as part of our organisational re-design of our community services, affecting approximately 400 staff directly. This parallels the challenges these, and other, staff face on a daily basis through their day to day roles.

We see 64% as a positive outcome as:
- this score demonstrates a year on year increase over the previous 3 years
- it is the first time we scored higher (percentage) than the sector national average

77% of our staff consider that the 'care of patients/service users is my organisation's top priority' which is a 7% increase on last year.

The LYPFT intends to take/has taken the following actions to improve this percentage, and so the quality of its services, by:
Our focus for looking at the Quality of Care specifically is by:

- ☑ Working with the Institute for Healthcare Improvement (IHI) who visited the Trust in March
- ☑ Making greater use of Service User Experience Feedback

We also know that having a more highly engaged workforce has a positive impact on patient care and we are therefore working on:

- The introduction of a 'happy app' to support organisation-wide improvement
- Implementing a 'Culture Club'
- Working with Skills Training UK

- Continuing to roll out the 'Affina' model for organisational development which helps teams develop and improve performance through team based working
- Continuing our focus on the health and wellbeing of our staff through a variety of supportive interventions such as coaching, resilience sessions and mediation. We are also improving our Staff Support Offering by engaging with Anchor Organisations Healthy Workplaces programme and the Leeds Health and Care Academy Mental Health first aid offer
- Continuing our recognition schemes such as the annual Trust Awards and monthly STAR Award

For the last 3 years we were asked to include the most recent LYPFT NHS Staff Survey results for indicators:

- *'KF19' reported in the LYPFT 2018 results as* ***Key Question 13c*** *(Percentage of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months)*
  In 2018 the percentage for this question was 16%; a 1% unwanted increase on 2017; however this was less than the Mental Health and Learning Disability sector average for 2018 of 17%.

And;

- '*KF27' reported in the LYPFT 2018 results as* ***Key Question 14*** *(Percentage of staff believing that the organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?) for the Workforce Race Equality Standard*
  In 2018 the LYPFT percentage for this question was 85%. This is a decrease of 2% from the 2017 result of 87% but 3% higher than the sector average of 82%.

What else are we doing?

- Continuing with our WREN (Workforce Race Equality Network) and launching a WDEN (Workforce Disability Equality Network)
- Training and support around appraisals to increase both quality and compliance
- Looking at Bullying and Harassment in the Trust by conducting a 'deep dive' and continuing to promote Compassionate Leadership, Freedom to Speak Up and our mediation services

Freedom to Speak Up Guardian

Having a 'Freedom to Speak Up Guardian' is a statutory requirement for NHS Trusts and the role follows national reports on whistleblowing such as The Mid Staffordshire NHS Foundation Trust's Public Inquiry, chaired by Robert Francis QC:
http://www.midstaffspublicinquiry.com

Our current Guardian, John Verity, took up his role in October 2017 and works across our organisation creating spaces for staff to share concerns about patient care and safety. The role is independent and reports directly to the Chief Executive and the Trust Board with the aim of ensuring that staff concerns can be heard within a supportive environment that encourages people to speak out.

The work of the Freedom to Speak Up Guardian also contributes to the creation of a national and regional network across NHS services, through which we can learn and support the emergence of best practice. The role is essentially connected to sensing and shaping the culture of our organisation.

The Freedom to Speak Up Guardian also supports and complements the work of our Staff Side representatives, Human Resources team, our bank staffing, equality and diversity forums, Monthly Trust induction, team meetings and more. It is important that the Guardian engages internally within the Trust to triangulate themes, patterns and issues that are brought to them by staff.

The role has added to the quality and effectiveness of our service through supporting staff to share their concerns confidentially. Wider communication regarding issues of patient safety will help us identify where we need to make changes to improve the quality of working lives and ultimately, patient care across LYPFT and the wider community.

Within the last year there were over 200 face to face contacts with the Guardian.

There are a number of meetings into which the Guardian reports to ensure issues are highlighted at the appropriate forum. This includes our relevant Clinical Improvement Forums, Trust-wide Clinical Governance meetings and Trust Board meetings. Lessons learned are also shared directly with managers, our Medical Director and we have a Non-Executive Director assigned to whistleblowing matters raised.

Our vision for 2019 includes simplifying our policies and procedures to make raising concerns a simpler process and as engagement with the Guardian has continued to increase, the hours dedicated to the role have been enhanced to ensure we continue with our commitment to it.

Patient safety incidents

The Trust is committed to continually improving the quality and safety of all services. Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about adverse incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning.

The open reporting of incidents (including near misses and 'errors') is positively encouraged by the Trust, as an opportunity to learn and to improve safety, systems and services.

The information below shows the number and percentage of patient safety incidents (PSIs) reported within the LYPFT during the reporting period and previous years, and the number and percentage of such patient safety incidents that resulted in severe harm or death.

Between 1 April 2018 and 31 March 2019 a total of 8489 patient safety incidents were recorded. Of these incidents 508 (6%) were categorised as severe harm, indicating long term significant harm (severity 4) or death (severity 5).

All patient deaths are categorised as a severity 5, which includes those confirmed as natural, expected deaths. This facilitates a review of all reported deaths to ensure that there is a clear view of mortality and to identify any learning.
We review all patient deaths weekly. The death of any person who has died within the last 6 months of care, who has been in receipt of inpatient mental health services, Care Coordination in Community Services or has accessed the Crisis service is subject to a more in-depth review. This can vary from establishing additional information (fact finding) to a full comprehensive investigation.

Where a family member or carer raises a concern about any element of care prior to the death of a service user a full comprehensive investigation is completed. We provide healthcare for patients across a wide breadth of partnership services and often we are not classified as the main provider of

the deceased person's care. For example we provide psychiatric input for people with cognitive impairment via our memory services and their GP is responsible for the person's ongoing physical healthcare needs.

The total number of deaths by Quarter are provided in the below table.

Learning From Deaths and Incidents	**Q1**	**Q2**	**Q3**	**Q4**
Total number of deaths reported 1 April – June 2018	**127**	**110**	**119**	**88**
Awaiting Cause of Death confirmation	**3**	**11**	**21**	**11**
LYPFT not the primary provider of care	**96**	**84**	**74**	**54**
ENE 1 (Expected Natural Death -Expected to occur within a timeframe)	**4**	**4**	**10**	**5**
ENE 2 (Expected Natural Death - Expected death but not expected in the timeframe)	**1**	**1**	**4**	**1**
UN 1 (Unexpected Death from Natural Causes i.e. cardiac arrest/stroke)	**7**	**2**	**2**	**2**
EU (Expected Unnatural Death i.e. alcohol or drug dependency)	**0**	**2**	**0**	**0**
UN 2 (Unexpected Natural Death from natural cause but did not need to be)	**3**	**0**	**0**	**2**
UU (Unexpected Unnatural Death)	**13**	**6**	**8**	**13**

LYPFT considers that this number and/or rate are as described for the following reasons:

- The Trust actively encourages incident reporting and has developed a supportive and responsive culture of patient safety
- The Trust takes a collaborative approach to reviewing incidents of severity 4 and 5
- The incidents reported as severity 4 and 5 are low in comparison with those reported as severity 1 (5939 incidents) and 2 (1799 incidents).

The Leeds and York Partnership NHS Foundation Trust intends to take/has taken the following actions to improve the percentage, and so the quality of its services by continuing to develop the below approach:

- The Trust policy stipulates that all known deaths are reported via DATIX, the Trusts incident reporting system.
- Incidents are discussed at monthly care group governance forums.
- A summary report (CLIP) is provided monthly to aid discussion and highlight concerns.
- All patient safety incidents reported as severity 4 and 5 are reviewed at the twice monthly Learning from Incidents and Mortality Meeting.
- The Trust uses the Mazars mortality review codes. Where a patient death is recorded as unexpected/unexplained a further review is undertaken to identify if any care or service delivery problems have contributed to the patient's death.
- All learning disability patient deaths are subject to a review whether unexpected or otherwise.

According to the NHS National Reporting & Learning System (NRLS) *(2015)* organisations that report more incidents generally have a better, more effective safety culture. Below is our data, including national comparison, as is currently available:

NB: our 'How to understand and improve your patient safety incident reporting to the National Reporting and Learning System (NRLS)' benchmark report is for data set: April 2018 to September 2018.

The top five categories of incident reported to the NRLS in Qtr. 1 - 4 were:	
Self-harm	1654
Violence	797
Falls	796
Absconder/Missing Person	513
Clinical Patient care	491
Broken down by severity/degree of harm the top five categories are:	
Severity 1 -	**No harm**
Self-harm	840
Violence	580
Falls	592
Absconder/Missing Person	433
Medication	369
Severity 2	**Low harm**
Self-harm	486
Violence	157
Falls	139
Clinical patient care	86
Accident	72
Severity 3	**Moderate harm**
Self-harm	73
Clinical patient care	19
falls	15
Violence	10
Substance abuse	7
Severity 4	**Severe harm**
Self-harm	2
Fall	1
Clinical patient care	1
Severity 5	**Death**
Death	28

Rate of incidents per 1,000 bed days:

Median average	44.02
LYPFT	40.95
Highest reporter	96.72
Lowest reporter	14.88 (NB there were three trusts with no rate assigned)

Number of incidents reported:

Median average	2,901
LYPFT	3,095
Highest reporter	8,134
Lowest reporter	1

Degree of harm/Severity Rating:

LYFPT	No harm	Low harm	Moderate harm	Severe harm	Death
Number	2,158	823	101	4	9
% of total reported incidents	69.7%	26.6%	3.3%	0.1%	0.3%
Highest reporter	**No harm**	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Number	6,038	1,801	232	9	54
% of total reported incidents	74.2%	22.1%	2.9%	0.1%	0.7%
Lowest reporter	**No harm**	**Low harm**	**Moderate harm**	**Severe harm**	**Death**
Number	403	134	55	2	24
% of total reported incidents	65.2%	21.7%	8.9%	0.3%	3.9%

52% of self-harm incidents resulted in the patient experiencing some degree of harm. Of the 52%, two were reported as severe harm (severity 4).

29% of reported patient safety incidents were recorded as self-harm incidents:
- 44% (733) of these incidents involved using a ligature as a means to self-harm, 205 incidents resulted in low harm (severity 2) to the patient; the remainder were graded as severity 1(no harm).

10% of all reported patient safety incidents were recorded as assault by a patient on a fellow patient; 368 of these incidents were graded as low harm, 151 of these incidents were graded as minimal harm and 5 as moderate harm (severity 3).

13% of patient safety incidents were reported as falls, whereby the patient was “found by staff laying on the floor”. These are suspected falls which were not been witnessed by staff; of the 13% low harm was sustained in 80 of these patient falls and moderate harm in 9. One fall resulted in severe harm, where the patient suffered severe head injury requiring medical intervention.

In addition to the three severe harm incidents referenced above, there was a clinical care incident whereby a service user had acquired a pressure ulcer.

There were 28 Unexpected, Unexplained deaths reported, which were subject to further investigation.

Inquests

Between the 1 April 2018 and 31 March 2019 we were registered by the Coroner to be involved in **39** inquests, all of which have been concluded. From these inquests, LYPFT received one Prevention of Future Death (PFD) report served by the Coroner under the Coroner’s (investigations) Regulation 28.

Learning Disabilities Mortality Review (LeDeR) Programme

We comply with reporting all Learning Disability Deaths to Bristol University, via the LeDeR system. The Trust is actively involved in the Northern Alliance Mortality Review Group where the sharing of findings and reviews is undertaken. Our Safety and Risk Lead participated in a presentation with NHS Improvement Academy, as part of their nomination for a Patient Safety Award. The award related to

the development and implemented use of Structured Judgement Reviews (SJRs). We were pleased to be an early adopter of SJRs within mental health services and we have been praised for adapting this methodology, as well as evidencing the benefits and value associated with this review process.

Falls Group and Pressure Ulcer management

Every 3 months we produce quality reports which provide an overview of pressure ulcers and falls. These provide assurance that all incidents relating to pressure ulcers and falls within LYPFT services are reported, reviewed and investigated; and that we have systems in place to share lessons and improve patient safety.

Falls

Our falls are reviewed by severity as follows:

Severity 1 Falls: no injuries sustained

	Q1 (2018/19)	Q2 (2018/19)	Q3 (2018/19)	Q4 (2018/19)
SS/LD Services	25	22	13	26
Leeds Care Group	130	108	122	153

Severity 2 Fall: first aid given, minor interventions

	Q1 (2018/19)	Q2 (2018/19)	Q3(2018/19)	Q4 (2018/19)
SS/LD Services	13	15	09	10
Leeds Care Group	24	37	42	36

Severity 3 Falls: medical treatment, surgery

	Q1 (2018/19)	Q2 (2018/19)	Q3(2018/19)	Q4 (2018/19)
SS/LD Services	0	01	02	0
Leeds Care Group	04	06	01	03

Examples of improvements arising from cases of falls include:

- Introduction of Falls 'safety huddles' across all inpatient wards for older people with mental health needs and inpatient wards for people living with dementia
- Falls audit in relation to the use of the falls multi-factorial risk assessment at The Mount inpatient services
- Development of a Falls Assessment Tool to raise awareness of risk of falls for service users who are admitted to the acute inpatient mental health service

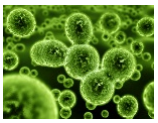
Pressure Ulcers

The table below details the pressure ulcers reported within our services in 2018/19 and identifies which of those reported were attributable to LYPFT:

	Q1 (2018/19)	Q2 (2018/19)	Q3 (2018/19)	Q4 (2018/19)
Attributable to LYPFT	03	01	5	05
Non-attributable to LYPFT	03	02	2	01

'React to Red' pressure ulcer prevention training has been held for clinical staff based across acute inpatient and older people services in LYPFT. It is planned that 'React to Red' will be made available through our e-learning system as well as face to face training days.

Infection Prevention Control Team



Over the year The Infection Prevention and Control Team (IPCT) have worked to improve our medical devices database, maintain cleanliness standards, manage outbreaks and implement the flu campaign. The team has made progress with this annual programme of work and their achievements for 2018/19 include:

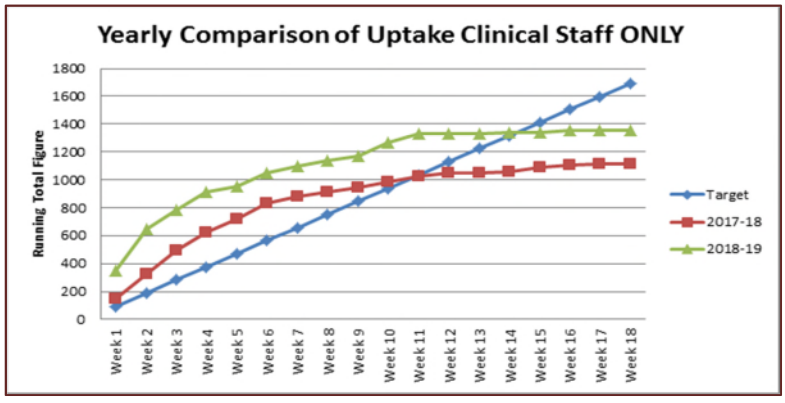
- There were no reportable cases of **Clostridium difficile (C. diff) or MRSA**

Key performance data is available via a series of reports from the IPCT information system to observe trends. Outbreaks remain at consistently low peaking over the winter months with the common causes remaining as influenza and norovirus. Learning from outbreaks has led to changes to the seasonal influenza procedure which will assist staff in identifying when to provide prophylactic treatment at an earlier stage.

YEAR	QTR 1	QTR 2	QTR 3	QTR 4
2018/19	0	0	3	4
2017/18	0	2	1	3
2016/17	1	0	3	1
2015/16	1	0	1	0

Reporting to the Board of Directors as part of the combined quality performance report has been strengthened with monthly reports on alert organisms, outbreaks, incidents and mandatory training.

- Our IPCT **environmental audits** are scored to provide an indication of compliance and benchmarking across the Trust. Overall achievement scores range between 86% and 98%. This represents acceptable compliance and minimal risk to service users
- The seasonal **flu vaccination programme** is complete. In 2017/18 we increased uptake from 55% to 65.5%. This season we achieved **79.4%.** The graph below demonstrates our continued commitment to this programme (uptake from our clinical staff) to ensure we keep our staff, service users, and the public as safe from flu as possible.



Safeguarding

In June 2018 our Safeguarding Team began a review of their 'Training Needs Analysis' (TNA). TNA is a process that identifies any gap between employee's training and training needs; to determine what training is required to meet a certain standard.

The work was commenced ahead of the publication of the *Adult Intercollegiate document (August 18).* This document has been produced by the Royal Colleges and offers recommendations for healthcare organisations and practitioners in standards of safeguarding knowledge, skills and expertise. This follows on from similar guidance found in the already established child intercollegiate document.

Child and adult safeguarding training is now combined to ensure our staff are compliant with both; and to reduce the need for staff to be released from clinical work more than once. Our **PREVENT** Level 3 target of 85% compliance by September 2018 was reached and exceeded. The current compliance figure is 95%.

Further work is being undertaken to promote early help for families within the Trust. This includes a greater emphasis on this within training; and additional supervision sessions for our Community Mental Health Team and Intensive Care Service.

The Safeguarding Team shared information and expertise to help reduce the risk of domestic abuse for 3645 cases this year. As with previous years our involvement with has remained equal between victims and perpetrators. The team are also supporting a city-wide task and finish group to look at the service provision required to address the needs of perpetrators and prevent reoffending. Our data shows a larger proportion of staff are using the DASH (Domestic Abuse Stalking and Honour based violence) risk assessment tool this year (130) compared to last year (106) indicating an increased awareness within our staff groups.

The Safeguarding Team provide regular governance and management reports on their service and its quality outcomes. This year they have supported the panels for a joint safeguarding review (spanning child/adult and domestic homicide, a serious case review; four learning lessons reviews; and four domestic homicide review.

SECTION 4

OUR QUALITY IMPROVEMENTS FOR THE FORTHCOMING YEAR

Quality Strategic Plan

Our Model

We have chosen to draw on the White Paper from the Institute for Healthcare Improvement (IHI) called *'A Framework for Safe, Reliable and Effective Care'* January 2017 to develop our Quality Strategic Plan, which was approved by the Trust Board in February 2018. This framework outlines the evidence base for conditions that support high quality, continuously improving, and compassionate care to flourish. It focuses on creating systems of safety.

Even with flourishing frontline services and with the right support in place, we need to have systems that will allow us to understand the quality performance in our system. A 'heat map' allows us to pinpoint good practice that we can learn from and the areas where teams might need some support to think differently. We want to create confidence in our members, those who fund us and those who regulate us, regarding the quality of our services.

Where help is needed, it should be the right help in the right way - an integrated approach. We expect our clinical teams to provide joined-up care to each service user. Our clinicians should expect the same of the supporting teams who are helping them to improve. We recognise the value of peer support in clinical work and believe that the same collaborative approach between teams will be effective alongside more formal support.

Too many objectives and priorities is not helpful for any of our teams. Locally owned objectives are the most motivating, however there will be a need to accommodate Trust-wide priorities and respond to national imperatives. We will work with our care groups and corporate staff to identify how we can best understand these priorities and learn from feedback given by our service users, carers, governors and other partners to make sense of what we prioritise and how we should work together to set and achieve objectives.

Lastly, we know that the need to work across boundaries internally – clinician to clinician, team to team and service to service – also applies to the systems we sit within in terms of 'place', Sustainable Transformation Partnership and also nationally. The same conditions that allow quality to flourish at the frontline will allow us to provide the right leadership, culture and learning to be good partners in systems committed to high quality care.

Our model will outline how we will:

1. Use evidence to build the conditions for quality care to flourish through our organisation.
2. Establish a system that helps us see how we are doing floor to Board.
3. Provide help and support where it is needed and do this in a joined-up way.
4. Develop systems to ensure that we can set and deliver Trust wide and local priorities with clarity and equity.
5. Use our integration skills to work across boundaries and systems with partners to make sure that we deliver joined-up high quality care as part of a system.

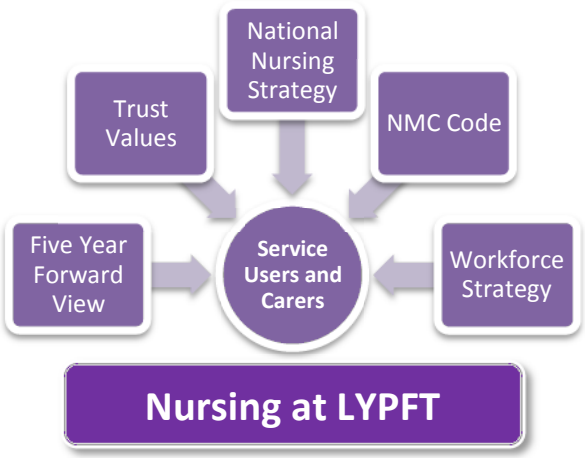
To support the delivery of this work we are partnering with the IHI. They will undertake an assessment and analysis of the existing culture, strategies, policies, and priorities of the organisation and identify what else is needed for us to work within our limitations as a public service to be successful in continuous quality improvement.

Nursing Strategy 2018-2021

We employ more than 720 registered nurses to meet the mental health needs of the communities we serve. The majority of our nursing staff are Mental Health or Learning Disability Nurses. Alongside these we also have our Adult nurses, Child Nurses and Midwives, all of whom form our community of nursing professionals. We also employ almost 650 support workers, who make an invaluable contribution to our service users through the care and support they offer every day.

The nursing service is part of the underpinning of our Trust. Our nursing staff work with our service users to help them feel safe, cared for and respected. We are committed to ensuring that our nurses are equipped to meet the fast moving, exciting challenges of future care provision. We must be active in identifying new ways of working; driving innovation and exercising our influence, to ensure that we continue to provide safe and effective care to our service users and carers not only across Leeds and York but also regionally and nationally.

Our **Nursing Strategy** is based several important drivers:



Most importantly, our Nursing Strategy is based on holding continuous conversations with our nursing staff. Through a series of workshops nurses told us what nursing means to them, what makes them *Proud to Nurse* and what our nursing should look like over the next three years. Our Nursing Strategy is the response to that conversation.

Mental health and learning disability nurses who feel respected, valued and supported, will demonstrate integrity, show empathy and make it easy for the communities we serve to achieve their goals by working to use their specialist knowledge and skills ensuring every contact is therapeutic and meaningful. To achieve this ambition our Strategy has established five core commitments:

- To demonstrate that we are living our Trust Values **we will work with individuals, families and communities to equip them to make informed choices and manage their own health.**

- In line with the Five Year Forward View and the National Nursing Strategy **we will promote a culture where improving the populations' health is a core competent of the practice of all nursing, midwifery and care staff**
- Our approach to recruiting and keeping our nursing staff will ensure that **we will have the right staff in the right places and at the right time.**
- We will demonstrate our commitment to our nursing workforce by ensuring that **we will have the right education, training and development to enhance our skills, knowledge and understanding.**
- To demonstrate our commitment to developing nursing roles and practice **we will lead and drive research to evidence the impact of what we do**

We have already seen our Strategy impact on the way nursing care is delivered through the creation of new nursing roles and were proud to see our first cohort of Nursing Associates registering in January 2019. We have also invested in the development of Advanced Nurse Practitioner roles; and have recruited into three posts. This is part of wider plans to develop our nursing career pathway so that we can support, develop and retain the talented nursing staff available to us.

We are proud to have developed this Nursing Strategy in partnership with our nursing staff and we hope you agree that it reflects their passion and ambition for nursing. The full strategy document details how we will support developments in the five core areas including a challenging action plan that is designed to improve the experience of nursing within the Trust, as well as patient experience and quality outcomes.

Our Nursing Strategy demonstrates how the nursing workforce will be part of achieving LYPFT's vision to **Provide Outstanding Mental Health and Learning Disability Services as an Employer of Choice**

Allied Health Professional Strategy

Our Allied Health Professional (AHP) Strategy for 2018-2021 was developed by engaging with our AHPs and connecting with the national AHP strategy *'AHPs into Action'.* Clear priorities emerged from this work.

AHP's are the third largest professional group working in the NHS; however their contribution to patient care is not always understood or maximised in terms of the clinical skills of this professional group. LYPFT is no exception to this and whilst we have developed how we use the AHP workforce, our staff told us that they could contribute more to improving the quality of patient care.
As part of our strategy work we identified six priorities, all of which will be underpinned by clear leadership and governance in the 6 AHP professions that work in our organisation:

Due to the nature of their training AHPs are in an ideal position to support improvements in the physical health of our service users and develop improved service user co-produced care. To this end our 2018/19 action plan included:

- Establishing clear cover and contact arrangements for AHPs to ensure our service users have access to the full range of skills AHPs offer.

- Establishing a mixed Occupational Therapy rotation to improve links with our partner organisations in Leeds; and supporting our staff to develop and maintain their full range of skills.
- Promoting the 'Food First' approach by establishing Dietitian only supplement prescribing.
- Delivering on safety huddles and co-produced initiatives that improve the safety of patient care.

The most significant progress we have made is in the provision of our Speech and Language Therapy service. We have worked with our partners to ensure our service users have access to a speech and language therapist. We have successfully introduced improved modified diets and fluids, reducing the choking risk for our service users. In addition, we now have a speech and language therapist carrying out research to help service users with a severe and enduring mental illness to recognise and manage their own choking risk. This work has been recognised internationally and the therapist has spoken at a conference in Australia to share the success of her work.

Preceptorship Nursing and Professions Preceptorship Programme

What is preceptorship?

As defined by the Department of Health (2010) preceptorship is:
'a period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning'.

The period of transition from being a newly registered practitioner to becoming an experienced member of a multidisciplinary team can be both exciting and challenging. We recognise that during the first year of practice the newly qualified practitioner needs particular support and guidance. To ensure all newly qualified staff are supported through their first year of practice we have developed the *Leeds and York Partnership NHS Foundation Trust Nursing and Professions Preceptorship Programme.* The programme provides a structured transition for newly registered practitioners during which they are supported to develop in their role.

Why preceptorship?

Preceptorship is a way of addressing some of the challenges that newly qualified practitioners face. It aims to provide assurance that each newly qualified practitioner meets the necessary practice and professional standards; and can demonstrate that our newly qualified staff members (preceptees) have the knowledge and skills needed to provide the best possible patient care. This builds confidence and self-belief.

Preceptorship includes monthly study days and workplace activities and our preceptorship leads meet with each preceptee twice during the programme, within their service area; ensuring that the quality of the programme is maintained and that preceptees are receiving adequate support. Where additional support is required this is arranged on an individual basis.

Benefits of our preceptorship programme

- Develop confidence of the practitioner
- Professional socialisation into the working environment
- Increased job satisfaction, leading to improved service user satisfaction
- Feeling values and respected by the Trust
- Feeling invested in and having the practitioners future career aspirations enhanced
- Practitioners feeling proud and committed to the Trust, colleagues and their service users
- Development of understanding of the commitment to working within their profession and regulatory body

☑ **An update of the preceptorship procedure (August 2018)**
The main changes to our procedure included:
- a reflection of the move towards a joint nursing and professions programme rather than the existing separate nursing and Allied Health Professional (AHP) programmes
- an update to include social workers and associates e.g. associate practitioners and nursing associates; to reflect changes within our workforce over the past couple of years

☑ **A change to recruitment of nurse preceptees**
In 2018 the decision was made to offer posts to all nurses qualifying from Leeds Beckett University and the University of Leeds. As a result the Trust successfully recruited 45 nurses to the 2018/2019 programme.

☑ **A joint nursing and professions preceptorship programme (November2018)**
We merged our nursing and AHP preceptorship programmes to develop learning across all professions to ensure preceptees learn in an environment that reflects their work setting.

☑ **Increased exposure to and raised awareness of the preceptorship programme offered at LYPFT at University level**
In 2018 nursing, occupational therapy and dietetic university degree students received sessions from LYPFT regarding support after graduation which included information on the preceptorship programme. Highlighting the preceptorship programme at University level raises the awareness of the benefits of working for our Trust.

Feedback to date has been positive:

'The importance of difficult conversations and how to approach them in different ways/sharing experiences with others and learning from this'

'Really useful market place, also our group got really into the action learning set and I think it helped the person, got us thinking and was good practice!'

'The role of dietitians and how and when to refer to service/the different types of Diabetes and treatment/using action sets to discuss work-based concerns and put into practice learning points'
'I know the preceptorship team and can approach them'

'The sessions really help to reflect on the skills of different professionals and how we work together – thanks ☺'

'I found this morning's session extremely useful!'

In addition to University sessions, feedback received tells us that preceptees would recommend working at LTPFT to others; and that the preceptorship programme plays a significant part in this. Our external partners 'Community Links' are also accessing the preceptorship programme for their newly qualified nurses and occupational therapists enhancing shared and best practice, partnership working and development of staff across services.

Plans for 2019/2020

Our plans for the next year include:

- continuation of the joint nursing and professions programme, with the addition of nursing associates and associate practitioners
- continuation of proactive nurse preceptee recruitment
- ongoing adaption and improvements to the programme based on feedback from preceptees

In addition, the Practice Learning and Development Team plans to collect further data in the upcoming year such information on job satisfaction and recommendations for the Trust as a place of work.

Development of our Quality Improvement Priorities (QIPs) for 2019/20

Development of our QIPs for 2019/20 has been through a consultative process, which has included:

- Triangulation with our organisation's vision and values; and Quality Strategy
- A retrospective review of service user, carer and public feedback to identify themes and areas for improvement
- Consideration of the feedback we received regarding our 2017/18 Quality Report and Account
- Engagement and meetings with key staff, service leads and our leadership team
- Dedicated sessions at our two Care Groups' Clinical Governance Councils to gain input and insight from Professional Leads to ensure the QIPs are meaningful and relevant to services
- Intelligence, data and information presented and discussed in relation to our current areas of concern and focus within our leadership and governance meetings
- Approval of the proposed QIPs through our Quality Committee
- Consultation with our Council of Governors (January 2019)

We aim to build on this for our 2019/20 Quality Report and Account

*We have ensured that at least two 2019/20 QIPs relate to each of **Patient Safety, Effectiveness and Patient Experience**, as recommended in the Quality Account Toolkit.*

The QIPs for 2019/20 have been aligned to the CQC domains: **Safe, Effective, Caring, Responsive and Well Led.** Whilst each QIP has been assigned to a predominant domain, all QIPs cut across more than one domain and a Well Led approach is required in all areas to succeed in their quality improvement aims.

Safe

Quality Project in National Deaf Child and Adult Mental Health Service (NDCAMHS)

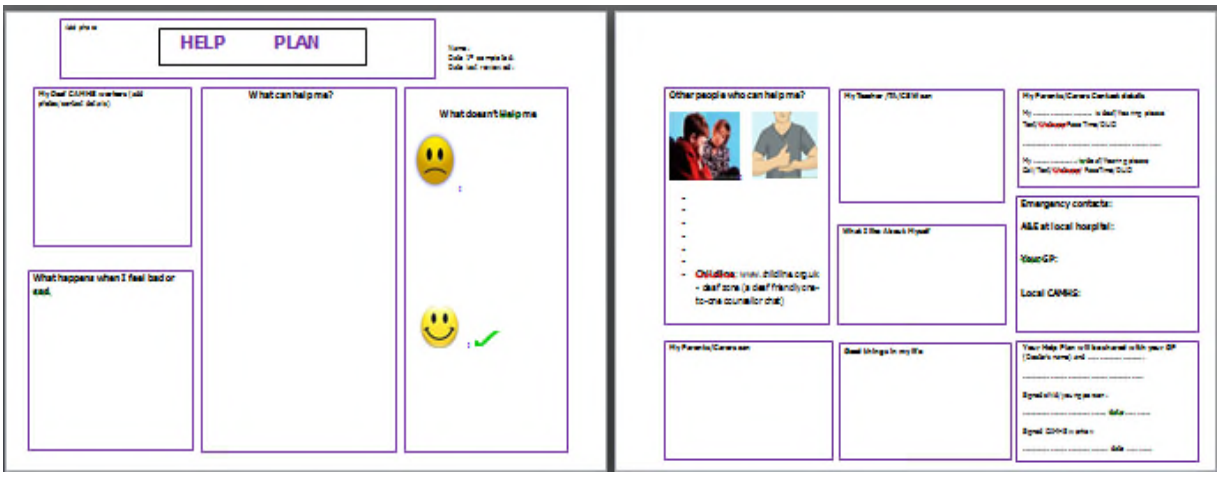
My Help Plan

The National Deaf CAMHS (Northern Arm) is a service commissioned regionally by NHS England, consisting of three multi-disciplinary teams based in Manchester, Newcastle and York. Between the teams, the service covers the North of England. Referrals are accepted for children and young people

up to the age of 18 where someone in the family is Deaf and where there is a significant mental health problem linked to this. We offer consultations, first appointments, full assessments and interventions. The service has a bilingual and bicultural model and our deaf and hearing staff work closely together with team interpreters to ensure both perspectives are equally considered. Assessments and interventions have been adapted over time to meet the needs of this service population.

One of our Quality Improvement Projects for 2018 was the development of an accessible Safety Plan. The existing risk management plan on our electronic patient record system is called the SAMP. This was developed for an adult population and is inaccessible for the young people using our service who have a variety of communication needs. Previously we piloted the use MYPLAN, which was developed in collaboration with young people accessing generic CAMHS in Leeds. However, the feedback from our young people told us that whilst the system was more visual, it was not accessible and did not make sense to them.

We then began a process of developing our own bespoke Safety Plan documentation. We did this via one of our service development days, where a small multidisciplinary team of professionals from a variety of backgrounds (deaf and hearing) collaborated to develop our own resource. This resource was trialled with individual service users with a variety of needs *(Learning Disability, no Learning Disability, British Sign Language users, spoken language users)*, ages; and adjustments were made according to the feedback given by these service users. The final version of the Safety Plan documentation was presented to our Care Group Clinical Governance Group who agreed to its implementation.
A template is used to create a bespoke plan for each young person. They are given their own copy and also encouraged to take a photo of this to have on their mobile phone. The plan is shared as appropriate with parents/carers and staff. This document is attached alongside the information sheet for parents, which we developed at the same time in consultation with parents.



Our 2019/20 QIPs for improving safety are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Safety	• Serious Incident investigations: - ongoing development to improve quality - identification of organisation-wide SI investigation themed action plan for learning and improvement	Progress will be monitored through relevant focus groups, Service and Care Group governance meetings, the Trust-wide Clinical Governance Group and
Suicide Prevention Plan; development of a Trust approach	• Engage with staff to/and develop a Strategy; and implement • Commence implementation plan and set new milestones for 2020/21 with leads	
Safety Planning across the Care	• Pilot of Safety Plan in Intensive Care, Acute Inpatient setting and Older People's Inpatient setting	

Groups	• Refine document and ensure fit with Care Director System • Develop and refine training programme • Deliver training internally and as part of the emerging Leeds Recovery College (including service users) • Roll out into practice across teams and agree further evaluation	our Quality Committee.

Suicide Prevention

We continue to learn from deaths and our major cause of mortality (death) is suicide. When we have a death within our service we work with the person's partner, family and carers to learn lessons from their experience, each and every time. We acknowledge that every death is a personal tragedy.

We connect and work in partnership with many services and plans which include the collaborative ICS (Integrated Care System) plan and the Leeds based plans for suicides in West Yorkshire across our place based and specialist services.

We need to continue with and strengthen this work with dedicated focus and are allocating increased resources; in order to concentrate on learning from what our staff do on a daily basis in order to provide safe care and prevent suicide throughout our services.

Liaison and Diversion Services

Our Liaison and Diversion (L&D) Services aim to provide early help and intervention for people with mental health, learning disability, substance misuse and other psychosocial vulnerabilities of all ages as they come to the attention of the criminal justice system. L&D services provide a prompt response to concerns raised by the police, probation service, youth offending teams or court staff, and provide critical information to decision-makers in the justice system, in real time, at the time a vulnerable people could be charged and sentenced for an offence.

L&D services also act as a point of referral and follow up for this group of service users, to ensure they can access support to attend treatment and rehabilitation appointments.

By doing this, L&D services are expected to help reduce reoffending, reduce unnecessary use of police and court time, ensure that health matters are dealt with by health care professions and reduce health inequalities for some of the most vulnerable people in the community.

Our service users most likely to be referred are:

- Complex, severe or persistent health needs
- Learning disabilities
- Substance misuse issues
- Acquired brain injury
- Severe or complex emotional /behavioural difficulties requiring a mental health and social care support that require enhanced specialist community intervention as part of an integrated multi-agency package of care
- Multiple sub threshold issues
- Repeat offenders
- Veterans
- Homelessness
- Risk including domestic violence, MAPPA, safeguarding issues
- Service users in acute crisis with eating disorders, depression, risk of suicide, psychosis, escalating self-harm and personality disorders
- Service users from minority ethnic or minority cultural background including traveller groups

Positive and Safe Group

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Positive & Safe Group actions and impact	• Develop service user involvement in training • Review and renewed approach to training • Roll out the new training programme to include syllabus and lesson plans for PMVA training • Commence application for PMVA training accreditation scheme	The 'De-escalation Task & Finish Group' will review of required regulatory standards and an options appraisal paper will be developed to look at how we will meet the new standards and the role service users/carers/family will have in the co-production of the training programme. Progress will be shared via the Care Group governance meetings, the Compulsory Training Group and the Trust-wide Clinical Governance Group. Training will be evaluated to ensure continuous improvement.

During 2018/19 the Positive and Safe Group has continued to promote the positive culture change that is embedded within the positive and safe support for people who may present with behaviour that challenges procedure, ensuring our services are safe and engaging to individuals accessing them.

We continue to promote and support the implementation of Safewards within our inpatient services and have been exploring how this can be adapted and implemented within other services and staff training. We have put structures in place that allow us to explore the data regarding the use of restrictive practice; enriching raw data with a narrative to ensure we can understand how and where we can make improvements. We have taken part in a national work stream to understand how to improve the data collected on both a local and national level.

2018 drew to a positive close with the appointment of a professional practice lead for the Positive and Safe agenda and the development of our 2 year action plan. This is an aspiring plan which will redesign our staff training, improve the care of service users who have an identified risk of or who are exhibiting behaviour that may lead to a restrictive intervention. In 2019 we will hold a service user forum in which we will commence the development of a network of service users interested in helping us deliver our action plan ensuring meaningful co-production at every level.

Effective

National Institute for Clinical Excellence (NICE) Guidelines: Learning Disability Service

In 2018/19 The Learning Disability (LD) Service implemented a Quality Improvement Plan to: "*Increase frontline staff engagement in the routine use of NICE guidelines to evaluate and improve clinical practice*". This work involved assessing NICE guidelines for relevance to LD services and completing baseline assessments against those guidelines.

To support this work, the service worked closely with the Trust's NICE Lead, to plan and facilitate a service wide Clinical Learning Event. The purpose and desired outcomes of the event were to:

- Explore how NICE guidelines help to ensure that we deliver high quality, safe and effective care to the people that use our services
- Increase awareness and understanding of the Trust's systems and processes for assessing and embedding NICE guidelines within the organisation

- Discuss ideas for how to engage frontline staff in the NICE relevance and baseline assessment process
- Hear case study examples of how the LD service staff have used NICE guidelines to improve their practice
- Apply learning for staff, by using a NICE guideline to assess and reflect on our own clinical practice

The event was chaired and facilitated by the service Clinical Lead and supported by the Trust NICE Lead who delivered a presentation on the system for how NICE is embedded within the organisation. Case study presentations were prepared and delivered by representatives from each of the seven professional groups.

50 staff attended the event. Attendees included both qualified and unregistered professionals; and representatives from all aspects of the service. The event was also evaluated and a report on the participant feedback was presented within the LD Clinical Governance meeting and at each team meeting. Of 32 respondents:

75% agreed or strongly agreed that they had increased their knowledge/awareness of how NICE guidelines help them provide high quality care
84% agreed or strongly agreed that they had increased their knowledge/awareness for assessing and embedding NICE guidelines within the organisation
75% agreed or strongly agreed that they were more aware of how NICE guidelines are being used in clinical practice
59% agreed or strongly agreed were more confident in using NICE guidelines to reflect on and improve their practice

Following the event, a Learning Disabilities NICE Guideline working group has been established and invited representatives include: Psychiatry and Psychology staff, Occupational Therapy, Physiotherapy, Speech & Language Therapy, Dietetics, Community Nursing, Inpatient Nursing, Unregistered staff from community services.

Our 2019/20 QIPs for improving effectiveness are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Service Redesign	Community Service Redesign Evaluation plan: people's experiences of our redesigned community services they receive are positive	Two questionnaires specific for service users and carers are being developed. The questionnaires will be issued to all service users/carers currently in receipt of our community services. Data collection will take place on a bi-annual basis beginning July 2019.
Continuous Quality Improvement (CQI)	Develop and include 'patient experience and impact' assessment as part of the CQI process when working with services to improve patient care and pathways. Reference patient Experience & Balancing Measures in all improvement training. Patient experience, and the approach towards assessing impact on other areas of the system, are integrated into the improvement training accreditation process.	We will evaluate the Patient Experience review and assess how this can relate to Continuous Improvement projects and activities going forward. A Continuous Improvement Peer Review group will be established with representation from service users and relatives. We will evidence that continuous improvement training projects and activities are able to clearly demonstrate the consideration of having had direct service user involvement. Establishment and sign off of the Terms of Reference for the Continuous Improvement Peer Review group. A set of measures will be used to evaluate progress of projects (available on request).

Mental Health Legislation	Reduction in document management issues identified by a monthly audit of 10% of legislation officers' caseloads. Re-audit of assessments of capacity in relation to medication for mental disorder. Redesign of the MHA face to face training to ensure it meets the needs of clinical staff; implement/evaluate.	Regular reports on reduction in document management issues will be produced. Results of the audit of capacity assessments in relation to medication for mental disorder will be measured against the November 2018 audit (baseline). Testing of the redesigned MHA training will take place with clinical staff and will be evaluated through staff feedback. Roll out of new training will be monitored and evaluated through staff feedback

Mental Health Legislation: Quality improvement and celebrations

The Mental Health Legislation Team

The Mental Health Legislation Team is here to offer advice and support to staff, patients and carers in all matters relating to the Mental Health Act (MHA), Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). We understand that an admission to hospital can be a very difficult time and our role is to ensure that the Trusts responsibilities under the relevant legislation are met and patients' rights are protected. We ensure that staff receive the appropriate training and support and meet regularly with patients and carers to make sure they understand their rights under the Acts.

Training

At LYPT we provided face-to-face mandatory training in Mental Capacity Act/Deprivation of Liberty Safeguards, Inpatient Mental Health Act and Community Mental Health Act for 948 staff over 73 sessions in 2018/19. Feedback from the training showed that 98.2% of attendees rated the training as excellent or good, with 1.8% rating it as satisfactory.

We have also provided training for partner healthcare providers in Leeds and at the University of Leeds for nursing and allied mental health practitioner students.

Defective detentions

There has been a reduction in the number of fundamentally defective detentions and unauthorised deprivations of liberty in 2018/19.Fundamentally defective detentions occur when the correct procedure has not been followed in relation to detention under the Mental Health Act (MHA) and these errors cannot be rectified. Incidents were identified through the robust systems in place in our Mental Health Legislation Department and our responsibilities under the Duty of Candour procedure were followed in each case.

Mental Health Act Managers (MHAMs)

Mental Health Act Managers (MHAMs) have a delegated responsibility to hear appeals and hold reviews of patients' detentions. They are not employed by the Trust and are independent in their decision making. We have continued to recruit MHAMs and are committed to ensuring that those carrying out this role reflect the diverse cultures of our patient groups. Joint MHAMs and clinician training took place over the year. The purpose of the training was to improve the understanding of the MHAMs role and evidence that clinicians need to be present to enable MHAMs to make appropriate decisions. The training was positively received and further training is planned for 2019.

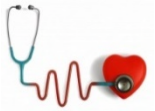
Assessments and recording

We continue our drive to ensure that assessments of capacity are completed appropriately in a timely manner and recorded on the Mental Capacity Assessment on PARIS, our electronic patient system. This enables the assessment to be easily located by both staff and our regulator.

A Best Interest Decision recording form has been developed and is available on PARIS. This guides staff through the recording of best interest decisions to ensure we are compliant with the Mental Capacity Act and Care Quality Commission requirements.

An audit of capacity assessments for all inpatients was completed this year and an action plan developed to drive forward improvements arising from the results. We are committed to ensuring that we receive valid consent from service users before we carry out any interventions, and good quality assessments of capacity are key to this. A re-audit will take place in early 2019.

Safe and Effective



Community Physical Health Monitoring and Improvement Service:

This service is designed to support the physical health needs of service users in our Community Mental Health Teams (CMHTs). As well as providing physical health monitoring to those people prescribed specific medications, service users are supported by the team to make healthy lifestyle changes by giving advice on diet, exercise, smoking and alcohol use. Where needed, the team can refer people to specialist services for further assessment.

The team will provide a city-wide service in locations across each of the CMHTs and will ensure that people receive the same monitoring and intervention, regardless of where they live.
The team are developing a set of Quality indicators for 2019/20 and beyond, which will include work on:

- Reducing non-attendance at appointments
- Increasing referrals to the One You Leeds stop smoking service and the number of people who see a stop smoking advisor
- Improving the referral process to Forward Leeds alcohol and drugs service
- Referral to specialist services for ongoing monitoring of conditions such as diabetes and high blood pressure
- Improving the experience of people who use the service

Relaunch of Smoke Free status in the Trust including review of the Nicotine Management and Smokefree Procedure:

We have been working to improve our Nicotine Management and Smokefree Procedure to ensure we are providing services in line with the latest national recommendations on supporting people to stop smoking. Our Smoke free lead is working with colleagues across the city to make sure that our approach focuses on reducing harm from cigarette smoking. This includes allowing e-cigarettes to be used in some areas of the Trust and improving the knowledge and skills of our staff to support service users with better access to nicotine replacement therapy.

We are pleased to include the work of our Community Physical Health Monitoring and Improvement team featured in our Quality Account Quality Improvement Priorities for 2019/20.

The following 2019/20 QIP addresses the domains of both Safe and Effective:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Physical Health Care	Service users in the care of Community Mental Health Teams who require physical health monitoring will receive this and any intervention needed from the city-wide Physical Health Monitoring and Improvement Team. The service will be implemented using a quality improvement approach. Reducing harm to service users, staff and visitors by review of the Trust's approach to Nicotine management.	Baselines and improvement measures will be identified to measure progress against from Quarter 1 2019; these include: o Activity of the service o Patient Reported Measures o Practice consistent with best practice standards (NICE etc.) o Transfer of physical health monitoring responsibilities to GP practice Launch and accessibility of the Trust Nicotine Management and Smoke Free policy. The increase in eligible service users receiving Nicotine Replacement Therapy or other treatment as per the Trust guideline will be monitored. A reduction in the number of smoking related incidents recorded in the Trust will show progress in reducing potential harm or harm. Accessibility to smoking cessation expertise in the Trust will be monitored. Aim to increase the number of staff trained to National Centre for Smoking Cessation and Training standard.

Me and My Medicines

Our Pharmacy Team are reviewing how they deliver their services in order to be more accessible to patients, carers and staff in both inpatient and community settings.
The team support our staff and service users in the choice and use of their medication by providing information and advice; and encouraging people to ask about medicines at any point in their care. Part of this work will involve working with colleagues from 'Me and My Medicines'. Me and My Medicines' is a campaign led by patients and supported by clinical staff to help people raise concerns and use their medicines better. This will help everyone benefit from more effective and safer care.
www.meandmymedicines.org.uk

me + my medicines

Caring

Always Events

Always Events® are *"those aspects of the patient and family experience that should always occur when patients interact with healthcare professionals and the health care delivery system"* (NHS England).

NHS England collaborated with Picker Institute Europe, the Institute for Healthcare Improvement (IHI) and NHS Improvement on an initiative for developing, implementing, and spreading an approach to reliably integrate Always Events into routine frontline services.

Always Events is a quality improvement methodology which seeks to understand what really matters to patients, people who use services, their families and carers so that changes can be identified to improve experience of care. Genuine partnerships between patients, service users, care providers, and clinicians are the foundation for co-designing and implementing reliable solutions that transform care experiences with the goal being an "Always Experience."

"**What matters to you**?" in addition to "**What's the matter**?"

Always Events national programme

The Chief Nursing Officer at NHS England and Executive Director of Nursing at NHS Improvement have jointly written to Chief Nurses in organisations like ours, as they are keen to see the majority of NHS provider trusts using this approach with service users and families to undertake their quality improvement work; and ensure service users have the best possible experience of care.

An Always Events toolkit was published in December 2016. This toolkit is for any organisation wanting to implement an Always Event using the Always Event methodology.

Always Events and learning disabilities

There are a growing number of providers of services to people with a learning disability who are co-designing Always Events with good success. In one Trust changes were implemented in collaboration with both staff and people using the service and feedback was extremely positive with 80% of people discharged from the learning disability team saying they felt supported when they were discharged.

We want to embrace every opportunity to design and improve care for our service users in collaboration with them, and their families and carers. To this end we have commenced work to introduce Always Events into our services at LYPFT.
An easy read document about Always Events can be found using the following link:
https://www.england.nhs.uk/wp-content/uploads/2018/08/always-events-easy-read-v2.pdf

Our 2019/20 QIP for improving Caring is:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Always Events	Development of Always events with all services. Pilot, roll-out across all services and embedding within the organisation and culture. Roll-out Always Events to other Requires Improvement area(s) and plan to roll out Trust wide.	*2018/19* This year we have already joined an NHS Improvement (NHSI) Always Events group to receive guidance and support. *2019/20* Plan to host a Trust workshop to decide on mission statement(s) to shape and form an Always Statement being produced. A steering group will be set up (staff, service users and carers) and we will agree the first area(s) to experience using the Always Event pathway (those areas Requiring Improvement on CQC inspection). We will pilot the use of Always Events in the area(s) identified, collect data on the use of Always Events and measure improvements via patient surveys/sampling for example. Reports on the pilot will include feedback from service users and staff; and lessons learned.

Recovery College: training courses in Leeds that focus on helping people to develop the knowledge and strength to overcome life's challenges

The development of Leeds' first Recovery College began in 2018. Recovery Colleges deliver comprehensive, peer-led education and training courses which focus on living well, both mentally and physically. They are run like any other college, providing education as a route to recovery and not as a form of therapy. Courses are co-devised and co-delivered by people with lived experience of mental illness and by mental health professionals.

Leeds Recovery College is led by us and aims to involve a wide range of different people and organisations across the city. Training and learning opportunities can be offered to service users, professionals and families alike, with people choosing the courses they would like to attend from a prospectus. As well as offering education alongside treatment for people they also change the

relationship between services and those who use them; they identify new peer workers to join the workforce, and they can replace some existing services.

The first course to be delivered was Wellness Recovery Action Planning. The Wellness Recovery Action Plan®, or WRAP, was developed by a group of people in the USA and particularly by Mary Ellen Copeland, who had personal experience of mental health, to share practical strategies for regaining and sustaining their own wellness. This work led to the development of WRAP as a way to manage some of the mental health experiences that the group shared.

Staff Wellbeing

Over the last year our sickness absence levels have remained fairly static between 4.8 to 5.0% however we have seen an increase in absence due to mental health and stress. To support our staff we hold annual health and wellbeing events across the Trust focussing on both mental and physical heath.

Last October we launched a financial wellbeing offer for staff called Neyber which provides financial advice and loans to staff, we provide an employee assistance programme to staff which offers a range of advice and one to one confidential counselling and support. We offer day one occupational health advice to staff off work with work related stress and use the HSE stress risk assessment to identify actions and support.

In 2019/20 we are planning to implement mental health first aid training for managers, increase our staff support for critical incidents and invest in a dedicated Health and Wellbeing Manager.

Responsive

Patient Experience Service Review

Our first step to addressing the findings of the Patient Experience review was to hold a workshop on 22 March 2019, which involved service users, carers and key stakeholders; to agree and shape these important areas of work. This was followed by the creation of a Steering Group (lead by the Executive Director of Nursing, Professions and Quality). These groups will focus on developing a 'Patient Experience, Carers and Involvement Strategy' that will prioritise the areas of work for the Trust over the next few years.

- LYPFT Carers
- Triangle of Care
- Public Involvement
- Patient experience and feedback

We will report on the progress of this piece of work through our Quality Committee, Council of Governors' annual members meeting and Service User and Carer groups.

Our 2019/20 QIPs for improving responsiveness are:

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
Patient Experience: Patient and Carer Feedback and	Implement actions arising from the outcome of the review of the Patient Experience Service,	Workshop held 22 March 2019 involving service users, carers and key stakeholders to agree and shape these important areas of work. Creation of a Steering Group (lead by the Executive Director of Nursing, professions and Quality). Develop a 'Patient Experience, Carers and Involvement Strategy' that will

Quality priority area	Projected quality improvement outcomes 2019/20	Progress monitoring and reporting measures
involvement	as appropriate	prioritise the areas of work for the Trust over the next few years.
Patient Experience: Complaints and investigations	High quality, timely response to concerns and complaints, handled as agreed with the complainant Triangulation of themes and learning from feedback, Complaints, concerns, PALS, SIs and Incidents, Inquests and Claims; and sharing of learning	*2018/19* Work has begun to review and quality improvement of the process, including recording and reporting via Datix; and we are participating in a peer review process of our complaint responses. *2019/20* Evaluate the current process for PALS and complaints using stakeholder feedback. Review our data recording system (Datix) to ensure the system configuration facilitates recording of the process, and reporting, appropriately. Develop an improvement plan from findings and commence implementation. Review of complaints paperwork, templates and training. Reports on progress will be shared with our Trustwide Clinical Governance Group and Quality Committee. Develop an annual triangulated thematic report of complaints litigation incidents, and SIs, and other experience feedback including themes and benchmarking; and support the development of Quality Improvement action plans within the care groups.
Patient Experience: Care Groups	Achievement of Triangle of Care: Stage 2 Submission January 2020	*2018/19* All baseline self-assessments are complete with action plans in place and carer leads identified. A carer feedback tool has received organisational approval. *2019/20* Central oversight of action plans is in place and reported monthly updates are provided to the Triangle of Care Steering group. Carer forums and carers lead forums to happen consistently. Care Group professional leads will report monthly update to Care Group Clinical Governance Councils. Completion of ELearning and/ face to face training will be monitored. Triangle Of Care Steering Group will review Stage 2 submission preparedness; and assess progress against the standards. Services to commence submission document- to be presented to Trust-wide Clinical Governance meeting December 2019 80% of assessments to be been completed.

Well Led

Learning and Organisational Development

Developing a culture based on Trust values and behaviours

We are committed to developing a caring and compassionate culture based on our Trust values and behaviours. The Kings Fund identify through their research that a key characteristic for culture change is having a clear vision, values and behaviours that set out how staff conduct themselves and interact with colleagues and service users, is vital. We know this is essential to the delivery of high quality services for our service users, as clear links and evidence exists that if staff experience is good this positively impacts on service user experience.

Over the past 2 years we have co-created our Learning and Organisational Development strategy, including a values and behavioural framework. In March 2018 every member of staff received their own personal copy of the behavioural framework toolkit **"Living our Values**". This includes a template for staff to consider how their current behaviour brings to life Trust values and what improvements and changes are needed. Recent feedback on this work indicates that our staff are developing a strong connection with the Trust's values and behaviours.

Apprenticeships

We are using apprenticeships to support the development of our new and existing employees. Apprenticeships support employment routes into the Trust for health care support workers and provide career development pathways for our existing support staff. These include Level 3 qualifications in health and social care and business administration and higher level support worker qualifications for nursing associates and associate practitioner roles.

As more apprenticeships are approved for delivery, we will expand the scope of how and when we use them. This will include developing our existing workforce to include degree level apprenticeships, achievement of professional qualifications in procurement, pharmacy, information technology, human resources and finance. We will also consider opportunities to use apprenticeships to deliver wider skills development to our staff, for example, leadership and management qualifications.

There are evidence based benefits to using apprenticeships to develop the workforce, these are:

- Increased staff morale and retention
- Upskilling existing staff and supporting career development
- Improved productivity and quality of care delivered

Developing Collective Leadership

We are committed to developing a collective leadership approach based on these values and behaviours. We aim to build a culture where everyone takes responsibility for the success of the organisation as a whole – not just for their own job, team or service and contrasts with traditional approaches based on developing individual capability. With collective leadership, this means leadership is distributed and allocated to wherever best expertise, capability and motivation exists within the Trust.

During 2018 our senior leadership community participated in a programme of development focused on developing a collective leadership approach. Leadership forum workshops provided a valuable networking and learning space and at the same time, fresh ideas and challenges to prompt leadership development and innovation.

We also further developed a local version of the NHS Leadership Academy's Mary Seacole Programme, aimed at first-time or middle leaders, which has enabled our staff to develop their leadership behaviours and impact. The 2018 programme has involved partnership delivery across the West Yorkshire Mental Health Collaborative and participants have as a result experienced a system leadership perspective to the programme.

Testimonial from Kate Ward, one of our Mary Seacole graduates:

"*To anyone thinking about joining the Mary Seacole programme, don't underestimate the work you need to put in. It's a course which you need to really immerse yourself in in order to be successful. Be confident in the fact that you are embarking on a journey which can really make a difference to not just yourself, but to the organisation and the people we deliver our services to. It's been a challenging, but fabulous journey for me and has spring boarded me to a new chapter in my NHS career.*"

We also delivered, in partnership with the Mental Health Collaborative, a shadow board programme. Shadow board is a powerful experiential learning programme for aspiring directors. Participants experience being part of a shadow board, alongside workshop learning on the role of the Board, strategic finance, risk; and culture and change.

Staff Engagement and Employee Voice 2018/19
Over the year we worked to further deliver increased levels of staff engagement through the following initiatives:

Staff Survey
We provided teams with bespoke team reporting analysis following publication of the 2017 results which resulted in us implementing 34 local action plans. Subsequently our June 2018 Leadership Forum focussed on giving teams the opportunity to share their achievements, challenges and encourage best practice across the organisation.

The main focus of our staff engagement activity in 2018/19 was the NHS Staff Survey. An extensive and dedicated engagement and communications campaign resulted in our highest ever response rate of 58.1% (1420 staff), a 1.8% increase of staff compared to 2017.

The Big Summertime Staff Conversations - Senior Leaders' listening events summer 2018
We held a series of Big Summertime Conversations between July and September 2018 led member of our Executive Team and supported by members of our Senior Leadership Teams. These events enabled us to share our priorities for the coming year and provided an opportunity to hear from staff across the organisation.

Developing High Performing Teams
A number of teams across the Trust have been supported to develop and implement change. The Trust has utilised the 'Affina Organisational Development' team development journey to support team development. This enables team leaders to work over a 6 month period to lead team development activity with their teams whilst being supported by a trained team coach. Feedback from the teams involved to date was positive and during 2019/20 the approach will be utilised at scale to support new teams and services in the Trust's community services.

Trust Appraisals
Work is continuing to develop our approach to appraisal in order to support our staff to perform highly in their roles. We are utilising a learning management system 'iLearn' to electronically record appraisals and provide good access to data for appraisers to ensure all staff receive an annual appraisal discussion and agreed development plan.

Clinical Supervision Training

Improving the experience of clinical supervision impacts positively on service user care; in terms of effectiveness, safety and caring. Since July 2017 the Trust has been committed to improving its performance on the uptake of clinical supervision by staff and the quality of clinical supervision offered. To support the latter, the Psychology and Psychotherapy workforce have led on the delivery of 'Clinical Supervision Training' and a flexible approach is being adopted, dependent upon where staff are based within the organisation.

Within the Leeds Care Group, the clinical supervision training package consists of some pre-reading and a 4-hour classroom based session to focus on skills acquisition and practice. Staff can book onto a training session via our electronic learning system. Within the Specialist Care Group, clinical supervision training is being offered in-house within the different service areas. The intention is for all

eligible staff or current clinical supervisors to complete the training. Training sessions within the Leeds Care group are currently being evaluated.

How our quality and quality priorities will be monitored throughout the year:

The QIPs described in sections 2 and 4 of this report will be monitored as identified with each indicator. At service level a progress review of the indicators will take place via the Care Group Clinical Governance Groups. This will enable service leads and services to know and share how they are doing in relation to their quality improvement goals and provide opportunity for them to identify actions early with regards to any delays in progress against the overall QIP.

Progress against the 2019/20 QIPs will also be monitored by our Quality Committee on a quarterly basis, before being presented to our Trust Board at the end of the year as part of the Quality Report and Account process. Reporting and monitoring in this way ensures that senior managers and the Trust Board are aware of how we are performing against our quality improvement priorities. It is also an opportunity for them to scrutinise and seek further assurance on any actions underway to make those improvements, in order to better ensure they are achieved.

SECTION 5

STATEMENTS FROM OTHERS ON THE QUALITY OF LYPFT SERVICES

healthwatch Leeds

Many thanks for the opportunity to comment on the LYPFT Quality Account. Healthwatch Leeds are keen to support all our partners to provide the best services possible and we work collaboratively on an ongoing basis with LYPFT to bring the voices of people in Leeds about their experiences of services. Healthwatch Leeds have undertaken a number of specific reviews into LYPFT services in this year looking at the Maternity mental health unit, The Mount, and talking to older people about the plans to move to older people focused services. We have also recently conducted an extensive piece of engagement work asking people in Leeds about their experiences of mental health crisis, of which the data is currently being analysed. For all our reports we work closely with LYPFT to support them to act on the themes and actions that the reports have highlighted.

In terms of the report, it is very positive to see that there has been a significant review of how LYPFT engage, listen and act on the experiences of service users and we look forward to working with LYPFT to support them to make this business as usual across all LYPFT services.

We felt that the report highlights a number of areas for development including:

Out of Area Placements
This made the news earlier this year as a cause of national concern; it causes great distress to patients and their families when they are placed out of area for their mental health care, often many miles away.

The report acknowledges that LYPFT did not meet their target to reduce these in 2018-19. The report talks only about 'bed days'; there is no indication of the number of people who have been affected in this way. It could be one person with a length of stay of x days or z number of people with a combined stay of x days. Knowing the number of people affected gives a much clearer understanding of how many families have been adversely affected in this way.

Delay in Young People with Dementia being seen by dementia service
It is concerning that young people with dementia have a delay before being seen by the team. This was seemingly linked to 'poor quality' information being put on the referral form. This is an extremely vulnerable client group (dementia at a young age causes considerable strain on families). LYPFT says the change in their referral form has got over this problem, but this needs to be continually monitored, with memory support workers now in post there should be no problem in getting the information required quickly.

NHS
Leeds
Clinical Commissioning Group

Ms Cathy Woffendin
Director of Nursing
Leeds & York Partnership NHS Foundation Trust
Trust Headquarters
Thorpe Park
Leeds
LS15 8ZB

25th April 2019

Dear Cathy,

Thank you for providing the opportunity to feedback on the Quality Account for Leeds & York Partnership NHS Foundation Trust (LYPFT) 2018 – 2019.

This report has been shared with key individuals within Leeds Clinical Commissioning Group (CCG) and this response is on behalf of the organisation. We acknowledge the report provided is in draft form and additional information will be added and amendments made before final publication. Please accept our observations of your report on this basis.

Overall we feel the document provides a comprehensive review of the quality priorities identified for LYPFT in 2018/19 and describes how these have been developed for 2019/20 in alignment with the Trust's explicit values and behaviours. We are pleased to note that you have reduced the number of acronyms used in this document and/or where these have been used, you have ensured that they are clearly defined and also added a glossary to help people better understand your communications. We confirm that the information provided in the account is in line with statutory requirements and demonstrates how intelligence gathered from patient/service users' experience, safety and clinical effectiveness has been used to inform organisational thinking.

There is evidence and examples of good work that has been undertaken during the year specifically in regards to service change and quality improvement as outlined at the beginning of the report and we particularly like the 'you said we did...' notes which evidences where you have listened and acted.

In terms of general feedback, the review of the 2018/19 priorities highlights that 20 Quality Improvement Priorities (QIP's) were identified however the document proceeds then to

explain progress in terms of broader headings and content appears disconnected in places. In addition, in the absence of clear benchmarking it is not easy to determine the extent to which particular priorities have been achieved and/or gain an appreciation of any barriers to progression. It is felt that a summary table of 2018/19 QIP's, highlighting ambitions and achievements/challenges to date would have enhanced this section and aid readers' understanding.

The report is also quite long and very detailed in places, particularly in relation to last year's priorities and the clinical audit sections, although does not allude to the benefit of how this information has improved quality. This distracts from the positive messages of the work being done as it makes it quite complex to navigate. Whilst the improvement work is acknowledged, the CCG notes that this reflects feedback made on the 2017/18 Quality Account.

The CCG is however particularly encouraged to note the commitment towards listening to the voices of patients and carers and hear how their experiences are being heard at senior level within the organisation and particularly acknowledge the increase seen in the number of compliments received. Also of note is the continued commitment to working with and improving the offer to carers and sustained focus on continuous improvement going forward in to 2019/20.

Some areas of the report would benefit from more detailed explanations where underperformance has been identified, such as highlighting the challenges and mitigation in place to meet the agreed trajectory to reduce the number of bed day's service users spent out of area (as this is an apparent underperformance highlighted in the data, although with no accompanying explanation). In relation to patient experience, this section provides information on how feedback is obtained and the number of contacts etc. but does not provide any insight to changes that have been made or service improvements as a result of cumulative patient feedback. Similarly regarding patient safety, this states the number of incidents but does not provide detail and the main purpose for reporting incidents is to identify the learning but this is not reflected within the report. Furthermore the CCG also notes that the deaths and suicide section has no reference to the national Learning Disabilities Mortality Review (LeDeR) programme, which is disappointing given LYPFT is our service for mental health and learning disabilities.

We congratulate the trust on the continued development and delivery of a local version of the NHS Leadership Academy's Mary Seacole Programme. It is pleasing to read the Trust has involved partnership and delivery of this programme across the West Yorkshire Mental Health Collaborative. We can also see collaboration around Quality Indicators within this account.

In relation to priorities identified for 2019/20 the CCG welcomes the emphasis on conducting focused activity around CQC inspection criteria to move towards an aspiration to achieve a rating of 'good' in the next inspection. Also, that there is a continued focus on the below QIP's in a new way in to next year;

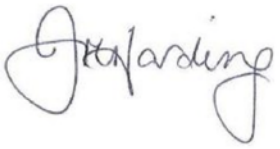
- Review of the Patient Experience Service and team structure
- Community Mental Health Services Redesign
- Implementation of a model for Quality Improvement to be used across the whole Trust

To strengthen this further the CCG would have liked to have seen a vison articulated around how the services provided by the Trust may start to be aligned more closely to localities in recognition of moving towards a collaborative working model with other providers and respecting Population Health Management, focused on outcomes for people accessing mental health services.

In preparation for the 2019/2020 Quality Account we offer our support in the creation of that account.

We welcome the opportunity to review the latest Quality Account, which throughout demonstrates a culture of respect for the service users, and we hope that this is accepted as a fair reflection. We look forward to seeing the progress made over the coming year.

Yours sincerely,



Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse

NHS Leeds Clinical Commissioning Group
Suites 2–4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
T: 0113 843 5470 W: www.leedsccg.nhs.uk facebook.com/nhsleeds @nhsleeds

Leeds and York Partnership NHS Foundation Trust's responses to stakeholder comments

Leeds and York Partnership
NHS Foundation Trust
Trust
Headquarters
Twenty One Fifty
Thorpe Park
Leeds LS15 8ZB

Tel: 0113 85 55914
cathy.woffendin@nhs.net

13 May 2019

Stuart Morrison and Hannah Davies
Healthwatch Leeds
Community Interest Company (CIC)
9542077
Ground Floor
The Old Fire Station
Gipton Approach
Gipton
Leeds LS9 6NL

Dear Stuart and Hannah

Re: Quality Reports and Account 2018/19

Thank you for your feedback on our draft Quality Report and Account, as shared with stakeholders for consultation at its quarter 3 stage of production.

We were pleased to read the positive feedback regarding the review of how we engage, listen and act upon the experience of those that touch our services. Your continued support through working with us and our services to embed this as business as usual is very much welcomed.

We await and look forward to receiving the outcome of the extensive engagement work conducted with people in Leeds regarding their experience of mental health crisis. Once again your support with any actions and learning identified through this work will be greatly valued as part of our quality improvement aims.

With regards to the two areas of concern highlighted:

Out of Area Placements
This indicator is currently reported on in a nationally determined way, which provides for us to be benchmarked with other organisations in a comparable way.

Based on an externally commissioned and comprehensive citywide review of patient flow across the system, Leeds is regarded to have broadly the correct number of beds to service the acute inpatient mental health needs of its adult and older population. However due to wider system pressures and general demand fluctuations, there is frequent need for additional beds not available in Leeds. A trajectory for reducing adult acute and PICU (psychiatric intensive care unit) out of area placements to zero by March 2021 in line with the Mental Health Five Year Forward View has been agreed between LYPFT and Leeds CCG. A range of initiatives to improve the system's ability to avoid unnecessary admission and to shorten inpatient stays has been agreed. Initiatives include the implementation of a new community model that will see improved access to

crisis assessment, gatekeeping and intensive home treatment that will enable early step down from inpatient wards. Further initiatives include the introduction of telephone line support and a crisis cafe facility over extended hours.

Delay in Young People with Dementia being seen by dementia service
We share your concern to ensure young people with dementia are seen by the service at the earliest opportunity. The related story identified within the document demonstrates our commitment to continuous quality improvement of our services and the positive impact this work can have on the timeliness and effectiveness of those services. We will of course continue to monitor this to ensure the positive change remains, as well as look to build on this in not just this areas but other services too.

Thank you for the comments within the draft document, these have been considered when finalising the content following the consultation, alongside the wider feedback. Revisions and updates have been included where possible. Whilst not all comments can be addressed for inclusion this time within the time restrictions of the production process; the context and essence of these will be used to inform future versions of the document and process.

Our aim to further enhance and grow our engagement with all stakeholders in creating future versions of this document and we look forward to working with you on this. Our newly commenced work within the Patient Experience remit, following a review of the service, will be instrumental in this also.

Yours sincerely

Cathy Woffendin
Executive Director of Nursing, Professions and Quality

Leeds and York Partnership
NHS Foundation Trust

13 May 2019

Trust
Headquarters
Twenty One Fifty
Thorpe Park Leeds
LS15 8ZB

Tel: 0113 85 55914
cathy.woffendin@nhs.net

Ms Jo Harding
Executive Director of Quality and Safety/Governing Body Nurse
NHS Leeds Clinical Commissioning Group
Suites 2-4,
WIRA House
West Park Ring Road, Leeds
LS16 6EB

Dear Jo

Re: Quality Reports and Account 2018/19

Thank you for your feedback on our draft Quality Report and Account, as shared with stakeholders for consultation at its quarter 3 stage of production.

We were pleased to read that NHS Leeds CCG have round the document to be comprehensive in terms of the quality priorities identified in 2018/19 and our description of how we have developed those for 2019/20.

With regards to last year's priorities, the detail of progress and format was kept to a brief explanation based on a consultative process during production. This led to the priorities being grouped into the broader headings alongside relevant stories of quality improvement to make them meaningful to readers. Positive comments have been received regarding this layout hence we have chosen to keep it as per the draft. As these priorities form part of our overall Operational Strategic Plan, a summary table and detailed reports will continue to be made available as part of our governance reporting and monitoring of these, which takes place through the governance groups identified with each one; in addition to the relevant committee level meetings and Board of Directors. We appreciate the later acknowledgement of continued focus on three of these priorities over the next year.

It was good to read the feedback regarding content and format and the use of acronyms within the document. We appreciate that the document remains quite lengthy and there is a challenge for us all in managing the extent of what is included whilst meeting the statutory requirements of the process and making it a meaningful read for our service users and public. Our communications team will be commencing work in May to produce a more accessible electronic version of the document that will be made available to the public. As advised at the time of sharing the document, the Clinical Audit section requires a Quarter 4 update and final edit to simplify the content; this will include a revised representation of the actions and learning and improvements resulting from our audit activity.

The positive feedback regarding the information within the document in terms of service user experience, safety and clinical effectiveness; how this has been used to form organisational thinking; and the good work that has been undertaken over the year, is very much welcomed. We will of course ensure this is shared with the services who worked with us to produce their stories of quality improvements.

With regards to benchmarking, this has been included where required (statutory sections) and available. We have added additional information regarding our incident process and learning. Thank you for noting the lack of reference to LeDeR, which was omitted in error. This is now included; to confirm our compliance and highlight our involvement in the Northern Alliance Mortality Review Group where the sharing of findings and reviews is undertaken. Following the commended work of our Safety and Risk team we were pleased to be an early adopter of Structured Judgement Reviews within mental health services; and we have been praised for adapting this methodology as well as evidencing the benefits and value associated with the process.

Thank you for the comments within the draft document, these have been considered when finalising the content following the consultation, alongside the wider feedback. Revisions and updates have been included where possible. Whilst not all comments can be addressed for inclusion this time within the time restrictions of the production process; the context and essence of these will be used to inform future versions of the document and process.

With regards to our vision on how we might align more closely to localities, as part of the Community Redesign we engaged widely with partners and stakeholders regarding the reconfiguration requirements. We recognise that developing a population health agenda will enable us to be clearer about how we orientate around our localities. Specifically, we are further developed in primary care mental health and older adult mental health services; and we are closely liaising with colleagues from the GP confederation and CCG to progress this work in more general adult services. Additionally we have a number of specialist services, mentioned within the document, that work across the provider/commissioner footprint (e.g. Deaf CAMHS).

We appreciate your offer of support working with us on the next Quality Report and Account; it is our aim to further enhance and grow our engagement with all stakeholders in creating future versions. Our newly commenced work within the Patient Experience remit, following a review of the service, will be instrumental in this during 2019/20.

Yours sincerely

Cathy Woffendin
Executive Director of Nursing, Professions and Quality

Acknowledgements

We would like to sincerely thank everyone who made a contribution to the content and publication of our 2019/20 Quality Report and Account. This includes, but is not limited to, patients, carers and representative groups, many of our staff, service and professional leads, the Senior Management Team and the Board of Directors.

This document provides an insight into how we are working to realise our values, our strategies and plans for these; and our aim to continually improve, which is at the heart of everything we do. We hope you find the document to demonstrate this and have enjoyed reading about the quality of our services.

If you would like to comment on this document you may do so:

- By e-mail to rebecca.le-hair@nhs.net
  Please ensure you place the phrase “Quality Account 2018/19 Feedback” as the subject of your e-mail.

- In writing to: The Head of Quality and Clinical Governance
  Quality Account 2018/19 Feedback
  Leeds & York Partnership
  Trust Headquarters
  2150 Century Way
  Thorpe Park, Colton
  LEEDS LS15 8ZB

Glossary

Adult Intercollegiate document: a guidance document that helps ensure that the health workforce, now and in the future, is equipped with the knowledge and skills they need to work in partnership with patients to safeguard them.
Appraisal: a method of reviewing the performance of an employee against nationally agreed standards within the NHS.
Anorexia Nervosa: an eating disorder and **psychological** condition marked by extreme self-starvation due to a distorted body image.
Audit: a review or examination and verification of accounts and records (including clinical records)
Board of Directors: the team of executives and non-executives who are responsible for the day to day running of an organisation.
Clinical supervision: a reflection process that allows clinical staff to develop their skills and solve problems or professional issues. This can take place on an individual basis or in a group.
Care Quality Commission (CQC): the independent Health and Social Care regulator for England.
Clinical coding: an electronic coded format that describes the condition and treatment given to a patient.
Commissioners: organisations that agree how money should be spent on health within a community. This could be for example Clinical Commissioning Groups (CCGs – Groups of GPs) or NHS England (the central government organisation).
Clostridium difficile (C diff): an infection caused by bacteria that affects the digestive system. It most commonly affects people who have been treated with antibiotics.
Continuous Improvement (CI): a management approach that organisations use to reduce waste, increase efficiency, and increase internal (employee) and external (customer/patient) satisfaction. It is an ongoing process that evaluates how an organisation works and ways to improve its processes.
CQUIN (Commissioning for Quality and Innovation): a financial incentive encouraging Trusts to improve the quality of care provided.
Datix: an electronic risk management system (database) used to record incidents, complaints and risks for example.
DOLS (Deprivation of Liberty): DoLS protect people who lack capacity to consent to being deprived of their liberty. This means that because an illness, an injury or a disability has affected the way their mind works they are not able to agree that they will not be allowed to do certain things.
Duty of Candour (DoC): a legal duty on hospital, community and mental health trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.
E-Rostering: an electronic staff management tool used to plan staff requirements and reported on staff hours worked, annual leave, sickness etc.
Friends and Family Test (FFT): a measure of satisfaction usually via a survey or text message, which asks if staff/ patients would recommend the service they received to their friends or family.
Information governance: the rules and guidance that organisations follow to ensure accurate record keeping and secure information storage.
Inquest: a judicial inquiry to ascertain the facts relating to an incident.
Legislation: a law or set of laws suggested by a government and made official by a parliament.
Medicines management: processes and guidelines which ensure that medicines are managed and used appropriately and safely
Mental Health Act (1983): the main piece of **legislation** that covers the assessment, treatment and rights of people with a **mental health disorder**. People detained under the Mental Health Act need urgent treatment for a **mental health disorder** and are at risk of harm to themselves or others.
Meticillin resistant Staphylococcus aureus (MRSA): blood stream infection caused by bacteria that is resistant to some treatments.
Methodology: a system of methods used in a particular area of study or activity

NHS England (NHSE): the central organisation that leads the NHS in England and sets the priorities and direction of the NHS
NHS Improvement (NHSI): an NHS organisation that supports us to provide consistently safe, high quality, compassionate care
National Institute for Health and Care Excellence (NICE): an organisation that provides national guidance and advice to improve health and social care with the aim of improving outcomes for people using the NHS and other public health and social care services
National NHS staff survey: a survey that gathers the views of staff working in the NHS to give an overall indication of their experience of working for the NHS
National Reporting and Learning System (NRLS): a central database of patient safety incident reports
Outcome Measures: a measure (using various tools) of the impact of the intervention from a clinician's perspective or a measure of progress related to a specific condition or issue
Patient Advice and Liaison Service (PALS): a service that provides a listening, enquiry and signposting service to ensure that patients, carers and public have their questions and concerns resolved as quickly as possible
Patient experience: feedback from patients on 'what happened and how they felt' in the course of receiving their care or treatment
Patient satisfaction: a measurement of how satisfied a person felt about their care or treatment
Payment by results: the system applied to some services whereby NHS providers are paid in accordance with the work they complete
Preceptee: a person undergoing preceptorship (see below)
Preceptor: an experienced member of staff who provides role support and learning experiences to the preceptee to assist them acquire new competencies
Preceptorship: a structured period of transition for a newly qualified member of clinical or therapy staff when then begin their employment in the NHS
Pressure ulcer: damage caused to the skin and the tissue below when it is placed under enough pressure to stop the blood flowing
Psychological: a mental or emotional rather than a physical cause.
Public Health England: an organisation that works to protect and improve national health and wellbeing, and reduce health inequalities
Risk Assessment: a process to identify risks and analyse what could happen as a result of them
Root Cause Analysis (RCA): a method of investigating and analysing a problem that has occurred to establish the root cause
Scrutiny Board (Health and Well-being and Adult Social Care): a function of the local authority with responsibility to hold decision makers to account for the services they provide
Strategy: the overall plan an organisation has to achieve its goals over a period of time
Subject Access Requests (SAR): requests made for personal information under the Data Protection Act 1998.
Standard Operating Procedure (SOP): a set of step-by-step instructions compiled by an organisation to help workers carry out routine task.
Sustainability and Transformation Plans (STPs): a group of local NHS organisations and councils that have drawn up proposals to improve health and care in the areas they serve. Some are now called Integrated Care Systems (ICS).

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF Leeds and York Partnership NHS FOUNDATION TRUST ON THE 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 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- inappropriate out-of-area placements for adult mental health services
- 100% enhanced Care Programme Approach (CPA) patients receiving follow-up contact within seven days of discharge from hospital.

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

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 is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 25 April 2019;
- feedback from governors, dated 23 April 2019;
- feedback from local Healthwatch organisations, dated 2 April 2019;
- feedback from Overview and Scrutiny Committee, dated 2 April 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the national patient survey, dated 9 August 2018;
- the national staff survey, dated 6 March 2018;

- Care Quality Commission Inspection, dated 27 April 2018
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 20 May 2019; and
- any other information included in our review.

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 the 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 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. 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 Partnership NHS Foundation Trust for our work or this report, except 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 (Revised) – 'Assurance Engagements other than Audits or Reviews of Historical Financial Information', issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller 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 affect 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 of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was 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 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

KPMG LLP
Chartered Accountants
Leeds

24 May 2019

PART C
ANNUAL ACCOUNTS
2018/19

KPMG

Independent auditor's report

to the Council of Governors of Leeds and York Partnership NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Leeds and York Partnership NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the statement of comprehensive income, statement of financial position, statement of changes in equity, statement of cash flows, and the related notes, including the accounting policies in note 1.

In our opinion:

— the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and

— the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

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

Overview	
Materiality: financial statements as a whole	£2.9m 1.63% of total revenue

Risks of material misstatement		vs 2018
Event driven	**New:** Accounting treatment of the PFI refinancing	n/a
	New: Fraudulent expenditure recognition	n/a
	Revenue recognition	equal
	Valuation of land and buildings	equal

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on:the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In arriving at our audit opinion above, the key audit matters, in decreasing order of audit significance, were as follows:

	The risk	Our response
PFI Refinancing (Finance Income: £6.5m; 2018 £0.136m.) *Refer to page Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, Section 1.7 of Note 1 to the Accounts (accounting policies) and Note 10 to the accounts (Finance Income).*	**Accounting treatment:** The Trust re-financed its PFI scheme and recognised the gain of £6.5m in 2018/19. This represents a material transaction in the Trust's financial statements. The Department of Health Guidance *Accounting for PFI Under IFRS* (the Guidance) states that the accounting treatment of refinancing gains received in the form of cash lump sums depends on whether or not the gain could be recovered by the Operator as a consequence of any future termination of the agreement by the Trust or the Operator. Where the gain could be recovered the accounting treatment is to recognise the gain as revenue over the remaining life of the agreement. Where there is no prospect of recovery the gain can be recognised in full in the year it is received There is a risk that the Trust, in recognising the gain in full in 2018/19 may have made judgements that are inconsistent with the terms of the PFI project agreement and the guidance issued by the Department.	Our procedures included: ▪ **Test of detail:** We agreed the PFI gain to the updated Deed of Safeguard and confirmed the Trust has received this payment by testing it back to the bank statement. ▪ **Critical assessment of the Trust's accounting treatment:** We critically assessed the Trust's rationale for recognising the refinancing gain in the year rather than recognising it over the remaining life of the agreement, by reference to the Guidance. ▪ **Critical assessment of the Project Agreement for the PFI scheme:** We critically assessed the type of PFI contract the Project Agreement was based on and in particular the Operator and Trust Default provisions within that Project Agreement to determine if there was any conditionality of the PFI refinancing gain.

	The risk	Our response
Fraudulent expenditure recognition (Accruals £7.4m; 2018: £5.9 million) *Refer to page Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, Section 1.6 of Note 1 to the Accounts (accounting policies) and Note 20 to the accounts (Trade and Other Payables)*	**Effects of irregularities** In the public sector, auditors also consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for instance by deferring expenditure to a later period). This may arise due to the audited body manipulating expenditure to meet externally set targets. As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may in some cases be greater than the risk of material misstatements due to fraud related to revenue recognition and so we had regard to this when planning and performing our audit procedures.	Our procedures included: ▪ **Control design and operation**: We considered the extent to which budgetary controls have been in operation throughout the year and have been found to operate effectively; ▪ **Control design and operation:** We considered the application of appropriate segregation of duties between those responsible for monitoring budgets and those preparing the financial statements which helps to prevent fraudulent manipulation of expenditure; ▪ **Test of detail:** We have completed a substantive analytical review of expenditure compared to the prior year in order to gain assurance over the completeness of the expenditure in year. ▪ **Test of detail:** We tested a sample of expenditure around the year end to gain assurance that cut off procedures at the Trust are working effectively and that that expenditure around the year end has been recognised in the correct financial year. ▪ **Test of detail:** We tested a sample of accruals in the year to test they were calculated on a reasonable basis and related to the 2018/19 financial year.

	The risk	Our response
NHS Revenue Recognition (NHS income £168.2 million; 2018: £141.5 million and NHS receivables £25.7 million; 2018: £3.2 million, Non NHS income £18 million; 2018 £15 million) *Refer to page Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, Section 1.20 of Note 1 to the Accounts (accounting policies) and Notes 1.5-1.55 to the accounts and Note 17 (Trade and Other receivables)*	**Effects of irregularities** The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which make up over 90% of income from activities. The Trust participates in the Agreement of Balances (AoB) exercise which is mandated by the Department of Health (the Department), covering the English NHS only, for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department's resource account. The AoB exercise identifies mismatches between income and expenditure and receivable and payable balances recognised by the Trust and its counter parties at the balance sheet date. Mismatches can occur for various reasons, but the most significant arise where the Trust and commissioners are yet to validate the level of estimated accruals for completed healthcare spells which have not yet been invoiced, accruals for non-contracted out-of- area treatments are not recognised by commissioners or potential contract penalties for non-performance are yet to be finalised. Where there is a lack of agreement, mismatches can be classified as formal disputes and referred to NHS England Area Teams for resolution. We recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial targets rather than financial incentives related to remuneration. We have classified Revenue from Patient Care Activities and Other Operating Revenue as a significant risk to respond to this requirement.	Our procedures included: ▪ **Test of detail:** We compared the actual income received from the Trust's CCG commissioners against the contracts agreed at the start of the year. We agreed any significant variations between the actual income and the agreed contract to signed contract variations and other correspondence agreeing the variation to the contract; ▪ **Test of detail:** We critically assessed the output from the Department of Health's Agreement of Balances exercise. We obtained evidence and explanations regarding the Trust's recognition of their income, where the output indicated by the Trust's income was not matched by corresponding expenditure in other NHS organisations' accounts; ▪ **Test of detail:** We agreed the receipt and recognition of Sustainability and Transformation Funding monies to correspondence from NHS Improvement; ▪ **Test of detail:** We agreed a sample of income received in March and April 2019 to supporting evidence to assess whether income had been accounted for in the correct financial year.

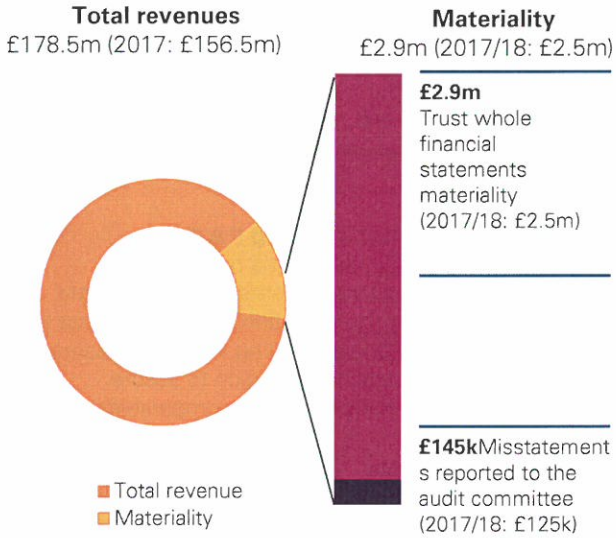
	The risk	Our response
Valuation of land and buildings (£37.9 million; 2017: £41.4 million) *Refer to page Audit Committee Report within the 'Board of Directors' Report in the Trust's Annual Report and Accounts, Section 1.6.2 of Note 1 to the Accounts (accounting policies) and Notes 14 (Property, Plant and Equipment) to the accounts.*	**Subjective valuation** Land and buildings are initially recognised at cost. Non-specialised property assets in operational use are subsequently recognised at current value in existing use (EUV). Specialised assets(such as hospitals) where a market value is not readily ascertainable, are subsequently recognised at the depreciated replacement cost (DRC) of a modern equivalent asset that has the same service potential as the existing property (MEAV). Trusts are responsible for ensuring their land and buildings are fairly valued. Guidance from NHSI has suggested that Trusts typically achieve this by performing an annual review for impairment, a periodic desk top valuation (usually every three years) and a full valuation(usually in five yearly intervals). The asset valuation and impairment review processes are both estimates and therefore present a significant risk to the audit. There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.	**Our procedures included:** ▪ **Control design and operation**: Assessing the competence, capability, objectivity and independence of the Trust's external valuer and considering the information provided to the Trust, to inform its assessment of market value movements, for consistency with the requirements of the Department of Health Group Accounting Manual; ▪ **Test of detail:** Considering whether the information provided to the valuer by the Trust, relating to the assets requiring to be valued, including details of in-year capital expenditure, changes in use and land area and floor space, was complete and agreed to the Trust's fixed asset records; ▪ **Test of detail:** Critically assessing the calculation of market value indices movements completed by the Trust, including re-performance of this calculation to confirm that no material movement in the value of land and building assets is indicated; ▪ **Test of detail:** Agreeing the data underpinning the Trust's calculation of market value movements to the RICS data obtained by the Valuation Office, the Trust's valuer, and corresponding with audit teams at other Trusts in the region to assure ourselves that indices are comparable ▪ **Test of detail:** Critically assessing the Trust's formal consideration of indications of impairment and surplus assets within its estate, including the process undertaken and the adequacy of the formal, written decision document used in the process; ▪ **Test of detail:** Testing a sample of the 2018/19 capital expenditure additions to confirm that the additions were appropriately valued in the financial statements; and ▪ **Test of detail:** Considering the adequacy of the disclosures about the key judgements and degree of estimation involved in a review of indices which concluded that there has been no material movement in the value of land and buildings since 31 March 2018.

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £2.9 million (2017/18: £2.5 million), determined with reference to a benchmark of total revenue (of which it represents approximately 1.63%(2017/18 2%)). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £145k (2017/18: £125k), in addition to other identified misstatements that warranted reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's headquarters in Leeds.



4. We have nothing to report on going concern

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

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement in Note 1.1.2 to the financial statements on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

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

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

5. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 91, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity

Auditor's responsibilities

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

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

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

— any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

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

We have nothing to report in these respects.

Our conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources is qualified

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

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

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

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risk identified during our risk assessment is set out below together with the findings from the work we carried out in that area.

	The risk	Our response
Financial Sustainability	As part of our responsibilities in relation to reaching our use of resources conclusion we are required to perform any work that we regard as necessary to allow us to conclude on whether the Trust has effectively, efficiently and economically exercised its functions. Due to the significant financial challenge in the sector we have undertaken a detailed consideration of the financial position and financial sustainability.	Our work included: **Financial sustainability:** We assessed the Trust's financial sustainability. This considered whether the financial results included significant non-recurring items of income within the reported headline result. We also considered the Trust's management of its cash position and delivery of CIPs through the year. **Future forecasts:** We reviewed the future forecasts for the Trust. This included: ▪ Performing an analysis of the Trust's forecast run rate position; ▪ Considering the core assumptions in the Trust's 2018/19 Annual Plan submission; ▪ Considering the extent to which recurrent cost improvement schemes were achieved in 2018/19 and identified for 2019/20; and ▪ Reviewing contracts with commissioners which have been agreed for 2019/20 and the supporting risk analysis reported to the Board. **Findings from our work:** Our work has confirmed that the Trust has adequate arrangements to deliver financial sustainability.
Response to Care Quality Commission (CQC) inspection	The Trust was subject to a Care Quality Commission inspection during January 2018. The report was published on 27 April 2018 and concluded on overall ratings of 'Requires Improvement'. This was the third successive 'Requires Improvement/ rating for the Trust. The CQC conclusion on whether the Trust's services were Well-Led was 'Good', and their conclusion on whether services 'are caring' and 'are responsive' were also 'Good'. The conclusions on whether services were 'safe' and 'effective' were 'required improvement'.	Our work included: ▪ **Review of Processes**: Reviewing the Trust's process to monitor and report on progress: having reviewed the CQC report and the Trust's process to develop an improvement plan to the CQC report in 2017/18. We reviewed the Trust's monitoring and reporting during 2018/19. We considered the Trust's plans for monitoring and reviewing the 2019 CQC Inspection Action Plan, We confirmed that the Trust's arrangements through 2018/19 were appropriate, including reporting to the 'CQC Fundamentals Group' and Board on the progress of the CQC Action Plans. We also confirmed that the Trust's plans for the current Inspection Action Plan will include the same approach as has operated through 2018/19. **Findings from our work:** Our work has confirmed that the Trust has adequate arrangements in place to address the findings of the CQC report.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Leeds and York Partnership Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

Rashpal Khangura for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants

1 Sovereign Square, Sovereign St, Leeds, LS1 4DA

24 May 2019

KPMG

FOREWORD TO THE ACCOUNTS

LEEDS AND YORK PARTNERSHIP NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2019, have been prepared by Leeds and York Partnership NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed:  (Chief Executive)

Name: Dr Sara Munro

Date: 23 May 2019

STATEMENT OF COMPREHENSIVE INCOME AS AT 31 March 2019	note	**Year ended 31 March 2019** £000	Year ended 31 March 2018 £000
Operating income	2, 3 & 4	186,143	156,513
Operating expenses	2 & 5	(158,402)	(148,387)
OPERATING SURPLUS		**27,741**	**8,126**
FINANCE COSTS			
Finance income	10	6,868	136
Finance expense - financial liabilities	12	(4,033)	(3,954)
Finance expense - unwinding of discount on provisions	25	(2)	(4)
PDC dividend payable		(301)	(450)
Share of profit/(loss) of associates/ joint ventures		70	
NET FINANCE COSTS		**2,602**	**(4,272)**
Gains (losses) on disposal of assets	11	**2,060**	(32)
Surplus from operations		32,403	3,822
SURPLUS FOR THE YEAR		**32,403**	**3,822**
Other comprehensive income			
Items that will not be reclassified to income or expenditure:			
Revaluation gains and (impairment losses) on intangible assets		8	(16)
Revaluation gains and (impairment losses) on property, plant and equipment		(1,353)	(3,967)
Other comprehensive income for the year		**(1,345)**	**(3,983)**
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**31,058**	**(161)**

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

STATEMENT OF FINANCIAL POSITION AS AT 31 March 2019	note	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Non-current assets			
Intangible assets	13	435	647
Property, plant and equipment	14	37,863	41,422
Trade and other receivables	17	4,577	4,324
Total non-current assets		**42,875**	**46,393**
Current assets			
Inventories	16	27	64
Trade and other receivables	17	31,613	6,717
Non-current assets for sale	19		440
Cash and cash equivalents	18	69,424	52,424
Total current assets		**101,064**	**59,645**
Current liabilities			
Trade and other payables	20	(18,343)	(10,278)
Borrowings	21	(1,881)	(1,736)
Provisions	25	(2,371)	(2,092)
Other liabilities	22	(1,447)	(1,226)
Total current liabilities		**(24,042)**	**(15,332)**
Total assets less current liabilities		**119,897**	**90,706**
Non-current liabilities			
Borrowings	21	(19,535)	(21,416)
Provisions	25	(1,963)	(1,961)
Total non-current liabilities		**(21,498)**	**(23,377)**
Total assets employed		**98,399**	**67,329**
Financed by (taxpayers' equity)			
Public dividend capital		19,581	19,569
Revaluation reserve		3,832	5,784
Other reserves		(651)	(651)
Income and expenditure reserve		75,637	42,627
Total taxpayers' equity		**98,399**	**67,329**

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

The accounts on pages 1 to 35 were approved by the Board on 23 May 2019 and signed on its behalf by:

Signed:  (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure Reserve £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2018	19,569	5,784	(651)	42,627	67,329
Surplus for the year				32,403	32,403
Revaluation gains and impairment losses on intangible assets		8			8
Revaluation gains and impairment losses property, plant and equipment		(1,353)			(1,353)
Public dividend capital received	12				12
Transfers to the income and expenditure account in respect of assets disposed of		(341)		341	
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(266)		266	
Movement in year subtotal	**12**	**(1,952)**		**33,010**	**31,070**
Taxpayers' equity at 31 March 2019	19,581	3,832	(651)	75,637	98,399

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY	Public Dividend Capital £000	Revaluation Reserve £000	Other Reserves £000	Income and Expenditure £000	Total Taxpayers Equity £000
Taxpayers' equity at 1 April 2017	19,569	10,446	(651)	38,127	67,491
Surplus for the year				3,822	3,822
Revaluation gains and impairment losses on intangible assets		(16)			(16)
Revaluation gains and impairment losses property, plant and equipment		(3,967)			(3,967)
Public dividend capital received					
Transfers to the income and expenditure account in respect of assets disposed of					
Transfer of the excess of current cost depreciation over historical cost depreciation to the Income and Expenditure Reserve		(679)		679	
Movement in year subtotal		**(4,662)**		**4,501**	**(161)**
Taxpayers' equity at 31 March 2018	19,569	5,784	(651)	42,627	67,329

Description of Reserves:

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

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

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

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

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

STATEMENT OF CASH FLOWS AS AT 31 March 2019	note	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Cash flows from operating activities			
Operating surplus from continuing operations		27,741	8,126
Operating surplus		**27,741**	**8,126**
Non-cash income and expense:			
Depreciation and amortisation	5	4,094	4,543
Impairments and reversals	14	1,915	1,557
(Increase)/decrease in trade and other receivables	17	(25,029)	592
(Increase)/decrease in inventories	16	37	(18)
Increase/(decrease) in trade and other payables	20	8,108	(1,407)
Increase/(decrease) in other liabilities	22	221	257
Increase/(decrease) in provisions	25	279	(724)
NET CASH GENERATED FROM OPERATIONS		**17,366**	**12,926**
Cash flows from investing activities			
Interest received	10	6,847	122
Purchase of intangible assets	13	(227)	(154)
Purchase of property, plant and equipment	14	(4,270)	(2,144)
Sales of property, plant and equipment		3,353	5
Net cash used in investing activities		**5,703**	**(2,171)**
Adjustment for net assets de-recognised on merger			
Cash flows from financing activities			
Public dividend capital received		12	
Capital element of private finance initiative obligations	21	(1,724)	(1,592)
Interest element of private finance initiative obligations	12	(4,027)	(3,953)
PDC dividend paid		(400)	(523)
Cash flows from (used in) other financing activities		70	
Net cash used in financing activities		**(6,069)**	**(6,068)**
Increase/(decrease) in cash and cash equivalents		17,000	4,687
Cash and Cash equivalents at 1 April		52,424	47,737
Cash and Cash equivalents at 31 March		**69,424**	**52,424**

Reconciliation of Statement of Financial Position to working balances adjustment in Cash Flow	2018/19 £000s	2017/18 £000s
(Increase)/decrease in receivables as per SOFP	(25,149)	528
Adjustments for receivables movements not related to I&E:		
- Increase/(decrease) in capital receivables		
- Financing transactions	120	64
(Increase)/decrease in receivables adjusted for non-I&E items	(25,029)	592
Increase/(decrease) in payables per SOFP	8,065	(1,975)
Adjustments for payables movements not related to I&E:		
- (Increase)/decrease in capital payables	61	557
- Financing transactions	(18)	11
Increase/(decrease) in payables adjusted for non-I&E items	8,108	(1,407)
Increase/(decrease) in Other Liabilities per SOFP	221	257
Adjustments for Other Liabilities movements not related to I&E:		
Increase/(decrease) in Other Liabilities adjusted for non-I&E items	221	257
Increase/(decrease) in provisions per SOFP	281	(720)
Adjustments for provisions movements:		
- Unwinding of discount on provisions	(2)	(4)
Increase/(decrease) in provisions for non I&E items	279	(724)
Opening capital payables	(685)	(1,242)
Capital payable written off		(171)
Closing capital payables	(624)	(685)
Change in capital payables in-year	**(61)**	**386**

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

Notes to the accounts

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

1 Accounting policies

NHS Improvement (NHSI), in exercise of the powers conferred has directed that the accounts of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2018/19 GAM issued by the Department of Health and Social Care. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), in accordance with EU endorsed IFRS and IFRIC, and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently, other than where new policies have been adopted, in dealing with items considered material in relation to the accounts.

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

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 Expenditure on employee benefits

Short term employee benefits

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

1.4 Pension costs

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

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

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates payable by employers and employees.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

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

Employers and employee contribution rates may be varied from time to time, as above, to reflect changes in the scheme's liabilities. In 2017/18 employee contributions are tiered depending on salary and range from 5% to 14.5%. Employer contributions for 2018/19 were 14.38%, including the administration levy (14.38% in 2017/18).

Notes to the accounts - 1. Accounting policies (continued)

1.4 Pension costs (continued)

b) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions
In 2018/19 the NHS pension scheme provided defined benefits, which are summarised below. The list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained:

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

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

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

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

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

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

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

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

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

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

Every three years all eligible employees are auto-enroled in either the NHS or alternative pension scheme. The auto-enrolment exercise was carried out in October 2016 and following this process, all employees who meet the criteria for the alternative pension scheme are enroled each month on a continuous basis, unless they specifically opt out.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined minimum of 5% (with a minimum 2% being contributed by the Trust) and from October 2018 the combined contribution rate will be 8% (with a minimum 3% being contributed by the Trust).

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

Notes to the accounts - 1. Accounting policies (continued)

1.5 Income recognition

Income is accounted for by applying the accruals convention. The main source of income for Leeds and York Partnership NHS Foundation Trust is from commissioners in respect of healthcare services provided under local agreements (NHS Contracts). Where income is received for a specific activity, which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.5.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations, which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability

1.5.2 Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a

The Trusts main healthcare contracts are agreed on a block contract basis.

1.5.3 Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

1.5.4 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5.5 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.6 Expenditure on goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.6.1 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the Leeds and York Partnership NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;

and if any of the following apply:

- the item has cost of at least £5,000;
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

The finance costs of bringing property, plant and equipment into use are not capitalised.

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

Any lease which does not meet the requirements of IAS 17 are assumed to be operating leases.

1.6.2 Measurement

Valuation

All property, plant and equipment are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

Land and buildings used for the Trust's purposes are stated in the Statement of Financial Position at their revalued amounts being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. In accordance with IFRS and NHS policy, a full revaluation is performed at least every five years, with an interim revaluation in the third year after the full revaluation. An impairment review is undertaken in all other years. The Trust believes that this is sufficiently regular to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost based on providing a modern equivalent asset;
- Non-operational land and buildings – fair value based on alternative use.

Professional valuations are carried out by the District Valuers of the Revenue and Customs Government Department. These valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation manual. A valuation was last undertaken as at 31 March 2019 and the assets were reviewed for impairment using the Modern Equivalent Asset (MEA) and alternative site methods as appropriate. From 31 March 2018 PFI assets are valued excluding VAT.

Plant and equipment assets were last indexed using the latest available Consumer Price Indices (CPI), being for February 2018, as issued by the Office for National Statistics.

It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 14.

1.6.3 Subsequent expenditure

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

1.6.4 Depreciation

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

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

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

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

Plant and machinery	
• Short life engineering plant and equipment	5 years
• Medium life engineering plant and equipment	10 years
• Long life engineering plant and equipment	15 years
• Short life medical and other equipment	5 years
• Medium life medical equipment	10 years
• Long life medical equipment	15 years
Transport	
• Vehicles	7 years
Furniture and fittings	
• Furniture	10 years
Information technology	
• Office and IT equipment	5 years
• Mainframe type IT installations	8 years

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

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

Notes to the accounts - 1. Accounting policies (continued)

1.6.4 Depreciation (continued)

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

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

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

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

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

1.6.5 Revaluation and Impairment

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

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

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

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

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

1.6.6 Non-current assets held for sale

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

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

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

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

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

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

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

Notes to the accounts - 1. Accounting policies (continued)

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; and
c) Operating lease for the land.

a) Services received

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

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

b) PFI assets and finance costs

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at cost to the PFI Provider but then revalued to 'fair value' by the District Valuer in accordance with the principles of 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. From 31 March 2018, PFI assets are valued

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, which 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, eg cash payments and surplus property, by the Trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

Leeds and York Partnership NHS Foundation Trust did make an initial 'bullet' payment of cash upfront of £5.4m. This was off set against the initial liability (based on the fair value cost of the building less the £5.4m).

1.8 Intangible Assets

1.8.1 Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. The Trust holds software licences as intangible assets. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Purchased computer software licences are capitalised as intangible non-current assets where expenditure of at least £5,000 is incurred. They are amortised over the shorter of the term of the licence and their useful economic lives, currently between 3 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, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

1.8.3 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. Subsequent intangible assets are measured at fair value. Revaluation gains, losses and impairments are treated in the same manner as for property, plant and equipment, see notes 1.6.2 and 1.6.5.

1.8.4 Amortisation

Intangible assets are amortised on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Amortisation is recognised in the Statement of Comprehensive Income.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first in - first out cost formula. Inventories are identified in note 16. The Trust's inventories do not include drugs, but comprise stationery, oil and other work stores.

1.10 Cash and cash equivalents

Cash and cash equivalents comprise cash in hand, balances with banks and investments. Cash and bank balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the Leeds and York Partnership NHS Foundation Trust's bank account belonging to patients (see "third party assets" below). Interest earned on bank accounts is recorded as "interest receivable" in the period to which it relates. Bank charges are recorded as operating expenditure in the periods to which they relate.

1.11 Provisions

Leeds and York Partnership NHS Foundation Trust provides for present legal or constructive obligations that are of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate in real terms. The discount rate for early retirement and injury benefit provisions (both use the HM Treasury's pension discount rate) is 0.29% (0.1% in 2017/18) in real terms. The discount rate for other provisions varies depending on the timing of the liability from 0.76% (up to 5 years), 1.14% (5 - 10 years) and 1.99% over 10 years (in 2017/18 the discount rates were -2.42%, -1.85% and -1.56% respectively).

1.11 Provisions (continued)

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party; the receivable is recorded as an asset, if it is virtually certain that reimbursement will be received and the amount of the receivable can be measured reliably.

Clinical negligence costs

From 1 April 2000, the NHS Litigation Authority (NHSLA) took over full financial responsibility for all Existing Liabilities Scheme (ELS) cases unsettled at that date and from 1 April 2002 all Clinical Negligence Scheme for Trusts (CNST) cases. Provisions for these are included in the accounts of the NHSLA. Although the NHSLA is administratively responsible for all cases from 1 April 2000, the legal liability remains with the Trust.

The NHSLA operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Leeds and York Partnership NHS Foundation Trust does not include any amounts in its accounts relating to these cases. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 25.

Non-clinical risk pooling

Leeds and York Partnership NHS Foundation Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises; these are the only amounts included in the accounts of the Leeds and York Partnership NHS Foundation Trust.

1.12 Contingencies

Contingent assets, ie assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control, are not recognised as assets, but are disclosed in note 26 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is possible. Otherwise, they are not recognised, but are disclosed in note 26 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Value added tax (VAT)

Most of the activities of Leeds and York Partnership NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.14 Corporation tax

Leeds and York Partnership NHS Foundation Trust is a Health Service Body within the meaning of s519A ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation Trust (s519A (3) to (8) ICTA 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities, which are not related to, or ancillary to, the provision of healthcare. Until the exemption is disapplied, the foundation trust has no corporation tax liability.

Notes to the accounts - 1. Accounting policies (continued)

1.15 Foreign exchange

The functional and presentational currency of the Trust is sterling.

Transactions that are denominated in a foreign currency are converted into sterling at the exchange rate ruling on the date of each transaction. Gains and losses that result are taken to the Statement of Comprehensive Income.

1.16 Third party assets

Assets belonging to third parties (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 30, in accordance with the requirements of the HM Treasury FReM.

1.17 Leases

Finance leases

Where substantially all the risks and rewards of ownership of a leased asset are borne by Leeds and York Partnership NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is also recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted by the interest rate implicit in the lease. The implicit rate is that which discounts the minimum lease payments and any unguaranteed residual interest to the fair value of the asset at the inception of the lease.

The asset and liability are recognised as property, plant and equipment at the inception of the lease and de-recognised when the liability is discharged, cancelled or expires.

The annual rental is split between the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each financial year is calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in the Statement of Comprehensive Income.

Contingent rentals are recognised as an expense in the period in which they are incurred. The liability is de-recognised 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 the average daily balance of cash held with the Government Banking Service, the National Loans Fund and PDC receivable/payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

In accordance with the requirements laid down by the Secretary of State (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the accounts. The dividend is not revised should any adjustment to net assets occur as a result of the audit of the accounts.

1.19 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the Health Service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses, which would have been made good through insurance cover had NHS foundation trust's not been bearing their own risks (with any insurance premiums being included as normal revenue expenditure). Note 31 is compiled directly from the losses and special payments register which is prepared, as per the DHSC GAM, on an accruals basis (with the exception of provisions for future losses).

1.20 Financial Instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase and sale of non-financial items (such as goods or services), which are entered into in accordance with Leeds and York Partnership NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie, when receipt or delivery of the goods or services is made.

Financial assets and financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policies for leases.

All other financial assets and financial liabilities are recognised when Leeds and York Partnership NHS Foundation Trust becomes a party to the contractual provisions of the instrument.

Derecognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or Leeds and York Partnership NHS Foundation Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'loans and receivables' and financial liabilities are classified as ‘other financial liabilities’.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments, which are not quoted in an active market, and are included in current assets.

Leeds and York Partnership NHS Foundation Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS receivables and other receivables.

Loans and receivables are recognised initially at fair value, net of transaction costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly, the estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the Statement of Financial Position date, Leeds and York Partnership NHS Foundation Trust assesses whether any financial assets, other than those held at ‘fair value through income and expenditure’ are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced through the use of a bad debt provision.

Notes to the accounts - 1. Accounting policies (continued)

1.21 Accounting standards that have been issued but have not yet been adopted

a) IASB standard and IFRIC interpretations
Under paragraph 30 of IAS 8, entities need to disclose any new IFRSs that are issued but not yet effective and that are likely to impact the entity.

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2018-19. These standards, IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

IFRS 16 Leases
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

'IFRS 17 Insurance contracts
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.

'IFRIC 23 Uncertainty over income tax treatments
Application required for accounting periods beginning on or after 1 January 2019.

b) Government Financial Reporting Manual (FReM) changes
In preparing the DH GAM, the Department of Health and Social Care must take account of the requirements of the Government FReM issued by HM Treasury. In some cases, where there is a compelling reason, HM Treasury may grant permission not to adopt a change to the FReM in the DH GAM.

c) Other changes
From 2013/14 the exemption applicable to NHS FTs from consolidating NHS charitable funds that they control has been removed. The effect on Leeds and York Partnership NHS Foundation Trust is the need to consider whether charitable fund income, expenditure, assets, liabilities and reserves should be consolidated within the Trusts main accounts. Income and expenditure between the Trust and the charitable fund would be eliminated on consolidation. Further details are included in note 1.25 - Charitable Funds.

1.22 Accounting standards issued that have been adopted early by Leeds and York Partnership NHS Foundation Trust
No new accounting standards or revisions to existing standards have been adopted early in 2018/19.

1.23 Critical accounting judgements and key sources of estimation uncertainty
In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates as the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.24 Private patient income cap
Previously, NHS Foundation Trusts were required to disclose private patient income where this exceeded the amount specified. This disclosure is no longer required.

1.25 Charitable funds

Under IAS 27 (revised) Leeds and York Partnership NHS Foundation Trust is required to consolidate any Charitable Funds that meet the definition of a subsidiary contained in the standard. HM Treasury has previously granted dispensation to NHS FT organisations in this respect, however this dispensation ended in 2013/14. Leeds and York Partnership NHS Foundation Trust has therefore considered the need to consolidate Charitable Funds within the main Trust accounts and concluded, although the Trust continues to meet the criteria within the accounting standard, the value of the Charitable Fund is not material and will not therefore be consolidated within the Trusts main accounts.

IAS 27 (revised) also requires specific disclosures to be included in the accounts. The dispensation previously granted did not include the requirement for appropriate disclosure and consequently note 33 - Charitable funds, continues to be included in the Trusts accounts in compliance with these disclosure requirements.

1.26 Transfer of services

Where the Trust transfers a function to, or receives a function from another entity within the Whole of Government Accounts boundary this represents a “machinery of government change” regardless of the mechanism used to effect the combination, eg, statutory merger or purchase of the business.

The Trust will normally account for a machinery of government change as a transfer by absorption. This includes all transfers of functions involving other bodies within the Department of Health’s Resource Accounting Boundary and transfers of functions involving local government bodies.

1.27 Investment in associates

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

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

Leeds and York Partnership NHS Foundation Trust is a 25% partner in the Collaborative Procurement Partnership LLP (CPP LLP), with 3 other NHS foundation trusts. The partnership was registered at Companies House on 18 January 2017 and began implementation on 8 November 2017, following a successful tender process to deliver services to the Department of Health and Social Care from 8 May 2018. For the year ended 31 March 2019 the CPP LLP is transacting based on a reimbursement of cost model and a gainshare on savings achieved.

Notes to the accounts

2 Operating segments

Leeds and York Partnership NHS Foundation Trust (LYPFT) provides mental health and learning disability services across the city of Leeds. Specialist services, eg, Forensics, Eating Disorders, CAHMS, Liaison and Perinatal, commissioned by NHS England are also provided by LYPFT in Leeds, York and North Yorkshire.

The majority of Trust income (by value) is on a block basis. The Trust contracted with Leeds Clinical Commissioning Groups (CCGs) for 53% of its income (60% in 2017/18). The Trust also had contracts with NHS England, Health Education England and Local Authorities for the provision of clinical services and education training services.

Two operating segments are reported below. The operating segments are care services and hosted services. The hosted services segment includes the Commercial Procurement Collaborative (CPC), Research & Development, and the Northern School of Child & Adolescent Psychotherapy. Operating segments are reported on the basis of full cost absorption.

The reportable segments are those used by the Trust's Board and management (the 'Chief Operating Decision Maker' as defined in IFRS 8, Operating Segments) to run the business . Segment information is presented on the same basis as that used for internal reporting purposes. The surplus or deficit for each segment is used to inform the Board of Directors on performance and to assist in negotiations with commissioners on the cost and resources needed to maintain services at a level consistent with the need of the population.

Further detail of each directorate can be found in the Annual Report of the Trust.

	Care Services		**Hosted Services**		**Total**	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Income by segment						
Income from activities	**140,302**	131,672			**140,302**	131,672
Other operating income	**35,158**	16,442	**10,683**	8,399	**45,841**	24,841
TOTAL INCOME	**175,460**	148,114	**10,683**	8,399	**186,143**	156,513
TOTAL EXPENDITURE	**(148,119)**	(139,819)	**(10,283)**	(8,568)	**(158,402)**	(148,387)
Operating surplus	**27,341**	8,295	**400**	(169)	**27,741**	8,126
Non Operating Income and Expenditure Total	**4,634**	(4,311)	**27**	7	**4,661**	(4,304)
Surplus/(Deficit) from continuing operations	**31,975**	3,984	**427**	(162)	**32,403**	3,822

a) Income includes £168m (£141m in 2017/18) from NHS organisations (primarily £102m from Leeds CCGs and £49m from NHS England).

b) Expenditure includes employee expenses £113,468k (£107,740k in 2017/18), premises £6,009k (£4,251k in 2017/18), depreciation and amortisation £4,094k (£4,543k in 2017/18) and establishment £2,334k (£1,926k in 2017/18).

3 Revenue from patient care activities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Clinical Commissioning Groups and NHS England	**129,137**	122,990
Foundation Trusts	**193**	157
Local Authorities	**346**	46
NHS other	**1,561**	11
Non-NHS:		
Income for social care clients	**8,719**	8,072
Other	**346**	396
Total revenue from patient care activities	**140,302**	131,672

Leeds and York Partnership NHS Foundation Trust participates in a pooled budget arrangement with Leeds CCGs 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 classed as commissioner requested services (CRS).

4 Other operating revenue	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Research and development	**1,692**	1,256
Education and training	**4,187**	4,209
Non-patient care services to other bodies	**1,427**	1,696
Provider sustainability fund	**21,957**	2,502
Other income:		
Inter NHS Foundation Trust	**1,666**	2,489
Inter NHS Trust	**1,319**	1,454
Inter RAB	**4,425**	4,471
Inter Other WGA bodies	**146**	192
Other (outside WGA)	**7,750**	5,294
Income in respect of staff costs where accounted on gross basis	**1,272**	1,278
Total Other Operating Revenue	**45,841**	24,841

5 Operating expenses	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Purchase of healthcare from NHS and DHSC bodies	**51**	165
Purchase of healthcare from non-NHS and non-DHSC bodies	**8,161**	6,635
Purchase of social care	**535**	536
Staff and executive directors costs	**113,468**	107,740
Non-executive directors	**216**	204
Supplies and services – clinical (excluding drugs costs)	**1,200**	730
Supplies and services - general	**1,405**	1,515
Drugs costs (drugs inventory consumed and purchase of non-inventory drugs)	**2,103**	2,316
Consultancy	**106**	430
Establishment	**2,334**	1,926
Premises - business rates collected by local authorities	**1,013**	954
Premises - other	**4,996**	3,297
Transport (business travel only)	**1,002**	971
Transport - other (including patient travel)	**674**	557
Depreciation	**3,879**	4,361
Amortisation	**215**	182
Impairments net of (reversals)	**1,915**	1,557
Increase/(decrease) in impairment of receivables	**(41)**	138
Provisions arising / released in year	**399**	(59)
Change in provisions discount rate	**(20)**	16
Audit services - statutory audit	**56**	59
Other auditor remuneration (payable to external auditor only)	**10**	10
Internal audit - non-staff	**84**	91
Clinical negligence - amounts payable to NHS Resolution (premium)	**258**	260
Legal fees	**311**	287
Insurance	**171**	225
Research and development - non-staff	**1,831**	1,416
Education and training - non-staff	**1,062**	1,111
Education and training - notional expenditure funded from apprenticeship fund	**88**	13
Operating lease expenditure (net)	**1,182**	1,165
Early retirements - non-staff	**11**	13
Redundancy costs - non-staff		239
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis	**7,268**	7,436
Car parking and security	**227**	175
Other losses and special payments - non-staff	**25**	34
Other	**2,207**	1,681
Total operating expenditure	**158,402**	148,387

£8,161k of expenditure categorised as purchase of healthcare from non NHS bodies relates to payments to private sector healthcare providers, (£6,635k in 2017/18).

Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg, PFI / LIFT) on IFRS basis £7,268k (£7,436k in 2017/18) includes premises cost £397k, operating leases £401k and supplies and services - general £6,470k, previously included under separate headings (2017/18: £356k, £389k and £6,691k respectively).

Details of the Directors' remuneration can be found in Section 2.4 of the annual report.

Notes to the accounts - 5. Operating expenses (continued)

5.1 Auditors remuneration

The Board of Governors appointed KPMG as external auditors of the Foundation Trust for the three year period commencing 1 June 2017, with an option to extend for a further year. The statutory audit fee will be £47k for 2018/19 excluding value added tax. This was the fee for an audit in accordance with the Audit Code issued by NHSi as updated in December 2014. Other audit remuneration was for audit related assurance services relating to the Quality Report £8k (£9k in 2017/18).

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Financial Audit	**47**	49
Other audit remuneration - audit related assurance services (Quality report)	**8**	9
Total	**55**	58

6 Operating leases

6.1 As lessee

The leases are for buildings, vehicles and other equipment. Building leases include the lease on Trust headquarters at Thorpe Park, which has been extended by three years to June 2022 and other non specialised properties used for clinical purposes. Vehicle leases are for cars supplied to qualifying staff under a vehicle lease scheme. Other equipment leases are mainly for photocopy equipment in the various Trust properties.

Payments recognised as an expense	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Minimum lease payments	**1,182**	1,165
Sub-lease payments		
	1,182	1,165

Total future minimum lease payments	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Not later than one year	**1,118**	951
Between one and five years	**829**	247
After 5 years		
Total	**1,947**	1,198

Notes to the accounts

7 Employee costs and numbers

7.1 Employee costs

	Year Ended 31 March 2019			Year Ended 31 March 2018		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**89,440**	**79,446**	**9,994**	84,993	75,755	9,238
Social security costs	**8,578**	**8,578**		8,265	8,265	
Employer contributions to NHS pension scheme	**11,069**	**11,069**		10,535	10,535	
Agency staff	**5,138**		**5,138**	4,470		4,470
Employee benefits expense	**114,225**	**99,093**	**15,132**	108,263	94,555	13,708

There were no employee benefits paid in the year ended 2018/19 (£nil in 2017/18)

In addition to the above:		
Charged to capital	**(194)**	
Recharged income	**(563)**	(523)
Total employee costs	**113,468**	107,740

Full details of the Directors' remuneration can be found in section 2.4 of the Annual Report, of which a summarised version is given below.

The disclosures required under the Hutton report can also be found in section 2.4 of the Annual Report.

	Year ended 31 March 2019	Year ended 31 March 2018
Directors' remuneration	**£000**	£000
Aggregate emoluments to Executive Directors	**711**	681
Remuneration of Non-Executive Directors	**216**	204
Pension cost	**102**	97
	1,029	982

Remuneration of Non-Executives include MH Act Managers £75k (£70k in 2017/18).

7.2 Monthly average number of people employed (wte)

	Year Ended 31 March 2019			Year Ended 31 March 2018		
	Total	**Permanently Employed**	**Other**	Total	Permanently Employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**193**	**182**	**11**	195	169	25
Administration and estates	**626**	**573**	**53**	610	549	61
Healthcare assistants and other support staff	**812**	**565**	**247**	786	553	233
Nursing, midwifery and health visiting staff	**738**	**695**	**43**	736	688	48
Scientific, therapeutic and technical staff	**327**	**322**	**5**	307	278	29
Social care staff	**6**	**6**		1	1	
Total	**2,702**	**2,343**	**359**	2,634	2,238	396

8 Retirements due to ill-health

During 2018/19 there were 2 (2 in 2017/18) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liability of this ill-health retirement will be £140k (£112k in 2017/18). The cost of this ill-health retirement will be borne by the NHS Business Services Authority - Pensions Division.

9 Better Payment Practice Code

	Year Ended 31 March 2019		Year Ended 31 March 2018	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**22,816**	**49,406**	22,739	45,232
Total Non-NHS trade invoices paid within target	**21,980**	**47,277**	21,946	43,579
Percentage of Non-NHS trade invoices paid within target	**96%**	**96%**	97%	96%
Total NHS trade invoices paid in the year	**998**	**6,069**	1,104	7,416
Total NHS trade invoices paid within target	**929**	**5,686**	1,018	6,779
Percentage of NHS trade invoices paid within target	**93%**	**94%**	92%	91%

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 2019 £000	Year ended 31 March 2018 £000
Bank accounts	**359**	136
PFI Re-financing	**6,509**	
Total	**6,868**	136

This figure includes accrued interest of £40k (2017/18 £19k).

11 Other gains and losses

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Gain on disposal of property, plant and equipment	**2,095**	2
Loss on disposal of property, plant and equipment	**(18)**	(34)
Loss on disposal of intangible assets	**(17)**	
Total	**2,060**	(32)

12 Finance costs

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Interest on obligations under finance leases		
Interest on obligations under PFI contracts:		
- main finance cost	**1,799**	1,933
- contingent finance cost	**2,234**	2,021
Total	**4,033**	3,954

13 Intangible assets

2018/19:	**Computer software - purchased £000**	**2017/18:**	**Computer software - purchased £000**
Gross valuation at 1 April 2018	726	Gross valuation at 1 April 2017	669
Additions purchased	21	Additions purchased	270
Disposals other than by sale	(56)	Disposals other than by sale	(1)
Impairments		Impairments	(16)
Reclassifications		Reclassifications	(47)
Revaluation/indexation	(113)	Revaluation/indexation	(149)
Gross valuation at 31 March 2019	**578**	**Gross valuation at 31 March 2018**	**726**
Accumulated amortisation at 1 April 2018	79	Accumulated amortisation at 1 April 2017	40
Disposals other than by sale	(39)	Disposals other than by sale	(1)
Revaluation	(121)	Revaluation	(149)
Impairments	9	Impairments	7
Charged during the year	215	Charged during the year	182
Accumulated amortisation at 31 March 2019	**143**	**Accumulated amortisation at 31 March 2018**	**79**
Net book value		**Net book value**	
Purchased	435	Purchased	647
Total at 31 March 2019	**435**	**Total at 31 March 2018**	**647**

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 2018/19 for the software licences and this led to an impairment charge to operating expenses of £9k (impairment charge of £7k in 2017/18).

Notes to the accounts

14. Property, plant and equipment

2018/19:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	2,175	36,126	555	882	335	7,098	863	48,034
Additions purchased			3,308	107		739	261	4,415
Additions donated								
Reclassifications		2,124	(2,204)			80		
Reclassified as held for sale								
Disposals	(355)	(470)		(31)	(36)	(1,380)	(231)	(2,503)
Revaluation/indexation (losses)/gains	10	(4,675)	(7)	14	10		1	(4,647)
Impairments		(1,387)						(1,387)
Reversal of Impairments								
At 31 March 2019	**1,830**	**31,718**	**1,652**	**972**	**309**	**6,537**	**894**	**43,912**
Accumulated depreciation at 1 April 2018		253		794	244	4,690	631	6,612
Disposals		(10)		(27)	(32)	(1,367)	(231)	(1,667)
Reclassified as held for sale								
Revaluation/indexation (losses)/gains		(4,695)	(7)	12	8		1	(4,681)
Impairments		1,900	7					1,907
Reversal of Impairments		(1)						(1)
Charged during the year		2,819		29	20	971	40	3,879
Accumulated depreciation at 31 March 2019		**266**		**808**	**240**	**4,294**	**441**	**6,049**
Net book value								
Total at 31 March 2019	**1,830**	**31,452**	**1,652**	**164**	**69**	**2,243**	**453**	**37,863**
Asset financing								
Owned	1,830	18,970	1,652	164	69	2,243	453	**25,381**
PFI		12,468						**12,468**
Donated		14						**14**
Total at 31 March 2019	**1,830**	**31,452**	**1,652**	**164**	**69**	**2,243**	**453**	**37,863**

The latest revaluation of land and buildings was carried out by the Valuation Office with an effective date of 31 March 2019.

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

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

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

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

14.1 Property, plant and equipment - prior year

2017/18:	Land	Buildings excluding dwellings	Assets under construct and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	2,935	43,805	712	910	368	6,482	823	56,035
Additions purchased			870	27	52	511	11	1,471
Additions donated								
Reclassifications		665	(1,026)			408		47
Reclassified as held for sale	(200)	(247)						(447)
Disposals				(69)	(91)	(303)		(463)
Revaluation/indexation (losses)/gains		(3,801)		14	6		29	(3,752)
Impairments	(560)	(4,296)	(1)					(4,857)
Reversal of Impairments								
At 31 March 2018	**2,175**	**36,126**	**555**	**882**	**335**	**7,098**	**863**	**48,034**
Accumulated depreciation at 1 April 2017		218		807	309	3,881	561	5,776
Disposals				(69)	(88)	(269)		(426)
Reclassified as held for sale		(4)						(4)
Revaluation/indexation (losses)/gains		(4,119)		13	4		21	(4,081)
Impairments		1,096						1,096
Reversal of Impairments		(110)						(110)
Charged during the year		3,172		43	19	1,078	49	4,361
Accumulated depreciation at 31 March 2018		**253**		**794**	**244**	**4,690**	**631**	**6,612**
Net book value								
Total at 31 March 2018	**2,175**	**35,873**	**555**	**88**	**91**	**2,408**	**232**	**41,422**
Asset financing								
Owned	2,175	20,768	555	88	91	2,408	232	**26,317**
PFI		15,090						**15,090**
Donated		15						**15**
Total at 31 March 2018	**2,175**	**35,873**	**555**	**88**	**91**	**2,408**	**232**	**41,422**

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

14.2 Classification of impairments for Parliamentary budgeting purposes

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Abandonment of assets in course of construction	**7**	1
Changes in Market Place	**1,909**	1,687
Reversals of impairments	**(1)**	(131)
At 31 March	**1,915**	1,557

15 Capital commitments

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

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Property, plant and equipment	**1,382**	175
Total	**1,382**	175

16 Inventories

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Energy, consumables and work in progress	**27**	64
Total	**27**	64
Of which held at net realisable value:	**27**	64

16.1 Inventories recognised in expenses

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Inventories recognised as an expense in the year	**57**	18
Total	**57**	18

Notes to the accounts

17 Trade and other receivables

	Current		Non-current	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Trade Receivables		953		
Contract receivables	**6,885**			
Accrued Income	**22,739**	3,096		
Allowance for impaired contract receivables	**(497)**	(548)		
Prepayments	**1,819**	1,015	**4,577**	4,324
VAT	**212**	570		
Other receivables	**455**	1,631		
Total	**31,613**	6,717	**4,577**	4,324

The majority of trade is with Clinical Commissioning Groups (CCGs), as commissioners for NHS patient care services. As CCGs are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Credit scoring is not applied to other receivables

17.1 Receivables past their due date but not impaired

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
By up to three months	**384**	802
By three to six months	**166**	52
Over six months	**241**	133
Total	**791**	987

The Trust does not consider the above debtors, past their due date, to be impaired, based on previous trends and experience.

17.2 Allowances for credit losses

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Balance at 1 April	**548**	410
Amount written off during the year	**(10)**	
Increase/(decrease) in receivables impaired	**(41)**	138
Balance at 31 March	**497**	548

The provision for impairment of receivables for the year ended 31 March 2019 has increased/decreased after taking all factors into consideration regarding the potential for recovery.

18 Cash and cash equivalents

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Balance at 1 April	**52,424**	47,737
Net change in year	**17,000**	4,687
Balance at 31 March	**69,424**	52,424
Made up of		
Cash with Government Banking Service	**69,294**	52,318
Commercial banks and cash in hand	**130**	106
Cash and cash equivalents as in statement of financial position	**69,424**	52,424
Cash and cash equivalents as in statement of cash flows	**69,424**	52,424

Notes to the accounts

19 Non-current assets held for sale

	Property, Plant and Equipment £000
Balance brought forward 1 April 2018	
Plus assets classified as available for sale in the year	**440**
Less Impairment of assets held for sale	
Less assets sold in the year	**(440)**
Balance carried forward 31 March 2019	

At 31 March 2019 there are no buildings held for sale (2 in 2017/18 - The Cottage at St Mary's House and Springfield Mount).

20 Trade and other payables

	Current	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Trade payables	**6,452**	1,214
Amounts due to other related parties		
Non NHS trade payables - capital	**624**	685
Accruals	**7,395**	5,871
Other	**3,872**	2,508
Total	**18,343**	10,278

21 Borrowings

	Current		Non-current	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
PFI liabilities	**1,881**	1,736	**19,535**	21,416
Total	**1,881**	1,736	**19,535**	21,416

22 Other liabilities

	Current	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Deferred Income	**1,447**	1,226
Total	**1,447**	1,226

Notes to the accounts

23 Finance lease obligations

There are no current finance leases in operation.

24 Private Finance Initiative (PFI) contracts

PFI schemes on-Statement of Financial Position

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

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

Minimum amounts payable under the contract:

Asset financing component	**Gross Payments**		**Present value of payments**	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Not later than one year	**5,769**	5,557	**5,554**	5,349
Later than one year, not later than five years	**23,076**	22,226	**18,676**	17,988
Later than five years	**19,230**	24,078	**12,000**	14,527
Sub total	**48,075**	51,861	**36,230**	37,864
Less: finance cost attributable to future periods	**(26,659)**	(28,709)	**(14,814)**	(14,712)
Total	**21,416**	23,152	**21,416**	23,152

Services component	**Gross Payments**	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Not later than one year	**6,485**	6,540
Later than one year, not later than five years	**25,940**	26,160
Later than five years	**21,616**	28,340
Total	**54,041**	61,040

The future services amounts due as at 31 March 2019 reflect an adjustment for the RPI indexation of the unitary payment applied during 2018/19.

The amount charged to operating expenses during the year in respect of services was £6,201k (2017/18 £6,430k).

24.1 Analysis of amounts payable to service concession operator

	Gross Payments	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Unitary payment	**13,290**	13,379
Consisting of:		
- Interest charge	**1,799**	1,933
- Repayment of finance lease liability	**1,736**	1,602
- Service element and other charges to operating expenses	**6,602**	6,819
- Capital lifecycle maintenance		
- Revenue lifecycle maintenance	**666**	617
- Contingent rent	**2,234**	2,021
- Addition to lifecycle prepayment	**253**	387
Total	**13,290**	13,379

The addition to lifecycle prepayment relates to a rent free period at the end of the contract £253k (£387k 2017/18). Service element and other charges to operating expenses includes the operating lease payments for the land element of the properties £401k (£389k 2017/18).

25 Provisions

	Current		Non-current	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Pensions relating to other staff	**142**	138	**1,439**	1,485
Legal claims	**113**	140		
Redundancy	**1,711**	1,499		
Other	**405**	315	**524**	476
Total	**2,371**	2,092	**1,963**	1,961

	Pensions relating to other staff £000	**Legal claims £000**	**Redundancy £000**	**Other £000**	**Total £000**
At 1 April 2017	1,702	86	1,938	1,047	4,773
Arising during the year	54	141	895	272	1,362
Change in discount rate	16				16
Used during the year	(139)	(38)	(505)		(682)
Reversed unused	(15)	(49)	(829)	(528)	(1,421)
Unwinding of discount	4				4
At 31 March 2018	1,622	140	1,499	791	4,052
At 1 April 2018	1,622	140	1,499	791	4,052
Arising during the year	119	61	1,031	153	
Change in discount rate	(20)				
Used during the year	(142)	(54)			
Reversed unused		(34)	(819)	(15)	
Unwinding of discount	2				
At 31 March 2019	**1,581**	**113**	**1,711**	**929**	**4,334**
Expected timing of cash flows:					
Between 1 April 2018 and 31 March 2019	142	113	1,711	405	2,371
Between 1 April 2019 and 31 March 2023	569			524	1,093
Thereafter	870				870
TOTAL	**1,581**	**113**	**1,711**	**929**	**4,334**

The pensions provision is in respect of employees who have taken early retirement through injury or prior to 1995. These provisions are calculated using current year payments and GAD tables as issued by the Office for National Statistics. The GAD tables provide an estimate of remaining lives, which the provision is based on. Payments made against the pensions provisions are quarterly to the NHS Business Services Authority Pensions Division. Due to the nature of the other provisions, there is no certainty regarding the timing of payments.

The legal claims provision is in respect of excess payments to NHS Litigation Authority for employers' and public liability claims. NHS Litigation Authority provides estimates of the likely outcome of the case and damages/costs to be paid. The provision is calculated based on these estimates. There is also a provision relating to employment tribunals £46k (£70k 2017/18).

£818k is included in the provisions of the NHS Litigation Authority at 31 March 2019 in respect of the clinical negligence liabilities of the Trust (31 March 2018 £9,315k).

Other provisions comprise the commitment placed on the Trust in ensuring it meets its obligations in respect of dilapidation costs £561k (£519k 2017/18) and for VAT recovered on software £368k (£272k 2017/18).

The unwinding of discount on the provisions appears as a finance cost on the face of the Statement of Comprehensive Income.

Leeds and York Partnership NHS Foundation Trust has no expected reimbursements for any class of provision made.

26 Contingent liabilities

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Other	**23**	38
Total	**23**	38

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 - £23k in 2018/19 and £38k in 2017/18). Due to the nature of the amounts and timing of the cash flows it would be impractical to estimate the value and timings of the amounts and cash flows.

27 Financial Instruments

Leeds and York Partnership NHS Foundation Trust's financial assets are classified either as "loans and receivables" financial assets. All the Trust's financial liabilities are classified as "other liabilities".

Leeds and York Partnership NHS Foundation Trust undertakes active financial risk management to manage its exposure to risk, particularly credit risk and treasury risk. Similar to general risk management, financial risk management requires identifying its sources, measuring it and implementing plans to address them.

27.1 Financial assets - carrying amount

	Loans and receivables £000
Receivables	5,082
Cash at bank and in hand	52,424
Total at 31 March 2018	**57,506**
Receivables	**29,433**
Cash at bank and in hand	**69,424**
Total at 31 March 2019	**98,857**

Ageing of over due receivables included in Financial Assets

Receivables overdue by:	
1-30 days	**1,925**
31-60 days	**304**
61-90 days	**81**
91-180 days	**166**
Greater than 180 days	**241**
	2,717

27.2 Financial liabilities - carrying amount

	£000
Embedded derivatives	
Payables	10,278
PFI and finance lease obligations	23,152
Provisions under contract	4,053
Total at 31 March 2018	37,483
Embedded derivatives	
Payables	**16,141**
PFI and finance lease obligations	**21,416**
Provisions under contract	**3,966**
Total at 31 March 2019	**41,523**

27.3 Fair values of loans and receivables and other financial liabilities

The fair value of current loans and receivables are considered to be equal to their carrying amounts. There are no non-current loans and receivables.

The fair values of current financial liabilities are considered to be equal to their carrying amounts.

27.4 Financial risk management

IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Leeds and York Partnership NHS Foundation Trust's activities are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Consequently the Trust's financial risks are relatively small in comparison with commercial entities. The Trust does not use financial instruments to alter or hedge its risk and therefore their importance to the Trust's finances are similarly relatively low.

Credit risk

This is the risk that other parties may not pay amounts that are due from them to Leeds and York Partnership NHS Foundation Trust. The majority of the Trust's income comes from contracts with other public sector bodies, however, and therefore the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the Trade and other receivables note.

Leeds and York Partnership NHS Foundation Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust mitigates the risks surrounding treasury management by investing in low risk banks/government backed investors. Trust treasury activity is subject to review by the Trust's internal auditors.

Liquidity risk

Leeds and York Partnership NHS Foundation Trust's net operating costs are incurred primarily under annual service agreements with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. Leeds and York Partnership NHS Foundation Trust also largely finances its capital expenditure from funds generated through operating surpluses. Consequently, the Trust is not considered to be exposed to significant liquidity risks (the inability of paying financial liabilities).

Leeds and York Partnership NHS Foundation Trust's main long term liability is its PFI obligation, with the contract ending in 2028. Further information on the commitments under this contract are provided in note 24.

Market risk

Market risk comprises three elements: foreign currency risk, interest rate risk and price risk.

Foreign currency risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be affected materially by foreign exchange gains and losses on foreign currency transactions. However the Trust has no foreign currency income and negligible foreign currency expenditure. Consequently, exposure to currency risk is not significant.

Interest rate risk

This is the risk that Leeds and York Partnership NHS Foundation Trust's income and expenditure could be materially affected by changes in interest rates on financial liabilities, e.g. borrowing and financial assets. However, a high percentage of the Trust's financial assets and a high percentage of its financial liabilities carry nil or fixed rates of interest. Leeds and York Partnership NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Price risk

As explained in note 24, Leeds and York Partnership NHS Foundation Trusts' annual unitary payment under its PFI scheme is subject to annual indexation in line with the RPIX. The Trust is therefore exposed to pricing risk in this regard. The annual adjustments are reflected in finance costs (contingent rent), operating expenses and property, plant and equipment additions respectively.

For 2018/19 the percentage increase in the unitary payment was 3.82%, equalling a monetary increase of £155k (2.72%, £208k in 2017/18). This was partially offset by a rebate of £116k.

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%.

2018/19 Uplift in unitary payment	**Actual uplift at 3.82%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	79	72	172
Recognised in operating expenses	76	62	277
Recognised in surplus/deficit	155	134	449
	155	134	449
Net impact of sensitivities on surplus/(deficit)		**21**	**(294)**

2017/18 Uplift in unitary payment	**Actual uplift at 2.72%**	**Uplift at 3.7%**	**Uplift at 5.5%**
	£000	**£000**	**£000**
Recognised in finance costs	24	77	174
Recognised in operating expenses	184	250	371
Recognised in surplus/deficit	208	327	545
	208	327	545
Net impact of sensitivities on surplus/(deficit)		**(119)**	**(337)**

28 Related party transactions

Leeds and York Partnership NHS Foundation Trust is a public benefit corporation, which was established by the granting of authorisation by the independent Regulator for NHS Foundation Trusts, NHS Improvement.

Government Departments and their agencies are considered by HM Treasury as being related parties. During the year the Trust has had a significant number of material transactions with other NHS Bodies. In addition, the Trust has had a significant number of material transactions in the ordinary course of its business with other Government Departments and other central and local Government bodies.

During the year 2018/19, Leeds and York Partnership NHS Foundation Trust had significant transactions with Leeds University, where 1 Non Executive Director of the Trust's Board holds a position of employment with the university.

28.1 Related party transactions - members of the Board of Directors

During the year Leeds and York Partnership NHS Foundation Trust had the following material transactions with entities, which are considered related parties to members of the Board of Directors of the Trust:

	Payments to Related Parties	Receipts from Related Parties	Amounts owed to Related Parties	Amounts due from Related Parties
	£000	**£000**	**£000**	**£000**
University of Leeds (2018/19)	**190**	**61**	**54**	**3**
University of Leeds (2017/18)	110	99		22

In 2018/19, the Trust had £5k of related party transactions with its charitable fund (2017/18 £3k).

28.2 Related party transactions - commitments (year ended 31/3/2020)

	Income £000
Leeds Clinical Commissioning Groups	102,536
NHS England	26,243
	128,779

These commitments are material transactions relating to NHS bodies.

The Trust has no expenditure commitments with related parties for the year ending 31 March 2020.

28.3 Related party transactions - UK Government ultimate parent

	Income		Expenditure	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Department of Health and Social Care	**2,950**	841		
Other DHSC Group bodies	**165,374**	141,107	**7,833**	7,704
Other	**492**	279	**20,331**	19,485
Total	**168,816**	142,227	**28,164**	27,189

	Receivables		Payables	
	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000	**Year ended 31 March 2019 £000**	Year ended 31 March 2018 £000
Department of Health and Social Care	**156**	33		
Other DHSC Group bodies	**25,624**	3514	**2,762**	2003
Other	**212**	570	**2,293**	210
Total	**25,992**	4,117	**5,055**	2,213

29 Intra-Government and other balances	**Current receivables £000**	**Non-current receivables £000**	**Current payables £000**	**Non-current payables £000**
Balances with other Central Government bodies	212		2,238	
Balances with Local Authorities			55	
Balances with NHS bodies	25,780		2,762	
Intra Government balances	**25,992**		**5,055**	
Balances with bodies external to Government	5,621	4,577	13,288	
At 31 March 2019	**31,613**	**4,577**	**18,343**	
Balances with other Central Government bodies	570			
Balances with Local Authorities			210	
Balances with NHS bodies	3,547		2,003	
Intra Government balances	**4,117**		**2,213**	
Balances with bodies external to Government	2,600		8,065	
At 31 March 2018	**6,717**		**10,278**	

Notes to the accounts

30 Third party assets

The Trust held £292k cash and cash equivalents at 31 March 2019 (£239k 2017/18), which relates to monies held on behalf of service users. This has been excluded from the cash and cash equivalents figure reported in the accounts.

31 Losses and special payments

There were 3 cases of losses totalling £10k (12 in 2017/18 totalling £3k) and 24 special payments totalling £32k (19 in 2017/18 totalling £31k) during the year. These amounts are reported on an accruals basis, excluding provisions for future losses.

Losses	**Number**	**Value £000**
Cash - other	1 (7)	0 (0)
Bad debts - other	2 (5)	10 (3)
Total	**3 (12)**	**10 (3)**
Special payments		
Ex-gratia - loss of personal effects	20 (12)	2 (1)
Ex-gratia - personal injury with advice	4 (7)	30 (30)
Ex-gratia - other	0 (0)	0 (0)
Special severance payments	0 (0)	0 (0)
Total	**24 (19)**	**32 (31)**

Figures in brackets relate to 2017/18.

32 Events after the reporting period

There were no events after the reporting period that had an impact on the Trust's 2018/19 accounts (2017/18: none).

33 Charitable Fund

	Year ended 31 March 2019 £000	Year ended 31 March 2018 £000
Income	**5**	3
Expenditure	**(10)**	(6)
Net movement in funds	**(5)**	(3)
Current assets	**114**	121
Current liabilities	**(14)**	(16)
Total Charitable Funds	**100**	105

The Charitable fund is not consolidated within these accounts but is disclosed in line with IAS 27 (revised).

CONTACT INFORMATION

Leeds and York Partnership NHS Foundation Trust
Trust Headquarters
2150 Century Way
Thorpe Park
Leeds
LS15 8ZB
Tel: 0113 85 55000
Web: www.leedsandyorkpft.nhs.uk

Chief Executive
If you have a comment for the Interim Chief Executive, please contact:
Dr Sara Munro
Chief Executive
Tel: 0113 85 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 85 55900
Email: ftmembership.lypft@nhs.net
Web: www.leedsandyorkpft.nhs.uk/membership

Communications
If you have a media enquiry, require further information about our Trust or would like more copies of this report please contact:
The Communications Team
Tel: 0113 85 55977
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 at
Web: www.leedsandyorkpft.nhs.uk
alternatively please contact
The Communications Team
Tel: 0113 85 55977
Email: communications.lypft@nhs.net