NHS
Leeds Community Healthcare
NHS Trust

Annual Report

and accounts

2018 | 2019

Inspected and rated
Good
Care Quality Commission

Contents

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Welcome

from our Chief Executive and Chair

We're delighted to share our annual report with you and we hope it will give you a flavour of our activities and finances in the previous financial year.

Our healthcare teams improve the lives of people in our local communities, often supporting the city's most vulnerable people and those with the most complex needs. This year has seen our teams going the extra mile, in often challenging circumstances, to deliver great care.

We are pleased to report that, once again, we have high levels of patient satisfaction and that we achieved our main performance and financial targets. Our colleagues should be proud of these achievements and you will see many examples of their hard work and commitment included in this report.

We know that an engaged and happy workforce is directly linked to the provision of good patient outcomes - this is one of the main reasons we have continued our commitment to supporting the health and wellbeing of our staff teams this year. We are particularly proud that our 2018 staff survey indicated a 9% increase (from 2017) in the amount of staff feeling recognised and valued at work and a 10% increase in staff feeling that senior managers try to involve staff in important decisions. We have been working hard to make sure that our leaders (both managerial and clinical) understand the value of involving people. Our results show we continue to improve year on year and that the confidence of colleagues to recommend LCH as both an employer and provider of services is growing.

To further enhance our support to staff this year we have started conversations about creating the best environment possible to support each other with our mental wellbeing. We have created open spaces for staff to talk about mental health and have committed to training 15 staff to become Mental Health First Aiders.

We pride ourselves too on being an organisation that promotes diversity and inclusion. We are delighted that our Black and Minority Ethic (BAME) reverse mentoring scheme has started here at LCH. This has seen BAME colleagues mentoring senior managers, providing an opportunity for our BAME staff to make connections and share their lived experiences first hand. This two-way approach echoes the values of our organisation - we always seek to treat everyone as an individual, whether this is patient or colleague, and partnerships such as this can only strengthen this resolve. Both of us were part of the first cohort, not least because we want this organisation to be one in which everyone is offered the opportunity to flourish and is encouraged to thrive.

Our services too are constantly growing and developing as we deliver new pathways of care for more people in the community. Quality Improvement is at the forefront of this work and we support staff to make continuous improvements to deliver care and services which are safer, more effective and more efficient. Quality Improvement (QI) programmes undertaken in the year are helping to improve both patient outcomes and staff experience.

With demand growing for services and a relentless focus on quality, it is important that we continue to work well with all partners across the city. We must work in this way, bringing our collective expertise together, if we are to provide the best possible care for all citizens of Leeds now and in the future. With this firmly in mind, we continue to build on our partnership work with the local authority and with other NHS and voluntary sector organisations, in order to reduce health inequalities and contribute fully to the health and social care agenda for this city. We also continue to work much more closely with our partners in primary care.

This work is already starting to reap benefits: improved communication between teams; less duplication of work; and providing seamless packages of care for some of the most vulnerable in our communities. Together we have also built our resilience across Leeds to respond to all year round pressures. Winter was a key example of this, across the city we were able to support people 24 hours a day, making sure patients received the care they needed in their own homes, or as close to their own home as possible. If a hospital stay was required, our teams played an important role in making sure people returned home safely, with a package of care in place as soon as possible.

We are extremely proud to be an 'anchor institute' for the city, working together with some of its biggest organisations to deliver better outcomes for people, drawing on the talents of our staff and benefitting people in all our communities.

Our achievements this year are very much the result of our outstanding colleagues both clinical and non-clinical. We must continue to celebrate and acknowledge their achievements and we hope that this annual report gives you a real sense of just how important the role of our teams are in supporting the health and social care needs of the people of Leeds.

We hope you enjoy reading our Annual Report and we look forward to another successful year in 2019/20.

Neil Franklin
Chair

Thea Stein
Chief Executive

Our vision

'We want to provide the best possible care to every community we serve.'

To do this, we make sure we live our values every day:

- **We are open and honest and do what we say we will**
- **We treat everyone as an individual**
- **We are continuously listening, learning and improving**

Quality priorities

To help us achieve our vision, we worked with patients, carers and members of the public throughout 2018/19 to develop our quality priorities. They told us that we could improve in the following four key areas:

Prevention, proactive care and self-management

Patient experience

New models of care

Our workforce

You can find out about how we are doing against our quality priorities in our Quality Account 2018/19. Visit: **www.leedscommunityhealthcare.nhs.uk**

Who we are and what we do

Leeds Community Healthcare NHS Trust (LCH) provides a range of community healthcare services to the people of Leeds. Care is always provided in, or as near to a person's home as is possible.

Our services are organised into three groups: Adult Services, Specialist Services, Children and Families.

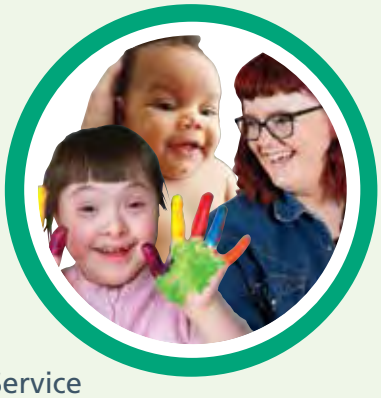
Adult Services

- 13 Neighbourhood Teams (NTs)
- Neighbourhood nights
- End of Life
- Health case management Leeds Integrated Discharge Service (LIDS)
- Community Care Beds and Community Bed Bureau
- Single Point of Urgent Referral (SPUR)
- Wound prevention and management
- Continence, Urology and Colorectal service
- Community Falls Service
- Community geriatricians

Specialist Services

- Improving Access to Psychological Therapies (IAPT)
- Podiatry (foot health)
- Musculoskeletal services
- Nutrition and dietetics
- Specialist dental services
- Prison health (Young Offenders Institute, Wetherby and Adel Beck Secure Children's Home)
- Healthcare services for police custody suites across Yorkshire and the Humber
- Community Intravenous Antibiotics Service (CIVAS)
- Tuberculosis (TB)
- Homeless Admissions Leeds Pathway (HALP)
- Neurology
- Stroke team
- Rehabilitation unit
- Speech and language therapy services
- Cardiac, respiratory and diabetes services
- Leeds sexual health
- Community gynaecology

Children and Families Services



Integrated Services for Children with Additional Needs (ICAN) including:

- Child Development Centres
- Paediatric neurodisability clinics and children's outpatient clinics
- Specialist child protection medical services
- Community Eye Service
- Audiology and newborn hearing
- Physiotherapy
- Occupational therapy
- Speech and language therapy
- Nutrition and dietetic services
- Daytime Wetting Service

Community Nursing Services:

- Continuing Care Nursing team
- Hannah House
- Inclusion nursing

Speech and Language Therapy including:

- Community service
- Feeding and swallowing
- Communication aids

Public Health Integrated Nursing Service (0-19):

- Health visiting
- School nursing
- Sickle Cell and Thalassaemia
- Watch-It weight management

Child and Adolescent Mental Health Services (CAMHS) including:

- Specialist Community Service
- In-patients service at Little Woodhouse Hall
- Infant mental health
- Criminal Justice Service
- Mindmate Single Point of Access (SPA)
- Eating disorders team
- Child and Adolescent Mental Health Services (CAMHS) in schools

For more detailed information about any of our services, please visit our website:
leedscommunityhealthcare.nhs.uk

Performance Report

How we're meeting our goals

Alongside our quality priorities, we've been working hard against four key goals for the people of Leeds this year.

Our four key goals:

1. **Provide high quality services**
2. **Recruit, develop and retain the staff we need now and for the future**
3. **Work with health and social care partners to deliver joined-up care close to home**
4. **Make sure services are fit for purpose now and in the future**

Goal 1

Provide high quality services

We deliver care to around 5,000 people every day. From April 2018 to March 2019 we delivered 1.5 million episodes of care to people across Leeds and (in some specialist cases) beyond. We always aim to provide high quality patient care.

During 2018-19 we asked ourselves, are services:

- **Safe**
- **Caring**
- **Responsive**
- **Effective** and
- **Well-led**

Safe

- No cases of infections such as MRSA or Clostridium Difficile were acquired by patients in our care.
- With the exception of one case, all incidents applicable for Duty of Candour were dealt with appropriately.
- We achieved more than a 50% reduction against the target for the number of avoidable category 3 pressure ulcers.
- During 2018-19 we have had two cases of avoidable category 4 pressure ulcers. We continue to focus on training in order to reduce this.

To help monitor the safety of our services, our Board uses key performance indicators (KPIs) and information gained from:

- Listening and talking to patients, carers and families
- Visiting services
- Meeting with staff as they deliver care

Saying Sorry (also known as Duty of Candour)

If a person suffers harm as a result of an error or omission in the care we deliver, we are committed to being open and honest. We will say:

- what happened
- what we are doing to put things right
- what actions we are taking to reduce the likelihood of a similar incident happening again
- we say 'Sorry'

Being Open

We have a 'Being Open with Patients' and 'Duty of Candour' policy and procedure. This is to make sure all staff understand their responsibilities. We deliver briefing sessions at service and team meetings and the 'Being Open with Patients' and 'Duty of Candour' policies feature in:

- the Trust's induction day for all new starters
- the serious incident investigators' training

Our compliance with Duty of Candour Regulations is monitored on a monthly basis by our Quality Committee.

Caring

Friends and Family Test (FFT)

Friends and Family Test
Have your say. Tell us what's working well… and what we could improve.

The Friends and Family Test (FFT) supports the principle that everyone who accesses NHS services should have the opportunity to provide feedback on their experience (NHS England).

The FFT question asks if people would recommend the NHS services they have used to their family and friends and offers a range of responses from Extremely Likely to Extremely Unlikely.

By the end of 2018/2019, the Friends and Family Test shows that more than 95% of our patients would recommend both our inpatient care and the care we deliver in the community.

You can find more detailed information about our FFT responses and how we collect and use this data in the Trust's Quality Account. Visit:
www.leedscommunityhealthcare.nhs.uk

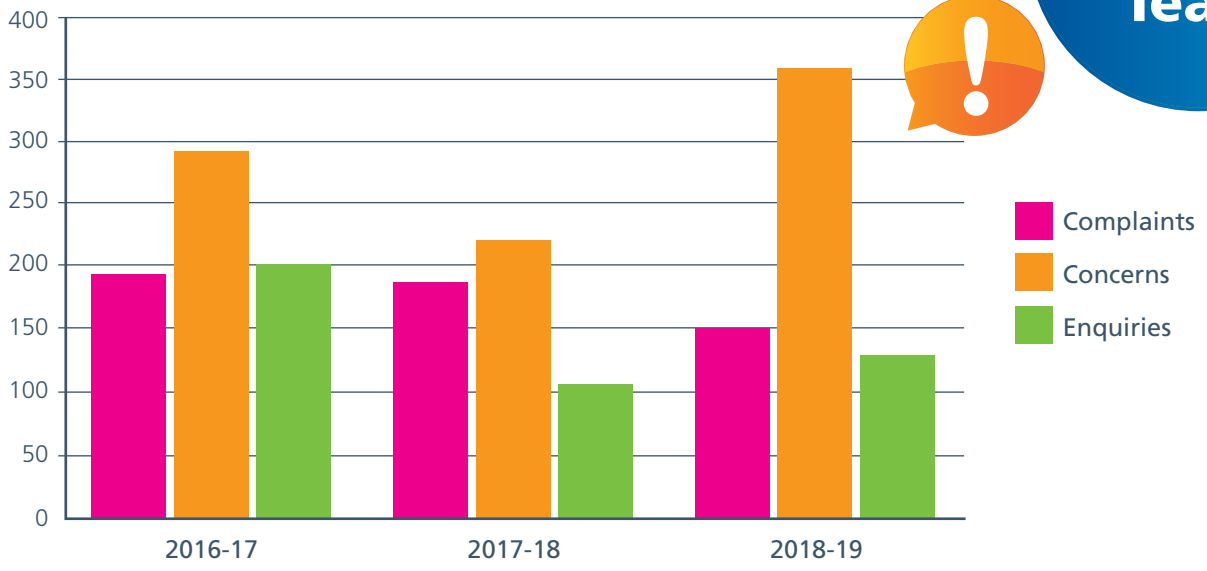
Learning from Patient Experience (queries, concerns and complaints)

We believe strongly in listening to our patients and really hearing what they have to say. This is even more important when something has gone wrong or when we are dealing with patients who have had a poor experience.

Our Patient Experience Team is here to help those who have a question or want to tell us something about our services. The team is also here as an alternative to approaching a service directly. The Patient Experience team works with all services in the Trust and with other health and social care partners in the city. They ensure a 'no wrong door policy', an approach agreed with *Healthwatch Leeds. This means that no matter which health or social care organisation in the city a person contacts in the first instance, the receiving organisation will pass the right information on. This is to make sure a person with a complaint, concern or question is not faced with having to tell their story to lots of different people.

During 2018/19 we received 152 complaints about the services we provide. During the year two people asked the Trust to re-open their complaints to look at issues again. Two referrals were made to the Parliamentary and Health Services Ombudsman but we have received no further contact from the Ombudsman. There were also 365 concerns received and a total of 126 enquiries recorded. We also received 1472 compliments.

Patient Experience feedback received 2016-2019



Of the complaints we received, we upheld either part, or all, of 43% of them. We answered more than half of the complaints we received within our target response time of 40 working days or less.

The table opposite shows the number of complaints, concerns and enquires received by the Patient Experience Team over the past three years.

More detailed information can be found in our Quality Account available on our website: **leedscommunityhealthcare.nhs.uk**

*Healthwatch Leeds helps local people get the best out of their local health and care services by bringing their voice to those who plan and deliver services in Leeds.

The top five themes for complaints in 2018/19 were:

1. Clinical judgement/treatment.
2. Appointment (for example, the waiting time, being unable to get an appointment or the failure or delay in a referral process).
3. Attitude, conduct, cultural and dignity issues.
4. Communications issues with the patient.
5. Access and availability (for example, availability of home visits, issues with the entrance to health centres or car parking facilities).

Responsive

- We meet all nationally reportable and internal targets for waiting times.
- At year end, the Trust was seeing more than 95% of patients on consultant-led pathways within 18 weeks.
- No patients have waited more than 52 weeks in our consultant led services.
- During 2018/2019, a joint proposal with NHS Leeds CCG was agreed to reduce the 'activity profile' within Adult Neighbourhood Teams. This has allowed our staff to spend much more time with patients when it is needed and has enhanced the quality of care.
- At the year-end all patients were waiting less than 6 weeks for diagnostic tests.
- More than 99% of patients were treated within 18 weeks of referral to Improving Access to Psychological Therapies (IAPT).

Effective

- We achieved the 80% target for clinical supervision throughout the year
- During 2018/19 **five (5)** national clinical audits and one (1) national confidential enquiry covered the NHS services that LCH provides. During that period LCH participated in **80%** of national clinical audits and **100%** of national confidential enquiries which it was eligible to participate in.
- The reports of **106** local clinical audits were completed by LCH in 2018-19
- In February 2018 we updated our NICE Guidance Policy and now allow ourselves two years to put in place complex care pathways with our patients.
- During 2018/19, services continued to review NICE guidance as it was published, and put in place changes to care pathways as required. Of the 38 pieces of guidance issued by NICE during 2016/17, we were able to fully put in place all relevant recommendations for 35 (92%) within our two year timeframe. This means that patients and their families were able to receive evidence-based care and treatment.
- Learning is shared at our strategic mortality surveillance group. It is also shared within business units and more widely across the whole organisation if required.

Well-led

We have continued to identify challenges and make progress in meeting them. Our performance assessment shows that:

- We are making good progress in reducing our staff turnover rate, which continues to be below the Trust's target of 15%, and remains below other benchmark community provider trusts. Our overall stability index meets our target of 85.5%
- We recognise the importance of annual appraisal for all staff and have consistently had overall monthly Trust appraisal rates above 80% across the year, but we are missing the target of 95%
- Our total sickness absence rate across the year has varied seasonally, as we would expect, with year-end position below the Trust target of 5.8%
- Our statutory and mandatory training percentage has consistently been at, or above, 90% across the year and we continue to look for new ways to support staff accessing and completing this important requirement.
- We continue to work hard to meet all requirements of the Equality Act 2010 Public Sector Equality duties.
- We currently hold an overall NHS Equality Delivery System2 (EDS2) grading of 'achieving' and have made progress in two agreed equality objectives:
  - Disability Confident Leaders accreditation
  - Workforce Disability Equality Standards (WDES)
- We continue to work with the local authority, other NHS and voluntary organisations in Leeds to reduce health inequalities.

Goal 2

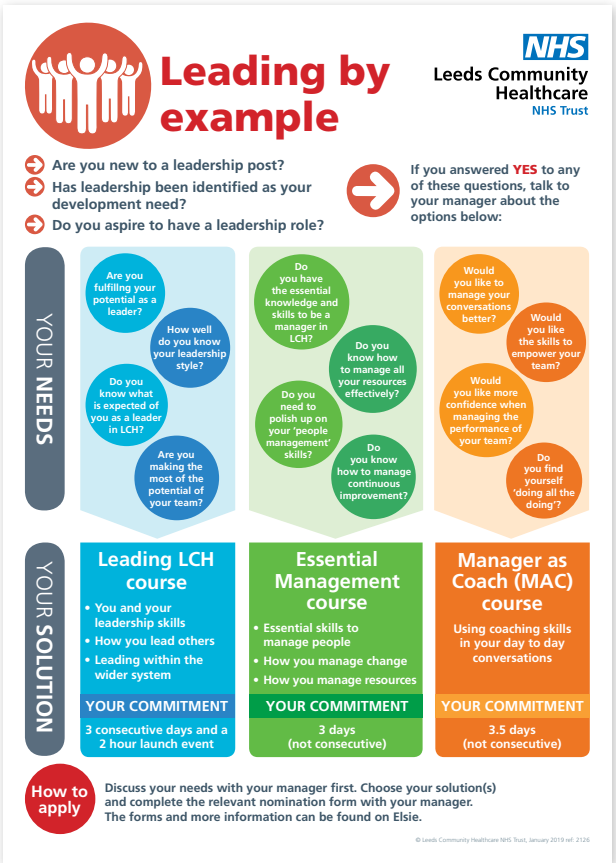
Recruit, develop and retain the staff we need now and for the future

We want to make sure that our Trust is able to deliver the best possible care in all our communities. In order to do this we need a workforce that can adapt and respond to current and future requirements, challenges and opportunities, both inside and outside of the organisation.

With this firmly in mind, a Workforce Strategy has been developed which sets out our key workforce priorities.

Our workforce priorities are:

- **Leadership and skills:** We will support the development of our leaders to make sure that every individual experiences good or excellent leadership and has access to the right level of training and development, regardless of where in the organisation they work. One example is our new leadership development offer:



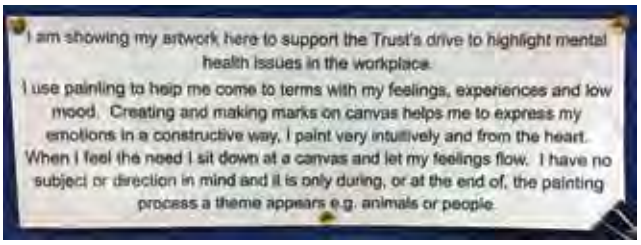
- **Resourcing:** We will recruit the right people with the right skills and deploy them to deliver the best possible care in all our communities now and in the future. Once we have attracted the best staff, we want to keep them engaged and motivated to remain with us and we have a range of initiatives in place to support this.
- **Integration and partnership:** We continue to work effectively with primary care, the city of Leeds and the Integrated Care System (ICS) in our area on workforce and human resources (HR) strategies, systems and plans. We're doing this to deliver benefits to our patients and communities. We're working with our health and care partners to promote career opportunities available across the city and we have trained ambassadors who continue our efforts to attract a future workforce.
- **Proactive analytics:** Our workforce systems have been improved with a newly-created Systems and Intelligence function. This delivers sophisticated workforce data and analytics to help us make the right business decisions. Our new e-rostering solution is also making sure we have the right staff, in the right place at the right time.

- **Wellbeing:** We place equal importance on mental health and wellbeing and physical health and wellbeing. Our Health and Wellbeing Group drives this work forward.

  Some examples include:

  - Open conversations with staff about their mental health.
  - Training for staff to become Mental Health First Aiders.
  - Regular displays at Trust HQ of artwork produced by a colleague who uses painting to help with her mental wellbeing.
  - Wellbeing in the Workplace workshops.

  Regardless of service area or geographical location, our workforce is more likely to be well at work and more engaged with work than in 2017-18.



Staff with their pledges at the Race for Equality event

- **Diversity and inclusion:** In line with the Trust values we want to make sure that every colleague is treated as an individual. One example of how we're doing this is through our newly established Reverse Mentoring Scheme. The scheme sees a black, Asian or minority ethnic (BAME) staff member act as a mentor to a Board member not from a BAME background. The aim is to begin new conversations about issues affecting BAME staff in the workplace.

  In March the Trust held a 'Race for Equality' event at Elland Road in Leeds which welcomed more than 100 delegates. The aim was to increase leaders' and managers' understanding of the Workforce Race Equality Standard and to increase awareness of the issues facing BAME colleagues.

LCH BAME Staff Network

#Raceforequality

Thea with her mentor Temba

NHS National Staff Survey 2018

Every year we take part in the NHS National Staff Survey. This year more than half our staff (52%) completed the survey. This compares well with the national average of 43%. In this year's survey, which is a year on year comparison, 46 of the 66 questions had positive changes from 2017:

Some areas for development:

- Staff ability to make suggestions to improve their working environment
- Continue to explore opportunities for career development
- Continue to work on team development to ensure people feel supported within their teams and by their teams.

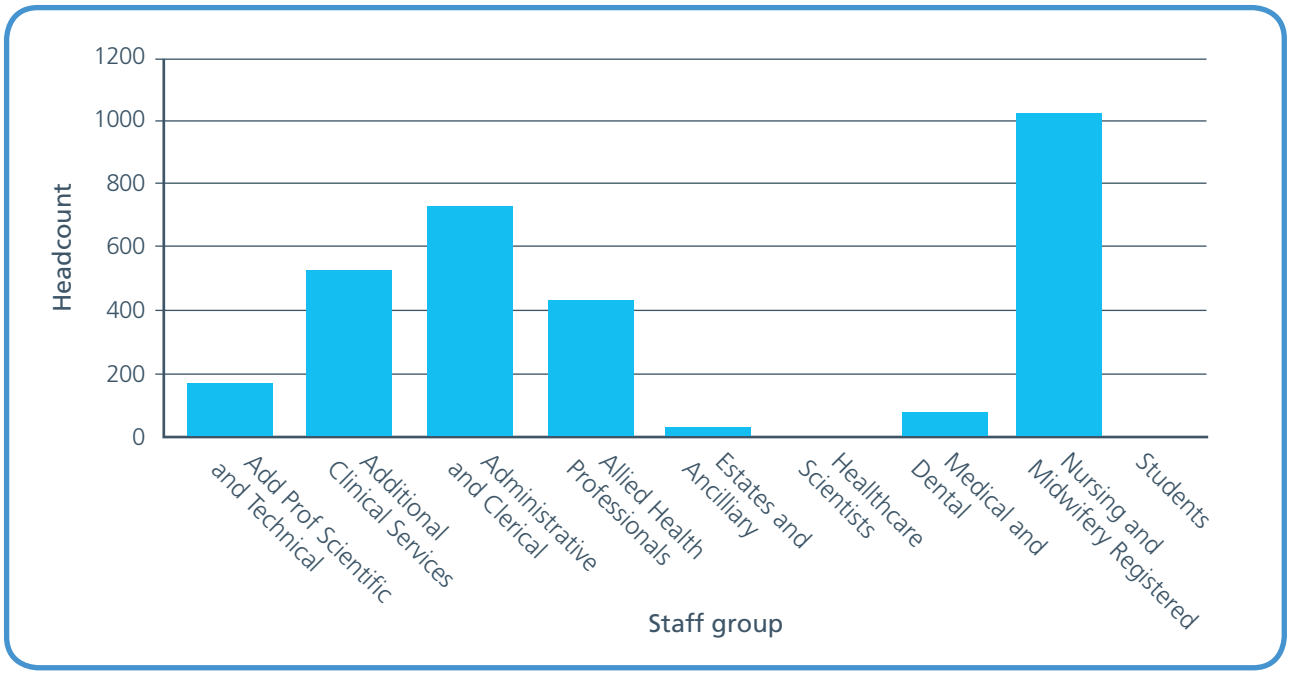
Staff flu campaign

Led by Infection Prevention and Control (IPC) Nurse, Jeanette Wood, with support from the IPC team, our 2018 flu immunisation campaign was endorsed by the Trust's now famous flu mascots 'Flo' and 'Frankie'- who helped vaccinate 75% of colleagues. This season, due to the mild weather, we saw lower levels of flu generally circulating through Leeds. But we know that flu is still a huge risk to the people we serve.

Opposite: Flo and Frankie celebrating the 2018 seasonal staff flu campaign with LCH staff

Workforce profile

Our workforce is organised into the following staff groups.



Speaking Up

Every NHS Trust has a Freedom to Speak Up Guardian (FSUG). The role was developed nationally, in response to the needs set out by Sir Robert Francis in his Freedom to Speak Up review. The aim is to promote a more open and supportive culture that encourages NHS colleagues to speak up about any issues of patient care, quality or safety.

Our current FSUG regularly attends Trust Board meetings, for the Board to check they are adequately supported in their role.

Our current Freedom to Speak Up Guardian is John Walsh.

Alongside our Freedom to Speak Up Guardian, the Trust has a number of ways for colleagues to tell us about their experiences. These include; direct line managers, Ask Thea (anonymous email to the Chief Executive), Human Resources (HR) team, Staffside team, direct access to directors, board member visits to services and Anti Bullying Officers.


NHS
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NHS Trust

Freedom to Speak Up Guardian

I'm John Walsh and I'm your Freedom to Speak Up Guardian.

I'm independent and completely impartial: my role is to support you in raising your concerns about patient care and patient safety. And, just as importantly, I'm also here to listen to your concerns about cultures and behaviours at work. I can help you to approach your manager, HR, staffside and Board members to get your voice heard.

If you have something you'd like to talk through with me, please get in touch and I'll work with you in person or by phone or email to find solutions.

You can call me on 07949 102 354 or email me at: lch.freedomtospeakup@nhs.net

Speaking up – it's a practice not a position

www.leedscommunityhealthcare.nhs.uk

We're proud of… …our innovative approach to recruitment - we showcased the work of our neighbourhood teams to potential new recruits on a fun and informative bus tour. Our approach was recognised by NHS Employers.

We're proud of… …our place in the Inclusive Top 50 employers list.

INCLUSIVE TOP50 UK EMPLOYERS

We're proud of… …our Communications Team who won a *national industry award, in the Best Event category. The acknowledgement was for the Trust's staff recognition schemes 'Thanks a Bunch' and 'Thank You Event'.

The Thank You Event 2018

thanks a bunch!

*Communicate magazine's Internal Communications & Engagement Awards

We're proud of… …our approach to upskilling our workforce. We're using our apprentice levy and we've introduced a new Nursing Associate role to our workforce.

Robyn Scargill, Nursing Associate working in the Community Neurological Rehabilitation Unit (CNRU), said: "I wanted to progress in the nursing profession but had a mortgage as well. This opportunity was the perfect stepping stone to be able to stay in work, earn a wage and be able to further my career."

We're proud of… …our organisation's work to lead the national development of a district nursing apprenticeship.

Go Further with an **Apprenticeship**

Goal 3

Work with health and social care partners to deliver joined up care close to home

Our care is organised into three service areas:

Children and Families

Adult

Specialist

Here's how we've been working to achieve Goal 3 across our different services.

Children and Families

Our vision is to work with children, young people and their families and with other colleagues across the Trust and the city (for example, teachers and commissioners) to make Leeds the best city for children to grow up in.

Our children's and families strategy, which sets out our commitment to this vision, was launched in May 2018. Some of the developments we're making to help us achieve this vision are highlighted below.

Children and young people service developments for 2018/19 include:

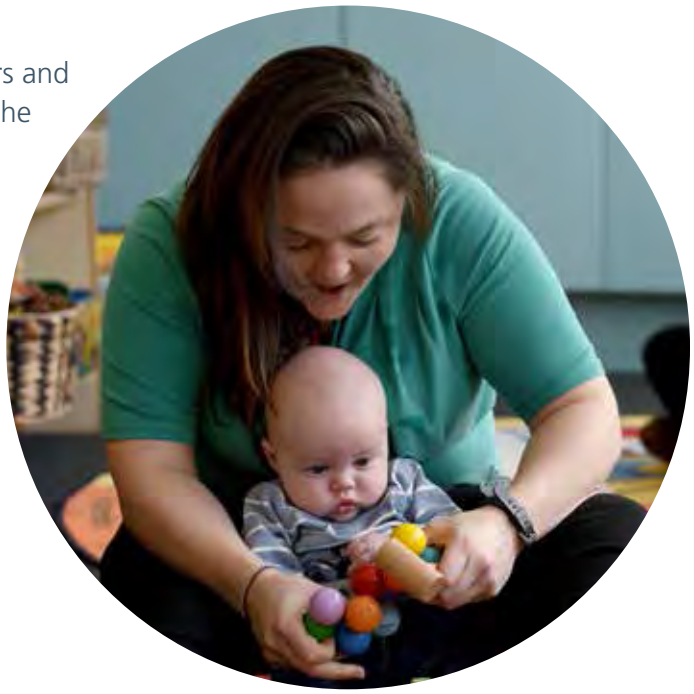
Child Health Hubs

Across all areas of Leeds, we've been looking at how we can work in a better way with primary care (you might know this as your family doctor or GP) to meet the needs of children, young people and families.

Since April 2018, we've been working with commissioners and GP colleagues on three pilot Child Health Hubs based in the community:

- Pudsey (focus on complex care)
- Harehills (focus on 0-19 and safeguarding)
- Beeston and Middleton (focus on young people's mental health)

The aim is to deliver better outcomes and reduce demand on services on the children's services that are provided in a hospital setting.



Changes to our 0-19 Healthy Child Pathway/Early Start Service

In November 2018, we were successful in winning the tender to deliver a refreshed and more innovative service for children and young people aged 0-19 years (or up to the age of 25 for those with additional needs).

Commissioned by Leeds City Council the 0-19 Public Health Integrated Nursing Service went live on 1 April 2019. A result of extensive consultation with over 800 children, young people, parents/carers and professionals, the refreshed service will be better for children and families in the following innovative ways:

- **One Team Approach** - brings together into six citywide teams Health Visitors, School Nurses, Nursery Nurses and Healthcare Support Workers. This will make sure that families see the right practitioner, at the right time, in the right place. It will provide the opportunity for families to continue to work with the same health practitioner over a longer period of time.
- **Located in Children's Centres in the community** - we are working towards bringing together the 0-19 Public Health Integrated Nursing Team within Children's Centres as part of Early Start Teams. This is an ambitious goal and will be achieved in a phased approach, the first step towards this will be each of the six teams re-locating to health centres in the local community.
- **ChatHealth for children and young people (11-19)** – a confidential text messaging service for children and young people in Leeds to send questions to a School Nurse. They will receive a reply that may include some brief advice, an offer of direct support from the service or signposting to other services.

ChatHealth

- **Flexible and accessible service** – increased flexibility and accessibility to the service. Clinical staff will be available 8.00am – 8.00pm on weekdays. Elements of the service will be delivered within these extended hours to better meet the needs of families.

You can view our **0-19 video** that explains the service on our website: **leedscommunityhealthcare.nhs.uk**

Gold Award for our Specialist Public Health Nurses (Health Visitors)

In October 2018, our 0-19 team was amongst a very small number of services to be awarded the UNICEF Baby Friendly Initiative Gold Award. The award is designed to provide parents with the best possible care to build close and loving relationships with their baby and to feed their baby in ways which will support their best health and development.

New care model for Child and Adolescent Mental Health Services (CAMHS)

2018/19 was the first full year of our pilot new care model for Child and Adolescent Mental Health Services. The main aim of the pilot is to reduce the number of unnecessary admissions for West Yorkshire children and young people to in-patient beds. Where an in-patient stay is necessary we aim to achieve this much closer to home in a modern, fit for purpose space. We have had good success in reducing in-patient days and have started to reinvest the money saved into community services to better support children and young people across West Yorkshire where they live. Together with the development of a new CAMHS unit which will be built in Leeds, there will have been a real transformation in CAMHS across West Yorkshire.

Speech and Language Therapy – Better Booking

In April 2018, we piloted a centralised appointments booking system to help drive down waiting times and improve how clinical time was used. Clinicians released control of their electronic diaries to our admin team to plan and book clinic or school appointments directly from waiting lists. This great partnership working has seen waiting times reduced from above 18 weeks (with some outlying long waits of 42 weeks) to an average wait time of between 9 and 13 weeks. Centralised booking is now being rolled out across other teams.

A Smoother Journey into Adulthood; Transitions Conference

In October 2018, we hosted a conference '*A Smoother Journey into Adulthood*', aimed at helping delegates gain a better understanding of:

- Children's and adult health services
- Empowering young people to become adults of the future - able to access adult health services and support effectively

The conference was well attended by partner organisations in Leeds as well as by colleagues from across our service areas.

Improving engagement with children and young people

In the last year, we have been busy developing a young people's forum which will begin meeting soon.

Young people have also been involved in reviewing our training session for young volunteers who take part in our recruitment panels. This is to make sure that training is appropriate and that it helps to prepare young people wishing to take part.

Progress towards a new CAMHS in-patient unit

Since the announcement that new mental health unit would be built in Leeds, to serve the children and young people of West Yorkshire, we've been busy asking young people staff and local people what they would like to see in the design of the building and services. The purpose built facility will be located in the grounds of St Mary's Hospital in Armley.

Artist's impression

We're proud of…

…Rebecca Fellows, Assistant Psychologist, from our Infant Mental Health Team. Her passion for service user participation saw her take the lead in organising a hugely successful conference for practitioners to look at the importance of supporting dads to be involved in the lives of their young children.

We're proud of…

…The Children's Community Nursing Team. They deliver an emotionally and physically demanding service, helping children and families lead lives that are as normal as possible by providing care, including dressings, wound care and chemotherapy for the children of Leeds in their own homes.

We're proud of…

…Lorraine Ingram, Health Visitor in the Infant Mental Health Team and all other staff involved in the Early Attachment Observation (EAO) assessment tool project. This ground-breaking area of practice has introduced a structured way for health visitors to talk to parents about how their baby is experiencing the world and their relationship with their parent. The project has become an important part of our universal offer which sees every child in Leeds have access to five key visits from our expert team between the age of 0 and 5.

Adult Services

Within our Neighbourhood Teams we continue our work to bring together adult services to provide multi-disciplinary, nursing and therapy care for frail and elderly people and those with long term conditions.

This work has been guided by feedback that the people of Leeds. Patients, carers and our staff told us that they want:

We have worked in partnership with primary care, adult social care, mental health and hospital providers to jointly understand local needs and improve our joined up response for people in Leeds.

> "Support that is about me, my life, where services work closer together by sharing trusted information and focusing on prevention to speed up responses, reduce confusion and promote dignity, choice and respect."

Neighbourhood Team bases

West 1

9 **Armley**
Armley Moor Health Centre

10 **Pudsey**
Pudsey Health Centre

West 2

11 **Holt Park**
Horsforth Clinic

12 **Woodsley**
Woodsley Health Centre

13 **Yeadon**
Yeadon Community Health Centre

North 1

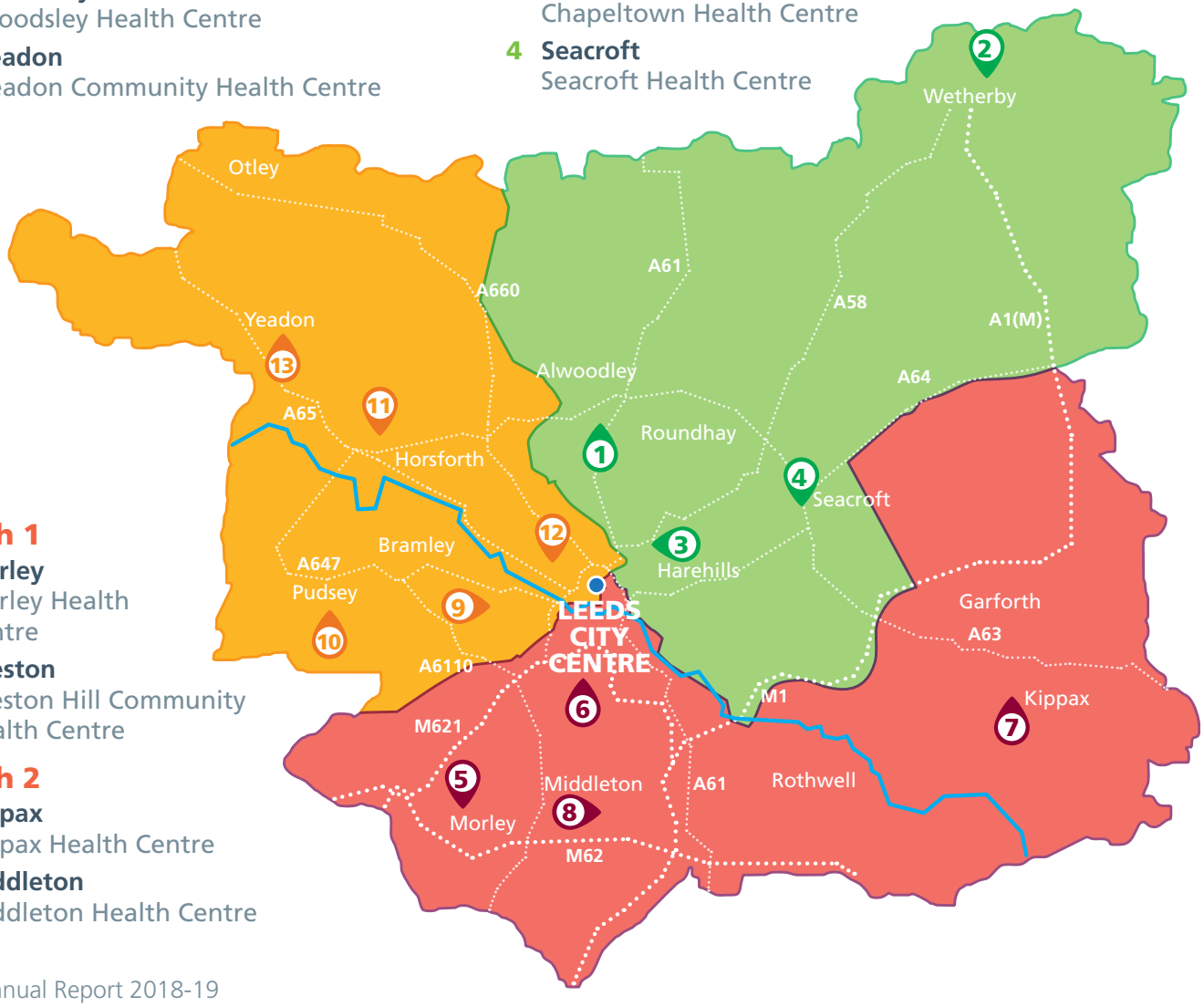
1 **Meanwood**
Meanwood Health Centre

2 **Wetherby**
Wetherby Health Centre

North 2

3 **Chapeltown**
Chapeltown Health Centre

4 **Seacroft**
Seacroft Health Centre



South 1

5 **Morley**
Morley Health Centre

6 **Beeston**
Beeston Hill Community Health Centre

South 2

7 **Kippax**
Kippax Health Centre

8 **Middleton**
Middleton Health Centre

How a Neighbourhood Team works:

- Our Neighbourhood Teams provide 24 hours a day care, 365 days a year.
- Team members who were previously district nurses, intermediate care nurses, community matrons and adult domiciliary physiotherapists work together as one team across 13 neighbourhoods.
- We work together with colleagues from adult social care to provide seamless care.
- We have 13 Neighbourhood Teams across the city. These are based around GP registered practices.
- Each team works in caseload clusters which cover one or more practices within an area. This is to make sure care is consistent and that we work with other health and care professionals to deliver proactive, joined-up care to people and their families.
- Teams really get to know their community and are able to respond in a timely way.

We also provide support through a range of teams who work alongside our Neighbourhood Teams.

These teams are:

- **Health Case Management:** specialist city-wide case management for people aged 18 years and over who are eligible for NHS Fast Track and Continuing Healthcare funding.
- **Leeds Integrated Discharge Service:** supports people who need extra help to plan for leaving hospital. We work with; Leeds Teaching Hospitals Trust, adult social care and Age UK.
- **City-wide services:** support for continence, wound prevention and management, falls and end of life.
- **Nursing and Therapy:** We offer this for some patients in our Community Care Beds
- **City-wide Bed Bureau:** matches people requiring community bed provision with available beds.
- **Single Point of Urgent Referral (SPUR):** manages patient referrals from community and hospital settings into a range of community services.

Adult Services developments for 2018/19 include:

Dementia, delirium and depression guidance

Neighbourhood Team colleagues have been provided with a Clinical Care Framework (best practice guidance) for dementia, delirium and depression (the 3Ds).

Safety Huddles

We have introduced safety huddles in Neighbourhood Teams and Community Care Beds services. These are the first safety huddles in NHS community settings to be recognised nationally by the NHS Improvement Academy. A safety huddle is a short multi-disciplinary briefing, held at the same time and place, and focused on the patients most at risk. Effective safety huddles involve agreed actions, are informed by visual feedback of data and provide the opportunity to celebrate success in reducing harm.

Local Care Partnerships

This is where health and care services come together to understand and jointly respond to people's needs. We are working more closely with colleagues in primary care (family doctors, GPs), third sector, social care and other local partners to put in place Local Care Partnerships. This includes working together on 'Population Health Management Programme' approaches as one of four national pilot sites.

Other ways we are working more closely with primary care and/ or third sector partners include the development of leg clubs, wound care hubs and a pilot project which sees our occupational therapists being based in GP practices.

Self-management/self care

We know that people have a key role in protecting their own health, choosing appropriate treatments and managing long-term conditions. Self-management or self-care is a term used to include all the actions taken by people to recognise, treat and manage their own health. They may do this independently or in partnership with services provided by health and social care services.

We have developed our approach to self-management or self-care with a focus on 'working with' people rather than 'doing to' people.

We're proud of…

…Fiona Allport, Clinical Pathway Lead for Self-Management and Rehabilitation and Marie Boul, Self-Management Team Lead, for their self-management project. This has had great outcomes for patients in our Neighbourhood Teams, improving patient independence and allowing more time for teams to focus on patients unable to self-manage.

We're proud of…

……Claire Morris, Neighbourhood Team Administrator. Claire often goes above and beyond in her role to support palliative patients' last wishes.

We're proud of…

…Stewart Miller, Neighbourhood Clinical Trainer. His days are spent out and about in our 13 Neighbourhood Teams, upskilling frontline clinicians in areas where training and development is needed.

We're proud of…

…Michelle Platt, District Nurse, for her outstanding end of life care and the support she provides to some of our most vulnerable patients and their families.

Specialist Services

It has been another busy year for Specialist Services. Our ambition at the start of the year was to:

- Maintain and improve
- Grow and develop
- Gain new business where appropriate

Here are just some of the ways we have done this throughout 2018/19.

Maintain and improve:

- **Providing the best possible care outside of a hospital setting:** we have continued our work with key partners within the West Yorkshire and Harrogate Health and Care Partnership and within Leeds. Our aim is to make sure that admissions to hospital are reduced and that discharges out of hospital are managed quickly and well, with appropriate packages of care wrapped around the patient.

- **Dental Service:** we were awarded a contract which came into effect from November 2018. Commissioners are working closely with service providers across the region to develop a new regional service model and set regional standards. We will be supported to develop and deliver the new service throughout 2019.

- **Police Custody:** in January 2018 we were awarded a new, regional four-year contract - with a possible further extension - to provide custodial care across Yorkshire and the Humber. This builds on the success of our previous contract and includes more investment in staffing and the introduction of a new resilience team. The new contract started in April 2018 following a major, and highly successful, recruitment drive.

- **Improving Access to Psychological Therapies (IAPT):** this service is subject to an upcoming tender process. Our IAPT team has been working hard over the last six months to develop a joint bid with Leeds and York Partnership Foundation Trust, third sector organisations and the GP Confederation and we are awaiting the outcome. We will continue to improve access for patients, between now and the award of the new contract, with the introduction of more staff and new investment in the service.

Grow and develop:

A number of services have had significant investment over the past year:

- **Stroke Service:** working closely with Leeds Teaching Hospitals Trust we have refreshed the way the service is delivered. This sees patients discharged earlier from hospital to receive rehabilitation at home.

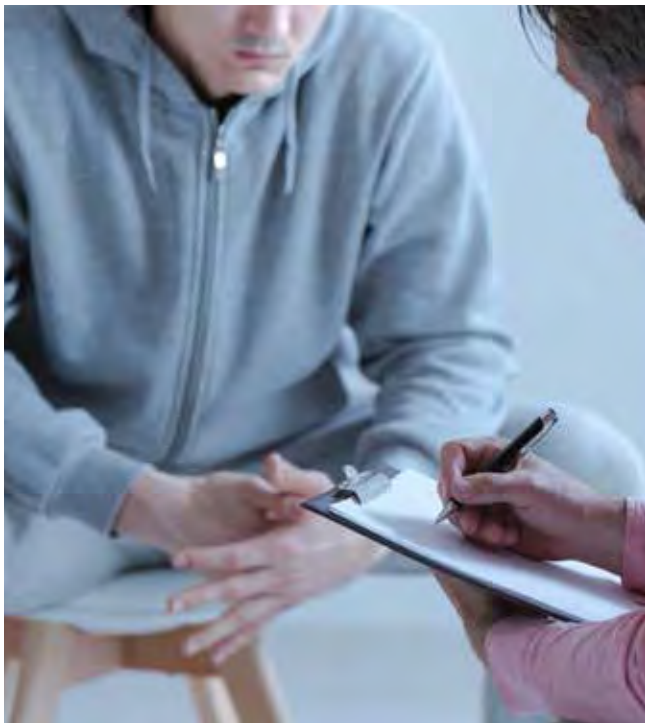
- **First Contact Physio:** we have started working with Primary Care (you may know this as your family doctor or GP) to put in place this pilot service. The service allows patients direct access to a physio appointment at their surgery without the need for a GP appointment first. In 2018 the service has been working in the LS8/9 and LS25/26 postcodes. The ambition is to achieve a citywide service offer in the next 2 years.

- **The Leeds Programme:** a tailor-made structured education programme for people with Type 2 Diabetes. Further investment was also targeted to our podiatry team (foot health) to introduce a Foot Protection Service for people living with diabetes.

- **Diabetes Service:** we are actively involved in work to develop the Diabetes Strategy for the city. Talks are underway with a wide range of stakeholders to plan for the introduction of a single point of access which will be introduced in 2019.

- **Virtual Ward:** the aim of the Virtual Ward is to promote and support an early discharge for medically fit patients who wish to return home rather than remain in hospital. Care needs are met at home by community nurses and therapists which often enhances the rate of recovery. In addition, hospital beds are released for the use of patients with acute healthcare needs. We introduced this service for people experiencing the serious effects of Chronic Obstructive Pulmonary Disorder (COPD) in Seacroft and Chapeltown and later extended to Armley and Middleton. Additional funding will be available for 2019/20 to extend the service across the city.

- **Secure Stairs:** is part of a national framework that looks at the needs of some very vulnerable children and young people whose particular mental healthcare requirements can be hard to meet through conventional services. Secure Stairs sets out a psychologically informed therapeutic approach for children and young people in secure settings. It looks, in a joined-up way, at assessment, sentence/intervention planning and care and makes sure that teams have the right skills to support these often high risk, high harm, high vulnerability children and young people. This approach was put in in place at Adel Beck Secure Children's Home in 2018/19 and will be introduced to Wetherby Young Offenders Institute in 2019.



Gain new business where appropriate:

We were successful in being awarded two new contracts from April 2019:

- **Liaison and Diversion Service:** this will operate in the Hull and Humber region, closely aligned to Hull and Humber Police Custody. The service will work with people to reduce re-offending and support their health and wellbeing.
- **Tier 3 Weight Management Service:** will fill a current gap in service for people needing/awaiting bariatric surgery. We will be the lead provider and work alongside partners at Leeds Teaching Hospitals Trust (LTHT).

Specialist Service Developments for 2018/19 also include:

A number of services have been working closely with Leeds Teaching Hospitals NHS Trust (LTHT) to deliver 'joined up' healthcare for patients who are between hospital and community care. The services involved include:

- Community Intravenous Antibiotics (CIVAS)
- Community Neurology Team
- Parkinson's Disease
- Long Term Conditions
- Community Gynaecology

To do this, we've improved the way we work together to deliver services in the best way possible for patients, for example we:

- Provide joint training and development
- Have integrated our nursing service for people with Parkinson's disease to make sure there is equal access for patients across Leeds (begins 1 April 2019)
- Introduced a single point of access and triage in Community Gynaecology to reduce duplication, improve access to appointments and reduce the number of appointments for patients

We're proud of… …Liz Keat, Outreach Nurse Gypsy/Traveller community. Liz received the Queen's Nurse Award for her work to support the Gypsy and Traveller community living in Leeds.

We're proud of… …Leeds Sexual Health Service. The team made significant improvements in response to patient feedback. This included changing clinic times to better meet patient need and developing its staff training and development.

We're proud of… …Mark Simpson and the Dietetics service who won a national award for the development of their e-referral system.

We're proud of…

…Dr Christine Comer, awarded a clinical lectureship in the field of Spinal Stenosis. Christine will focus on expanding Allied Health Professional-led clinical research, and be looking at how we put in place a long term plan for improving community based musculoskeletal care (the care of muscles and bones) across Leeds.

We're proud of…

…Alex Hammond, Business Development Manager. Alex stepped up to lead a project at a time of strained capacity, developing a large, strategic piece of work within very tight timescales.

We're proud of…

…Lee Maloney, Clinical Advisor (Informatics). Working in partnership, Lee overhauled an important Police Custody clinical system - a huge project that has improved the way we work.

We're proud of…

…Post-Traumatic Stress Disorder (PTSD) team. They made improvements in childhood trauma patient care; including introducing PTSD champions across a number of services.

We're proud of…

…Gail Fort, Podiatry Service Manager. With over 30 years' experience of working in community care, Gail is a passionate, committed and enthusiastic service manager who looks after a happy, fulfilled workforce.

Goal 4

Services are fit for purpose now and in the future

To make sure our services are fit for purpose we aim to make sure we are:

- Working in partnership
- Involving people in our plans
- Meeting our legal obligations
- Providing value for money

Working in partnership

The NHS isn't a single service; it's a collection of separate organisations providing all the health care that people need to keep them as well as possible from the birth until the end of life.

In the past, separate organisations haven't worked together as well as they could have done and that hasn't helped our patients. Now there's a real determination to work together in partnership so that we can offer the people of Leeds, West Yorkshire and, in some specialist cases, beyond the care that meets their needs.

We share, we learn from each other and we make sure that we are providing the services people need in places they can easily get to. It's complicated, and things don't always happen as quickly as we'd like, but there is a genuine will to make the NHS the best it can be and to spend the money that's available as wisely as we can.

We're a proud partner to the following organisations:

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) brings together all health and care organisations in six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield to meet the needs of people as close to home as possible.

You can find out more at:
www.wyhpartnership.co.uk

Leeds Academic Health Partnership (LAHP)

Leeds Academic Health PARTNERSHIP

As a founding partner in what is one of the biggest partnerships of its kind in the UK, we work with other LAHP partners to bring together research, evidence and experts to secure a healthy future for Leeds.

Other LAHP partners are three of the universities in Leeds, the city's NHS trusts, NHS Leeds Clinical Commissioning Group and the City Council. Its wider membership includes the Yorkshire and Humber Academic Health Science Network, Yorkshire Cancer Research, St Gemma's Hospice and Leeds City College.

You can find out more at:
www.leedsacademichealthpartnership.org

GP Confederation

LEEDS GP CONFEDERATION

The Leeds GP Confederation was established in March 2018. Its purpose is to improve the quality and sustainability of General Practice whilst developing integrated models of care for the populations it serves: www.leedsgpconfederation.org.uk

Our other NHS partners in Leeds are:

- NHS Leeds Clinical Commissioning Group: www.leedsccg.nhs.uk
- Leeds Teaching Hospitals NHS Trust: www.leedsth.nhs.uk
- Leeds and York Partnership NHS Foundation Trust: www.leedsandyorkpft.nhs.uk

But the NHS only makes up part of the health and social care jigsaw. Services and support are offered by charity and voluntary groups, which the NHS refers to as 'the third sector'. Sometimes these are 'commissioned' – which means there is a contract which sets out the quality and quantity of services to be provided and the amount paid for them; sometimes they are provided on a voluntary basis and no money changes hands.

Local councils also have responsibility for public health and for providing social care – this means care that isn't considered to be nursing. You can find out more about Leeds City Council's health and social care here: www.leeds.gov.uk/residents/health-and-social-care

Involving people in our plans

To make sure that we provide the best possible care to every community in Leeds and, in some specialist cases, beyond, we continually review what's working well, what isn't and where we can make improvements.

As a result we sometimes propose changes to our services. This can include anything from changing the time of a clinic and extending surgery times, to asking people to attend appointments at a different health centre. Gaining feedback on our plans from patients, carers, partners, the public and staff is essential if we are to get things right and make the right decisions.

Here is one of the ways we have involved and engaged patients, carers and the public in our work this year:

New child mental health unit

It is very important to the Trust that the voice of young people, families, staff and the local community has a strong presence in the development of the new CAMHS in-patient unit to be built in Leeds and we will continue to work together to make sure we get it right.

So far, we have held two engagement sessions with young people and one session with parents and carers. The sessions have helped us to understand what is important to people in the design of the new building and how we can improve both patient and visiting experience at the new unit. We have also asked for feedback on plans developed so far.

We have also held a drop-in information session for members of the public to view and comment on initial plans. Our staff, construction and design representatives were all on hand to answer any questions about the unit.

We will continue to involve young people, their families and carers, member of the public, staff and our partners throughout the project.

Artist's impression

Meeting our legal obligations

We recognise the legal obligations we have as a provider of NHS funded healthcare. We take care to uphold these responsibilities in order to work as efficiently as possible with our partners and within our local community.

Here are some examples of how we do this:

Emergency preparedness and resilience

We continue to fulfil our requirements set out in the Civil Contingencies Act 2004. The requirements make sure that we are able to respond in the best way possible to any form of disruption to normal service or a major incident. This includes:

- **Major Incident Plan:** regularly updated to ensure it is fit for purpose.
- **Management on call:** a dedicated and trained on-call team who lead our response to a significant event (This Major Incident Plan and the on-call team are regularly tested through desk-top, situation-based training sessions and communications tests).
- **Emergency Team:** members take part in regular multi-agency exercises and events to strengthen and reinforce our ability to contribute as part of a wider multi-agency response to a major incident.
- **Business continuity plans:** are in place to protect against the impact of a wide range of emergency situations which may affect normal service delivery.
- **Operational Pressures Escalation Levels (OPEL) plans:** these plans have been introduced to detail the triggers which would prompt escalation (inside our organisation and across the local health economy) and the actions required to mitigate and manage an incident. These plans have been developed with, and are aligned to, the OPEL plans of our partner organisations.
- **Local, regional and national exercises:** we work closely with partners in key areas to make sure our plans work well within the wider health economy.
- **Local Health Resilience Partnership:** as an active member we take part in a number of associated forums and groups along with more local planning-based task groups.
- **Emergency planning functions:** full plans are put in place to deal with national issues that may affect service delivery. Most recently, planning has involved national issues relating to clinical waste and Brexit.

Health and Safety

We are committed to maintaining an environment where the health and safety of staff, patients, visitors, contractors and the public is assured. This is in line with Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999).

Health and Safety in our Trust is overseen by a Health and Safety Group. The group meets every three months and is chaired by the Executive Director of Finance and Resources. The group's membership includes staff-side representatives.

Our Trust Board has approved a Health and Safety Policy, which works alongside our corporate governance processes.

The following people work together to make sure we meet safety standards:

- Health and Safety Officer
- Risk Manager
- Security Officer
- Infection Prevention and Control Team
- Estates Team

The team does this by completing a programme of inspections and assessments of all the buildings we own or occupy and by providing suitable training, advice and support to staff.

Health and safety data, in particular Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) reports following serious incidents, show a declining number of serious health and safety incidents occurring and reported to the Health and Safety Executive (HSE) in 2018/19.

There were five events that met the criteria for reporting to the HSE under RIDDOR Regulations.

In 2018/19, the HSE did not issue our Trust with any statutory enforcement notices. A statutory enforcement notice would see an employer having to take immediate action to improve health and safety risks for its employees.

Fraud

We have a zero tolerance to fraud and we work hard to prevent, deter, detect and investigate it. Our counter fraud work is undertaken by a counter fraud specialist from our Internal Audit team and is overseen by the Executive Director of Finance and Resources. Our counter fraud work complies with the NHS Standards for Providers of NHS services.

Modern Slavery Act 2015

We meet our responsibilities under this act, as our suppliers are subject to standard NHS terms and conditions.

Disclosure of personal data related incidents

The General Data Protection Regulations (GDPR) were introduced as part of a new UK Data Protection Act 2018 (DPA), which repealed and replaced the 1998 Act.

The new legislation strengthens the rights of data subjects, while increasing the responsibilities of organisations to process personal data in a lawful and transparent manner. This means that:

- Incidents calculated as externally reportable **must** be reported to the Information Commissioner's Office (ICO), through NHS Digital's Data Security and Protection Toolkit (DSPT).
- The approach to the management of personal data related incidents has been revised and a different reporting and escalation criteria was produced by NHS Digital in September 2018 - Guide to the Notification of Data Security and Protection Incidents.

Risks to data security are managed by making sure that all colleagues with access to patient-identifiable data have the required access permissions and have completed their compulsory information governance training. All IT equipment is fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

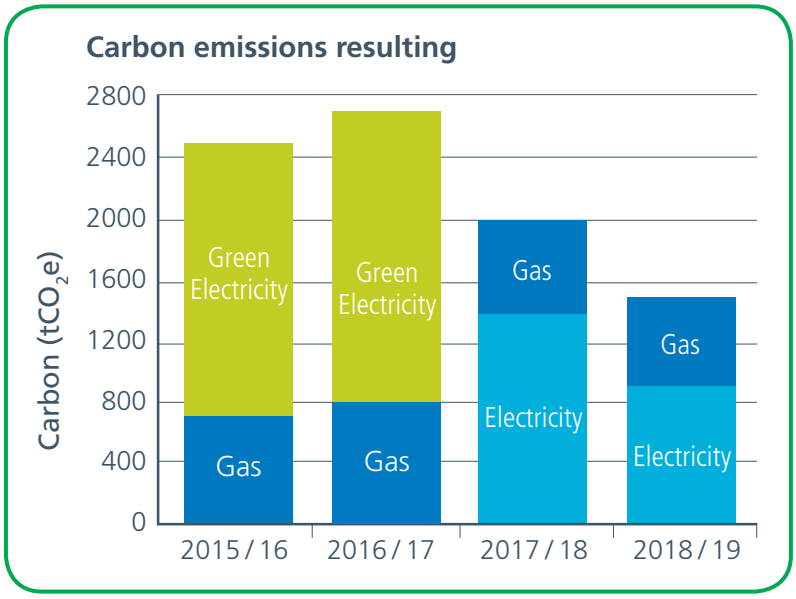
The Trust made a self-assessment against the Data Security and Protection Toolkit (DSPT) that all data security standards had been met as at 31 March 2019.

Sustainability performance

Since the 2007 baseline year, the NHS has undergone, and continues to undergo, significant restructuring. The services provided by Leeds Community Healthcare have been provided by different organisations since 2007. Where information is available, this section reports on our sustainability performance.

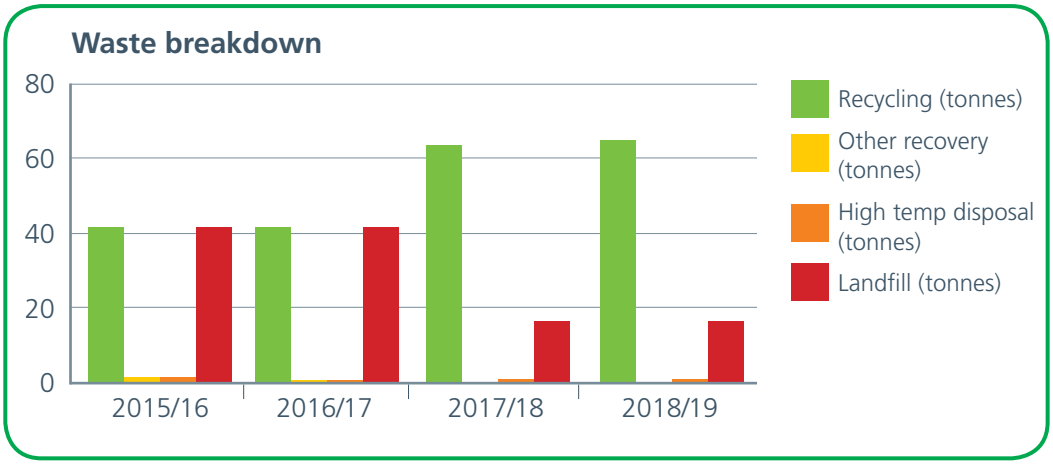
Energy

2018/19 saw a significant reduction in our carbon emissions as a result of the mild winter. Our electricity generating fuels mix currently has 40% renewables.



Waste

Waste volumes in 2018/19 were consistent with the previous year. During the year we introduced segrator bins to pre-sort waste. Landfill disposal is minimised. Clinical waste tonnages have had to be estimated because the Trust's specialist waste contrator ceased providing services during the year with a subsequent loss of data.



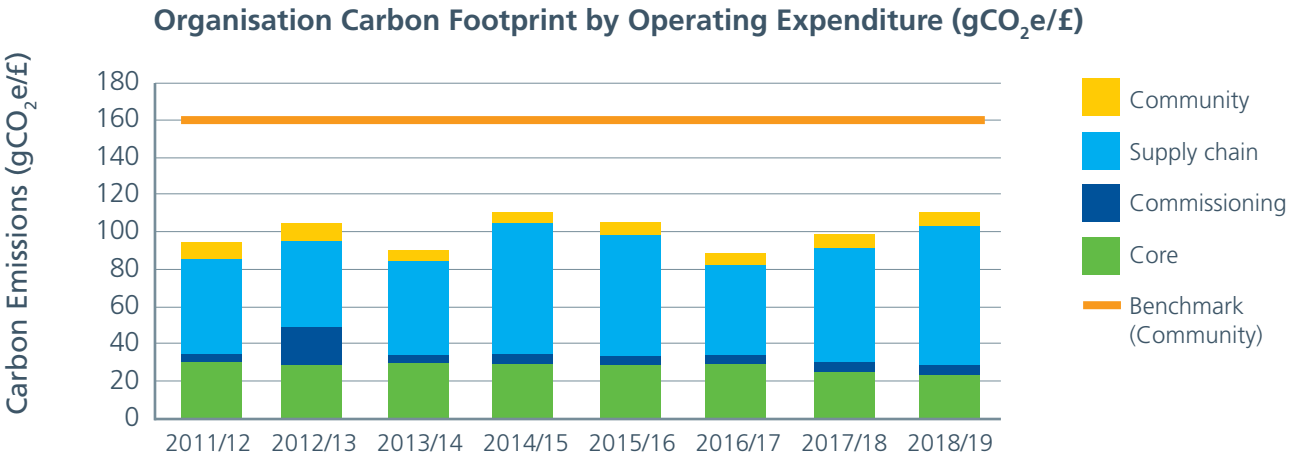
Travel

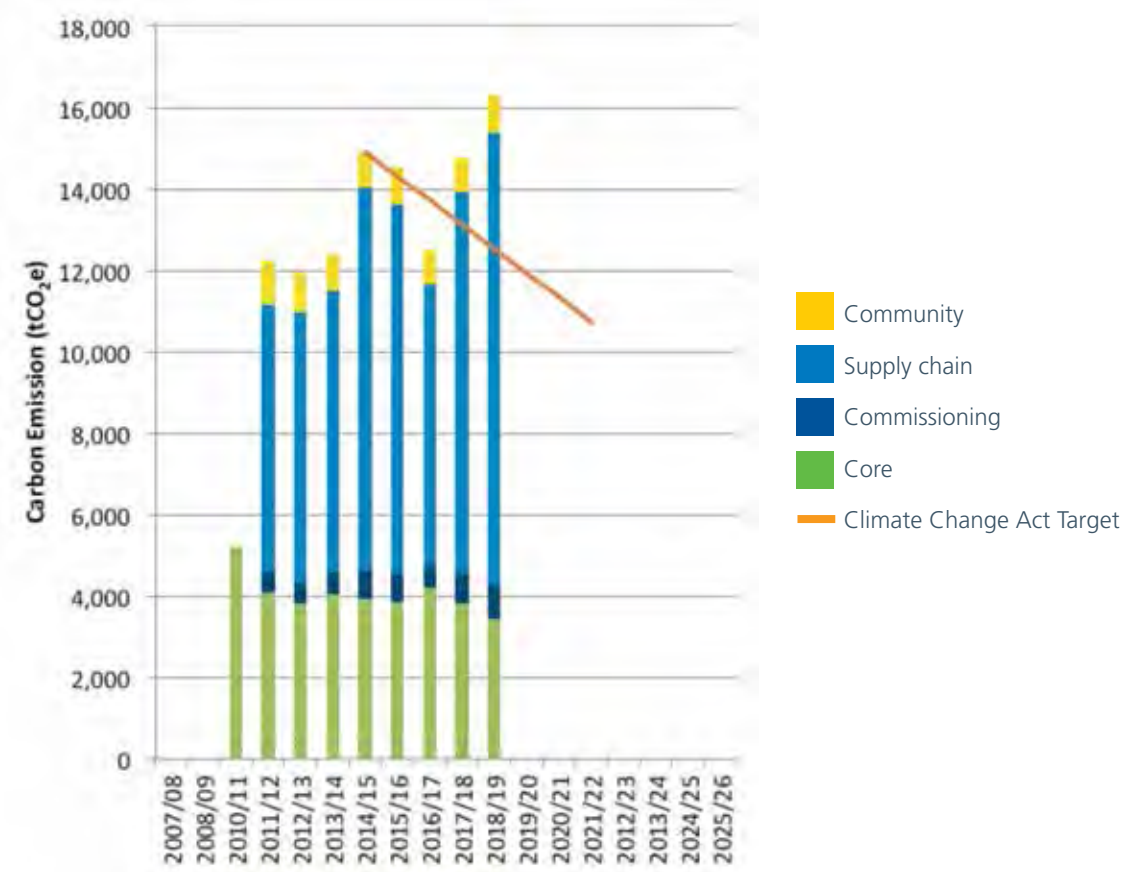
Many of our services are provided to people in their own homes or in facilities located in their community. Whilst this reduces the need for patients to travel to receive care it does mean that the number of miles travelled by staff (business travel and fleet in the table) to deliver care is high. The figures are increasing due to the increased range of services we provide and the intention to provide more care locally. However, we recognise that we need to do more to provide high quality, local care whilst minimising the impact of the resultant carbon emissions.

Category	Mode	2015 / 16	2016 / 17	2017 / 18	2018 / 19
Staff* commute	miles	2,609,998	2,393,859	2,386,163	2,618,643
	tCO_2e	958.99	865.70	862.38	933.09
Business travel and fleet	miles	3,043,042	3,472,501	3,742,745	3,843,610
	tCO_2e	1,118.10	1,255.78	1,352.67	1,369.56
Active and public transport	miles	n/a	n/a	n/a	30,267
	tCO_2e	n/a	n/a	n/a	5.48
Total cost of business travel	£	1,380,000	1,427,910	1,411,240	1,523,722

*Calculated using national travel survey data

Overall summary of carbon





The Trust continues to take its sustainability obligations seriously. For example, we are planning to use our buildings more efficiently which should reduce the amount of space we need to heat and light. In 2018/19 we reduced the building floor space we used despite an increase in staff providing new services. We aim to go further in 2019/20

Context info	2015 / 16	2016 / 17	2017 / 18	2018 / 19
Floor space (m2)	39,504	40,558	37,454	36,043
Number of staff	2,717	2,492	2,483	2,726

Providing value for money

Financial performance summary

Once again the Trust has met its financial targets and once again, my thanks are due to everyone who has played their part in that achievement. Over eight years now, Leeds Community Healthcare staff have successfully balanced the need to deliver high quality care whilst living within our financial resources. That is not always easy and they deserve great credit for managing that in what is clearly recognised as a very challenging financial environment for the NHS.

In past years a number of our services have faced the challenge of competitive tendering. During 2018/19, the Trust was required by commissioners to bid to retain services. The funding available for services that are being tendered usually provides a challenge in terms of reducing the Trust's cost base. However that is a challenge that we continue to meet through innovative new service models. As you will read elsewhere in this Annual Report, in 2018/19 we were successful in retaining and winning new services which provides a stable financial basis for the future.

In line with a general trend in the NHS, the Trust will increasingly work in partnership with commissioners and other service providers to design new ways of delivering services. This will require the Trust to manage its finances more flexibly with our partners and across health and social system. We have a stable, successful financial foundation on which to build and we are excited to be at the heart of the opportunities these new ways of working will bring.

The Trust commenced 2018/19 planning to meet a control total (target income and expenditure surplus) of £2.5m including £1.3m Provider Sustainability Funding (PSF). During the year we took advantage of an opportunity offered by NHS Improvement to improve our planned surplus by £0.5m in return for £1m additional Provider Sustainability Funding. This additional PSF will be used to support the costs of the CAMHS in-patient facility being developed on the St Mary's Hospital site. We also received further PSF of £1.6m at the end of the financial year as part of the national share out of PSF not earned by Trusts during the year. This additional PSF is provided as cash only; it cannot be spent on day to day running costs. Our year end surplus was £5.6m, as required by our original plans and subsequent allocation of PSF.

Target	Target	Performance	Achieved
Planned surplus on income and expenditure	£5,656k	£5,656k	✓
Remain within External Finance Limit	(£3,100k)	(£3,100k)	✓
Remain within Capital Resource Limit	£2,051k	£1,950k	✓
Capital Cost Absorption Rate	3.50%	3.50%	✓
Agency control total	£6,410k	£5,365k	✓
Use of Resources	2	1	✓
Better Payment Practice Code:			
Non NHS invoices (number and value)	95% & 95%	96% & 95%	✓✓
NHS invoices (number and value)	95% & 95%	98% & 98%	✓✓
CIP recurrent savings in year	£3,228k	£3,058k	✗
CIP non-recurrent savings in year	£1,500k	£1,670k	✓

The Trust's capital investment strategy continues to be one of aiming to invest all its internally generated capital resources and remaining within the capital resource limit agreed with NHS Improvement.

During 2017/18 the Trust spent just less than £2m on the continuing roll-out of our Electronic Patient Record, upgrading and maintaining our buildings, clinical equipment and information technology.

Planning for the new CAMHS unit continues with an expected construction start date early in the new calendar year.

In 2019/20 the Trust expects to deliver a control total surplus of £1.7m including £1.2m PSF. We have once again protected front line services from cost improvement plans for the year but will actively seek opportunities for delivering care more efficiently during the year. Our financial planning has identified and budgeted for a number of risks. This Annual Report will be published a number of months into the financial year by when we will know the extent to which any further financial risks have materialised. We are proud of our reputation for providing high quality services within our financial resources; something we plan to continue.

Signed ..... Chief Executive

Date 24 May 2019 .....

Strategic risks

Risk management is part of the culture of the organisation from risk assessments in clinical practice to the consideration of risks which underpin the Board's decisions.

We have looked at our four strategic goals and how we are meeting them in an earlier section of this report. In setting our four strategic goals we also think about the risks and of not achieving them.

As a Trust we have 18 strategic risks connected to our goals. These are grouped in the four following themes (these are also known as strategic risk clusters).

Our four key goals

Risk management is considered in more detail in our Annual Governance Statement which can be found on pages 50-60 of this report.

Accountability report

Corporate governance

The Trust Board - what we do and how we do it

Along with all NHS trusts across the country, we have a Board of Directors to guide our work. The purpose of our Board is to govern effectively, and to build patient, public and stakeholder confidence that health and healthcare is in safe hands.

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services
- Accessible and responsive health services
- Public money spent in a way that is fair, efficient, effective and economic
- Being a good employer
- Patient and the public engagement in shaping health services

The Board plays a key role in:

- Shaping the strategy, vision and purpose of the Trust
- Holding the organisation to account for the delivery of strategy
- Ensuring value for money
- Working to shape a positive culture

The Trust Board has both Executive and Non-Executive Directors. It is a unitary Board, which means that both Executive and Non-Executive Directors share the same liabilities and joint responsibility for every decision of the Board. Led by an independent chair and made up of both executive and independent non-executive members, the Board has collective responsibility for the performance of our organisation.

The Trust's Chair and Chief Executive have led these functions throughout 2018/19.

The structure of our Board of Directors is shown on the next page.

Changes to the Board

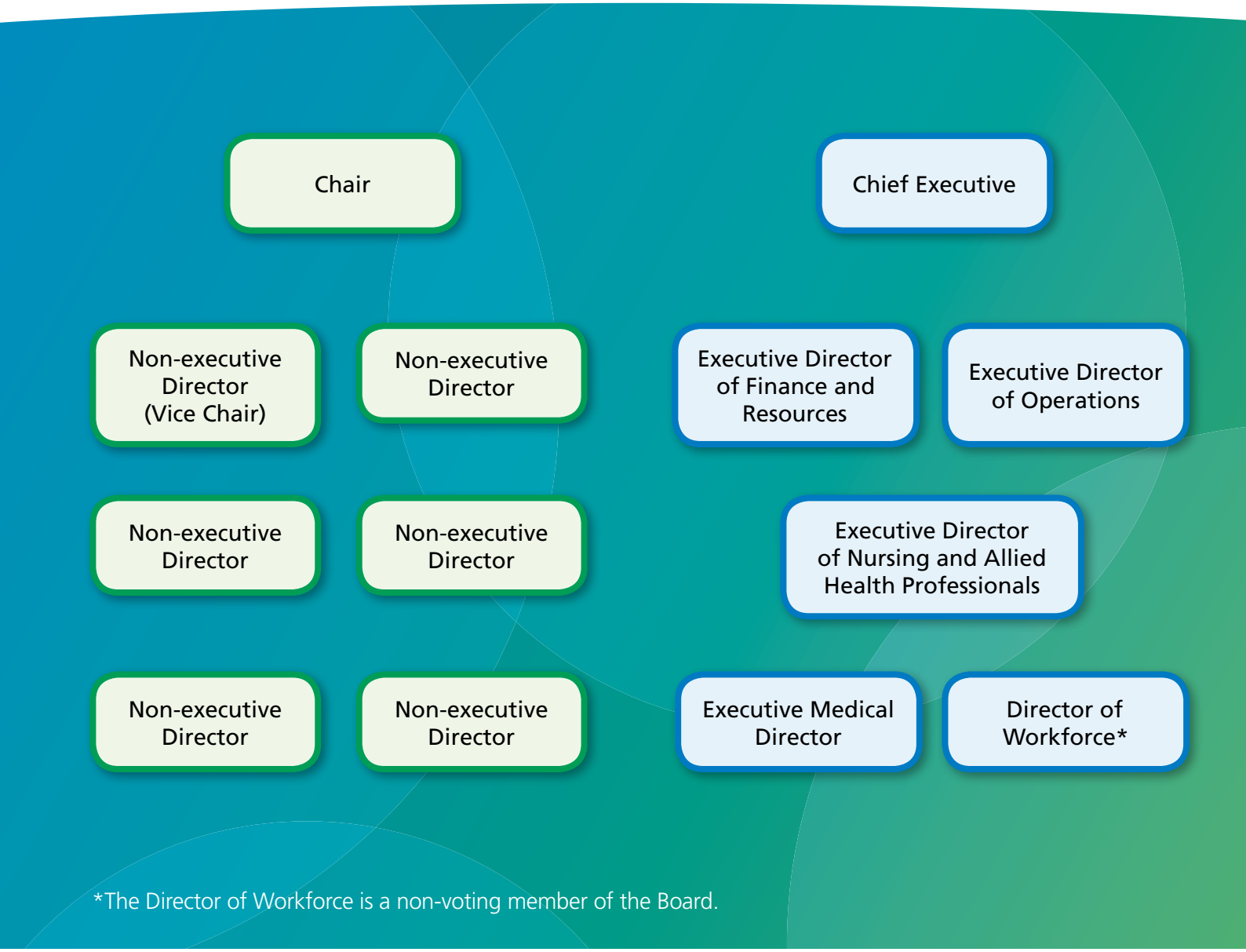
Following the secondment (2 October 2017 to 31 August 2018) and subsequent retirement of Sue Ellis, Director of Workforce, the Trust recruited a job-sharing role of Director of Workforce, Organisational Development and System Development. Jenny Allen and Laura Smith joined the Trust's Management Team on 4 June 2018. Between October 2017 and June 2018, Ann Hobson was interim Director of Workforce. Sue Ellis retired on 31 August 2018.

After a period of secondment, Marcia Perry, Executive Director of Nursing left Leeds Community Healthcare NHS Trust to take up a new substantive post on 1 April 2019. The post of Interim Director of Nursing was covered by Steph Lawrence, who then obtained the substantive post from 1 April 2019.

Dr Amanda Thomas, Executive Medical Director, retired on 16 October 2018 following a period of ill health. The role of Interim Executive Medical Director was covered by Dr Phil Ayres from 1 January 2018 to 31 May 2018 and then by Dr Ruth Burnett from 1 August 2018 to 31 March 2019. Dr Burnett was recruited to the substantive post on 1 April 2019.

Richard Gladman stepped down as non-executive director in January 2019 and was instated as an associate non-executive director.

Our Board structure during 2018/19



*The Director of Workforce is a non-voting member of the Board.

All directors have made a declaration that they comply with the 'fit and proper person test' that was introduced from November 2014.

Board members have an annual appraisal, which is a thorough review of the assessment of their performance, reflecting on their contribution to the Trust during the year and setting objectives for the coming year.

The Board has continued with its development programme during the year. It has a programme of workshops to support Board members' development, covering such topics as quality improvement, equality and diversity, digital strategy and system planning. Both executives and non-executives attend training days and networking events to improve their knowledge base and remain up to date with current NHS matters.

Director's interests

Our Director's declare interests that they have in associated businesses or areas of work. These are shown in the following table:

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift received within the past 12 months: in excess of £25
Neil Franklin	None	None	None	Board member (acting in an advisory capacity only), Donisthorpe Hall Care Home	Donisthorpe Hall, Care Home	None	None	None
Thea Stein	None	None	None	CQC Reviewer	None	None	None	None
Jane Madeley	None	None	None	Chief Financial Officer, University of Leeds	None	None	Any contracts between the University of Leeds, Leeds Faculty of Medicine and Health, Leeds Academic Health Partnership and Leeds Community Healthcare NHS Trust	None
Tony Dearden	None	None	None	Fee paid Medical Member of First Tier Tribunal (Health, Education and Social Care Chamber), i.e. mental health tribunals. Fellow, Royal College of Psychiatrists.	None	None	None	None
Brodie Clark	None	None	None	Non-executive Director Compass	Compass (services for drug and alcohol misuse)	None	None	None

Director's interests cont'd

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift received within the past 12 months: in excess of £25
Richard Gladman	None	None	None	Programme Director, Health and Social Care Information Centre (NHS Digital) Programme Director for Yorkshire and Humber Health and Care Record	None	None	None	None
Laura Smith* (from 4 June 2018)	Director of Workforce in the GP Confederation Leeds	None	None	None	None	None	None	None
Jenny Allen* (from 4 June 2018)	Director of Workforce in the GP Confederation Leeds	None	None	None	Indirect interest – husband is a partner at KPMG, which is involved in financially auditing the Trust. KPMG also bid and contract for contracts with NHS Providers. Husband is also a Trustee for Age UK Leeds.	None	None	None
Prof Ian Lewis	None	None	None	Fellow (retired) of The Royal College of Paediatrics and Child Health Trustee: Rossett School Harrogate	Occasional teaching/ facilitating for Medical Mediation Foundation	None	None	None

Director's interests cont'd

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift received within the past 12 months: in excess of £25
Bryan Machin	None	None	None	From 11 June 2018 two days per week – Director of Finance for the East Yorkshire and Harrogate Health and Care Partnership ('Integrated Care System')	None	None	None	None
Dr Ruth Burnett (from 1 Aug 2018)	Interim Medical Director Leeds GP Confederation	None	None	None	None	None	None	None
Dr Phil Ayres (until 31.05.18)	None	None	None	None	None	None	None	None
Sam Prince	None	None	None	None	None	None	None	None
Marcia Perry (until 31.10.18)	None	None	None	None	None	None	None	None
Steph Lawrence (from 01.10.18)	Acting Director of Nursing Leeds GP Confederation	None	None	Trustee for Carers Resource, Bradford	Trustee for Carers Resource, Bradford	None	None	None
Ann Hobson* (until 03.07.18)	None	None	None	Husband works for West Yorkshire Police – Leeds Community Healthcare provides health input into West Yorkshire Police Custody Suites	None	None	None	None

* Non-voting Board member

V1 15 March 2019. Board approved 29 03 2019

V2. 10 May 2019 – Audit Committee amended – Sue Ellis and Amanda Thomas info is not relevant as they were not at LCH.

In preparing the annual report and accounts for 2018/19 each director has confirmed that they know of no information which would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and; has taken 'all the steps that he or she ought to have taken' to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Board meetings and business in 2018/19

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally six times during the year.

At these meetings, the Board takes strategic decisions and monitors the operational performance of the Trust. Any member of the public is welcome to attend the formal meetings; the dates are advertised on the Trust's website. Board meeting agendas, papers, minutes and future dates are posted on the Trust's website. A briefing document is provided to staff following each Board meeting, which provides information from the main agenda items of the meeting.

The Board has also met informally on a further six occasions. These events have taken the form of strategic workshops and have involved a wider group of senior leaders.

In addition, an annual general meeting was held in September 2018.

The quality of care is at the heart of all that the Trust does; the over-arching approach to quality within the Trust is captured within the quality strategy for 2018-2021. The strategy describes an overarching quality objective to strengthen the approach to quality improvement with a focus on understanding data in order to give the necessary assurances on the quality of services. Using this approach the Trust is focussing on four priority areas:

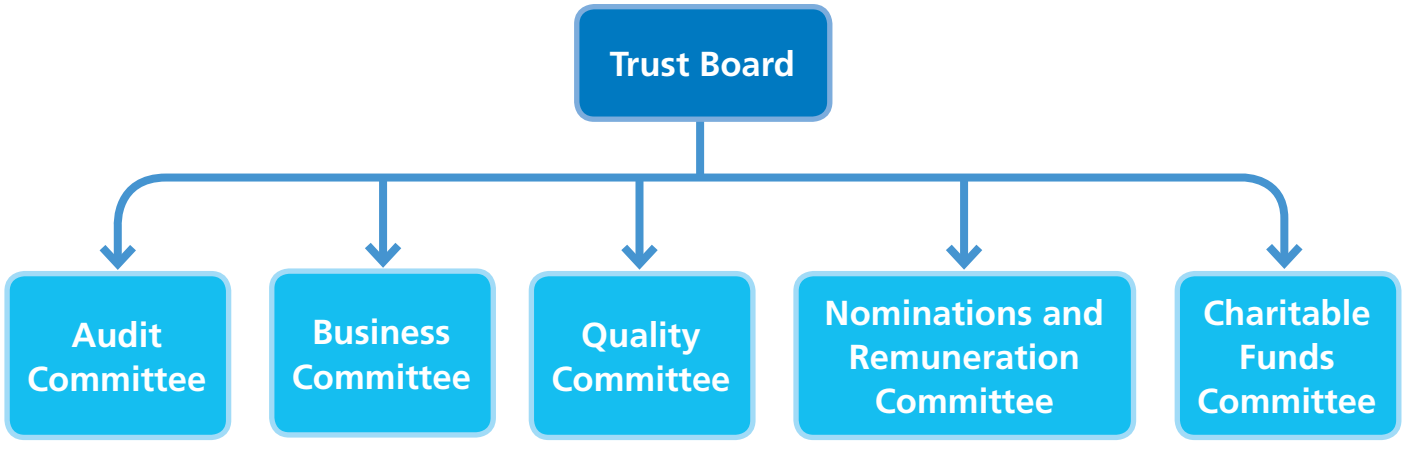
- Prevention, pro-active care and self-management
- Patient experience and engagement
- New models of care
- Workforce

All actions to ensure the Trust provides high quality services are overseen closely by the Board.

The Board receives regular updates on strategic service developments and regular integrated performance reports (the report brings together quality and financial information in one document). Information in the report is aligned to the Care Quality Commission's (CQC) five domains (safe, caring, effective, responsive and well-led).This is the main way the Board assesses that we meet all national and local standards and targets for the services we provide.

The Board's committees (decision making groups)

The Trust has five committees that make sure it carries out its duties effectively, efficiently and economically. These are shown in the organisation chart below.



Details of the functions of each committee can be found in our Annual Governance Statement 2018/19.

In addition, the Trust has a 'Committees in Common' arrangements with a number of NHS organisations. A 'Committees in Common' approach allows NHS Trusts to establish their own committees, which all meet at the same time and with the same remit and common agenda. The three Committees in Common are:

- **West Yorkshire Mental Health Services Collaborative Committees in Common:** This comprises of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnerships NHS Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership NHS Foundation Trust) working together to ensure high quality, sustainable mental health services.
- **Leeds Providers' Integrated Care Collaborative, which is the four NHS healthcare providers in Leeds:** Leeds Community Healthcare NHS Trust, Leeds GP Confederation, Leeds and York Partnership NHS Foundation Trust, and Leeds Teaching Hospitals NHS Trust who have agreed to collaborate in delivering city-wide efficient and sustainable primary, community, and secondary care hospital services (including mental health services in the community and hospital) for patients.
- **Leeds Primary Healthcare Collaborative**, which is Leeds Community Healthcare NHS Trust and the Leeds GP Confederation whose aim is to jointly deliver city-wide seamless and efficient primary care and community health services for patients.

These are reflected in the Trust's current scheme of delegation.

Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the *NHS Trust Accountable Officer Memorandum*. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance
- value for money is achieved from the resources available to the Trust
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them
- effective and sound financial management systems are in place
- annual statutory accounts are prepared in a format directed by the Secretary of State to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

Signed ..... Chief Executive

Date 24 May 2019 .....

Annual Governance Statement 2018/19

Scope of responsibility

"As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS 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 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 Trust Accountable Officer Memorandum*."

Thea Stein

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS 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 Leeds Community Healthcare Trust NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust recognises that it is operating in a healthcare environment where patient safety, quality of care and service sustainability are paramount and are of mutual benefit to stakeholders and the organisation alike. The Trust manages clinical risks (i.e. risks to individual patients through clinical activity) and financial and business risks (i.e. risks that threaten the achievement of statutory financial duties or the safeguarding of the Trust's assets) in order to deliver its objectives in a controlled manner. Subject to controls and assurances being in place, and in line with the Trust's risk appetite statement, the Trust accepts manageable risks, but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Risk management is embedded within the culture of the organisation from risk assessment in clinical practice to the consideration of risk underpinning the Board's decisions. Risks are identified and aligned to strategic goals. Risk tolerance ie the level at which risk is escalated, is clearly set out in the Risk Management Policy and Procedure.

The Chief Executive has overall responsibility for the Trust's management of risk. The executive team have been allocated management of risk types as follows:

- **Chief Executive:** Risks to staff and stakeholder engagement, integration and system change programmes
- **Executive Director of Finance and Resources:** Risks to efficiency, income and expenditure, IT infrastructure, partnership governance
- **Executive Director of Operations:** Risks to major change projects, business tenders, contracted activity
- **Executive Director of Nursing and Executive Medical Director:** Risks to clinical quality assessment and clinical quality improvement

- **Director of Workforce:** Risks to staff capacity and capability

The role of each director is to ensure that appropriate and robust arrangements are in place to:

- identify and assess risks
- eliminate or reduce risks to an acceptable level, in line with the Trust's risk appetite
- comply with policies and procedures, and statutory and external requirements
- maintain the Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) is to enable the Board to assure itself that risks to the success of its strategic goals and corporate objectives are being managed effectively. The BAF aligns strategic risks to the revised corporate objectives identified in the Trust's operational plan. Directors regularly review strategic risks to evaluate whether the BAF strategic risk scores are appropriate and identify any additional controls or sources of assurance required.

The Trust employs an experienced risk manager who delivers risk management training, coordinates the risk register and the board assurance framework and provides support and direction in all risk management related matters.

Members of staff receive information and are briefed on risk management procedures as part of the induction process. Bespoke risk management training is provided to teams and services. Managers are trained in risk management procedures both as part of the induction process and as part of ongoing training, coaching and support. All training includes awareness of the Trust's risk appetite and how this should be applied in decision-making processes.

The Trust has a quarterly risk management newsletter to share lessons that can be learned from incidents and complaints, the latest information about risk management, training courses available and examples of good practice across the Trust. There is a 'lessons learned' portal on the Trust's intranet, for managers to share information about incidents and improvement.

There has been a targeted approach to risk management training during 2018/19 as it was identified that some services did not have suitable and sufficient health and safety risk assessments. Support, in the form of individual and group training sessions has been provided, as well as an accessible library of risk assessment templates. A training session is now being delivered to inform managers of their role and responsibilities with regards to staff health, safety and risk management, with a strong focus on risk assessment technique. This is part of the Trust's refreshed essential management training programme which commenced in February 2019.

The risk and control framework

The Trust's risk management policy defines the risk management framework and sets out the approach the Trust will take to the management of risk within the organisation ensuring that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

The risk management procedure supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk.

The Trust has systems in place that contribute to the identification of risk from a number of sources - the following are examples:

- Review of performance and working practice
- Clinical practice
- Legislation, national policy and guidance
- Risk assessments
- Incident reports
- Complaints
- Claims
- Audit and work place surveys
- Patient satisfaction surveys
- External / internal audits
- Regulators' inspections and reports

Any of the above can inform the risk assessment process and therefore the population of the Trust's risk register. Risks are identified in a proactive way, for example: changes or introduction of new processes, new equipment, different ways of working etc will initiate a risk assessment. In addition, individual staff may identify risks whilst carrying out their duties or risks may be identified through discussions in team meetings etc.

The risk management policy and procedure is supported by content contained in the Trust intranet in a bespoke risk management webpage, and is available to all directors, SMT, service managers, clinical leads and staff-side representatives.

The risk register is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The electronic risk management system used by this Trust to record and monitor risks is 'Datix'. The risk register contains in summary: a description of the risk, the risk owner, any controls in currently in place, actions to be completed, and the initial, current and target risk scores. Risk register extracts from Datix are frequently drawn to allow for scrutiny of risk by appropriate managers, committees and the Board.

The Trust's risk appetite is aligned with its four strategic goals. The senior management team determine the Trust's risk appetite and review this on an annual basis. The risk appetite statement is appended to the risk management policy and procedure, which is on the Trust's internal website.

Data security risk is managed through a system of general managers and heads of service that act as information asset owners and work with the Senior Information Risk Owner to manage data security and other information related risks. This process has been significantly enhanced in 2018/19 through the work required to ensure Trust compliance with the General Data Protection Regulation (GDPR).

Data security risks are also mitigated through a number IT activities which include the release of regular updates from software suppliers to ensure the Trust IT infrastructure remains protected from vulnerabilities. Typically the Trust will test any new releases on a small group of devices to ensure there are no compatibility issues before releasing the updates in line with a monthly cycle. These updates are received by desktops and laptops as they connect to the corporate IT network. Through experience of using the Electronic Patient Record, it became apparent that certain users of laptops were not connecting to the corporate network or restarting their laptops regularly enough for the updates to be effective. This has culminated in an awareness campaign in the Adult Business Unit which provides advice and guidance on how to ensure the device remains protected and up to date with the latest software.

The Trust also continues to conduct annual penetration tests using accredited third party organisations, with the latest report undertaken through the 'Cyber Essentials Scheme' and received on the 14 December 2018. The resulting action plan is being co-ordinated and monitored by NHS Digital with a number of improvements identified for implementation before 31 May 2019.

Additional activities in 2018/19 such as the testing of Business Continuity Plans in response to a cyber-attack and reminding staff of the importance of protecting their smart card through the Trust's risk management newsletter, have all been designed to help keep sensitive data secure and reduce the risk of unintended loss or breach.

Counter fraud measures help to protect NHS resources against fraud and ensure they are used for their intended purpose, the delivery of patient care. The Trust has a lead Counter Fraud Specialist who manages delivery of a counter fraud work plan, which is scrutinised by the Audit Committee. The Counter Fraud Specialist also presents an annual report to the Committee which summarises counter fraud activity undertaken at the organisation in the preceding year.

In April 2019, a Self-Review Toolkit was completed and submitted to the NHS Counter Fraud Authority. There are four key areas which are reviewed as part of the self-review toolkit: strategic governance, inform and involve, prevent and deter, and hold to account. The Trust has declared full compliance with 22 out of the 23 standards, with partial compliance for one standard.

Governance structures and accountability

The Board leads the Trust by undertaking three main roles:

- Formulating strategy
- Ensuring accountability by holding the organisation to account for the delivery of the strategy and through seeking assurance that systems of control are robust and reliable
- Shaping a positive culture for the Board and the wider Trust

The Board consists of six non-executive directors (including the Chair), and five executive directors. In addition, there is one non-voting member of the Board.

There is a clear division of responsibilities between the Chair and Chief Executive. The Trust's Chair and Chief Executive have discharged their leadership functions throughout the whole of 2018/19.

The Director of Workforce is a non-voting member of the Board.

The Board has met on thirteen occasions in 2018/19; this has comprised six formal meetings held in public, six informal meetings or strategic workshops plus an annual general meeting. Attendance at Board meetings has been good and all meetings have been quorate.

The quality of services remains the Trust's first priority and, to this end, the Board's agenda features reports reflecting key quality matters. Information presented to the Board provides essential assurance. Board meetings have received papers on the Trust's quality strategy, patient experience topics and the maintenance of safe staffing levels. The Directors conduct regular visits to frontline services.

The Board has standing orders, a scheme of reservation and delegation of powers and standing financial instructions. These provide a governance framework that enables the organisation to demonstrate it is well governed and that it meets requirements of corporate governance codes of practice.

The Board has an annual work plan, which demonstrates the scheduling of required and discretionary business. The five Board committees all have terms of reference and work plans which have been reviewed during 2018/19.

The Board receives a performance brief and a suite of reports aligned to the five Care Quality Commission (CQC) domains. This is the primary mechanism for assessing compliance with national and local targets. The performance brief brings quality and financial information together in one report.

The Board receives regular updates on strategic service developments, for example work to enhance integration across primary and secondary health care and social care and the introduction of new ways of working.

The Board receives and considers extracts from the risk register and the board assurance framework at each meeting to gain assurance as to the effective management of risk in the organisation. Through these arrangements, the Board receives timely information about existing and potential risks to the Trust.

The Board also receives minutes and assurance reports from each of its committees at Board meetings.

The Board wishes to assure itself that it operates effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance. In doing so, it is mindful of the best practice contained within codes of governance.

The Board and committees undertake an annual self-assessment against elements of the NHS Improvement Well-Led Framework and has drawn out a number of priorities to enhance the effectiveness of elements of the Trust's governance. The results being reported to the Board and are contained in committees' annual reports. The committees' chairs' also meet collectively to discuss committees' effectiveness.

The Trust has a needs-based Board development programme. A feature of which is a series of Board workshops taking place every two months (six events in 2018/19). Senior leaders from corporate services and business units (including clinical leads) also participate in these sessions.

The individual performance of all Board members is reviewed through a formal appraisal process and any individual development needs are identified and supported.

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

The Board has appointed five committees to carry out specific functions and provide assurance that the Trust is carrying out its duties effectively, efficiently and economically. These are detailed below.

Audit Committee
(Chair: Jane Madeley)

The Committee comprises three non-executive directors. The Chair of the Committee is a qualified accountant and is a Chief Financial Officer in the higher education sector. The Executive Director of Finance and Resources, the Company Secretary, the Internal Auditor and the External Auditor attend on a routine basis. The Audit Committee met formally six times during 2018/19.

The Audit Committee provides an overarching governance role and reviews the work of the other committees, whose work can provide relevant assurance to the Audit Committee's own scope of work. It also has responsibility for overseeing the work of the Information Governance Group. The Committee receive minutes from this sub-group, receives papers on any matters escalated to the Committee and periodically reviews the effectiveness of the sub-group in discharging its delegated responsibilities.

During the year, the Committee has received regular reports on progress from internal audit, external audit, the local counter fraud specialist, the security management service and from information governance specialists.

The Committee has considered a range of financial control reports and a number of governance papers, and has oversight of the board assurance framework, which it reviewed twice in full during the year.

The chair of each of the Board's committees produced an annual report, which provides assurance to the Audit Committee on how each committee has met its terms of reference during the year. The committees undertake a self-assessment exercise, the results of which are included in their annual reports. The committees' chairs also met to discuss the flow of business through the committees.

Quality Committee
(Chair: Professor Ian Lewis)

The Quality Committee's membership comprises the Trust's Chair, two non-executive directors, the Chief Executive and two executive directors. A number of other senior officers attend each meeting. The Committee met on ten occasions in 2018/19.

The Committee provides assurance to the Board that high standards of care are provided by the Trust and that adequate and appropriate quality governance structures, processes and controls are in place to:

- Promote quality, in particular safety and excellence in patient care
- Identify, prioritise and manage clinical risk and assure the Board that risks and issues are being managed in a controlled and timely manner
- Ensure effective evidence-based clinical practice
- Produce the annual Quality Account and monitor progress

The Committee exercises these functions in the context of the Trust's Quality Strategy. The Quality Strategy 2018-2021 provides an overarching framework for quality within the Trust and sets out a programme of work to achieve four key objectives and seven action areas focused on patient safety, clinical effectiveness and patient experience. The Committee has received an update on a quarterly basis and has sought assurance about the implementation of specific actions.

Within that strategic framework, the Quality Committee and the Board monitors serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's incident and serious incident management policy.

Business Committee
(Chair: Brodie Clark)

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives; other senior officers attend as required. The Business Committee held ten meetings in 2018/19.

The Committee provides assurance to the Board on the financial and performance management processes within the organisation, including monitoring the delivery of the Trust's business plan and oversight of significant projects.

The Committee oversees business and commercial developments and makes investment decisions in line with the scheme of delegation and the Trust's investment policy and ensures that the Board has a sufficiently robust understanding of key performance, financial and investment issues to enable sound decision-making.

The Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance. There has been consideration of recruitment and retention initiatives, sickness absence management and leadership approaches.

The committee has assumed an extended role in terms of oversight of the Trust's main projects. The Committee receives in-depth reports from the project leads and reports from the Change Board, which provides an overview of inter-connectivity for the main projects.

Nominations and Remuneration Committee
(Chair: Neil Franklin)

The Nominations and Remuneration Committee's membership comprises the Chair and two further non-executive directors; the Committee is supported by the Director of Workforce. The Committee has met four times in 2018/19.

The role of the Nominations and Remuneration Committee is to nominate executive directors, including the Chief Executive, for appointment and advise and make recommendations to the Board about appropriate remuneration and terms of service for the Chief Executive, Executive Directors, directors and any senior managers not covered by national Agenda for Change terms and conditions of employment.

The Committee also gives full consideration to and make plans for succession planning for the Chief Executive and other Executive Directors taking into account the challenges and opportunities facing the Trust and the skills and expertise needed.

It monitors and reviews any exceptional and/or significant employee relations cases of high risk to the Trust including those relating to employment cases of high cost or of reputational significance.

The Committee ratifies and agrees any awards at the discretion of the Trust as the employer. One such duty is to review the nominations for the Clinical Excellence Awards and to encourage maximum participation from staff across the eligible consultant body. In December 2018 it was confirmed that applications received for Clinical Excellence Awards successfully demonstrated an increasing level of diversity.

Charitable Funds Committee
(Chair: Brodie Clark)

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director; the Committee is supported by the Executive Director of Nursing. The Committee has held four meetings during 2018/19.

The purpose of the committee is to give assurance to the Board that the Trust's charitable activities are discharged within the law and regulations set by the Charity Commissioners for England and Wales. The Committee oversees charitable activities, approves charitable funds expenditure, agrees an investment policy for charitable funds and monitors investments on a regular basis.

Principal risks

There are eighteen strategic risks aligned to the Trust's four strategic goals, which are grouped into four strategic risk 'clusters':

- Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes

- Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
- Failure to engage and empower the Trust's workforce and the ability to recruit, retain and develop staff
- Failure to maintain a viable and sustainable organisation

The board assurance framework (BAF) records: risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans have been identified and the BAF has been revised during 2018, in line with the Trust's operational plan. These risks are assigned to a lead executive to manage. Each of the strategic risks is also assigned to one of the Board's committees for oversight and scrutiny. Overall in-depth scrutiny is provided by Audit Committee. Sources of assurance are reviewed by the Board subcommittees and this information is reported at each Board meeting.

Scrutiny of risks

The Risk Review Group meets quarterly to review new risks that have been added to the risk register. They also review escalated and de-escalated risks and risks that have recently been closed. The group acts as a moderator for risk grading, ensuring appropriate ownership of the risk and ensuring that effective management of the risk is being recorded. The group also maintains an oversight of the practical application of the risk management procedure.

The Board receives a significant risks and risk assurance report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures, as well as information about risks scoring 12 (high). It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The report also includes the BAF summary advising the Board of the current assurance level determined for each of the Trust's strategic risks. The Senior Management Team reviews a significant risks report on a monthly basis. The Quality Committee reviews in more detail the clinical and operational risks and the Business Committee reviews non-clinical risks, rated as high.

Assurance of risk mitigation is provided to the Board through the Senior Management Team, and through the Quality and Business Committees in relation to clinical and non-clinical risks. The Audit Committee assures the risk management process.

Together, these mechanisms allow for the appropriate identification, monitoring, control and mitigation of risks, which may have an impact on the Trust's objectives.

Incident reporting

The Trust has a strong, open incident reporting culture. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and training and regular communications. Learning from incidents is shared with staff through the Trust's quarterly risk management newsletter, at staff forums and as a learning resource on the Trust's internal website for all staff to access. This has been developed to share anonymised learning from incidents across the organisation. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Serious incidents are reported and managed in accordance with the Trust's incident and serious incident policy. The majority of managers have had serious incident investigation training and root cause analysis is carried out to ensure that systemic problems are resolved so that similar incidents do not occur.

In 2018, an internal audit review evaluated the robustness of processes in place for the identification, investigation, reporting and management of incidents and serious incidents including how lessons learned are dealt with and communicated and disseminated across the Trust. The review concluded a reasonable assurance opinion.

Safe, sustainable and effective staffing

The Trust has a range of strategies, systems and processes in place to ensure safe, sustainable and effective staffing.

The overall approach to workforce is described in the Trust's Workforce Strategy (2019-21) which was approved by the Board on 1 February 2019. The Workforce Strategy is aligned with the Trust's strategic goals and priorities, responding to external, internal and cultural factors which are currently or anticipated to impact on our workforce requirements. Progress on delivery of the Workforce Strategy's priorities is overseen by the Trust's Business Committee, a subcommittee of the Board.

The Trust's workforce plan supports the delivery of our operational business plan and is embedded in service needs as well as triangulated with finance and activity data. The plan is updated annually and receives sign off at both Business Committee and the Board; the latter at a public Board meeting.

The Board receives a twice-yearly Safe Staffing report from the Director of Nursing, in line with NQB's 2016 guidance; incorporating professional judgement and outcomes. Regular reports are also received at Board from the Guardian for Safe Working Hours.

Our services are constantly growing and developing as we deliver new pathways of care; and care for more and more people in the community. Any new service or service change is subject to a Quality Impact Assessment (QIA) and this would include where new roles mean a significant change to the way care is delivered.

Triangulation takes place both at the regular Senior Management Team meeting (SMT) and across the Board and its sub-committees, of finance, workforce and activity / performance information, to ensure comprehensive oversight of staffing and any issues arising.

A key element of this triangulation is the monthly Performance Brief, which brings together information under the Safe and Caring, Effective, Responsive, Well Led and Financial domains; together with actions being taken to address areas of concern, celebration, and learning. The Performance Brief is reviewed at SMT, Business Committee and Board.

In addition, general managers and clinical leads undertake performance panels at service and business unit level, with escalations from the monthly Senior Operations Performance Panel put before SMT for consideration and further escalation if required. Discussions at these panels focus on both quantitative data and the professional judgement of the senior managerial and clinical leaders engaged in delivery of the service.

Our organisational risk register captures workforce-related risks, including any associated with resourcing / staffing challenges. The higher scoring risks are escalated and regularly scrutinised and discussed at Committees and Board.

The Trust is in the process of rolling out an e-rostering system to further improve the capability of our staffing systems. E-rostering will enable us to better monitor, analyse and plan staffing patterns and resource requirements. Implementation is taking place in a phased approach, with the first 3 services now live. The e-rostering project is overseen by the Trust's Change Board.

NHS pension obligations

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

Equality and diversity

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

The Trust has a legal obligation under the Equality Act 2010 and Public Sector Equality Duty, to provide equality in access to service provision and within employment and has a nominated Board member who champions this agenda at Board level.

The Business Committee discharges a significant role in overseeing the workforce aspects of the Trust's performance, which includes providing assurance to the Board around equality and diversity. In recognition of the importance of equality and diversity, the Business Committee receives performance information around equality and diversity mandatory training compliance and Workforce Race Equality Standard (WRES) indicator 1, on the percentage of BME staff in senior roles. On a quarterly basis the Business Committee receives more in-depth analysis and updates on a range of proactive work around this wider agenda, which includes the delivery against the Workforce Race Equality Standard (WRES) Action Plan and shortly to receive the Workforce Disability Equality Standard (WDES) Action Plan.

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

The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board, ensures that plan is adhered to. The Trust has consistently met the financial targets set by regulators. The Business Committee also receives an annual report on the Trust's reference costs, which are an indicator of the Trust's efficiency in delivering its services. The Trust's overall reference costs for 2017/18 are 100. Delivery of cost improvement plans during 2018/19 has been good and the Trust has reported a use of resources metric of 1 being the lowest risk all year.

The Audit Committee reviews all internal audit reports and monitors the Trust's implementation of any recommendations. Annually the Trust's external auditors are required to provide a Value for Money conclusion. For 2018/19 the auditors concluded that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2019. The effectiveness of the Trust's services is regularly assessed by the Trust's Quality Committee and by the Board.

Carbon reduction delivery plans

The Trust has undertaken risk assessments and has a sustainable development management plan in place. During 2019/20 it will be reviewed to take into account UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Information governance

The Trust recognises that information is an important asset, supporting both clinical and management needs and is fully committed to ensuring that personal information is protected and used appropriately. The Trust has submitted a self-assessed score that all data security standards have been met for the Data Security and Protection Toolkit (DPST), which is the successor to the Information Governance Toolkit.

The Trust's Information Governance Group develops relevant policies and strategies to control data security and other information related risks. As a community Trust, sharing information has been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced the risk of data loss through the use of mobile devices. The Trust has demonstrated its commitment to being an accountable data controller by appointing a Data Protection Officer. The Information Governance Group has revised the information governance policies and procedures to ensure they are robust and compliant with the General Data Protection Regulation and the Data Protection Act 2018 (in force from 25 May 2018).

In recognition of the importance of data security, there is a nationally set target of 95% of staff compliance with information governance training. Training compliance is closely monitored, and attendance is enforced where necessary.

One incident was reported to the Information Commissioner's Office (ICO) by the Trust during 2018/19. A complaint response letter was sent to an incorrect recipient on more than once occasion due to being addressed incorrectly. The ICO required the Trust to carry out the three following actions:

- Staff members to confirm the patient's contact details prior to sending out correspondence
- Procedures to be reviewed for the updating of patient addresses and that staff read this procedure. Regular review and monitoring of the process
- Review the content of the mandatory induction data protection training and also the frequency of refresher training to ensure that sufficient practical guidance is given to staff in how to comply with the GDPR

Data quality

The Trust reports monthly on its performance against national key performance indicators in line with NHS Improvement's Single Oversight Framework and other indicators as contained within contracts with commissioners.

The Trust works to evidence good standards of data quality and accuracy in its performance reporting and is confident that key national indicators e.g. waiting times are accurate.

Annual Quality Account

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. The Quality Account priorities have been developed in conjunction with stakeholders, services and senior managers to ensure that the measures can facilitate improvements in services for all communities and stakeholders and align to the Quality Strategy and business objectives. This year's Quality Account highlights some of the work that staff and partners do every day and reflects the commitment and drive to provide the best possible standards of care throughout all services.

The Trust recognises the complex needs of its community and strives to achieve consistent delivery of high quality care to maximise patient safety and experience. The Quality Account provides a balanced view of the Trust's achievements and failures and is relevant to all its communities, but also recognises the improvements it continues to make and the collaborative work with partners to make real improvements across the whole health economy.

The Trust has robust systems and processes to ensure the accuracy of data provided in the Quality Account. This includes data cleansing and data validation processes as well as oversight arrangements provided by Committees and committee subgroups.

Waiting times data is one important area where the Trust needs to ensure the information is accurate. In order to ensure this, a weekly report is downloaded by the Business Intelligence Team, which identifies any potential patient breaches. This report is reviewed and validated in the consultant-led services, where explanations are provided against any patients who are listed on the report with a waiting time over 17 weeks. The validator is required to update the patient record where an error has been made. The updated validations form the basis for the figures submitted to NHS Improvement and NHS England.

Review of effectiveness

As Accountable 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 NHS trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board and the Audit Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Chief Executive has responsibility for reviewing the effectiveness of the system of internal control. The review of the effectiveness of the system of internal control is informed by the work of internal auditors, the comments made by external auditors in the ISA260 report, the continuing engagement of the Audit Committee, managers and clinical leads who have responsibility for the development and

maintenance of the internal control framework. The Audit Committee undertakes a role in terms of providing assurance to the Chief Executive.

Internal audit

TIAA Limited has been the provider of internal audit services since 1 April 2015. This contract was reviewed and renewed in 2018. The Head of Internal Audit has provided an opinion that concludes that, based on the work undertaken in 2018/19, reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives. No emerging risks have been identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

In areas reviewed by internal audit where it was assessed that the effectiveness of internal control arrangements provided less than 'substantial' assurance, recommendations were made to further strengthen the control environment. Resultant management actions, which are monitored by the Audit Committee, have been completed or are being progressed in a satisfactory manner.

Clinical audit

Clinical audit is vital to the quality and effectiveness of clinical services and is a fundamental part of the quality improvement process. It plays a pivotal role in providing assurances about the quality of services. Findings from clinical audit are used to ensure that action is taken to protect patients from risks associated with unsafe care, treatment and support.

Clinical audit is managed at service level with the support of the quality and professional development directorate. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the course of the year. The 2018/19 programme comprised of 37 mandatory audits, 51 recommended audits and a further 38 audits which had been determined locally.

CQC compliance

The Trust is fully compliant with the registration requirements of the Care Quality Commission.

The Trust received a CQC inspection in the fourth quarter of 2016/17 and the report arising from the inspection was received by the Trust in mid-2017. The Trust currently has an overall rating of 'Good'.

NHS Improvement oversight

NHS Improvement has assigned the Trust a segment rating of '2'; this indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

The Trust works with a range of regulators including the CQC, HM Inspectorate of Prisons, and Ofsted.

Conclusion

During 2018/19, no significant control issues have been identified by the Trust's systems of internal control.

The Trust is a well-established health care provider that has built a system of internal control based on sound foundations. The Trust has a strong safety culture and sees quality of care as the primary objective. Ongoing scrutiny enhances learning and strengthens governance.

The annual governance statement shows that the Trust has the necessary control arrangements in place to manage risks and take action when incidents occur.

Strong financial control and the achievement of statutory financial duties support the view that, clinically and financially, the Trust has effective and improving systems in place.

Signed .....

Chief Executive

Date 24 May 2019 .....

Remuneration and staff report

Policy on senior managers' contracts

The table below provides details on the contracts for each senior manager who has been employed during the year. The contracts do not make any specific provisions for compensation for early termination in addition to the notice periods.

Name and title	Contract date	Date of Expiry	Notice period
Ann Hobson Interim Director of Workforce	2 October 2017	3 June 2018	3 months
Bryan Machin Executive Director of Finance and Resources	9 May 2011	No end date	6 months
Marcia Perry Executive Director of Nursing	10 August 2015	31 March 2019	6 months
Samantha Prince Executive Director of Operations	4 July 2011	No end date	6 months
Thea Stein Chief Executive	1 October 2014	No end date	6 months
Dr Amanda Thomas Executive Medical Director **Dr Phil Ayres** Interim Medical Director	5 September 2011 Internal secondment from LTHT 1 January 2018 and then employed by LCH from 9 April 2018	16 October 2018 31 May 2018	6 months
Dr Ruth Burnett Interim Medical Director Medical Director	1 August 2018 1 April 2019	31 March 2019 No end date	 6 months
Jennifer Allen Director of Workforce, OD and System Development	4 June 2018	No end date	6 months
Laura Smith Director of Workforce, OD and System Development	4 June 2018	No end date	6 months
Stephanie Lawrence Acting Executive Director of Nursing Executive Director of Nursing and Allied Health Professionals	1 October 2018 1 April 2019	31 March 2019 No end date	 6 months

Payments to past senior managers (subject to audit)

We have not made any awards to past senior managers in addition to the remuneration disclosed later in this report.

The Trust can confirm:

- One senior manager received a performance related payment in 2018/19
- There were no senior managers service contracts awarded during 2018/19
- There were no payments to past senior managers during 2018/19
- There were no payments for loss of office during 2018/19
- There was no senior off-payroll engagement during 2018/19

Number of individuals that have been deemed 'Board members, and / or senior officers with significant financial responsibility' during the financial year = 16*. This figure includes off payroll and on-payroll engagement.

*Please note this number has increased since previous year due to a number of interim arrangements in place

Senior managers' remuneration report (subject to audit)

	2018 / 2019						2017/ 2018					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Jennifer Allen – Director of Workforce, OD and System Development (from 04.06.18)	45 - 50				100 - 102.5	145 - 150						
Dr Phil Ayres – Interim Executive Medical Director (until 31.05.18)	5 - 10					5 - 10	35 - 40					35 - 40
Ruth Burnett – Interim Medical Director (from 01.08.18)	80 - 85	<0.1			32.5 - 35	115 - 120						
Brodie Clark – Non-Executive Director	5 - 10	1.1				5 - 10	5 - 10	0.7				5 - 10
Dr Tony Dearden – Non-Executive Director	5 - 10	0.3				5 - 10	5 - 10	0.4				5 - 10
Susan Ellis – Director of Workforce (until 01.10.17)							45 - 50				7.5 - 10	50 - 55
Neil Franklin – Chair	20 - 25	0.6				20 - 25	20 - 25	0.4				20 - 25
Richard Gladman – Non-Executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Ann Hobson – Interim Director of Workforce (02.10.17 to 03.06.18)	15 - 20	<0.1				15 - 20	45 - 50				45 - 50	80 - 85

	2018 / 2019						2017/ 2018					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Stephanie Lawrence – Acting Executive Director of Nursing and Allied Health Professionals (from 01.10.18)	40 - 45				30 - 32.5	75 - 80						
Ian Lewis – Non Executive Director (from 01.07.17)	5 - 10					5 - 10	0 - 5					0 - 5
Bryan Machin – Executive Director of Finance and Resources	115 - 120	0.1				115 - 120	115 - 120	0.1				115 - 120
Jane Madeley – Non-executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Marcia Perry – Executive Director of Nursing (until 30.09.18)	45 - 50	0.1				45 - 50	90 - 95	0.1			5 - 7.5	95 - 100
Samantha Prince – Executive Director of Operations	100 - 105	0.1				100 - 105	95 - 100	0.1			15 - 17.5	110 - 115
Laura Smith – Director of Workforce, OD and System Development (from 04.06.18)	45 - 50				105 - 107.5	150 - 155						
Thea Stein – Chief Executive	140 - 145	0.1	5 - 10			145 - 150	140 - 145	0.1				140 - 145
Elaine Taylor Whilde – Non Executive Director (01.04.16 to 30.06.17)						0 - 5	5 - 10	1.0				5 - 10
Dr Amanda Thomas – Executive Medical Director (until 16.10.18)	25 - 30		35 - 40			65 - 70	95 - 100		60 - 65			155 - 160

Pension details for senior managers
(subject to audit)

Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2019 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2019 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2018 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2019 £'000
Jennifer Allen – Director of Workforce, OD and System Development (from 04.06.18)	2.5 - 5	10 - 12.5	15 - 20	45 - 50	174	94	301
Ruth Burnett – Interim Medical Director (from 01.08.18)	0 - 2.5	2.5 - 5	5 - 10	20 - 25	64	23	119
Susan Ellis – Director of Workforce (to 01.10.17)	0	0	0	0	1,039	0	0
Ann Hobson – Interim Director of Workforce (02.10.17 to 03.06.18)	0	0	25 - 30	70 - 75	527	1	562
Stephanie Lawrence – Acting Executive Director of Nursing and Allied Health Professionals (from 01.10.18)	0 - 2.5	2.5 - 5	20 - 25	60 - 65	337	45	450
Marcia Perry – Executive Director of Nursing (until 30.09.18)	0 - 2.5	0 - 2.5	35 - 40	110 -115	649	39	758
Sam Prince – Executive Director of Operations*	0	0	0	0	613	0	0
Laura Smith – Director of Workforce, OD and System Development (from 04.06.18)	2.5 - 5	10 - 12.5	20 - 25	55 - 60	216	100	351

* Individual ceased to be a member of the scheme before the start of the financial year

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's (or other allowable beneficiary's) pension payable from the scheme. CETVs are calculated in accordance with Statutory Instrument number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include 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.

Fair pay disclosures (subject to audit)

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.

The banded remuneration of the highest paid director for the Trust in the financial year 2018/19 was £151,604 (2017/18, £159,144). This was 5.0 (2017/18, 5.5) times the median remuneration of the workforce, which was £30,306 (2017/18 £28,746). The multiple is the less than last year as the highest paid director has changed from being the medical director to the chief executive officer. This has seen a reduction in the remuneration of the highest paid director of 4.7% whilst the median salary has increased by 5.4% as a result of the pay award which was weighted to the lower paid in the NHS.

In 2018/19 total remuneration ranged from £17,460 to £169,326 (2017/18, £16,523 to £170,527). One medical staff employee was paid more than the highest paid director.

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

Staff costs and numbers including senior officers (subject to audit)

Staff costs			2018/19	2017/18
	Permanent £000	Other £000	Total £000	Total £000
Salaries and wages	81,251	2,758	84,009	80,490
Social security costs	7,803	0	7,803	7,353
Apprenticeship levy	390	0	390	373
Employer's contributions to NHS pensions	10,366	0	10,366	9,991
Pension cost - other	31	0	31	13
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	(690)	0	(690)	265
Temporary staff	0	5,516	5,516	6,226
Total gross staff costs	**99,151**	**8,274**	**107,425**	**104,711**
Of which: Costs capitalised as part of assets	391	0	391	282

The majority of the increase in staff costs is as a result of the 2018/19 national agenda for change pay award.

Average staff numbers in post by occupation groupings

Average number of employees (WTE basis)			2018/19	2017/18
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	52	27	79	81
Administration and estates	658	77	735	711
Healthcare assistants and other support staff	459	30	489	476
Nursing, midwifery and health visiting staff	890	38	928	923
Nursing, midwifery and health visiting learners	5	0	5	3
Scientific, therapeutic and technical staff	433	22	455	490
Healthcare science staff	1	0	1	1
Other	34	1	35	29
Total average numbers	**2,532**	**195**	**2,727**	**2,714**
Of which: Number of employees (WTE) engaged on capital projects	4	3	7	6

On average there were 13 whole time equivalent more staff in post in 2018/19. This is the net change in respect of services that were newly commissioned in year such as the Yorkshire & Humber Police Custody Service less services that were decommissioned.

Expenditure on consultancy

The Trust had no expenditure on consultancy services during 2018/19.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2019	16
Of which, the number that have existed:	
For less than one year at the time of reporting	2
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	1
For between three and four years at the time of reporting	2
For four or more years at the time of reporting	10

All but one of the existing engagements have contractual clauses to request assurance on tax status. All but one of these appointments relates to forensic medical examiners; given the nature of their work the off-payroll contractual arrangement gives the Trust the best value for money.

For all new off-payroll engagements or those that reached six months in durations between 1 April 2018 and 31 March 2019, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	2
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	2
Number engaged directly (via PSC contracted to department) and are on the departmental 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

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0

Trade Union support

The Trust has a track record of working positively with Staff side representatives and supports a number of employees to undertake work associated with the Joint Negotiation and Consultation Forum (JNCF), and to support individual colleagues. There were 12 employees who undertook the role of accredited trade union officials and were given paid time off to undertake these duties. The amount of time that they spent on this varied, to meet the demands of their members.

Reporting on time off for Trade Union facility time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 (the Regulations) came into force on 1 April 2017. The Regulations require the Trust, as a public sector employer, to report and publish information annually on how much time is spent by their local union officials on paid 'trade union facility time'. For the year April 2018 to March 2019 the Trust is reporting in the four following categories:

Category one: What was the total number of your employees who were relevant union officials during the relevant period?

Number of employees who were relevant union officials during the relevant period	12
Full-time equivalent employee number	9.86

Category two: How many of your employees who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time?

Percentage of time	Number of employees
0%	0
1-50%	11
51%-99%	0
100%	1

Category three: Provide the figures requested in the first column of the table below to determine the percentage of your total pay bill spent on paying employees who were relevant union officials for facility time during the relevant period.

Pay bill spend	Figures
Provide the total cost of facility time	£43,919
Provide the total pay bill	£107,034,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.04%

Category four: As a percentage of total paid facility time hours, how many hours were spent by employees who were relevant union officials during the relevant period on paid trade union activities?

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	24.46%

A summary of the time off for trade union facility time is published on the Trust website.

Exit packages

The figures reported here relate to exit packages agreed in year. The actual date of departure might be in a subsequent period, and the expense in relation to departure costs may have been accrued in a previous period. The data here is therefore presented on a different basis to other staff cost expenditure in the accounts.

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
£10,000 - £25,000	2	-	2
Total number of exit packages by type	2	-	2
Total cost (£)	£24,000	£0	£24,000

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirements are met by the NHS Pensions Scheme and are not included in the table. There were no other departures during 2018/19.

Staff sickness

The table below illustrates a total number of days lost through sickness absence across the calendar year. These figures are supplied to the Trust by the Department of Health. This is to make sure a standard approach is taken and so that figures can be compared across NHS organisations.

	Calendar Year	
	2017	2018
Total days lost	32,038	31,839
Total staff years	2,485	2,503
Average working days lost	12.9	12.7

Signed .....

Chief Executive

Date 24 May 2019 .....

Leeds Community Healthcare NHS Trust

Annual Accounts for the period

1 April 2018 to 31 March 2019

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts;
- assess the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and
- use 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.

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

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

By order of the Board

24/5/19 Date ..... Chief Executive

24/5/19 Date ..... Executive Director of Finance

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF LEEDS COMMUNITY HEALTHCARE NHS TRUST

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Leeds Community Healthcare NHS 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 Taxpayers Equity and 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
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in 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.

Going concern

The Directors have 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 its 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").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

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.

Other information in the Annual Report

The Accountable Officer is 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.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 1, the directors are 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 . As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 48 (annual report) the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

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 its 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

As explained in the statement set out on page 48 (annual report), the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its 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.

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:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

We have nothing to report in these respects.

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

This report is made solely to the Board of Directors of Leeds Community Healthcare NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board 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 Community Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS4 1DA

24 May 2019

Statement of Comprehensive Income

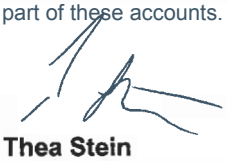
	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	145,276	142,243
Other operating income	4	10,364	7,283
Operating expenses	7,8,9	(149,282)	(144,623)
Operating surplus/(deficit) from continuing operations		**6,358**	**4,903**
Finance income	12	153	70
Finance expenses	13	-	-
PDC dividends payable		(715)	(488)
Net finance costs		**(562)**	**(418)**
Other gains/(losses)	14	(140)	(46)
Share of profit/(losses) of associates/joint arrangements	21	-	-
Gains/(losses) arising from transfers by absorption	46	-	-
Corporation tax expense		-	-
Surplus/(deficit) for the year from continuing operations		**5,656**	**4,439**
Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations		-	-
Surplus/(deficit) for the year		**5,656**	**4,439**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(574)
Revaluations	19	-	3,428
Share of comprehensive income from associates and joint ventures	21	-	-
Fair value gains/(losses) on equity instruments designated at fair value through OCI	21	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability/asset	38	-	-
Other reserve movements		-	43
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains/(losses) on financial assets mandated at fair value through OCI	22	-	-
Recycling gains/(losses) on disposal of financial assets mandated at fair value through OCI	14	-	-
Foreign exchange gains/(losses) recognised directly in OCI		-	-
Total comprehensive income/(expense) for the period		**5,656**	**7,336**

Adjusted financial performance (control total basis):		
Surplus/(deficit) for the period	5,656	4,439
Remove impact of consolidating NHS charitable fund	-	-
Remove net impairments not scoring to the Departmental Expenditure Limit	-	212
Remove (gains)/losses on transfers by absorption	-	-
Remove I&E impact of capital grants and donations	5	4
Prior period adjustments	-	-
Remove non-cash element of on-SoFP pension costs	-	-
CQUIN risk reserve adjustment (2017/18 only)	-	-
Remove 2016/17 post audit STF reallocation (2017/18 only)	-	-
Adjusted financial performance surplus/(deficit)	**5,661**	**4,655**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	16	30	53
Property, plant and equipment	17	29,310	29,310
Investment property	20	-	-
Investments in associates and joint ventures	21	-	-
Other investments / financial assets	22	-	-
Receivables	25	-	-
Other assets	26	-	-
Total non-current assets		**29,340**	**29,363**
Current assets			
Inventories	24	-	-
Receivables	25	9,449	8,849
Other investments / financial assets	22	-	-
Other assets	26	-	-
Non-current assets held for sale / assets in disposal groups	27	-	-
Cash and cash equivalents	28	26,483	23,244
Total current assets		**35,932**	**32,093**
Current liabilities			
Trade and other payables	29	(9,774)	(11,029)
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	(580)	(1,361)
Other liabilities	31	(1,099)	(1,042)
Liabilities in disposal groups	27.1	-	-
Total current liabilities		**(11,453)**	**(13,432)**
Total assets less current liabilities		**53,819**	**48,024**
Non-current liabilities			
Trade and other payables	29	-	-
Borrowings	32	-	-
Other financial liabilities	30	-	-
Provisions	34	-	-
Other liabilities	31	-	-
Total non-current liabilities		**-**	**-**
Total assets employed		**53,819**	**48,024**
Financed by			
Public dividend capital		395	256
Revaluation reserve		12,026	12,032
Financial assets reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		41,398	35,736
Total taxpayers' equity		**53,819**	**48,024**

The notes on pages 82 to 125 form part of these accounts.



Signed
Name **Thea Stein**
Position **Chief Executive**
Date **24 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital £000	Revaluation reserve £000	Financial assets reserve* £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2018 - brought forward	**256**	**12,032**	**-**	**-**	**-**	**35,736**	**48,024**
Impact of implementing IFRS 15 on 1 April 2018	-	-	-	-	-	-	-
Impact of implementing IFRS 9 on 1 April 2018	-	-	-	-	-	-	-
Surplus/(deficit) for the year	-	-	-	-	-	5,656	**5,656**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Transfer to retained earnings on disposal of assets	-	(6)	-	-	-	6	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on financial assets mandated at fair value	-	-	-	-	-	-	-
Fair value gains/(losses) on equity instruments designated at fair value	-	-	-	-	-	-	-
Recycling gains/(losses) on disposal of financial assets	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	139	-	-	-	-	-	**139**
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	-	-	-	-	-	-
Taxpayers' equity at 31 March 2019	**395**	**12,026**	**-**	**-**	**-**	**41,398**	**53,819**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017 - brought forward	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**
Prior period adjustment	-	-	-	-	-	-	-
Taxpayers' equity at 1 April 2017 - restated	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**
Surplus/(deficit) for the year	-	-	-	-	-	4,439	**4,439**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	-
Transfer from revaluation reserve to income and expenditure reserve	-	-	-	-	-	-	-
Other transfers between reserves	-	-	-	-	-	-	-
Impairments	-	(574)	-	-	-	-	**(574)**
Revaluations	-	3,428	-	-	-	-	**3,428**
Transfer to retained earnings on disposal of assets	-	(361)	-	-	-	361	-
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	-
Fair value gains/(losses) on available for sale financial investments	-	-	-	-	-	-	-
Recycling gains/(losses) on available for sale financial investments	-	-	-	-	-	-	-
Foreign exchange gains/(losses) recognised directly in OCI	-	-	-	-	-	-	-
Other recognised gains and losses	-	-	-	-	-	-	-
Remeasurements of the defined net benefit pension scheme liability/asset	-	-	-	-	-	-	-
Public dividend capital received	-	-	-	-	-	-	-
Public dividend capital repaid	-	-	-	-	-	-	-
Public dividend capital written off	-	-	-	-	-	-	-
Other movements in public dividend capital in year	-	-	-	-	-	-	-
Other reserve movements	-	43	-	-	-	-	**43**
Taxpayers' equity at 31 March 2018	**256**	**12,032**	**-**	**-**	**-**	**35,736**	**48,024**

Information on reserves

Public dividend capital
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 predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Other reserves
The Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not specifically included.

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus/(deficit)		6,358	4,903
Non-cash income and expense:			
Depreciation and amortisation	7.1	1,973	1,724
Net impairments	8	-	212
Income recognised in respect of capital donations	4	-	-
Amortisation of PFI deferred credit		-	-
Non-cash movements in on-SoFP pension liability		-	-
(Increase)/decrease in receivables and other assets		(879)	(2,331)
(Increase)/decrease in inventories		-	-
Increase/(decrease) in payables and other liabilties		(952)	1,637
Increase/(decrease) in provisions		(781)	(37)
Tax (paid)/received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		-	52
Net cash generated from/(used in) operating activities		**5,719**	**6,160**
Cash flows from investing activities			
Interest received		153	70
Purchase and sale of financial assets/investments		-	-
Purchase of intangible assets		-	(1)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(2,336)	(1,628)
Sales of property, plant, equipment and investment property		-	348
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions/disposals of subsidiaries		-	-
Net cash generated from/(used in) investing activities		**(2,183)**	**(1,211)**
Cash flows from financing activities			
Public dividend capital received		139	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest on loans		-	-
Other interest		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
PDC dividend (paid)/refunded		(436)	(809)
Financing cash flows of discontinued operations		-	-
Cash flows from/(used in) other financing activities		-	-
Net cash generated from/(used in) financing activities		**(297)**	**(809)**
Increase/(decrease) in cash and cash equivalents		**3,239**	**4,140**
Cash and cash equivalents at 1 April - brought forward		**23,244**	**19,104**
Cash and cash equivalents transferred under absorption accounting	46	-	-
Cash transferred to NHS foundation trust upon authorisation as FT		-	-
Cash and cash equivalents at 31 March	28	**26,483**	**23,244**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going concern

These accounts have been prepared on a going concern basis.

The Trust's financial monitoring throughout 2018/19 provides evidence that financial duties and targets will be met or exceeded. The Trust has achieved the Control Total set by NHS Improvement for 2018/19; historically, the Trust has achieved all its financial duties.

The Trust's financial performance is monitored externally by NHS Improvement through monthly reporting and regular meetings. Internally, the Trust's financial performance has been monitored monthly by the Senior Management Team and the Business Committee, and by the Board at each of its meetings.

The Trust has reported a use of resources risk rating of 1 since it was introduced in October 2016. A rating of 1 represents the lowest risk rating for provider organisations.

The Trust's financial plan for 2019/20 demonstrates delivery of the Board approved surplus and Control Total required by NHS Improvement. Based on this plan the forecast use of resources risk rating for 2019/20 is 1.

The Trust has low levels of outstanding debt; the majority of the contract income is paid in month.

The Trust's liquidity remains very strong with over £26m in the bank at the year end. The financial plan for 2019/20 demonstrates the Trust has sufficient cash resources to meet its operational and capital investment commitments for 2019/20.

The Board of Directors is an experienced team. During the financial year there have been the substantive appointments of Medical Director, Director of Nursing and Allied Health Professionals and Director of Workforce. Three Non-Executive Directors, including the Chair, had their terms of office extended during 2018/19.

The Board has considered the matter of the Trust as a going concern at its meeting on 29 March 2019, and through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future. This is in line with the Group Accounting Manual 2018/19 paragraph 4.11-4.16.

Note 1.3 Interests in other entities

Joint operations
Joint operations are arrangements in which the Trust has joint control with one or more other parties and has the rights to the assets, and obligations for the liabilities, relating to the arrangement. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The Trust provides sexual health services under a joint operation with Leeds Teaching Hospitals NHS Trust. As lead provider the contract income flows to the Trust, and Leeds Teaching Hospitals NHS Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to Leeds Teaching Hospitals NHS Trust.

The Trust provides forensic child and adolescent mental and physical health services under a joint operation with South West Yorkshire Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust, and South West Yorkshire Partnership NHS Foundation Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and a share of any profit or loss is transferred to South West Yorkshire Partnership NHS Foundation Trust.

Note 1.4 Revenue

Note 1.4.1 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.

With the exception of the Provider Sustainability Fund, income payments are not dependant on the timing of satisfaction of performance obligations.

The Provider Sustainability Fund (PSF) enables NHS providers to earn income linked to the achievement of financial controls and performance targets. Access to both the general and targeted elements of PSF are unlocked as NHS providers meet their financial control totals. At each quarter, a minimum of 70% of allocated funding will be released upon achievement of the financial control total, with up to a further 30% released where a provider also meets its agreed trajectories for delivery of operational standards.

In line with IFRS 15, PSF should be accounted for as variable consideration. Paragraph 51 of the Standard identifies that consideration would be variable if a fixed amount is promised as a performance bonus.

In accordance with the Standard an entity is required to estimate the amount of consideration to which it will be entitled, in exchange for transferring promised goods or services. The Standard notes that the 'most likely amount' method of predicting consideration to which an entity will be entitled to, may be an appropriate method of estimation if there are only two possible outcomes; achieving a performance bonus or not. The method of estimation employed must be applied consistently throughout the contract.

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 IFRS 15 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.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this in the transaction price and derecognises the relevant portion of income.

Where the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner and they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Revenue from non-NHS contracts
The Trust receives revenue from contracts with non-NHS 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 the Trust is aware of a penalty based on contractual performance, the Trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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.

The Trust's research contract values are not considered material.

Revenue from other contracts
The Trust has no other income under IFRS 15 that is considered material.

Note 1.4.2 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.

Note 1.4.3 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.

The Trust's other income relates to rental income and lease car income.

Note 1.5 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs 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 financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Trust operates an alternative mandatory scheme, National Employment Savings Trust, for employees who do not qualify for or choose not to become a member of the NHS Pension Scheme.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition
Property, plant and equipment is capitalised where:

- 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 be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, have broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, eg, plant and equipment, then these components are treated as separate assets and depreciated over their own useful lives.

Note 1.7.2 Measurement
Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:
- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowings costs. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure
Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses 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'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of:
(i) the impairment charged to operating expenses; and
(ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss are reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
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 ie:
- 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 abandoned 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'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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 useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions
The Trust has no Private Finance Initiative or Local Improvement Finance Trust transactions.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	5	87
Dwellings	-	-
Plant & machinery	5	10
Transport equipment	-	-
Information technology	5	5
Furniture & fittings	10	10

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.8 Intangible assets

Note 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. 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.

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 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.

Software
Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently, intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Information technology	-	-
Development expenditure	-	-
Websites	-	-
Software licences	5	5
Licences & trademarks	-	-
Patents	-	-
Other (purchased)	-	-
Goodwill	-	-

Note 1.9 Inventories

The Trust has no inventories.

Note 1.10 Investment properties

The Trust has no investment properties.

Note 1.11 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)

The Trust does not contribute to the Carbon Reduction Commitment Scheme.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition
Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services) which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, and are recognised when, and to the extent which, performance occurs ie when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement
Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as loans and receivables and are subsequently measured at amortised cost.

Financial liabilities are classified as other financial liabilities and are subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts, through the expected life of the financial asset or financial liability, to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability, and is recognised in the Statement of Comprehensive Income as a financing income or expense.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Following the adoption of IFRS 9 the Trust determines the value of its credit losses using a matrix approach. The Trust has only one class of financial asset - trade receivables. The non-NHS trade receivables have been categorised by type of debt and based on historic performance the value of defaults has been assessed and a provision made for this value. Receivables with other NHS bodies are subject to the agreement of balances exercise and no credit loss is provided for.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Note 1.14.1 The Trust as lessee
Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property, plant and equipment.

The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance expenses in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

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.

Note 1.14.2 The Trust as lessor
Finance leases
Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases
Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation 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 the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 34.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution 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.

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 35 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 35, 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 Trust'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.

Note 1.17 Public dividend capital

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 predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable 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 during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for:
(i) donated assets (including lottery funded assets)
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health and Social Care (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 annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

Note 1.18 Value added tax

Most of the activities of the 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.

Note 1.19 Corporation tax

Health service bodies are generally exempt from corporation tax, as they are either part of the Department of Health and Social Care or have specific exemption provided by sections 985 and 986 of the Corporation Tax Act 2010 (CTA 2010). Having reviewed these sections the Trust is satisfied it fulfils the definition of a health service body. The Trust has been established under section 25 of the National Health Service Act 2006 (as amended in 2012). This legislation states NHS trusts have been established to provide goods and services for the purposes of the health service. This is further defined as:

- the provision of goods and services for any purposes related to the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and
- the promotion and protection of public health.

Since the Trust only carries out services as described above, it has established no wholly or partially owned subsidiaries, and is therefore a health service body as defined by the Corporation Tax Act 2010, the Trust is exempt from corporation tax.

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items are translated at the spot exchange rate on 31 March
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction, and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.22 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 that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

Note 1.24 Transfers of functions to/from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net loss/gain corresponding to the net assets/liabilities transferred is recognised within expenses/income, but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve.

Note 1.25 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

In line with IAS 16 the Trust is responsible for ensuring the carrying value of its fixed assets reported in the Statement of Financial Position is up to date. The Trust completed a full revaluation of its land and buildings in 2017/18. In 2018/19, the Trust was advised by the District Valuers Office (an independent expert body) that the estimated movement in assets values is less than 3%. As a result the Trust's Management has decided there is no material difference to the carrying values and has therefore not revalued its estate this year.

In accordance with IFRS 15 Revenue from contracts, the Trust has included the full value of the Provider Sustainability Fund income. This arrangement enables provider organisations access to income linked to achievement of financial controls and performance targets, as such it is classified as variable consideration. As the Trust has met these targets in full the total value of this income has been recognised in year.

With the introduction of IFRS 9 Financial Instruments, NHS bodies have to adopt a provisions matrix approach to determine the value of provisions in respect of all financial instruments. The only financial instrument the Trust has is its trade receivables. The Trust has had to estimate its irrecoverable debt value using the matrix for 2018/19. This has reduced the provision for bad debts by circa £30k on previous years. The prior period has not been restated; changes to the carrying amount as a result of IRFS 9 adoption are recognised as part of the opening balance of reserves and are subject to disclosure notes. The value of this is not considered to be material.

Note 1.25.1 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

An estimate of the redundancy and employment tribunal costs has been made and included in the Trust's expenditure for 2018/19 as required under IAS 37. The estimated value of this is £314k for redundancies and £266k for legal claims.

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 14 Regulatory Deferral Accounts Not EU-endorsed
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.

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.

Note 2 Operating segments

All activity at Leeds Community Healthcare NHS Trust is healthcare related and the majority of the Trust's revenue is received from within UK government departments.

The main proportion of operating expenses are payroll related and are for the staff directly involved in the provision of healthcare and the indirect and overhead costs associated with that provision. It is deemed that the business activities that earn revenues for the Trust, and in turn incur the expenses, are therefore one broad provision on which it is deemed appropriate to identify as only one segment, namely healthcare.

Monthly operating results are published for assessment and review by the Trust's Chief Operating Decision Maker, which is the overall Trust Board that includes Executive and Non-Executive Directors. The financial position of the Trust to date, the Trust's Statement of Financial Position and Cash Flow and projections of future performance are assessed as a whole Trust rather than individual component parts that make up the sum total. In addition, all reporting of the position of the Trust is presented on a whole Trust basis that again implies a single operating segment under IFRS 8. As all decisions affecting the Trust's future direction and viability are made based on the overall total presented to Board, the Trust is satisfied that the single segment of healthcare is appropriate and consistent with the principles of IFRS 8.

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	2018/19 £000	2017/18 £000
Acute services		
Elective income	-	-
Non elective income	-	-
First outpatient income	-	-
Follow up outpatient income	-	-
A & E income	-	-
High cost drugs income from commissioners (excluding pass-through costs)	-	-
Other NHS clinical income	1,071	692
Mental health services		
Cost and volume contract income	-	-
Block contract income	1,598	1,621
Clinical partnerships providing mandatory services (including S75 agreements)	-	-
Clinical income for the secondary commissioning of mandatory services	-	-
Other clinical income from mandatory services	-	-
Community services		
Community services income from CCGs and NHS England	111,071	109,827
Income from other sources (eg local authorities)	29,676	29,822
All services		
Private patient income	-	-
Agenda for Change pay award central funding	1,546	-
Other clinical income	314	281
Total income from activities	**145,276**	**142,243**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2018/19 £000**	**2017/18 £000**
NHS England	9,020	8,079
Clinical Commissioning Groups	104,719	104,059
Department of Health and Social Care	1,546	-
Other NHS providers	319	281
NHS other	-	-
Local authorities	28,550	28,444
Non-NHS: private patients	-	-
Non-NHS: overseas patients (chargeable to patient)	-	-
Injury cost recovery scheme	-	-
Non NHS: other	1,122	1,380
Total income from activities	**145,276**	**142,243**
Of which:		
Related to continuing operations	145,276	142,243
Related to discontinued operations	-	-

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

The Trust made no charges relating to patients who are overseas visitors.

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	391	371
Education and training (excluding notional apprenticeship levy income)	1,801	1,535
Non-patient care services to other bodies	334	121
Provider sustainability/sustainability and transformation fund income (PSF/STF)	3,953	2,417
Income in respect of employee benefits accounted on a gross basis	967	722
Other contract income	2,364	1,622
Other non-contract operating income		
Research and development (non-contract)	-	-
Education and training - notional income from apprenticeship fund	73	16
Receipt of capital grants and donations	-	-
Charitable and other contributions to expenditure	-	-
Support from the Department of Health and Social Care for mergers	-	-
Rental revenue from finance leases	-	-
Rental revenue from operating leases	481	479
Amortisation of PFI deferred income/credits	-	-
Other non-contract income	-	-
Total other operating income	**10,364**	**7,283**
Of which:		
Related to continuing operations	10,364	7,283
Related to discontinued operations	-	-

Other contract income totalled £2,364k; of which £801k was rental income, £288k was lease car income and £1,001k was income to fund projects supporting the transformation of care pathways.

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	316
Revenue recognised from performance obligations satisfied in previous periods	-

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	2019 £000
within one year	-
after one year, not later than five years	-
after five years	-
Total revenue allocated to remaining performance obligations	-

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (i) contracts with an expected duration of one year or less and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

The Trust has no income associated with fees and charges.

Note 7.1 Operating expenses

	2018/19 £000	2017/18 £000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	1,563	1,345
Purchase of social care	-	-
Staff and executive directors costs *	107,034	104,429
Remuneration of non-executive directors	53	54
Supplies and services - clinical (excluding drugs costs)	10,511	9,983
Supplies and services - general	5,026	3,537
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	854	875
Inventories written down	-	-
Consultancy costs	-	-
Establishment	3,330	3,346
Premises	12,384	12,259
Transport (including patient travel)	1,951	1,777
Depreciation on property, plant and equipment	1,956	1,700
Amortisation on intangible assets	17	24
Net impairments	-	212
Movement in credit loss allowance: contract receivables/contract assets	(59)	-
Movement in credit loss allowance: all other receivables and investments	-	1
Increase/(decrease) in other provisions	(30)	(28)
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services - statutory audit	48	47
other auditor remuneration (external auditor only)	-	-
Internal audit costs	96	94
Clinical negligence	260	371
Legal fees	36	84
Insurance	116	129
Research and development	19	12
Education and training	642	519
Rentals under operating leases *	1,331	1,446
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (eg PFI/LIFT)	-	-
Charges to operating expenditure for off-SoFP PFI/LIFT schemes	-	-
Car parking & security	250	260
Hospitality	-	-
Losses, ex gratia & special payments	50	27
Grossing up consortium arrangements	-	-
Other services, eg external payroll	817	812
Other **	1,027	1,308
Total	**149,282**	**144,623**
Of which:		
Related to continuing operations	149,282	144,623
Related to discontinued operations	-	-

* The prior year figures for these items of expenditure have been restated to correct an error in 2017/18 to provide accurate comparative information. Operating costs for 2017/18 overall remain the same as reported last year.

** £740k of other expenditure relates to external recharges in respect of joint operations with Leeds Teaching Hospitals NHS Trust and South West Yorkshire Partnership NHS Foundation Trust.

Note 10 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.

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) 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

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.

Other pension costs

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish to join the NHS Pension Scheme this is the Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP). The Trust has expensed £31k during the year in respect of contributions for employees under the NEST scheme.

Note 11 Operating leases

Note 11.1 Leeds Community Healthcare NHS Trust as a lessor

This note discloses income generated in operating lease agreements where Leeds Community Healthcare NHS Trust is the lessor.

Leasing arrangements where the Trust is a lessor relate to the sub-letting of health centres and clinics, where the lessee is generally a GP practice or other healthcare provider.

	2018/19 £000	2017/18 £000
Operating lease revenue		
Minimum lease receipts	481	479
Contingent rent	-	-
Other	-	-
Total	**481**	**479**

	2019 £000	2018 £000
Future minimum lease receipts due:		
- not later than one year;	507	453
- later than one year and not later than five years;	1,289	1,118
- later than five years.	95	65
Total	**1,891**	**1,636**

Note 11.2 Leeds Community Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Leeds Community Healthcare NHS Trust is the lessee.

The Trust has leases in respect of accommodation, vehicles and photocopiers.

	2018/19 £000	2017/18 £000
Operating lease expense		
Minimum lease payments	1,331	1,446
Contingent rents	-	-
Less sublease payments received	-	-
Total	**1,331**	**1,446**

	2019 £000	2018 £000
Future minimum lease payments due:		
- not later than one year;	1,273	1,303
- later than one year and not later than five years;	3,313	3,806
- later than five years.	533	725
Total	**5,119**	**5,834**
Future minimum sublease payments to be received	-	-

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19 £000	2017/18 £000
Interest on bank accounts	153	70
Interest income on finance leases	-	-
Interest on other investments/financial assets	-	-
Other finance income	-	-
Total finance income	**153**	**70**

Note 13.1 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2018/19 £000	2017/18 £000
Interest expense:		
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	-	-
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	-	-

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19 £000	2017/18 £000
Total liability accruing in year under this legislation as a result of late payments	-	-
Amounts included within interest payable arising from claims under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 14 Other gains/(losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	-	193
Losses on disposal of assets	(140)	(239)
Total gains/(losses) on disposal of assets	**(140)**	**(46)**
Gains/(losses) on foreign exchange	-	-
Fair value gains/(losses) on investment properties	-	-
Fair value gains/(losses) on financial assets / investments	-	-
Fair value gains/(losses) on financial liabilities	-	-
Recycling gains/(losses) on disposal of financial assets mandated as fair value through OCI	-	-
Total other gains/(losses)	**(140)**	**(46)**

Assets disposed of during the year relate to the write off of equipment no longer in use and not saleable.

Note 15 Discontinued operations

Note 16.1 Intangible assets - 2018/19

	Software licences	Total
	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**259**	**259**
Transfers by absorption	-	-
Additions	-	-
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to/from assets held for sale	-	-
Disposals/derecognition	(212)	**(212)**
Valuation/gross cost at 31 March 2019	**47**	**47**
Amortisation at 1 April 2018 - brought forward	**206**	**206**
Transfers by absorption	-	-
Provided during the year	17	**17**
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to/from assets held for sale	-	-
Disposals/derecognition	(206)	**(206)**
Amortisation at 31 March 2019	**17**	**17**
Net book value at 31 March 2019	**30**	**30**
Net book value at 1 April 2018	**53**	**53**

Note 16.2 Intangible assets - 2017/18

	Software licences £000	Total £000
Valuation/gross cost at 1 April 2017 - as previously stated	**258**	**258**
Transfers by absorption	-	-
Additions	1	1
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to/from assets held for sale	-	-
Disposals/derecognition	-	-
Valuation/gross cost at 31 March 2018	**259**	**259**
Amortisation at 1 April 2017 - as previously stated	**182**	**182**
Transfers by absorption	-	-
Provided during the year	24	24
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to/from assets held for sale	-	-
Disposals/derecognition	-	-
Amortisation at 31 March 2018	**206**	**206**
Net book value at 31 March 2018	**53**	**53**
Net book value at 1 April 2017	**76**	**76**

Note 17.1 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**10,241**	**15,670**	**-**	**2,169**	**4,898**	**589**	**33,567**
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	664	-	120	1,306	-	**2,090**
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-
Disposals/derecognition	-	(40)	-	(213)	(899)	(400)	**(1,552)**
Valuation/gross cost at 31 March 2019	**10,241**	**16,294**	**-**	**2,076**	**5,305**	**189**	**34,105**
Accumulated depreciation at 1 April 2018 - brought forward	**-**	**217**	**-**	**1,493**	**2,018**	**529**	**4,257**
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	705	-	277	949	25	**1,956**
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-
Disposals/derecognition	-	(11)	-	(198)	(809)	(400)	**(1,418)**
Accumulated depreciation at 31 March 2019	**-**	**911**	**-**	**1,572**	**2,158**	**154**	**4,795**
Net book value at 31 March 2019	**10,241**	**15,383**	**-**	**504**	**3,147**	**35**	**29,310**
Net book value at 1 April 2018	**10,241**	**15,453**	**-**	**676**	**2,880**	**60**	**29,310**

Note 17.2 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - as previously stated	**9,550**	**14,715**	**65**	**3,446**	**4,159**	**584**	**32,519**
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	-	490	67	905	-	**1,462**
Impairments	(339)	(698)	-	-	-	-	**(1,037)**
Reversals of impairments	-	(85)	-	-	-	-	**(85)**
Revaluations	1,030	1,280	-	-	-	-	**2,310**
Reclassifications	-	550	(555)	-	-	5	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-
Disposals/derecognition	-	(92)	-	(1,344)	(166)	-	**(1,602)**
Valuation/gross cost at 31 March 2018	**10,241**	**15,670**	**-**	**2,169**	**4,898**	**589**	**33,567**
Accumulated depreciation at 1 April 2017 - as previously stated	**-**	**1,219**	**-**	**2,365**	**1,287**	**504**	**5,375**
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	514	-	322	839	25	**1,700**
Impairments	-	(222)	-	-	-	-	**(222)**
Reversals of impairments	-	(114)	-	-	-	-	**(114)**
Revaluations	-	(1,118)	-	-	-	-	**(1,118)**
Reclassifications	-	-	-	-	-	-	-
Transfers to/from assets held for sale	-	-	-	-	-	-	-
Disposals/derecognition	-	(62)	-	(1,194)	(108)	-	**(1,364)**
Accumulated depreciation at 31 March 2018	**-**	**217**	**-**	**1,493**	**2,018**	**529**	**4,257**
Net book value at 31 March 2018	**10,241**	**15,453**	**-**	**676**	**2,880**	**60**	**29,310**
Net book value at 1 April 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**

Note 17.3 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019							
Owned - purchased	10,241	15,215	-	504	3,147	35	**29,142**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	168	-	-	-	-	**168**
Net book value at 31 March 2019	**10,241**	**15,383**	**-**	**504**	**3,147**	**35**	**29,310**

Note 17.4 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018							
Owned - purchased	10,241	15,280	-	676	2,880	60	**29,137**
Finance leased	-	-	-	-	-	-	**-**
On-SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	**-**
Off-SoFP PFI residual interests	-	-	-	-	-	-	**-**
Owned - government granted	-	-	-	-	-	-	**-**
Owned - donated	-	173	-	-	-	-	**173**
Net book value total at 31 March 2018	**10,241**	**15,453**	**-**	**676**	**2,880**	**60**	**29,310**

Note 18 Donations of property, plant and equipment

The Trust received no donations of property, plant and equipment during 2018/19.

Note 19 Revaluations of property, plant and equipment

The Trust has not revalued property, plant and equipment during 2018/19.

Note 20.1 Investment Property

The Trust has no investment property.

Note 21 Investments in associates and joint ventures

The Trust has no investments in associates and joint ventures.

Note 22 Other investments/financial assets (non-current)

The Trust has no non-current other investments/financial assets.

Note 22.1 Other investments/financial assets (current)

The Trust has no current other investments/financial assets.

Note 23 Disclosure of interests in other entities

The Trust has no interests in unconsolidated subsidiaries, joint ventures, associates or unconsolidated structured entities.

Note 24 Inventories

The Trust has no inventories.

Note 25.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	8,395	
Contract assets*	-	
Trade receivables*		4,272
Capital receivables	-	-
Accrued income*		2,381
Allowance for impaired contract receivables/assets*	(8)	
Allowance for other impaired receivables	-	(100)
Deposits and advances	-	-
Prepayments (non-PFI)	490	585
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	30	309
VAT receivable	489	1,378
Corporation and other taxes receivable	-	-
Other receivables	53	24
Total current trade and other receivables	**9,449**	**8,849**
Non-current		
Contract receivables*	-	
Contract assets*	-	
Trade receivables*		-
Capital receivables	-	-
Accrued income*		-
Allowance for impaired contract receivables/assets*	-	
Allowance for other impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	-	-
Of which receivables from NHS and DHSC group bodies:		
Current	5,182	3,679
Non-current	-	-

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 25.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets £000	All other receivables £000
Allowances as at 1 Apr 2018 - brought forward		**100**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	100	(100)
Transfers by absorption	-	-
New allowances arising	65	-
Changes in existing allowances	(33)	-
Reversals of allowances	(91)	-
Utilisation of allowances (write offs)	(33)	-
Changes arising following modification of cotractual cash flows	-	-
Foreign exchange and other changes	-	-
Allowances as at 31 Mar 2019	**8**	**-**

Note 25.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables £000
Allowances as at 1 Apr 2017 - as previously stated	**106**
Transfers by absorption	-
Increase in provision	59
Amounts utilised	(7)
Unused amounts reversed	(58)
Allowances as at 31 Mar 2018	**100**

Note 25.4 Exposure to credit risk

The Trust reviewed its exposure to credit risk following the introduction of IFRS 9. NHS debt is resolved through the agreement of balances process and, as such, is not considered to be a credit risk. A provision matrix was used to categorise the debts and review historical losses over a two year period. The historical debt rates of Non-NHS debt were determined by calculating invoices written off as a percentage of total Non-NHS debt. Forward looking macro-economic factors were considered and the final credit losses rates were calculated.

The main credit risk to the Trust is from ex-employee debt and the credit loss rate to be applied to this type of debt was calculated as 26.75%. Overall an £8k credit loss allowance has been recognised for Non-NHS receivables in 2018/19.

Note 26 Other assets

The Trust has no other assets.

Note 27 Non-current assets held for sale and assets in disposal groups

	2018/19 £000	2017/18 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	-	165
Transfers by absorption	-	-
Assets classified as available for sale in the year	-	-
Assets sold in year	-	(165)
Impairment of assets held for sale	-	-
Reversal of impairment of assets held for sale	-	-
Assets no longer classified as held for sale, for reasons other than sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	-	-

The asset sold in 2017/18 was Garforth Clinic.

Note 27.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups.

Note 28 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19 £000	2017/18 £000
At 1 April	23,244	19,104
Transfers by absorption	-	-
Net change in year	3,239	4,140
At 31 March	26,483	23,244
Broken down into:		
Cash at commercial banks and in hand	3	4
Cash with the Government Banking Service	26,480	23,240
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	26,483	23,244
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	26,483	23,244

Note 28.1 Third party assets held by the Trust

The Trust holds no third party assets.

Note 29 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	2,628	1,662
Capital payables	126	372
Accruals	3,478	5,674
Receipts in advance (including payments on account)	-	-
Social security costs	1,265	1,164
VAT payables	-	-
Other taxes payable	793	755
PDC dividend payable	-	-
Accrued interest on loans*	-	-
Other payables	1,484	1,402
Total current trade and other payables	**9,774**	**11,029**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,552	2,345
Non-current	-	-

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 29.1 Early retirements in NHS payables above
There are no early retirements included in NHS payables.

Note 30 Other financial liabilities

The Trust has no other financial liabilities.

Note 31 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	1,099	1,042
Deferred grants	-	-
PFI deferred income/credits	-	-
Lease incentives	-	-
Other deferred income	-	
Total other current liabilities	**1,099**	**1,042**
Non-current		
Deferred income: contract liabilities	-	-
Deferred grants	-	-
PFI deferred income/credits	-	-
Lease incentives	-	-
Other deferred income	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 32 Borrowings

The Trust has no borrowings.

Note 32.1 Reconciliation of liabilities arising from financing activities

The Trust has no liabilities arising from financing activities.

Note 33 Finance leases

The Trust has no finance leases.

Note 34.1 Provisions for liabilities and charges analysis

	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Redundancy	Other	Total
	£000	£000	£000	£000	£000	£000	£000	£000
At 1 April 2018	-	-	**333**	-	-	**1,028**	-	**1,361**
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	-	18	-	-	63	-	**81**
Utilised during the year	-	-	(37)	-	-	(24)	-	**(61)**
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	-	(48)	-	-	(753)	-	**(801)**
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2019	-	-	**266**	-	-	**314**	-	**580**
Expected timing of cash flows:								
- not later than one year;	-	-	266	-	-	314	-	**580**
- later than one year and not later than five years;	-	-	-	-	-	-	-	-
- later than five years.	-	-	-	-	-	-	-	-
Total	-	-	**266**	-	-	**314**	-	**580**

In respect of legal claims the uncertainty as to amounts and timings relates to the time taken to determine whether or not the Trust is liable and if so, what the value of that liability will be.

In respect of redundancy and other provisions, the uncertainty as to amounts and timings relates to the time that will need to be taken to complete the formal processes.

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

Note 34.2 Clinical negligence liabilities

At 31 March 2019, £619k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2018: £657k).

Note 35 Contingent assets and liabilities

The Trust has no contingent assets and liabilities.

Note 36 Contractual capital commitments

The Trust has no contractual capital commitments.

Note 37 Other financial commitments

The Trust is committed to making payments under non-cancellable contracts (which are not leases, PFI contracts or other service concession arrangement), analysed by the period during which the payment is made:

	31 March 2019 £000	31 March 2018 £000
not later than 1 year	933	876
after 1 year and not later than 5 years	844	1,142
paid thereafter	-	-
Total	**1,777**	**2,018**

Note 38 Defined benefit pension schemes

The Trust has no defined benefit pension schemes.

Note 39 On-SoFP PFI, LIFT or other service concession arrangements

The Trust has no On-SoFP PFI, LIFT or other service concession arrangements.

Note 40 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust has no Off-SoFP PFI, LIFT or other service concession arrangements.

Note 41 Financial instruments

Note 41.1 Financial risk management

In accordance with IFRS 7, trusts should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the Trust is exposed at the end of the reporting period. Because of the continuing service provider relationship that the Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. In addition financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Trust Board. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations.

The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust currently has no borrowings.

The Trust may borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings would be for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care, the lender, at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies, 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 note 25.4.

Liquidity risk

The majority of the Trust's operating costs are incurred under contracts with Clincial Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit.

The Trust is not therefore exposed to significant liquidity risks.

Note 41.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,440	-	-	**8,440**
Other investments/financial assets	-	-	-	-
Cash and cash equivalents at bank and in hand	26,483	-	-	**26,483**
Total at 31 March 2019	**34,923**	-	-	**34,923**

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	6,577	-	-	-	**6,577**
Other investments/financial assets	-	-	-	-	-
Cash and cash equivalents at bank and in hand	23,244	-	-	-	**23,244**
Total at 31 March 2018	**29,821**	-	-	-	**29,821**

Note 41.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied restrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	6,289	-	6,289
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2019	6,289	-	6,289

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Other borrowings	-	-	-
Trade and other payables excluding non financial liabilities	6,686	-	6,686
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	6,686	-	6,686

Note 41.4 Fair values of financial assets and liabilities

The book value (carrying value) of financial assets and liabilities is a reasonable approximation of fair value.

Note 41.5 Maturity of financial liabilities

	2019	2018
	£000	£000
In one year or less	6,289	6,686
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	6,289	6,686

Note 42 Losses and special payments

	2018/19		2017/18	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	3	-	1	-
Fruitless payments	-	-	2	93
Bad debts and claims abandoned	31	36	36	17
Stores losses and damage to property	1	1	1	6
Total losses	**35**	**37**	**40**	**116**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	7	13	9	3
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**7**	**13**	**9**	**3**
Total losses and special payments	**42**	**50**	**49**	**119**
Compensation payments received		-		-

There are no cases which exceed £300k to disclose.

Note 43 Gifts

There are no gifts to disclose.

Note 44.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

Note 44.2 Initial application of IFRS 15

IFRS 15 Revenue from contracts with customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

The application of IFRS 15 has had no financial impact on the Trust, the only changes being presentational.

Note 45 Related parties

Details of related parties transactions are as follows:

	Expenditure with Related Party	Revenue from Related Party	Amounts owed to Related Party	Amounts due from Related Party
	£	£	£	£
University of Leeds Jane Madeley (Non-Executive Director) *Chief Financial Officer, University of Leeds*	275,215	30,821	45,035	9,148
Care Quality Commission Thea Stein (Chief Executive Officer) *Executive Reviewer*	104,244	-	-	-
Royal College of Paediatrics and Child Health Ian Lewis (Non-Executive Director) *Fellow*	1,000	-	-	-
Royal College of Psychiatrists Dr Tony Dearden (Non-Executive Director) *Fellow*	8,084	-	-	-
Leeds GP Confederation Jenny Allen (Director of Workforce) *Director of Workforce, Leeds GP Confederation* Ruth Burnett (Medical Director) *Medical Director, Leeds GP Confederation* Stephanie Lawrence (Interim Executive Director of Nursing) *Director of Nursing, Leeds GP Confederation* Laura Smith (Director of Workforce) *Director of Workforce, Leeds GP Confederation*	-	75,202	-	18,140
West Yorkshire Police Ann Hobson (Interim Director of Workforce until 03/06/2018) *Husband is an employee*	-	7,850,514	16,659	526,219

The Department of Health & Social Care is regarded as a related party. During the year 2018/19 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department as listed below:

Barnsley Hospital NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale & Huddersfield NHS Foundation Trust
Care Quality Commission
East and North Hertfordshire NHS Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Health Education England
Hull University Teaching Hospitals NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust
London North West Healthcare NHS Trust
Manchester University NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
Midlands Partnership NHS Foundation Trust
NHS Airedale, Wharfedale and Craven CCG
NHS Barnsley CCG
NHS Birmingham and Solihull CCG
NHS Blackburn with Darwen CCG
NHS Bolton CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Business Services Authority
NHS Calderdale CCG
NHS Chorley and South Ribble CCG
NHS Doncaster CCG
NHS East Lancashire CCG
NHS East Riding of Yorkshire CCG
NHS Enfield CCG
NHS England
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Hartlepool and Stockton-on-Tees CCG
NHS Herts Valleys CCG
NHS Heywood, Middleton & Rochdale CCG
NHS Horsham and Mid Sussex CCG
NHS Hull CCG
NHS Lambeth CCG
NHS Leeds CCG
NHS Lewisham CCG
NHS Resolution
NHS Newcastle Gateshead CCG
NHS North Cumbria CCG
NHS North of England Commissioning Support Unit
NHS North Durham CCG
NHS North East Lincolnshire CCG
NHS North Kirklees CCG
NHS North Lincolnshire CCG
NHS North Norfolk CCG
NHS North Tyneside CCG
NHS Northumberland CCG
NHS Nottingham City CCG
NHS Salford CCG
NHS Sandwell and West Birmingham CCG
NHS Scarborough and Ryedale CCG
NHS Sheffield CCG
NHS Somerset CCG
NHS Thanet CCG
NHS Vale of York CCG
NHS Wakefield CCG
NHS Wigan Borough CCG
North Tees and Hartlepool NHS Foundation Trust
Public Health England
Rotherham Doncaster and South Humber NHS Foundation Trust
Royal Liverpool and Broadgreen University Hospitals NHS Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
The Christie NHS Foundation Trust
The Rotherham NHS Foundation Trust
University Hospital Southampton NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies as listed below:

Cardiff and Vale University Local Health Board
Community Health Partnerships
East Riding of Yorkshire Council
HM Revenue and Customs
Kirklees Metropolitan Council
Leeds City Council
NHS Pension Scheme
NHS Property Services
Sheffield City Council
The West Yorkshire Combined Authority
West Yorkshire Police and Crime Commissioner and Chief Constable

The Trust has received receipts from Leeds Community Healthcare Charitable Trust and Related Charities for which the Trust Board is Corporate Trustee. These are solely to reimburse the Trust for purchases made for the Charity as an agent.

The audited accounts of the Charity are available from the Trust's Communications Team.

Note 46 Transfers by absorption

The Trust has no transfers by absorption.

Note 47 Prior period adjustments

The Trust has no prior period adjustments.

Note 48 Events after the reporting date

The Trust has no events after the reporting date.

Note 49 Final period of operation as a Trust providing NHS healthcare

This is not relevant to the Trust.

Note 50 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	16,870	33,952	18,178	30,890
Total non-NHS trade invoices paid within target	16,232	32,287	17,487	29,827
Percentage of non-NHS trade invoices paid within target	96.2%	95.1%	96.2%	96.6%
NHS Payables				
Total NHS trade invoices paid in the year	917	19,732	935	17,588
Total NHS trade invoices paid within target	897	19,360	918	17,483
Percentage of NHS trade invoices paid within target	97.8%	98.1%	98.2%	99.4%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 51 External financing

The Trust is given an external financing limit against which it is permitted to underspend:

	2018/19 £000	2017/18 £000
Cash flow financing	(3,100)	(4,140)
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**(3,100)**	**(4,140)**
External financing limit (EFL)	**(3,100)**	**(2,941)**
Under/(over) spend against EFL	**-**	**1,199**

Note 52 Capital Resource Limit

	2018/19 £000	2017/18 £000
Gross capital expenditure	2,090	1,463
Less: Disposals	(140)	(403)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal from capital grants in kind	-	-
Charge against Capital Resource Limit	**1,950**	**1,060**
Capital Resource Limit	2,051	1,816
Under/(over) spend against CRL	**101**	**756**

Note 53 Breakeven duty financial performance

	2018/19 £000
Adjusted financial performance surplus/(deficit) (control total basis)	5,661
Remove impairments scoring to Departmental Expenditure Limit	-
Add back non-cash element of On-SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus/(deficit)	**5,661**

Note 54 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000	2018/19 £000
Breakeven duty in-year financial performance	2,577	1,809	1,425	2,007	2,985	3,350	4,655	5,661
Breakeven duty cumulative position	2,577	4,386	5,811	7,818	10,803	14,153	18,808	24,469
Operating income	134,978	139,906	142,863	146,668	156,367	148,654	149,526	155,640
Cumulative breakeven position as a percentage of operating income	1.9%	3.1%	4.1%	5.3%	6.9%	9.5%	12.6%	15.7%

Thank you for taking the time to read our Annual Report and Accounts for 2017/18. You can also view this document via our website at **www.leedscommunityhealthcare.nhs.uk** where you can also find the full accounts.

Our Quality Account is also available on our website or hard copies can be requested by email to **lch.pet@nhs.net** or call **0113 220 8585**.

If you would like any of our reports in an alternative format or large print please email **lch.comms@nhs.net** or call **0113 220 8512**.

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