NHS
Leeds Community Healthcare
NHS Trust

Annual Report
and Accounts 2023-2024

Contents

Foreword

As ever, we look back on the past 12 months with pride and recognition for our colleagues who, even through difficult times, have provided timely and effective care to the people of Leeds. We extend our thanks to them for the support they provide day and night, all year round, and for their outstanding ability to deliver highly complex care in, or as close as possible, to a person's own home.

We have continued to provide the highest levels of care, with an unrelenting focus and intention to support people living with the highest levels of deprivation. Our Health Equity section provides many clear examples of this. We have done this alongside colleagues in the health, social care and voluntary sectors all of whom share our ambition for all people across our community to be given the best start in life, to remain healthy and to age well.

Whether frontline or in support roles, we know our colleagues need access to the best possible resources to provide modern healthcare. Improvements in this area have been a key focus of the year and you will find examples in this report of how we have digitised processes to improve patient care. This commitment was further backed, in year, with the introduction of an Associate Director of Digital Transformation to our strategic team. We recognise the importance of digital solutions within a community model of care and our intention is to grow and expand in this field, whilst ensuring our services remain accessible to all.

Our teams have done much this year to move further through the recovery phase of COVID-19, and we have continued to do all we can to respond to staff health and wellbeing needs. We enjoyed a record response to our Staff Survey, with improvements in almost all areas. Whilst you can read more about our successes within this report, the results also confirmed that our focus on health and wellbeing must remain strong into 2024/25. We must remain vigilant to the needs of colleagues who still report feeling burned out and overwhelmed. We know that great healthcare begins with team members who feel well enough to provide it to others.

Working collaboratively remains a high priority, and successful work to strengthen partnership working continued. One strong and evidence backed example, is our work with Yorkshire Ambulance Service, to clinically triage patients and provide alternative community support before an ambulance is dispatched. Working together, we have diverted many patients away from the hospital door over the past year and this is a prime example of one of our core principles – to keep a person well and at home. This targeted in-reach is further exemplified in our continued funding of the Enhance project, which sees our Neighbourhood Teams working with multiple and diverse third sector organisations to provide non clinical wraparound care to people on neighbourhood caseloads across the city.

Relationships with Leeds 'Place' and with the West Yorkshire Integrated Care Board remained strong. However, we recognise that across all health and social care partnerships across the City and indeed regionally and nationally, the scale of the financial challenge is high, with Trusts being stretched to their financial limits. Our Financial report will give you some indication of the scale of stewardship required this year and this position intensifies into 2024/25. As such, in January we launched our Quality and Value Programme, a three-year programme which seeks to review all our systems, processes and care pathways to identify where and how our organisation can offer even better value for money.

During 2023/24 we experienced some further industrial action, and we are pleased to report that this impacted minimally on our services and that robust plans were in place to mitigate against disruption of services and to ensure safe levels of care.

The Trust also navigated a significant time of change for its executive team, and you can read more about this in the Directors' Report. Thea Stein, who had been Chief Executive of the Trust for nine years, stepped down in August to assume the role as Chief Executive at the Nuffield Trust, a national independent health think tank. Bryan Machin, who provided financial oversight to the Trust as its Director of Finance since the Trust's inception in 2011, also left to begin his retirement. We extend our sincere thanks to them both for their service and dedication to the Trust, not least through a very challenging and remarkable period in NHS history. From April 2024, Selina Douglas joins the Trust as its new Chief Executive. We know that her experience of working in strategic roles across diverse health and social care sectors will be of huge benefit to us as we move forward.

In closing, we would like to reaffirm our pride in this organisation. It is our privilege to work alongside our colleagues and partners in the city and we very much look forward to even more progress over the coming year.

Thank you,

Brodie Clark CBE
Chair

Sam Prince
Interim Chief Executive

About the Trust

How we work

Leeds Community Healthcare NHS Trust (LCH) serves a population of around 812,000 people and delivers care to around 5,000 people every day. We are an award-winning Trust, with many staff recognised nationally for their achievements.

We employ more than 3,400 people, who provide a range of community healthcare services for the people of Leeds and some specialist care services across the wider Yorkshire and the Humber area. Care is always provided in, or as near to, a person's own home as possible.

Our services are organised into three business units: Adult Services, Children and Families Services and Specialist Services. The three business units are supported by Corporate Service teams. A full list of our services is set out below.

Adult Services

- 13 Neighbourhood Teams
- Wharfedale Recovery Hubs
- Neighbourhood Nights Palliative and End of Life Care
- Community Cancer Support Service
- Health Case Management
- Bed Bureau
- Single Point of Urgent Referral (SPUR)
- Leeds Integrated Discharge Service
- Community Care Beds
- Therapy Supported Discharge
- Tissue Viability Service
- Continence, Urology and Colorectal Service
- Community Falls Service
- Community Geriatricians

Specialist Services

- Community Neurology Team
- Community Stroke Team
- Speech and Language Therapy (SLT) Services and Speech and Swallowing Service
- Leeds Mental Wellbeing Service (LMWS)
- Diabetes Leeds Partnership
- Adult and Children's Nutrition and Dietetics
- Tier 3 Weight Management
- Podiatry (foot health)
- Community Dental Service
- Musculoskeletal Services
- Leeds Community Pain Service
- First Contact Physiotherapy
- Custodial Healthcare (Wetherby Young Offenders Institute and Adel Beck Secure Children's Home)
- Police Custody Suites Healthcare Services across Yorkshire and the Humber
- Liaison and Diversion (Hull and Humber)
- Reconnect (Hull and Humber, operational from April 2023)
- Community Intravenous Antibiotics Service (CIVAS)
- Tuberculosis (TB)
- Homeless and Health Inclusion Team (HHIT)
- Cardiac Service
- Respiratory Service
- Respiratory Virtual Ward
- Leeds Sexual Health
- Community Gynaecology
- Long COVID Community Rehabilitation Service

Children and Families Services

- Integrated Children's Additional Needs Service (ICAN):
  - Child Development Centre
  - Occupational Therapy
  - Physiotherapy
  - Community Paediatrics
  - Paediatric Neurodisability Clinics
  - Child Protection Medical Service
  - Growth and Nutrition
  - Adoption and Fostering
  - Springfield Neonatal Follow Up Clinic
  - Audiology
  - Continuing Care and Health Short Breaks
  - Inclusion Nursing Service
  - Hannah House
- Children and Young People's Mental Health Services (CYPMHS):
  - Crisis Service
  - Community Outreach Service
  - Transitions Service
  - MindMate Single Point of Access
  - Community Teams
  - Eating Disorders Service
  - Learning Disability Team
  - MindMate Support
  - Youth Justice Service Team
  - Input to Therapeutic Social Work Team
  - Crisis Call Line
- Children's Community Nursing Service
- Children's Speech and Language Therapy
- 0-19 Public Health Integrated Nursing Service (0-19 PHINS)
- Infant Mental Health Service
- Children's Community Eye Service
- School Immunisations Service

Our purpose is to provide high quality community healthcare. We do this by working together with other organisations and groups, involving, and developing our colleagues, and using our resources wisely to continually improve services. We work in partnership with the NHS, social care, the criminal justice system and the third sector.

The Trust was rated Good overall in its most recent inspection by the Care Quality Commission (CQC), and we were pleased to have been rated Outstanding for our Sexual Health Services.

We promote equity of service delivery to different groups throughout the organisation. We continue to raise awareness of equality and support our staff networks (Race Equality, Disability, Neurodiversity and Long-term Conditions, and LGBTQIA+) in their efforts to create an inclusive environment for patients and staff. We believe that a workforce that reflects its community will be able to serve that community better.

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

How we work

The Trust's culture is underpinned by our vision:

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

We have three values that support this vision:

- 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.

We uphold the visions and values through our How We Work Behaviours:

Caring for our patients

Making the best decisions

Leading by example

Caring for one another

Adapting to change and delivering improvements

Working together

Finding solutions

Patient stories

Patient stories and case studies are shared with our Board by patients or by the services that support them. These stories highlight our vision, values and behaviours in action.

Here is Sue's story:

Taking control of diabetes

Our Structured Education Programme (LEEDS), developed by two of our Diabetes Specialists helped Sue take control of her diabetes.

The LEEDS Programme (Learning, Empowering, Enabling, Diabetes Self-Management) is a quality assured programme for people living with Type 2 Diabetes. It is delivered by Diabetes Facilitators either in face-to-face sessions at a choice of citywide venues or through an online course (delivered via MS Teams Live Events).

Sue had been living with Type 2 diabetes since 2014. Medication doses, including insulin, increased over the years to try to control her blood glucose levels. Sue was regularly referred to the Community Diabetes Team and in October 2022 was re-referred due to worsening symptoms. In March 2023, Sue was fitted with a Continuous Glucose Monitoring Sensor but was also introduced to the LEEDS Programme, so that she could feel empowered to better self-management of her condition.

Learning • Empowering • Enabling • Diabetes • Self-management

THE LEEDS PROGRAMME

Sue attended three sessions of the LEEDS Programme and said of her experience:

> "I have seen a real improvement in my general health and wellbeing. I feel more educated and confident now in controlling my condition with medication. I know so much more about how a healthy lifestyle and the effect diet and drinking alcohol has. The programme has really helped me set goals that were important for me."

You can read more patient stories in the Trust's Quality Account 2023/24.

Visit: **www.leedscommunityhealthcare.nhs.uk**

Leeds Community Healthcare's strategic goals

The Trust Board agreed four strategic goals for 2023/24:

- To deliver outstanding care.
- To ensure our workforce community can deliver the best possible care in all the communities that we work with.
- To work in partnership to deliver integrated care closer to home and reduce health inequalities.
- To use our resources wisely and efficiently.

These strategic goals guided our approach to how we provided care, managed our resources, and worked with our health and social care partners to meet the needs of patients, at the same time as looking after the health and wellbeing of our colleagues.

Key risks

In Spring 2023, a review and benchmarking exercise streamlined the number of strategic risks connected to our goals (from 21 to 10) for 2023/24. Each strategic risk has a Lead Director(s) and Lead Committee(s). The level of assurance given for the management, and reduction of severity, of these risks is reported to the Trust Board at each of its meetings:

- **Risk 1:** Failure to deliver quality of care and improvements.
- **Risk 2:** Failure to manage demand for services.
- **Risk 3:** Failure to invest in digital solutions.
- **Risk 4:** Failure to be compliant with legislation and regulatory requirements.
- **Risk 5:** Failure to deliver financial and performance targets.
- **Risk 6:** Failure to have sufficient resource for transformation programmes.
- **Risk 7:** Failure to maintain business continuity (including response to cyber security).
- **Risk 8:** Failure to have suitable and sufficient staff resource (including leadership).
- **Risk 9:** Failure to involve and engage staff.
- **Risk 10:** Failure to collaborate.

The Performance Overview in this report describes how the Trust managed its strategic risks to achieve our goals during 2023/24. These arrangements receive oversight and scrutiny through the Board Assurance Framework.

Risk management, including the Board Assurance, is considered in more detail in our Annual Governance Statement, which can be found on page 80 of this report.

Performance Report

Performance Overview

In their Foreword, the Trust Chair and Interim Chief Executive commented on how the Trust continued, during 2023/24, to move through the recovery phase of COVID-19. We recognised the impact on our staff personally and professionally and have focussed on strengthening our support offer.

Our work on prevention, and championing self-care, also continued as 'Sue's Story,' earlier in this report highlights. Working in partnership across the city we have found more ways to empower patients to take control of their own health and lead on some, or all, aspects of their care. This year saw an ever-increasing focus on those living with the greatest inequity.

As such, we continue to develop a suite of Equity data sets for the Trust on Access (referrals/appointment outcomes and waiting lists) and Outcomes (incidents/outcome measures and mortality) analysed by deprivation and ethnicity. The Leeds Place based Integrated Care Board Delivery Subcommittee (of which Leeds Community Healthcare is a member) monitors progress against Core20PLUS5 (an approach to reducing healthcare inequalities) at a city/system level. Our approach to health equity includes Core20PLUS5 considerations and contributes to its achievement.

The Board seeks to make sure that the Trust is delivering the priorities it agreed for the year and that operational, or day-to-day, performance meets the expectations of our patients, commissioners, partners, and regulators. It does this through a wide range of formal and informal processes, formal public Board meetings, a committee structure and through engagement with patients, colleagues and stakeholders.

The Trust's operational performance against a range of national and local targets and standards is assessed and reported on, internally and externally. The targets and standards are derived from the NHS Oversight Framework, our contracts, and local priorities.

They are grouped into five domains which align to the Care Quality Commission's (CQC) governance framework – we then add a finance domain. Monitoring of the individual measures within these domains gives us an overall view of the Trust and our current performance. The Board considers a Performance Brief at each meeting which describes our current performance. This is available as part of the Board papers which are published on the Trust's website:

www.leedscommunityhealthcare.nhs.uk

In the following sections we outline how we delivered against our priorities for the year and our performance against key performance indicators (KPIs).

How we met our Strategic Goals

Our Trust vision is that 'we provide the best possible care in every community we serve'. To continue our work to achieve this vision, we set ourselves four strategic goals, alongside Trust priorities for 2023/24. Although our priorities are matched to a particular goal, they work well with our other goals too.

Here are our four goals and the priorities we had to support them:

Goal 1 – Deliver outstanding care

***Priority:* Be responsive to the needs of our populations as we deliver safe and effective care on our journey to outstanding care.**

In line with our values of continuing to listen, learn and improve we have engaged with our teams (and wider stakeholders) and developed an action plan so we can better identify, share, and embed learning from patient safety incidents across the organisation. This was finalised and launched in January 2024. Our Patient Safety Incident Response Plan (PSIRP) has identified our local safety priorities in addition to national priorities as a blueprint for the Trust's approach to learning and improving in the forthcoming year.

Within our **Adult Services** we have taken learning from national 'gold standard' models and begun a pilot for a newly developed 'Response Team' to improve coordination and allocation of 'unplanned' work and reduce disruption to planned visits. Early feedback is positive. Citywide rollout and impact data collection will take place during 2024/25.

In addition, our Neighbourhood Team, supported by the Integrated Care Board, worked with Yorkshire Ambulance Service (YAS) and Local Care Direct, to better connect YAS to primary and community services. This pilot directed people to services that offer a better experience of unplanned 'same day care' by providing the right care first time and reducing ambulance transportation to the Emergency Department (ED). From July to December 2023, 247 cases were either closed remotely or referred for a 'Quick Response' from the Neighbourhood Team. These patients would otherwise have had an ambulance sent and a trip to the Emergency Department, potentially experiencing long waiting times. We are pleased that the pilot was extended until the end of March 2024 because of its positive results.

The involvement of our service user and carers is essential to our goal of delivering outstanding care.

Across our **Children and Families service** our Youth Board has been involved with a range of projects and services this year. For example, supporting a Patient Led Assessment of the Care Environment (PLACE) at our community respite facility for children with special needs and debilitating illnesses (Hannah House - see picture opposite). This is the first-time young people have been involved; the two youth board members were supported to join a Healthwatch representative, and a Friend of LCH, to bring a young person's perspective to the assessment.

We have also revamped our Involvement Group (was Parent and Carer Forum) to make sure anybody can be involved, not just parents and carers. It is now open to anyone over the age of 19. We also launched our Involvement Newsletter to celebrate and promote our work with children, young people and adults.

Goal 2 - Use our resources wisely and efficiently

***Priority:** To deliver our Cost Improvement Plan target and contribute to Leeds Health and Care Partnership's Cost Improvement Plan, while ensuring we maintain a focus on quality and safety.*

Alongside achieving our cost improvement plan, we continue to look at ways to innovate and transform the way our services are delivered.

Some examples of how we have achieved this include:

- Our key role in the **Home First programme** - more information can be found on page 16. A methodology to capture and track the financial benefits of the programme has recently been agreed and although there is no direct financial saving for LCH, growth in community capacity and a change in processes has significantly reduced the length of time people spend in hospital and social care beds. Ultimately, this will lead to significant financial benefits across the Leeds health and social care system.
- As described in the foreword, improving our digital technology has been, and will continue to be, a key area of focus through the year.
- A large and complex project to introduce a new electronic patient record (SystmOne) into Children and Young People's Mental Health Services has been completed during the year. As a result, we have been able to introduce an Electronic Prescribing System which allows for a more efficient and effective approach to the prescribing of medicines for our patients.
- Following the successful joining together of our electronic patient record (SystmOne) and e-Community software, more recently we have been able to begin testing new allocation software in our Neighbourhood Teams. Once in place this will enable a more efficient and streamlined process for scheduling visits.
- Working with the Integrated Care Board, our Night service team has undertaken a service review and has been able to deliver targeted improvements delivering cost savings through a significant reduction in service provision by the independent sector but also ensuring there is a consistent level of quality in provision and continuity of care between the Neighbourhood Teams and Nights Service.
- Following an options appraisal and Equality Impact Assessment process undertaken alongside the Integrated Care Board (ICB), the Long COVID Community Rehabilitation Service has been redesigned improving financial sustainability by ensuring the service can be delivered within the financial envelope set aside by commissioners. Further opportunities for redesign of the service, alongside other system partners, will start to be explored in 2024/25.
- As we aim to ensure all our services are clinically and financially sustainable, we have begun reviews of a number of our specialist services in readiness for a commissioner tender process in 2024/25.

Goal 3 - Enable our workforce to thrive and deliver the best possible care

***Trust Priority:* Support our workforce to recover and flourish, with enhanced focus on resourcing and health and wellbeing.**

We recognise our teams as the key asset in all that we do. Great patient care can only be provided by colleagues who feel supported both in small ways and on a larger scale to deliver on our vision to 'deliver the best possible care to every community we serve.'

From practical changes, such as the introduction of a Trust-wide uniform store with minimum stock levels, in order to reduce colleague waits for receiving new uniform, to an intensive focus on career development, such as our successful Nursing career pathways work, to uplift Trainee Community Matrons (TCMs) to Community Matrons through a new competency framework and paperwork review (12 TCMs were appointed as Community Matrons as a result). We remain committed to improving the working environment and career opportunities of our colleagues.

This has been further evidenced at service level within our Children and Families service, Black and Minority Ethnic (BME) colleagues have accessed a mentoring programme and apprenticeship support, for roles such as speech and language therapy, social work and nursing. The wider organisation is now learning from this work to further improve access to apprenticeships and development posts.

Encouraging the right people to come and work with us has always been important to the Trust, as demonstrated by our ongoing Hyper local recruitment success. But so too is retaining the right skills and experience within our existing workforce. We believe Trustwide initiatives put in place this year have contributed to a sustained improvement (reduction) in staff turnover. At 31 March 2024, our staff turnover was at a very healthy 9%, which is well within the Trust's maximum acceptable threshold of 14.5%.

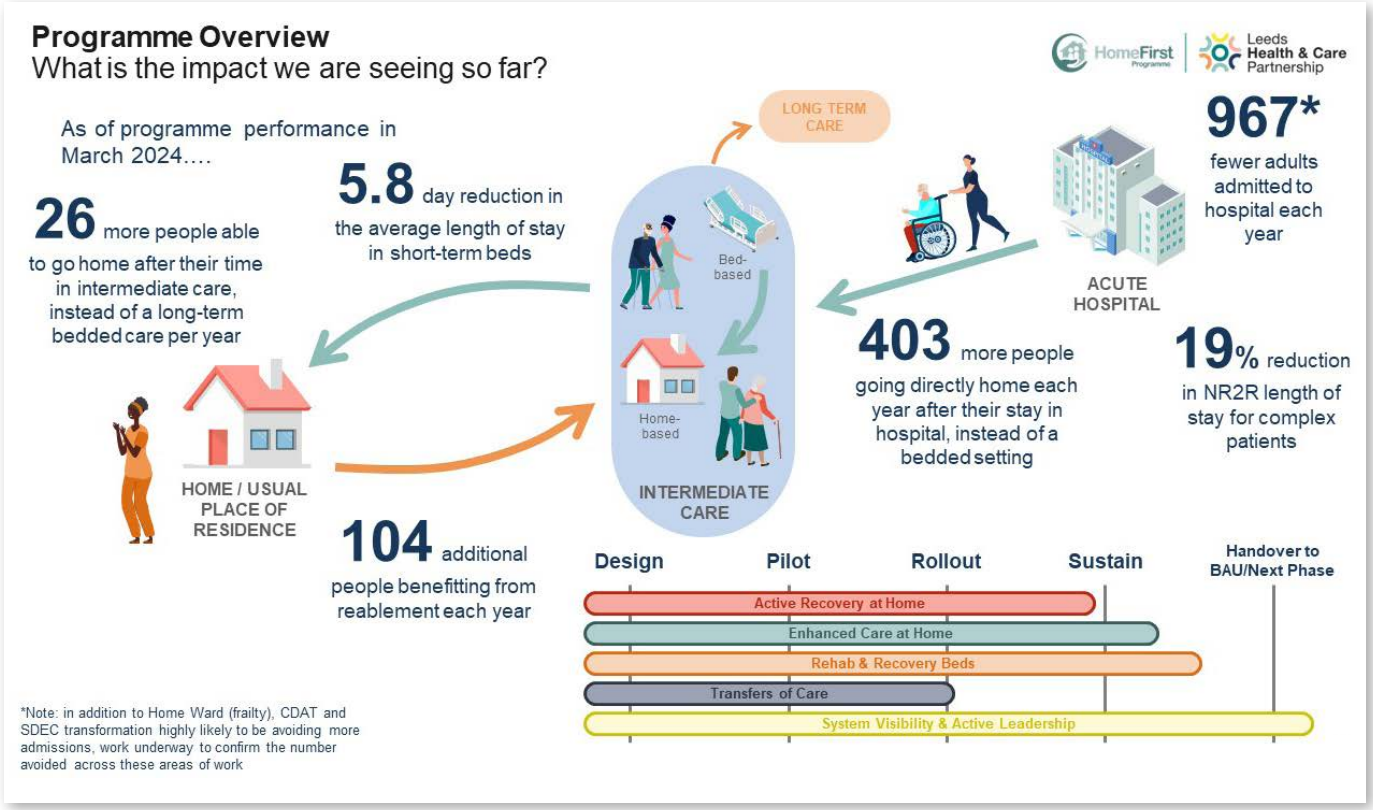
These initiatives include:

- **Talent Development programme for BME colleagues:** To increase diverse and inclusive representation across all leadership tiers and to make sure our future staffing model better reflects the communities we serve.
- **Neurodiversity and Wellbeing awareness sessions:** 400 colleagues attended five virtual sessions to understand more about Neurodiversity, both from a workplace perspective and in terms of working with neuro diverse patients.
- **BME Diverse recruitment panels:** Over 20 colleagues volunteered to be part of a pool of people involved in the full recruitment and selection process for all posts at Band 7 or above. The process was put in place early February 2023.
- **Hyper local recruitment:** An award-winning area of focus (which seeks to recruit through targeted communications to postcodes near to our clinics and sites). We are up to almost 200 recruits in the 18 months the initiative has been running.
- **International Community Nurses:** We are currently welcoming a third group of international colleagues to the Trust.

Goal 4 - To work in partnership to deliver integrated care, care closer to home and reduce health inequalities

***Trust Priority:** Work pro-actively across the system with all the communities we serve to improve health outcomes, improve patient flow and continue to drive integration.*

The HomeFirst programme continues to see progress citywide in its aims of improving access to intermediate care and the outcomes for Leeds residents using these services.



As part of this programme, we have introduced a 'Home Ward' supporting patients with Frailty and Respiratory conditions. Both wards are there to provide support and care to people who become suddenly unwell but can be safely cared for in their own home. They can also support people to return home from hospital sooner. The Home Wards have consistently performed above national expectations over 2023/24, benchmarking positively against other areas regionally and nationally with regards to use.

Our respiratory ward is equivalent to 12 beds and consistently achieves 80% 'bed' use, working efficiently to get patients on and off the ward in a timely way. Plans are in place to develop the referral criteria, to make best use of all available capacity and increase average use levels more. The first area being looked at is 'Bronchiectasis', although this relates to a small number of patients, developments here could have a real impact on reducing length of hospital stay.

Our frailty ward received its highest number of referrals in October 2023; a total of 387. The service changed the way it worked to include national requirements and 'other' system offers.

Our **Enhance** partnership with Leeds Older People's Forum has been funded since 2022/23 and went live in June – July 22. It sees us investing in Leeds' third sector partners' skills and networks to keep people well and socially connected and in turn, reducing the pressure on Leeds Community Healthcare, the hospitals and wider health and social care system. In 2024/25 Enhance partners will support patients referred by a wider range of LCH services, with a focus on the people and services where the most time savings can be made for LCH clinicians. During the year we will also be formally evaluating the success of the partnership with a view to developing a cost-effective proposal for the future.

A key success in Children and Families service this year was the introduction of a community led Community IntraVenous Antibiotics Service (CIVAS) for children. Launched in February 2024, it followed 12 months of hard work from a dedicated Leeds Community Healthcare team in partnership with colleagues at Leeds Teaching Hospitals Trust.

In our specialist services we continue to collaborate with partners on a number of high-level projects, as demonstrated through the retention of the contract with commissioner Leeds City council for the Leeds Sexual Health service. We will continue to be the lead provider working alongside Leeds Teaching Hospitals NHS Trust, Leeds GP Confederation and Forum Central (the collective voice for the health and social care third sector in Leeds) to provide the innovative new model - focussed on reducing inequalities in sexual and reproductive health across communities, by removing barriers to access. Innovations include a new Digital Health Hub, to manage capacity and demand and to direct people quickly and easily to the right service and a new, interactive website that can 'talk to' the patient management system (SystmOne) to support online booking, live web chats and online prescription ordering. Also, a new telephone contact centre to make sure there is an entry point for those without digital access.

In further collaborative work we also provided project management support to the Community Dental Service (CDS) Time to Shine Project, for the West Yorkshire Community Dental Service Collaborative.

Key outcomes so far are:

- Creation of one service specification for the whole of West Yorkshire.
- Task and Finish Group set up to achieve one General Anaesthetic pathway for West Yorkshire.
- Out of Area Patients process review.
- Work to reduce data collection differences across the Collaboration to reduce service offer differences.

Pilots are ongoing between Community Dental Services in West Yorkshire, with learning shared. The pilots are also looking at ways to upscale moving forward.

On a trustwide level we continue to work on the following:

Health Equity Strategy 2021 - 24: The next phase in looking at and addressing inequity in our care and pathways will begin in May 2024. A Board workshop in October 2023 agreed a specific Health Equity strategic goal, which will be further developed to identify success measures, and to inform upcoming health equity activity.

The Public Sector Equality Duty: requires us to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. Our Equity and Quality Impact Assessment goes beyond the removal or minimisation of disadvantages suffered by people due to their protected characteristics to include focus on deprivation and health inclusion groups. This year, 22 initial EQIAs have been brought to panel with risks identified and mitigated. 17 have had a further review to confirm that the proposed action and mitigation has successfully reduced identified risks.

Accessible information Standard: All providers of NHS care must meet this standard; to identify, record, flag, share and meet people's information and communication needs. We have gone beyond the legal requirements to apply this to people with a disability, impairment or sensory loss. We have also included other vulnerable / marginalised groups. For example, people with low levels of literacy and other community languages. Working with communities and partners, we have increased recording of communication needs and developed a new template to share these needs across our services. This template has been shared as an example of good practice with partners. Further work to support sharing of communication needs across partners, and compliance with the Accessible Information Standards, is being overseen by the Person-Centred Care Expert Advisory Group, in which LCH is represented.

Engagement Principles: The way we work with patients, carers, families and communities is important for the success of all our Goals, and so this year we also developed our Engagement Principles.

Our Engagement Principles set out how we work with people, particularly from community groups experiencing inequalities, to make sure we are listening to all voices and so that we can act on what we hear. These Principles will be at the centre of everything we do and will also support us in being a good partner in the City's ambition to deliver joined up care that is well communicated and compassionate.

Person centred

We will put patients and carers at the centre and focus on the strengths that each individual and community brings.

We will be open and honest about what is possible and will be led by people rather than strategy and plans.

Accessible

We will work to ensure all our engagement activity is easily accessible to everyone.

We are committed to breaking down barriers to engagement including meeting any communication needs as required by the Accessible Information Standard.

Inclusive

We will listen and act on the experiences of those at the highest risk of health inequalities.

We will ask the right questions so we can fully understand the needs of the communities we serve.

Faciliatative

We will build engagement into every contact.

We will enable an engagement culture that offers as many different opportunities as possible, leading to a greater understanding of experiences.

Active

We will proactively support people to share their experiences.

We will act on what we hear, share learning and report outcomes.

We will keep up to date on local and national engagement work to inform our own work.

We will actively seek opportunities to engage and capture experience across priority LCH workstreams.

Outcomes

All engagement activity will have measured outcomes to both our services and the people who use them.

We will be clear on how we measure positive impacts and what this will mean for people and communities.

We will continue to develop the Engagement Principles during 2024/25 with service users, patients and third sector partners.

Performance Analysis

This section gives a more detailed analysis of how we performed in key areas during 2023/24.

Our Performance Monitoring Processes

The Trust Board monitored a wide range of Key Performance Indicators (KPIs) across six domains:

- **Safe** - people are protected from abuse and avoidable harm.
- **Caring** - staff involve and treat people with compassion, kindness, dignity, and respect.
- **Effective** - people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

- **Responsive -** services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice, and continuity of care.
- **Well-led -** leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
- **Finance -** our resources are managed well and put to the best uses.

The Board was supported in its monitoring of operational performance by the Quality Committee, Business Committee, and the Senior Operations Performance Panel. Each of our three Clinical Business Units provided monthly written reports on their performance, including risks, key initiatives in support of our staff, and plans for improvement to the Senior Operations Performance Panel. These reports covered all six domains.

A summary of these details was reported to committees every two months, and then presented to Board for final review.

Next year we are committed to including measures from our System Viability Work, to reflect the context that we now work within. We are also developing equity measures for the responsive domain indicators, to make sure we are managing waiting lists equitably.

All the Performance Reports considered by the Trust Board are available as part of the Board papers on our website **www.leedscommunityhealthcare.nhs.uk**

Our Performance against Key Performance Indicators

The Trust's services worked exceptionally hard to achieve our performance targets in 2023/24 and we are proud of our ongoing commitment to provide high quality services.

We achieved many of our targets despite another difficult year of complex demand and reduced staffing.

Difficulties still exist however, for patients able to access services in a timely way. The total number of patients on our waiting lists increased again this year, as did the average amount of time they needed to wait. Despite this, most of our patients waited less than 18 weeks to start treatment. We continue to look at ways to improve this, within the resources we have available. Throughout next year, we want all our patients to have a positive experience of our services.

Safe

We are proud that our services continued their excellent track record of safety. Our Serious Incident Rate remained well below the target of 0.1 per 1,000 contacts for the whole of the year. With the improvement work led by the Trust Falls Improvement Group we saw a reduction in the number of falls with harm compared to the previous year. This approach is being reflected in the forthcoming year and is aligned with our Patient Safety Incident Response Framework (PSIRF).

We are in the process of putting in place NHS England's new Patient Safety Incident Response Framework (PSIRF). The framework sets out the NHS' approach to developing and maintaining effective systems and processes for responding to patient safety incidents

for the purpose of learning and improving patient safety. Reporting on the new process is in development.

Rates for community acquired infections remained at significantly low levels, and we remained well below our internal targets for the numbers of avoidable pressure ulcers.

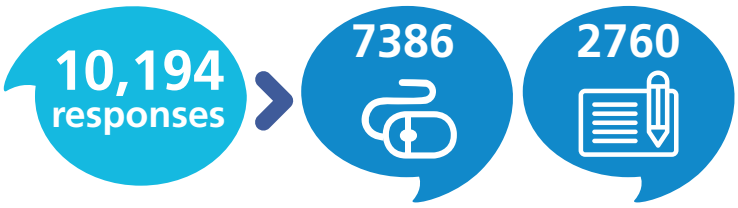
The number of patient safety incidents remained at levels consistent with previous years.

We have maintained a positive level of reporting, which we believe is a critical feature of our open and transparent culture around patient safety. This is highlighted by our reporting of incidents without harm. In 2023/24, 88.03% of our reported patient safety incidents involved no harm occurring to patients.

Caring

Friends and Family Test (FFT)

We ask people who use our services how we did via the Friends and Family Test (FFT). We do this through an online link, a QR (Quick Response) Code, paper postcards and text message. The FFT is available in a standard easy-read format and is translated into the most spoken five languages in Leeds. We also have child friendly surveys, developed alongside children and young people. We want to make giving feedback easier for people whose first language is not English, and for those people with communication or accessibility needs.



Between 1 April 2023 and 1 April 2024, 10,194 Friends and Family Test (FFT) responses were shared. Of those, 73% of people (7386) used the online survey, an increasingly popular option. We also received responses in writing from 27% of people (2760). Making sure people can get in touch in different ways is important to us.

Survey results showed that 95% of people (9628) felt our services were good or very good, 2% of people (244) said poor or very poor and 3% of people (272) felt their service was neither good nor poor.

Concerns, Complaints and Compliments

We welcome all forms of feedback as an opportunity to improve. It can be difficult to speak up when things go wrong but, for our teams to learn from and develop services, or to share good practice and celebrate when things go well, we must be ready to listen.

In 2023/24 we received 1419 compliments, concerns, and complaints. This was down 15% overall from the previous year (1654 in 2022/23). We saw a minimal difference in the number of complaints, a 46% decrease in concerns and a 3% decrease in compliments between 2022/23 and 2023/24.

Year	2022-23	2023-24
Compliments	965	933
Concerns	544	342
Complaints	145	144
Total	1654	1419

There were 144 complaints received in 2023/24. Of the 144, 129 related to our services only, 15 related to our and other organisations (multi-sector complaints). Ten were withdrawn and five were rejected due to being a test or a duplicate. Nine were not for our organisation.

There were 342 new concerns received in 2023/24. All concerns are shared with the service. Concerns are responded to directly wherever possible, and services use the feedback to create service improvements where they can.

More detailed information on the themes relating to our complaints can be found in the Trust's Quality Account: **www.leedscommunityhealthcare.nhs.uk**

Effective

Annual Audit Report – Effectiveness

The effectiveness of our services is measured primarily through our compliance with NICE (National Institute for Health and Care Excellence) guidelines, and by our Annual Audit Programme (AAP). Our teams recorded strong progress once again in these areas as:

- For 2021/22 there is 1 open NICE Guidance.
- For 2022/23 there are 4 open NICE Guidance.
- For 2023/24 there are 29 open NICE Guidance.

Three Trust wide audits and 135 local audits were registered as part of the AAP for 2023/24:

Number of Trust-Wide Audits 2023-24	
Trust-Wide Audits*	3
TOTAL	3

*Infection Prevention and Control Suite of Audits
Risk, Health and Safety Environmental Audit for high-risk areas
Record Keeping Audits

Number of Service Specific Clinical Audits Registered 2023-24	
Adult Business Unit	17
Children's Business Unit	38
Specialist Business Unit	70
Corporate including Medicine Management	10
TOTAL	135

- At the end of the 2023/24 the AAP is in a much-improved position compared to the end of the 22/23 AAP. This is due to a significant drive in 2023/24 for a more robust process for the AAP which has now been implemented by the Clinical Effectiveness Team. The Team is actively contacting services to ensure that all pending registration forms are submitted. The Team also contacts Clinical and Operational Heads of Service for quarterly updates.
- The audit registration and summary report form has been updated to include equity analysis and the Clinical Effectiveness Team are working on how they can report on and demonstrate assurance via the Trust's Quality Assurance and Improvement Group (QAIG) that services are delivering safe and effective care and reporting any associated risks.

- There has been a significant drive for a more robust process which has now been put in place, by the Clinical Effectiveness Team. The Team is actively contacting services to ensure that all pending registration forms are submitted. The Team contact Clinical and Operational Heads of Service for quarterly updates.
- The Annual Audit Plan was sent to services in February for completion, with a return date of 12 April 2024. There have been 110 local audits registered to date, again a much-improved number compared to the previous year. For the 2024/25 programme, the Clinical Effectiveness Team's baseline expectations will be that 100% of registration forms will be returned at the beginning of the rolling AAP to ensure a comprehensive programme.
- The Record Keeping Audit documentation toolkit was sent to services in March 2024.
- The new Clinical Audit training has proved popular, further dates have been added to the Clinical Effectiveness Training Programme for 2024.

Future Plans for the 2024-25 Annual Audit Plan Year

- To improve on progress to date, audits will not be registered if the correct form is not submitted and received. Exceptions to this standard will be assessed on a case-by-case basis to ensure audits planned for the latter part of the year are representative of the registration form, as the focus of the audit may not be fully established in Quarter One.
- Review of the record keeping audit toolkit to take place during 2024-25 with a view to launch the new toolkit for 2025-26.
- Infection Prevention Control and Record Keeping audits will be added as Priority 2 audits from Quarter One 2024-25.
- To bring equity analysis into audit looking at standards we meet and do not meet, and disproportionate outcomes.

Responsive

The number of people waiting for care has grown steadily through the year. We have been unable to meet all our targets to see people in a timely way.

The areas under pressure:

- Children's Neurodevelopmental Services
- Community Gynaecology
- Continence, Urology and Colorectal Service (CUCS)
- Children's Occupational Therapy

They have all experienced significant increases in referrals and demand for services has outstripped capacity.

Work to improve waiting times for children requiring neurodevelopmental services, including autism assessments, continues both in Leeds and nationally. Locally, we have been able to increase paediatrician capacity. We have also been working closely with partners across Leeds to address increased demand and to look at different ways we can provide the service.

Waiting times in Community Gynaecology have been high throughout the year. This service is delivered in partnership with Leeds Teaching Hospitals NHS Trust (LTHT), Meanwood Practice Specialist Menopause Clinic and GPs. There have been delays in the triage of patients waiting for the community service and therefore delay in delivering care to them. We are working closely with our partners to improve this situation.

The time patients wait for care in the Continence, Urology and Colorectal (CUCS) Service has increased through this year. This has been due to an increase in the complexity of patients and reduced availability of specialist staff. The service has put actions in place to address this, including dedicated triage and clinicians working across multiple specialisms.

There is a national shortage of Children's Occupational Therapists and, due to a high number of vacant posts, the number of children waiting for care increased. The vacant posts are now filled, and work is ongoing to see children currently waiting for care in a timely manner.

The Children's Audiology Service is our single diagnostic service, aiming to provide access to diagnostic checks within six weeks. Our performance against this standard has improved steadily throughout the year but remains significantly below the standard of 99%. We will continue to focus on improving our performance and have put in place service changes and productivity improvements to respond to a continuing backlog that first developed due to COVID-19.

Our Neighbourhood Teams and Home Ward (Frailty) services deliver an urgent community response to people in need of support who may otherwise be admitted to hospital. We aim to reach those patients within two hours of referrals. We have improved our response times in relation to this over the year and are now consistently exceeding the national target of 70%.

Well-led

Turnover during the year has remained consistently below the 14.5% target, ranging between 12.5% and 9% which is really pleasing to see and healthy. Turnover rates within the nursing and midwifery staff group were higher than we would wish but the Trust has responded to this through a range of retention initiatives including development of our staff through apprenticeships and other interventions, engagement with staff and utilising feedback from exit interview as well as initiating 'stay' conversations. Additionally, we have continued our excellent work on recruitment including international recruitment, recruiting from within our local communities and the development of several clinical apprenticeship roles.

Overall sickness absence during 2023/24, month by month, has tracked below the absence levels in the previous year. Short-term sickness absence levels remained within tolerance throughout the year. Our focus remains on supporting the prevention of and return from long-term sickness absence, where stress/anxiety/depression remains the most prevalent sickness absence reason. This picture is replicated in other NHS organisations and indeed the wider UK workforce, but nonetheless considerable efforts continue to be made to keep all our staff well and at work.

Most of our staff are in work most of the time. We want them to be the best they can be and to provide care as safely and effectively as they can. An annual appraisal can support

that. Whilst our annual appraisal rates are steadily improving from last year, we continue to hover around the mid 70% which remain below our target of 90%. New appraisal paperwork has been introduced to make the appraisal experience more people focussed and a new appraisal season has been piloted and shown some success. Compliance with statutory and mandatory training continues to be high just falling short of the 90% target, mainly due to much of the training available online and can be completed by staff at a time that suits them.

It is pleasing to note that our continued focus on the Workforce Race Equality Standards (WRES) resulted in some improvements in increasing the diversity of our workforce. 12.3% of our overall workforce now identifies as Black, Asian or Minority Ethnic (BAME) background, and 7.9% of staff are in Senior roles. We know we have much more work to do in this area. We strongly believe that this focus is necessary and that the benefits will be seen not just in improvements on race equality standards but in other areas where we need to see improvement such as the Workforce Disability Equality Standards.

Finally, as set out elsewhere in this report, our Staff Survey results have continued to improve year on year demonstrating good engagement with our workforce across Leeds Community Trust.

Information on the risk and control framework can be found in the Annual Governance Statement on page 80 of this report.

Task Force on Climate-Related Financial Disclosures (TCFD)

Further information on this can be found within our Sustainability Report.

Our 2023/24 Key Performance Indicators

Indicator	Target	2022/23	2023/24
Patient Safety Incidents reported as Harmful (per 1k contacts)	1.42 to 2.09	1.83	2.08
Serious Incidents (per 1k contacts)	0 to 0.4	0.02	0
Validated number of Patients with Avoidable Category 3 Pressure Ulcers*	8 per year	2	4
Validated number of Patients with Avoidable Category 4 Pressure Ulcers*	0 per year	6	1
Validated number of Patients with Avoidable Unstageable Pressure Ulcers*	10 per year	6	2
Number of teams who have completed Medicines Code Assurance Check 1 April 2019 versus total number of expected returns	100%	100%	100%
Duty of Candour Breaches	1 per year	0	0
Attributed MRSA Bacteraemia Infections	0 per year	0	4
Clostridium Difficile Infections	3 per year	0	0
Never Event Incidence	0 per year	0	0

Indicator	Target	2022/23	2023/24
CAS Alerts Outstanding	0 per year	0	1
Patient Satisfaction - Percentage of Respondents Reporting a 'Very Good' or 'Good' Experience in Community Care (FFT)	95%	92%	93%
Total Number of Formal Complaints Received	No Target	136	139
Mixed Sex Accommodation Breaches	No Target	0	0
Number of NICE guidelines with full compliance versus number of guidelines published in 2019/20 applicable to LCH	100%	98%	98%
Number of NICE guidelines with full compliance versus number of guidelines published in 2020/21 applicable to LCH	No Target	100%	100%
Number of Unexpected Deaths in Bed Bases	No Target	7	6
NCAPOP audits completion rate	100%	100%	100%
Priority 2 audit completion rate	100%	39%	72%
Percentage of patients waiting more than 18 weeks for a Consultant service (as of 31 March)	92%	62.7%	43.7%
Number of patients who waited more than 52 weeks for a Consultant service	0 per year	11	534
Percentage of patients waiting less than 6 weeks for a diagnostic test (as of 31 March)	99%	50.3%	32.6%
Percentage of patients waiting less than 18 weeks for a non-Consultant service (as of 31 March)	95%	87.5%	65.7%
Staff Turnover	14.5%	12.9%	9.0%
Percentage of staff who left the organisation within 12 months	20%	14.3%	14.6%
Short term sickness absence rate (%)	3%	1.8%	1.6%
Long term sickness absence rate (%)	3.50%	4.4%	4.3%
AfC Staff Appraisal Rate	90%	72.1%	74.9%
Statutory and Mandatory Training Compliance	90%	86.1%	87.0%
Percentage of Staff that would recommend LCH as a place of work (Staff FFT)	60%	64.8%	
Percentage of staff who are satisfied with the support they received from their immediate line manager	52%	71.5%	
WRES indicator 1 - Percentage of BME staff in Bands 8-9, VSM	No Target	7.2%	7.9%
Starters / leavers net movement	Above 0	179	144

*The Trust transitioned to the Patient Safety Incident Response Framework (PSIRF) in January 2024. This is a big change in the framework that has changed how we report on incidents. We therefore did not monitor incidents via these indicators through the latter part of the year as more qualitative monitoring processes were in place. This means that our year end numbers are not comparable to previous years.

Sustainability

Over 2023 we have continued to see a gradual increase in the Trust's carbon emissions profile. However, this is in keeping with the sustainability department's predictions for emissions. which have changed dramatically over the past three years. During 2020-2021 emissions significantly decreased due to the response to the pandemic, then drastically increased following the surge of activity as business returned to normal with the additional patient backlog. During 2023 this upwards trend has continued but at a steadier rate comparative to the previous volatile years.

Over 2023/24 the recording of the Trust's carbon data has improved in accuracy, most notably in procurement. This improved data collection has decreased the overall carbon emissions of the Trust from 8782 tCO2e in 2022/23 to 4701 tco2e.

It is important not to celebrate this reduction as, although our emissions have decreased with improved recording, the Trust's carbon trend within both travel and estates continues to rise. If emissions continue to rise in these areas Net Zero will likely become unattainable without radical change. Narrative will always be provided with data submission to stipulate if emission changes are due to improved recording or following a project. This will allow the sustainability department to provide a transparent and accurate review of the Trust's progression.

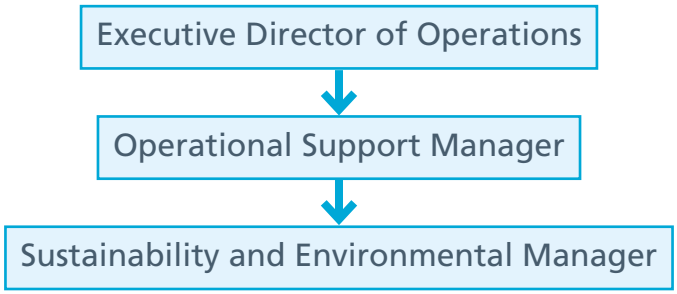
Despite this gradual increase in travel and estates a variety of interventions have been carried out over the past year in keeping with the Trust's sustainability project list. This includes the continual promotion of the changes to the salary sacrifice and business lease schemes, along with reducing the carbon cap of the vehicles these schemes offer. Bike shelters have been installed across the Trust's retained estate, in a step towards promotion of active travel and away from single car occupancy. The Estates department have also opportunistically upgraded lighting to LED, for example in the reception at Burmantofts Health Centre.

Moving into 2024 work will be aligned with the Trust's Quality and Value programme to aid in the delivery of projects that offer both increased value and carbon saving measures. Projects will likely span across all the carbon dense areas of the Trust, procurement, estates, waste and travel. The sustainability department will continue along the trajectory outlined in the Trusts' 2022-2025 Green Plan moving into 2024/2025. This does include providing advice into wider climate change adaptation requirements.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Progress against the Green Plan is monitored twice-yearly by the Trust's Business Committee and Board. The Sustainability and Environmental Manager also attends the Estates Strategy Implementation Board, which in turn reports through to Business Committee.

The Executive Director of Operations is accountable for the delivery of the Green Plan with specific responsibilities shared across the Executive Team. The portfolio will move to Finance and Resources in the course of 2024/25.



The direct operational team is small but the Trust works to ensure that sustainability is a golden thread throughout the business of the organisation.

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024 .....

Our Staff

NHS Staff Survey

The annual NHS Staff Survey invites everyone working in the NHS to give their views on working life. It is completely independent, and we encourage colleagues to use this important feedback tool.

We are proud to say we achieved another record response rate of 61.7%. We have consistently improved response rates over the last 4 years. Comparing response rates over the last four years we are +3.4% (2022) +9.7% (2021) and +16.7% (2020). We have achieved this through dedicated resource to engage with people on the staff survey, collaborating between teams and services, putting in place an effective communication and engagement plan, and receiving senior level sponsorship from the Chief Executive, directors, and general managers. We will look at response rates with teams and identify key actions to boost response rates for 2024.

Our 2023 key findings, compared to 2022 include:

- Highest response rate to date 61.7% (up 3.4% on 2022).
- Increased Engagement and Morale scores for the overall Trust and across all business units.
- Significant improvements and increased scores against 6 of the 7 People Promise themes.
- Overall, 85% of questions recorded an improved score.
- Our scores are in the average range (and on some occasions) higher than the Community Trust comparator group. A real improvement on last year where typically we scored just below the average score.
- We are above the national average scores for all 7 People Promise themes and Engagement and Morale scores.

You can find our full results and benchmark reports by visiting the NHS Staff Survey website and searching 'Leeds Community Healthcare' Local results for every organisation: www.nhsstaffsurveys.com

Awards and recognition

External awards

During the year we were delighted that so many individuals, teams and services received national and regional recognition.

The Trust was awarded the NHS Pastoral Care Quality Award to recognise our work in international recruitment and our commitment to providing high-quality pastoral care to internationally educated nurses and midwives during recruitment processes and their employment.

Christine Comer, Head of Musculoskeletal Service, was recognised as Highly Commended at the Yorkshire and Humber Clinical Research Network Research Awards in the Research Allied Health Professional of the Year category.

Steph Lawrence MBE, Executive Director of Nursing and Allied Health Professionals was highly commended in the inaugural William Rathbone X Annual Award.

The Finance Team were named Finance Team of the Year at the regional Healthcare Financial Management Association Awards.

Dr Jill Halstead-Rastrick, Podiatrist, Clinical Head of Service for Podiatry & Clinical Lead for Research was presented with an academic award in the House of Lords by the Royal College of Podiatry.

Hayley Ingleson (Leeds Community Healthcare NHS Trust and Leeds Primary Care Practice Learning Facilitator - Nursing) was shortlisted for Educator of the Year at the Nursing Times Awards 2023.

Best Recruitment and Workforce Planning Strategy winner at the 2023 HR Excellence Awards.

Noor Ul Haq, Registered Nurse and Pastoral Support Lead, awarded the International Community Nurse of the Year at the Queen's Nursing Institute Ceremony.

The Integrated Children's Additional Needs Service (ICAN) shortlisted as a finalist for the Health Innovation Award at the National SEND Awards for their Innovation Project. It involved making reasonable adjustments in bloods clinics for children and young people with additional needs, to create an individually tailored experience.

Details of our awards during the year can be found on our website:
https://www.leedscommunityhealthcare.nhs.uk/our-news/awards/

Internal awards

We continued to celebrate achievement through our monthly internal 'Thanks a Bunch awards.' Staff nominated their colleagues for being shining examples of our Trust behaviours. In 2023/24 directors presented 12 awards personally thanking nominated staff for their continued hard work and commitment.

Our 2023/24 annual staff awards built upon the monthly recognition scheme theme and were an in-person event, replacing the online approach taken in the previous two years due to COVID-19. The award winning 'Thank You' event saw directors surprising colleagues at staff meetings to congratulate teams and individuals for their outstanding efforts

Building capacity

A commitment to maximising capacity continues to be at the forefront of our work. The aim being to continue to deliver the best possible care to the people of Leeds and beyond.

Our hyper-local recruitment success and the introduction of our second cohort of international nurses is highlighted in this report. We have also been delighted to win this year a national HR Excellence Award for our hyper-local recruitment success.

Other initiatives that have helped us to build, or maintain, staffing capacity include:

- Enhanced reward measures targeted at priority services and shifts.
- Continued promotion of 'InstantPay' to allow in-month access to wages for shifts worked.
- Collaborative work with health and social care partners to address shared resourcing challenges.
- Continued development of our apprenticeship programmes.

A positive employee relations climate is held in place by our values and behaviours and our People Before Process approach. Also, a regular schedule of formal and informal partnership meetings with Trade Union colleagues and staff network representatives.

Our work in the 'Leeds system' continues, including the delivery this year of a flexible working 'We Can Flex' programme for Leeds, a central role in the Leeds One Workforce Strategic Board and providing workforce expertise for the GP Confederation.

Inclusion

To meet our ambition to be more representative of our communities and to further tackle and reduce outstanding disparity in colleague experience, the Equality, Diversity, and Inclusion Forum, chaired by the Trust's Chair, has continued to bring employee perspectives, experiences, and ideas together. One area identified for improvement was to increase the number of staff who identify as Black Minority Ethnic (BME). We recently launched a bespoke Talent Development Programme for colleagues who identify as BME, to widen our talent pool and diversify our workforce.

We have continued to encourage discussions about inequality and cultural awareness through our Cultural Conversations work, and completion of the 5th cohort of Allyship and Reverse mentoring programmes.

Our Race Equality Network has supported an increased visibility of colleagues from Black and Minority Ethnic (BME) backgrounds on recruitment panels and improved cultural awareness by linking into national campaigns, religious holidays and sharing personal stories through our internal communications channels.

We believe all LGBTQIA+ people should be accepted without exception and promote this through the NHS Rainbow badge. We were involved with Phase II of the Rainbow Badge initiative and hold bronze level accreditation. Work will continue to develop the newly formed LGBTQIA+ staff network group.

Supporting colleague wellbeing continues to be a focus of attention. Highlights from last year include:

- A new Disability, Neurodiversity and Long-Term Conditions Staff Network, with over 50 members.
- Accreditation as a Mindful Employer.
- Neurodiversity awareness sessions attended by over 400 colleagues – this demonstrates a need for awareness and support around this topic.
- Launch of an enhanced Employee Assistance Programme, to provide colleagues with a range of wellbeing support and resources, including access to counselling.

Whilst we continue to make progress across many of the Equality, Diversity and Inclusion areas, we know there is still much to do.

Staff health and wellbeing

We provide and commission a full range of employee wellbeing services to support colleagues' physical and mental wellbeing at work; and to provide additional help and guidance in the event of ill health.

The support colleagues have accessed during 2023/24 includes:

- Over 1100 appointments with occupational health clinicians.
- Over 400 support calls with the Trust's Employee Assistance Programme.
- Over 75 phased return to work programmes, to make sure that people returning to work after a lengthy period of absence have the right support to do so successfully.

This support has contributed to LCH successfully increasing employee attendance during 2023/24, largely due to a steady reduction and stabilisation of long-term sickness absence. A position further reflected in the NHS Staff Survey, with 68% of colleagues saying we take positive action for staff health and wellbeing: up 2% from 2022. Also, 78% of colleagues said their immediate manager is interested in listening to them when describing the challenges they face.

We continue to offer a wide range of support covering physical, mental, and financial wellbeing, including structured and preventative work on psychological health and wellbeing for colleagues.

This includes:

- **A new critical incident debriefing model:** Critical Incident Staff Support Pathway (CriSPP), which has supported over 50 requests for either group or individuals to be debriefed.

- **Schwartz Rounds:** Over 16 support sessions, to come together and reflect on the various emotional and social challenges associated with working in healthcare.
- **Staff Development Day for Health and Wellbeing Champions (over 60 people) and Mental Health First Aiders (over 70 people):** To work on our health and wellbeing objectives and to hear feedback on how to better support their development.

During 2023, we also became a 'Mindful Employer'. See the Inclusion section of this report for details of our commitment to neurodiversity awareness and our new Disability, Neurodiversity and Long-Term Conditions staff network group.

As living costs have continued to rise, there has also been an even closer focus on financial wellbeing, to make sure that we are providing colleagues with access to a range of support when they need it. This includes the facility to 'stream' some of their earned wages sooner than pay date, access a range of webinar based financial sessions, co-ordinated with our Anchor organisations, as well as the recent decision to continue to pay the Real Living Wage for a further year.

Work continues to raise awareness to managers and staff on the wide range of health and wellbeing support available.

Financial Performance

At the start of the year, we formulated our income, expenditure and workforce plans, ensuring that we continued to use our resources wisely and efficiently.to not only maintain day-to-day services, but to continue to, innovate and improve service provision and pathways, both within our own services and across Leeds, all within block contract income arrangements.

Despite a challenging financial environment, managing the costs of hyper-inflation and the impact of industrial action the Trust ended the year with a surplus of £309k, details of our performance are included within the table below.

The financial performance recognised by NHS England excludes a number of technical items such as impairments of land and buildings and capital grants and donations, taking this into consideration the Trust ended the year with an adjusted surplus of £267k.

Summary Income and Expenditure Position

	2023-24 £'000
Operating income	227,088
Operating expenditure	(228,206)
Operating surplus / (deficit) from continuing operations	**(1,118)**
Net financing costs	1,415
Surplus / (Deficit)	**309**
Adjusting items	(42)
Adjusted surplus / (deficit)	**267**

As an NHS Trust we are required to abide by our own statutory duties to carry out our functions effectively, efficiently and economically, however we are also a partner of the West Yorkshire Integrated Care System. The importance of this for financial performance is the role we play in ensuring the West Yorkshire System is also able to manage within the resources allocated.

Due to competing demand for investment the Integrated Care Board (ICB) in Leeds was unable to provide for the full cost of rising demand and growth in our services, but Leeds Community Healthcare NHS Trust was able to manage these costs by utilising its own resources. These resources were available in 2023/24 only, mainly due to interest rates generating a higher-than-expected level of income on cash balances and the pace of recruitment into vacant posts. By using our own resources in this way we were able to contribute positively to the financial performance of the West Yorkshire health and social care system which also has a statutory duty to break-even.

Despite a challenging labour market, the Trust has been highly successful in recruiting to vacancies alongside this we have reduced our reliance on agency staff, allowing the Trust to perform better than planned against its agency control total.

Cash and Capital Expenditure

The Trust continues to manage cash well with a closing cash and cash equivalents balance of £43.5m, an increase of £2.3m. Alongside this we have continued to meet the majority of our commitment to the Better Payment Practice Code, which requires payment of all trade creditor invoices within 30 days of receipt of a valid invoice (unless other terms have been specifically agreed with the supplier). The target set is 95% for both value and number of invoices. The results for the year are shown in the table on page 35. Three out of the four targets were above 95%, with the exception being the NHS by number, which was slightly below target at 94.7%

We invested £15.9m in capital assets which matched our revised capital resource limit. The table below summarises how we made this investment:

Capital Expenditure

Capital scheme	Year Actual £k
Estates	1,621
Clinical equipment	480
IT	725
PDC Capital - Frontline Digitisation	1,748
Sub-total Capital Expenditure	***4,574***
Lease Cars IFRS 16	485
Property Leases IFRS 16 - Additions	3,210
Property Leases IFRS 16 - Remeasurement	3,210
Lease Disposals	(42)
Sub-total Finance Lease Expenditure	***11,300***
Total Capital Expenditure	**15,874**

We invested in a new 10-year lease and fit out for White Rose Office Park (£4.5m). This facility replaced the previous accommodation at Stockdale House and enabled the Trust to

move a number of services into a modern purpose built, energy efficient environment with better transport links, which will help with the delivery of services for the Trusts health population in the short and medium term.

The Trust also made a £2.5m investment into digital infrastructure and new technology, the latter being possible due to the Trust's successful bid for national monies of £1.75m for frontline digitisation. The funding has supported delivery of the Trusts strategic priorities, being used primarily to support improvements in computer hardware, enabling staff to make full use of digital tools available to support delivery of care, the introduction of digital letters and the implementation of a patient prioritisation tool based on health equity to enable active waiting list management.

Efficiency

In delivering our financial position the Trust planned and delivered £8.2m of efficiency savings of which £3.7m was recurrent and £4.5m non recurrent.

Recurrent savings were achieved mainly as a result of the management of inflationary cost uplifts on goods and services along with income growth generating a contribution to infrastructure costs.

Non recurrent savings were achieved largely due fortuitous gains on interest receivable and vacancies. Overall delivery of savings during 2023/24 represented a reduction of c3.6% of the total trust income.

In summary at the end of 2023/24 financial performance remains strong performing well against all the targets sets, this is the 13th straight year that Leeds Community Healthcare has met its targets and the challenge to achieve that does not get any easier.

Key Financial Performance Targets

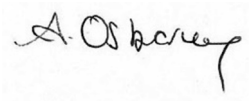
Key Financial Duties	Target	Performance	Achieved
Planned surplus on income and expenditure	£0.3m	£0.3m	✔
Remain within External Financing Limit	£7.6m	£7.6m	✔
Remain within Capital Resource Limit	£15.9m	£15.9m	✔
Capital Cost Absorption Rate	3.50%	3.50%	✔
Agency	£4,600k	£3,793k	✔
Better Payments Practice Code:			
Non NHS invoices (number and value)	95% and 95%	95.3% and 97.3%	✔ ✔
NHS invoices (number and value)	95% and 95%	94.7% and 99.4%	✔
CIP recurrent savings in year	£8,252k	£8,252k	✔

Forward look

As we move into the new financial year, the scale of financial challenge for the NHS and Leeds Community Healthcare, is significant.

To ensure the Trust can live within the funding allocated we will have to manage the full impact of inflationary costs alongside reductions in growth funding and local costs pressures. This represents an unprecedented efficiency target of £15.8m, with costs having to reduce by just over 7%.

Despite the enormity of the task, we have responded positively to challenge and in January 2024 the Trust launched its Quality and Value Programme. The programme represents a three-year drive to transform the way in which we deliver our services and as I reflect on the engagement and commitment I have seen to date from all colleagues, I am optimistic that the Trust will rise to the challenge delivering safe, high-quality services that are affordable.



Andrea Osborne
Interim Director of Finance and Resources

Legal obligations and how we are meeting them

Improving Health Equity

In May 2021 we formally committed, through approval of our first Health Equity strategy, to address unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways.

The development and delivery of the strategy is the first stage in our long-term commitment to address what is a long-term problem of inequities in health across our population and delivery. Nationally and across regional and local systems, focus on addressing health inequalities continues. Our strategy supports us to move from intent to action, identifying and addressing inequities within our own provision of care as well as contributing to cross-system action to address wider determinants.

We deliver our strategy through nine areas of work. Highlights of this year include identifying and addressing inequity through:

- **Person-centred care** – increasing recording of communication needs; based on learning from this, revising the template for recording communication needs; development of easy read and Plain English patient information; delivery of Health Literacy awareness sessions.

- **Quality and Safety** – embedding the use of equity data in quality reports to identify whether the risk of harm from healthcare is experienced unequally across different groups of patients, the mechanisms that drive these differences in risk and possible solutions; introducing feedback from patients and carers 'did bias or equitable care issues play a part in this' as part of the Duty of Candour process.
- **Availability and use of data** – improvements in inclusion of equity data achieved through clear expectations that Committee and Board reports must all consider data through an equity lens and improved availability of equity data through the development of a suite of self-service equity reports and equity data embedded within newly developed dashboards.
- **Workforce and leadership** – delivery of phase 1 of rollout of our Cultural Conversations programme, with eight services/departments across all three Business Units and corporate teams, including training for service leads on cultural competence and facilitating conversations with teams about working with different cultures and identities.

This works well with delivery of our statutory duties:

- **Accessible Information Standards** require us to identify, record, flag, share and meet the communication needs of people with disabilities and sensory impairments. Working with system colleagues to respond to patient and carer feedback, and reporting to the Leeds Health and Wellbeing Board, we have broadened the focus of our communication recording to include community languages as well as reasonable adjustments. Communication needs are recorded, flagged and shared through a template in our electronic patient record. Procurement of digital communication tools considers how we increase accessibility of information by systematising how we continue to meet people's communication needs.
- **Equality Delivery System (EDS22)** is the revised national framework for assessing equality in the NHS, with domain 1 focussed on commissioned services. For maximum effect, we worked as a Leeds-wide system to assess and develop improvement plans for equity in delivery by with the ICB and NHS Trusts across 2 pathways - maternity and children and young people's mental health services. Data and feedback from patients, carers and the third sector, identified strengths, particularly in use of data to understand the totality of patient access journey (referrals, waiting lists, cancelled and missed appointments) demonstrating that we are rating 'achieving' in terms of fairness across communities. This has also identified actions for improvement around understanding how the mental health needs of all protected characteristic and health inclusion groups can be better met, for example through trauma-informed approaches; the collection of demographic information and subsequent analysis in relation to ensuring services users are free from harm and service user experience.
- **Armed Forces Covenant** includes a legal obligation to have due regard to the principles of the covenant for the Armed Forces community, which includes currently serving members of the UK Armed Forces (regular and reserve), veterans, and family members. This means consciously considering the Covenant when developing, delivering, and reviewing policies and decisions which may impact the Armed Forces community. In practice this includes consideration of access, experience, and outcomes of the Armed Forces community in EQIAs and acting to address disadvantages the Armed Forces community might face compared to the general population, such as mitigating the risk of longer waiting times due to a mobile lifestyle or proactive engagement for example, Leeds Mental Wellbeing Service.

You can read more about this in our 2023/24 Quality Account on our website: **www.leedscommunityhealthcare.nhs.uk**

Emergency Preparedness and Resilience

All NHS Trusts are required to adhere to the requirements of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and to take part in the annual assurance audit against the EPRR Core Standards. The purpose of this process is to assess the preparedness of the NHS - both commissioners and providers - against a set of common NHS EPRR Core Standards to provide assurance that NHS Trusts in England, NHS England, and the Integrated Care Boards are resilient and prepared to respond to emergencies whilst maintaining the ability to continuing to deliver safe patient care.

In 2022/23 the NHS EPRR Annual Assurance process changed from a self-assessment against the NHS England Core Standards to a revised process where NHS organisations were required to provide and submit supporting evidence via a secure portal directly to NHS England. The scoring mechanism and evidence requirement for the exercise changed considerably from the year before and subsequently we were assessed as being non-compliant. This was also the case for all the other Trusts in the North East region.

To address the feedback from the NHSE 2022/23 Annual Assurance audit the Trust has worked closely with Internal Audit to develop a focused EPRR Improvement Plan which has been approved by our Business Committee.

Whilst work is underway, through the implementation of the EPRR Improvement Plan, to improve our level of compliance we continue to fulfil our requirements as set out in the Civil Contingencies Act 2004. The NHS Emergency Preparedness, Resilience and Response Framework requires the Trust to ensure we can respond in a robust and co-ordinated way to any form of disruption to normal service delivery or a major incident. This includes the development and regular review of:

- **A Major Incident Plan** which is regularly tested and updated to ensure it is fit for purpose in line with the Trust's Command and Control and On-call arrangements.
- **Business Continuity plans** to protect against the impact of a wide range of emergency situations which may affect normal service deliver.
- **Emergency planning functions** to manage national issues that may impact the ability of the Trust to continue to deliver safe services.
- **Training** – the majority of Trust On-call Managers have now attended the NHS England Principles of Health Command Training programme at either a Strategic (Gold) or Tactical (Silver) level and in addition a number of our On-call Directors have also undertaken the Joint Emergency Services Interoperability Principles (JESIP) training provided through the West Yorkshire Resilience Forum.

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 the Health and Safety at Work Act 1974 and the Management of Health and Safety at Work Regulations 1999.

We recognise that putting in place effective health and safety arrangements depends on managers, staff and their representatives working together at all levels.

The Health and Safety Group is the forum that enables staff to be involved in developing and reviewing the Trust's health and safety arrangements. The group which met five times in 2023/24 is chaired by the Executive Director of Workforce Finance and Resources and its membership includes staff-side representatives.

The Health and Safety Group reviews and proposes changes and developments of the health and safety management system to make sure there is continuous improvement against health and safety performance.

Counter Fraud

We do not tolerate 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 and Human Trafficking Statement

In accordance with the Modern Slavery Act 2015, Leeds Community Healthcare can confirm that it meets its responsibilities under this act. As an NHS organisation, suppliers are subject to standard NHS terms and conditions.

Disclosure of Personal Data Related Incidents

The UK GDPR and the related Data Protection Act 2018 (collectively 'Data Protection Legislation'), and the Common Law Duty of Confidentiality are the primary legal frameworks under which the Trust processes Personal Data.

These pieces of legislation outline our obligations and responsibilities regarding the Personal Data we hold and use, and the rights that individuals may have over that Personal Data.

Included within these obligations is the requirement that incidents evaluated as being externally reportable due to non-compliance with legislation must be reported to the Information Commissioner's Office (ICO), and in line with NHS requirements this is done through NHS Digital's Data Security and Protection Toolkit (DSPT).

For details of the personal data related incidents reported by the Trust during 2023/24 please see the Annual Governance Statement on page 80.

Safeguarding

Safeguarding is about working closely with families and partner agencies in health and social care to respect the rights of everyone to live life free from abuse, neglect or emotional harm.

The Trust is committed to safeguarding our population through effective multiagency working and public engagement in line with our organisation's vision and values while recognising Leeds City Council's Social Work service as the lead agency.

The Trust approved a three-year strategy in August 2023. The strategy sets out our direction of travel and priorities for Safeguarding 2023-2026 and outlines the vision of making safeguarding everybody's business, and recognising safeguarding is fundamental to our duty as care providers.

Duty of Candour

The Quality Committee monitors the Trust's compliance with Duty of Candour requirements on a regular basis. This ensures that applicable incidents have met the criteria of a safety notifiable incident which are:

- A rapid review was carried out to understand the initial facts in relation to what happened, what went wrong and what we could have done better.
- The people affected were informed and necessary apologies given.
- The people affected were provided with an explanation of how we would investigate and asked if they required any specific questions to be answered within the investigation.

Going Concern Assessment

Going Concern is an accounting principle that requires organisations to consider whether they can continue their operations for the foreseeable future when preparing their Accounts.

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

The Board considered the matter of the Trust as a going concern at its meeting on 28 March 2024. Our formal financial reporting begins on page 79.

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024 .....

Accountability Report
Corporate Governance Report

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.
- Making sure public money is spent in a way that is fair, efficient, effective and economic.
- Being a good employer.
- Engaging patients and the wider public 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's Chair and Chief Executive/Interim Chief Executive have led these functions throughout 2023/24.

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 Board discharges its day-to-day management of the Trust through the Chief Executive, Executive Directors and non-voting Directors, and senior staff through a scheme of delegation which is approved by the Audit Committee.

Board Composition

Considering the wide experience of the whole Board, the Board believes that its membership is balanced, complete and appropriate and that no individual or group of individuals dominate the Board. There is a clear division of responsibilities between the Chair of the Trust and Chief Executive which ensures a balance of power and authority. The Board has a wide range of skills, and a significant number of members have a medical, nursing or other health professional background. Non-Executive Directors have wide-ranging expertise and experience with backgrounds in finance, digital, healthcare, legal, and third sector.

Here are the people on our Board of Directors as at 31 March 2024

Brodie Clark CBE
Chair

Samantha Prince
Interim Chief Executive

Helen Thomson
Non-Executive Director (Vice Chair)

Richard Gladman
Non-Executive Director

Andrea North
Interim Executive Director of Operations

Andrea Osborne
Interim Executive Director of Finance and Resources

Alison Lowe OBE
Non-Executive Director

Professor Ian Lewis
Non-Executive Director

Stephanie Lawrence MBE
Executive Director of Nursing and Allied Health Professionals

Dr Ruth Burnett
Executive Medical Director

Khalil Rehman
Non-Executive Director

Rachel Booth
Associate Non-Executive Director*

Jenny Allen and Laura Smith
Director of Workforce*

*Non-voting members

Meet the Board
Non-Executive Directors

Brodie Clark CBE
(Trust Chair)

Brodie was appointed as Trust Chair in August 2020 and has previously been a non-executive director at the Trust since September 2014. He chairs the Nominations and Remuneration Committee and is a member of the Charitable Funds Committee.

Brodie has had extensive public sector experience with 32 years in the Prison Service and nine years in the UK Border Agency. His experience has included governing prisons, responsibility for the high security prison estate and latterly he developed and successfully led the UK Border Force through a modernising programme with security and risk at its core. He is experienced in dealing with large scale complex national and international risk activity and in delivering transformational change agendas within demanding operational settings. He was awarded the CBE in 2010 for his work on UK border security.

He is a strong believer in the power and voice of local communities and seeks to support that through his role with the Trust.

Helen Thomson DL
(Vice Chair)

Helen was appointed as a Non-Executive Director in May 2019. She is Vice Chair of the Trust, chairs the Quality Committee and is a member of the Business Committee. Helen is also the Trust's Senior Independent Director which includes duties such as providing support to the Chair, co-ordinating the Chair appraisal process, intervening to resolve issues of concern on the Board, and taking part in the succession planning process for the Chair role where a reappointment or new appointment is necessary.

Helen holds an MA in Leading Innovation and Change from York University and a first degree in management from Leeds University. She is a Registered Nurse and Midwife and a Registered Midwife Teacher as well as a qualified coach.

After beginning her nursing career in Leeds sha has held clinical, management and education posts across West Yorkshire. She held a number of NHS Board posts since 1993 as Director of Operations, Chief Nurse and CEO until her retirement in 2014.

Helen is now an independent healthcare consultant and a Trustee of the charity Sue Ryder where she chairs the Health and Social Care Sub-committee.

She was appointed Deputy Lieutenant for West Yorkshire in 2012 and Vice Lord Lieutenant in 2022.

She is a former Council member of the University of Huddersfield where she Chaired the Audit Committee and a former member of the Independent Reconfiguration Panel of the Department of Health and Social Care.

Alison Lowe OBE

Alison was appointed as a non-Executive Director in December 2020. She chairs the Charitable Funds Committee and is a member of the Quality Committee and Nominations and Remuneration Committee.

Alison has worked for voluntary organisations for nearly thirty years including as Chief Executive of Touchstone, a mental health charity in Leeds and wider West Yorkshire for nearly 20 years.

Alison is currently the Deputy Mayor for Police and Crime in West Yorkshire on behalf of the Mayor, Tracey Brabin. Alison has also been involved in local government for 29 years as a local councillor representing Armley and she was Deputy Lord Mayor in 2003-4. Alison was made an Honorary Alderwoman of Leeds in 2020.

Alison has substantial experience in developing inclusive leadership teams and was awarded an honorary Doctor of Laws by the University of Leeds for her contribution to Equality, Diversity and Inclusion across 30 years working in the region.

Professor Ian Lewis

Ian was appointed as a Non-Executive Director in July 2017. Ian serves on the Quality Committee (Vice Chair) and Audit Committee. He was a senior clinician and was Executive Medical Director of Alder Hey Children's NHS Foundation Trust in Liverpool between 2011 and 2015, having previously been a Divisional Medical Director and Consultant Paediatric Oncologist at Leeds Teaching Hospitals NHS Trust.

He also co-chaired the Children and Young People's Health Outcomes Forum - an independent group of professionals who advised the government, which operated between 2012 and 2016.

He served as a Trustee of The Candlelighters Trust (1985-2011), Martin House Children's Hospice (1990-2010) and Bone Cancer Research Trust (2006-present) within the charitable sector.

Richard Gladman

Richard was appointed to a Non-Executive Director role on the Trust's Board commencing April 2016. Richard chairs the Business Committee and is deputy chair of Audit Committee. He acts as Board champion for the Freedom to Speak Up Guardian work at the Trust. Through his own consultancy business, Richard specialises in digital healthcare transformation, designing and delivering complex programmes. He is a specialist in programme delivery and commercial management, particularly centred on patient record and population health management solutions.

Over his career Richard has held senior positions with PwC, IBM, PA Consulting and Deloitte where he headed the UK Human Capital Healthcare team. He has led work across the UK, Europe and the Middle East. Richard has a degree in Economics and is a qualified accountant.

Khalil Rehman

Khalil was appointed as a Non-Executive Director in December 2020. He chairs the Audit Committee and is deputy chair of the Business Committee.

Khalil has spent his career at the intersections of finance, social impact and digital innovations across the private, public and third sectors. He brings significant board and corporate governance experience alongside a sense of curiosity, inclusivity and compassion.

Khalil has a background in successfully delivering humanitarian projects, public health and global healthcare services across Africa, South Asia and other developing countries. He was Chief Executive of an international health charity between 2011-18 and Director of Finance and IT of a leading North West based social care charity previously.

Khalil also spent ten years in investment banking in mergers and acquisitions and corporate finance advisory roles, followed by a stint in academia at one of the world's top universities as a Research Fellow in social care and postgraduate teaching. He is currently a non-executive director at Salix Homes and a non-executive director at East Lancashire Hospitals Trust.

Rachel Booth (Associate)

Rachel was appointed as an Associate Non-Executive Director in December 2020. Having been previously a member of the Business Committee, she took over the role of Chair of this committee in November 2023. She is also a member of the Nominations and Remuneration Committee, and more recently the Audit Committee.

Rachel is a qualified lawyer with over 20 years' experience of working in health and social care. A litigator by background she spent several years at DLA Piper, a global commercial law firm where she specialised in health and social care regulation, before moving to an in-house legal role with Bupa in 2007.

Rachel's current role is Legal Director, leading a team which manages legal services for Bupa's care homes, dental and health clinics across the UK and Ireland. She sits on multiple Executive and Risk Committees as well as occupying the role of Speak Up Officer, managing Bupa's whistleblowing process.

Executive Directors

Thea Stein

(Chief Executive – to 31 August 2023)

Thea joined Leeds Community Healthcare in October 2014. Previously, Thea was Chief Executive of Carers Trust, a post which she held from September 2012. Thea has also worked at a senior level in the public sector across England and Scotland. Previous roles have included Chief Executive of Yorkshire Forward and Chief Executive of one of the former primary care trusts in Leeds, as well as working in public health and primary care commissioning. Thea started her career as a clinical psychologist working in homelessness and drug and alcohol services.

Sam Prince

(Executive Director of Operations to 31 August 2023, Interim Chief Executive 1 September 2023 to 15 April 2024s)

Born and raised in Leeds, Sam became Interim Chief Executive in September 2023, her previous role was as Executive Director of Operations at the Trust, a position she held since it began in 2011. Before this, she was responsible for establishing the Trust as an official NHS provider, something she achieved in her role as Managing Director of NHS Leeds Community Healthcare.

Sam brings to the role a wealth of health and social care experience, specifically serving the people of Leeds. She has worked across all sectors of the NHS including community, mental health, commissioning, and acute services. From 2020 onwards, as part of the national drive to protect people against the global pandemic, she successfully led the Covid 19 Vaccination Programme for the City.

Passionate about 'Team Leeds' and working in a way that patients and their families can understand, she has led many partnerships across the city, collaborating with both the public and voluntary sector to improve access and outcomes for people in need of care and support.

Sam holds an MBA from the University of Durham Business School, gained after studying with the Open University. As her leadership career began with few formal qualifications, she remains committed to harnessing potential through workforce training and development and to creating an inclusive culture for all.

Bryan Machin

(Executive Director of Finance and Resources – to 31 July 2023, with last working day 12 July 2023, then Interim Executive Director of Finance and Resources from 1 November 2023 to 4 February 2024)

Bryan had over 10 years' experience at Director level prior to joining Leeds Community Healthcare NHS Trust in May 2011. Commencing with the NHS as a graduate finance trainee, Bryan has worked at senior levels in community and mental health providers, in acute Trusts, at strategic health authorities and in commissioning organisations. This breadth of experience gives him the opportunity to look at financial issues from a range of perspectives and propose practical solutions to problems.

Steph Lawrence MBE

(Executive Director of Nursing and Allied Health Professionals, Interim Deputy Chief Executive from 1 September 2023)

Steph was born and has spent most of her working life in Yorkshire. She trained as a nurse in Calderdale. As well as being a Registered Nurse for adults, she also holds qualifications in children's nursing, district nursing and a master's degree in advanced Practice and is a non-medical prescriber.

She is currently leading on the National District Nurse Apprenticeship Standard and is the Chair of the Trailblazer group for this work. She has held several senior leadership posts within nursing across provider and commissioning organisations. Her current role is Executive Director of Nursing and AHPs for Leeds Community Healthcare NHS Trust and Leeds GP Confederation. She also works as the National Professional Advisor for Community Services at the Care Quality Commission (CQC). From September 2023 Steph was appointed as Interim Deputy Chief Executive for Leeds Community Healthcare NHS Trust.

Steph is passionate about ensuring high quality care for patients and for carers in their own homes and other community settings and still practices clinically on a regular basis. Stephanie was awarded an MBE for her services to district nursing in 2022.

Dr Ruth Burnett

(Executive Medical Director)

Ruth qualified as a GP in Oxford and, alongside mainstream practice, worked as the Clinical Commissioning Group (CCG) Locality Lead for Urgent Care and as a GP with an Extended Role (GPER) in musculoskeletal medicine. She continues to see patients in practice.

She became the Medical Director for Buckinghamshire MSK community service in 2011 and then stepped into a national Medical Director role in 2013. Before taking up her current post, she worked for six years as a Medical Director across a mixture of community MSK services, primary care, out of hours and urgent care, new models of care and prison healthcare.

She has a passion for increasing the effectiveness of primary and community services for both patients and staff and the model she created with the Prime Minister's Challenge Fund in 2014, Practice Assist, was shortlisted in the HSJ finals in the category 'Primary Care Innovation'.

Her contribution to medical leadership was recognised in Senior Fellowship of the Faculty of Medical Leadership and Management in 2021.

Yasmin Ahmed

(Interim Executive Director of Finance and Resources from 26 June to 25 December 2023)

Yasmin joined LCH in January 2023 as Deputy Director of Finance and Resources. She has over twenty years' experience, operating in key leadership positions within the NHS, across various providers and commissioners in West Yorkshire and the rest of England.

Yasmin is an ACCA qualified accountant and has held responsibilities throughout her career that include, financial management and control, business planning, strategic leadership, change management and improvement. She brings a wealth of experience to the role.

Alongside her financial experience, Yasmin is passionate about improving health outcomes and making a real difference to people's lives. She is a volunteer for the Stroke

Association's Here for You Programme, supporting stroke survivors to learn new ways to cope. A programme close to Yasmin's heart, following her lived experience of providing care to a family member following a stroke.

A strong advocate for equality and diversity, Yasmin is committed to promoting equality of service and strives to create an inclusive environment for patients and colleagues.

Andrea Osborne

(Interim Executive Director of Finance and Resources from 5 February 2024 to present)

Andrea joined LCH in February 2024 as Interim Director of Finance and Resources. Based in Tameside she has over twenty years' experience as a qualified accountant, gained mostly within the hospital sector. In 2016 she moved to work within mental health and community services, where she found her passion for this area of healthcare.

With a strong focus on listening to the staff voice to affect change, Andrea is also a keen advocate for health equity, she describes it as a privilege to use her financial experience to support some of the most vulnerable people in our communities, many of whom have long-term or lifelong illnesses.

Andrea North

(Interim Executive Director of Operations from 1 September 2023 to present)

Andrea has over 40 years' experience of working in Leeds, starting her career as a nursing assistant at Meanwood Park Hospital, whilst waiting to begin her nurse training. After qualifying in 1984 with a registration in what would now be referred to as learning disability, Andrea developed a passion for person centred care, supporting the closure of the hospital and a move into the community for the people who lived there.

Andrea then went on to train as a social worker specialising in working with people with a physical disability or acquired brain injury. It was while working for the Local Authority that she started to question the 'false' distinctions between health and social care, fighting for people to receive services and funding that truly met their needs.

After choosing operational leadership as her career path Andrea used her influence to challenge 'the system', pushing organisational boundaries, and introducing new ways of working across health and social care. She went on to study Health and Social Care leadership at Huddersfield University, always with the aim of improving services for the people of Leeds.

As General Manager for the Specialist Business Unit, she was responsible for a broad portfolio of services including those supporting people in the criminal justice system and others marginalised within society. Andrea is passionate about developing services that reach all communities and has led several successful tenders for new business.

Directors

Jenny Allen and Laura Smith

(Director of Workforce - job share)

Jenny and Laura job share our Director of Workforce, organisational development and System Development role.

Jenny studied law at university before joining the NHS on the National Graduate Management Scheme as a general management trainee in 1998. She has held several senior HR and Workforce leadership roles across NHS organisations including at Leeds Teaching Hospitals Trust and NHS Digital before commencing with Leeds Community Trust.

Jenny has previously run her own HR consulting business, has held associate lecturer roles at several local universities and is a published academic author in the field of HR and management. She is also an associate editor for an academic journal.

Laura also joined the NHS in 2000 as a General Management trainee, and has held leadership roles in general management, human resources (HR) and organisational development across acute organisations, primary care trusts and national organisations. She is an accredited coach and mentor as well as a qualified HR professional.

What matters most to both Laura and Jenny in work is people: "the people we work with and the patients and population we work for, both across the City of Leeds and the wider geographic communities served by LCH."

Changes to the Board

During 2023/24 there were eight changes to individual members of the Board, outlined as follows:

- Thea Stein stood down as Chief Executive on 31 August 2023.
- Sam Prince was appointed as Interim Chief Executive from 1 September 2023.
- Steph Lawrence was appointed as Interim Deputy Chief Executive from 1 September 2023.
- Andrea North was appointed as Interim Executive Director of Operations from 1 September 2023.
- Bryan Machin stood down as Executive Director of Finance and Resources on 31 July due to retiring, with his last working day being 12 July.
- Yasmin Ahmed was appointed as Interim Executive Director of Finance and Resources from 26 June to 25 December 2023.
- Bryan Machin returned as Interim Executive Director of Finance and Resources from 1 November 2023 to 4 February 2024.
- Andrea Osborne was appointed as Interim Executive Director of Finance and Resources from 5 February 2024 to present, while recruitment for a substantive post holder took place.

In addition to the changes listed above, Selina Douglas was appointed as substantive Chief Executive from 15 April 2024 and therefore was in post during the approvals process for the Annual Report and Accounts 2023/24.

A 'fit and proper' Board

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 main components of this are:

- The Chair conducts individual performance evaluations of the Non-Executive Directors and the Chief Executive, which involves obtaining feedback from a variety of stakeholders;
- The Senior Independent Director conducts a performance evaluation of the Chair, which involves obtaining feedback from a variety of stakeholders;
- The Chief Executive conducts performance evaluations of the Trust Leadership Team.

The Board has continued with its development programme during the year, including an externally facilitated National Cyber Security Centre assured session on Cyber Security.

The Trust has a programme of workshops to support Board members' development, and in 2023/24 covered such topics as organisational strategy, health equity, equality and inclusion, sustainability, and priorities 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

All directors have made a declaration that they comply with the revised 'fit and proper person framework' that was introduced from September 2023.

Each director has confirmed in writing that they know of no information that would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and each 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.

All Non-Executive Directors are considered to be independent (demonstrated through annual appraisals, declarations of interest and independence, and Board and Committee minutes).

Director's declarations of interests for disclosure 2023/24

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 shareholdings 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 £35 in connection with the Trust
Brodie Clark CBE (Trust Chair)	None	None	None	None	None	None	None	None
Thea Stein (CEO until 31 Aug 2023)	None	None	None	Trustee of Nuffield Trust CQC Executive reviewer	None	None	None	None
Sam Prince (Interim CEO from 1 September 2023)	None	None	None	None	None	None	Justice of the Peace – England and Wales (North and West Yorkshire)	None
Helen Thomson (Deputy Lieutenant for West Yorkshire)	Helen Thomson Ltd	Director Helen Thomson Ltd	None	Trustee: Sue Ryder	Trustee: Sue Ryder	None	None	None
Alison Lowe OBE	Blue Light Commercial from 1 May 2022	None	None	Trustee, Together Women Trustee Citizens Advice Leeds	Trustee Citizens Advice Leeds Trustee, Together Women	None	Deputy Mayor for Policing and Crime in West Yorkshire from 9 August 2021	None
Richard Gladman	Verbena Digital Limited Directorship	Verbena Digital Ltd – Owner	None	Non-Executive Director Humber and North Yorkshire Integrated Care Board	None	None	None	None
Ian Lewis	None	None	None	Trustee: Rossett School Harrogate (until March 2024)	None	None	None	None

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 shareholdings 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 £35 in connection with the Trust
Khalil Rehman	NED at Salix Homes Ltd Director, TSI Caritas Ltd NED at University of Central Lancashire (UCLAN)	None	None	Director at Medisina Foundation Ltd NED at East Lancashire Hospitals NHS Trust Ltd Interim Director of Finance – Touchstone Leeds Ltd	Consultancy/ Advisory work for Touchstone Leeds Ltd	None	None	None
Rachel Booth (Associate Member)*	None	None	None	None	Full time employee of Bupa which holds some NHS contracts in its care homes, dental and hospital businesses in the UK	None	None	None
Andrea Osborne (Interim Executive Director of Finance and Resources from 5 Feb 2024)	None	None	None	None	None	None	None	None
Dr Ruth Burnett	None	None	None	Medical Director Leeds GP Confederation Performs GP work at Crossley Street Surgery, Wetherby on an unpaid basis as part of Continuing Professional Development and maintaining registration Facilitator Windsor Leadership Trust	None	None	None	None

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 shareholdings 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 £35 in connection with the Trust
Steph Lawrence MBE	None	None	None	Executive Director of Nursing and AHP's for Leeds GP Confederation Fellow of Queen's Nursing Institute Working two days per month for Queen's Nursing Institute on a voluntary basis from 1 March 2024. Work one day a week for the CQC	None	None	None	Formal dinner provided by a local university £50 12 October 2023
Laura Smith*	Director of Workforce Leeds GP Confederation Leeds	Associate of Prospect Business Consulting and WellNorth Enterprises	None	Director of Workforce Leeds GP Confederation Leeds	None	None	None	None
Jenny Allen*	None	None	None	Director of Workforce Leeds GP Confederation Leeds Volunteering for Zarach, a Leeds based charity Indirect interest – husband is a partner at KPMG. KPMG bid and contract for contracts with NHS Providers Husband is a Trustee for Age UK Leeds	Volunteering for Zarach, a Leeds based charity	None	None	None

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 shareholdings 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 £35 in connection with the Trust
Andrea North (Interim Director of Operations from Sept 2023)	None	None	None	None	None	None	None	None
Bryan Machin (Executive Director of Finance and Resources until 31 July '23, then Interim Executive Director of Finance and Resources from 1 Nov '23 - 4 Feb '24)	None	None	None	Trustee and Vice-chair of St Anne's Community Services (Registered Charity, Housing Association and Company Limited by Guarantee) Non-Executive Director Bradford Teaching Hospitals NHS Foundation Trust from December 2023	Zero hours contract with Community Ventures Management Ltd (any financial arrangements with Community Ventures or any affiliated company will be undertaken by other senior Finance staff	None	None	None
Yasmin Ahmed (Interim Executive Director of Finance and Resources from 26 June to 25 Dec 2023)	None	None	None	None	None	None	None	None

* Non-voting Board member
Board approved
Audit Committee approved

Board meetings and business in 2023/24

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally seven 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 Board has further encouraged the public to attend during the year with some Board meetings being held in community venues across Leeds.

The dates are advertised on the Trust's website, and Board meeting agendas, reports and minutes are published online.

The Board has also met informally on a further five occasions during 2023/24. These events have taken the form of a Board development programme and have involved a wider group of senior leaders.

Attendance at formal Board meetings is outlined below:

	26 May	28 Jun	4 Aug	6 Oct	8 Dec	2 Feb	28 Mar	
Brodie Clark	✔	✗	✔	✔	✔	✔	✔	6/7
Richard Gladman	✔	✔	✔	✔	✔	✔	✔	7/7
Ian Lewis	✔	✔	✔	✔	✔	✔	✔	7/7
Helen Thomson	✔	✔	✔	✔	✔	✗	✔	6/7
Alison Lowe	✔	✔	✔	✔	✗	✗	✔	5/7
Rachel Booth (Associate)	✔	✔	✔	✔	✔	✔	✔	7/7
Khalil Rehman	✔	✔	✔	✔	✔	✔	✔	7/7
Thea Stein	✔	✔	✔					3/3
Ruth Burnett	✔	✔	✔	✗	✔	✔	✔	6/7
Bryan Machin	✔	✔			✔	✔		4/4
Sam Prince	✔	✔	✔	✔	✔	✔	✔	7/7
Steph Lawrence	✔	✔	✔	✔	✔	✔	✔	7/7
+Jenny Allen/Laura Smith	✔	✔	✗	✔	✔	✔	✔	6/7
Andrea North			✔	✔	✔	✔	✔	5/5
Yasmin Ahmed			✔	✔	✗			2/3
Andrea Osborne							✔	1/1

+Officer in attendance (job share)

In addition, an Annual General Meeting was held on 19 September 2023. This was held in person at the Thackray Museum, Leeds.

Leeds Community Healthcare NHS Trust has a commitment to providing high quality care and reducing health inequalities within our communities. The Trust aims to innovate, build and standardise to deliver high quality, safe and effective care that provides patients, families and carers with the best patient experience. All actions to ensure the Trust meets this commitment 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 it meets 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 we carry out our duties effectively, efficiently and economically.

Details of the functions of each committee can be found in our Annual Governance Statement 2023/24 which starts on page 80.

In addition, the Trust has three 'Committees in Common' arrangements involving 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 two 'Committees in Common' are:

- West Yorkshire Mental Health Services Learning Disabilities and Autism Collaborative. 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 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.

- West Yorkshire Community Health Services Provider Collaborative. This comprises of eight community providers in West Yorkshire (Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Mid Yorkshire Teaching Hospital Trust, Leeds Community Healthcare NHS Trust, Locala and Yorkshire Ambulance Service NHS Trust) working together to collectively improve outcomes and make the most of resources.

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

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024 .....

Compliance with the Code of Governance

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The Code of Governance for NHS Provider Trusts (the Code) was published by NHS England. The purpose of the Code is to assist the boards of NHS trusts and NHS foundation trusts with ensuring good governance and to bring together best practice from public and private sector corporate governance.

The Code is issued as best practice, but also contains a number of main principles, supporting principles and code provisions on a 'comply or explain' basis. The Leeds Community Healthcare NHS Trust has applied the principles of the Code of Governance for NHS Provider Trusts on a 'comply or explain' basis. The Code of Governance for NHS Provider Trusts, most recently revised in October 2022, is based on the principles of the UK Corporate Governance Code and now applies to NHS Trusts in addition to Foundation Trusts.

A full review of compliance with the Code was submitted to the Trust Board to support this statement. A copy of the full report to the Trust Board is available on request from the Company Secretary. The Trust carried out a detailed self-assessment against the requirements of the Code and submitted the assessment to the Trust Board for approval and to support the statement that the Trust complies with the principles of the Code with the exception as listed in the following table.

Disclosures required to be reported on in the Annual Report

Provision	Requirement	Section in Annual Report
Section A, 2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	Annual Governance Statement
Section A, 2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	Accountability Report, Annual Governance Statement, Performance Overview and Analysis Report

Provision	Requirement	Section in Annual Report
Section A, 2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision- making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	Performance Overview and Analysis Report
Section B, 2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent.	Accountability Report (Directors' Report)
Section B, 2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	Accountability Report (Directors' Report), Annual Governance Statement (Directors' attendance tables)
Section C, 4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	Accountability Report (Directors' Report)
Section C, 4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Compliant for 2023/24. The last development review was undertaken in 2022. It is recommended that an external Well-led review be undertaken during 2024/25.

Provision	Requirement	Section in Annual Report
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline. • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition. • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives. • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served. • the gender balance of senior management and their direct reports.	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans. • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit. • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Annual Governance Statement
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Statement of Directors' responsibilities
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Governance Statement

Provision	Requirement	Section in Annual Report
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Governance Statement
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	Going Concern Statement
Section E, 2.3	Where a trust releases an executive director, e.g to serve as a non-executive director elsewhere, the remuneration. disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	N/A during 2023/24

Comply or explain provisions

Provision	Requirement	Comply/Explain
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	Comply Trust vision and values agreed for 2023/24. The Board also agreed its four strategic goals and a number of priorities that are aimed at supporting the delivery of the strategic goals. The strategic goals inform the Trust's Strategic and Operational plans. The Board receives quarterly reports on progress towards achieving its priorities. When setting its strategic priorities, the Board will take account of the ICB's strategic priorities, both at ICB and Leeds Place level.

Provision	Requirement	Comply/Explain
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	Comply The Board regularly review performance using the Performance Brief in Board Committees and within the Board meeting to measure and monitor the quality, effectiveness and efficiency of healthcare delivery.
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	Comply All executive directors and non-executive directors, through the Board sub-committees have an opportunity to receive and influence the Internal Audit Plan for areas of high risk prior to it being signed off by the Audit Committee. Should the Board require, the internal auditors can be asked to look at any areas of concern for the Board; internal auditors can be commissioned by the Audit Committee where the Board or NEDs have concerns about areas of performance. The Business Committee and the Board of Directors receives annual performance reports which show data relating to WRES and WDES.
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	Comply The Board has formally approved its Board sub-committee structure including the Quality Committee which receives assurance on clinical governance and quality matters. Assurances on clinical governance and clinical quality are made to the Board of Directors through reports made by the chair of the Quality Committee. The Trust produces a Quality Report which sets out progress against the Trust's quality improvement priorities.

Provision	Requirement	Comply/Explain
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners.	Comply Engagement with stakeholders is reported to Public Board via the Chief Executive's report and within the Annual General Meeting.
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	Comply The Trust has a Freedom to Speak Up Guardian (FTSUG) and FTSUG Ambassadors. The Board receives a six-monthly report from the FTSUG. There is a nominated FTSU Board Champion who meets regularly with the FTSUG.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	Comply The Trust has a Managing Conflicts of Interest Policy and Procedure which includes Standards of Business conduct. Registers are in place and available on request. Registers of Director interests are published within the Annual Report.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Requirement noted. If and when applicable resignations would be reported to Board.
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Comply Agendas for the Board are prepared by the Chair, CEO and Company Secretary.

Provision	Requirement	Comply/Explain
Section B, 2.2	The chair is also responsible for ensuring that directors receive accurate, timely and clear information that enables them to perform their duties effectively.	Comply The Chair takes an active role in specifying the format of the information provided to directors. The Chair is clear as to the timeframe in which information should be distributed to the Board of Directors.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	Comply The Chair ensures that there is effective contribution from all members of the Board, in particular the non-executive directors and the opportunity to challenge the executive directors. The Code of Conduct contains information about our values and makes reference to the Nolan Principles. The Chair allows sufficient time for discussion at Board meetings. The Board encourages its sub-committees to look at areas in detail where needed. Board and sub-committee meetings run in accordance with Trust values
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	Comply The Chair of the Trust and the Chief Executive abide by the division of responsibilities as set out in the standing orders and standing financial instructions. The roles of the Chair and Chief Executive are undertaken by two different individuals. The Chair of the Trust has completed a declaration as to their independence. Whilst the Chair is required only to do this on appointment we test this (as for all other NEDs) on an annual basis. The Chair of the Trust has not previously been the Chief Executive of the Trust. The Board has identified a deputy chair and a senior independent director. The Audit Committee is not attended by the Chair of the Trust on a regular basis; however, an invitation is extended for them to attend once a year.

Provision	Requirement	Comply/Explain
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	Comply The Board comprises five non-executive directors excluding the Chair in comparison to 5 executive directors, therefore, at least half the Board comprises non-executive directors. On appointment and annually thereafter the NEDs are required to declare their independence. All the non-executive directors have been determined to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	Comply This is evidenced through the annual declaration of interest forms.
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	Comply The Board has made a clear determination as to the membership of the committees in the agreed terms of reference. The Trust has two NEDs with clinical backgrounds, other NEDs have a diverse range of skill sets.
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Requirement noted and included within the Terms of Reference.

Provision	Requirement	Comply/Explain
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	Comply The Senior Independent Director undertakes the annual appraisal of the Chair.
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	Comply The CEO reports directly to the Chair, with Executive Directors reporting to the CEO. Appointment of Executive Directors include the relevant NED on the interview panel and inclusion of others with the assessment centre process. Annually the CEO reports formally to the Nominations and Remuneration Committee on his appraisal meetings and objective setting with each Executive. The Chair holds a quarterly meeting with the non-executive directors as a group without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	Comply The expected time commitment is set out in the letter of appointment and in accepting the appointment Directors confirm that they are able to allocate sufficient time to the role.

Provision	Requirement	Comply/Explain
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Comply – Company Secretary in post.
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	Comply The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	Comply The Board acts as a unitary Board, with Executive and Non-Executive Directors sharing the same liabilities and joint responsibilities for all decisions taken by the Board. A schedule of matters reserved for the Board is in place.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	Comply The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.

Provision	Requirement	Comply/Explain
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	Comply The Board meets in public seven times per year and meets privately for Board development sessions or workshops six times per year. There are also extraordinary meetings held when required. A schedule of matters reserved for the Board is included in the standing orders and standing financial instructions, and this is reviewed annually by the Audit Committee and agreed by the Board to ensure it remains fit for purpose.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Comply – use of external recruitment and adherence to recommendations for selection panel. Nominations and Remuneration Committee has received reports on succession planning.
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other nonexecutive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, nonexecutive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Requirement noted – appointments conducted in accordance with this.

Provision	Requirement	Comply/Explain
Section C, 4.1	Directors on the board of directors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	Comply All new Board members are required to sign a self-attestation form. DBS checks are completed for all new Board members. All Board members are compliant with the revised requirements in the FPPT Framework following the Kark review. This is reported to Board annually in March.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	Comply The Trust Chair has served four years to date, with a further six years as a NED prior to that. The term ends in 2025 and it is understood that a process to recruit a new Chair is then required. Discussions have commenced with NHS England regarding this. At present, two of the NEDs have exceeded six years in post. However, in both cases their terms have been agreed with NHS England and no further terms will be issued upon expiry of their current terms.
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Comply Each member of the Board is subject to an annual appraisal. Each Committee of the Board produces an annual report, reporting delivery against annual work plan and objectives. The Audit Committee reviews the annual reports from Committees.
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	Comply All Board members have an appraisal with agreed personal development plan.

Provision	Requirement	Comply/Explain
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors to ensure there is appropriate succession planning.	Requirement noted. The Nominations and Remuneration Committee undertakes succession planning for Director roles.
Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Comply – would adhere to this if ever required.
Section C, 5.1	All directors should receive appropriate induction on joining the board of directors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Comply Induction programme and training offered to Board members.
Section C, 5.2	The chair should ensure that directors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, and committees. The trust should provide the necessary resources for its directors to develop and update their skills, knowledge and capabilities. Where directors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Comply – available to all.
Section C, 5.4	The chair should ensure that new directors receive a full and tailored induction on joining the board. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/or materials that are consistent with their individual and collective development programme.	Comply Induction programme and training offered to Board members.

Provision	Requirement	Comply/Explain
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Comply – addressed within appraisal and mid year review processes.
Section C, 5.8	The chair is responsible for ensuring that directors receive accurate, timely and clear information. Management has an obligation to provide such information but directors should seek clarification or detail where necessary.	Comply The Chair of the Trust ensures that directors receive information in a format they require and within a timescale that will allow sufficient time to prepare for the meetings. The Chair also allows sufficient time and opportunity for clarification questions to be asked in the meeting. Directors are also encouraged to seek clarification outside of the meeting in order to assist discussion at the Board meetings. There are opportunities to input to how the reports will be presented and the information they contain.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	Comply – as above.
Section C, 5.10	The board of directors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Comply Appropriate papers and reports are presented to the Board of Directors. The Board has an annual business cycle which sets out the standard papers that will be presented to them, and the Board can also agree to receive a report on any matter if it requires. The Board of Directors will from time-to-time ask for information it requires to allow it to carry out its role and to be assured of performance. Any member of the Board of Directors can request any item to be reported to Board meetings and may also ask for this to be looked at in more detail in the Board sub-committee structure.

Provision	Requirement	Comply/Explain
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	Comply The Board of Directors seeks assurance directly and through its committees via assurance and escalation reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors can request external assurance as appropriate.
Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of nonexecutive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	Comply All directors have access to professional independent advice at the Trust's expense (including legal advice and access to auditors).
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties.	Comply Committees are supported by the relevant executive director, senior manager/s and Trust staff.
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	Comply This would be explored in appraisal and mid year review and be raised as a separate issue if this was not taking place. The non-executive directors will challenge the executive directors if papers are not sufficiently detailed or clear. The non-executive directors will use their skills and experience to challenge the decisions of the executive in an appropriate and professional manner having due regard to necessary standards of care required in such a role.
Section C, 5.17	The trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply – cover is renewed each year and overseen by the Company Secretary.

Provision	Requirement	Comply/Explain
Section D, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the trust operates.	Comply The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience. The Trust Chair is not a member of the Audit Committee.
Section D, 2.2	The main roles and responsibilities of the audit committee should include: • monitoring the integrity of the financial statements of the trust and any formal announcements relating to the trust's financial performance, and reviewing significant financial reporting judgements contained in them. • providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy. • reviewing the trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself. • monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors. • reviewing and monitoring the external auditor's independence and objectivity. • reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements. • reporting to the board of directors on how it has discharged its responsibilities.	Comply – evidenced in the Audit Committee annual report to June Public Board each year.

Provision	Requirement	Comply/Explain
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years.	Comply The Trust's external auditors were appointed in 2020. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust.
Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	Explain Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2024/25.

Provision	Requirement	Comply/Explain
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	Comply The Trust complies with the national guidance on VSM remuneration with respect to bonuses, and has paid these to some VSMs in some years – any decisions about this are made by the Nominations and Remuneration Committee.
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Comply Remuneration for the Chair and NEDs set in accordance with this guidance.

Provision	Requirement	Comply/Explain
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Has not arisen - requirement noted.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply – should this ever be required.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	Comply The Nominations and Remuneration Committee has delegated responsibility for setting all executive director remuneration, and for other senior managers not covered by the Agenda for Change terms and conditions of service. This is evidenced in the Committee's terms of reference and the Standing orders and Standing Financial Instructions.

Publicly available information

Provision	Requirement	Section in Annual Report
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is outlined in the Standing orders, standing financial instructions and scheme of reservation and delegation of powers which is available on the Trust's external website.
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement on Board of Directors page on Trust's external website.

Provision	Requirement	Section in Annual Report
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the trust.	The terms of reference of the Nominations and Remuneration Committee are published on Board and Committee Governance page on Trust's external website.

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

The Chief Executive of NHS England 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 and
- 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, other items of comprehensive income and cash flows for the year.

As far as I am aware, there is no relevant audit information of which the trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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 ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024 .....

Statement of Director's 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 and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 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.

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the Board

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024

Signed ..... **Andrea Osborne**
Executive Director of Finances and Estates

Date 19 June 2024

Corporate Governance Report
Annual Governance Statement 2022/23

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**.

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 (LCH), 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 LCH for the year ended 31 March 2024 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 is paramount and 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 way. With controls and assurances in place, and in line with the Trust's statement of how much risk it will accept ('risk appetite'), manageable risks are tolerated - but not where there is a foreseeable risk of harm or adverse outcomes to patients.

Careful risk management is embedded within the culture of the organisation, from risk assessments in clinical practice to considering the risk in each Board decision. Risks are identified and aligned to strategic goals. Risk tolerance, i.e. 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 and members of the Trust Leadership Team have been given responsibility for managing risk types:

- 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, data security, contractual and partnership governance, health and safety of staff.
- Executive Director of Operations: Risks to major change projects, business tenders, contracted activity, environmental sustainability.
- Executive Director of Nursing and Allied Health Professionals and Executive Medical Director: Risks to clinical quality assessment, clinical quality improvement, clinical governance.
- 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 approach to risk.
- Comply with policies and procedures, and statutory and external requirements.
- Maintain the Board Assurance Framework.

The Trust employs an experienced Risk Manager who delivers risk management training, coordinates the risk register and provides support and direction in all risk management related matters.

Mandatory health and safety training was introduced in 2023/24, this incorporates risk assessment training. In addition to the mandatory training, bespoke training is provided to support teams and services with managing risk. A competency relating to risk management has been included in the managers competency framework developed by the organisational development team. There is a page dedicated to risk management on the Trust intranet, this provides access to and signposts to advice and guidance, e-learning and the policy and procedure. All training includes awareness of the Trust's approach to risk and how this should be applied in decision-making processes.

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, making sure 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 for example:

- Review of performance and working practice.
- Clinical practice.

- Legislation, national policy and guidance.
- Risk assessments.
- Incident reports.
- Complaints.
- Claims for compensation.
- Audit and workplace surveys.
- Patient satisfaction surveys.
- External/internal audits.
- Regulators' inspections and reports.
- External environment within which the Trust operates.

Any of the above can be part of the risk assessment process. Risks are identified in a proactive way, for example: changes or introduction of new processes, new equipment, and different ways of working will initiate a risk assessment.

The Risk Management Policy and procedure is supported by content in a bespoke risk area of the Trust's intranet which is available to all staff.

The Board Assurance Framework (BAF) enables the Board to be assured that risks to the success of strategic goals and corporate objectives are being managed effectively. The BAF aligns strategic risks to the revised strategic goals and priorities in the Trust's operational plan.

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 Trust uses an electronic risk management system to record and monitor risks. The risk register includes: a description of the risk, the risk owner, any controls currently in place, actions to be completed, and the initial, current and target risk scores. Extracts and themes from the risk register are frequently scrutinised by appropriate managers, committees, and the Board. Risk Key Performance Indicators (KPIs) have been introduced during 2023/24 in order to improve the effectiveness of the risk management process. KPIs highlight the number of risks with overdue review and risks with static scores. KPIs are reported to the Business Units, Trust Leadership Team, and the Board Committees.

The Trust's **risk appetite** is aligned with its four strategic goals. The Trust Leadership Team defines the Trust's risk appetite and reviews this on an annual basis. Any proposed amendments are subject to review by the Audit Committee and approval by the Board. The risk appetite statement is an appendix of the Risk Management Policy, which can be found on the Trust's intranet. The risk appetite was reviewed in 2023, whereby the Trust Leadership Team agreed that the appetite remained appropriate, and no changes were required for 2023.

In addition to the operation of the risk management strategy, risk management is embedded in the Trust in a number of ways, for example:

- There is a lessons learnt portal on the 'Making Stuff Better' page on the Trust's intranet, where managers can share information about incidents, learning and improvements.

- The risk manager provides guidance, support and training to staff appropriate to their authority and duties.
- Trust employees receive training in equality and diversity, and quality and equality impact assessments are completed for all strategy, policies, and business cases so that the full impact on protected groups is identified and taken into account.
- The Trust has policies in place to encourage employees to highlight risks and report concerns, for example through the whistleblowing policy.

Risk assurance process and scrutiny of risks

Each Business Unit's performance group includes a review of new risks that have been added to the Trust's Risk Register. They also review escalated, de-escalated and recently closed risks and acts as a moderator for risk grading, making sure risks are 'owned' and ensuring that effective management of the risk is being recorded. The groups also maintain an oversight of the practical application of the risk management procedure with support from the Risk Manager. Risks are also reviewed by individual risk owners and by the appropriate directors.

Assurance creates the bedrock of evidence which gives the Trust confidence that risk is being controlled effectively, or highlights that certain controls are ineffective or there are gaps that need to be addressed. The Trust's Board Assurance Framework (BAF) records strategic risks including 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 are identified and the BAF has been revised during 2023, in line with the Trust's operational plan. These strategic risks are assigned to a lead executive to manage. Each of the strategic risks are also assigned to one of the Board's committees for oversight and scrutiny. Overall scrutiny of the BAF process is provided by Audit Committee. Sources of assurance are reviewed and evaluated by the committees to provide an indication to the Board of the current assurance level for each strategic risk. This information is used to populate the BAF. A summary of this information is presented at each Board meeting.

The Board receives a significant risks 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 Trust Leadership Team reviews the report in advance of the Board. The Quality Committee reviews high scoring 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 Quality, Audit, and Business Committees in relation to clinical and non-clinical risks. The Audit Committee also provides assurance to the Board on 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.

Data security risks are managed through the Information Governance / Data Protection and Information Technology teams through a series of Trust Policies, technical controls and network of staff who act as information asset owners. These individuals work with the Senior Information Risk Owner to manage data security and other information-related risks.

Data Security risks continue to be managed through a series of coordinated activities which have included:

- The ongoing release of software patches to ensure our electronic devices remain as resilient as possible to the threat of computer viruses and other cyber security risks.
- The pursuit of Cyber Essentials Plus accreditation, which has led to the introduction of improved threat detection and software patch management.
- Third party penetration tests designed to identify vulnerabilities in the Trust security architecture are conducted regularly.
- The development and testing of service level Business Continuity plans to ensure the Trust can respond to and maintain clinical services in the event of a cyber incident.
- The importance of maintaining awareness of data security, awareness to phishing emails and other cyber-risks have been highlighted to staff through articles in the Trust's regular staff briefings and simulated Phishing Campaigns.
- The ongoing training and awareness activities for all staff.
- The sharing of learning from reported incidents and near misses.

All of these activities are designed to help ensure that sensitive information is protected, and the risk of unintended loss or disclosure is minimised.

Other significant risk areas that have been reviewed and will continue to be key risk areas for the year ahead are detailed below.

- Imbalance of Capacity and Demand - Increasing demand for services (specific risks on the risk register relate to Neighbourhood Teams, CAMHS, Speech and Language Therapy, ICAN) coupled/reflected with increased complexity of the services required, resulting in potential for reduced quality of patient care, delay in treatment, deterioration in health and wellbeing of patients, and additional pressure on staff, exacerbated by vacancies to some hard to recruit to roles.
- Neurodiversity waiting times - There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.

Throughout the year the Trust has focused on the controls and mitigating actions relating to the corporate risks arising from an imbalance of capacity and demand impacting on patients and staff. For example, services are working with commissioners to develop sustainable solutions, risk-based prioritisation of waiting lists, a waiting list management programme, sharing staff wellbeing initiatives and recruitment and retention drives.

Data quality and the accuracy of performance reporting, including waiting list information, is reviewed regularly. Validations on waiting list data are collected directly from services on a regular basis and reviews of other Key Performance Indicators (KPIs) happen at performance review meetings across all levels of the Trust. More specific pieces of work to test out and provide assurance around data quality are carried out on a service-by-service basis, which will be supported by the creation of a Data Quality Framework to aid consistency and accuracy of reporting.

The Trust reports monthly on its performance against national KPIs in line with NHS Improvement's Single Oversight Framework and national contract requirements. Specific service indicators in contracts are monitored monthly via internal performance monitoring processes.

Governance structures and accountability

Our Board is made up of six non-executive directors (including the Chair), five executive directors and two non-voting members of the Board - the Director of Workforce (job share role, and an Associate Non-Executive Director). The Board leads the Trust by carrying out three main roles:

- Formulating strategy.
- Holding the organisation to account for the delivery of strategy and seeking assurance that systems of control are robust and reliable.
- Shaping a positive culture for the Board and the wider Trust.

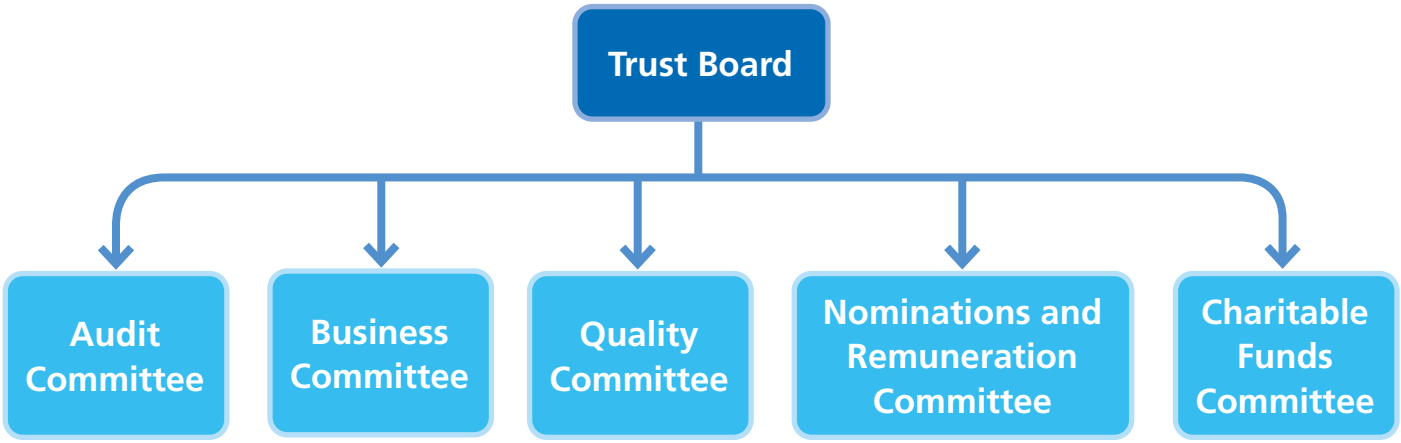
There is a clear division of responsibilities between the Chair and Chief Executive, and both have discharged their leadership functions throughout the whole of 2023/24. The division of responsibilities is set out in the Trust's standing orders and standing financial instructions (scheme of delegation section).

The Board held seven formal meetings in public in 2023/24. The Annual General Meeting was held in person in September 2023. Board member attendance at Board meetings is set out in the Director's report (starting on page 86) and all meetings have been quorate.

The quality of services remains the Trust's first priority, so the Board's agendas feature reports on our quality strategy, patient experience topics and the maintenance of safe staffing levels. Information presented to the Board provides essential assurance and our directors regularly 'visit' frontline services to engage with and support staff and to view the service provided to patients.

The Board has Standing Orders, a scheme of reservation and delegation of powers and standing financial instructions. These are regularly reviewed and provide a governance framework which allows the Trust to show it is well governed and that it meets the requirements of corporate governance codes of practice. It also has an annual work plan, which schedules required and discretionary business.

The Board discharges its responsibilities through five Committees (see following diagram). Each committee has Board-approved terms of reference and work plans which have been reviewed during 2023/24. Each committee's minutes and assurance reports are presented at Board meetings.



A performance brief and suite of reports which mirror the five Care Quality Commission (CQC) domains is produced for each Board meeting so that our compliance with national and local targets can be assessed. The meetings also receive regular updates on strategic service developments, for example, work to improve how primary and secondary health services and social care work together and the introduction of new ways of working.

Extracts from the Risk Register and the Board Assurance Framework are considered at each meeting so the Board can be assured that risks are being managed in the organisation. The extracts give timely information about existing and potential risks to the Trust.

The Board wants to be sure that it is operating effectively and regularly seeks opportunities to evaluate its effectiveness and strengthen its performance, remaining mindful of the best practice contained within codes of governance.

The Trust Board and committees undertake an annual self-assessment against elements of the NHS England/CQC Well-Led Framework. This assessment has drawn out a number of priorities to enhance the effectiveness of elements of the Trust's governance. The results are reported to the Board and are contained in committees' annual reports.

The Trust has a needs-based Board development programme. In addition to the formal Board meetings, there was an externally facilitated Board development session focussing on cyber security, and four Board workshops during 2023/24.

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

The Board's five committees are chaired by non-executive directors and are:

Audit Committee

Chair: Khalil Rehman

The Audit Committee comprises three non-executive directors, one of whom is a qualified accountant. The Associate non-executive director also joined the Committee from March 2024. The Audit Committee met formally six times during 2023/24 and is routinely attended by the Executive Director of Finance and Resources, the Company Secretary, Internal Audit and External Audit representatives.

The Committee provides an overarching governance role and reviews the work of the other committees which provides relevant assurance to the Audit Committee's own scope

of work. It also has responsibility for overseeing the work of the Data Protection and Cyber Security Panel, which formally changed into the Information Governance Approval Group in December 2023. The Committee receives minutes from this sub-group, receives papers on any matters escalated to it and periodically reviews the effectiveness of the sub-group.

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

The Committee has considered a range of financial control reports and a number of governance papers, and has oversight of risk management processes including the Board Assurance Framework, which it reviewed during the year.

The Chair of each of the Board's committees produces an annual report, which is reviewed by the Audit Committee to provide assurance to the Board that each committee has met its terms of reference during the year. Each committee undertakes a self-assessment exercise which is reported in their annual report.

Audit Committee attendance

Attendee	21 Apr	10 May (Informal)	22 Jun	14 July	13 Oct	15 Dec	8 Mar	Total (7)
Richard Gladman	✔	✔	✔	✗	✔	✔	✔	6/7
Ian Lewis	✔	✔	✗	✔	✔	✔	✔	6/7
Khalil Rehman	✔	✔	✔	✔	✔	✔	✔	7/7
Rachel Booth							✔	1/1
Bryan Machin* (Retired July 2023, returned as Interim Nov 2023 - Feb 2024)	✔	✔	✔			✗		3/4
Yasmin Ahmed*				✔	✔	✗		2/3
Andrea Osborne*							✔	1/1

*Executive Director/Interim Executive Director in attendance

Quality Committee

Chair: Helen Thomson

The Quality Committee's membership comprises three non-executive directors and three executive directors with other senior officers also attending each meeting. The Committee met on seven occasions in 2023/24. Two additional informal meetings were held in the form of a joint workshop with members of the Quality Assurance and Improvement Group, which is a sub-group of the Committee.

The Committee provides assurance to the Board that the Trust provides high standards of care, 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 2021/24 which aims to respond to challenges presented with innovation, standardisation, and a focus on improvement.

We continue to work in a challenging landscape and the Trust ensures we continue to provide services that are clinically effective, safe, well-led, and responsive to patient's needs, offering a positive patient experience. The Committee has received regular updates on progress with the strategy and has sought assurance about the implementation of specific actions.

The Committee also has responsibility for overseeing the work of two subgroups: the Quality Assurance and Improvement Subgroup, and the Safeguarding Committee.

The Quality Committee and the Board monitor serious incidents, incidents and complaints and the associated action plans. All serious incidents are managed in accordance with the Trust's Incident Management Policy (including Serious Incidents).

Quality Committee attendance

Member	22 May	24 Jul	25 Sep	27 Nov	22 Jan	26 Feb	25 Mar	Total (7)
Helen Thomson	✔	✔	✔	✔	✔	✗	✔	6/7
Ruth Burnett	✔	✔	✔	✔	✔	✔	✔	7/7
Ian Lewis	✔	✔	✗	✔	✔	✔	✔	6/7
Alison Lowe	✔	✗	✔	✗	✔	✔	✔	5/7
Steph Lawrence	✔	✔	✔	✔	✔	✔	✔	7/7
Andrea North*			✔	✔	✔	✔	✔	5/5
Sam Prince*	✔	✗	✔	✔	✔	✔	✔	6/7
Thea Stein	✔	✔						2/2

*Interim CEO/Interim Executive Director in attendance

Business Committee

Chair: Richard Gladman (to October 2023) / Rachel Booth (from November 2023)

The Business Committee's membership comprises three non-executive directors, the associate non-executive director, the Chief Executive and two further executives. Other senior officers attend as required. The Business Committee held 10 meetings in 2023/24.

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. It also 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. During 2023/24 the Committee considered recruitment and retention initiatives, sickness absence management and leadership approaches. It also has responsibility for overseeing the work of the Health and Safety Group. This Group provides an overarching view of health and safety and ensures that the Trust complies with its health and safety obligations by monitoring adherence with its policies and procedures. The Committee receives minutes from the Health and Safety Group and papers on any matters escalated to it. It also periodically reviews the effectiveness of the Health and Safety Group in discharging its delegated responsibilities.

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

Business Committee attendance

Attendee	26 Apr	24 May	28 Jun	26 Jul	27 Sept	27 Oct	30 Nov	24 Jan	28 Feb	27 Mar	Total (10)
Richard Gladman	✔	✔	✔	✔	✔	✔	✔	✔	✔	✗	9/10
Helen Thomson	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
Khalil Rehman	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
Rachel Booth	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
Thea Stein	✗	✔	✔	✔							3/4
Bryan Machin	✔	✔	✔				✔	✔			5/5
Sam Prince*	✔	✔	✔	✔	✔	✔	✔	✔	✔	✗	9/10
Andrea North*					✔	✔	✔	✔	✔	✔	6/6
Yasmin Ahmed*				✔	✗	✔	✗				2/4
Andrea Osborne*									✔	✔	2/2
+Laura Smith/ Jenny Allen	✔	✔	✔	✗	✔	✔	✔	✔	✔	✔	9/10

*Officer (job share) in attendance

*Interim CEO/Interim Executive Director in attendance

Nominations and Remuneration Committee

Chair: Brodie Clark CBE

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 2023/24.

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 which are high risk to the Trust, including high-cost employment cases 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 2023/24 the Committee approved the recommendations for the remuneration of the interim Director appointments, supported the recruitment of the substantive Chief Executive and continued to support various staff financial incentive schemes which were targeted responses to the challenging workforce situation.

Nominations and Remuneration Committee attendance

Attendee	22 Jun	15 Sept	15 Dec	15 Mar	Total (4)
Brodie Clark	✔	✔	✔	✔	4/4
Alison Lowe	✗	✔	✔	✔	3/4
Rachel Booth	✔	✔	✔	✔	4/4
+Jenny Allen/ Laura Smith	✔	✔	✔	✔	4/4

+Officer (job share) in attendance.

Charitable Funds Committee

Chair: Alison Lowe OBE

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 and met four times during 2023/24.

The purpose of the Committee is to give assurance to the Board that the Trust's charitable activities happen 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.

Charitable Funds Committee attendance

Attendee	23 Jun	15 Sept	15 Dec	12 Mar	Total (4)
Brodie Clark	✗	✔	✔	✔	3/4
Alison Lowe	✔	✔	✔	✔	4/4
Bryan Machin	✔		✗		1/2
Stephanie Lawrence	✔	✔	✔	✔	4/4
Yasmin Ahmed		✔	✗		1/2
Andrea Osborne				✔	1/1

Incident reporting and learning from incidents

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 a suite of training has been developed in alignment with the implementation of the Patient Safety Incident Response Framework (PSIRF). Work continues to strengthen learning from incidents in a co-ordinated centralised way. In addition to digital repositories, the Trust has service level and Trust-wide forums for sharing including the monthly Making Stuff Better sessions and quarterly Safety summits. The Trust Board approved the Patient Safety incident Response Plan (PSIRP) in February 2024 which describes the Trust approach to learning and improvement, and the Trust is introducing new learning response tools to support a proportionate approach to learning from incidents.

An internal audit during 2023 found some good practice but made a series of recommendations to improve the way that the Trust shares, embeds and provides evidence of learning from adverse incidents.

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, which is aligned with the Trust's strategic goals and priorities, responding to external, internal, and cultural factors including market conditions which are currently (or anticipated) to impact on our workforce requirements. Its primary aim is to attract, develop and retain the best people in order to deliver outstanding care. The Workforce Strategy's key themes are outlined below, all of which contribute to safe, sustainable and effective staffing:

1. Resourcing

We maximise our workforce capacity for delivery of the best possible care, by fully exploring all options available to us.

2. Organisation Design

We know what workforce and what skills LCH needs to deliver the best possible care, now and in the future; and take action to enable its delivery.

3. Leadership

LCH managers are consistently inclusive, capable, put people before process and are aligned with LCH values. We support our existing and aspiring leaders to achieve this.

4. Inclusion

We are much more representative of our communities. Disparities in employee experience have substantially reduced; with any remaining disparity actively tackled.

5. Wellbeing

We look after our people through improved psychological, physical and financial wellbeing; leading to best-ever attendance, capability and satisfaction.

6. System Partner

We enable further successful integration and joint working for services and clinical pathways. We feel and act as part of #TeamLeeds.

7. Foundations

We provide excellent workforce and HR services to our customers, in support of the provision of outstanding care.

Progress on delivery of the Workforce Strategy's priorities is overseen by the Board, with the Business Committee providing additional scrutiny and assurance.

The Trust's Workforce Plan supports the delivery of our operational business plan and is embedded in service needs. It is also triangulated with finance and activity data. The Plan is updated each year and is signed off by both the Business Committee and the Board at a meeting in public.

The Board receives a twice-yearly Safe Staffing report from the Executive Director of Nursing and Allied Health Professionals, in line with the National Quality Board's 2016 guidance incorporating professional judgement and outcomes. Quarterly reports are also received at Board from the Guardian for Safe Working Hours.

Workforce data is an important part of the Trust's business continuity approach, with daily, real-time workforce and capacity information informing decision making and planning.

Triangulation of data including financial, workforce and activity/performance information, takes place at the Trust Leadership Team meeting and at the Board and its subcommittees'

meetings, to ensure comprehensive oversight of staffing and any issues arising.

Our services grow and develop 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) which includes any new roles which create a significant change to the way care is delivered.

CQC compliance

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

Register of Interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the **'Managing Conflicts of Interest in the NHS'** guidance.

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 organisation'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.

The Board receives in-depth analysis and updates on a range of proactive work around this wider agenda through the Workforce Strategy. This includes delivery against the Workforce Race Equality Standard (WRES) action plan and the Workforce Disability Equality Standard (WDES) Action Plan. The Equality, Diversity and Inclusion Forum, which is chaired by the Trust's Chair, continues to bring employee perspectives, experiences and ideas in pursuit of our ambition to be much more representative of our communities and to further tackle and reduce outstanding issues of disparity in staff experience. The Trust also has three staff networks: Disability, Neurodiversity and Long-Term Conditions, LGBTQIA+; and the Race Equality Network.

Climate Change

The Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS

programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has consistently met the financial targets set by its regulators.

The Board sets an annual budget to meet the Trust's financial obligations. For 2023/24 revenue and capital resources were agreed between the Trust and its commissioners enabling the Board to agree a budget to deliver balance revenue and capital plans. The revenue plan was subsequently amended to a £250k surplus by agreement with the West Yorkshire ICS in November 2023.

Throughout the year the Trust worked in collaboration with partner organisations in Leeds and across the West Yorkshire ICS to ensure that best use was made of NHS resources.

The Trust maintained its financial governance arrangements throughout 2023/24 with the Business Committee and Board continuing to receive financial reports at each of their meetings, and the Audit Committee receiving assurances on financial governance from management, internal and external auditors.

Under the National Audit Office Code of Audit Practice, the external auditor is required to consider if the Trust has proper arrangements in place to deliver value for money in its use of resources and provides a commentary on those arrangements.

On the basis of the work reported to Audit Committee in 2023/24 the external auditor has not identified any significant weaknesses in the Trust's value for money arrangements.

The effectiveness of the Trust's services is regularly assessed by the Trust's Quality Committee and by the Board.

Information Governance

Compliance with Data Protection legislation, data security, data ownership and transparency are of paramount importance to the Trust. The Trust is committed to ensuring that personal data is protected, and any confidential data is used appropriately and ethically.

The Trust complies with the relevant legislation and national codes of practice and actively supports the transparency of information. The Trust complies with the UK General Data Protection Regulation (UK GDPR) and employs a Data Protection Officer (DPO). The DPO duties include:

- Promoting the organisation's responsibilities, which empowers the organisation to be compliant with the Data Protection legislation.
- Ensuring there is subject matter expert provision for internal and external stakeholders to achieve compliance with privacy and information security in relation to the organisation activities.

- Protecting information, its integrity and availability throughout the lifecycle of the information.

The Senior Information Risk Owner (SIRO) ensures that there is effective information governance in place. The SIRO chairs the Information Governance Approval Group which reports quarterly to the Audit Committee and in turn to the Board. The Caldicott Guardian is the Deputy Chair of the Information Governance Approval Group, and works closely with the SIRO and the DPO, particularly where there are any identified information risks relating to patient data.

The Trust ensures effective information governance through a number of technical and organisational controls including education, policies and procedures, IT / information security controls, IT vulnerability testing, and by demonstrating annual compliance with the Data Security Standards of the Data Security and Protection Toolkit (DSPT).

The Trust demonstrates compliance with the 10 Data Security Standards, an outcome from the National Data Guardians' 'Review of data security, consent and opt outs' report, via a self-assessment within the Data Security and Protection Toolkit (DSPT). This submission is independently audited.

In recognition of the importance of data security, there is a target of 95% of staff compliance with information governance training. Training compliance is closely monitored, reminder emails are sent, and system lockouts are enforced where necessary.

All incidents relating to a potential breach of personal data are reported, investigated and, where appropriate, remedial actions are implemented. The Trust reported three incidents to the Information Commissioner's Office (ICO) during 2023/24.

Details of the incidents are:

The first breach occurred when a complaint response letter was sent to an incorrect address twice and the eventual disposition of the letter was unknown due to the passage of time. The ICO confirmed that it was satisfied with the Trust's response, particularly regarding transparency and attempts to locate the letter and confirmed that no further action would be taken.

The second breach happened when a Bank Member of staff accessed the records of her mother-in-law on two occasions, in the knowledge that this would be against her wishes. The ICO was satisfied with the Trust's response, particularly regarding the disciplinary actions taken and confirmed that no further action would be taken.

The third breach took place when a copy of records provided to a patient contained GP data in addition to LCH data, due to 'share in' status of the SystmOne record. No further action was required from the ICO.

Data Quality and Governance

Data quality and the accuracy of performance reporting, including waiting list information, is reviewed regularly. Validations on waiting list data are collected directly from services on a regular basis and reviews of other Key Performance Indicators (KPIs) happen at performance review meetings across all levels of the Trust. More specific

pieces of work to test out and provide assurance around data quality are carried out on a service-by-service basis, which is being supported by the implementation of a Data Quality Framework to aid consistency and accuracy of reporting.

The Trust reports monthly on its performance against national KPIs in line with NHS Improvement's Single Oversight Framework and national contract requirements. Specific service indicators in contracts are monitored monthly via internal performance monitoring processes.

In addition to the operation of the risk management strategy, risk management is embedded in the Trust in a number of ways, for example:

- There is a lessons learnt portal on the 'Making Stuff Better' page on the Trust's intranet, where managers can share information about incidents, learning and improvements.
- The risk manager provides guidance, support and training to staff appropriate to their authority and duties.
- Trust employees receive training in equality and diversity, and quality and equality impact assessments are completed for all strategy, policies, and business cases so that the full impact on protected groups is identified and taken into account.
- The Trust has policies in place to encourage employees to highlight risks and report concerns, for example through the whistleblowing policy.

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.

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 is a separate report and describes the quality of services offered by an NHS healthcare provider. The Quality Account is an important way for local NHS services to report on quality and highlight improvements in the services delivered to local communities and stakeholders. The quality of the services is measured by looking at patient safety, the effectiveness of the treatments that patients receive, and patient feedback about the care provided.

The Quality Account priorities for LCH have been developed in conjunction with stakeholders, services and senior managers. These priorities will make sure that Trust activity drives improvements in services for all communities, stakeholders and aligns to the Quality Strategy and business objectives. The Quality Account highlights a selection of initiatives, clinical practice and events that have happened throughout the year to reflect 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 seeks to provide a balanced view of the Trust's achievements and areas for improvement. The Trust acknowledges the developments it continues to make and the collaborative work with partners to make real progress across the whole health economy.

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

Internal audit

Audit Yorkshire has been the provider of the Trust's internal audit services since 1 April 2022. The overall Head of Internal Audit opinion for the 2023/24 reporting period provides Significant Assurance, that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

This opinion is based solely on the matters that came to the attention of Audit Yorkshire during the course of the internal audit reviews carried out during the year and is not an opinion on all elements of the risk management, control and governance processes or the ongoing financial viability or the ability to meet financial obligations which must be obtained by Leeds Community Healthcare NHS Trust from its various sources of assurance.

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

During 2023/24 it must be noted that gaps in leadership and capacity, particularly within the Executive Team, had proved challenging and impacted on the delivery of the audit plan and resulting Head of Internal Audit opinion.

External audit

Mazars LLP were appointed as the Trust's external auditors in 2020/21 following a formal tender process carried out by the Auditor Appointment Panel and approved by Trust Board. The agreed contract period was three + one + one years.

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.

During 2023/24 four national clinical audits covered the NHS services that the Trust provides. During that period, the Trust participated in 100% of national clinical audits More information about these is in our Quality Account (separate document).

Working in collaboration

Partnership working is one of LCH's strategic goals: Collaborating with partners to enable people to live better lives, and most services deliver some part of their service in partnership – from informal arrangements to more formal partnership agreements.

We recognise the importance of collaborative working and the benefits that integration can bring for our service users, patient and carers. The Trust is a member of a number of collaboratives on a West Yorkshire footprint including the Mental Health, Learning Disability and Autism Collaboration, and the Community Health Services Provider Collaborative. Partnership working with the Voluntary and Community Sector (VCS) is described and delivered through our third sector strategy.

Working at System level: West Yorkshire Health and Care Partnership (WYH&CP), an integrated care system

Over the last 12 months the Trust has continued to be actively involved in the development of the WYH&CP.

The Partnership is made up of the NHS, councils, hospices, Healthwatch, the voluntary community social enterprise sector. The Partnership supports 2.4 million people, living in urban and rural areas.

The WYH&CP takes a place-based approach across Bradford District and Craven; Calderdale, Kirklees, Leeds, and Wakefield that highlights the strengths, capacity, and knowledge of all those involved. This way of working is supported by West Yorkshire wide priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities, children and young people. The Partnership provides greater opportunities

to deliver the Five-Year Plan ambitions, ensuring that all people are given the best start in life, are able to remain healthy and age well.

Leeds Health and Care Partnership (LHCP)

"We know that people's lives are better when those who deliver health and care work together."

The Leeds Health and Care Partnership (LHCP) includes health and care organisations from across Leeds who are working together to improve the health of people in Leeds. The LHCP understands that by listening to people, and by sharing knowledge and resources, it can make a bigger difference to people's lives.

Represented through the LCH Chief Executive, The Leeds Committee of the West Yorkshire Integrated Care Board makes decisions about the best way to allocate resources across the City that will have the biggest impact on improving health outcomes, people's experiences and reducing health inequalities.

NHS England oversight

NHS England has assigned the Trust a segment rating of '2' which 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

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

The annual governance statement demonstrates that the Trust has the necessary control arrangements in place to manage risks and takes 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.

During 2023/24, no significant control issues have been identified by the Trust's systems of internal control.

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024 .....

Remuneration and Staff Report

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.

Three of the senior manager roles for the Trust are joint appointments with the Leeds GP Confederation; one day per week of the remuneration for the Medical Director, the Executive Director of Nursing and Allied Health Professionals and the Director of Workforce, Organisational Development and System Development is recharged to the GP Confederation.

The Interim Director of Operations held a non-managerial role within the Trust for five months of the year and the Interim Director of Finance between July and December held a non-managerial role for six months of the year.

Senior managers' remuneration - single total figure (subject to audit)

	2023 / 2024						2022 / 2023					
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**
Thea Stein – Chief Executive	65 - 70	-	-	-	-	65 - 70	155 - 160	0	-	-	-	155 - 160
Samantha Prince Interim Chief Executive 01/09/23 - 31/03/24 Executive Director of Operations 01/04/23 - 30/08/23	140 - 145	100	0 - 5	-	-	145-150	110 - 115	-	-	-	-	110 - 115
Bryan Machin – Executive Director of Finance and Resources	65 - 70	-	-	-	-	65 - 70	125 - 130	0	-	-	-	125 - 130
Yasmin Ahmed – Interim Executive Director of Finance and Resources	75 - 80	-	-	-	15 - 17.5	90 - 95	-	-	-	-	-	-
Andrea Osborne – Interim Executive Director of Finance and Resources	20 - 25	-	-	-	0	20 - 25	-	-	-	-	-	-
Ruth Burnett – Executive Medical Director	110 - 115	-	0 - 5	-	0	115 - 120	105 - 110	-	-	-	27.5 - 30	135 - 140
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	95 -100	1,600	0 - 5	-	72.5 - 75	170 - 175	85 - 90	6,100	-	-	25 - 27.5	110 - 115

	2023 / 2024						2022 / 2023					
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**
Andrea North – Interim Director of Operations	60 - 65	100	-	-	57.5 - 60	120 - 125	-	-	-	-	-	-
Jennifer Allen – Director of Workforce, OD and System Development	55 - 60	-	0 - 5	-	0	55 - 60	50 -55	-	-	-	15 -17.5	70 - 75
Laura Smith – Director of Workforce, OD and System Development	55 - 60	-	0 - 5	-	0	55 - 60	50 - 55	-	-	-	15 -17.5	70 - 75
Brodie Clark CBE – Chair	35 - 40	400	-	-	-	40 - 45	40 - 45	0	-	-	-	40 - 45
Richard Gladman – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Ian Lewis – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Alison Lowe – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Helen Thomson – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Khalil Rehman – Associate Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Rachel Booth – Associate Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15

Total remuneration for senior managers with shared responsibilities

	2023 / 2024						2022 / 2023					
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**
Ruth Burnett – Executive Medical Director	140 - 145	-	5 -10	-	0	145 -150	130 - 135	-	-	-	35 - 37.5	170 - 175
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	120 - 125	2,000	0 - 5	-	87.5 - 90	215 - 220	100 - 105	7,700	-	-	30 - 32.5	140 - 145
Jennifer Allen – Director of Workforce, OD and System Development	65 - 70	-	0 - 5	-	0	70 - 75	60 - 65	-	-	-	17.5 - 20	80 - 85
Laura Smith – Director of Workforce, OD and System Development	65 - 70	-	0 - 5	-	0	70 - 75	65 - 70	-	-	-	17.5 - 20	85 - 90

Senior managers' remuneration – pension benefits (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 2023 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Jennifer Allen – Director of Workforce, OD and System Development	0	17.5 - 20.0	25 - 30	70 - 75	404	112	566	9
Ruth Burnett – Executive Medical Director	0	10 - 12.5	20 - 25	45 - 50	315	39	405	20
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	2.5 - 5.0	30 - 32.5	45 - 50	120 - 125	730	239	1059	16
Laura Smith – Director of Workforce, OD and System Development	0 - 2.5	20 - 22.5	30 - 35	85 - 90	459	129	643	9
Andrea North – Interim Director of Operations	2.5 - 5.0	5 - 7.5	25 - 30	75 - 80	24	10	59	8
Yasmin Ahmed – Interim Director of Finance	0 - 2.5	0	5 - 10	0	51	7	86	8
Andrea Osbourne – Interim Director of Finance	0 - 2.5	0	30 - 35	90 - 95	723	0	794	0

No other senior managers are members of the pensions scheme.

*Andrea Osborne, Interim Director of Finance is on secondment from Pennine Healthcare NHS Foundation Trust.

Five of the senior managers have been affected by the McCloud Remedy.

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 2008 number 1050 Occupational Pension Schemes (Transfer Values) Regulations 2008.

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2024.

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).

Payments to past directors (subject to audit)

There have been no payments made to past directors.

Fair pay disclosures (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration and salary of the highest paid director in their organisation and the median and 25th and 75th percentiles remuneration and salary of the organisation's workforce.

Total remuneration used here includes gross pay plus all direct payments (taxable or not) this includes salary, non-consolidated performance related pay, clinical excellence awards, on-call payments, benefits-in-kind and all re-imbursed expenses. It does not include severance payments, employer pension contributions or cash equivalent transfer value of pensions.

Range of remuneration

During 2023/24 the Trust's staff were paid annualised salaries ranging from £11,208 to £213,087. The Trust's highest paid director was the Interim Chief Executive/Executive Director of Operations whose salary was £142,071; In total 15 medical members of staff earned more than the Chief Executive/Executive Director of Operations on an annualised basis in 2023/24, three substantive members, 12 agency staff.

The percentage changes in pay of the highest paid director (the Chief Executive/Executive Director of Operations):

Percentage changes	2023/2024		2022/2023	
	Salary and allowances	Performance related pay and bonus	Salary and allowances	Performance related pay and bonus
Highest paid Director	-9.5%	100%	3%	0%
Other employees	2%	100%	4.7%	0%

The highest paid director for 2023/24 was the Interim Chief Executive/Executive Director of Operations. Five members of staff received a performance bonus in 2023/24. In 2023/24 six members of staff received a performance related bonus compared to no payments in 2022/23.

The total annualised remuneration and salaries for the Trust's staff including agency is shown in the table below.

2023/2024	25th percentile	Median	75th percentile
Total Renumeration (£)	28,185	36,608	46,389
Salary component of total remumeration (£)	28,185	36,608	46,389
Pay ratio information	5.2:1	4.0:1	3.2:1

2022/2023	25th percentile	Median	75th percentile
Total Renumeration (£)	28,436	37,129	46,638
Salary component of total remumeration (£)	28,436	37,129	46,638
Pay ratio information	5.5:1	4.2:1	3.4:1

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director/member in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest paid director/member in Leeds Community Healthcare NHS Trust in the financial year 2023/24 was £145k - £150k (2022/23, £155k - £160k). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Year	25th percentile pay ratio		Median pay ratio		75th percentile pay ratio	
	Total remuneration	Salary	Total remuneration	Salary	Total remuneration	Salary
2023/24	5.2:1	5.2:1	4.0:1	4.0:1	3.2:1	3.2:1
2022/23	5.5:1	5.5:1	4.2:1	4.2:1	3.4:1	3.4:1

The salary of the Interim Chief Executive/Executive Director of Operations was 5.2 times more than the employee who was paid the 25th percentile point in 2023/24; the median ratio is 4.0 times more than the employee in this position and 3.2 times more than the 75th percentile employee. The total remuneration includes all payments such as travel expenses not just salary; these ratios are very similar for both measures. The ratios between the highest paid director and other staff have reduced for all categories between 2022/23 and 2023/24. The majority of staff in the Trust received a pay increase in 2023/24.

Staff Report

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

Staff costs	2023/24			2022/23		
	Permanent £k	Other £k	Total £k	Permanent £k	Other £k	Total £k
Salaries and wages	113,387	8,143	121,530	110,497	6,881	117,378
Social security costs	12,215	467	12,682	11,808	349	12,157
Apprenticeship levy	583	22	605	546	16	562
Employer's contributions to NHS pensions	21,084	806	21,890	19,054	305	19,359
Pension cost - other	52	2	54	98	3	101
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	34	0	34	245	0	245
Temporary staff	0	3,793	3,793	0	4,213	4,213
Total gross staff costs (including seconded out)	**147,355**	**13,233**	**160,588**	**142,248**	**11,767**	**154,015**
Of which: Costs capitalised as part of assets	**13**	**0**	**13**	**57**	**0**	**57**

Average staff numbers in post by occupation groupings (subject to audit)

Average number of employees (WTE basis)	2022/23			2022/23		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	50	27	77	50	24	74
Administration and estates	845	58	903	812	40	852
Healthcare assistants and other support staff	586	33	619	553	25	578
Nursing, midwifery and health visiting staff	895	54	949	854	44	898
Nursing, midwifery and health visiting learners	4	0	4	10	0	10
Scientific, therapeutic and technical staff	578	20	598	531	27	558
Healthcare science staff	0	0	0	0	0	0
Other	50	1	51	49	0	49
Total average numbers	**3,008**	**193**	**3,019**	**2,859**	**160**	**3,019**
Of which: Number of employees (WTE) engaged on capital projects	**0**	**1**	**1**	**1**	**0**	**1**

Expenditure on consultancy

The Trust has no spend on consultancy services during 2023/24 (2022/23 £Nil spend).

Off-payroll engagements

The Trust had the following off-payroll engagements as of 31 March 2024, that were for more than £245 per day and where engagement was for six months or more. The £245 threshold is set to approximate the minimum point of the pay scale for a Senior Civil Servant.

Length of all highly paid off-payroll engagements

Number of existing engagements as of 31 March 2024	17
Of which, the number that have existed:	
For less than one year at the time of reporting	4
For between one and two years at the time of reporting	6
For between two and three years at the time of reporting	0
For between three and four years at the time of reporting	0
For four or more years at the time of reporting	7

Seven of the off-payroll appointments relate to forensic medical examiners and nine are individuals who provide clinical supervision to some of our senior clinical staff. Given the nature of the individual's work the off-payroll arrangements give the Trust the best value for money.

Off-payroll workers engaged at any point during the financial year

The Trust must also disclose how many off-payroll contractors who worked for the Trust at any time during 2023/24 where the earnings were £245 or more per day, this picks up all agency staff who are employed by and on the payroll of an umbrella company.

For all off-payroll engagements between 1 April 2023 and 31 March 2024, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2024	80
Of which:	
Number not subject to off-payroll legislation*	63
Number subject to off-payroll legislation and determined as in-scope of IR35*	0
Number subject to off-payroll legislation and determined as out of scope of IR35*	17
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

*A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

The Trust is required to disclose how many members of the Board or those with significant financial responsibility have been subject to off-payroll arrangements during the financial year 2023/24.

Number of off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, during the financial year.	0
Total number of individuals on payroll and off-payroll that have been deemed 'Board members, and/or, senior officials with significant financial responsibility' during the financial year. This figure must include both on payroll and off-payroll engagements.	14

Gender composition

*Directors here are either NEDs or individuals who have (either substantively or on an interim bases) sat on the Board of Directors at any time between April 2023 – March 2024. There are no Very Senior Managers (VSMs) below Board level.

Role	Gender	Headcount	%	FTE
Directors	Female	12	0.34%	11.20
	Male	4	0.11%	4.00
Employees	Female	2991	85.19%	2512.11
	Male	504	14.35%	467.77
	Grand total	3511	100%	2995.08

Staff turnover

	2023									2024		
Month	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**01**	**02**	**03**
Headcount	3408	3418	3429	3458	3454	3474	3480	3486	3495	3519	3540	3509
Leavers Headcount	31	26	23	26	31	41	28	21	21	21	21	50
Starters Headcount	41	38	37	53	37	57	42	31	26	61	39	23
Turnover Rate (Headcount)	0.90%	0.75%	0.67%	0.75%	0.90%	1.19%	0.81%	0.61%	0.61%	0.61%	0.61%	1.45%
Turnover Rate (12m)	13.39%	13.02%	12.47%	11.91%	11.55%	11.53%	10.99%	10.76%	10.24%	9.86%	9.75%	9.83%

Engagement

In the National Staff Survey staff engagement is measured across three sub scores: motivation, involvement and advocacy. Overall staff engagement is measured as an average across these three scores. Staff engagement scores fall between 0 and 10, where the higher the score, the more engaged the staff.

	Engagement 2020	Engagement 2021	Engagement 2022	Engagement 2023	Morale 2020	Morale 2021	Morale 2022	Morale 2023
LCH	7.2	6.9	7.1	7.2	6.0	5.8	5.9	6.1

The Trust is proud to say it achieved a record response rate of 61.7% overall. We have consistently achieved improved response rates over the last four years and maintained or slightly improved on engagement or morale scores. For 2023 there were increased engagement scores for the overall Trust and across all Business Units. The engagement score is significant as there are correlations between staff engagement, patient experience and patient outcomes. For this reason, it is used to compare each NHS Trust with others and is used by the CQC in their Well-Led assessments. Our scores for engagement and morale are well above the national average (6.9 engagement and 5.9 morale) and in line with community sector.

Trade Union facility time reporting

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	9
Full-time equivalent employee number	6.40

Percentage of time spent on facility time: 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%	2
1-50%	7
51%-99%	0
100%	0

Percentage of pay bill spent on facility time: 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	Figuress
Provide the total cost of facility time	£58,660.27
Provide the total pay bill	£160,588,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x100	0.037%

Paid trade union activities: 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) x100 **= 9.01%**

Exit packages (subject to audit)

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

2023/2024

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Number of other departures where special payments have been made Number	Total number of exit packages Number
Total exit packages	0	0	0
Total number	0	0	0
Total cost (£)	**0**	**0**	**0**

2022/2023

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Number of other departures where special payments have been made Number	Total number of exit packages Number
Less than £10,000	1	0	1
Total number	1	0	1
Total cost (£)	**9,727**	**0**	**9,727**

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 and Social Care. This is to make sure a standard approach is taken and so that figures can be compared across NHS organisations.

Staff sickness	2023	2022
Total days lost	66,125	73,709
Total staff years	1,073,186	1,029,957
Average working days lost (per WTE)	6.16%	7.16%

Source: NHS Digital – Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse. Periods covered: January to December 2023 and January to December 2022

Staff policies applied during the financial year

LCH's employment policies are available online at LCH Policies and Guidelines (leedscommunityhealthcare.nhs.uk). The suite of policies includes due regard to the important equality, diversity and inclusion considerations intrinsic to LCH's work and strategic goals.

Further information about LCH's Equality, Diversity & Inclusion actions and ambitions including its Public Sector Equality Duty publications and declarations are available at: **www.leedscommunityhealthcare.nhs.uk/about-us-new/equality-and-diversity/**

Signed ..... **Sam Prince**, Interim Chief Executive

Date 19 June 2024

Parliamentary Accountability and Audit Report

We disclose the mandated content (fees and charges, remote contingent liabilities, losses and special payments and gifts) in the accounts.

Leeds Community Healthcare NHS Trust

Annual accounts for the year ended 31 March 2024

Independent auditor's report to the Directors of Leeds Community Healthcare NHS Trust

Report on the audit of the financial statements

Opinion on the financial statements

We have audited the financial statements of Leeds Community Healthcare NHS Trust ('the Trust') for the year ended 31 March 2024, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2023/24 as contained in the Department of Health and Social Care Group Accounting Manual 2023/24, and the Accounts Direction issued by the Secretary of State with the approval of HM Treasury as relevant to NHS Trusts in England.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2024 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2023/24; and
- have been properly prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, and taking into account the requirements of the Department of Health and Social Care Group Accounting Manual, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. The Directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of the Directors and the Accountable Officer for the financial statements

As explained more fully in the Statement of Directors' Responsibilities in Respect of the Accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2023/24 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern.

As explained in the Statement of the Chief Executive's Responsibilities as the Accountable Officer of the Trust, the Accountable Officer is responsible for such internal control as the Accountable Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error. The Accountable Officer is responsible for ensuring that the financial statements are prepared in a format directed by the Secretary of State.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed on the next page.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the Trust, we identified that the principal risks of non-compliance with laws and regulations related to the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012), and we considered the extent to which non-compliance might have a material effect on the financial statements.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- inquiring with management and the Audit Committee, as to whether the Trust is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- communicating identified laws and regulations throughout our engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- considering the risk of acts by the Trust which were contrary to applicable laws and regulations, including fraud.

We evaluated the Accountable Officer's incentives and opportunities for fraudulent manipulation of the financial statements (including the risk of override of controls) and determined that the principal risks were related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to year end expenditure accruals, significant one-off or unusual transactions and the risk of fraud in revenue and expenditure recognition.

Our audit procedures in relation to fraud included but were not limited to:

- making enquiries of management and the Audit Committee on whether they had knowledge of any actual, suspected or alleged fraud;
- gaining an understanding of the internal controls established to mitigate risks related to fraud;
- discussing amongst the engagement team the risks of fraud;
- addressing the risks of fraud through management override of controls by performing journal entry testing, testing of accounting estimates, and consideration of any significant transactions outside the normal course of business; and
- addressing the risk of fraud through revenue and expenditure recognition by testing a sample of income and expenditure transactions around the year-end, testing year end accruals and year end receivables.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management and the Audit Committee. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in April 2021.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

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

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2024.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of Accountable Officer's responsibilities, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under section 21 of the Local Audit and Accountability Act 2014 (as amended) to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. 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 its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in May 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Accounts Direction made under the National Health Service Act 2006; and
- the other information published together with the audited financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception under the Code of Audit Practice

We are required to report to you if:

- in our opinion the Annual Governance Statement does not comply with the guidance issued by NHS England; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act; or
- we issue a report in the public interest under section 24 and schedule 7(1) of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 and schedule 7(2) of the Local Audit and Accountability Act 2014.

We have nothing to report in respect of these matters.

Use of the audit report

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 Directors of the Trust 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 Directors of the Trust, as a body, for our audit work, for this report, or for the opinions we have formed.

Certificate

We certify that we have completed the audit 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.

Alastair Newall, Key Audit Partner
For and on behalf of Forvis Mazars LLP

One St Peter's Square
Manchester
M2 3DE

24 June 2024

Statement of Comprehensive Income

	Note	2023/24 £000	2022/23 £000
Operating income from patient care activities	3	212,824	205,467
Other operating income	4	14,264	13,065
Operating expenses	7, 9	(228,206)	(219,779)
Operating surplus / (deficit) from continuing operations		**(1,118)**	**(1,247)**
Finance income	11	2,446	943
Finance expenses	12	(688)	(563)
PDC dividends payable		(343)	(396)
Net finance costs		**1,415**	**(16)**
Other gains / (losses)	13	12	1
Surplus / (deficit) for the year		**309**	**(1,262)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(1,307)	1,732
Revaluations	17	204	-
Total comprehensive income / (expense) for the period		**(794)**	**470**
Adjusted financial performance (control total basis)			
Surplus / (deficit) for the period		309	(1,262)
Remove net impairments not scoring to the Departmental expenditure limit		(43)	2,289
Remove I&E impact of capital grants and donations		1	15
Adjusted financial performance surplus / (deficit)		**267**	**1,042**

Statement of Financial Position

	Note	31 March 2024 £000	31 March 2023 £000
Non-current assets			
Intangible assets	14	190	116
Property, plant and equipment	15	35,173	33,540
Right of use assets	18	60,509	56,464
Receivables	19	19	20
Total non-current assets		**95,891**	**90,140**
Current assets			
Receivables	19	9,553	14,002
Cash and cash equivalents	20	43,536	41,206
Total current assets		**53,089**	**55,208**
Current liabilities			
Trade and other payables	21	(24,664)	(26,640)
Borrowings	23	(7,114)	(6,214)
Provisions	25	(636)	(602)
Other liabilities	22	(1,220)	(1,050)
Total current liabilities		**(33,634)**	**(34,506)**
Total assets less current liabilities		**115,346**	**110,842**
Non-current liabilities			
Borrowings	23	(53,499)	(50,283)
Provisions	25	(354)	(20)
Total non-current liabilities		**(53,853)**	**(50,303)**
Total assets employed		**61,493**	**60,539**
Financed by			
Public dividend capital		2,526	778
Revaluation reserve		14,504	15,914
Income and expenditure reserve		44,463	43,847
Total taxpayers' equity		**61,493**	**60,539**

The notes on pages 125 to 172 form part of these accounts.

Signed

Name Samantha Prince
Position Interim Chief Executive
Date 19 June 2024

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2024

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	**778**	**15,914**	**43,847**	**60,539**
Surplus / (deficit) for the year	-	-	309	**309**
Other transfers between reserves	-	(307)	307	**-**
Impairments	-	(1,307)	-	**(1,307)**
Revaluations	-	204	-	**204**
Public dividend capital received	1,748	-	-	**1,748**
Taxpayers' equity at 31 March 2024	**2,526**	**14,504**	**44,463**	**61,493**

Statement of Changes in Taxpayer's Equity for the year ended 31 March 2023

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2022 - brought forward	**778**	**14,182**	**45,109**	**60,069**
Surplus / (deficit) for the year	-	-	(1,262)	**(1,262)**
Impairments	-	1,732	-	**1,732**
Taxpayers' equity at 31 March 2023	**778**	**15,914**	**43,847**	**60,539**

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 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.

Other reserves
Leeds Community Healthcare NHS Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not specifially included in the taxpayers' equity.

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

Statement of Cash Flows

	Note	2023/24 £000	2022/23 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(1,118)	(1,247)
Non-cash income and expense			
Depreciation and amortisation	7	9,412	8,587
Net impairments	8	(43)	2,289
Income recognised in respect of capital donations	4	(15)	-
(Increase) / decrease in receivables and other assets		4,362	(7,244)
Increase / (decrease) in payables and other liabilities		(2,811)	10,303
Increase / (decrease) in provisions		33	225
Net cash flows from / (used in) operating activities		**9,820**	**12,913**
Cash flows from investing activities			
Interest received		2,446	943
Purchase of intangible assets		(128)	-
Purchase of PPE and investment property		(3,456)	(4,635)
Initial direct costs or up front payments in respect of new right of use assets		(266)	-
Receipt of cash lease incentives (lessee)		106	-
Receipt of cash donations to purchase assets		15	-
Net cash flows from / (used in) investing activities		**(1,283)**	**(3,692)**
Cash flows from financing activities			
Public dividend capital received		1,748	-
Capital element of finance lease rental payments		(7,012)	(6,399)
Interest paid on finance lease liabilities		(688)	(563)
PDC dividend (paid) / refunded		(255)	(512)
Net cash flows from / (used in) financing activities		**(6,207)**	**(7,474)**
Increase / (decrease) in cash and cash equivalents		**2,330**	**1,747**
Cash and cash equivalents at 1 April - brought forward		**41,206**	**39,459**
Cash and cash equivalents at 31 March	20	**43,536**	**41,206**

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 2023/24 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.

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 financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

Leeds Community Healthcare NHS Trust Board specifically considered the matter of going concern at its Board meeting on 28 March 2024. The Trust Board concluded that after considering the matters in the paper and having an awareness of all relevant information, that there are no material uncertainties related to events or conditions which may cast significant doubt on the ability of the Trust to continue as a going concern.

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. Leeds Community Healthcare NHS Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

Leeds Community Healthcare NHS Trust provides the following services as lead provider. The contract income flows to the Trust and the relevant partner recharges expenditure associated with the provision of the service. Leeds Community Healthcare NHS Trust distributes a share of any profit or loss to the relevant partner.

Sexual Health Services - Partner: Leeds Teaching Hospitals NHS Trust

Forensic Child and Adolescent Mental and Physical Health services - Partner: South West Yorkshire Partnership NHS Foundation Trust

Leeds Mental Wellbeing Service - Partners: Leeds and York Partnership NHS Foundation Trust, Northpoint, Touchstone, Community Links, Leeds GP Confederation, Women's Counselling Service and Homestart Leeds

Court Liaison and Diversion Services - Partner: Community Links

Weight Management Services - Partners: Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust

Leeds Community Healthcare NHS Trust provides a community care beds service under a joint operation with Leeds City Council. The Trust is the lead provider and contract income flows to the Trust. Leeds City Council recharges expenditure associated with the service. The total cost of this service is recognised by Leeds Community Healthcare NHS Trust.

Leeds Community Healthcare NHS Trust provides a 10 bed dementia service under a joint operation with Leeds City Council. Leeds City Council is the lead provider and contract income flows to them. Leeds Community Healthcare NHS Trust recharges expenditure associated with the service to Leeds City Council.

NHS Charitable Fund

Leeds Community Healthcare NHS Trust is the Corporate Trustee to the Leeds Community Healthcare Charitable Trust. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund.

Leeds Community Healthcare Trust has decided not to consolidate the charitable funds into these accounts as the transactions and balances are not material.

Note 1.4 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).

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.

Revenue from NHS contracts

The main source of income for Leeds Community Healthcare NHS Trust is contracts with commissioners for health care services and is in the form of aligned payment and incentive contracts, the main form of contracting between NHS providers and their commissioners for 2023/24. Funding envelopes are set at an Integrated Care Board (ICB) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The Trust agreed fixed element payments with commissioners, based on funding for an agreed level of activity. The fixed element also included CQUIN funding of 1.25% of the contract value.

In addition, where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received. The LVA payments schedule was provided nationally and identified those relationships where, on the basis of historical activity, the annual value of activity between the ICB and the Trust for 2023/24 is expected to be below £500,000.
In addition the Trust received additional non recurrent income during the financial year to reimburse specific costs incurred.

Revenue from non-NHS contracts

Revenue is recognised by Leeds Community Healthcare NHS Trust from non-NHS commissioners for health care services under IFRS 15. The revenue is recognised as and when performance obligations are satisfied.
The performance obligation relating to the delivery of the health care is satisfied over the time the healthcare is received and consumed simultaneously by the customer, as the Trust performs it. At the year end, the Trust accrues income relating to activity delivered in that year.

Where Leeds Community Healthcare NHS 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.

Note 1.5 Other forms of income

Grants and donations

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. Where a grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Other income

Within the other income category, Leeds Community Healthcare NHS Trust includes any income received in the period not identified separately. It includes categories such as rental income, recruitment support, joint project income, lease car income and employee salary sacrifice VAT income.

Note 1.6 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 two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care 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: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

Note 1.7 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 1.8 Property, plant and equipment

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 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.

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.

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.

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.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

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.

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’ cease 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 expenditure.

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 is 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.

De-recognition

Assets intended for disposal are reclassified as ‘held for sale’ once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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.

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.

This includes assets donated to Leeds Community Healthcare NHS Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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
Buildings, excluding dwellings	5	80
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	10	10

Note 1.9 Intangible assets

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 where it meets the requirements set out in IAS 38.

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.

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. Revaluations 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 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.

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.

Useful lives 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
Software licences	2	5

Note 1.10 Inventories

Leeds Community Healthcare NHS Trust does not hold inventories and the cost of inventory items are expensed through the income and expenditure account.
During 2023/24 Leeds Community Healthcare NHS Trust received inventories including personal protective equipment from the Department of Health and Social Care. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at an estimated cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 Financial assets and financial liabilities

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.

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 profit and loss. 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 leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets so classified are subsequently measured at amortised cost.

Financial liabilities so classified 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 recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, Leeds Community Healthcare NHS 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 as 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).

At the end of the reporting period, the Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss', require an allowance for an expected credit loss. Lifetime credit losses are recognised if there is objective evidence of impairment as a result of one or more events that occurred after initial recognition of the asset and that have an impact on the estimated future cash flows of the asset. However NHS bodies are not allowed to recognise any impairments against intra-DHSC balances as it is expected that they will be recoverable, therefore no lifetime credit losses are made against NHS bodies.

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.

De-recognition
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 1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 3.51% applied to new leases commencing in 2023 and 4.72% to new leases commencing in 2024.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term or other systematic basis. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by an HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. The cost model is not considered to be an appropriate proxy for the value of the right of use asset in the following circumstances;
where consideration exchanged is identified as significantly below market value;
there are no terms that require lease payments to be updated for market conditions or there is a significant period between those updates in a longer- term lease;
or if the fair value or current value in use could fluctuate significantly due to changes in market prices and conditions.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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

Income from operating leases is recognised on a straight-line basis or another systematic 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 1.14 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 HM Treasury's discount rates effective from 31 March 2024:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.26%	3.27%
Medium-term	After 5 years up to 10 years	4.03%	3.20%
Long-term	After 10 years up to 40 years	4.72%	3.51%
Very long-term	Exceeding 40 years	4.40%	3.00%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2024:

	Inflation rate	Prior year rate
Year 1	3.60%	7.40%
Year 2	1.80%	0.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.45% in real terms (prior year: 1.70%).

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 25.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

Leeds Community Healthcare NHS 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 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 26 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 26, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.16 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.

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 public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-Trusts-and-foundation-Trusts.

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 calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax
Most of the activities of Leeds Community Healthcare NHS 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 1.18 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.

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2023/24.

Note 1.20 Standards, amendments and interpretations in issue but not yet effective or adopted

The following standards have been issued but not yet adopted by DHSC
IFRS 14 Regulatory Deferral Accounts - Not applicable to DHSC bodies as it is not UK endorsed
IFRS 17 Insurance Contracts (IFRS 17) is being applied by HM Treasury in the Government Financial Reporting Manual (FReM) from 1 April 2025 (with limited options for early adoption)

Note 1.21 Critical judgements in applying accounting policies

In the application of Leeds Community Healthcare NHS Trust's accounting policies, management is required to make judgments, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates, and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period, or in the period of the revision and future periods if the revision affects both current and future periods.

In line with IFRS 9 Financial Instruments, Leeds Community Healthcare NHS Trust uses a provisions matrix approach. Within Financial Instruments the Trust has trade receivables and lease obligations.

Leeds Community Healthcare NHS Trust has had to estimate its irrecoverable debt value using the matrix for 2023/24, as disclosed in note 19.1.

As part of the adoption of IFRS 16, Leeds Community Healthcare NHS Trust reviewed all leases to determine whether a revaluation model or cost model would be used as a basis for valuing property leases. On review, it was determined that the property leases are subject to regular rent reviews throughout the lease term, based on the Retail Prices Index (RPI) and market conditions. As the rental values are regularly updated to account for market conditions, the Trust has applied the cost model when accounting for the property leases under IFRS16.

IFRS 16 has been applied to all leases held by the Trust with a length of over 12 months and over £5k in value.

Note 1.22 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 for Leeds Community Healthcare NHS Trust;

Property Valuation and Asset Lives

Valuations have been undertaken by Leeds Community Healthcare NHS Trust's expert independant valuer, the District Valuer, part of the Valuation Agency Office, as at 31st March 2024. All operational assets have been valued on a current value in existing use basis. The land and building valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care. These valuations will therefore be subject to changes in market conditions and market values. As part of this valuation the asset lives are also estimated by the District Valuer and are subject to professional judgement.

Two properties, Otley and Horsforth, have been designated by the Trust as surplus assets, with no plan to bring them back into use and have been valued by the District Valuer at fair value.

The Valuation Office Agency has valued the estate on the 31st March 2024 as £28,254k, with Land being £9,730k and Buildings £19,523k

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

Note 3.1 Income from patient care activities (by nature)	2023/24 £000	2022/23 £000
Mental health services		
Income from commissioners under API contracts*	32,447	27,602
Services delivered under a mental health collaborative	189	183
Community services		
Income from commissioners under API contracts*	141,017	134,501
Income from other sources (e.g. local authorities)	32,497	30,586
All services		
National pay award central funding**	22	6,291
Additional pension contribution central funding***	6,652	5,894
Other clinical income	-	410
Total income from activities	**212,824**	**205,467**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation.

https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

** Additional funding was made available by NHS England in 2023/24 and 2022/23 for implementing the backdated element of pay awards where government offers were made at the end of the financial year. 2023/24: In March 2024, the government announced a revised pay offer for consultants, reforming consultant pay scales with an effective date of 1 March 2024. Trade Unions representing consultant doctors accepted the offer in April 2024. 2022/23: In March 2023, the government made a pay offer for staff on agenda for change terms and conditions which was later confirmed in May 2023. The additional pay for 2022/23 was based on individuals in employment at 31 March 2023.

***The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2023/24 £000	2022/23 £000
NHS England	13,921	22,603
Clinical commissioning groups	-	36,180
Integrated care boards	166,223	115,505
Other NHS providers	189	593
Local authorities	30,398	29,500
Non NHS: other	2,093	1,086
Total income from activities	**212,824**	**205,467**
Of which:		
Related to continuing operations	212,824	205,467

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

Leeds Community Healthcare NHS Trust has made no charges relating to patients who are overseas visitors.

Note 4 Other operating income

	2023/24			2022/23		
	Contract income £000	Non-contract income £000	Total £000	Contract income £000	Non-contract income £000	Total £000
Research and development	351	-	**351**	347	-	**347**
Education and training	4,308	447	**4,755**	4,111	426	**4,537**
Non-patient care services to other bodies	73	-	**73**	58	-	**58**
Reimbursement and top up funding		-	**-**	220	-	**220**
Income in respect of employee benefits accounted on a gross basis	3,370	-	**3,370**	3,186	-	**3,186**
Receipt of capital grants and donations and peppercorn leases	-	15	**15**	-	-	**-**
Charitable and other contributions to expenditure *	-	80	**80**	-	300	**300**
Revenue from operating leases	-	556	**556**	-	482	**482**
Other income **	5,064	-	**5,064**	3,935	-	**3,935**
Total other operating income	**13,166**	**1,098**	**14,264**	**11,857**	**1,208**	**13,065**
Of which:						
Related to continuing operations			14,264			13,065

* This is notional income in respect of protective personal equipment provided centrally by the Department of Health and Social Care to the Trust as part of the Covid-19 response.

** Other income totalled £5,144k: this includes £1,126k rental income, £1,420k contribution to the integrated mental wellbeing service for Leeds, £575k for First Contact Practitioners working for GPs, £440k for Local Care Partnerships income to fund projects supporting the transformation of care pathway, £211k One Adoption funding, £121k Therapeutic Support for Leeds City Council , £188k Alliance Project, £254k lease car income, £183k contribution to headquarters renovation, £71k Winter Vaccination, £126k Cardiac Rehabilitation project, £64k HomeFirst Project, £85k HEE Training Income and £280k various other income.

Note 5 Additional information on contract revenue (IFRS 15) recognised in the period

	2023/24 £000	2022/23 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	371	594

Note 6 Operating leases - Leeds Community Healthcare NHS Trust as 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 office accomodation, health centres and clinics, where the lessee is a GP practice or other healthcare organisation.

Leasing arrangements are generally managed through a formal leasing process, with an ongoing review process. For some GP practices, where this is not in place, there are regular reviews of the GP commissioning arrangements with the ICB.

Any vacant space is reviewed, to ensure there is no long term void space and short term arrangements may be made with 3rd parties.

Note 6.1 Operating lease income

	2023/24	2022/23
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	556	482
Total in-year operating lease income	**556**	**482**

Note 6.2 Future lease receipts

	31 March 2024	31 March 2023
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	495	376
- later than one year and not later than two years	481	327
- later than two years and not later than three years	481	327
- later than three years and not later than four years	468	327
- later than four years and not later than five years	465	314
- later than five years	570	358
Total	**2,960**	**2,029**

Note 7 Operating expenses

	2023/24	2022/23
	£000	£000
Staff and executive directors costs	160,541	153,713
Remuneration of non-executive directors	128	128
Supplies and services - clinical (excluding drugs costs)	28,185	27,586
Supplies and services - general	7,280	6,991
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	994	1,006
Establishment	3,765	3,520
Premises	9,354	8,227
Transport (including patient travel)	2,040	1,827
Depreciation on property, plant and equipment	9,358	8,532
Amortisation on intangible assets	54	55
Net impairments	(43)	2,289
Movement in credit loss allowance: contract receivables / contract assets	61	65
Increase / (decrease) in other provisions	-	20
Fees payable to the external auditor		
audit services- statutory audit	92	68
Internal audit costs	92	100
Clinical negligence	683	578
Legal fees	219	142
Insurance	107	112
Research and development	124	109
Education and training	1,721	1,120
Expenditure on short term leases	599	540
Expenditure on low value leases	96	103
Redundancy	34	245
Car parking & security	362	334
Hospitality	6	7
Losses, ex gratia & special payments	11	385
Other services, eg external payroll	1,355	1,105
Other	988	872
Total*	**228,206**	**219,779**
Of which:		
Related to continuing operations	228,206	219,779
Related to discontinued operations	-	-

* Includes VAT

All expenditure includes VAT where not recoverable

Note 7.1 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2023/24 or 2022/23.

Note 8 Impairment of assets

	2023/24	2022/23
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(43)	2,289
Total net impairments charged to operating surplus / deficit	**(43)**	**2,289**
Impairments charged to the revaluation reserve	1,307	(1,732)
Total net impairments	**1,264**	**557**

The impairment of assets is due to the full revaluation of Leeds Community Healthcare NHS Trust's estate undertaken by the District Valuer. A net impairment gain of £43k has been included in operating expenses during the year and the £1,307k impairment has been included in the revaluation reserve. The net impact on the value of assets was an overall reduction of £1,264k and was due to changes in market prices. Full details can be found in Note 17.

Note 9 Employee benefits

	2023/24	2022/23
	Total	Total
	£000	£000
Salaries and wages	121,530	117,378
Social security costs	12,682	12,157
Apprenticeship levy	605	562
Employer's contributions to NHS pensions	21,890	19,359
Pension cost - other	54	101
Termination benefits	34	245
Temporary staff (including agency)	3,793	4,213
Total gross staff costs	**160,588**	**154,015**
Recoveries in respect of seconded staff	-	-
Total staff costs	**160,588**	**154,015**
Of which		
Costs capitalised as part of assets	13	57

Note 9.1 Retirements due to ill-health

During 2023/24 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2023). The estimated additional pension liabilities of these ill-health retirements is £52k calculated on an average basis and will be borne by the NHS Pension Scheme (£620k in 2022/23).

Note 10 Pension costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care 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 2024, is based on valuation data as 31 March 2023, updated to 31 March 2024 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 2020. The results of this valuation set the employer contribution rate payable from April 2024. The Department of Health and Social Care has recently laid Scheme Regulations confirming the employer contribution rate will increase to 23.7% of pensionable pay from 1 April 2024 (previously 20.6%). The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

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 Leeds Community Healthcare NHS 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).

Leeds Community Healthcare NHS Trust has incurred expenditure of £54k during the year in respect of contributions for employees under the NEST scheme.

Note 11 Finance income

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

	2023/24	2022/23
	£000	£000
Interest on bank accounts	2,446	943
Total finance income	**2,446**	**943**

Note 12.1 Finance expenditure

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

	2023/24	2022/23
	£000	£000
Interest expense:		
Interest on lease obligations	688	563
Total finance costs	**688**	**563**

Note 12.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

Leeds Community Healthcare NHS Trust has no expenditure in respect of late payments of commercial debts.

Note 13 Other gains / (losses)

	2023/24	2022/23
	£000	£000
Gains on disposal of assets	12	1
Total gains / (losses) on disposal of assets	**12**	**1**
Other gains / (losses)	-	-
Total other gains / (losses)	**12**	**1**

Gain on disposal of assets relates to gains on the disposal of lease cars held by the Trust under IFRS 16.

Note 14 Intangible assets - 2023/24

	Software licences
	£000
Valuation / gross cost at 1 April 2023 - brought forward	**307**
Additions	128
Valuation / gross cost at 31 March 2024	**435**
Amortisation at 1 April 2023 - brought forward	**191**
Provided during the year	54
Amortisation at 31 March 2024	**245**
Net book value at 31 March 2024	**190**
Net book value at 1 April 2023	**116**

Note 14.1 Intangible assets - 2022/23

	Software licences
	£000
Valuation / gross cost at 1 April 2022	**307**
Valuation / gross cost at 31 March 2023	**307**
Amortisation at 1 April 2022	**136**
Provided during the year	55
Amortisation at 31 March 2023	**191**
Net book value at 31 March 2023	**116**
Net book value at 1 April 2022	**171**

Note 15 Property, plant and equipment - 2023/24

	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 2023 - brought forward	**9,518**	**22,072**	**729**	**2,120**	**9,033**	**189**	**43,661**
Additions	-	242	23	515	2,346	1,335	**4,461**
Impairments	(788)	(519)	-	-	-	-	**(1,307)**
Reversals of impairments	-	-	-	-	-	-	**-**
Revaluations	-	(353)	-	-	-	-	**(353)**
Reclassifications	-	752	(752)	-	-	-	**-**
Valuation/gross cost at 31 March 2024	**8,730**	**22,194**	**-**	**2,635**	**11,379**	**1,524**	**46,462**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**2,262**	**-**	**1,463**	**6,209**	**187**	**10,121**
Provided during the year	-	667	-	123	941	37	**1,768**
Impairments	-	237	-	-	-	-	**237**
Reversals of impairments	-	(280)	-	-	-	-	**(280)**
Revaluations	-	(557)	-	-	-	-	**(557)**
Accumulated depreciation at 31 March 2024	**-**	**2,329**	**-**	**1,586**	**7,150**	**224**	**11,289**
Net book value at 31 March 2024	**8,730**	**19,865**	**-**	**1,049**	**4,229**	**1,300**	**35,173**
Net book value at 1 April 2023	**9,518**	**19,810**	**729**	**657**	**2,824**	**2**	**33,540**

Note 15.1 Property, plant and equipment - 2022/23

	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 2022	**9,708**	**19,118**	**2,213**	**1,880**	**7,706**	**189**	**40,814**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	1,642	565	240	1,331	-	**3,778**
Impairments	(250)	(3,894)	-	-	-	-	**(4,144)**
Reversals of impairments	60	3,153	-	-	-	-	**3,213**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	2,053	(2,049)	-	(4)	-	**-**
Valuation/gross cost at 31 March 2023	**9,518**	**22,072**	**729**	**2,120**	**9,033**	**189**	**43,661**
Accumulated depreciation at 1 April 2022	**-**	**1,775**	**-**	**1,351**	**5,268**	**186**	**8,580**
Provided during the year	-	861	-	112	941	1	**1,915**
Impairments	-	(553)	-	-	-	-	**(553)**
Reversals of impairments	-	179	-	-	-	-	**179**
Revaluations	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2023	**-**	**2,262**	**-**	**1,463**	**6,209**	**187**	**10,121**
Net book value at 31 March 2023	**9,518**	**19,810**	**729**	**657**	**2,824**	**2**	**33,540**
Net book value at 1 April 2022	**9,708**	**17,343**	**2,213**	**529**	**2,438**	**3**	**32,234**

Note 15.2 Property, plant and equipment financing - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	8,730	19,311	-	1,049	4,229	1,300	**34,619**
Owned - donated/granted	-	554	-	-	-	-	**554**
Total net book value at 31 March 2024	**8,730**	**19,865**	**-**	**1,049**	**4,229**	**1,300**	**35,173**

Note 15.3 Property, plant and equipment financing - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	9,518	19,246	729	657	2,824	2	**32,976**
Owned - donated/granted	-	564	-	-	-	-	**564**
Total net book value at 31 March 2023	**9,518**	**19,810**	**729**	**657**	**2,824**	**2**	**33,540**

Note 15.4 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease		14,847					**14,847**
Not subject to an operating lease	8,730	5,018	-	1,049	4,229	1,300	**20,326**
Total net book value at 31 March 2024	**8,730**	**19,865**	**-**	**1,049**	**4,229**	**1,300**	**35,173**

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2023

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	14,803	-	-	-	-	**14,803**
Not subject to an operating lease	9,518	5,007	729	657	2,824	2	**18,737**
Total net book value at 31 March 2023	**9,518**	**19,810**	**729**	**657**	**2,824**	**2**	**33,540**

Note 16 Donations of property, plant and equipment

Leeds Community Healthcare NHS Trust received a £15k donation from the Leeds Community Heathcare charity towards the upgrade of the garden at Hannah House.

Note 17 Revaluations of property, plant and equipment

Land and buildings are included in the Statement of Financial Position at their valuation on 31 March 2024. A comprehensive and full valuation was undertaken by the District Valuer part of the Valuation Office Agency, an independent RICS valuer, in accordance with RICS guidance.

The valuation took into account improvements undertaken during the year as well as their current condition. The valuation methodology assumes that our buildings will be maintained to their current condition over their remaining lives. The valuation was undertaken on a current value in existing use basis, as defined in DHSC GAM and reflecting the adaptation approved by Financial Reporting Advisory Board to IAS16.

The impact of the valuation on land and property in full use is a net reduction in value of £1,307k.

The useful lives applied to property, plant and equipment assets are shown in note 1.8.

The properties at Otley and Horsforth have been identified by the Leeds Community Healthcare NHS Trust as surplus with no plan to bring them back into use. These have been measured by the District Valuer at fair value. The values from the District Valuer is £570k for Otley and £445k for Horsforth These properties are not currently classed as held for sale in the accounts and are within Property, Plant and Equipment.

Note 18 Leases - Leeds Community Healthcare NHS Trust as a lessee

This note details information about leases for which the Trust is a lessee. Leeds Community Healthcare NHS Trust has other short term leases in respect of property rental, vehicles and photocopiers.

Note 18.1 Right of use assets - 2023/24

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**62,598**	**475**	**63,073**	**61,250**
Additions	3,210	485	**3,695**	-
Remeasurements of the right of use asset	7,647	-	**7,647**	7,647
Movements in provisions for restoration / removal costs	335	-	**335**	-
Disposals / derecognition	(364)	(135)	**(499)**	-
Valuation/gross cost at 31 March 2024	**73,426**	**825**	**74,251**	**68,897**
Accumulated depreciation at 1 April 2023 - brought forward	**6,447**	**162**	**6,609**	**5,950**
Provided during the year	7,327	263	**7,590**	6,686
Disposals / derecognition	(343)	(114)	**(457)**	-
Accumulated depreciation at 31 March 2024	**13,431**	**311**	**13,742**	**12,636**
Net book value at 31 March 2024	**59,995**	**514**	**60,509**	**56,261**
Net book value at 1 April 2023	**56,151**	**313**	**56,464**	**55,300**

Note 18.2 Right of use assets - 2022/23

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2022 - brought forward	**-**	**-**	**-**	**-**
IFRS 16 implementation - adjustments for existing operating leases / subleases	62,422	279	**62,701**	61,080
Additions	-	212	**212**	-
Remeasurements of the right of use asset	176	2	**178**	170
Disposals / derecognition	-	(18)	**(18)**	-
Valuation/gross cost at 31 March 2023	**62,598**	**475**	**63,073**	**61,250**
Accumulated depreciation at 1 April 2022 - brought forward	-	-	**-**	-
Provided during the year	6,447	170	**6,617**	5,950
Disposals / derecognition	-	(8)	**(8)**	-
Accumulated depreciation at 31 March 2023	**6,447**	**162**	**6,609**	**5,950**
Net book value at 31 March 2023	**56,151**	**313**	**56,464**	**55,300**
Net book value at 1 April 2022	**-**	**-**	**-**	**-**

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 23.

	2023/24	2022/23
	£000	£000
Carrying value at 31 March	**56,497**	**-**
IFRS 16 implementation - adjustments for existing operating leases	-	62,517
Lease additions	3,535	212
Lease liability remeasurements	7,647	178
Interest charge arising in year	688	563
Early terminations	(54)	(11)
Lease payments (cash outflows)	(7,700)	(6,962)
Carrying value at 31 March	**60,613**	**56,497**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Income generated from subleasing right of use assets in £167k and is included within revenue from operating leases in note 4.

Note 18.4 Maturity analysis of future lease payments

	Total	Of which leased from DHSC group bodies:	**Total**	Of which leased from DHSC group bodies:
	31 March 2024	**31 March 2024**	**31 March 2023**	**31 March 2023**
	£000	**£000**	**£000**	**£000**
Undiscounted future lease payments payable in:				
- not later than one year;	7,732	7,097	6,720	6,251
- later than one year and not later than five years;	29,625	27,715	25,029	24,574
- later than five years.	26,241	24,221	27,355	27,317
Total gross future lease payments	**63,598**	**59,033**	**59,104**	**58,142**
Finance charges allocated to future periods	(2,985)	(2,375)	(2,607)	(2,592)
Net lease liabilities at 31 March 2024	**60,613**	**56,658**	**56,497**	**55,550**

Note 19 Receivables

	31 March 2024 £000	31 March 2023 £000
Current		
Contract receivables	6,252	5,373
Allowance for impaired contract receivables / assets	(132)	(71)
Prepayments (non-PFI)	2,301	1,167
Operating lease receivables	-	-
PDC dividend receivable	118	206
VAT receivable	839	832
Other receivables	175	6,495
Total current receivables	**9,553**	**14,002**
Non-current		
Other receivables	19	20
Total non-current receivables	**19**	**20**
Of which receivable from NHS and DHSC group bodies:		
Current	1,251	8,061
Non-current	19	20

Note 19.1 Allowances for credit losses

	2023/24	2022/23
	Contract receivables and contract assets	Contract receivables and contract assets
	£000	£000
Allowances as at 1 April - brought forward	**71**	**6**
New allowances arising	132	68
Reversals of allowances	(71)	(3)
Allowances as at 31 Mar 2024	**132**	**71**

Note 19.2 Exposure to credit risk

NHS debt is resolved through the agreement of balances process and, as such, is not considered to be a credit risk. In line with IFRS 9 Leeds Community Healthcare NHS Trust uses a provision matrix to categorise the debts and reviews 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.

Leeds Community Healthcare NHS Trust has a credit risk from ex-employee debt and the credit loss rate to be applied to this type of debt was calculated as 26.75%. For specific disputed debt, a credit risk of 100% has been applied and for any other outstanding debt over 6 months a credit risk has been applied at 50%. Overall a £132k credit loss allowance has been recognised for non-NHS receivables in 2023/24.

Note 20 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.

	2023/24	2022/23
	£000	£000
At 1 April	**41,206**	**39,459**
Net change in year	2,330	1,747
At 31 March	**43,536**	**41,206**
Broken down into:		
Cash at commercial banks and in hand	2	3
Cash with the Government Banking Service	43,534	41,203
Total cash and cash equivalents as in SoFP	**43,536**	**41,206**
Total cash and cash equivalents as in SoCF	**43,536**	**41,206**

Note 21 Trade and other payables

	31 March 2024 £000	31 March 2023 £000
Current		
Trade payables	5,784	4,689
Capital payables	1,438	433
Accruals	12,409	16,934
Social security costs	1,557	1,583
Other taxes payable	1,353	1,132
Pension contributions payable	2,107	1,864
Other payables	16	5
Total current trade and other payables	**24,664**	**26,640**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	3,697	1,571
Non-current	-	-

Note 22 Other liabilities

	31 March 2024 £000	31 March 2023 £000
Current		
Deferred income: contract liabilities	1,220	1,050
Total other current liabilities	**1,220**	**1,050**
Total other non-current liabilities	**-**	**-**

Note 23 Borrowings

	31 March 2024 £000	31 March 2023 £000
Current		
Lease liabilities	7,114	6,214
Total current borrowings	**7,114**	**6,214**
Non-current		
Lease liabilities	53,499	50,283
Total non-current borrowings	**53,499**	**50,283**

Note 24 Reconciliation of liabilities arising from financing activities

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2023	**56,497**	**56,497**
Cash movements:		
Financing cash flows - payments and receipts of principal	(7,012)	**(7,012)**
Financing cash flows - payments of interest	(688)	**(688)**
Non-cash movements:		
Additions	3,535	**3,535**
Lease liability remeasurements	7,647	**7,647**
Application of effective interest rate	688	**688**
Early terminations	(54)	**(54)**
Carrying value at 31 March 2024	**60,613**	**60,613**

	Lease Liabilities	Total
	£000	£000
Carrying value at 1 April 2022	**-**	**-**
Cash movements:		
Financing cash flows - payments and receipts of principal	(6,399)	**(6,399)**
Financing cash flows - payments of interest	(563)	**(563)**
Non-cash movements:		
Impact of implementing IFRS 16 on 1 April 2022	62,517	**62,517**
Additions	212	**212**
Lease liability remeasurements	178	**178**
Application of effective interest rate	563	**563**
Early terminations	(11)	**(11)**
Carrying value at 31 March 2023	**56,497**	**56,497**

Note 25 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2023	**125**	**476**	**21**	**622**
Arising during the year	-	55	335	**390**
Utilised during the year	-	-	(1)	**(1)**
Reversed unused	-	(21)	-	**(21)**
At 31 March 2024	**125**	**510**	**355**	**990**
Expected timing of cash flows:				
- not later than one year;	125	510	1	**636**
- later than one year and not later than five years;	-	-	336	**336**
- later than five years.	-	-	18	**18**
Total	**125**	**510**	**355**	**990**

In respect of legal claims the uncertainty as to amounts and timings relates to the time taken to determine whether or not Leeds Community Healthcare NHS 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.

Other provisions include a dilapidation provision for the offices at White Rose for £355k and £20k in respect of clinicians' pensions liaibility arising from the 2019/20 Pension Annual Allowance Charge Compensation Scheme (PAACCS).
The clinicians' pension liability figure has been calculated by NHS England and use the latest available information on actual uptake of the scheme. They are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the election forms where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100). Future liabilities based on individual member data and scheme rules are then discounted to give a total.

Note 25.1 Clinical negligence liabilities

At 31 March 2024, £432k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2023: £1,288k).

Note 26 Contingent assets and liabilities

	31 March 2024 £000	31 March 2023 £000
Value of contingent liabilities		
Redundancy	(1,817)	(1,264)
Gross value of contingent liabilities	**(1,817)**	**(1,264)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(1,817)**	**(1,264)**

Leeds Community Healthcare NHS Trust has a possible obligation arising from its employ and deploy model of staffing. The redundancy liability would arise should a decision be made by the third parties to terminate the deployment contracts.

Leeds Community Healthcare NHS Trust has no contingent assets in 2023/24

Note 27 Other financial commitments

Leeds Community Healthcare NHS 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 2024 £000	31 March 2023 £000
not later than 1 year	17,335	18,057
after 1 year and not later than 5 years	11,147	9,982
after more than 5 years	582	-
Total	**29,064**	**28,039**

Note 28 Financial instruments

Note 28.1 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 Leeds Community Healthcare NHS 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.

Leeds Community Healthcare NHS 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.

Leeds Community Healthcare NHS 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

Leeds Community Healthcare NHS 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.
Leeds Community Healthcare NHS Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

Leeds Community Healthcare NHS Trust has no borrowing in 2023/24.

The Trust may borrow from government for capital expenditure, subject to affordability, as confirmed by NHS England. 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 England. Interest rates are confirmed by the Department of Health and Social Care, the lender, at the point borrowing is undertaken.

Leeds Community Healthcare NHS Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of Leeds Community Healthcare NHS 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 2024 are in receivables from customers, as disclosed in note 19.2.

Liquidity risk

The majority of Leeds Community Healthcare NHS Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit.

Leeds Community Healthcare NHS Trust is not therefore exposed to significant liquidity risks.

Note 28.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	6,314	-	-	**6,314**
Cash and cash equivalents	43,536	-	-	**43,536**
Total at 31 March 2024	**49,850**	**-**	**-**	**49,850**

Carrying values of financial assets as at 31 March 2023	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	11,817	-	-	**11,817**
Cash and cash equivalents	41,206	-	-	**41,206**
Total at 31 March 2023	**53,023**	**-**	**-**	**53,023**

Note 28.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Obligations under leases	60,613	-	**60,613**
Trade and other payables excluding non financial liabilities	19,652	-	**19,652**
Total at 31 March 2024	**80,265**	**-**	**80,265**

Carrying values of financial liabilities as at 31 March 2023	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Obligations under leases	56,497	-	**56,497**
Trade and other payables excluding non financial liabilities	22,061	-	**22,061**
Total at 31 March 2023	**78,558**	**-**	**78,558**

Note 28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 March 2024	31 March 2023
	£000	£000
In one year or less	27,385	28,781
In more than one year but not more than five years	29,625	25,029
In more than five years	26,241	27,355
Total	**83,251**	**81,165**

Note 29 Losses and special payments

	2023/24		2022/23	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	11
Bad debts and claims abandoned	1	1	2	1
Total losses	**1**	**1**	**3**	**12**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	5	13
Ex-gratia payments	4	10	2	359
Total special payments	**5**	**11**	**7**	**372**
Total losses and special payments	**6**	**12**	**10**	**384**
Compensation payments received				

Ex-gratia payments in 2022/23 includes £359k of refunds of VAT on salary sacrifice lease car payments made to employees.

Note 30 Related parties

Details of related parties transactions must be disclosed in accordance with IAS 24; these are as follows:

Organisation and related party	Revenue from Related Party	Expenditure with Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£000	£000	£000	£000
Crossley Street Surgery, Wetherby		**347**		**14**
Ruth Burnett (Medical Director)				
Performs unpaid GP work as part of CPD and maintaining registration				
Leeds GP Confederation	**1,280**		**85**	
Jenny Allen (Director of Workforce)				
Director of Workforce, Leeds GP Confederation				
Ruth Burnett (Medical Director)				
Medical Director, Leeds GP Confederation				
Stephanie Lawrence (Executive Director of Nursing and Allied Health Professionals)				
Director of Nursing, Leeds GP Confederation				
Laura Smith (Director of Workforce)				
Director of Workforce, Leeds GP Confederation				
Community Ventures Limited		**489**		**73**
Bryan Machin (Executive Director of Finance and Resources)				
Advisory work				
Prospect Business Consulting		**1**		
Laura Smith (Director of Workforce)				
Associate				
Care Quality Commission		**124**		
Stephanie Lawrence (Executive Director of Nursing and Allied Health Professionals)				
The Queen's Nursing Institute	**12**		**14**	
Stephanie Lawrence (Executive Director of Nursing and Allied Health Professionals)				
Fellow				
Touchstone Leeds Ltd		**2,123**		**328**
Khalil Rehman (Non-Executive Director)				
Consultancy / Advisory work				

The Department of Health and Social Care is regarded as a related party. During the year 2023/24 Leeds Community Healthcare NHS 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:

Bradford District Care NHS Foundation Trust
Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust
Greater Manchester Mental Health NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Lancashire Teaching Hospitals NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Medway NHS Foundation Trust
North Cumbria Integrated Care NHS Foundation Trust
Pennine Care NHS Foundation Trust
Northern Care Alliance NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
University College London Hospitals NHS Foundation Trust
University Hospitals of Derby and Burton NHS Foundation Trust
University Hospitals Sussex NHS Foundation Trust
York and Scarborough Teaching Hospitals NHS Foundation Trust
East of England Ambulance Service NHS Trust
Imperial College Healthcare NHS Trust
Leeds Teaching Hospitals NHS Trust
Leicestershire Partnership NHS Trust
Mid Yorkshire Hospitals NHS Trust
Mersey and West Lancashire Teaching Hospitals NHS Trust
University Hospitals Coventry And Warwickshire NHS Trust
NHS Hertfordshire and West Essex ICB
NHS Humber and North Yorkshire ICB
NHS Kent and Medway ICB
NHS Lancashire and South Cumbria ICB
NHS Norfolk and Waveney ICB
NHS North Central London ICB
NHS North East and North Cumbria ICB
NHS Nottingham and Nottinghamshire ICB
NHS South Yorkshire ICB
NHS West Yorkshire ICB
NHS England
NHS North of England Commissioning Support Unit
North East and Yorkshire Regional Office
UK Health Security Agency
NHS Resolution
Care Quality Commission
Department of Health and Social Care

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:

Community Health Partnerships Ltd
HM Revenue and Customs
Humberside Police and Crime Commissioner and Chief Constable
Kirklees Metropolitan Council
Leeds City Council
National Employment Savings Trust (NEST)
National Employment Savings Trust
NHS Pension Authority
NHS Property Services
West Yorkshire Combined Authority (Policing and Crime)
West Yorkshire Police and Crime Commissioner and Chief Constable
North Yorkshire Police and Crime Commissioner and Chief Constable
South Yorkshire Police and Crime Commissioner and Chief Constable

Leeds Community Healthcare NHS Trust has also had transactions with Macmillan Cancer Support, NHS Providers and a subsidiary company of Currys PLC which the Department of Health and Social Care has deemed to be related parties of entities within the Departmental Group.
The Trust has received a receipt from Leeds Community Healthcare Charitable Trust for £15k, for which the Trust Board is Corporate Trustee. This was a contribution towards the Hannah House Garden refurbishment. A debtor of £174k is held by the Trust in relation to the Charity for transactions made.

Note 31 Events after the reporting date

Leeds Community Healthcare is not aware of any events after the reporting date

Note 32 Better Payment Practice code

	2023/24 Number	2023/24 £000	2022/23 Number	2022/23 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	13,786	53,301	15,402	48,987
Total non-NHS trade invoices paid within target	13,140	51,857	14,805	48,169
Percentage of non-NHS trade invoices paid within target	95.3%	97.3%	96.1%	98.3%
NHS Payables				
Total NHS trade invoices paid in the year	300	24,982	292	22,104
Total NHS trade invoices paid within target	284	24,843	290	22,103
Percentage of NHS trade invoices paid within target	94.7%	99.4%	99.3%	100.0%

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 33 External financing limit

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

	2023/24 £000	2022/23 £000
Cash flow financing	(7,594)	(8,146)
External financing requirement	**(7,594)**	**(8,146)**
External financing limit (EFL)	(7,594)	(8,146)
Under / (over) spend against EFL	**-**	**-**

Note 34 Capital Resource Limit

	2023/24 £000	2022/23 £000
Gross capital expenditure	15,931	4,168
Less: Disposals	(42)	(10)
Less: Donated and granted capital additions	(15)	-
Charge against Capital Resource Limit	**15,874**	**4,158**
Capital Resource Limit	15,875	4,158
Under / (over) spend against CRL	**1**	**-**

Note 35 Breakeven duty financial performance

	2023/24 £000
Adjusted financial performance surplus / (deficit) (control total basis)	267
Breakeven duty financial performance surplus / (deficit)	**267**

Note 36 Breakeven duty rolling assessment

	2008/09 £000	2009/10 £000	2010/11 £000	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000
Breakeven duty in-year financial performance		-	-	2,577	1,809	1,425	2,007	2,985
Breakeven duty cumulative position	-	-	-	2,577	4,386	5,811	7,818	10,803
Operating income		-	-	134,978	139,906	142,863	146,668	156,367
Cumulative breakeven position as a percentage of operating income		0.0%	0.0%	1.9%	3.1%	4.1%	5.3%	6.9%

	2016/17 £000	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000
Breakeven duty in-year financial performance	3,350	4,655	5,661	2,045	1,557	507	1,042	267
Breakeven duty cumulative position	14,153	18,808	24,469	26,514	28,071	28,578	29,620	29,887
Operating income	148,654	149,526	155,640	171,312	187,920	195,550	218,532	227,088
Cumulative breakeven position as a percentage of operating income	9.5%	12.6%	15.7%	15.5%	14.9%	14.6%	13.6%	13.2%

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the TAC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs

	Permanent £000	Other £000	2023/24 Total £000	2022/23 Total £000
Salaries and wages	113,387	8,143	**121,530**	117,378
Social security costs	12,215	467	**12,682**	12,157
Apprenticeship levy	583	22	**605**	562
Employer's contributions to NHS pension scheme	21,084	806	**21,890**	19,359
Pension cost - other	52	2	**54**	101
Other post employment benefits	-	-	**-**	-
Other employment benefits	-	-	**-**	-
Termination benefits	34	-	**34**	245
Temporary staff	-	3,793	**3,793**	4,213
Total gross staff costs	**147,355**	**13,233**	**160,588**	**154,015**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**147,355**	**13,233**	**160,588**	**154,015**
Of which				
Costs capitalised as part of assets	13	-	**13**	57

Average number of employees (WTE basis)

	Permanent Number	Other Number	2023/24 Total Number	2022/23 Total Number
Medical and dental	50	27	**77**	74
Ambulance staff	-	-	**-**	-
Administration and estates	845	58	**903**	852
Healthcare assistants and other support staff	586	33	**619**	578
Nursing, midwifery and health visiting staff	895	54	**949**	898
Nursing, midwifery and health visiting learners	4	-	**4**	10
Scientific, therapeutic and technical staff	578	20	**598**	558
Healthcare science staff	-	-	**-**	-
Social care staff	-	-	**-**	-
Other	50	1	**51**	49
Total average numbers	**3,008**	**193**	**3,201**	**3,019**
Of which:				
Number of employees (WTE) engaged on capital projects	-	1	**1**	1

Reporting of compensation schemes - exit packages 2023/24

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	-	-	**-**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**-**	**-**	**-**
Total cost (£)	£0	£0	**£0**

Reporting of compensation schemes - exit packages 2022/23

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	1	-	**1**
£10,000 - £25,000	-	-	**-**
£25,001 - 50,000	-	-	**-**
£50,001 - £100,000	-	-	**-**
£100,001 - £150,000	-	-	**-**
£150,001 - £200,000	-	-	**-**
>£200,000	-	-	**-**
Total number of exit packages by type	**1**	**-**	**1**
Total resource cost (£)	£10,000	£0	**£10,000**

Exit packages: other (non-compulsory) departure payments

	2023/24		2022/23	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	**-**	**-**	**-**	**-**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Thank you for taking the time to read our Annual Report and Accounts for 2023-2024. You can also view this document on our website at www.leedscommunityhealthcare.nhs.uk where you can also find the full accounts.

If you would like hard copies of this report or an accessible version of the financial statements and notes on pages 119-174, please email **lch.comms@nhs.net**

Our Quality Account is also available on our website.

If you would like any of our reports in an alternative format or large print please email **lch.pet@nhs.net** or call **0113 220 8585**.