NHS
Leeds Community Healthcare
NHS Trust

Annual Report
and Accounts 2021-2022

Contents

Foreword

There can only be one way to open this year's Annual Report and that is by saying a heartfelt thank you to all our Trust colleagues, both clinical and corporate, for their continued hard work and their dedication during another challenging 12 months. The effects of the pandemic over this past two years have created continuous pressure and challenge beyond anything we have previously experienced and the Trust and the City are entirely grateful for your resilience, your commitment, your dedication and your immeasurable contribution to the health and welfare of our citizens. So, thank you.

This year we have been strengthened by our continued learning and our further experience and we have delivered our services in an even smarter, more considered and more effective manner. Unlike last year we have had more time to think through how we could do things in a much more informed and efficient way. We made more decisions locally. We sharply focused our priorities as a Trust (and as a key part of the wider Leeds Health and Care system) on patient need and we critically assessed those elements of services which we should continue, enhance or, indeed, which we could pause.

There have been many highlights and significant accomplishments during the year. We have a real determination to work in partnership so that we can offer the people of Leeds and West Yorkshire services that truly meet their needs. The Vaccination Programme is a significant example of all partners in the City working together in the best interests of the community that we serve. More than 150 members of this Trust, both substantive and bank staff, remain part of the Leeds COVID-19 vaccination workforce and the Trust's Director of Operations continues to hold the Senior Responsible Officer role for the programme.

We are at the forefront of supporting people across Leeds experiencing new, long-lasting health problems, 12 or more weeks after a confirmed or suspected COVID-19 infection through the multi award-winning Leeds Long Covid Community Rehabilitation Service. Another successful partnership between Leeds Community Healthcare NHS Trust and Leeds Teaching Hospitals NHS Trust. So far over 1,500 people have accessed this service.

We have worked in collaboration with Primary Care to launch integrated wound clinics, delivered jointly with staff from this Trust and from GP practices, providing those patients who are mobile with an additional and convenient way to access wound care.

We have been particularly pleased to develop and implement the organisation's first Third Sector Strategy. It has been co-produced with Forum Central, the umbrella organisation for the third sector in Leeds, and designed to consolidate and further increase partnership working towards improving health outcomes for the people of Leeds. Together with Leeds Older People Forum we have launched the Enhance Programme, which is making available £25 - £100,000 grants to third sector organisations to test and develop partnership approaches that support safe and sustainable discharge from hospital into a secure home environment, avoiding both delayed discharges and readmissions.

The NHS has been very clear that health services should be delivered as close as possible to people in their own homes and communities and within local neighbourhoods. We have highlighted just a few areas where we are strongly developing integrated working and co-delivery between Leeds Community Healthcare NHS Trust (LCH) and the third sector

and other partners. There is still much more that we must do and we will continue to work with partners and communities to support this continued and essential focus.

We have also and importantly continued our focus on staff health and wellbeing by building on our established culture of openness and support. This includes refreshing our support offer for colleagues with everything from financial to emotional issues and introducing support groups for cohorts of staff including shielding staff; staff with children; a men's group and launching a new Health and Wellbeing Engagement Group.

We once again were overwhelmed by the kindness and generosity of people and organisations who have donated goods to support our teams. Every donation was gratefully received, and we are sincerely appreciative.

We are extraordinarily proud of all our staff and partners that work across Leeds. We look forward to continuing working with you over the coming year with a view to be the best we can be and play our part in improving and supporting the physical and mental health of every citizen in Leeds.

Brodie Clark CBE
Chair

Thea Stein
Chief Executive

About the Trust

How we work

Leeds Community Healthcare NHS Trust serves a population in Leeds of approximately 868,000 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 3,260 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, Specialist Services and Children and Families Services. The three business units are supported by Corporate Service teams.

Adult Services

- 13 Neighbourhood Teams
- 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
- Community Neurology Rehabilitation Unit (currently closed)
- Speech and Language Therapy (SLT) Services; Adult Learning Disability SLT, 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
- Prison Healthcare (Wetherby Young Offenders Institute, and Adel Beck Secure Children's Home)
- Healthcare services for police custody suites across Yorkshire and the Humber
- Liaison and Diversion (Hull and Humber)
- 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) Hubs:
  - Child Development Centre
  - Occupational Therapy
  - Physiotherapy
  - Community Paediatrics
  - Paediatric Neurodisability Clinics
- ICAN Citywide Services:
  - Child Protection Medical Service,
  - Growth and Nutrition Adoption and Fostering Springfield
  - Audiology
- Child and Adolescent Mental Health Services (CAMHS):
  - 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
- Continuing Care and Health Short Breaks
- Inclusion Nursing Service
- Hannah House
- Children's Community Nursing Service
- Children's Speech and Language Therapy
- 0-19 Public Health Integrated Nursing Service (0-19 PHINS)
- Watch-It 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 staff, and using our resources wisely to continually improve services. 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 equality of service delivery to different groups throughout the organisation. We continue to raise awareness of race equality and support our Race Equality Network's 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 far more effectively.

We have continued to work on improving the way we learn from measuring clinical outcomes. This includes working with partners and commissioners to use outcome measures for pathways and supporting Leeds-wide health management work for patients. We have developed access to more meaningful data, joint working between clinicians, commissioners and other partners and shared learning between services. We are also improving the way we discuss clinical outcome measures as part of shared decision making with patients. We are making better use of the data available to deliver the best possible care to all our service users and to meet our aim of improving health equity in the City.

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 hold three values close to our heart:

- 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.

Everyone at the Trust aims to uphold these values and achieve the vision by following seven 'How we work' behaviours:

Leeds Community Healthcare's strategic goals

The Trust Board agreed four strategic goals for 2021/22:

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

The continued COVID-19 pandemic has impacted on many aspects of our work. These strategic goals guided our approach to responding to and recovering from each wave of the pandemic, working with our health and social care partners to meet the needs of patients whilst looking after the health and wellbeing of our staff.

Key risks

In 2021/22 we identified and managed 20 strategic risks connected to our goals. These are grouped in the four following themes and the level of assurance given for the management and mitigation of these risks is reported to the Trust Board at each of its meetings:

- Failure to provide high quality, safe, equitable and clinically effective services that reflect and respond to the needs of the whole population served, particularly within the context of the pandemic.
- Failure to engage and empower the Trust's workforce and to recruit, retain and develop staff, and failure to work in a resilient and safe environment.
- Failure to deliver integrated care closer to home, as a result of failing to work in partnership with stakeholders to deliver service solutions.
- Failure to maintain a viable and sustainable organisation and failing to make sure our information technology systems are adequate, and our data is secure.

During our continued response to the pandemic the most significant issue has been the capacity of services which had been altered due to national guidelines and social distancing requirements, as well as staff absence during the pandemic. There was a risk that we would not be able to deliver services in a timely and equitable manner and additional sources of assurance were included in the Board Assurance Framework to make sure that the risk was managed effectively.

Our business continuity arrangements have been severely tested during the pandemic. We have responded to the challenges by understanding where the system pressures were, and then flexing our workforce accordingly.

The Performance Overview in this report describes how the Trust managed its strategic risks in order to achieve our goals during 2021/22. 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 34 of this report.

Performance Overview Report 2021/22

In their Foreword to this Annual Report, the Trust Chair and Chief Executive have commented on how 2021/22 was another challenging year for the Trust and its staff, as we continued to respond to the COVID-19 pandemic. However, as they noted, it was not a year without achievement. Our staff responded magnificently to each new wave of challenge, stepping up to meeting additional demands, beginning to reduce waiting lists, developing new services, introducing new ways of working with patients and supporting each other as the Trust developed its staff health and wellbeing support offers.

Despite the challenges of COVID-19, we strove to provide the best possible services every day to all the communities we serve.

The Trust Board seeks assurances about the services we provide through a wide range of formal and informal processes. Due to COVID-19, Board members were not able to visit our services and talk to staff and patients as often as they would like. Our formal governance processes have continued as 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.

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.

In the following sections we outline how we delivered against our priorities for the year and then go on to present our performance against key performance indicators.

Trust Priorities

Our five Trust Priorities for 2021/22 were agreed by the Board to drive achievement of the Trust's four strategic goals and support delivery of system priorities. The Trust Priorities were developed during our response to the COVID-19 pandemic at a time when there was some expectation that services would be able to return to normal during the year; that proved not to be the case. Whilst the ongoing response to COVID-19 has taken precedence, progress in other areas has been made.

The Trust has fundamentally changed the way we work to maximise our ability to meet the evolving needs or our communities, and to improve the health and wellbeing of our patients, families, carers and staff. Innovating and developing our services is the way we do things at Leeds Community Healthcare NHS Trust to make sure we continue to deliver high quality care.

In 2021/22 we took a qualitative focus to measuring progress on our priorities, meaning we have tried to capture how our priorities are making a difference where they matter most: in the communities we serve.

You can read more about our services throughout this Annual Report and in our Quality Account which can be found on our website:
https://www.leedscommunityhealthcare.nhs.uk/about-us-new/access-to-information/quality1/

Priority 1 - Build our services back better

We planned for the reset and recovery of all services that had stopped or paused during wave 1 of the pandemic. We sought to address any backlogs that had been created in services and worked proactively to embed any new changes and innovations that had been created as a result of the unprecedented circumstances of COVID-19.

A key part of our approach was to support patients with much improved self-management resources and information. We have:

- Enhanced patient experience by providing greater choice, and timely information.
- Increased treatment options available to patients through a range of self-management materials.
- Increased service delivery capacity through enabling appropriate self-management of conditions by patients.
- Improved waiting list management for services by increasing efficiency of patient flow from point of referral to treatment.

We know there is still much more to do and are working hard to do it.

Digital technology

We have continued to develop innovative ways of using digital technology to offer different means of accessing and experiencing our services, where it is right for our patients.

We know that digital services such as virtual appointments are not for everybody, but where patients do want to access services digitally, we are working with partners in the City to make sure they are not excluded from doing so by lack of equipment or knowledge. We have made a small start; using the Trust's Charitable Funds we have provided 20 tablets with pre-loaded sim cards to unpaid carers accessing LCH services to allow virtual access to services, appointments and healthcare information. A further 20 will have been provided early in 2022/23.

Improving our services

At LCH we continually aim to improve our services and highlight just two examples here.

We have supported a 'Home First' project which is an ongoing improvement to the hospital discharge pathway in Leeds. In July 2021 we supported Leeds Teaching Hospitals NHS Trust Rapid Improvement Week, involving many partners such as Adult Social Care, local commissioners and the charity sector. In September 2021 we ran several workshops with citywide partners to design and put in place the Transfer of Care (ToC) Hub in Leeds and continue to support this work with the Hub which is now operational.

Our Cardiac and Respiratory Rehabilitation Service has used learning from the COVID-19 pandemic to further develop their programmes offering a more person centred and flexible approach including face-to-face, digital and home-based options. We also ran a successful seven-month pilot with Leeds City Council, Active Leeds to offer a personal cardiac rehabilitation physical activity programme using a health coaching, goal setting approach. 195 people went through the pilot choosing a wide range of activities. Early results and patient feedback are extremely positive. We aim to continue to expand and develop the programmes making sure that they are flexible and personalised.

New services

Although the focus has been very much on re-establishing and improving our existing services, we have worked with our commissioners to introduce new services.

- A new Child and Adolescent Mental Health Service (CAMHS) crisis helpline has been set up to support young people with mental health concerns. The service is now fully integrated within CAMHS and continues to have wider system benefits such as reducing patient flow in hospital settings.
- The Long Covid Rehabilitation Pathway was set up to support people whose lives have been significantly impacted by new, long lasting symptoms 12 weeks or more after a confirmed or suspected COVID-19 infection. The team has set up three clinics across Leeds as well as seeing patients in their homes when required and now has a team consisting of Physiotherapists, Occupational Therapists, Therapy Assistants, Psychological Therapists and Clinic Fellows who have supported over 1,500 patients. The service has won a number of awards; you can read about them on page 20.

Priority 2 - Play a full part in '#TeamLeeds' ongoing response to COVID-19, standing ready for further surges, supporting the Vaccination Programme, supporting system resilience and patient flow

The Leeds COVID-19 Vaccination Programme continued throughout 2021/22, responding efficiently and quickly to national guidance and public demand. By 31 March over 1.6 million doses had been administered through a 'Team Leeds' approach.

Vaccinations have been delivered in a range of settings including: 19 Primary Care Networks, 15 Community Pharmacies, a Community Vaccination Centre at Elland Road, 60 schools, community venues, Care Homes, shopping centres, faith centres, a vaccine bus and to people who are housebound.

More than 150 members of the Trust, both substantive and bank staff, remain part of the Leeds COVID-19 vaccination workforce. Many other members of our staff contributed their time and expertise to the infrastructure and running of the Vaccination Programme in areas including finance, human resources, training, project management and eRostering.

Throughout the pandemic LCH staff along with staff from partners in all sectors across Leeds worked flexibly to support colleagues. Sometimes this required them to work in services or teams unfamiliar to them. Staff were supported by their new colleagues and offered training to develop the skills and competencies needed to work confidently. We would like to thank everyone for working in this way as this allowed us to maximise capacity across our services and respond quickly to areas with greatest pressure.

Working closely with our partners at Leeds Teaching Hospitals NHS Trust we know how much pressure they have been under as a result of continuing COVID-19 admissions, responding to patient demand and the challenges of discharging patients safely, in a timely way. Our service developments throughout the year focussed on making sure the Leeds Health System works as well as it can by providing alternatives to hospital care.

- **The Community Intravenous Administration service (CIVAS)** commenced home administration of Sotrovimab for clinically extremely vulnerable COVID-19 positive patients.
- **The Homeless Health Inclusion Team (HHIT)**, are a partner (alongside Bevan Healthcare, Leeds City Council, and Leeds and York Partnership NHS Foundation Trust) in delivering the new Leeds Out of Hospital Coordinated Housing, Health and Care project for homeless people. This is already seeing success in improving outcomes for people and the project will continue to learn about approaches that can reduce the risks to their health.
- **The Virtual Ward Respiratory** continued to grow and, working with Leeds Teaching Hospitals NHS Trust, developed appropriate referral criteria to make sure the ward consistently reached maximum capacity.
- **Enhanced Community Response** – As part of the development of an urgent community response offer for Leeds, there has been continued progress to increase the capacity and capability of the Virtual Ward (Frailty). Over the period October 2019 to March 2022 this new service saved 12,100 bed days.
- **Therapy Supported Discharge (TSD)** - The team is providing support to all patients in Discharge to Assess beds. They are also assisting with complex discharges from hospital and providing an intense rehabilitation offer to the patient. Recruitment into the team is continuing in the next month along with the support into the Transfer of Care Hub.

Priority 3 - Promote and support the health and wellbeing of our workforce

At LCH, caring for one another is one of our seven behaviours, and Wellbeing and Inclusion are two of the key themes outlined in our LCH Workforce Strategy.

The 2021 NHS Staff Survey results show that 74% of staff agree that their manager takes a positive interest in employee health and wellbeing (up 1% from 2020).

During the year we focused on the health and wellbeing needs of diverse communities and groups within LCH. 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 regular 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.

A new Equality, Diversity and Inclusion Forum was launched in October 2021, chaired by the Trust Chair, which will 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.

To effect change on changing language used thought the Trust the Race Equality Network has encouraged conversations about inequality and cultural awareness through our education programmes Allyship and Reverse mentoring programmes.

The network has also helped facilitate an increased visibility of staff from Black and Minority Ethnic (BME) background on recruitment panels and improved cultural awareness by linking into national campaigns and religious holidays, and sharing personal stories through our internal communications channels all of which have been well received.

LCH has received accreditation as a Disability Confident Leader, one of only 22 NHS Trusts, in recognition of the public commitment shown, and progress being made in Equality and Diversity.

LCH believes in workplaces where all LGBTQ+ people are accepted without exception and promotes this through the NHS Rainbow badge, which currently has over 600 staff members, who are Rainbow Ambassadors. LCH secured one of only 40 places, to be involved with Phase II of the Rainbow Badge initiative, moving away from pledge based towards an assessment model; Bronze, Silver or Gold. A Rainbow Ambassadors Group actively participates in LGBT History Month and Pride Month.

Staff health and wellbeing

As is the case across the NHS and wider society, the pandemic and its associated challenges has led to heightened absence amongst our workforce, with high levels of absence correlating with surges in the pandemic. You can read more about sickness absence on page 65.

We made workforce health and wellbeing a key priority for 2021/22 and enhanced our support for staff through:

- Appointment to an additional Clinical Psychologist role focused on workplace wellbeing.
- Targeted support for teams identified as particularly under pressure/experiencing the impact of the pandemic.
- Improved communications and promotion of broad range of health and wellbeing interventions and support available for staff.
- Continued focus on Employee Voice, including regular Team LCH and cohort-specific discussion and feedback sessions, weekly engagement with Trade Union colleagues, and additional promotion of our award-winning Freedom to Speak Up service.
- Refreshing our support offer for colleagues with everything from financial to emotional matters (known as our Feel Good Pledge).

- Refresh of the Staff Health and Wellbeing Engagement Group, with Non-Executive Director, Rachel Booth appointed as the Trust Board Wellbeing Guardian.
- Introduction of Schwartz Rounds.

As living costs rise, a closer focus is being made to Financial Wellbeing, with work to promote pensions uptake, a review of InstantPay introduced for bank workers, and access to financial advice available through the Employee Assistance Programme.

Priority 4 - Develop integrated provision with a stronger focus on prevention, self-management and pro-active care

Please see system wide project updates under priority 2 on page 13.

The care that we provide is not provided in isolation. Often our patients will also be receiving care or support from other organisations and we want to make sure that organisational boundaries do not impact adversely on that care. We have a strong partnership ethos and have developed this even further during 2021/22.

Our **Community Cancer Support Service** has been successfully rolled out to seven Primary Care Networks (PCN) in Leeds. Providing personalised care and support for patients living with and beyond cancer. It evaluated very positively with both patients and professionals in November 2021 and in 2022 has secured an additional year's funding from Macmillan Cancer Support to continue the development of the service.

During the year we have started our work with partners in the Third Sector to:

- Develop more inclusive, accessible services.
- Connect better across shared agendas.
- Develop self-management approaches.
- Co-produce services.

Together with Leeds Older People Forum we have launched the **Enhance Programme**, which is making available grants of £25 - £100,000 for third sector organisations to test and develop partnership approaches that support safe and sustainable discharge from hospital and neighbourhood teams into a secure home environment, avoiding both delayed discharges and readmissions. Leeds Older Peoples' Forum is managing the scheme which builds on learning from the Time to Shine programme.

We have worked with our partners in primary care to open, at pace, **integrated wound clinics** in four different areas of Leeds, which are staffed jointly by our staff and GP practice staff. Seeing patients in the clinics will increase capacity in our Neighbourhood Teams and GP Practices; at the same time giving patients who are mobile an additional method of accessing wound care.

In partnership with primary care in the city we launched our **integrated diabetes service**, providing a specialist workforce to facilitate integration, develop care pathways, and manage variation in diabetes care.

Priority 5 - Work pro-actively across the organisation and with #TeamLeeds to understand and improve health equity

The Board approved out Health Equity Strategy in May 2021 committing the Trust to work pro-actively and at greater pace to improve health equity.

Equity is being embedded in proactive approaches within our services and corporate quality functions, including research, evidence-based guidance and outcomes. It will be part of the review of incidents and within patient experience to understand any inequalities affecting particular communities or communities we are not hearing from and why, and act to address these.

We know:

- People in the most deprived areas wait an average of 1.2 days less than the rest of the population.
- 41% of people on the waiting list are in the most deprived quintile which is slightly more than the % of the Leeds population in the lowest quintile, but reflective of the higher rates of referrals for patients in more deprived areas; and higher prevalence of key conditions.
- At an aggregated ethnicity level, there is very little difference in average number of days waiting between people from aggregated minority ethnic groups (0.8 days less) and white patients.
- Nearly 80% of Black and Black British people on the waiting list live in the most deprived areas.
- Over half of other minority ethnic groups on the waiting list live in the most deprived areas.

We are committed to improving our understanding of our health inequity, committed to improving our services in response and committed with partners to improving health equity for all the communities we serve.

During the year the Trust supported six Third Sector partner bids for NHS Charities Together funding to address the medium to longer term impacts on inequalities that have been made more challenging due COVID-19 and to increase the strength of individuals and communities.

The bids by Basis Yorkshire and BID Services were successful. BID services funding will support the emotional and physical wellbeing of adults who are deaf, hard of hearing, visually impaired and dual sensory impaired by enabling BID services to provide befriending support and peer support groups. Basis Yorkshire funding will improve access to services for women sex workers, it will enable continued employment of a project worker to build on work with staff in GP practices to increase awareness and improve effectiveness of staff and systems to engage with women sex workers.

Operational Performance

The Board approved a wide range of Key Performance Indicators (KPIs), across six domains, safe, caring, effective, responsive, well-led and finance to measure operational performance during the year.

For many KPIs the impact of the pandemic in 2021/22 and 2020/21 meant that performance deteriorated on a number of indicators, making like for like comparison with previous years meaningless in trying to assess the Trust's performance. However, where a significant, sustained trend is identified, it is identified within this section.

The Board and its Committees maintained scrutiny on all the KPIs throughout the year, seeking assurance that the Trust's performance was as good as it could be across all domains, as the pandemic impacted on all services.

That impact was most pronounced in the responsive section where our performance of 84% waiting under 18 weeks for an appointment in a Consultant led service compares poorly with 94% in 2019/20. We remain determined to return to, and improve on, this as soon as we can.

All the Performance Reports considered by the Trust Board are available as part of the Board papers on our website **https://www.leedscommunityhealthcare.nhs.uk/about-us-new/board-of-directors/board-papers-and-meetings/**

Safe

The Trust made the delivery of safe services throughout the pandemic an absolute priority, recognising the increased risks of harm to our patients from staff unavailability, lockdowns and patient isolation. We saw an increase in patient safety incidents reported as harmful (from 1.37 per thousand contacts to 1.98) but this remained within our acceptable range. Most patient safety incidents result in no injury or minimal harm. We strengthened our processes for managing our patient safety incidents, ensuring we identify as much learning as possible to reduce the recurrence of harmful incidents. As an example, a focus on reducing harm from patient falls in their own home, resulted in a 43% reduction in major harm fall incidents in 2021/22.

We continue with an intense focus on elimination Category 4 pressure ulcers and reducing to an absolute minimum the number of Category 3 pressure ulcers. Whilst in 2021/22 there was one Category 4 pressure ulcer, this was reduced from four in 2020/21, and 12 in 2017/18. Category 3 pressure ulcers have reduced from an average of 11 over the previous four years to two in 2021/22. Our Neighbourhood Team staff have worked under very difficult circumstances throughout the past two years; the very significant reduction in incidences of pressure ulcers is a testament to their focus and professionalism.

Caring

LCH treats every complaint very seriously and seeks to learn from any occasion when we did not get it right for our patients. Whilst complaints were lower during the pandemic at 102 in both 2020/21 and 2021/22 than they have been in the preceding year, 203 in 2019/20, we draw no conclusion from that as, regrettably, we were unable to provide the same quantity of service during the pandemic as we had previously.

We remain delighted that those patients who choose to rate our services highly in the Friends and Family Test surveys take the time to do so. Indeed, the percentage of people reporting a very good or good experience in community care has been over 93% for the

last five years, and despite the consequences of the pandemic on how services have been delivered, reached 94% in 2021/22. We recognise that, at 4,283 respondents, this is only a very limited snapshot of how patients feel about our services and we aim to improve our engagement with patients in 2022/23.

Effective

LCH will always seek to provide the highest quality evidence-based care. Implementing NICE guidelines has remained a priority during COVID-19 but the capacity to do this fully has been impacted by the pandemic response. Nonetheless, 93% of relevant guidelines from 2019/20 have been implemented and 96% from 2020/21.

LCH were eligible for and participated in four national clinical audits and one national confidential enquiry for the services the Trust delivers. We took part in all national audits applicable to the organisation. In addition, LCH reviewed 88 audit reports from local clinical audits and identified learning where appropriate. Low risk audits were paused between November 2021 and April 2022 due to capacity and demand difficulties across the services, however all high-risk audits and low risk audits where resources allowed continued.

We wish to make sure that outcomes for patients are excellent and have been continuing to develop ways in which we can effectively measure those outcomes. Whilst therapy outcome measures are in use across ten services in the Trust, developing and implementing a reliable and reportable system of measuring clinical outcomes across many more services will:

- Allow greater public transparency and accountability.
- Provide clinical staff a better basis for judging and improving their practice.
- Offer patients an improved basis on which to make improved choices about their care.
- Provide better evidence for the planning and improvement of services.

Responsive

The impact of COVID-19 on our services has been seen most starkly in the length of time many patients are waiting for our services. Prior to the pandemic our waiting time performance was good with over 94% patients in the three preceding years receiving treatment in under 18 weeks. It is a testament to all our staff that the percentage of patients waiting under 18 weeks fell no lower than 84% (reportable) and 88% (non-reportable) in 2021/22. However, we are acutely conscious that these numbers hide many people who are currently waiting too long for our services. The very significant fall in the percentage of patients waiting less than six weeks for a diagnostic test, from 88% in 2019/20 to 39% in 2021/22 has been unavoidable due to COVID-19 but, again, we know the impact this has on patients. We are sorry for any delays patients have had in receiving care; we are determined to recover our services to be at least as responsive to patient need as they were before COVID-19.

Well-led

As you can read elsewhere in this report, we have recognised the impact of the pandemic on our staff both professionally and personally and have sought to support them through a range of initiatives. The impact on our key performance indicators in the well-led domain through both 2020/21 and 2021/22 has been significant.

Since October 2021 we have seen an increase in the number of staff leaving the Trust. During the height of the pandemic, as turnover rates reduced significantly it was anticipated that there would be a rise in turnover due to a recovery in the labour market, increasing employment rates, a decrease in unemployment rates and a shortage of registered professionals nationally. This has been our experience. In March 2020 the turnover rate was 12.6%, falling to 10.2% a year later but rising to 13.9% in March 2022. Turnover rates for the nursing and midwifery staff group were high towards the end of the year which resulted in higher vacancy rates in this staff group. The main reasons for leaving were cited as voluntary resignation, for work life balance and promotion. The Trust has responded to this through a range of recruitment initiatives such as international recruitment, recruiting from within our local communities and the development of several clinical apprenticeship roles. Retention of our existing staff is a critical resourcing initiative for us in a tight and exceptionally competitive labour market.

Short term sickness rates increased throughout 2021/22 with a particularly sharp increase in the second six months, rising to 2.8% in March 2022. Immediately prior to the pandemic, short-term sickness was 2.2%. Long term sickness absence was also significantly higher than expected. The rate of 4.6% in March 2022 comparing with 4.0% in March 2019. The most prevalent reason for long-term sickness was reported by staff as anxiety/ feeling stretched and stress/depression. We have continued to focus on the provision of psychological support for staff and wider emotional wellbeing. We know that with COVID-19 still prevalent and wider economic pressures on staff, looking after our staff's health and wellbeing will be a vital focus for the foreseeable future.

The vast majority 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. Our annual appraisal rates have fallen from 88% immediately prior to the pandemic to in 2019/20 to 79% in March 2022. The Board has consciously relaxed our targets for appraisal in view of the capacity pressures on services but appraisals remain a key part of our support to staff and we will seek to reintroduce the requirement for an annual appraisal as soon as possible. Compliance with statutory and mandatory training has not fallen as much as appraisal rates and at 88% at the end of the year was only 2% less than two years previously. This is because much training is now available online and can be completed by staff at a time that suits them.

It is pleasing to note that whilst there is much work remaining to be done, our Workforce Race Equality Standard (WRES) Well Led indicators and our WRES Staff Survey results for 2021 have improved and continue to do so.

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 our staff to complete it as an important feedback mechanism. 52% of our staff completed the 2021 survey which was up 7% from 2020.

Here is a summary of our results covering support from managers and satisfaction with working life:

Awards and recognition

External awards

During the year, the Leeds Long Covid Rehabilitation team was recognised on both the national and international stage. It has been multi award-winning. The team won; Clinical Leadership Team of the Year award at the British Medical Journal (BMJ) Awards 2021, a Medipex Innovations Award in the Management of Long Term Conditions category and they also won the Healthcare Financial Management Association Finance Award for Close Partnering and Collaboration – Yorkshire and Humber. All a fantastic accolade to the team's outstanding achievements in supporting people with Long Covid.

We were also delighted to win Team of the Year at the Nursing Times awards for our partnership work with St Gemma's Hospice, Bevan Healthcare, Leeds Street Outreach, and BARCA-Leeds for widening access to palliative and end-of-life care for homeless and vulnerably housed people in Leeds.

These are some of the awards we have won. Details of all our awards during the year can be found on our website: **https://www.leedscommunityhealthcare.nhs.uk/our-news/awards/**

Internal awards

We saw a significant increase in the last 12 months for nominations for our internal Thanks a Bunch awards. Staff nominate their colleagues for being shining examples of our Trust behaviours. This year directors presented over 50 Thanks a Bunch awards, personally thanking nominated staff for their continued hard work and commitment.

For the second year running we held our annual staff awards as a virtual 'Thank You' event. Senior managers popped up unannounced in virtual staff meetings to congratulate teams and individuals for their outstanding efforts.

Our Front of House Team won Team of the Year at the Thank You Event in January 2022 for outstanding contribution for staff and patients. As the first point of contact for most services users, staff visiting sites and external contactors and partners, throughout the pandemic they have been resilient, flexible and demonstrated a positive, can-do attitude.

Financial Performance

2021/22 was the second year that Leeds Community Healthcare NHS Trust operated under an emergency financial regime introduced to stabilise the NHS financially during COVID-19.

The Trust was allocated revenue resources within which we managed our day-to-day expenditure and break-even. That resource was allocated through the West Yorkshire and Harrogate Integrated Care System and all the constituent organisations, NHS Trusts and Clinical Commissioning Groups worked together to make sure the System collectively managed the ongoing COVID-19 response and started to address the waiting lists that had built up. The three trusts in Leeds and NHS Leeds CCG worked together in the same way.

During the financial year Leeds Community Healthcare NHS Trust fully assessed its expenditure plans against the revenue income and assessed that it could meet all its financial commitments, begin to address waiting lists and support partner NHS organisations and Leeds City Council in their service obligations. The Trust was also able to invest significantly in launching the Enhance Programme with Leeds Older People's Forum, to test and develop partnership approaches that support safe and sustainable discharge from hospital into a secure home environment.

At no time during the year was a shortage of revenue resources a reason that the Trust was unable to deliver a value for money response to service need; the constraining factor was predominantly the unavailability of staff.

At the end of the year we recorded a £0.5m surplus. This outturn is specific to 2021/22, resulting from the NHS emergency financial regime. The support that we were able to provide to other organisations, the initiatives we were able to progress and the surplus result from the allocation of non-recurrent (or 'one-off') revenue resources and, unfortunately, the level of staff vacancies. Excluding non-recurrent income and expenditure the Trust does have an underlying recurrent deficit. However, at less than 1.5% of turnover and recognising the ongoing challenges of fully recruiting staff to the funded establishment, this is not of undue concern.

The capital resources allocated to the Trust for 2021/22 were £3.1m which was almost fully spent. We were able to commence the total refurbishment of Seacroft Health Centre which will be completed in 2022/23. We continued our strategy of significant investment in our buildings to reduce backlog maintenance, ensuring that they are safe environments for staff and patients with over £620,000 being invested specifically in fire safety works across our estate. Once again, we continued to invest in new and replacement clinical equipment and maintained significant investment levels in information technology.

Key Financial Duties	Plan	Outturn	Variance	Performance
Surplus on income and expenditure	£0k	£492k	£492k	✔
Remain with External Financing Limit *	£160k	£160k	-	✔
Remain within Capital Resource Limit *	£3,123k	£3,123k	-	✔
Capital Cost Absorption Rate	3.50%	3.50%	-	✔
Agency	£4,306k	£3,599k	-£707k	✔
Better Payments Practice Code:				
Non NHS invoices - number	95%	96%	+1%	✔
Non NHS invoices - value	95%	98%	+3%	✔
NHS invoices - number	95%	99%	+4%	✔
NHS invoices - value	95%	100%	+5%	✔

* targets confirmed after year end

Leeds Community Healthcare NHS Trust has an excellent track record of meeting its income and expenditure financial targets every year since its creation in 2011/12. Looking forward, whilst I am confident that Leeds Community Healthcare NHS Trust will operate within allocated revenue and capital resources in 2022/23 there is no doubt that, at the time of writing in May 2022, the financial outlook for the NHS generally is challenging in terms of the indicative resources available, the current economic conditions and the high expectations that patients quite rightly have of the NHS generally and Leeds Community Healthcare services specifically.

I have no doubt that the Trust will do as it has done throughout the challenges of COVID-19, striving to provide the best possible care for the communities we serve whilst remaining within the financial resources available.

Bryan Machin
Executive Director of Finance and Resources

Legal obligations and how we are fulfilling these

Improving Health Equity

We have a statutory duty under the Equality Act 2010 that focusses on opposing discrimination on the grounds of protected characteristics.

In May 2021 LCH 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.

You can read more about our Health Equity Strategy in our 2021/22 Quality Account on our website: **https://www.leedscommunityhealthcare.nhs.uk/about-us-new/access-to-information/quality1/**

Emergency Preparedness and Resilience

We are required to adhere to the requirements of the NHS England Emergency Preparedness, Resilience and Response (EPRR) Assurance Process. The purpose of this process is to assess the preparedness of the NHS - both commissioners and providers - against common NHS EPRR Core Standards in order to provide assurance that both the NHS in England and NHS England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care.

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

- A Major Incident Plan which is regularly updated to ensure it is fit for purpose along with management on call arrangements.
- Business Continuity plans to protect against the impact of a wide range of emergency situations which may affect normal service delivery.
- Emergency planning functions to deal with national issues that may affect service delivery. Most recently, planning has involved national issues relating to Coronavirus (COVID-19).

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 the effective implementation of our health and safety arrangements depends on managers, staff and their representatives working together at all levels to ensure that safe working practices are in place.

The Health and Safety Group is the forum that enables staff to be involved in developing, enabling and reviewing the Trust's health and safety arrangements. The group which met six times in 2021/22 is chaired by the Executive Director of 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 ensure the continuous improvement of health and safety performance.

Counter Fraud

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

Modern Slavery 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 NHS organisation suppliers are subject to standard NHS terms and conditions.

Disclosure of personal data related incidents

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

The legislation strengthens the rights of data subjects, while increasing the responsibilities of organisations to process personal data in a lawful and transparent manner. This means that incidents calculated as externally reportable must be reported to the Information Commissioner's Office (ICO), through NHS Digital's Data Security and Protection Toolkit (DSPT).

For details of the personal data related incidents reported by the Trust during 2021/22 please see the Annual Governance Statement (page 34).

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 2020. The strategy sets out LCH's direction of travel and priorities for Safeguarding 2020-2023 and outlines the vision of making safeguarding everybody's business, and recognising safeguarding is fundamental to our duty as care providers.

Duty of Candour

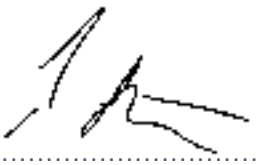
The Quality Committee monitors the Trust's compliance with Duty of Candour requirements on a monthly basis. This ensures that applicable incidents have met the criteria of a safety notifiable incident which are:

- A 72 hour 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. The sort of questions the Trust considers are: do we have contracts to provide sufficient income? Have we enough cash to pay for things we need to run the business (staff and non-staff)? Can we afford to buy any capital equipment we might need? Do we have strong, stable management? Are we meeting external requirements? Do we understand our risks and are they being mitigated and managed appropriately?

The Trust has prepared its 2021/22 accounts on a going concern basis. The Board considered the matter of the Trust as a going concern at its meeting on 31 March 2022. Our formal financial reporting begins on page 67.



Signed ..... **Thea Stein,** Chief Executive

Date 17 June 2022 .....

Accountability Report

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

The Trust's Chair and Chief Executive have led these functions throughout 2021/22.

Here are the people on our Board of Directors as at 31 March 2022

Brodie Clark CBE
Chair

Thea Stein
Chief Executive

Helen Thomson
Non-Executive Director
(Vice Chair)

Richard Gladman
Non-Executive Director

Sam Prince
Executive Director
of Operations

Bryan Machin
Executive Director of
Finance and Resources

Alison Lowe OBE
Non-Executive Director

Professor Ian Lewis
Non-Executive Director

Steph Lawrence
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
Executive Director of Workforce*

*Non-voting members

Changes to the Board

Non-Executive Director Jane Madeley stepped down on 31 March 2021, after serving the Trust for 10 years. Khalil Rehman, who was previously an Associate Non-Executive Director, then took over this role from 1 April 2021.

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 Board has continued with its development programme during the year. It has a programme of workshops to support Board members' development, covering such topics as 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 'fit and proper person test' that was introduced from November 2014.

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.

Director's declarations of interests for disclosure 2021/22

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 in received within the past 12 months: in excess of £35 in connection with the Trust
Brodie Clark CBE (Trust Chair)	Clark Advisory Ltd-business closed October 2021	None	None	None	None	None	None	None
Thea Stein (CEO)	None	None	None	Trustee of Nuffield Trust CQC Executive reviewer	None	None	None	None
Helen Thomson	Helen Thomson Ltd	Director Helen Thomson Ltd	None	Trustee: Sue Ryder Council Member University of Huddersfield until August 2021	Trustee: Sue Ryder Executive Director of Pennine Acute Hospitals NHS Trust -Appointment ended 30 September 2021	None	None	None
Alison Lowe (from 1 Dec 2020)	None	None	None	Chief Executive Touchstone until 6 August 2021 Trustee Citizens Advice Leeds Trustee at Together Women, a charity working with women offenders	Trustee Citizens Advice Leeds Chair of Leeds Survivor Led Crisis Service-appointment ended January 2022	None	Deputy Mayor for Policing and Crime in West Yorkshire from 9 August 2021	None
Richard Gladman	Director of Verbena Digital Ltd	Verbena Digital Ltd	Verbena Digital Ltd	None	None	None	None	None
Prof Ian Lewis	None	None	None	Trustee: Rossett School Harrogate	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 share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Khalil Rehman	NED, Salix Homes Ltd	None	None	Director, Medisina Foundation Ltd Non-Executive Director East Lancashire Hospitals NHS Trust	Advisory work for Touchstone	None	None	None
Rachel Booth (Associate Member)*	None	None	None	None	Full time employee of BUPA which contracts with NHS through its Cromwell Hospital, Dental and Care Homes business areas	None	None	None
Bryan Machin	None	None	None	Trustee (from January 2020) and Vice-chair (from November 2021) of St Anne's Community Services. (Registered Charity, Housing Association and Company Limited by Guarantee)	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.	None	None	None	None
Sam Prince	None	None	None	None	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 share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Any other area of potential conflict	Details of any hospitality or gift in received within the past 12 months: in excess of £35 in connection with the Trust
Steph Lawrence	None	None	None	Executive Director of Nursing and AHPs for Leeds GP Confederation. National Professional Advisor for Community Services for CQC since April 2021. Supporting a domiciliary home care agency since January 2022 – Be Caring who have contracts in Leeds, Liverpool, Manchester and Newcastle. Providing advice around their governance processes including attending their Quality Committee meetings. Fellow of Queen's Nursing Institute.	None	None	None	None
Laura Smith*	None	None	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 (February 2022). Trustee for Hollybank Trust. 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 (February 2022)	None	None	None

*Non-voting members

Board meetings and business in 2021/22

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally eight times during the year, including additional Board meetings that replaced some previously scheduled informal meetings, in order for the Board to progress and monitor its response to the pandemic. 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, and the Board has encouraged the public to attend virtually during the year. The dates are advertised on the Trust's website, with a live link to the meetings, and Board meeting agendas, reports and minutes are published online.

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

In addition, an Annual General Meeting was held on 14 September 2021. This was held virtually in order to comply with Government guidelines for social distancing.

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 in order 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 provides high quality services are overseen closely by the Board.

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

The Board's committees (decision making groups)

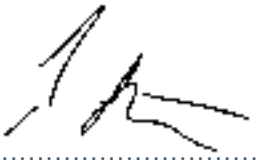
The Trust has five committees that make sure we carry out our duties effectively, efficiently and economically.

Details of the functions of each committee can be found in our Annual Governance Statement 2021/22 which starts on page 34.

In addition, the Trust has two '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.

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



Signed ..... **Thea Stein**, Chief Executive

Date 17 June 2022 .....

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

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

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place 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 ..... **Thea Stein**, Chief Executive

Date 17 June 2022 .....

Corporate Governance Report
Annual Governance Statement 2021/22

Scope of responsibility

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

Thea Stein

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS Trust (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 2022 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 Senior Management 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 a qualified, experienced Risk and Safety Manager who delivers risk management training, coordinates the risk register and provides support and direction in all risk management related matters.

Every member of staff is briefed on the Trust's risk management procedures as part of our induction process and bespoke training is provided to support teams and services with managing risk. Managers are also trained in risk management procedures in their induction process and as part of ongoing training, coaching and support. All training includes awareness of the Trust's approach to risk and how this should be applied in decision-making processes.

There is a 'lessons learned' portal on the Trust's intranet, where managers can share information about incidents, learning and improvements.

There has been a targeted approach to risk management training during 2021/22 in response to a realisation that that some services did not have a suite of suitable and sufficient risk assessments. Individual and group training sessions have been provided, along with an accessible library of risk assessment templates. A training session around a manager's role and responsibilities in staff health, safety and risk management has also been delivered and this has a strong focus on risk assessment technique. Due to pressures imposed on services by the pandemic, only a limited number of training sessions have been delivered.

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.

During 2021/22 there has been a continued focus on ensuring that risks associated with COVID-19 were assessed and mitigated effectively. This included assessments of clinically extremely vulnerable and at risk staff, creating and maintaining COVID-19 secure environments, and ensuring that the large cohort of staff who were suddenly asked to work from home where possible were able to do so safely by assessing their new work space and providing equipment as required.

The Risk Management Policy and procedure is supported by content in a bespoke risk and safety 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. Risks relating to COVID-19 and the Reset and Recovery programme are also captured, assessed, mitigated and reported in the risk register.

The Trust's **risk appetite** is aligned with its four strategic goals. The Senior Management 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 2022 with a particular focus on whether it reflected the changed and difficult climate the Trust continues to work in.

Data security risk is managed through a system of general managers and heads of service or other lead managers who act as information asset owners. These individuals work with the Senior Information Risk Owner to manage data security and other information-related risks. This process has been significantly improved through efforts to ensure the Trust remains compliant with the General Data Protection Regulation (GDPR).

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

- The 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 use of Microsoft Azure (cloud) services for the storage of Trust data files ensures there are multiple copies of data stored geographically, to support recovery should there be a failure in a specific data centre.
- Third party penetration tests designed to identify vulnerabilities in the Trust security architecture. The latest penetration test was completed in January 2022. Any issues highlighted will be incorporated into an action plan to mitigate the threats.
- Business Continuity Plan testing to make sure that the Trust is able to respond to a cyber-attack were tested in April 2021. These tests are repeated on an annual cycle.
- 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.
- Through the Internal Audit Programme a specific Disaster Recovery / Business Continuity Audit has been commissioned, to ensure major clinical system suppliers have adequate arrangements in place to restore data and service following a major incident.

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

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

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. The accurate

completion of key demographic information is monitored via the Data Quality Maturity Index. More specific pieces of work to test out and provide assurance around data quality are carried out on a service-by-service basis.

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). The Trust also has 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.

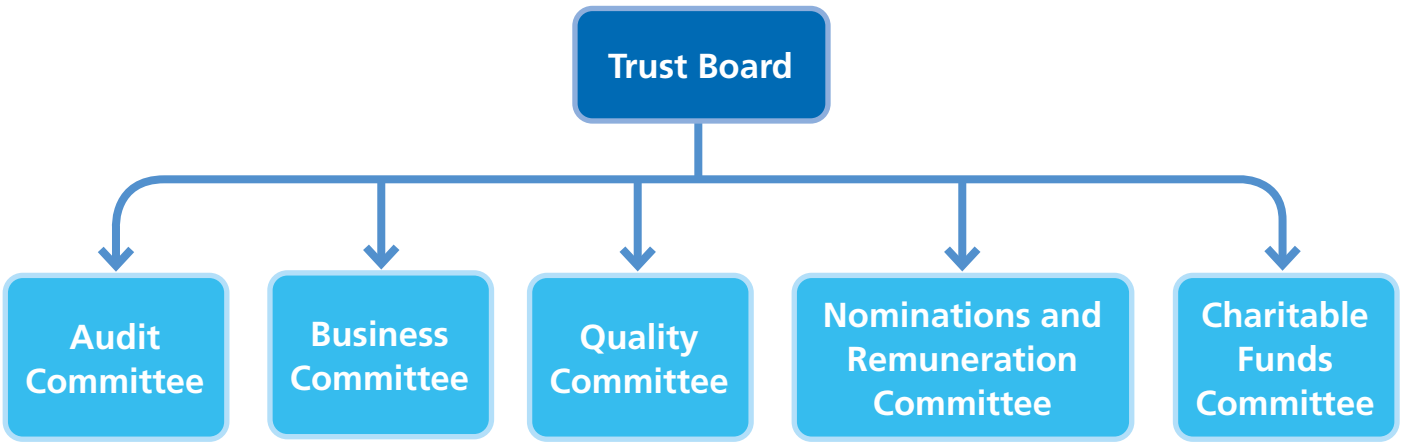
There is a clear division of responsibilities between the Chair and Chief Executive and both have discharged their leadership functions throughout the whole of 2021/22.

The Board met twelve times in 2021/22: eight formal meetings were held in public. During the year, the public was discouraged from physically attending the Trust's premises to attend Board meetings, instead a live link to the Board meetings was published on the Trust's website to allow the public to 'attend' the meetings. The Annual General Meeting was held virtually in September 2021 and by offering various ways of accessing the meeting, reasonably good attendance was achieved. Board member attendance at Board meetings has been good 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 support staff and see them in action. Many visits in 2021/22 took place virtually rather than being actual visits to sites.

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. A temporary amendment was made to the standing orders at the Board meeting on 7 January 2022 in order to respond effectively to the COVID-19 situation which was rapidly escalating. This was to reduce Board and committee agendas to ensure that essential business was covered, and the focus was on patient and staff safety and the Trust's COVID-19 response. This revision was revoked on 31 March 2022 when the system pressures had eased.

The Board's five committees (see diagram below) have Board approved terms of reference and work plans which have been reviewed during 2021/22. 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 get 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 Improvement/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 being reported to the Board and are contained in committees' annual reports. The committee chairs also meet collectively to discuss committee effectiveness.

The Trust has a needs-based Board development programme. In response to the pressures caused by the COVID-19 pandemic, the programme was reduced to allow for additional Board meetings.

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

The Trust has published an up-to-date register of interests 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. It is available on the Trust website.

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 Audit Committee met formally six times during 2021/22 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 Information Governance Group. 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 in order 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 reports. The committees' chairs also met to discuss the flow of business through the committees in November 2021.

Quality Committee

Chair: Helen Thomson

The Quality Committee's membership comprises four non-executive directors and three executive directors with other senior officers also attending each meeting. The Committee met on 10 occasions in 2021/22. Some meetings had their agendas reduced to essential business only during the peaks of the pandemic.

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.

The Quality Strategy for Leeds Community Healthcare NHS Trust for 2021-2024 has been developed during our response to the international COVID-19 pandemic where we have responded to the challenges presented with innovation, standardisation and a focus on improvement.

We continue to work in a challenging landscape and have aimed to incorporate how we will capitalise on the opportunities the pandemic has brought to deliver care in alternative ways. This means we can build our services back better with the learning and experience we have gained from our pandemic response to ensure 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 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 Mental Health Act Governance Group ceased to operate following the transfer of the Child and Adolescent Mental Health Inpatient Service to Leeds and York Partnership NHS Foundation Trust on 1 April 2021.

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 and Serious Incident Management Policy.

Business Committee

Chair: Richard Gladman

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives. Other senior officers attend as required. The Business Committee held 10 meetings in 2021/22.

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 2021/22 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.

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 five times in 2021/22.

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.

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 three times during 2021/22.

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. The Committee has an operational subgroup to support delivery of the Committee's objectives.

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 and Safety 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 2021, 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 Senior Management 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.

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 training and regular communications. Learning from incidents is shared with staff at forums and through a learning resource on the Trust's intranet for all staff to access, which has been developed to share anonymised, learning from incidents across the organisation. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

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

Information Governance

Data security, data ownership and transparency are of paramount importance to the Trust, supporting both clinical and organisational management needs. The Trust is committed to ensuring that personal data is protected, and any confidential data is used appropriately.

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

- Promoting the accountability principle within the Regulation which empowers the organisation to be compliant with the Data Protection Act 2018.
- 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 and also supporting the move to integrated care modelling.

The Senior Information Risk Owner (SIRO) ensures that there is effective information governance in place. The SIRO chairs the Information Governance 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 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 mechanisms 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). During the 2021-2022 reporting year all standards were met.

In recognition of the importance of data security, there is a nationally set target of 95% of staff compliance with information governance training. Training compliance is closely monitored and 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 two incidents to the Information Commissioner's Office (ICO) during 2021/22. Details of the incidents are:

The first breach occurred when confidential patient information was shared in error in an email to a staff member. The ICO concluded the investigation with no further action to be taken but good practice recommendations provide regarding data sharing and information handling.

The second incident was in relation to a letter being inadvertently sent to a parent of a child. The letter was in connection with a safeguarding enquiry and could potentially have led to harm. At the time of writing this report the incident was awaiting an ICO response.

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 seven 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. Regular 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 Senior Management Team meeting and at the Board and its subcommittees' meeting, 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.

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. A new Equality, Diversity and Inclusion Forum launched in October 2021, chaired by the Trust's Chair. The Forum's objectives are 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.

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. During 2021/22 NHS England continued the emergency financial regime introduced the previous year in response to the impact of COVID-19 on NHS services. The Trust had a break-even target for the year and the outturn was a small surplus. The Trust worked in collaboration with partner organisations in Leeds to ensure the best use was made of Leeds' NHS resources. The Trust maintained its financial governance arrangements throughout 2021/22 with the Business Committee and Board continuing to receive financial reports at each of their meetings.

The Trust has a 'use of resources' metric of 1, which means it has a low risk.

During 2021/22 the financial regime for the year included an implied efficiency requirement and as the Trust exceeded its financial target the level of efficiency required was delivered.

The Audit Committee reviews all internal audit reports and monitors how the Trust implements any recommendations. The Trust's external auditors are required to provide a Value for Money conclusion each year.

For 2021/22 the auditors concluded that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2022.

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

Sustainability

The Trust has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust's first Sustainable Development Management Plan (SDMP) and Sustainable Implementation Plan were approved by the Trust Board in December 2020. This committed the Trust to taking environmental issues into consideration during our decision-making processes to avoid the consequences of our actions further on.

The Sustainability Department has now updated and developed the Trust's Green Plan for 2022-2025 and this was approved at the Board meeting on 31 March 2022. The development of the Green Plan, which was a requirement of NHS England and NHS Improvement, NHS Greener programme; is to outline NHS Trusts' plans for the next three years to decrease overall carbon emissions from the collective NHS. Our Green Plan contains in-depth detail of specific goals and aims for each carbon dense areas of the Trust, along with a thorough strategy of how to engage staff and encourage a cultural shift toward sustainable practices. The plan outlines the Trust's commitment to become

Net Zero by 2045 and the impacts this will have across the whole of the Trust following the Trust officially declaring a climate emergency on the 5 November 2021. Over the past 12 months the Trust has made progression in the following areas which has impacted the goals for climate action over the next upcoming year.

Carbon emissions

The Sustainability team has developed the Trusts total carbon emission profile with improved accuracy comparative to previous years. The data and methodology will be accredited by an external company to ensure our results are as precise as possible. These results will act as a strong baseline to judge our future progress against.

Estates

We continue to opportunistically increase the efficiency of our retained sites. An example of this is the renovation of Seacroft Health Centre which when fully renovated will have the following sustainable benefits incorporated:

- A complete switch to low energy LED PIR control lighting; meaning lights will switch off when rooms are unoccupied.
- Recruit technology which automatically switches lights off when there is sufficient daylight.
- Improved insulation throughout the building.
- PV solar array on the roof to generate energy on-site.

Other work over the past year which has added to the sustainability of the Trust is the replacement of the roofs at Bramley and Halton Clinics, as well as the 2nd floor roof at Morley Health Centre which includes thermal insulation in accordance with the requirements of Approved Document Part L of the Building Regulations which will have a positive impact on maintaining heat within the building resulting in reducing energy consumption and cost.

Travel

Mileage throughout the Trust continues to remain lower than pre-pandemic levels, which has been aided with the adoption of new ways of working, such as the use of digital care delivery and the implementation of a hybrid home working model across the Trust. We have also started to place carbon caps on the cars available through the Trusts salary sacrifice and lease car schemes to reduce the emissions from our fleet.

Waste

We have been able to establish the specific waste streams we currently utilise and how this waste is disposed. This is important as we can now identify which waste is disposed in the most eco-friendly manner and where we need to work with our waste providers to improve recycling and greener waste disposal methods. We have started the process of reviewing all the single use plastic products we order throughout the Trust and exploring alternatives that we plan to introduce throughout the coming years.

Staff engagement

Four workshops have been held throughout the past year aimed at engaging individuals through the Trust to express both their concerns and any ideas to the Sustainability team and gather general feedback regarding sustainability. We launched our 'Dear LCH…' pledge campaign where staff members submit their sustainability pledge and express their hopes of the future and we continue to develop and promote the use of the MyLCH Sustainability intranet page. We also circulate a monthly newsletter.

Carbon reduction delivery plans

As estate is our second highest emitting area, we have committed to gradually reducing our carbon impact and emissions throughout our estate over the next 10-15 years. One of our main performance indicators in this area will be our gas, electric and water output which will be monitored closely on a quarterly basis from this year. The table below details our energy usage from 2017-2021, where we can see there has been a steady decline in over the past four years, this in part may be due to the variety of factors such as the pandemic and the opportunistically upgrading of our building facilities. We will continue along this trajectory through the actions highlighted within the Trust's Green Plan with a specific focus on reviewing and targeting building updates and staff energy use awareness campaigns.

Energy Use and Carbon Production

Resource utilities		2017/18	2018/19	2019/20	2020/21
Gas	Use (kwh)	3559853	3032789	3262510	2169056
	kgCO2e	655582.53	557911.86	599812.46	703601.48
	tCO2e	655.58	557.91	599.81	703.60
Electricity	Use (kwh)	3150855	2852896	2656344	2169055.58
	kgCO2e	1066207.30	807569.27	678961.53	460555.57
	tCO2e	1066.21	807.57	678.96	460.56
Total	Use (kwh)	6710708	5885685	5918854	4338111.581
	kgCO2e	1721789.83	1365481.14	1278773.99	1164157.06
	tCO2e	**1721.79**	**1365.48**	**1278.77**	**1164.17**

The method of calculating carbon has significantly improved in accuracy over the past two years. As a result, we have recalculated all the past years with the most valid method so that they are truly comparative.

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.

Review of effectiveness

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.

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.

Thea Stein

Internal audit

TIAA Limited has been the provider of the Trust's internal audit services since 1 April 2015. The Head of Internal Audit has provided an opinion which concludes that for the areas reviewed during the year, Leeds Community Healthcare NHS Trust has reasonable and effective risk management, control and governance processes in place. Not having completed all of the planned work due to the global Covid-19 pandemic has not impacted on our overall assessment.

This opinion is based solely on the matters that came to the attention of TIAA 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 your 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.

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 2021/22, the Trust participated in 100% of national clinical audits and 100% of national confidential enquiries that it was eligible to participate in, as well as completing locally determined clinical audits. More information about these is in our Quality Account (separate document).

CQC compliance

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

NHS England and NHS Improvement oversight

NHS England and NHS Improvement have 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 take action when incidents occur.

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

During 2021/22, no significant control issues have been identified by the Trust's systems of internal control.

Signed  **Thea Stein**, Chief Executive

Date 17 June 2022

Remuneration and Staff Report

Resourcing work has continued to enable us to maximise our workforce capacity and supply in response to the pandemic, recovery from the pandemic and changes to the labour market. This includes, but is not limited to:

- Upscaling the Staff Bank to maximise LCH's flexible workforce capability.
- Improvement to our induction and onboarding processes.
- Alignment of workforce capacity with highest service priorities.
- Capacity enhancing reward measures targeted at priority services and shifts.
- Introduction of 'InstantPay' functionality to enable bank workers faster in-month access to pay for shifts worked.
- Implementation of a new NHS Jobs system.
- Supporting staff to gain settled status in preparation for EU exit.
- Working collaboratively with health and social care partners to address shared resourcing challenges.
- Targeted recruitment campaigns in communities, with universities and across multiple media channels.
- International recruitment pilot of 10 nurses.
- Development of clear career pathways for clinical support workers and business administration.

Turnover rates have increased, standing at 15.0% in February 2022. This correlates with labour market trends, particularly across health and social care. A range of retention measures have been introduced in additional to the resourcing innovations described above.

The overall sickness absence for February was 6.8% consisting of 4.6% long term absence mainly due to stress, anxiety and depression and short-term absence at 2.2%, mostly due to covid-related absences. We are expecting to see the sickness absence rates reduce as we start to come out of the pandemic, which is supported by the recent February figures. Whilst remaining above tolerance, current sickness absence levels are the lowest since September 2021.

Recruitment across the range of LCH vacancies continue to yield strong results, with over 50 more staff recruited than in the previous year, although in line with national trends a number of registered roles are more difficult to fill in the current labour market. 609 vacancies have been advertised and 577 appointments made. The Trust has on occasion recruited additional staff to vacancies in anticipation of future turnover.

A positive employee relations climate is underpinned by LCH's values and behaviours and People Before Process approach, together with a regular schedule formal and informal partnership meetings with Trade Union colleagues and staff network representatives.

Our work in the 'Leeds system' continues, including the development of staff sharing agreements for Leeds, a central role in the Leeds One Workforce Strategic Board,

workforce expertise for the GP Confederation, and the implementation of the innovative Employ / Deploy approach for Primary Care Networks (PCNs).

The start of a Leeds Place Based Partnership (PBP) and the introduction of the LCH Third Sector Strategy both bring further opportunities for working together on shared priorities for the benefit of our Workforce Strategy ambitions, overall business objectives, and, most importantly, our communities.

Partnership Working

The Workforce Sharing Agreement we designed to enable the deployment of NHS staff to care homes in cases of urgent resourcing need has been picked up both regionally and nationally for use by other organisations.

The LCH Employ/Deploy model that we offer to Primary Care Networks (PCNs) continues to see a significant increase in take up with two thirds of PCNs now actively using the model. We employ 44 staff members through the Additional Roles Reimbursement Scheme and a further 22 were employed to staff primary care vaccination centres as needed.

Through joint working with the GP Confederation, we have supported the development and introduction of a suite of employment terms and conditions and policies and procedures for the Confederation.

LCH continues to play a central role in the Leeds One Workforce Strategic Board, which refreshed its priorities during 2020/21. The Director of Workforce is now the lead for Leeds on the Workforce Portability priority, focused on facilitating joint and integrated working between health and care organisations.

Senior managers' remuneration (audited)

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.

	2021 / 2022						2020 / 2021					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Jennifer Allen – Director of Workforce, OD and System Development	50 - 55	-	-	-	27.5 - 30	80 - 85	60 - 65	-	-	-	12.5 - 15	70 - 75
Rachel Booth – Associate Non-Executive Director (from 01.12.20)	10 - 15	-	-	-	-	10 - 15	0 - 5	-	-	-	-	0 - 5
Ruth Burnett – Executive Medical Director	100 - 105	-	-	-	25 - 27.5	125 - 130	100 - 105	-	-	-	25 - 27.5	125 - 130
Brodie Clark CBE – Non-Executive Director (until 07.05.20) Interim Chair (from 08.05.20 to 10.08.20) Chair (from 11.08.20)	35 - 40	<0.1	-	-	-	40 - 45	25 - 30	0.1	-	-	-	25 - 30
Neil Franklin – Chair (until 07.05.20)	-	-	-	-	-	-	0 - 5	<0.1	-	-	-	0 - 5
Richard Gladman – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	80 - 85	6.1	-	-	47.5 - 50	130 - 135	70 - 75	-	0 - 5	-	12.5 - 15	90 - 95

Name and title	2021 / 2022 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	2020 / 2021 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
Ian Lewis – Non Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Alison Lowe – Non-Executive Director (from 01.12.20)	10 - 15	-	-	-	-	10 - 15	0 - 5	-	-	-	-	0 - 5
Bryan Machin – Executive Director of Finance and Resources	120 - 125	-	-	-	-	120 - 125	120 - 125	<0.1	-	-	-	120 - 125
Jane Madeley – Non-executive Director (until 31.03.21)	-	-	-	-	-	-	10 - 15	-	-	-	-	10 - 15
Samantha Prince – Executive Director of Operations	110 - 115	-	0 - 5	-	-	115 - 120	105 - 110	<0.1	-	-	-	105 - 110
Khalil Rehman – Associate Non-Executive Director (from 01.12.20)	10 - 15	-	-	-	-	10 - 15	0 - 5	-	-	-	-	0 - 5
Laura Smith – Director of Workforce, OD and System Development	50 - 55	-	-	-	32.5 - 35	85 - 90	55 - 60	-	-	-	7.5 - 10	65 - 70
Thea Stein – Chief Executive	150 - 155	<0.1				150 - 155	150 - 155	<0.1				150 - 155
Helen Thomson – Non Executive Director (from 01.05.19)	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15

Total remuneration for senior managers with shared responsibilities

	2021 / 2022						2020 / 2021					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Jennifer Allen – Director of Workforce, OD and System Development	60 - 65	-	-	-	35 - 37.5	95 - 100	70 - 75	-	-	-	12.5 - 15	85 - 95
Ruth Burnett – Executive Medical Director	130 - 135	-	-	-	30 - 32.5	160 - 165	130 - 135	-	-	-	30 - 32.5	160 - 165
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	100 - 105	7.7	-	-	57.5 - 60	165 - 170	90 - 95	-	0.5	-	17.5 - 20	110 - 115
Laura Smith – Director of Workforce, OD and System Development	60 - 65	-	-	-	37.5 - 40	100 - 105	65 - 70	-	-	-	10 - 12.5	80 - 85

Pension details for senior managers (audited)

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 2022 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2022 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2021 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2022 £'000
Jennifer Allen – Director of Workforce, OD and System Development	0 - 2.5	2.5 - 5	20 - 25	40 - 45	330	29	369
Ruth Burnett – Executive Medical Director	2.5 - 5	0 - 2.5	15 - 20	30 - 35	323	9	267
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals	2.5 - 5	2.5 - 5	30 - 35	75 - 80	590	56	662
Laura Smith – Director of Workforce, OD and System Development	0 - 2.5	2.5 - 5	25 - 30	55 - 60	378	31	419

No other senior managers are members of the pension scheme.

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.

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).

Compensation payments for loss of office

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook.

Fair pay disclosures

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 2021/22 the Trust's staff were paid annualised salaries ranging from £12,096 to £157,596. The Trust's highest paid director was the Chief Executive Officer whose salary was £151,540; 2 senior medical staff were paid more than the highest paid director in 2021/22 (1 in 2020/21).

The percentage changes in pay of the highest paid director (the Chief Executive) and all other employees was as follows:

Percentage changes 2020/21 to 2021/22

	Salary and allowances	Performance related pay and bonus
Highest paid Director	0.0%	0.0%
Other employees	6.8%	36.2%

The highest paid director did not receive a pay award or performance related bonus in 2021/22. Only one member of staff received a performance bonus in 2021/22 this was a director, in 2020/21 another director received a performance bonus. These were awarded under the national VSM pay scheme. The small number of transactions has resulted in a large percentage increase; the actual change in bonus payments was £1,457.

The total annualised remuneration and salaries for the Trust's staff including agency was as tabled below.

Percentile total remuneration	£
25th	25,103
Median	33,256
75th	42,121

Percentile salary	£
25th	24,882
Median	33,960
75th	42,121

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 2021/22 was £151,660 (2020/21, £151,591). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Year	25th percentile pay ratio		Median pay ratio		75th percentile pay ratio	
	Total remuneration	Salary	Total remuneration	Salary	Total remuneration	Salary
2021/22	6.0:1	6.1:1	4.6:1	4.5:1	3.6:1	3.6:1
2020/21	6.2:1	6.3:1	4.8:1	4.7:1	3.8:1	3.8:1

The salary of the Chief Executive Officer was 6.1 times more than the employee who was paid the 25th percentile point in 2021/22; the median ratio is 4.5 times more than the employee in this position and 3.6 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 2020/21 and 2021/22 as the highest paid director did not receive a pay award in 2021/22 when most other employees received the nationally negotiated agenda for change increase.

Staff Report

Staff costs and numbers including senior officers (audited)

Staff costs	2021/22			2020/21		
	Permanent £k	Other £k	Total £k	Permanent £k	Other £k	Total £k
Salaries and wages	97,844	6,152	103,996	95,294	5,496	100,790
Social security costs	9,872	273	10,143	9,206	224	9,430
Apprenticeship levy	485	13	498	457	11	468
Employer's contributions to NHS pensions	18,413	223	18,636	17,447	226	17,673
Pension cost - other	74	2	76	62	2	64
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	35	0	35	1,018	0	1,018
Temporary staff	0	3,599	3,599	0	2,544	2,544
Total gross staff costs (including seconded out)	**126,723**	**10,262**	**136,985**	**123,484**	**8,503**	**131,987**
Of which: Costs capitalised as part of assets	**407**	**0**	**407**	**339**	**0**	**339**

Average staff numbers in post by occupation groupings (audited)

Average number of employees (WTE basis)	2021/22			2020/21		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	50	32	82	50	26	76
Administration and estates	764	48	812	742	40	782
Healthcare assistants and other support staff	554	20	574	531	42	573
Nursing, midwifery and health visiting staff	875	48	923	933	36	969
Nursing, midwifery and health visiting learners	14	0	14	9	0	9
Scientific, therapeutic and technical staff	539	21	560	505	21	527
Healthcare science staff	0	0	0	0	0	0
Other	44	0	44	35	2	37
Total average numbers	**2,840**	**169**	**3,009**	**2,806**	**168**	**2,974**
Of which: Number of employees (WTE) engaged on capital projects	**7**	**0**	**7**	**7**	**0**	**7**

Gender composition

Gender	Headcount	%	FTE
Female	2,821	86.5	2385.43
Male	439	13.5	406.24
Total	3,260	100.0	2791.67

Staff turnover

Staff Turnover Rate metric shows the proportion of leavers against an average headcount over a defined period. The below table shows the overall headcount and the number of leavers each month, also the turnover rate over a rolling 12-month period as indicated by the '12m'.

Month/year	Overall headcount	Overall starters headcount	Overall leavers headcount	Overall leavers (12m)	Overall % turnover
April 2021	3,147	0	27	334	10.8%
May 2021	3,133	31	36	343	11.1%
June 2021	3,126	31	34	363	11.7%
July 2021	3,120	25	33	378	12.1%
August 2021	3,092	25	45	407	13.1%
September 2021	3,114	41	38	420	13.5%
October 2021	3,085	35	44	445	14.3%
November 2021	3,087	37	17	444	14.2%
December 2021	3,081	14	24	443	14.2%
January 2022	3,099	59	46	464	14.9%
February 2022	3,108	22	23	470	15.1%
March 2022	3,102	31	39	432	13.9%

More information about our workforce statistics, including staff turnover, can be found on NHS Digital's website at:

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/january-2021

The series is an official statistics publication complying with the UK Statistics Authority's Code of Practice.

Engagement

The Levels of Engagement score at Leeds Community Healthcare remains positive although has reduced slightly to 6.95 from 7.2 in 2019 and 2020. This engagement score is used to compare NHS trusts nationally and is the score used by the Care Quality Commission in its Well Led assessments. The level of engagement nationally is 6.8.

Expenditure on consultancy

The Trust has spent £70k on consultancy services during 2021/22. Of this £50k was a Leeds place-based review of the future of the COVID-19 Vaccination Programme and the £20k remainder was in respect of a review of the facilities management services.

Off-payroll engagements

The Trust had the following off-payroll engagements as of 31 March 2022, 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 2022	16
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	1
For between three and four years at the time of reporting	1
For four or more years at the time of reporting	13

Eleven of the off-payroll appointments relate to forensic medical examiners; four are individuals who provide clinical supervision to some of our senior clinical staff and the final post is a niche specialism where we buy-in what we need when we need it. 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 2021/22 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 2021 and 31 March 2022, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2021 and 31 March 2022	74
Of which:	
Number not subject to off-payroll legislation*	58
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*	16
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 2021/22.

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

Reporting on time off for Trade Union facility time

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

Number of employees who were relevant union officials during the relevant period	12
Full-time equivalent employee number	9.39

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%	6
1-50%	6
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	£48,217.54
Provide the total pay bill	£136,543,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x100	0.035%

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 **= 3.4%**

Exit packages

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 is therefore presented on a different basis to other staff cost expenditure in the accounts.

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Number of other departures where special payments have been made Number	Total number of exit packages Number
£10,000 - £25,000	1	0	1
Total number	1	0	1
Total cost (£)	**£17,051**	**£0**	**£17,051**

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.

Calendar year	Average FTE*	Adjusted FTE days lost to Cabinet Office definitions*	Average sick days per FTE*	FTE days available**	FTE days recorded sickness absence**	Sickness absence rate
2021	2,840	37,860	13.3	1,036,484	61,417	5.9%
2020	2,804	30,925	11.0	1,023,366	50,167	4.9%

Source: NHS Digital – Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse. Periods covered: January to December 2021 and January to December 2020

*Figures converted by DH to best estimates of required data items
**Statistics published by NHS Digital from ESR Data Warehouse

Data items: ESR does not hold details of the planned working/non-working days for employees, so days lost and days available are reported based upon a 365-day year.

For the Annual Report and Accounts the following figures are used:

The number of FTE days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.

The number of FTE days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure.

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

Signed  **Thea Stein**, Chief Executive

Date 17 June 2022

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 2022

Statement of directors' responsibilities in respect of the accounts

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

- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- make judgements and estimates which are reasonable and prudent
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts 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

.....17 June 2022.....Date.....  .....Chief Executive

…….17 June 2022.....Date.....  ...Director of Finance

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 2022, 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 the summary of significant accounting policies. 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 2021/22 as contained in the Department of Health and Social Care Group Accounting Manual 2021/22, 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 2022 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 2021/22; 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, 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 Directors are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. 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, 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 2021/22 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 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.

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.

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, and significant one-off or unusual transactions.

Our audit procedures were designed to respond to those identified risks, including non-compliance with laws and regulations (irregularities) and fraud that are material to the financial statements. Our audit procedures included but were not limited to:

- discussing with management and the Audit Committee the 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.

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; and
- addressing the risks of fraud through management override of controls by performing journal entry testing.

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 2022.

We have not completed our work on the Trust's arrangements. On the basis of our work to date, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have not identified any significant weaknesses in arrangements for the year ended 31 March 2022.

We will report the outcome of our work on the Trust's arrangements in our commentary on those arrangements within the Auditor's Annual Report. Our audit completion certificate will set out any matters which we are required to report by exception.

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 December 2021.

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 Improvement; 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.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

Audit Completion Certificate issued to the Directors of Leeds Community Healthcare NHS Trust for the year ended 31 March 2022

In our auditor's report dated 20 June 2022 we explained that the audit could not be formally concluded until we had completed the work necessary to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness is its use of resources.

This work has now been completed.

No matters have come to our attention since 20 June 2022 that would have a material impact on the financial statements on which we gave our unqualified opinion.

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

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 2022.

On the basis of our work, having regard to the guidance issued by the Comptroller and Auditor General in December 2021, we have nothing to report in this respect.

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.

Mark Dalton Key Audit Partner
For and on behalf of Mazars LLP

5th Floor
3 Wellington Place
Leeds
LS1 4AP

30 August 2022

Statement of Comprehensive Income

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	3	183,688	170,731
Other operating income	4	11,862	17,189
Operating expenses	6.1, 8	(194,681)	(185,957)
Operating surplus / (deficit) from continuing operations		**869**	**1,963**
Finance income	11	22	7
Finance expenses	12.1	-	-
PDC dividends payable		(402)	(348)
Net finance costs		**(380)**	**(341)**
Other gains / (losses)	13	3	(80)
Surplus / (deficit) for the year		**492**	**1,542**
Total comprehensive income / (expense) for the period		**492**	**1,542**

Statement of Financial Position

	Note	31 March 2022 £000	31 March 2021 £000
Non-current assets			
Intangible assets	15.1	171	231
Property, plant and equipment	16.1	32,234	30,985
Receivables	24.1	30	-
Total non-current assets		**32,435**	**31,216**
Current assets			
Receivables	24.1	6,816	5,551
Cash and cash equivalents	27.1	39,459	39,619
Total current assets		**46,275**	**45,170**
Current liabilities			
Trade and other payables	28.1	(16,968)	(13,857)
Provisions	33.1	(367)	(1,769)
Other liabilities	29	(1,276)	(1,183)
Total current liabilities		**(18,611)**	**(16,809)**
Total assets less current liabilities		**60,099**	**59,577**
Non-current liabilities			
Provisions	33.1	(30)	-
Total non-current liabilities		**(30)**	**-**
Total assets employed		**60,069**	**59,577**
Financed by			
Public dividend capital		778	778
Revaluation reserve		14,182	14,182
Income and expenditure reserve		45,109	44,617
Total taxpayers' equity		**60,069**	**59,577**

The notes on pages 80 to 118 form part of these accounts.

Signed

Name Thea Stein

Position Chief Executive

Date 17 June 2022

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2022

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2021 - brought forward	**778**	**14,182**	**44,617**	**59,577**
Surplus / (deficit) for the year	-	-	492	**492**
Taxpayers' equity at 31 March 2022	**778**	**14,182**	**45,109**	**60,069**

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2020 - brought forward	**441**	**14,186**	**43,071**	**57,698**
Surplus / (deficit) for the year	-	-	1,542	**1,542**
Other transfers between reserves	-	(4)	4	**-**
Public dividend capital received	337	-	-	**337**
Taxpayers' equity at 31 March 2021	**778**	**14,182**	**44,617**	**59,577**

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
The Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not specifically 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	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		869	1,963
Non-cash income and expense:			
Depreciation and amortisation	6.1	1,934	2,032
(Increase) / decrease in receivables and other assets		(1,205)	4,214
Increase / (decrease) in payables and other liabilities		2,123	(353)
Increase / (decrease) in provisions		(1,372)	995
Net cash flows from / (used in) operating activities		**2,349**	**8,851**
Cash flows from investing activities			
Interest received		22	7
Purchase of intangible assets		-	(52)
Purchase of PPE and investment property		(1,996)	(2,327)
Sales of PPE and investment property		5	-
Net cash flows from / (used in) investing activities		**(1,969)**	**(2,372)**
Cash flows from financing activities			
Public dividend capital received		-	337
PDC dividend (paid) / refunded		(540)	(283)
Net cash flows from / (used in) financing activities		**(540)**	**54**
Increase / (decrease) in cash and cash equivalents		**(160)**	**6,533**
Cash and cash equivalents at 1 April - brought forward		**39,619**	**33,086**
Cash and cash equivalents at 31 March	27.1	**39,459**	**39,619**

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 2021/22 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.

The Trust Board specifically considered the matter of going concern at its meeting on 31 March 2022. The Board concluded that after considering the matters in the paper, and having an awareness of all relevant information, there are no material uncertainties related to events or conditions which may cast significant doubt about 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. The Trust includes within its financial statements its share of the assets, liabilities, income and expenses.

The Trust provides sexual health services under a joint operation with The Leeds Teaching Hospitals NHS Trust. As lead provider the contract income flows to the Trust, and The Leeds Teaching Hospitals NHS Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and usually a share of any profit or loss is transferred to The Leeds Teaching Hospitals NHS Trust. As the NHS financial regime was amended for 2021/22 in light of the Covid-19 pandemic the full financial impact of the contract has been borne by Leeds Community Healthcare.

The Trust provides forensic child and adolescent mental and physical health services under a joint operation with South West Yorkshire Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust, and South West Yorkshire Partnership NHS Foundation Trust recharges expenditure associated with the provision of this service. The total cost of the service is recognised by Leeds Community Healthcare NHS Trust and usually a share of any profit or loss is transferred to South West Yorkshire Partnership NHS Foundation Trust. As the NHS financial regime was amended for 2021/22 in light of the Covid-19 pandemic the full financial impact of the contract has been borne by Leeds Community Healthcare.

The Trust is lead provider of an integrated mental wellbeing service for Leeds under a joint operation with Leeds and York Partnership NHS Foundation Trust, Northpoint, Touchstone, Community Links, Leeds GP Confederation, Women's Counselling Service and Homestart Leeds. As lead provider the contract income flows to the Trust and the other providers recharge expenditure associated with the provision of this service. The total cost of this service is recognised by Leeds Community Healthcare NHS Trust and usually a share of any profit or loss is transferred to the provider partners. As the NHS financial regime was amended for 2021/22 in light of the Covid-19 pandemic the full financial impact of the contract has been borne by Leeds Community Healthcare.

The Trust provides court liaison and diversion services under a joint operation with Community Links. As lead provider the contract income flows to the Trust and Community Links recharges expenditure associated with the provision of this service. The total cost of this service is recognised by Leeds Community Healthcare NHS Trust and usually a share of any profit or loss is transfered to Community Links. As the NHS financial regime was amended for 2021/22 in light of the Covid-19 pandemic the full financial impact of the contract has been borne by Leeds Community Healthcare.

The Trust provides weight management services under a joint operation with The Leeds Teaching Hospitals NHS Trust and Leeds and York Partnership NHS Foundation Trust. As lead provider the contract income flows to the Trust and the other providers recharge expenditure associated with the provision of this service. The total cost of this service is recognised by Leeds Community Healthcare NHS Trust and usually a share of any profit or loss is transfered to the partner providers. As the NHS financial regime was amended for 2021/22 in light of the Covid-19 pandemic the full financial impact of the contract has been borne by Leeds Community Healthcare.

The 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.

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

NHS Charitable Fund

The Trust is the Corporate Trustee to the Leeds Community Healthcare Charitable Trust and Related Charities. The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary. This is 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 the Trust has the ability to affect those returns and other benefits through its power over the fund.
The Trust has decided not to consolidate the charitable funds into these accounts as the transactions 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 the Trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners, where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year these blocks were set for individual NHS providers directly, but the revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration. The Trust has no Elective Recovery Fund income.

Revenue from non-NHS contracts

The Trust receives revenue from contracts with non-NHS commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year.

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

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

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

Revenue from other contracts

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

Note 1.5 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 the grant is used to fund capital expenditure, it is credited to the consolidated Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition of the benefit.

Other income

The Trust's other income relates to property rental, lease car income, projects to support transformation of local systems and the First Contact Practitioner service.

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 the 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 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 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

The Trust has no discontinued operations for 2021/22.

Note 1.9 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 a cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, 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’ ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust.

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 the Trust by the Department of Health and Social Care or NHS England as part of the response to the coronavirus pandemic.

The Trust received no donated assets during 2021/22.

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

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

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	90
Plant & machinery	5	10
Information technology	5	5
Furniture & fittings	10	10

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

Note 1.10 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. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value 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

	Min life Years	Max life Years
Software licences	2	5

Note 1.11 Inventories

In 2020/21 and 2021/22, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. 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 a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.12 Investment properties

The Trust has no investment properties.

Note 1.13 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 1.14 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 the Office of National Statistics (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. These 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 income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

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

Financial assets 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 as 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, the Trust recognises an allowance for expected credit losses.

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

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 1.15 Leases

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

The Trust as a lessee

Finance leases

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

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the Statement of Financial Position and subsequently as a reduction of rentals on a straight-line basis over the lease term. Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Trust as a lessor

Finance leases

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

Operating leases

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

Note 1.16 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 2022:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	0.47%	Minus 0.02%
Medium-term	After 5 years up to 10 years	0.70%	0.18%
Long-term	After 10 years up to 40 years	0.95%	1.99%
Very long-term	Exceeding 40 years	0.66%	1.99%

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 2022:

	Inflation rate	Prior year rate
Year 1	4.00%	1.20%
Year 2	2.60%	1.60%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (prior year: minus 0.95%).

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

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims, are charged to operating expenses when the liability arises.

Note 1.17 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 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, 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 1.18 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 1.19 Value added tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.20 Corporation tax

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

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

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

Note 1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.22 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

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

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

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

Note 1.23 Third party assets
Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.24 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 1.25 Gifts

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

Note 1.26 Transfers of functions to / from other NHS bodies
For functions that have been transferred to the Trust from another NHS body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

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

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

Note 1.27 Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

Note 1.28 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases
IFRS 16 Leases will replace *IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, removing the distinctions between operating leases and finance leases, by recognising a right of use asset and obligation in the Statement of Financial Position for most leases. Some leases are exempt through application of practical expedients explained below. For those recognised in the Statement of Financial Position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. For 2022/23 this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. The Trust has no existing peppercorn leases. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The Trust will need to replace the lease for St George's Centre during 2022/23. This lease has still to be negotiated and an estimate, based on experience and historic costs, has therefore been used in calculating the impact of IFRS 16.

The Trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening Statement of Financial Position and the in-year impact on the Statement of Comprehensive Income and capital additions as follows:

	£000
Estimated impact on 1 April 2022 Statement of Financial Position	
Additional right of use assets recognised for existing operating leases	66,514
Additional lease obligations recognised for existing operating leases	(66,325)
Changes to other statement of financial position line items	(189)
Net impact on net assets on 1 April 2022	**-**
Estimated in-year impact in 2022/23	
Additional depreciation on right of use assets	(6,992)
Additional finance costs on lease liabilities	(598)
Lease rentals no longer charged to operating expenditure	7,349
Other impact on income / expenditure	(89)
Estimated impact on surplus / deficit in 2022/23	**(330)**
Estimated increase in capital additions for new leases commencing in 2022/23	**1,396**

Other standards, amendments and interpretations

IAS 37 – onerous contract amendment. If endorsed by HM Treasury this will be applicable from 2022/23; it means any impairment loss in fulfilling a contract should be recognised, this is unlikely to impact on NHS trusts.

Annual improvements 2018-2020 - these include a series of minor amendments and clarifications to a number of standards (IFRS 1, IFRS 9, IFRS 16 and IAS 41) which if endorsed by HM Treasury will become applicable from 2022/23. A watching brief is being maintained; these are not likely to be significant for the NHS.

IFRS 17 - insurance contracts, this is a new standard to be implemented from 2023/24 if endorsed by HM Treasury. It will require the Trust to review existing arrangements and may require some re-classification.

IAS 1 – classification of liabilities. If HM Treasury endorses this standard, liabilities will need to be reviewed and changes could be made to classification of current and non-current liabilities for 2023/24.

IAS 1 - disclosure of material accounting policies and sustainability reporting requirements. If endorsed by HM Treasury this will become applicable from 2023/24.

IAS 8 - estimates; changes to the definition of estimates; effective from 2023/24 if endorsed.

IAS 16 - Property, Plant and Equipment proceeds before intended use, subject to Treasury endorsement. Unlikely to impact on NHS trusts.

Note 1.29 Critical judgements in applying accounting policies

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

In line with IFRS 9 Financial Instruments, the Trust uses a provisions matrix approach to determine the value of provisions in respect of all financial instruments. The only financial instrument the Trust has is its trade receivables. The Trust has had to estimate its irrecoverable debt value using the matrix for 2021/22, as disclosed in Note 24.2.

Note 1.30 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:

In estimating the likely impact of IFRS 16 on 2022/23, management have had to make judgements on new / replacement leases to be included in the calculation as disclosed in note 1.28.

An estimate of the redundancy, legal claims and clinicians' pension costs has been made and included in the Trust's expenditure for 2021/22 as required under IAS 37. The estimated value of this is £241k for redundancies, £125k for legal claims and £31k for clinicians' pensions.

The Trust has used valuations carried out at 31 March 2020 by its independent professional valuer (the District Valuer, part of the Valuation Office Agency) to determine the value of property. The land and building valuations and assessment of useful lives are based on the Royal Institute of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care. Since the last valuation, Management has continued to liaise with the District Valuer to be aware of any movement in property values and is satisfied that the valuation at 31 March 2020 is a reasonable estimate of the value of the Trust's land and buildings.

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)	2021/22 £000	2020/21 £000
Mental health services		
Block contract / system envelope income *	-	1,665
Services delivered under a mental health collaborative **	89	-
Community services		
Block contract / system envelope income ***	147,319	133,512
Income from other sources (eg local authorities)	30,255	29,159
All services		
Additional pension contribution central funding ****	5,656	5,359
Other clinical income *****	369	1,036
Total income from activities	**183,688**	**170,731**

* The Trust ceased to provide inpatient mental health services at the end of 2020/21.

** The Trust is commissioned by Leeds and York Partnership NHS FT to provide services.

*** As part of the Covid-19 pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year and for 2021/22, a revised financial framework was built on these arrangements but with a greater focus on system partnership, and providers derived most of their income from these system envelopes.

**** 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.

***** In 2021/22 this includes non recurrent income for equipment and agency staff. The prior year income was central funding for annual leave that staff carried forward from 2020/21 and for annual leave owed in respect of overtime and additional hours worked.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2021/22 £000	2020/21 £000
NHS England	14,353	17,283
Clinical Commissioning Groups	138,990	124,290
Other NHS providers	178	2
Local Authorities	29,041	27,993
Non NHS: other	1,126	1,163
Total income from activities	**183,688**	**170,731**
Of which:		
Related to continuing operations	183,688	170,731

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

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

Note 4 Other operating income

	2021/22			2020/21		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	324	-	**324**	359	-	**359**
Education and training	3,071	224	**3,295**	3,058	156	**3,214**
Non-patient care services to other bodies	325		**325**	283		**283**
Reimbursement and top up funding	1,056		**1,056**	5,303		**5,303**
Income in respect of employee benefits accounted on a gross basis	3,117		**3,117**	2,184		**2,184**
Charitable and other contributions to expenditure *		293	**293**		2,457	**2,457**
Rental revenue from operating leases		490	**490**		491	**491**
Other income **	2,962	-	**2,962**	2,898	-	**2,898**
Total other operating income	**10,855**	**1,007**	**11,862**	**14,085**	**3,104**	**17,189**
Of which:						
Related to continuing operations			11,862			17,189
Related to discontinued operations			-			-

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

** Other income totalled £2,912k; this includes £698k rental income, £161k lease car income and £435k for Local Care Partnerships income to fund projects supporting the transformation of care pathway, £579k for First Contact Practitioners working for GPs, £93k NHSX funding, £214k One Adoption funding, £126k Therapeutic Support for Leeds City Council and £154k recruitment support funding from NHS England.

Note 5.1 Additional information on contract revenue (IFRS 15) recognised in the period

	2021/22	2020/21
	£000	£000
Revenue recognised in the reporting period that was included in contract liabilities at the previous period end	290	265

Note 5.2 Transaction price allocated to remaining performance obligations

The Trust has no income in respect of remaining performance obligations.

Note 5.3 Fees and charges

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

The Trust has no income associated with fees and charges.

Note 6.1 Operating expenses

	2021/22	2020/21
	£000	£000
Staff and executive directors costs	136,543	130,630
Remuneration of non-executive directors	128	96
Supplies and services - clinical (excluding drugs costs)	25,803	20,837
Supplies and services - general *	6,646	7,714
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	928	799
Consultancy costs	70	9
Establishment	3,601	2,627
Premises	6,581	6,701
Transport (including patient travel)	1,427	1,370
Depreciation on property, plant and equipment	1,874	1,982
Amortisation on intangible assets	60	50
Movement in credit loss allowance: contract receivables / contract assets	(78)	94
Increase / (decrease) in other provisions	(86)	17
Fees payable to the external auditor		
- audit services - statutory audit **	68	68
Internal audit costs	98	98
Clinical negligence	445	318
Legal fees	70	11
Insurance	125	124
Research and development	5	28
Education and training	693	1,044
Rentals under operating leases	7,112	7,721
Redundancy	35	1,018
Car parking and security	322	270
Hospitality	5	2
Losses, ex gratia and special payments	59	99
Other services, eg external payroll	1,094	1,066
Other ***	1,053	1,164
Total	**194,681**	**185,957**
Of which:		
Related to continuing operations	194,681	185,957

* 2021/22 expenditure includes £293k, (2020/21 £2,457k) for protective equipment issued by DHSC as part of the Covid pandemic response

** Auditors remuneration figures include irrecoverable VAT

*** Other expenditure includes £669k relating to external recharges in respect of joint operations, (2020/21 £816k).

Note 6.2 Other auditor remuneration

The Trust has no other auditor remuneration costs in 2021/22 or 2020/21.

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2021/22 or 2020/21.

Note 7 Impairment of assets

The Trust has no impairment of assets in 2021/22 or 2020/21.

Note 8 Employee benefits

	2021/22	2020/21
	£000	£000
Salaries and wages	103,996	100,790
Social security costs	10,145	9,430
Apprenticeship levy	498	468
Employer's contributions to NHS pensions	18,636	17,673
Pension cost - other	76	64
Termination benefits	35	1,018
Temporary staff (including agency)	3,599	2,544
Total gross staff costs	**136,985**	**131,987**
Recoveries in respect of seconded staff	-	-
Total staff costs	**136,985**	**131,987**
Of which		
Costs capitalised as part of assets	407	339

Employee benefits here include £407k which has been capitalised and £35k which is not included in staff and directors costs at note 6.1.

Note 8.1 Retirements due to ill-health

During 2021/22 there were 4 early retirements from the Trust agreed on the grounds of ill-health (5 in the year ended 31 March 2021). The estimated additional pension liabilities of these ill-health retirements is £316k (£247k in 2020/21).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay.

The 2016 funding valuation also tested the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HM Treasury published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Other

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish to join the NHS Pension Scheme this is the Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP). The Trust has expensed £76k during the year in respect of contributions for employees under the NEST scheme.

Note 10 Operating leases

Note 10.1 Leeds Community Healthcare NHS Trust as a lessor

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

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

	2021/22 £000	2020/21 £000
Operating lease revenue		
Minimum lease receipts	490	491
Total	**490**	**491**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease receipts due:		
- not later than one year;	482	491
- later than one year and not later than five years;	1,381	1,385
- later than five years.	362	598
Total	**2,225**	**2,474**

Note 10.2 Leeds Community Healthcare NHS Trust as a lessee

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

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

	2021/22 £000	2020/21 £000
Operating lease expense		
Minimum lease payments	7,112	7,721
Total	**7,112**	**7,721**

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due:		
- not later than one year;	6,953	7,092
- later than one year and not later than five years;	23,969	26,307
- later than five years.	30,947	41,510
Total	**61,869**	**74,909**
Future minimum sublease payments to be received	-	-

	31 March 2022 £000	31 March 2021 £000
Future minimum lease payments due by category of lease:		
- not later than one year land / buildings;	6,792	6,823
- not later than one year other;	161	269
- later than one year and not later than five years land / buildings;	23,824	26,038
- later than one year and not later than five years other;	145	269
- later than five years land / buildings;	30,947	41,510
Total	**61,869**	**74,909**

Note 11 Finance income

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

	2021/22	2020/21
	£000	£000
Interest on bank accounts	22	7
Total finance income	**22**	**7**

Note 12.1 Finance expenditure

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

The Trust has no finance expenditure.

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

The Trust has no expenditure in respect of late payment sof commercial debts.

Note 13 Other gains / (losses)

	2021/22	2020/21
	£000	£000
Gains on disposal of assets	5	-
Losses on disposal of assets	(2)	(80)
Total gains / (losses) on disposal of assets	**3**	**(80)**
Other gains / (losses)	-	-
Total other gains / (losses)	**3**	**(80)**

Note 14 Discontinued operations

The Trust has no discontinued operations.

Note 15.1 Intangible assets - 2021/22

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2021 - brought forward	**307**	**307**
Valuation / gross cost at 31 March 2022	**307**	**307**
Amortisation at 1 April 2021 - brought forward	**76**	**76**
Provided during the year	60	**60**
Amortisation at 31 March 2022	**136**	**136**
Net book value at 31 March 2022	**171**	**171**
Net book value at 1 April 2021	**231**	**231**

Note 15.2 Intangible assets - 2020/21

	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2020	**255**	**255**
Additions	52	**52**
Valuation / gross cost at 31 March 2021	**307**	**307**
Amortisation at 1 April 2020	**26**	**26**
Provided during the year	50	**50**
Amortisation at 31 March 2021	**76**	**76**
Net book value at 31 March 2021	**231**	**231**
Net book value at 1 April 2020	**229**	**229**

Note 16.1 Property, plant and equipment - 2021/22

	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 2021 - brought forward	**9,708**	**18,601**	**492**	**1,982**	**6,990**	**189**	**37,962**
Additions	-	-	2,238	171	716	-	**3,125**
Reclassifications	-	517	(517)	-	-	-	**-**
Disposals / de-recognition	-	-	-	(273)	-	-	**(273)**
Valuation / gross cost at 31 March 2022	**9,708**	**19,118**	**2,213**	**1,880**	**7,706**	**189**	**40,814**
Accumulated depreciation at 1 April 2021 - brought forward	**-**	**1,019**	**-**	**1,520**	**4,256**	**182**	**6,977**
Provided during the year	-	756	-	102	1,012	4	**1,874**
Disposals / de-recognition	-	-	-	(271)	-	-	**(271)**
Accumulated depreciation at 31 March 2022	**-**	**1,775**	**-**	**1,351**	**5,268**	**186**	**8,580**
Net book value at 31 March 2022	**9,708**	**17,343**	**2,213**	**529**	**2,438**	**3**	**32,234**
Net book value at 1 April 2021	**9,708**	**17,582**	**492**	**462**	**2,734**	**7**	**30,985**

Note 16.2 Property, plant and equipment - 2020/21

	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 2020	**9,708**	**18,025**	**359**	**2,086**	**5,847**	**189**	**36,214**
Additions	-	-	879	189	1,143	-	**2,211**
Reclassifications	-	746	(746)	-	-	-	**-**
Disposals / de-recognition	-	(170)	-	(293)	-	-	**(463)**
Valuation / gross cost at 31 March 2021	**9,708**	**18,601**	**492**	**1,982**	**6,990**	**189**	**37,962**
Accumulated depreciation at 1 April 2020	**-**	**347**	**-**	**1,654**	**3,208**	**169**	**5,378**
Provided during the year	-	762	-	159	1,048	13	**1,982**
Disposals / de-recognition	-	(90)	-	(293)	-	-	**(383)**
Accumulated depreciation at 31 March 2021	**-**	**1,019**	**-**	**1,520**	**4,256**	**182**	**6,977**
Net book value at 31 March 2021	**9,708**	**17,582**	**492**	**462**	**2,734**	**7**	**30,985**
Net book value at 1 April 2020	**9,708**	**17,678**	**359**	**432**	**2,639**	**20**	**30,836**

Note 16.3 Property, plant and equipment financing - 2021/22

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2022							
Owned - purchased	9,708	16,785	2,213	529	2,438	3	**31,676**
Owned - donated / granted	-	558	-	-	-	-	**558**
Net book value total at 31 March 2022	**9,708**	**17,343**	**2,213**	**529**	**2,438**	**3**	**32,234**

Note 16.4 Property, plant and equipment financing - 2020/21

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2021							
Owned - purchased	9,708	17,009	492	462	2,734	7	**30,412**
Owned - donated / granted	-	573	-	-	-	-	**573**
Net book value total at 31 March 2021	**9,708**	**17,582**	**492**	**462**	**2,734**	**7**	**30,985**

Note 17 Donations of property, plant and equipment

The Trust received no donations of property, plant and equipment during 2021/22.

Note 18 Revaluations of property, plant and equipment

The Trust has not revalued its property, plant and equipment during 2021/22.

The Trust sought advice from the District Valuer in respect of the movement in property prices during 2021/22. The District Valuer indicated price movements were not material since the last revaluation in 2019/20 and no revaluation exercise has been undertaken in 2021/22. The revaluation exercise undertaken in 2019/20 was carried out by a Member of the Royal Institution of Chartered Surveyors who is a salaried employee of the Valuation Office Agency.

The Valuer's report for the 2019/20 revaluation exercise was issued at the end of March 2020 just as the World Health Organisation had declared a global pandemic. The District Valuer concluded that in the light of this they were faced with an unprecedented set of circumstances on which to base a judgement. This resulted in the valuation for 2019/20 being caveated with a material valuation uncertainty.

The District Valuer has stated that valuations are no longer subject to material uncertainty as markets are functioning with a sufficient volume of transactions.

Note 19 Investment Property

The Trust has no investment property.

Note 20 Investments in associates and joint ventures

The Trust has no investments in associates and joint ventures.

Note 21 Other investments / financial assets (non-current)

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

Note 21.1 Other investments / financial assets (current)

The Trust has no current other investments / financial assets.

Note 22 Disclosure of interests in other entities

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

Note 23 Inventories

The Trust has no inventories.

Note 24.1 Receivables

	31 March 2022	31 March 2021
	£000	£000
Current		
Contract receivables	4,814	3,931
Allowance for impaired contract receivables / assets	(6)	(91)
Prepayments (non-PFI)	1,164	1,126
PDC dividend receivable	90	-
VAT receivable	701	493
Other receivables	53	92
Total current receivables	**6,816**	**5,551**
Non-current		
Other receivables	30	-
Total non-current receivables	**30**	**-**
Of which receivable from NHS and DHSC group bodies:		
Current	772	-
Non-current	30	-

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed in 2020/21 affecting the application of the accounting policy under IFRS 15, this change continued into 2021/22. This difference in application is explained in note 1.4 of the accounts.

Note 24.2 Allowances for credit losses

	2021/22		2020/21	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 April - brought forward	**91**	**-**	**6**	**-**
New allowances arising	5	-	98	-
Reversals of allowances	(83)	-	(4)	-
Utilisation of allowances (write offs)	(7)	-	(9)	-
Allowances as at 31 March 2022	**6**	**-**	**91**	**-**

Note 24.3 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 the 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. The Trust has reviewed the nature and value of other outstanding debt at the end of 2021/22 and has made an additional provision to mitigate the risk of non-payment.

The main credit risk to the Trust is from ex-employee debt and the credit loss rate to be applied to this type of debt was calculated as 26.75%. Overall a £6k credit loss allowance has been recognised for non-NHS receivables in 2021/22.

Note 25 Other assets

The Trust has no other assets.

Note 26.1 Non-current assets held for sale and assets in disposal groups

The Trust has no non-current assets held for sale and assets in disposal groups to disclose for the accounting period.

Note 26.2 Liabilities in disposal groups

The Trust has no liabilities in disposal groups.

Note 27.1 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.

	2021/22	2020/21
	£000	£000
At 1 April	**39,619**	**33,086**
Net change in year	(160)	6,533
At 31 March	**39,459**	**39,619**
Broken down into:		
Cash at commercial banks and in hand	3	3
Cash with the Government Banking Service	39,456	39,616
Total cash and cash equivalents as in SoFP	**39,459**	**39,619**
Total cash and cash equivalents as in SoCF	**39,459**	**39,619**

Note 27.2 Third party assets held by the Trust

The Trust has no third party assets.

Note 28.1 Trade and other payables

	31 March 2022 £000	31 March 2021 £000
Current		
Trade payables	3,824	3,202
Capital payables	1,290	161
Accruals	7,034	6,082
Social security costs	1,638	1,540
Other taxes payable	1,132	990
PDC dividend payable	-	48
Other payables	2,050	1,834
Total current trade and other payables	**16,968**	**13,857**
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	1,235	1,844
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

There are no early retirements included in NHS payables.

Note 29 Other liabilities

	2022 £000	2021 £000
Current		
Deferred income: contract liabilities	1,276	1,183
Total other current liabilities	**1,276**	**1,183**
Total other non-current liabilities	**-**	**-**

Note 30.1 Borrowings

The Trust has no borrowings.

Note 30.2 Reconciliation of liabilities arising from financing activities - 2021/22

The Trust has no financial liabilities arising from financing activities for 2021/22.

Note 30.3 Reconciliation of liabilities arising from financing activities - 2020/21

There were no financial liabilities arising from financing activities for 2020/21.

Note 31 Other financial liabilities

The Trust has no other financial liabilities.

Note 32 Finance leases

The Trust has no finance leases for 2021/22.

Note 33.1 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2021	**211**	**1,558**	**-**	**1,769**
Arising during the year	15	35	31	**81**
Utilised during the year	-	(17)	-	**(17)**
Reversed unused	(101)	(1,335)	-	**(1,436)**
At 31 March 2022	**125**	**241**	**31**	**397**
Expected timing of cash flows:				
- not later than one year;	125	241	1	**367**
- later than one year and not later than five years;	-	-	1	**1**
- later than five years.	-	-	29	**29**
Total	**125**	**241**	**31**	**397**

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

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

Other provisions are in respect of clinicians' pensions liaibility arising from the 2019/20 Pension Annual Allowance Charge Compensation Scheme (PAACCS). These figures have 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 33.2 Clinical negligence liabilities

At 31 March 2022, £955k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2021: £1,460k).

Note 34 Contingent assets and liabilities

	31 March 2022 £000	31 March 2021 £000
Value of contingent liabilities		
Redundancy	(988)	-
Gross value of contingent liabilities	**(988)**	**-**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(988)**	**-**
Net value of contingent assets	**-**	**-**

The 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.

Note 35 Contractual capital commitments

	31 March 2022 £000	31 March 2021 £000
Property, plant and equipment	620	-
Total	**620**	**-**

Note 36 Other financial commitments

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

	31 March 2022 £000	31 March 2021 £000
- not later than one year	14,747	10,913
- after one year and not later than five years	14,389	2,010
- paid thereafter	-	-
Total	**29,136**	**12,923**

Note 37 Defined benefit pension schemes

The Trust has no defined benefit pension schemes.

Note 38 On-SoFP PFI, LIFT or other service concession arrangements

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

Note 39 Off-SoFP PFI, LIFT and other service concession arrangements

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

Note 40 Financial instruments

Note 40.1 Financial risk management

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

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

Currency risk

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

The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust currently has no borrowings.

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

The majority of the Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2022 are in receivables from customers, as disclosed in note 24.3.

Liquidity risk

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

The Trust is not therefore exposed to significant liquidity risks.

Note 40.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	4,891	**4,891**
Cash and cash equivalents	39,459	**39,459**
Total at 31 March 2022	**44,350**	**44,350**

Carrying values of financial assets as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other receivables excluding non financial assets	3,932	**3,932**
Cash and cash equivalents	39,619	**39,619**
Total at 31 March 2021	**43,551**	**43,551**

Note 40.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2022	Held at amortised cost	Total book value
	£000	£000
Trade and other payables excluding non financial liabilities	12,422	**12,422**
Total at 31 March 2022	**12,422**	**12,422**

Carrying values of financial liabilities as at 31 March 2021	Held at amortised cost	Total book value
	£000	£000
Trade and other payables excluding non financial liabilities	9,561	**9,561**
Total at 31 March 2021	**9,561**	**9,561**

Note 40.4 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 2022	31 March 2021
	£000	£000
- in one year or less	12,430	9,561
Total	**12,430**	**9,561**

Note 40.5 Fair values of financial assets and liabilities

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

Note 41 Losses and special payments

	2021/22		2020/21	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	1	89
Bad debts and claims abandoned	23	23	19	9
Stores losses and damage to property	1	8	-	-
Total losses	**24**	**31**	**20**	**98**
Special payments				
Ex-gratia payments *	11	306	2	1
Total special payments	**11**	**306**	**2**	**1**
Total losses and special payments	**35**	**337**	**22**	**99**
Compensation payments received		-		-

* This includes payments to staff in respect of the Flowers legal case. The costs were accrued in 2020/21 and payments made during 2021/22. The total value paid to staff was £278k and is recorded as 2 transactions.

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

Note 42 Gifts

The Trust made no gifts in 2021/22.

Note 43 Related parties

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

	Revenue from Related Party	Expenditure with Related Party	Amounts due from Related Party	Amounts owed to Related Party
	£	£	£	£
Crossley Street Surgery, Wetherby Ruth Burnett (Medical Director) *Performs unpaid GP work as part of CPD and maintaning registration*	-	156,600	-	26,833
Leeds GP Confederation Jenny Allen (Director of Workforce) *Director of Workforce, Leeds GP Confederation* Ruth Burnett (Medical Director) *Medical Director, Leeds GP Confederation* Stephanie Lawrence (Executive Director of Nursing and AHPs) *Director of Nursing, Leeds GP Confederation* Laura Smith (Director of Workforce) *Director of Workforce, Leeds GP Confederation*	2,200,541	-186,888	479,661	-
KPMG LLP Jenny Allen (Director of Workforce - non-voting Board Member) *Husband is a partner*	-	120,846	-	49,950
Touchstone Support Alison Lowe (Non-Executive Director) *Chief Executive, Touchstone until 6 August 2021* Kahlil Rehman (Non-Executive Director) *Advisor, from 4 January 2022*	-	1,881,029	-	-
University of Huddersfield Helen Thomson (Non-Executive Director) *Council Member*	113,504	-	17,657	-

The Department of Health is regarded as a related party. During the year 2021/22 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department as listed below:

Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale and Huddersfield NHS Foundation Trust
Care Quality Commission
Department of Health and Social Care
East of England Ambulance Service NHS Trust
Great Ormond Street Hospital for Children NHS Foundation Trust
Guy's and St Thomas' NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Health Education England
Hull University Teaching Hospitals NHS Trust
Imperial College Healthcare NHS Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
Manchester University NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
NHS Bradford District and Craven CCG
NHS Business Services Authority
NHS England
NHS Herts Valleys CCG
NHS Hull CCG
NHS Improvement
NHS Leeds CCG
NHS North of England Commissioning Support Unit
NHS Northumberland CCG
NHS Nottingham and Nottinghamshire CCG
NHS Resolution
NHS Rotherham CCG
NHS Sunderland CCG
NHS Wakefield CCG
North Cumbria Integrated Care NHS Foundation Trust
North Tees and Hartlepool NHS Foundation Trust
Oxford Health NHS Foundation Trust
Pennine Care NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
The Leeds Teaching Hospitals NHS Trust
The Rotherham NHS Foundation Trust
UK Health Security Agency
University Hospitals of Derby and Burton NHS Foundation Trust
University Hospitals Sussex NHS Foundation Trust
West Midlands Ambulance Service University NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust
York and Scarborough Teaching Hospitals NHS Foundation Trust

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

Bradford City Council
Cardiff and Vale University Local Health Board
Community Health Partnerships Ltd
Hackney London Borough Council
HM Revenue and Customs
Kirklees Metropolitan Council
Leeds City Council
National Employment Savings Trust
NHS Pension Authority
NHS Property Services
West Yorkshire Combined Authority (Policing and Crime)

The Trust has also had transactions with a subsidiary company of Currys PLC which the Department of Health and Social Care has deemed to be a related party of entities within the Departmental Group.

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

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

Note 44 Transfers by absorption

The Trust has no transfers by absorption.

Note 45 Prior period adjustments

The Trust has made no prior period adjustments.

Note 46 Events after the reporting date

The Trust has no events after the reporting date.

Note 47 Better Payment Practice code

Non-NHS Payables	2021/22 Number	2021/22 £000	2020/21 Number	2020/21 £000
Total non-NHS trade invoices paid in the year	14,124	41,082	12,661	34,026
Total non-NHS trade invoices paid within target	13,494	40,192	12,281	33,363
Percentage of non-NHS trade invoices paid within target	95.5%	97.8%	97.0%	98.1%
NHS Payables				
Total NHS trade invoices paid in the year	371	21,239	471	19,351
Total NHS trade invoices paid within target	368	21,238	468	19,346
Percentage of NHS trade invoices paid within target	99.2%	100.0%	99.4%	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 48 External financing limit

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

	2021/22 £000	2020/21 £000
Cash flow financing	160	(6,196)
External financing requirement	**160**	**(6,196)**
External financing limit (EFL)	160	(6,196)
Under / (over) spend against EFL	**-**	**-**

Note 49 Capital Resource Limit

	2021/22 £000	2020/21 £000
Gross capital expenditure	3,125	2,263
Less: Disposals	(2)	(80)
Charge against Capital Resource Limit	**3,123**	**2,183**
Capital Resource Limit	3,123	2,365
Under / (over) spend against CRL	**-**	**182**

Note 50 Breakeven duty financial performance

Adjusted financial performance (control total basis):	2021/22 £000	2020/21 £000
Surplus / (deficit) for the period	492	1,542
Remove I&E impact of capital grants and donations	15	15
Adjusted financial performance surplus / (deficit)	**507**	**1,557**

Note 51 Breakeven duty rolling assessment

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

	2017/18	2018/19	2019/20	2020/21	2021/22
	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance	4,655	5,661	2,045	1,557	507
Breakeven duty cumulative position	18,808	24,469	26,514	28,071	28,578
Operating income	149,526	155,640	171,312	187,920	195,550
Cumulative breakeven position as a percentage of operating income	12.6%	15.7%	15.5%	14.9%	14.6%

Thank you for taking the time to read our Annual Report and Accounts for 2021/22. You can also view this document via 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 67-118, 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**.