NHS
Leeds Community Healthcare
NHS Trust

Annual Report
and Accounts 2024-2025

Contents

Foreword

The annual report is undoubtedly a time to reflect on the challenges and major successes of 2024/25. Without the hard-working and truly dedicated 3,400 employees of Leeds Community Healthcare Trust, such excellence would not have been possible. Their dedication, in clinical, corporate and support roles, across the entire Leeds footprint and beyond, has maintained the highest standard of service and support in providing the best possible care to the people we serve.

In this report we hope you will see the quantity and quality of the work our teams have achieved for, and with, our patients at a time of increasing financial and societal pressure and significant political change. All of which has been set against a backdrop of increasing demand, higher acuity, and financial pressure.

Our successes have been many and there are numerous examples of excellent partnership developments, including HomeFirst, the 'Enhance' programme, relationships with the GP Confederation and the ongoing work with Leeds City Council in the Alliance. We have put in place new services which strongly demonstrate our partnership ambition, including Leeds Sexual Health Service and West Yorkshire Dental Service. We are active members of several 'collaboratives', working alongside our Leeds system partners, including community and mental health providers as part of the West Yorkshire system. We also held an important Board to Board with Leeds Teaching Hospitals NHS Trust, to reaffirm our commitment to working together on a 'closer to home' agenda.

Innovation has been high on the agenda, and you can read more about this on page 15 where we take a look at our Digital Strategy. Innovations which include a new clinical and safeguarding supervision app for recording clinical supervision, and improvements to the systems and processes used for sharing medical records so that, where possible, colleagues have the right information at their fingertips.

The Trust's first ever Green Plan, which launched in 2022, came to the end of its final year. Positive progress has been made over this three-year period in areas such as buildings and estate, travel and procurement. We are pleased to have achieved our overall goal to embed sustainability where it had not previously been considered. We now have solid foundations in place for our 2025-2028 Green Plan refresh, which will include focused work to reduce our carbon emissions.

This year has been one of ongoing financial challenge, with the Leeds system requiring a 7% cost improvement programme across all Leeds NHS commissioned services. Our Quality and Value programme (which you can read about in this report) has been central to our financial balance, alongside redesigning services to make best use of digital initiatives and looking at new ways to deploy our workforce. Twelve services have undertaken a Quality and Value review with more to follow. We are pleased to have delivered financial balance this year and, importantly, we have commenced work with our partners across West Yorkshire to further develop our medium-term forward financial plan.

Our internal staff networks continue to be an important way to listen to the experience of colleagues and during 2024/25, notably this included 'safe spaces' for Race Equality Network members to talk about personal safety - a theme amplified by the summer of unrest experienced in Leeds and nationally. We are pleased to see that this year's NHS Staff

Survey has seen an improvement in the experience of global majority colleagues, however, there is more to be done to support colleagues who identify as having a disability or neuro divergent condition. Executive leadership of all our networks is now in place, and this has created a much more clearly defined 'frontline to Board' discussion alongside a new Board committee, focusing on People and Culture, which will further enhance this work in forthcoming years. You can read more about our commitment to equality, diversion and inclusion in the body of this report.

There have been significant changes to the board with a new chief executive in April 2024 alongside two new executive director appointments. In addition, two new non-executive directors (NEDs) have been appointed, one as an associate. These new additions have brought a fresh perspective to the board from other systems, as well as expertise in digital. Our thanks are extended to Steph Lawrence, MBE, who retired as Executive Director of Nursing and Allied Health Professionals (AHPs) at the start of the financial year following an exceptional 37-year career in nursing. Steph's contribution was outstanding. Her five-year leadership, which saw our nurses and AHPs through the COVID-19 pandemic, was testimony to her professionalism. Also, Richard Gladman stepped down as a non-executive director after eight years of dedication to our services. We would like to extend our sincere thanks to him for his stewardship and oversight over the years, including that of several of the Trust's key committees. We wish him well in all his future endeavours.

As a Trust we also undertook an independent Well-led developmental review during 2024/25. The final report spoke highly of the contribution of the Trust and the actions associated with this review are in the main body of our annual report, along with some recommendations for where improvements will be made.

Whilst 2024/25 has been a time of considerable change in our organisation, we have continued to deliver safe and responsive services for the residents we serve. We are proud of the work undertaken by our team, and we will continue to advocate for community provision both locally and nationally.

Thank you,

Brodie Clark CBE
Chair

Selina Douglas
Chief Executive

About the Trust

How we work

Leeds Community Healthcare NHS Trust (LCH) serves a population of over 800,000 people and delivers care to around 5000 people every day. We are an award-winning Trust, with many of our services and teams recognised locally, regionally and nationally for their achievements.

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

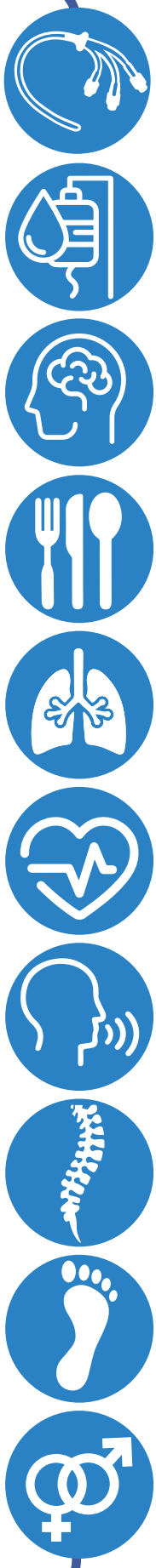
Our services are organised into three business units: Adult Services, Children and Families Services and Specialist Services. The three business units are supported by Corporate Service teams. A full list of our patient facing services is set out below.

Adult Services

- 13 Neighbourhood Teams
- Triage Hubs
- Response Team
- Home Ward
- Wharfedale Recovery Hub
- Neighbourhood Nights
- Palliative and End of Life Care
- Self-Management
- Integrated Clinics
- Health Case Management
- Bed Bureau
- Community Care Beds / Recovery Beds
- Therapy Supported Discharge
- Community Discharge Team
- Transfer of Care

Specialist Services

- Community Neurology Team
- Community Stroke Team
- Speech and Language Therapy (SLT) Services and Speech and Swallowing Service
- Leeds Mental Wellbeing Service (LMWS)
- Diabetes Leeds Partnership
- Adult and Children's Nutrition and Dietetics
- Tier 3 Weight Management
- Podiatry (foot health)
- Community Dental Service
- Musculoskeletal Services
- Leeds Community Pain Service
- First Contact Physiotherapy
- Custodial Healthcare (Wetherby Young Offenders Institute, Adel Beck Secure Children's Home and Aldine House Secure Children's Home)
- Police Custody Suites Healthcare Services across West Yorkshire, South Yorkshire, 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
- Tissue Viability
- Continence, Urology and Colorectal Service (CUCS)
- Falls



Children and Families Services

- Integrated Children's Additional Needs Service (ICAN):
  - Occupational Therapy
  - Physiotherapy
  - Community Paediatric Clinics
  - Paediatric Neurodisability Clinics
  - Child Protection Medical Service
  - Growth and Nutrition Clinics
  - Adoption and Fostering Service
  - Springfield Neonatal Follow Up Clinic
  - Audiology Service
  - Continuing Care and Healthy Short Breaks
  - Inclusion Nursing Service
  - Hannah House
- Children and Young People's Mental Health Services (CYPMHS):
  - Crisis Service
  - Community Outreach Service
  - Transitions Service
  - MindMate Single Point of Access (to be delivered by Northpoint from July 2025)
  - MindMate Support
  - Youth Justice Service Team
  - Input to Therapeutic Social Work Team
  - Crisis Call Line
  - Eating Disorders Service
  - Enhanced Support Team
  - Therapies Team
  - Medication Support
- Children's Community Nursing Service
- Children's Speech and Language Therapy
- 0-19 Public Health Integrated Nursing Service (0-19 PHINS)
- Infant Mental Health Service
- Children's Community Eye Service
- School Immunisations Service

Our vision is to provide the best possible care to every community we serve. We do this by working together with other organisations and groups, involving, and developing our colleagues, and using our resources wisely to continually improve services. We work in partnership with the wider NHS, social care, the criminal justice system and the third sector.

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

We promote equity throughout the organisation, and we continue to support our staff networks (Race Equality; Disability, Neurodiversity and Long-term Conditions; and LGBTQIA+) to create an inclusive environment for patients and colleagues. We believe that a workforce that reflects its community will serve that community better.

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

How we work

The Trust's culture is underpinned by our vision:

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

We have three values that support this vision:

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

We uphold the visions and values through our **how we work behaviours**:


Caring for our patients


Making the best decisions


Leading by example


Caring for one another


Adapting to change and delivering improvements


Working together


Finding solutions

Leeds Community Healthcare's strategic goals

The Trust Board agreed five strategic goals for 2024/25:

- To work with communities to deliver personalised care.
- To use our resources wisely and efficiently both in the short and longer term.
- To enable our workforce to thrive and deliver the best possible care
- Collaborating with partners to enable people to live better lives.
- To embed equity in all that we do.

These strategic goals set the direction for how we provided care, managed our resources, and worked with our health and social care partners to meet the needs of patients, whilst looking after the health and wellbeing of our teams.

Key risks

We reviewed our strategic risks connected to our goals in spring 2024, allocating an assigned Lead Director(s) and Lead Committee(s) to each strategic risk. The level of assurance given for the management and mitigation of these risks is reported to the Trust Board at each of its meetings:

- **Risk 1:** Failure to deliver quality of care and improvements.
- **Risk 2:** Failure to manage demand for services.
- **Risk 3:** Failure to implement the digital strategy.
- **Risk 4:** Failure to be compliant with legislation and regulatory requirements.
- **Risk 5:** Failure to deliver financial sustainability.
- **Risk 6:** Failure to have sufficient resource for transformation programmes.
- **Risk 7:** Failure to maintain business continuity (including response to cyber security).
- **Risk 8:** Failure to have suitable and sufficient staff resource (including leadership).
- **Risk 9:** Failure to prevent harm and reduce inequalities experienced by our patients.
- **Risk 10:** Failure to collaborate.

The Performance Overview in this report describes how the Trust managed its strategic risks to achieve our goals during 2024/25. 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 82 of this report.

Performance report

Performance overview

This has been a challenging year. There have been competing priorities; to maintain service quality, continue to transform services, achieve financial balance and meet key performance indicators. Every colleague has played their part in achieving on each of these priorities.

We work as part of a complex system and with a wide range of partners across health and social care to make sure no-one stays in hospital longer than they need to. When they do arrive home, we make sure they have timely access to services that promote their independence.

This has been the third year we have worked with Enhance, a partnership of third-sector providers, LCH services and Leeds Older People's Forum, to keep people well and healthy at home. The Enhance Programme, evaluated by Leeds Beckett University, not only demonstrated the impact for people using the service, but also the important financial benefits to the system.

We have also been successful in bidding to provide sexual health services. Leeds Sexual Health - a partnership of LCH, Leeds Teaching Hospitals, Leeds GP Confederation and Forum Central, started a new contract in July. Since that time, we have transformed the service and made access easier through our digital first innovations.

We have provided a digital front door for patients to access the service and request medications, 24/7 at their convenience. This has made the service more accessible for patients and streamlined the administrative processes. This work has been shortlisted for a HSJ award for the online HIV prevention and chlamydia treatment programme.

By working together we've achieved great things:

- **2,599** referrals
- **85%*** of participants live with frailty (**29%** severe)
- **40%** live in IMD 1 and 2 areas
- **97%** have 1+ Long Term Conditions (**40%** have 6+ LTCs)
- **39% to 49%** positive return on investment for the wider health system
- **82%**** said Enhance saved time for LCH staff

The data above relates to Enhance work in years 1-3 (July 2022 - March 2025).
*Second round evaluation report by the Health and Care Evaluation service.
**of 33 LCH referrers who completed an impact survey.

"[Enhance] does relieve pressure. I have repeat callers - it's loneliness and [the patient] has a relationship with us. One patient with mental health illness was ringing our office every other day, they were worried about [a benefit claim] and other things and wanted a nurse to help. The [Enhance] worker went out and sorted it all out, and the patient doesn't really call us anymore." (NTC)

Leeds Older People's Forum

- **2,429** individual participants
- Over **£900k** in new benefit claims**
- **495** LCH/ third sector collaborations in year 3

The data above relates to Enhance work in years 1-3 (July 2022 - March 2025).
**yearly equivalent amount.

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

Our operational performance against a range of local and national targets and standards is assessed, and reported on, within the organisation and outside of it. The targets and standards are taken from the NHS Oversight Framework, our contracts, and local priorities.

They are grouped into five domains which work alongside the Care Quality Commission's (CQC) governance framework – we then add a finance domain. By looking closely at individual measures within these domains, we get an overall view of the Trust and our current performance. The Board considers what is called a **Performance Brief** at each meeting and this describes our current performance. The Performance Brief is available as part of the Board papers which are published on our website:

www.leedscommunityhealthcare.nhs.uk

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

How we met our Strategic Goals

Our strategic goals connect to each other and need to be achieved equally well if we are to deliver the best possible care. Most, if not all, of our priorities work toward a few of our strategic goals at the same time. The table below shows how our goals work together. Below this, we look at some of our key projects in more detail, to show how our goals have been achieved this year.

Priority	Personalised care	Workforce	Partnerships	Equity	Using resources
The Quality and Value Programme	✔	✔	✔	✔	✔
Equality Impact Assessment (EqIA) Process	✔			✔	
Patient Safety Incident Framework	✔			✔	
Digital Strategy	✔	✔	✔	✔	✔
Home First	✔	✔	✔	✔	✔
The 'Lead' Programme		✔			✔
The 'I Thrive'/ 'We Thrive' initiative	✔	✔		✔	
Racial Equity in Care	✔			✔	
Staff Engagement Networks		✔		✔	

Here are the some of our main achievements:

The Quality and Value Programme

This year was the first of our three-year cost improvement programme known as 'Quality and Value'. We had a challenging £15.8m of savings to achieve - more than 7% of our total budget. Our aim was to get to financial balance without compromising on quality, safety, effectiveness, and equity.

Any large organisational change can be a challenge, particularly where a significant amount of budget needs to be saved. To address this as positively as possible with frontline colleagues, we designed a 'staff led' improvement methodology that prioritised colleague ideas for change (see photos below from our Quality and Value design workshops). This made sure everyone could contribute as the experts in their service area. The way we communicated was also reviewed and adapted throughout the programme, to respond to how colleagues were feeling about the programme and how it was going.

Quality and Value achievements - year one include:

- Redesigns of over 10 clinical services – such as a new single point of access for Community Intravenous Antibiotics Service (CIVAS), virtual training packages for Infant Mental Health, and design of a 'best place of care' initiative for the whole organisation.
- Retaining and mobilising a new service at Wetherby Young Offenders Institute (YOI) and Community Dental.
- Over £1m alone saved in managing underutilised estates.
- Supporting corporate services, such as HR, to self-assess and action their own transformation opportunities.
- Rolling out digital innovations to all services such as digital letters and an online information hub, such as In Leeds Sexual Health.

Here's some feedback we received from colleagues about the Quality and Value programme:

"I feel this is the most radical change I've seen for some time. I contributed to the workstream very early on with only my suggestions. I'm delighted to see some of them have gone from ideas to policy change." (Community Matron, Adult Business Unit)

"Made sure EVERYONE's ideas are shared and have allowed each staff member to have a voice and be heard." (Continence, Urology and Colorectal Service (CUCS), Specialist Business Unit)

Equality Impact Assessment (EqIA) Process

The focus on quality remained as important as our finances. To make sure service decisions were compliant with the aims of the Public Sector Equality Duty, our Equality Impact Assessment (EqIA) process was reviewed. An EqIA looks at how changes to a service might affect patients. As so many changes were happening, the number of EqIAs needed went up. Now, more work is done at a service and business unit level, before it is seen and agreed at a senior level so that we can be sure the impact of change is better understood. Working with our key partners this year has strengthened this process even more.

One example of feedback from our partners is:

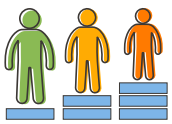
"I felt extremely supported during Tuesdays EqIA review, the meeting was well chaired and facilitated a very helpful discussion that provided me with some very helpful pointers for the evaluation work to be completed."

This year, the Quality and Value programme has:

Achieved financial balance by finding savings of at least **£15.8m**.

Helped **12** services to redesign how they work, with fantastic feedback from colleagues.

Saved more than **£2m** on non-essential spending.



Started **37** EqIAs, with 13 already approved.

Prepared for the sale of buildings in Otley and Horsforth (no longer used for patient care) and stopped buying space across the city (St Mary's Hospital, St George's Centre, and office space in Killingbeck). By reducing building space, we don't have to find savings elsewhere.

Launched fantastic digital projects, such as the Patient Information Hub and digital letters for patients, to help us work better in future.

The Patient Safety Incident Framework

Incident reporting and learning from incidents:

We have continued to put in place the Patient Safety Incident Response Framework (PSIRF) this year. The PSIRF challenges us to think and respond differently when a patient safety incident occurs. It's a learning and improvement framework that looks at how a system and a culture can support improvement. Six of our patient safety specialists completed the National Patient Safety Syllabus training (levels three and four) this year, and this is supporting us to look at incidents using the most up to date methods.

The PSIRF means we must have support in place for patients and colleagues involved in patient safety incidents. We need to create a safe and 'just' culture where people feel confident to speak up when things don't go as planned. We are responding by developing strong systems to involve colleagues and patients in patient safety investigations and quality improvements. The Trust was thrilled to hear a colleague's experience of this at the May 2025 safety summit:

> "Reviewing the incident from a systems and processes perspective, to identify meaningful learning, was a positive and supportive experience. Sharing this experience is supporting the 'being open' culture across the Trust."

An important piece of work in January-March of 2025 looked at safety data across the organisation to inform a refresh of the Patient Safety Incident Response Plan (PSIRP) for 2025/26.

Digital Strategy

In 2024/25 our refreshed Digital Data and Technology Strategy listened to the needs and views of colleagues, partners and patients. Our first ever Trust Digital Innovation event took place in May 2024, with over 150 colleagues coming together to look at how digital solutions could transform services.

Our digital vision is to:

'Harness digital and data opportunities which allow us to work safely and better together, promoting health and wellbeing and ensuring the best possible care is provided to all those we serve.'

So, over the next three years our aim is to recover and sustain our digital maturity and continue to innovate and transform.

The strategy was approved in December 2024, and since then we have made good progress towards achieving our digital vision and the Trust strategic goals:

A new digital screening tool within our electronic patient record system helps us to collect information for each patient on how they could access our services online. This is so important as we seek to transform our services and 'go digital'. It means no patient is left behind. Where patients do not have access, we have been able to introduce them to neighbourhood support to access online services.

"The implementation of simplified e-referral processes has facilitated a more efficient and transparent referral pathway. This has resulted in an improved inter-service communication, reduced patient wait times, and improved continuity of care through more thorough handovers."

In October 2024, our Leeds Sexual Health service successfully launched its 'Information Hub' as part of a large-scale project to develop our website. It hosts the 'Reciteme' toolbar which means patients can convert web content into different languages and control a range of features including fonts and background colours. The pages include updated service Information written in plain English and improved ways to contact the service online to request medications at any time of day, rather than waiting for the phone lines to open or become free.

The Information Hub project was expanded to include all our services in March 2025 and work is now taking place to improve patient information and self-management support across the website.

To continue our drive for efficiency and to reduce environmental impact, we have introduced a hybrid mail system. This allows patients to receive communications from our services digitally, including appointment letters and our Friends and Family Test (FFT) surveys.

"The introduction of text-based feedback has provided a more accessible and efficient method for gathering patient and family feedback, leading to improved patient experience".

To make sure our staff are fully supported with the tools / technologies to do their jobs effectively and well, we have introduced a new clinical and safeguarding supervision app for recording clinical supervision. We have also improved the systems and processes for sharing medical records so that, where possible, colleagues have the right information at their fingertips.

HomeFirst

HomeFirst Programme | Leeds Health & Care Partnership

This year, we continued to play an important role in the HomeFirst programme. By working in true partnership with system partners, we delivered a new model of intermediate care within the existing workforce, funding and organisational arrangements.

HomeFirst is five projects that work together to provide the best possible independence and outcomes for Leeds' residents. Clinical staff and leaders worked flexibly with other colleagues to design and deliver the following:

- **Active Recovery at Home:** Home-based intermediate care to make best use of workforce numbers and deliver the best outcomes for people accessing these services.
- **Enhanced Care at Home:** Preventive services to avoid further care and treatment, particularly emergency admissions to hospital, that could be addressed sooner and before they become serious.

- **Rehabilitation and Recovery Beds:** Bed-based intermediate care to improve patient outcomes and reduce the amount of time a person must stay in a short-term bed.
- **System Visibility and Active Leadership:** Making better use of the wealth of information across our health care system to produce system wide and service level dashboards, also putting in place the right governance across the system to support decision making.
- **Transfers of Care:** New model to minimise delays to discharge for a patient and to make sure they are supported by all those involved in their care to achieve independence after leaving hospital.

From relieving seasonal pressures on the acute hospital, to a reduction in long-term care, HomeFirst has enjoyed some real achievements. Most importantly, Leeds' residents are receiving highly effective services and achieving much better outcomes:

- **899 people avoiding a hospital admission** each year.
- A **31% reduction in discharge delays** for people requiring ongoing support after hospital.
- **470 people supported to return home** after hospital instead of being discharged to a bedded setting each year.
- **A reduction of 8.1 days** in the average length of stay spent by people admitted to our short-term beds.
- **565 additional people able to benefit** from reablement each year, supported to regain their independence at home, following a stay in hospital.
- **152 people per year able to return to their own home** following a stay in a short-term bed, instead of going into a long-term residential placement.
- **33% decrease in readmission rates** after receiving home-based reablement.

Learn Engage Accelerate and Develop (LEAD) Programme

In response to the launch of the Quality and Value Programme (April 2024), the Organisational Development team put in place 15 training modules on a range of topics to support leaders and managers to take teams and services through transformational change.

Topics include:

- Compassionate and Courageous Leadership.
- The art of the Honest Conversation.
- Finance and Data analysis.
- Governance and Risk.
- Patient Involvement and Quality Improvement methodology.

Modules are reviewed regularly to refresh content in response to both internal and external context and other requirements.

I Thrive/We Thrive Programme

We commissioned the Inspiring Leaders Network to provide a development programme for a range of colleagues who identified as being from diverse backgrounds. The 'I Thrive' programme began in March 2024.

A new and positive approach called 'We Thrive' was included in the programme. This saw development times organised to support the line managers of people taking part in 'I Thrive'. It gave space to explore and address known challenges in supporting and developing people from culturally diverse backgrounds.

The aims of the I Thrive/We Thrive programme included:

- Reducing limiting beliefs and habits, replacing them with empowering ones.
- Freeing people from the stress and worry of past negative experience.
- Understanding differences and enriching relationships with others.
- Developing deeper rapport, being more persuasive and having greater leadership influence.
- Feeling more resourceful even in challenging situations.
- Enhancing self-appreciation and self-esteem.
- Setting appropriate, achievable, and motivating goals for self, service/department, and the organisation.

Sixteen talented colleagues completed the course (pictured opposite), and outcomes included growth in personal confidence; ability to lead and influence change; career progression and leadership and communication skills. Managers of the participants also benefited from the programme, improving their awareness of barriers to progression that people from culturally diverse backgrounds experience, and a better connection and relationship with their team member.

A celebration event in December 2024 marked the end of the course. Participants and their managers shared their experience and the impact of the programme with our Chief Executive and Board members. With their consent, we are tracking the progress of programme attendees and thinking about how to continue supporting diverse groups to develop and progress in the organisation.

I Thrive, We Thrive is part of our BME Development programme which also saw a number of people complete the Institute of Leadership and Management (ILM) 5 Coaching programme. This means we are now able to offer coaches that represent our diverse workforce.

"I have developed a lot as a person; I am more confident in voicing my opinion in a group of people or a meeting. I feel more confident in approaching people in higher roles to have a conversation and share my opinion. I have got more self-belief and feel more confident when making independent decisions."

"I would never have applied for a higher banded role before this programme. I now recognise that I have lots to offer."

"The programme was a game-changer. It not only equipped me with tailored leadership skills but also helped me rediscover my confidence. During the course, I applied for another higher role, this time, with a renewed sense of purpose and preparation. And this time, I succeeded."

Racial Equity in Care

Achieving racial equity is fixed firmly in our strategic objective. When we invest in equity and inclusion, we invest in performance. When we commit to equity, we ignite productivity - not just through better collaboration, but through a shared sense of purpose. We want to make sure there is equity in everything we do, and our long-term health equity plan moves us 'from intent to action'.

Our racial equity work centres on '**naming racism, identifying how it operates and acting to address it'** (Jones, 2018). Here are some key successes this year that support further development of our anti-racist approaches:

- ✔ A new Racial Equity in Care Group, co-chaired by the Director of Nursing and Allied Health Professionals and a member of the staff Race Equality Network.
- ✔ Data reporting with an equity lens on ethnicities in referrals, waiting times, missed appointments and patient safety incidents.
- ✔ In Equity and Quality Impact Assessments (EqIAs) we have included the needs of diverse ethnic groups, looking in a more joined up way at how religion and/or additional communication needs may be impacted by service change or policy development.
- ✔ Delivery of cultural competency training to 25 leaders to support the rollout of a Cultural Conversations programme.
- ✔ Review and alignment of three anti-racism frameworks: **Race and Health Observatory anti-racism principles**; **North West BAME Assembly anti-racist framework** and; **NHSE Patient and Carer Race Equality Framework** to look at areas of work that the evidence shows could have a real and lasting effect on care delivery and support functions.

Our improvement plan for 2025/26 includes actions in six key areas:

- Leadership: naming and committing to act on racism.
- Lived experience: ethnically diverse community, patient and carer engagement and coproduction in services and in our anti-racism work.
- Data and analysis.
- Policy and processes.
- Culturally competent service delivery.
- Partnerships.

A workforce improvement plan is already in place as part of the Inclusion/Workforce Race Equality standard objective of our Workforce Strategy. In line with this, our Racial Equity in Care improvement plan recognises that good anti-racist approaches in care depend on ethnically diverse and culturally competent people, policies and processes.

Here Is some feedback from a member of the Racial Equity in Care Group:

"As a Black mental health nurse, I've seen firsthand how deeply race can shape the care people receive. For me, a Race Equity in Care Group isn't just about highlighting disparities - it's about doing the work to build safer, fairer, and more inclusive spaces for both patients and staff. Everyone deserves to feel seen, heard and have access to good quality care."

The **Patient and Carer Race Equality Framework (PCREF)** looks at developing anti-racist approaches in mental health providers. For us, this relates to Leeds Mental Wellbeing Service and Children and Young People's Mental Health Services. Our wider racial equity in care work incorporates the three PCREF domains:

- Leadership and governance.
- Organisational competencies.
- Patient and carer feedback mechanisms.

Staff Engagement and Networks

Engagement continues to be an important part of our work. We keep a range of formal and informal opportunities in place to support questions, concerns, ideas and feedback. We also look closely at our engagement data to make sure we know about, and are responding to, themes that are important to our people.

This year we have been delighted to see our two newer staff networks continue to develop: Disability, Neurodiversity and Long-Term Conditions and LGBTQIA+. Our well-established Race Equality Network is also flourishing. To make sure support for these forums is firmly in place at Trust Board and throughout the Trust, each network now has a dedicated Executive Director sponsor.

Feedback about being part of one of our newly formed groups:

"Being part of making LCH more inclusive to LGBTQIA+ staff builds a sense of community and belonging among LGBTQIA+ colleagues."

Performance Analysis

This section gives a more detailed analysis of how we performed in key areas during 2024/25.

Our Performance Monitoring Processes

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

- **Safe -** people are protected from abuse and avoidable harm.
- **Caring -** staff involve and treat people with compassion, kindness, dignity, and respect.
- **Effective -** people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.
- **Responsive -** services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice, and continuity of care.
- **Well-led -** leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.
- **Finance -** our resources are managed well and put to the best uses.

Our Digital, Data and Technology Strategy sets out to deliver insight and intelligence. We are on a journey to strengthen our performance reporting and working with NHS England, to put their Making Data Count methodology in place, we now use Statistical Process Control (SPC) charts to track the performance of indicators against these six domains in our Performance Brief. Our reporting looks at what is changing and what needs action - this gives us a much higher degree of assurance. We look forward to continuing this work in 2025/26 when we will undertake a deep dive review of all aspects of our performance and accountability processes.

This will include a plan to create a new look integrated performance report, a library of key performance indicators and a framework to drive improvement.

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

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

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

Our Performance against Key Performance Indicators

The Trust's services worked exceptionally hard to achieve our performance targets in 2024/25 and we are proud of our ongoing commitment to provide high quality services.

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

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

Safe - means people are protected from avoidable harm.

We are proud that our services continued their excellent track record of safety. Once again, our Serious Incident Rate remained well below the target of 0.1 per 1,000 contacts for the whole of the year. With the improvement work led by the Trust Falls Improvement Group, we continued to see a reduction in the number of falls with harm, compared to the previous year.

We have completed our first year of putting in place the NHS England's new Patient Safety Incident Response Framework (PSIRF). The framework has set out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

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

There were 5408 incidents relating to the Trust during 2024/25. This represents a stable reporting picture when compared to previous years.

Of the total LCH incidents 88.11% reported were no or low harm, which we believe is a feature of our open and transparent culture around patient safety. 7.2% were moderate or severe harm incidents and subject to investigation in line with the Trust's Patient Safety Incident Response Plan (PSIRP). The remaining 4.69% were deaths which were reported and managed in line with the Trust Mortality process.

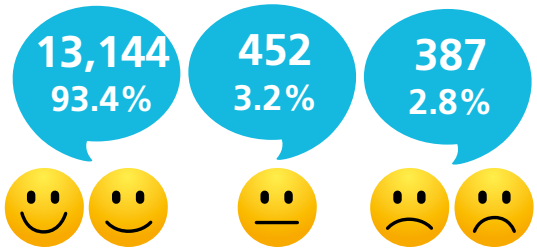
Caring - means staff treat people with compassion, kindness dignity and respect.

Friends and Family Test (FFT)

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

Between 1 April 2024 and 1 April 2025, 14,068 Friends and Family Test (FFT) responses were shared.

Survey results showed that 93.4% of people (13,144) felt our services were good or very good, 2.8% of people (387) said the service was poor or very poor and 3.2% of people (452) felt their service was neither good nor poor. There were 85 respondents who said they did not know.



Concerns, Complaints and Compliments

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

In 2024/25 we received 1590 compliments, concerns, and complaints, which is a 12% increase in feedback. We saw a minimal difference in the number of complaints, an 11.4% increase in concerns and a 14.1% increase in compliments between 2023/24 and 2024/25.

Year	2023-24	2024-25
Compliments	933	1064
Concerns	342	381
Complaints	144	145
Total	1419	1590

Of the 145 complaints received in 2024/25, 138 related to LCH services only, seven related to LCH and other organisations (multi-sector complaints).

There were 381 new concerns received in 2024/25. All concerns are shared with the service. Concerns are responded to directly wherever possible, and services use the feedback to create service improvements where they can.

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

Effective - means people's care, treatment and support achieves good outcomes, promotes a good quality of life, and is based on the best available evidence.

Over the past year, we have improved how we measure and show service effectiveness. We have done this by building a clearer evaluation framework and using information we already have, to make accountability and patient outcomes even better. A phased change plan put effort into finding meaningful metrics, bringing health equity into measurement frameworks, and improving the visibility of these measures.

Our work this year lays the foundation for a more joined up and meaningful approach to measuring effectiveness, one that works well with regulatory requirements, is responsive to patient needs, and looks at long-term, sustainable improvement.

Some of the key measures we use to assess whether we are delivering the best quality, effective care for the people we serve include:

National Institute for Health and Care Excellence (NICE)

The effectiveness of our services is measured in part by our compliance with NICE Guidance. In 2024/25 we assessed 148 pieces of NICE guidance. Of those, 25 were assessed as being relevant to our services, 10 were for information only and 15 for assessment.

We currently have 19 open pieces of NICE guidance received between 2021-2025. All have been reviewed at our NICE Guidance meeting and given to dedicated members of staff (Quality Leads) for action to achieve compliance. Our internal standard is to achieve this within two years. Our Quality Committee is kept up to date on our position through six monthly reports that detail any risks that come with non-compliance beyond two years. We currently have three pieces of guidance older than two years. Actions are reviewed and prioritised monthly at our NICE Group meeting and there is progress on all actions.

Year	Open NICE Guidance
2021-2022	4
2022-2023	2
2023-2024	7
2024-2025	6

Audit

National Audits:

During 2024/25, five national clinical audits covered the NHS services we provide. We took part fully in two out of the five national clinical audits we were eligible for during this time. We were identified as an outlier for Cohort 5 of the Epilepsy 12 national audit, An action plan was developed and put in place to make sure we are compliant going forward and so that we can continue to take part fully in future.

We are making important efforts to achieve compliance with both the Sentinel Stroke National Audit (SSNAP) and National Audit of Cardiac Rehabilitation (NACR), as we have been unable to submit data due to problems with its collection and reporting. We are aware of the potential risk to shared learning, and to our reputation, of not contributing to all national audits. Our aim is to take part in any audits that apply to our organisation as soon as possible.

Local audits:

Three Trust wide audits and 151 service specific audits were registered to be completed in 2024-2025, an increase from the previous year. A higher number of completed audits is expected to support learning and improvement in clinical practice and the Clinical Effectiveness Team is working with services to look at how we share this learning.

Number of Service Specific Clinical Audits Registered 2024-25	
Adult Business Unit	16
Children's Business Unit	60
Specialist Business Unit	62
Corporate including Medicine Management	7
TOTAL	151

Clinical audit training continues to be delivered every three months and drop-in sessions have been offered to support colleagues to complete annual audit plans.

To further improve the care we provide during 2025/26, we will make sure our audit programme works well with our Board Assurance Framework and our key strategic goals and risks.

Research and Development

The last year saw us greatly increase our research activities and involve more colleagues in the process. Our studies supported 300 patients to access innovative treatments while offering colleagues the chance to work with advanced technology such as, devices to improve stroke patients' arm movements, and Artificial Intelligence (AI) to make the best use of mental health triage. We are also set to launch a self-management app for people with musculoskeletal arm pain.

Our research advisor secondment scheme (introduced in 2023) and a rise in successful personal research fellowship awards, have allowed the research team to focus on developing colleagues in line with our strategic goals. Participants from diverse professional backgrounds have contributed to studies including self-management for swallowing difficulties, a medication toolkit for dementia patients, and a peer mentorship for respiratory and musculoskeletal rehabilitation. We have also partnered with the Leeds Older People's Forum on a community-led self-management programme for older adults with hip or knee pain who also have two or more long-term health conditions at the same time.

Making access to research even better and improving health outcomes for the people of Leeds, is important to us. We do this better when working in partnership with universities and other clinical organisations, including primary care, Leeds and York Partnership NHS Foundation Trust, and Leeds Teaching Hospitals NHS Trust.

Joint research is looking closely at 'out of hospital' care and at how we can work together better across individual organisations. The work has gathered pace and investment over the last 12 months, and the aim is to create a research model that is right for Leeds.

The developing research culture has supported a range of activities in our own organisation too:

- **Research Champions' Network:** The aim is to have a research champion in each of our services.
- **Visibility:** The research team communicates regularly through newsletters/ bulletins, Trust induction and board and business unit meetings.
- **Sharing:** Outcomes from research activity, including research mapping work.
- **Feedback:** Looking at reviews from research participants and colleagues. Of the patients who returned our research survey, 100% said they would recommend taking part.

GIRFT

The Frailty Home (Virtual) Ward and Getting it Right First Time (GIRFT) initiative (programme by NHS England to improve patient care) looks at:

- **Expert reviews:** Experienced clinical staff look at different areas of clinical practice and find ways to improve.

- **Data collection:** Data collection and analysis informs how well services and organisations are performing.
- **Sharing success:** Good practices from one organisation are shared with others.
- **Support:** The GIRFT team helps make any recommended changes.

Working together in this way helps to provide better care for patients and saves money by reducing unnecessary differences in how care is provided. An action plan that looks at the recommendations has been developed for 2025/26.

Our Frailty Home (Virtual) Ward allows patients to receive hospital-level care at home. Our clinical teams use technology to check on patients from a distance (remotely) to provide treatment that means hospital beds can be kept free for those who need them most. In April 2024, the ward increased the number of patients to 55, with an average of 84 referrals per week between January - March 2025. The team has received positive feedback, including thanks from families for compassionate care, reassurance and a thorough service. At the end of 2024, the Frailty Home (Virtual) Ward took part in a benchmarking exercise with NHS England as part of the **Getting it Right First Time (GIRFT) initiative** (see above).

More information on effectiveness can be found in our Quality Account 2024/2025: **www.leedscommunityhealthcare.nhs.uk**

Responsive - means services are tailored to meet the needs of individual people and are delivered in a way to ensure flexibility, choice and continuity of care.

The number of people waiting for care has steadily reduced throughout the year, but we have been unable to meet all our targets to see people in a timely way.

The areas under pressure:

- Children's Neurodevelopmental Services.
- Continence, Urology and Colorectal Service (CUCS).
- Community Dental Services.

These services have seen increases in referrals and are also struggling to see the people added to the waiting list during and immediately following the COVID-19 pandemic.

A successful waiting list initiative 'Access LCH' saw more clinics taking place to reduce waiting times. It looked at making sure access for people who may find it difficult to attend our services was improved and included conversations with individuals to better understand their accessibility needs. The learning from 'Access LCH' will be brought into our approach to waiting lists in the coming year.

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

Due to an increase in the complexity of patients and the reduced availability of specialist

staff, the time patients wait for care in the Continence, Urology and Colorectal (CUCS) Service has increased this year. The service has put actions in place to address this, including dedicated triage and clinicians working across multiple specialisms.

The Children's Audiology Service is our single diagnostic service, aiming to provide access to diagnostic checks within six weeks. Our performance against this standard has improved steadily throughout the year and we are now able to provide services within the standard of 99%.

Our Neighbourhood Teams and Home Ward (Frailty) services deliver an urgent community response to people in need of support who may otherwise be admitted to hospital. We aim to reach those patients within two hours of referral, and we routinely meet/exceed expectations against the national target of 70%.

Well-led - means leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation and promotes an open and fair culture.

The overall rate at which colleagues have left the Trust and new ones have joined us, (known as turnover) has remained consistently below the 14.5% target during the year, ranging between 9.3% and 10.9%. This is pleasing to see and healthy. We continue to look closely at out turnover rates across all staff groups and if any group is higher than we would wish, we respond to address any concerns. Last year, no such action was required.

Since the start of the year, overall sickness absence has been trending upwards and continues to be higher than the year before. Short-term absence remained within tolerance, but we continue to look at the prevention of, and return to work after, long-term sickness, where stress, anxiety or depression is the main reason. Our picture is the same as in other NHS organisations and within the wider UK workforce. We remain committed to supporting our colleagues to remain well and in work.

For our colleagues to provide care as safely and effectively as they can, we need them to be the best they can be, an annual appraisal can support with this. We have seen a much-improved appraisal rate this year, increasing to and staying around mid-80%, against a 90% target. This could be due to a new 'appraisal season' which we tried out in some areas with some success. Due to the availability of online training which can be completed in a flexible way, people completing statutory and mandatory training is staying at high 80%, just falling short of a 90% target.

We're proud to see our continued focus on Workforce Race Equality Standards (WRES) making an impact. Colleagues from Black and Minority Ethnic (BME) backgrounds now make up 14% of our workforce. This progress is encouraging, but there's much more to do to make sure fairness in experience and opportunity across the Trust exist for all protected characteristics.

Our commitment to meaningful change remains strong, and we will keep driving actions to achieve the NHS Equality Diversity and Inclusion improvement plan's outcomes. Everyone deserves to feel valued, heard, and empowered.

Finally, as set out elsewhere in this report, our Staff Survey results have continued to improve year on year, demonstrating good relationships with our colleagues.

Information on the risk and control framework can be found in the Annual Governance Statement on page 82 of this report.

Our 2024/25 Key Performance Indicators

Indicator	Target	2023/24	2024/25
Duty of Candour Breaches	1 per year	6	5
Attributed MRSA Bacteraemia Infections	0 per year	4	3
Clostridium Difficule Infections	3 per year	0	0
Never Event Incidence	0 per year	0	0
CAS Alerts Outstanding	0 per year	1	1
Patient Satisfaction - Percentage of Respondents Reporting a 'Very Good' or 'Good' Experience in Community Care (FFT)	95%	93%	93%
Total Number of Formal Complaints Received	No Target	139	162
Percentage of patients currently waiting under 18 weeks (Consultant-Led)	92%	43.7%	26.2%
Number of patients who waited more than 52 weeks for a Consultant service	0 per year	534	1104
Percentage of patients waiting less than 6 weeks for a diagnostic test	99%	32.6%	98.2%
Percentage of patients waiting less than 18 weeks for a non-Consultant service	95%	60.0%	61.1%
Staff Turnover	14.5%	10.5%	10.9%
Percentage of staff who left the organisation within 12 months	20.0%	13.8%	21.4%
Total sickness absence rate (monthly) (%)	6.50%	6.0%	5.9%
AfC Staff Appraisal Rate	90.0%	75.2%	83.5%
Statutory and Mandatory Training Compliance	90.0%	86.0%	88.8%
Starters / leavers net movement	0	144	-12
Compliance in Level 1 and 2 Patient Safety Training	No Target		84.6%
Number of Patient Safety Incident Investigations (PSII)	No Target		4
Number of overdue PSII actions	No Target		3
Number of Pressure Ulcers incidents	No Target		145
Number of Falls incidents	No Target		106
Number of Deteriorating Patient incidents	No Target		11
Number of Meatal Tear incidents	No Target		18
Number of Clinical Triage incidents	No Target		0

Indicator	Target	2023/24	2024/25
Compliance with statutory Duty of Candour	No Target		50%
Zero tolerance RTT waits over 65 weeks for incomplete pathways	0		
Zero tolerance RTT waits over 78 weeks for incomplete pathways	0		615
Community health services two-hour urgent response standard	70%	72.1%	79.4%
Available virtual ward capacity per 100k head of population	No Target		
Number of CAMHS Eating Disorder patients breaching the one-week standard for urgent care	No Target		15
% CAMHS Eating Disorder patients currently waiting less than four weeks for routine treatment	95%	57.1%	50.0%
Number of children and young people accessing CAMHS - year to date	No Target		3369
Percentage of Children over five currently waiting more than 18 weeks for a Neurodevelopmental Assessment	No Target		96%
No of Patients accessing treatment with LMWS service	No Target	30977	32041
IAPT - Percentage of people receiving first screening appointment within two weeks of referral	No Target	63.2%	62.9%
IAPT - Percentage of people referred should begin treatment within 18 weeks of referral	95%	98.1%	99.4%
IAPT - Percentage of people referred should begin treatment within six weeks of referral	95%	88.5%	93.6%
'RIDDOR' incidents reported to Health and Safety Executive	No Target	0	6
The overall percentage of staff who have identified as BME (including exec. board members)	14%		13.70%

Glossary of abbreviations

AfC Agenda for Change
BME Black and Minority Ethnic
CAMHS Child and Adolescent Mental Health Service
CAS Central Alerting System
FFT Friends and Family Test
LMWS Leeds Mental Wellbeing Service
MRSA Methicillin Resistant Staphylococcus Aureus
PSII Patient Safety Incident Investigations
RIDDOR Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
RTT Referral To Treatment

Sustainability

Progress against 2022-2025 Green Plan

2024-25 was the final year in the Trust's first Green Plan launched in 2022. Overall positive progress has been made over this three-year period, achieving the overarching goal of embedding sustainability into the organisation where previously it had not been considered. Although there has been no decline in carbon emissions, the projects associated within the 2022-2025 Green Plan were designed to create a sound foundation for sustainability rather than a direct influence on emissions. These essential building blocks will now allow for more precise projects to be proposed in the 2025-2028 Green Plan refresh, which will lead to a reduction in emissions.

Achievements

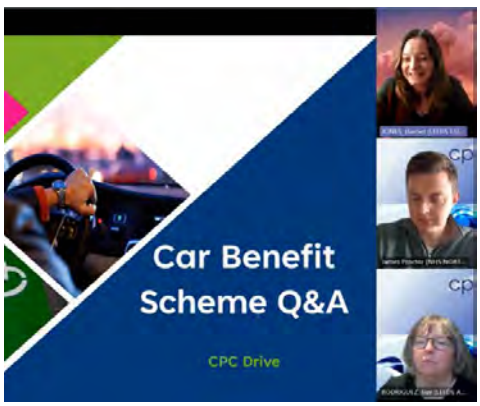
Over the past year there have been both achievements and challenges. Although the challenges have echoed those of previous years, the sustainability team has turned these challenges into strategic opportunities. These will be taken into next year through the publication of the Green Plan refresh. Below is a summary of the achievements over the past financial year.

Building and estates

- Deep dive work into which health centres will be invested into long term and prioritising boiler replacement schemes following the creation of the heat decarbonisation plans.
- Installation of 12 bike shelters and maintenance stands across retained estate.

Travel

- Significant improvements made to the inhouse vehicle staff benefit schemes to make green vehicles more affordable. This work has been nominated at the national Staff Benefit Awards with the ceremony taking place in June 2025. Several successful comms efforts to communicate the updates to staff have been launched. This included the popular Coffee Morning Q&A webinars.
- Improvement in active travel facilities across estate.
- Staff travel survey completed with good response rate of over 10% to review commuting habits.



Procurement

- Improved collaborative joint working with the Trust's main procurement partner – Leeds and York Partnership NHS Foundation Trust (LYPFT).
- Inclusion of sustainability criteria in the Procurement Strategy and tender processes developed by LYPFT with LCH input.
- Re-commencement of the clinical procurement group.

Waste

- Implementation of the 'tiger waste' streams; resulting in more appropriate waste treatment, lower carbon emissions and reduced costs.
- General waste policy updated.
- Hand dryers replace paper towels across estate.

Carbon emissions

Over the past 12 months, the Trust's carbon emissions have stabilised (following COVID 19 period), particularly within categories where the Trust has control: estates, travel and waste. Procurement emissions have decreased significantly over the past three years but, as emissions are linked to Trust spend, it is not reflective of true emission decline.

Green Plan refresh 2025-2028

The 2025-2028 Green Plan refresh is due to be approved and published by 31 July 2025. Following the Trust's first green plan, this refresh aims to be more ambitious. Carbon emission reduction will be the primary performance measurement and target. The plan will still be focused around the four main emitting areas of the Trust, however, there will be additional subsections which we expect will have a significant impact on emissions. This includes digital, medicines, staff engagement and climate adaptability.

The tactics and projects of this refresh are centred around a three-step change ambition:

1. Halt the increase in the Trust's carbon emissions.

2. Stabilise emissions into a plateau phase.

3. Facilitate the decline of emissions through project implementation.

A change from the previous 2022-2025 Green Plan, all projects proposed in the refresh will have SMART (Specific, Measurable, Achievable, Relevant and Time bound) goals associated with them. All projects have been formed with the view that they will lead to some degree of emission decline.

Task Force on Climate-Related Financial Disclosures (TCFD)

NHS England's NHS Foundation Trust Annual Reporting manual expects Trusts to adhere to the TCFD recommendations through a phased approach. Against the recommendations of the TCFD, LCH is at the very first stage of its climate adaptability journey, which includes raising a formal risk acknowledging how the Trust will be impacted by climate change. Moving into 2025-2026 it has been confirmed that a sustainability and climate adaptability (SCA) director led taskforce will be established. This will make sure the appropriate actions and projects are put in place to adhere to our climate adaptability responsibilities and our net zero journey.

Task force on Climate-Related Financial Disclosures (TCFD) Pillars

The Trust's position against the TFCD pillars for climate adaptability is summarised below.

Governance Pillar

Describe the board's oversight of climate-related issues:

Trust Board has oversight over climate-related issues; they approve the overall Green Plan and receive bi-annual updates on performance against the plan. Whilst the current Green Plan does not refer to climate adaptability, this features as a key priority within the Trust's 2025-28 Green Plan refresh and, as such, has been presented and discussed with Business Committee during 2024/25 as part of the development of the plan.

The Board will be formally approving the refresh of the Trust's Green Plan during 2025. Reporting against the refreshed plan will further strengthen the Board oversight of all climate related issues.

Describe management's role in assessing and managing climate-related issues:

Currently Business Committee is updated on a six monthly basis on sustainability progress, however at present this does not include climate adaptability. Moving forward into 2025, communication to Business Committee on climate adaptability will be facilitated through the formation of the SCA steering group. This will be a regular group consisting of managers from a variety of key departments including estates, procurement and facilities. Each department will report progress to the Director responsible for sustainability and will be the primary link to Business Committee.

Risk Management Pillar

Describe the organisation's processes for identifying and assessing climate-related risks:

In March 2025 the sustainability department raised a formal climate adaptability preparedness risk. This was the first step in guiding departments across the Trust to undertake individual risk assessments for potential climate change scenarios which could result in disruption to services. This includes, but is not limited to, flooding, supply chain failures or prolonged heat waves.

Describe the organisation's processes for managing climate-related risks:

Processes for managing risks are through the Trusts existing governance structures. We recognise however there is more we can and should do in relation to climate change and adaptability and that this warrants a refreshed process / governance arrangement. A strengthened approach will be introduced during 2025-26.

Describe how processes for identifying, assessing and managing climate-related risks are integrated into the organisations overall risk management approach:

Collaboration with the Trust's Emergency Response Planning department has already been established through the raising of the climate adaptability preparedness risk. Over the next year, there is an aim to integrate climate adaptability into Trust wide business continuity plans. This action will be monitored and overseen by the SCA steering group with initial input and guidance from the Emergency Response Planning Department.

Metrics and Target Pillar

Disclose the metrics used by the organisation to assess climate-related risks and opportunities in line with its strategy and risk management process:

LCH is compliant with its business continuity management systems, however it recognises more climate-related specific work needs to be carried out. A key step will be to evaluate how prepared the systems are for specific climate adaptability related risks such as prolonged heatwaves or buildings at risk of surface flooding. Moving into 2025 this will be a focal point in the initial stages of climate adaptability planning.

Describe the targets used by the organisation to manage climate-related risks and opportunities and performance targets:

At this stage, the reported metrics used within the Green Plan are related to carbon emissions and sustainability targets. Currently there are no specific performance targets associated with climate adaptation. Through the raising of the climate preparedness risk, it is anticipated that these targets will start to form as work progresses.

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

2024/25 saw a change in Board leadership with the Executive Director of Finance now being responsible for the delivery of the Green Plan with specific responsibilities shared across the Executive Team.

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

Signed Sara Munro .....

Sara Munro, Interim Chief Executive

Date 25 June 2025 .....

Our Staff

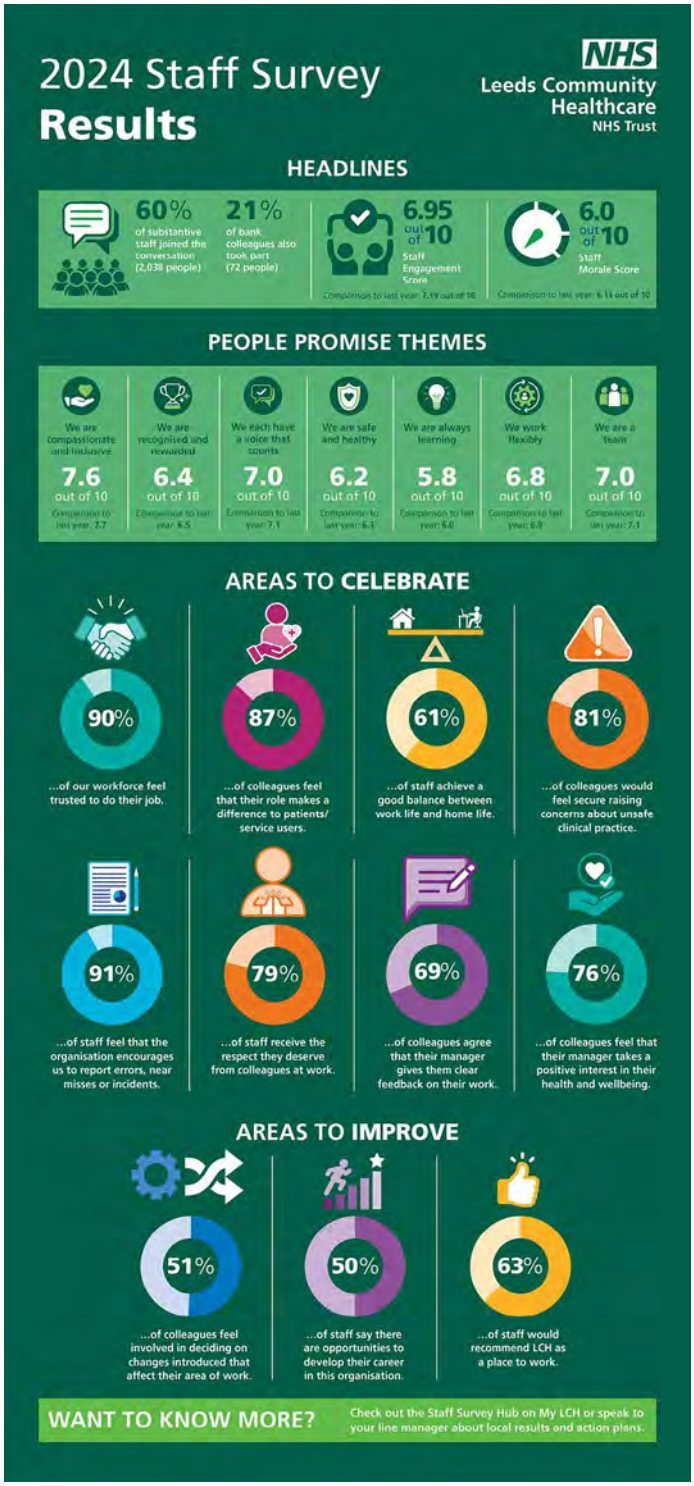
NHS Staff Survey

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

We are proud to say we achieved another high response rate of 60%. We have consistently achieved high response rates over the last four years. Comparing response rates over the last few years we are -1.5% (2023), +1.9% (2022), +8.7% (2021). We have achieved this through a combination of a dedicated resource to engage around the staff survey, collaborating between teams and services, putting in place an effective communication and engagement plan, and receiving senior level sponsorship from the CEO, directors and general managers.

Our 2024 key findings, compared to 2023 include:

- Of the 108 questions in the survey, we maintained our scores in 75 questions.
- We maintained our scores in four of the seven People Promise Themes.
- We had decreases in both our engagement and morale scores.
- In comparison to our benchmark group of Community Trusts, we rank slightly below average across five People Promise Themes.



- We are above the national average score for all seven People Promise themes and Engagement and Morale scores.

You can find our full results and benchmark reports by visiting the NHS Staff Survey website and searching **Leeds Community Healthcare - Local Results**
www.nhsstaffsurveys.com

Awards and recognition

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

External awards

2025 Awards

- The Homeless Health and Inclusion/Homeless Health Intervention Beds teams won a Leeds Quality and Care award.

2024 Awards

- The Love to Learn Training and Development team was shortlisted in the Nursing Times Awards Technology and Data in Nursing category for our innovative learning platform.
- The 0-19 Public Health Integrated Nursing Service won Team of the Year at the Unite-CPHVA 2024 Excellence Awards. This was for their work to offer holistic learning opportunities for undergraduate nursing students on placement.
- The HomeFirst project led by Team Leeds (Leeds Community Healthcare NHS Trust, Leeds Teaching Hospitals NHS Trust, and Leeds City Council) was shortlisted for the Patient Experience Network National Awards.
- Helen Heer, Speech and Language Therapist and Rebecca Kelly, Specialist Physiotherapist in the LCH Community Neurological Rehabilitation Team were awarded an internship as part of the Integrated Clinical Academic (ICA) Programme. The ICA programme is funded by Health Education England (HEE) and is run by the National Institute for Health Research (NIHR).
- Victoria Carruthers, Specialist Occupational Therapist in the LCH Community Neurological Discharge Team was awarded the National Institute for Health and Care Research (NIHR)-funded Pre-doctoral Clinical Academic Fellowship.
- LCH Musculoskeletal Service Physiotherapists, Paul Brown and Krystal Tang were both awarded a Masters in Research, as part the National Institute of Health Research (NIHR) INSIGHTS Programme.
- Anna Crowle, Physiotherapist in the LCH Integrated Children's Additional Needs Service (ICAN) Service has been awarded Health and Care Research (NIHR) Clinician Researcher Credentials Framework funding for an MSc in Health and Clinical Research Delivery.
- NHS South Yorkshire Integrated Care Board and West Yorkshire Integrated Care Board were shortlisted in two categories of: HRH The Prince of Wales Award for its Integrated Approaches to Care and the Nursing in the Community work: Creating and sustaining nurse/carer partnerships. Facilitated across Leeds, by Leeds Community Healthcare NHS Trust colleagues Hayley Ingleson, Senior Practice Learning Facilitator, Emma Jackson, Patient Engagement, Experience and Participation Officer and John Walsh, Organisational Development Lead and Freedom to Speak Up Guardian.
- The 'Collaboration safety improvements between A&E and police custody detainees' were shortlisted in the Dame Elizabeth Anionwu Award in the Inclusivity in Nursing and Midwifery category, Nursing Times Awards 2024. New pathways and paperwork, improved standards and training improvements allowed for a more effective and quicker discharge process.

- Craig Russo (OBE), Operational Lead for Humberside Police Custody received a Highly Commended Champion of the Year Award in the UK Parliament Week Awards in recognition of his voluntary work and the work for Leeds Community Healthcare in Police Custody Humberside in patient safety improvement and leading new pathways.
- Dr Ruth Burnett, Executive Medical Director, was awarded the Senior Fellowship of the Faculty of Medical Leadership and Management (FMLM) Conference. FMLM Fellows include a broad range of clinical leaders recognised for their leadership experience, skills, and contribution to healthcare.

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

Internal awards

We continue to celebrate colleague achievements through our monthly recognition scheme, Thanks a Bunch. This year, our directors hand delivered 12 surprise bouquets of flowers and certificates to unsuspecting staff members who had been nominated by colleagues for being shining examples of the Trust behaviours.

Our 2024/25 annual staff awards, the Thank You Event, builds upon this monthly recognition scheme, with directors surprising winning and highly commended colleagues and teams at bases and locations across the city. This year we received 70 nominations from across the organisation in the following categories: Leader of the Year, Team of the Year, Kate Granger Patient Care, Making Stuff Better, Project of the Year and Colleague of the Year.

Inclusion

At the heart of our commitment to inclusion is the Equality, Diversity, and Inclusion Forum, led by our Trust's Chair. This is where our employees come together to share their experiences, perspectives, and ideas, helping us build a workplace that truly reflects the communities we serve.

Our staff networks, Disability, Neurodiverse and Long-Term Conditions, LGBTQIA+, and Race Equality staff networks all play a vital role in encouraging cultural awareness. Through national campaigns, religious and cultural celebrations, or personal stories shared across our internal channels, these voices help shape an environment where everyone feels seen, heard, and valued.

Together, we're working toward a future where differences in experience and opportunity are a thing of the past.

Staff health and wellbeing

We provide and commission a full range of employee wellbeing services to support colleagues' physical and mental wellbeing at work; and to provide additional help and guidance in the event of ill health. At a challenging time for NHS colleagues, who are working with a high degree of uncertainty and change, this has never been more important.

Support during 2024/25 has included:

- Over 1200 appointments with Occupational Health clinicians.
- Over 300 support calls with the Trust's Employee Assistance Programme.

Our wide range of support includes structured and preventative work on psychological health and wellbeing such as:

- **A new critical incident debriefing model:** Critical Incident Staff Support Pathway (CriSPP), which has supported over 130 requests for group or individuals briefs.
- **Schwartz Rounds:** Over 25 support sessions, to come together and reflect on the various emotional and social challenges associated with working in healthcare.
- **Staff Development Day for Health and Wellbeing Champions (over 60 people) and Mental Health First Aiders (over 70 people):** To work on our health and wellbeing objectives and to hear feedback on how to better support their development.

As living costs continue to rise, we continue to provide colleagues with access to a range of financial support when they need it. This includes support to 'stream' some of their earned wages sooner than pay day, access to financial webinars, as well as currently continuing to pay the Real Living Wage.

We continue to raise awareness to managers and staff on the wide range of health and well-being support available.

Financial Performance

At the start of the year, we formulated our income, expenditure and workforce plans, ensuring that we had sufficient income to cover our day-to-day operating expenditure. Our financial plan was stretching, a surplus of £1m, and was underpinned by the requirement to deliver a savings target of £15.8m (7%).

Despite a challenging financial environment and increased demand for our services we ended the year with a surplus of £1,931k, details of our performance are included within the table below.

The financial performance recognised by NHS England excludes a number of technical items such as impairments of land and buildings and capital grants and donations, taking this into consideration the Trust ended the year with an adjusted surplus of £1,943k.

Summary Income and Expenditure Position

	2024-25 £000
Operating Income	238,248
Operating Expenses	(237,919)
Operating surplus / (deficit) from continuing operations	**329**
Net Financing Costs	1,782
Other gains / (losses)	(180)
Surplus / (deficit) for the year	**1,931**
Adjusting items	12
Adjusted financial performance surplus / (deficit)	**1,943**

You will have read earlier in this report about our Quality and Value Progamme. This strong financial performance would not have been achieved without the commitment and engagement seen from all our teams throughout this programme.

At the end of the year, we achieved our savings target in full, recurrent savings of £9,130k, were mainly achieved through review and redesigning a number of our service offers via our quality and value programme, rationalisation of our Estate and strengthening our business processes in relation to procurement of goods and services.

We recognised at the outset that service redesign and transformation would take time and so we introduced a range of measures that would allow us to control our costs and minimise non-essential spending. These measures were effective not only in achieving financial balance, generating non recurrent savings of £6,648k, but also enabled us to re-direct resources, temporarily, to invest in a targeted programme to reduce waiting lists.

As an NHS Trust we are required to abide by our own statutory duties to carry out our functions effectively, efficiently and economically, however we are also part of the West Yorkshire Integrated Care System (ICS); this means that we have a shared objective to work together to achieve financial balance. We contributed positively to the financial performance of the West Yorkshire ICS by managing the costs of rising demand within our services, when, the Integrated Care Board (ICB) in Leeds was unable to provide financial support for the cost of growth, as well as over-achieving against our financial plan.

Cash and Capital Expenditure

Having strong cash balances is critical to our financial sustainability, it means we have sufficient resources to pay our staff, our suppliers and invest in our capital infrastructure. We continue to manage our cash well with a closing cash and cash equivalent balance of £50.9m.

We achieved our commitment to the Better Payment Practice Code, which requires payment of all trade creditor invoices within 30 days of receipt of a valid invoice (unless other terms have been specifically agreed with the supplier). The target set is 95% for both value and number of invoices and we achieved this in full across both NHS and Non-NHS suppliers.

Capital Expenditure

Capital scheme	2024/25 Outturn £k
Estate Maintenance	1,521
Clinical Equipment	407
IT - National Cyber Security	415
Sub-Total	**2,343**
PDC Capital - Frontline Digitisation	1,306
PDC Funding - EPR Project	210
Sub-Total Capital Expenditure	**3,859**
Lease cars IFRS 16	369
Lease Car Remeasurement	10
Property Leases IFRS 16 - Additions	437
Property Leases IFRS 16 - Remeasurement	3,172
Sub-Total Finance Lease Expenditure	**3,988**
Lease Disposals	(79)
Owned Asset Disposals	(140)
Disposals	**(219)**
Total Capital Expenditure	**7,628**

We continued to invest in our estates undertaking a number of programmes of work including refurbishments at Morley, Bramley and Chapeltown Health Centres, as well as maintenance at all of the Trust sites in the year, with items being picked up through regular building inspections.

Following last year's CCTV upgrade the Estates team worked closely with the Security Service on various projects, including the estate wide emergency personal address (PA) system.

We have also been working hard to make our estate more sustainable and resilient to climate change. Every site has now had a building management system installed, which allows us control energy usage from a central location.

Aligned to our refreshed Digital Data and Technology strategy we have invested £1,931m in enhancing our digital maturity. We continued to benefit from national funding of £1,516m that allowed us to improve our digital hardware within the Trust and improve systems by installing robotic automation projects and a wound care system. Part of the national funding was also received to enhance the Trust's integration with the Yorkshire and Humber Care record system.

The main lease expenditure was due to the remeasurement of property leases with Community Health Partnership and Monroe, relating to a number of health centres and White Rose Office Park. The Trust also entered a new property lease for St George's Centre to accommodate the new Sexual Health contract and a number of vehicle leases.

In summary, at the end of 2024/25 financial performance remains strong and for the 14th year running we have achieved all our financial targets, this is a significant achievement, and my thanks go out to all of our staff for their engagement and support.

Key Financial Performance Targets

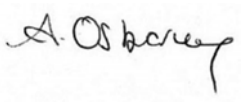
Key Financial Duties	Plan	Outturn	Variance	Achieved
Surplus on income and expenditure	£1,000k	£1,931k	£931k	✔
Remain within Capital Resource Limit*	£15,020k	£7,628k	£7,392k	✔
Capital Cost Absorption Rate	3.50%	3.50%	0.00%	✔
Agency	£3,759k	£2,408k	£1,351k	✔
Better Payment Practice Code:				
Non-NHS invoices - number	**95%**	95%	+0%	✔
Non-NHS invoices - value	95%	97%	+2%	✔
NHS invoices - number	95%	98%	+3%	✔
NHS invoices - value	95%	97%	+2%	✔

*The Trust is permitted to underspend against the CRL, slippage was utilised by Partners across the WY ICS.

Forward look

As we move into the new financial year, the scale of financial challenge for the NHS and Leeds Community Healthcare, remains significant. We know now there will be changes to key components of our operating model, including the need to reverse corporate cost growth, the redesign the role of Integrated Care Boards and the bringing together of NHS England and the Department of Health and Social Care, all of which will have a significant impact on our day-to-day workings.

Nevertheless, this brings enormous opportunities for us, and I am confident that, through our values and behaviours, we can build on the strong foundations we have established within our Quality and Value programme; to continue to transform the way we work to deliver services that are safe, effective and affordable.



Andrea Osborne
Interim Director of Finance and Resources

Legal obligations and how we are meeting them

Improving Health Equity, Inclusion and Wellbeing

2024/25 marks the fourth year of our formal commitment, through approval of our Health Equity strategy, to addressing unfair and avoidable differences in the health of different groups and communities, by working with communities and partners to create equitable care and pathways. This year, we have added a fifth strategic priority to embed equity in everything we do, marking the centrality of our commitment to fairness in our care.

Our strategy supports us to move from intent to action, identifying and addressing inequities within our own provision of care as well as contributing to cross-system action to address wider determinants.

- **Person-centred care** – increasing recording of communication needs across our patient population; development of easy read and Plain English patient information; delivery of Health Literacy awareness sessions; launch of the accessibility tool for online patient information.
- **Quality and Safety** – embedding the use of equity data in quality reports to identify whether the risk of harm from healthcare is experienced unequally across different groups of patients, the mechanisms that drive these differences in risk and possible solutions; inclusion of equity in the review and development of our Patient Safety Incident Response Plan (PSIRP).
- **Availability and use of data** – improvements in inclusion of equity data achieved through clear expectations that Committee and Board reports must all consider data through an equity lens and improved availability of equity data through the development of a suite of self-service equity reports and equity data embedded within newly developed dashboards. This year equity measures for waiting lists have been added to the performance brief, using SPC charts to track the odds ratios over time of the likelihood that people in IMD1 (most deprived) will wait longer for care than people in IMD2-10.
- **Workforce and leadership** – the rollout of our Cultural Conversations programme continues, with cultural competency training delivered monthly to support service leads with their own cultural competence and when facilitating conversations with teams about working with different cultures and identities.

This works well with delivery of our statutory duties:

- The **Public Sector Equality Duty** requires us to have due regard to the need to eliminate discrimination, advance equality of opportunity and foster good relations between different people when carrying out their activities. Our Equity and Quality Impact Assessment goes beyond the removal or minimisation of disadvantages suffered by people due to their protected characteristics to include focus on deprivation and health inclusion groups. This year, 37 EqIAs have been brought to panel with risks identified

and mitigated. Sixteen have had a further review to confirm that the proposed action and mitigation has successfully reduced identified risks. This year we have also embedded Equity Impact Assessments in our policy development and review processes. To date 40 policies have been reviewed and ratified with strengthened consideration and mitigation of the barriers diverse groups experience in healthcare.

- **Accessible Information Standards** require us to identify, record, flag, share and meet the communication needs of people with disabilities and sensory impairments. Working with system colleagues to respond to patient and carer feedback, we have broadened the focus of our communication recording to include community languages as well as reasonable adjustments around disability. Communication needs are recorded and shared through a template in our electronic patient record. This year we have taken part in a pilot to develop a national self- assessment framework for the revised Accessible Information Standards. Procurement of digital communication tools is also supporting us to increase accessibility of information and systematising how we continue to meet people's communication needs.
- **Equality Delivery System (EDS22)** is the national framework for assessing equality in the NHS, with domain 1 focussed on commissioned services. For maximum effect, we worked as a Leeds-wide system to assess and develop improvement plans for equity in services delivering palliative and end of life care. Data and feedback from patients, carers and the third sector identified strengths, particularly in the delivery of personalised safe care, accessible information and creativity in engagement with diverse communities demonstrating that we are rating 'achieving' in terms of fairness across communities. This has also identified actions for improvement around data collation and analysis; cultural competence, increasing and using feedback from groups and communities who experience inequalities, barriers to accessing services and are seldom heard. These actions build on the delivery of the 2023 EDS improvement plan for mental health services.
- **Armed Forces Covenant** includes a legal obligation to have due regard to the principles of the covenant for the Armed Forces community, which includes currently serving members of the UK Armed Forces (regular and reserve), veterans, and family members. This means consciously considering the Covenant when developing, delivering and reviewing policies and decisions which may impact the Armed Forces community. In practice this includes consideration of access, experience and outcomes of the Armed Forces community in EQIAs and acting to address disadvantages the Armed Forces community might face compared to the general population, such as mitigating the risk of longer waiting times due to a mobile lifestyle and prioritising care where this is a result of service. In 2024, we gained VCHA accreditation. Delivery of our ongoing improvement plan is overseen by our Armed Forces steering group, chaired by the Medical Director as Exec Lead for Armed Forces in Leeds Community Healthcare.
- **Patient and Carer Race Equality Framework:** (PCREF) is an anti-racism framework for mental health services. In Leeds Community Healthcare these are Leeds Mental Wellbeing Service and Children and Young Peoples Mental Health Services. In 2024, we have been working with system partners to understand the experience of mental health services of racialised communities, building on our work to contribute to the Synergi partnership pledges to reduce ethnic inequalities in mental health. This work is contributing to the development of our PCREF action plan for delivery next year. While the PCREF is a requirement for mental health services, we are expanding this to consider

racial equity in our physical health services. This work will be overseen by a new Racial Equity in Care group, co-chaired by a member of our staff Race Equality Network and the Director of Nursing, as our Executive Lead for this work.

- **NHSE reporting requirements:** As required by **NHS England's Statement on Information on Health Inequalities (duty under section 13SA of the National Health Service Act 2006)** information on health inequalities for Talking Therapies and children and young people's mental health access has been provided for publication in the national annual reports **NHS Talking Therapies, for anxiety and depression, Annual reports - NHS England Digital** and **Mental Health Bulletin - NHS England Digital** respectively.

You can read more about this in our 2024/25 Quality Account on our website: **www.leedscommunityhealthcare.nhs.uk**

Emergency Preparedness and Resilience

LCH continues to fulfil its requirements as a provider of NHS-funded healthcare as set out in the Civil Contingencies Act 2004. Additionally, all NHS Trusts are required to adhere to the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework and to take part in the annual assurance audit against the NHSE Core Standards. The purpose of this process is to assess the preparedness of the NHS – both commissioners and providers, against a common set of NHS EPRR core standards to provide assurance that NHS Trusts, NHS Integrated Care Boards and NHS England are resilient and prepared to respond to any form of disruption to normal service provision. This also includes being able to respond to incidents and emergencies whilst maintaining the ability to continue to deliver safe patient care.

In the year 2022/23 the annual core standards scoring system changed considerably from previous years and this has once again led to the Trust being assessed as non-compliant for the year 2023/24. The Trust has however demonstrated considerable improvement in many of the key areas of the core standards and in order to address the outstanding core standards the Trust has revisited its EPRR Workplan to focus on areas of non-compliance with a view to the Trust increasing its level of compliance ahead of the October 2025 submission.

- **Plan updates:** Throughout the year any outstanding Emergency Plans and Policies have been updated in line with the latest NHSE guidance.
- **Exercising:** The Trust Annual Exercise took place in October 2024 and focused on IT disruption. The exercise was well attended and highlighted a number of points regarding our preparedness to manage longer-term incidents. Learning from the exercise highlighted the need for services to review their business continuity arrangements and to consider how they would maintain safe service delivery during a prolonged disruption. Learning from a previous system failure had also highlighted the requirement to consider back up arrangements and processes in the event of a prolonged system outage.
- **Internal Audit review of Business Continuity arrangements:** The Trust Annual Exercise took place in October 2024 and focused on IT disruption. The exercise was well attended and highlighted a number of points regarding our preparedness to manage longer-term incidents. Learning from the exercise highlighted the need for services to review their

business continuity arrangements and to consider how they would maintain safe service delivery during a prolonged disruption. Learning from a previous system failure had also highlighted the requirement to consider back up arrangements and processes in the event of a prolonged system outage.

- **Trust Learning and Exercising Group:** This newly formed group held its first meeting in March of this year. The purpose of the group is to test business continuity arrangements and take learning from exercises and incidents at national, regional and local level to update our plans and demonstrate the continuous improvement of our business continuity and emergency response planning arrangements.

- **Training:** The Learning and Exercising Group also provides a valuable learning and training opportunity for Trust on-call Managers.

  All Trust 2nd On-call Managers have now completed the NHS England Principles of Health Command Training at a Strategic level. Following the launch of the new Trust on-call arrangements all 1st On-call Managers will be required to undertake the Principles of Health Command training at a Tactical level.

  The Trust has also been represented at a number of national, regional and local webinars more recently about Adverse Weather and Climate adaptability.

Health and Safety

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

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

The Health and Safety Group is the forum that enables staff to be involved in developing and reviewing the Trust's health and safety arrangements. The Group, which met four times in 2024/25 was chaired by the Director of Workforce and its membership includes staff side representatives.

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

Counter Fraud, Bribery and Corruption

We do not tolerate fraud and work hard to prevent, deter, detect and investigate it.

We have a Local Counter Fraud Specialist (LCFS) and there are a number of policies in place to support countering fraud, bribery and corruption. This work is overseen by the Trust's Executive Director of Finance and Resources with regular oversight and scrutiny undertaken by Audit Committee. It is our policy that all allegations of fraud must be referred to the Trust's LCFS or Executive Director of Finance and Resources. We raise awareness of all aspects of fraud and regularly publish newsletters / articles, run training

programmes for our staff and teams as well as having a dedicated intranet page that directs staff to key information and contacts so they can refer issues directly to the LCFS

Our counter fraud work complies with all relevant standards and annually we complete a counter fraud functional standard return (CFFSR) which supports us to self-review the counter fraud, bribery and corruption work that we have carried out over the previous twelve months.

We can confirm that the CFFSR shows a green rating across all requirements for 2024/25.

Modern Slavery and Human Trafficking Statement

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

Disclosure of Personal Data Related Incidents

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

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

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

For details of the personal data related incidents reported by the Trust during 2024/25 please see the Annual Governance Statement on page 82.

Safeguarding

Safeguarding involves working collaboratively with families and partner organisations across health and social care to uphold every individual's right to live free from abuse, neglect, and emotional harm.

LCH is dedicated to promoting the safety and wellbeing of our community through strong multi-agency partnerships and active public engagement, in alignment with our organisation's vision and values. We acknowledge Leeds City Council's Social Work service as the lead agency in this area.

The Trust approved a three-year Safeguarding Strategy (2023-2026), setting out our priorities and direction, is going to plan. The strategy reinforces our commitment to making safeguarding a shared responsibility and recognises its central role in fulfilling our duty of care.

LCH safeguarding team work extremely hard to ensure awareness and training where required for new and emerging safeguarding themes.

Duty of Candour

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

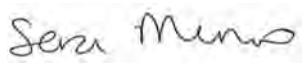
- An investigation was carried out to understand the initial facts in relation to what happened, what went wrong and what we could have done better.
- Applicable incidents were discussed at a Rapid Review or Duty of Candour Decision Meeting.
- The people affected were informed, necessary apologies given and any immediate learning shared.
- The people affected were provided with an explanation of how we would investigate and asked if they would like to be involved including if they required any questions to be answered within the investigation.

Going Concern Assessment

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

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

The Board considered the matter of the Trust as a going concern at its meeting on 28 March 2024. Our formal financial reporting begins on page 81.

Signed  **Sara Munro**, Interim Chief Executive

Date 25 June 2025

Accountability Report

Corporate Governance Report

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

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

Our Board is accountable to the public and stakeholders for:

- High quality, safe health services.
- Accessible and responsive health services.
- Making sure public money is spent in a way that is fair, efficient, effective and economic.
- Being a good employer.
- Engaging patients and the wider public in shaping health services.

The Board plays a key role in:

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

The Trust's Chair and Chief Executive/Interim Chief Executive have led these functions throughout 2024/25.

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

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

Board Composition

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

Here are the people on our Board of Directors as at 31 March 2025

Brodie Clark CBE
Chair

Selina Douglas
Chief Executive

Helen Thomson
Non-Executive Director (Vice Chair)

Rachel Booth
Non-Executive Director

Sam Prince
Executive Director of Operations

Andrea Osborne
Executive Director of Finance and Resources

Alison Lowe OBE
Non-Executive Director

Professor Ian Lewis
Non-Executive Director

Lynsey Yeomans
Executive Director of Nursing and Allied Health Professionals

Dr Ruth Burnett
Executive Medical Director

Khalil Rehman
Non-Executive Director

Lynne Mellor
Associate Non-Executive Director*

Jenny Allen and Laura Smith
Director of Workforce*

*Non-voting members

Meet the Board
Non-Executive Directors

Brodie Clark CBE
(Trust Chair)

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

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

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

Helen Thomson Deputy Lieutenant
(Vice Chair)

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

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

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

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

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

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

Alison Lowe OBE

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

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

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

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

Professor Ian Lewis

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

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

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

Richard Gladman (to June 2024)

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

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

Khalil Rehman

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

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

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

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

Rachel Booth (Associate Non-Executive Director to 30 Sep 2024, then Non-Executive Director from 1 October to present)

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

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

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

Lynne Mellor (Associate Non-Executive Director from 1 Nov 2024 to present)

Lynne is passionate about the NHS and supporting the local community.

She has considerable experience at Board level, both in the UK and globally, driving innovation and thought leadership across large multinationals; Lynne has held a number of senior leadership positions most latterly in BT plc as Director of Strategy, Transformation and Operations. She has a demonstrable track record in leading small to complex change in public and private sectors.

Lynne is an experienced Non-Executive Director having served for several years on the Board of York and Scarborough Teaching hospitals, championing improvements for patients and staff with a particular focus on digital, sustainability and culture change.

She is a co-owner of a business consultancy which has expertise in transformation, and technology covering for example, artificial intelligence and cyber security solutions.

Lynne holds a Master of Business Administration degree together with a number of professional business qualifications.

Executive Directors

Selina Douglas

(Chief Executive 15 April – to present)

Selina took up the role of Chief Executive at LCH from April 2024. LCH is a community provider based in the city of Leeds delivering mental health and community services to wide and diverse population beyond the city boundaries.

Selina has a strong Adult Care background from operational teams to Director of Commissioning and Enterprise across three London boroughs. As part of this role Selina was the lead Adult Social Care Director for the London Borough of Hammersmith and Fulham. Selina has held senior roles in both Sustainability and Transformation Plans/Clinical Commissioning Groups and provider Trusts, such as Northeast London NHS Foundation Trust. Selina is committed to the voluntary sector and spent three years as the Managing Director at Turning Point, as well as currently being a Trustee for Waythrough.

Sam Prince

(Interim Chief Executive to 14 April 2024, Executive Director of Operations 15 April 2024 to present)

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

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

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

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

Steph Lawrence MBE

(Executive Director of Nursing and Allied Health Professionals, Interim Deputy Chief Executive to 30 August 2024)

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

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

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

Dr Ruth Burnett

(Executive Medical Director)

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

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

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

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

Andrea Osborne

(Interim Executive Director of Finance and Resources to 20 June 2024, and substantive from 1 July 2024)

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

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

Andrea North

(Interim Executive Director of Operations to 14 April 2024)

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

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

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

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

Sheila Sorby

(Interim Executive Director of Nursing and Allied Health Professionals from 1 - to 30 September 2024)

Sheila joined LCH in 2019 as Deputy Director of Nursing and Quality and is currently the Interim Director of Nursing and Allied Health Professionals at LCH.

Based in West Yorkshire, Sheila has over 32 years as a Registered General Nurse and has worked in community and primary care services for 20 years, an

achievement reflected in her Queens Nurse title. Sheila is passionate about doing the best for our people – our patients, our staff, our families, and our carers. Driving quality and improvements with a skilled and diverse workforce to deliver safe and effective care to people, out of hospital, is what enthuses her every day.

Lynsey Yeomans

(Executive Director of Nursing and Allied Health Professionals from 1 October 2024 - to present)

Lynsey joined LCH in October 2024. She began her nursing career 25 years ago in her home city of Glasgow, where she was as a paediatric nurse. Lynsey brings a wealth of experience to Leeds from a wide variety of settings, including community children's nursing, education and training. She has worked in Quality roles in NHS England, as well as being Chief Nurse for the North West Ambulance Service and Deputy Director of Nursing and AHPs at Pennine Care.

A real advocate for learning from the voice of patients and their loved ones, Lynsey strives to provide the best possible care whilst being mindful of the use of public money.

Alongside her commitment to nursing, Lynsey enjoys running and has recently completed her second marathon in Manchester. She advocates through her running club, Marple Runners, for how movement can help with personal health and wellbeing.

Directors

Jenny Allen and Laura Smith

(Director of Workforce - job share)

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

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

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

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

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

Changes to the Board

During 2024/25 there were ten changes to individual members of the Board, outlined as follows:

- Selina Douglas was appointed as Chief Executive from 15 April 2024.
- Sam Prince was appointed as Deputy Chief Executive from 15 April 2024.
- Andrea North stood down as Interim Executive Director of Operations from 15 April 2024.
- Steph Lawrence stood down as Executive Director of Nursing and Allied Health Professionals and Deputy Chief Executive on 30 August 2024 due to retiring.
- Sheila Sorby was appointed as Interim Executive Director of Nursing and Allied Health Professionals from 1 September to 30 September 2024.
- Lynsey Yeomans was appointed as Executive Director of Nursing and Allied Health Professionals from 1 October 2024.
- Andrea Osborne was appointed as Executive Director of Finance and Resources from 1 July 2024, previously undertaking the role in an interim capacity from 5 February 2024.
- Richard Gladman stood down as Non-Executive Director on 30 June 2024.
- Rachel Booth moved from an Associate Non-Executive Director role to a Non-Executive Director role on 1 October 2024 following a recruitment process.
- Lynne Mellor joined as an Associate Non-Executive Director on 1 November 2024 following a recruitment process.

A ‘fit and proper’ Board

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

The main components of this are:

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

The Trust has a programme of workshops to support Board members’ development, and in 2024/25 covered such topics as organisational strategy and review of services, performance management, health equity, equality and inclusion, business planning and the well-led developmental review. Both executives and non-executives attend training days and networking events to improve their knowledge base and remain up to date with current NHS matters.

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

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

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

Director's declarations of interests for disclosure 2024/25

The register of interests for Trust Board members and decision makers is available on the Trust website at the following link:

https://lch.mydeclarations.co.uk/declarations

Board meetings and business in 2024/25

As with all NHS Trusts, we are required to hold formal Board meetings in public. The Board has met formally six times during the year. At these meetings, the Board takes strategic decisions and monitors the operational performance of the Trust. Any member of the public is welcome to attend the formal meetings. The Board has further encouraged the public to attend during the year with some Board meetings being held in community venues across Leeds.

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

The Board has also met informally on a further five occasions during 2024/25. These events have taken the form of a Board development programme and have involved a wider group of senior leaders.

Attendance at formal Board meetings is outlined below:

	7 Jun	19 Jun	3 Sep	4 Oct	6 Dec	6 Feb	
Brodie Clark	✔	✔	✔	✔	✔	✔	6/6
Richard Gladman	✔	✔					2/2
Ian Lewis	✔	✔	✔	✔	✔	✔	6/6
Helen Thomson	✔	✔	✔	✗	✔	✔	5/6
Alison Lowe	✔	✔	✗	✔	✔	✔	5/6
Rachel Booth (Associate until 30 September 2024, NED from 1 October)	✔	✔	✗	✔	✔	✔	5/6
Khalil Rehman	✔	✔	✔	✔	✔	✔	6/6
Lynne Mellor (Associate from 1 Nov 2024)					✔	✔	2/2
Selina Douglas	✔	✔	✔	✗	✔	✗	4/6
Sam Prince	✔	✔	✗	✔	✔	✔	5/6
Ruth Burnett	✔	✔	✔	✗	✔	✔	4/6
Andrea Osborne	✔	✔	✔	✔	✔	✔	6/6
Steph Lawrence (until 31 Aug 2024)	✔	✔					2/2
Sheila Sorby (1 -30 Sep 2024)			✔				1/1
Lynsey Yeomans (from 1 Oct 2024)	✔	✔	✗	✔	✔	✔	6/7
+Jenny Allen/Laura Smith	✔	✔	✔	✔	✔	✔	6/6

+Officer in attendance (job share)

In addition, an Annual General Meeting was held on 17 September 2024. This was held in person at the Trusts headquarters, White Rose Office Park, Leeds.

Leeds Community Healthcare NHS Trust has a commitment to providing high quality care and reducing health inequalities within our communities. The Trust aims to innovate, build and standardise 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 meets this commitment are overseen closely by the Board.

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

The Board's committees (decision making groups)

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

Details of the functions of each committee can be found in our Annual Governance Statement 2024/25 which starts on page 82.

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

- West Yorkshire Mental Health Services Learning Disabilities and Autism Collaborative. This comprises of the four mental health and community NHS trusts in West Yorkshire (Bradford District Care NHS Foundation Trust, Leeds and York Partnerships NHS Foundation Trust, Leeds Community Healthcare NHS Trust, and South West Yorkshire Partnership NHS Foundation Trust) working together to ensure high quality, sustainable mental health services.
- Leeds Primary Healthcare Collaborative, which is Leeds Community Healthcare NHS Trust and the Leeds GP Confederation whose aim is to jointly deliver city-wide seamless and efficient primary care and community health services for patients.
- West Yorkshire Community Health Services Provider Collaborative. This comprises of eight community providers in West Yorkshire (Airedale NHS Foundation Trust, Bradford District Care NHS Foundation Trust, Calderdale and Huddersfield NHS Foundation Trust, Harrogate and District NHS Foundation Trust, Mid Yorkshire Teaching Hospital Trust, Leeds Community Healthcare NHS Trust, Locala and Yorkshire Ambulance Service NHS Trust) working together to collectively improve outcomes and make the most of resources.

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

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

Date 25 June 2025 .....

Compliance with the Code of Governance

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

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

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

Table 1: Disclosures required to be reported on in the Annual Report

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

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

Provision	Requirement	Evidence	Comply
Section C, 4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline. • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition. • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives. • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served. • the gender balance of senior management and their direct reports.	Annual Report Nominations and Remuneration Committee Annual Equality, Diversity and Inclusion Report that evidences compliance with the Public Sector Equality Duty (evidenced through Business Committee and Board minutes)	Annual Governance Statement – Nominations and Remuneration Committee summary, and Equality and Diversity section
Section D, 2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed. • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans. • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit. • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	Annual Report Process for appointment of auditors	Annual Governance Statement

Provision	Requirement	Evidence	Comply
Section D, 2.6	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	Annual Report	Statement of Directors' responsibilities
Section D, 2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	Annual Report Board Assurance Framework Process	Annual Governance Statement
Section D, 2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	Annual Report Audit Committee Risk Management Reports	Annual Governance Statement
Section D, 2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	This is described in the Annual Accounts - Finance	Going Concern Statement
Section E, 2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration. disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	Requirement noted - should this ever be the case this would be described in the Annual Report and Accounts	N/A

Table 2: Comply or explain provisions

Provision	Requirement	Comply
Section A, 2.2	The board of directors should develop, embody and articulate a clear vision and values for the trust, with reference to the ICP's integrated care strategy and the trust's role within system and place based partnerships, and provider collaboratives. This should be a formally agreed statement of the organisation's purpose and intended outcomes and the behaviours used to achieve them. It can be used as a basis for the organisation's overall strategy, planning, collaboration with system partners, and other decisions.	Trust vision and values agreed for 2024/25. The Board also agreed its five strategic goals and a number of priorities that are aimed at supporting the delivery of the strategic goals. The strategic goals inform the Trust's Strategic and Operational plans. The Board receives quarterly reports on progress towards achieving its priorities. When setting its strategic priorities, the Board will take account of the ICB's strategic priorities, both at ICB and Leeds Place level.
Section A, 2.4	The board of directors should ensure that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy, the quality of its healthcare delivery, the success of its contribution to the delivery of the five year joint plan for health services and annual capital plan agreed by the ICB and its partners, and to ensure that risk is managed effectively. The board should regularly review the trust's performance in these areas against regulatory and contractual obligations, and approved plans and objectives, including those agreed through place-based partnerships and provider collaboratives.	The Board regularly review performance using the Performance Brief in Board Committees and within the Board meeting to measure and monitor the quality, effectiveness and efficiency of healthcare delivery.
Section A, 2.5	The board of directors should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and performance. Where appropriate and particularly in high risk or complex areas, the board of directors should commission independent advice, eg from the internal audit function, to provide an adequate and reliable level of assurance.	All executive directors and non-executive directors, through the Board sub-committees have an opportunity to receive and influence the Internal Audit Plan for areas of high risk prior to it being signed off by the Audit Committee. Should the Board require, the internal auditors can be asked to look at any areas of concern for the Board; internal auditors can be commissioned by the Audit Committee where the Board or NEDs have concerns about areas of performance. The Business Committee and the Board of Directors receives annual performance reports which show data relating to WRES and WDES.

Provision	Requirement	Comply
Section A, 2.6	The board of directors should report on its approach to clinical governance and its plan for the improvement of clinical quality in the context of guidance set out by the Department of Health and Social Care (DHSC), NHS England and the Care Quality Commission (CQC). The board should record where in the structure of the organisation clinical governance matters are considered.	The Board has formally approved its Board sub-committee structure including the Quality Committee which receives assurance on clinical governance and quality matters. Assurances on clinical governance and clinical quality are made to the Board of Directors through reports made by the chair of the Quality Committee. The Trust produces a Quality Report which sets out progress against the Trust's quality improvement priorities.
Section A, 2.7	The chair should regularly engage with stakeholders including patients, staff, the community and system partners, in a culturally competent way, to understand their views on governance and performance against the trust's vision. Committee chairs should engage with stakeholders on significant matters related to their areas of responsibility. The chair should ensure that the board of directors as a whole has a clear understanding of the views of the stakeholders including system partners.	Engagement with stakeholders is reported to Public Board via the Chief Executive's report and within the Annual General Meeting.
Section A, 2.9	The workforce should have a means to raise concerns in confidence and – if they wish – anonymously. The board of directors should routinely review this and the reports arising from its operation. It should ensure that arrangements are in place for the proportionate and independent investigation of such matters and for follow-up action.	The Trust has a Freedom to Speak Up Guardian (FTSUG) and FTSUG Ambassadors. The Board receives a six-monthly report from the FTSUG. There is a nominated FTSU Board Champion who meets regularly with the FTSUG.
Section A, 2.10	The board of directors should take action to identify and manage conflicts of interest and ensure that the influence of third parties does not compromise or override independent judgement.	The Trust has a Managing Conflicts of Interest Policy and Procedure which includes Standards of Business conduct. Registers are in place and available on request. Registers of Director interests are published within the Annual Report.
Section A, 2.11	Where directors have concerns about the operation of the board or the management of the trust that cannot be resolved, these should be recorded in the board minutes. If on resignation a non-executive director has any such concerns, they should provide a written statement to the chair, for circulation to the board.	Requirement noted. If and when applicable resignations would be reported to Board.

Provision	Requirement	Comply
Section B, 2.1	The chair is responsible for leading on setting the agenda for the board of directors and ensuring that adequate time is available for discussion of all agenda items, in particular strategic issues.	Agendas for the Board are prepared by the Chair, CEO and Company Secretary.
Section B, 2.2	The chair is also responsible for ensuring that directors receive accurate, timely and clear information that enables them to perform their duties effectively.	The Chair takes an active role in specifying the format of the information provided to directors. The Chair is clear as to the timeframe in which information should be distributed to the Board of Directors.
Section B, 2.3	The chair should promote a culture of honesty, openness, trust and debate by facilitating the effective contribution of non-executive directors in particular, and ensuring a constructive relationship between executive and non-executive directors.	The Chair ensures that there is effective contribution from all members of the Board, in particular the non-executive directors and the opportunity to challenge the executive directors. The Code of Conduct contains information about our values and makes reference to the Nolan Principles. The Chair allows sufficient time for discussion at Board meetings. The Board encourages its sub-committees to look at areas in detail where needed. Board and sub-committee meetings run in accordance with Trust values
Section B, 2.5	The chair should be independent on appointment when assessed against the criteria set out in Section B, provision 2.6. The roles of chair and chief executive must not be exercised by the same individual. A chief executive should not become chair of the same trust. The board should identify a deputy or vice chair who could be the senior independent director. The chair should not sit on the audit committee. The chair of the audit committee, ideally, should not be the deputy or vice chair or senior independent director.	The Chair of the Trust and the Chief Executive abide by the division of responsibilities as set out in the standing orders and standing financial instructions. The roles of the Chair and Chief Executive are undertaken by two different individuals. The Chair of the Trust has completed a declaration as to their independence. Whilst the Chair is required only to do this on appointment we test this (as for all other NEDs) on an annual basis. The Chair of the Trust has not previously been the Chief Executive of the Trust. The Board has identified a deputy chair and a senior independent director. The Audit Committee is not attended by the Chair of the Trust on a regular basis; however, an invitation is extended for them to attend once a year.

Provision	Requirement	Comply
Section B, 2.7	At least half the board of directors, excluding the chair, should be non-executive directors whom the board considers to be independent.	The Board comprises five non-executive directors excluding the Chair in comparison to five executive directors, therefore, at least half the Board comprises non-executive directors. On appointment and annually thereafter, the NEDs are required to declare their independence. All the non-executive directors have been determined to be independent.
Section B, 2.8	No individual should hold the positions of director and governor of any NHS foundation trust at the same time.	This is evidenced through the annual declaration of interest forms.
Section B, 2.9	The value of ensuring that committee membership is refreshed and that no undue reliance is placed on particular individuals should be taken into account in deciding chairship and membership of committees. For foundation trusts, the council of governors should take into account the value of appointing a non-executive director with a clinical background to the board of directors, as well as the importance of appointing diverse non-executive directors with a range of skill sets, backgrounds and lived experience.	The Board has made a clear determination as to the membership of the committees in the agreed terms of reference. The Trust has two NEDs with clinical backgrounds, other NEDs have a diverse range of skill sets.
Section B, 2.10	Only the committee chair and members are entitled to be present at nominations, audit or remuneration committee meetings, but others may attend by invitation of the particular committee.	Requirement noted and included within the Terms of Reference.
Section B, 2.11	In consultation with the council of governors, NHS foundation trust boards should appoint one of the independent non-executive directors to be the senior independent director: to provide a sounding board for the chair and serve as an intermediary for the other directors when necessary. Led by the senior independent director, the foundation trust non-executive directors should meet without the chair present at least annually to appraise the chair's performance, and on other occasions as necessary, and seek input from other key stakeholders. For NHS trusts the process is the same but the appraisal is overseen by NHS England as set out in the chair appraisal framework.	The Senior Independent Director undertakes the annual appraisal of the Chair.

Provision	Requirement	Comply
Section B, 2.12	Non-executive directors have a prime role in appointing and removing executive directors. They should scrutinise and hold to account the performance of management and individual executive directors against agreed performance objectives. The chair should hold meetings with the non-executive directors without the executive directors present.	The CEO reports directly to the Chair, with Executive Directors reporting to the CEO. Appointment of Executive Directors include the relevant NED on the interview panel and inclusion of others with the assessment centre process. Annually the CEO reports formally to the Nominations and Remuneration Committee on his appraisal meetings and objective setting with each Executive. The Chair holds a quarterly meeting with the non-executive directors as a group without the executive directors present.
Section B, 2.14	When appointing a director, the board of directors should take into account other demands on their time. Prior to appointment, the individual should disclose their significant commitments with an indication of the time involved. They should not take on additional external appointments without prior approval of the board of directors, with the reasons for permitting significant appointments explained in the annual report. Full-time executive directors should not take on more than one non-executive directorship of another trust or organisation of comparable size and complexity, and not the chairship of such an organisation.	The expected time commitment is set out in the letter of appointment and in accepting the appointment Directors confirm that they are able to allocate sufficient time to the role.
Section B, 2.15	All directors should have access to the advice of the company secretary, who is responsible for advising the board of directors on all governance matters. Both the appointment and removal of the company secretary should be a matter for the whole board.	Company Secretary in post.
Section B, 2.16	The board of directors as a whole is responsible for ensuring the quality and safety of the healthcare services, education, training and research delivered by the trust and applying the principles and standards of clinical governance set out by DHSC, NHS England, the CQC and other relevant NHS bodies.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.

Provision	Requirement	Comply
Section B, 2.17	All members of the board of directors have joint responsibility for every board decision regardless of their individual skills or status. This does not impact on the particular responsibilities of the chief executive as the accounting officer.	The Board acts as a unitary Board, with Executive and Non-Executive Directors sharing the same liabilities and joint responsibilities for all decisions taken by the Board. A schedule of matters reserved for the Board is in place.
Section B, 2.18	All directors, executive and non-executive, have a responsibility to constructively challenge during board discussions and help develop proposals on priorities, risk mitigation, values, standards and strategy. In particular, non-executive directors should scrutinise the performance of the executive management in meeting agreed goals and objectives, receive adequate information and monitor the reporting of performance. They should satisfy themselves as to the integrity of financial, clinical and other information, and make sure that financial and clinical quality controls, and systems of risk management and governance, are robust and implemented.	The Board acts as a unitary Board and challenge is made by both the executive and non-executive directors. The non-executive directors will in particular challenge on the performance of the executive directors in achieving the standards, targets and measures set.
Section B, 2.19	The board of directors should meet sufficiently regularly to discharge its duties effectively. A schedule of matters should be reserved specifically for its decisions.	The Board meets in public seven times per year and meets privately for Board development sessions or workshops six times per year. There are also extraordinary meetings held when required. A schedule of matters reserved for the Board is included in the standing orders and standing financial instructions, and this is reviewed annually by the Audit Committee and agreed by the Board to ensure it remains fit for purpose.
Section C, 2.1 (NHS foundation trusts only)	The nominations committee, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors. The nominations committee should give full consideration to succession planning, taking into account the future challenges, risks and opportunities facing the trust and the skills and expertise required within the board of directors to meet them. Best practice is that the selection panel for a post should include at least one external assessor from NHS England and/or a representative from the ICB, and the foundation trust should engage with NHS England to agree the approach.	Use of external recruitment and adherence to recommendations for selection panel. Nominations and Remuneration Committee has received reports on succession planning.

Provision	Requirement	Comply
Section C, 3.1 (NHS trusts only)	NHS England is responsible for appointing chairs and other nonexecutive directors of NHS trusts. A committee consisting of the chair and non-executive directors is responsible for appointing the chief officer of the trust. A committee consisting of the chair, nonexecutive directors and the chief officer is responsible for appointing the other executive directors. NHS England has a key advisory role in ensuring the integrity, rigour and fairness of executive appointments at NHS trusts. The selection panel for the posts should include at least one external assessor from NHS England.	Requirement noted – appointments conducted in accordance with this.
Section C, 4.1	Directors on the board of directors should meet the 'fit and proper' persons test described in the provider licence. For the purpose of the licence and application criteria, 'fit and proper' persons are defined as those having the qualifications, competence, skills, experience and ability to properly perform the functions of a director. They must also have no issues of serious misconduct or mismanagement, no disbarment in relation to safeguarding vulnerable groups and disqualification from office, be without certain recent criminal convictions and director disqualifications, and not bankrupt (undischarged). Trusts should also have a policy for ensuring compliance with the CQC's guidance Regulation 5: Fit and proper persons: directors.	All new Board members are required to sign a self-attestation form. DBS checks are completed for all new Board members. All Board members are compliant with the revised requirements in the FPPT Framework following the Kark review. This is reported to Board annually in March.
Section C, 4.3	The chair should not remain in post beyond nine years from the date of their first appointment to the board of directors and any decision to extend a term beyond six years should be subject to rigorous review. To facilitate effective succession planning and the development of a diverse board, this period of nine years can be extended for a limited time, particularly where on appointment the chair was an existing non-executive director. The need for extension should be clearly explained and should have been agreed with NHS England.	The Trust Chair has served five years to date, with a further six years as a NED prior to that. The term ends in August 2025 and a process to recruit a new Chair will shortly commence. At present, two of the NEDs have exceeded six years in post. However, in both cases their terms have been agreed with NHS England.

Provision	Requirement	Comply
Section C, 4.5	There should be a formal and rigorous annual evaluation of the performance of the board of directors, its committees, the chair and individual directors. NHS England leads the evaluation of the chair and non-executive directors of NHS trusts. NHS foundation trusts and NHS trusts should make use of NHS Leadership Competency Framework for board level leaders.	Each member of the Board is subject to an annual appraisal. Each Committee of the Board produces an annual report, reporting delivery against annual work plan and objectives. The Audit Committee reviews the annual reports from Committees.
Section C, 4.6	The chair should act on the results of the evaluation by recognising the strengths and addressing any weaknesses of the board of directors. Each director should engage with the process and take appropriate action where development needs are identified.	All Board members have an appraisal with agreed personal development plan.
Section C, 4.11	The board of directors should ensure it retains the necessary skills across its directors to ensure there is appropriate succession planning.	Requirement noted. The Nominations and Remuneration Committee undertakes succession planning for Director roles.
Section C, 4.12	The remuneration committee should not agree to an executive member of the board leaving the employment of the trust except in accordance with the terms of their contract of employment, including but not limited to serving their full notice period and/or material reductions in their time commitment to the role, without the board first completing and approving a full risk assessment.	Would adhere to this if ever required.
Section C, 5.1	All directors should receive appropriate induction on joining the board of directors and should regularly update and refresh their skills and knowledge. Both directors and, for foundation trusts, governors should make every effort to participate in training that is offered.	Induction programme and training offered to Board members.
Section C, 5.2	The chair should ensure that directors continually update their skills, knowledge and familiarity with the trust and its obligations for them to fulfil their role on the board, and committees. The trust should provide the necessary resources for its directors to develop and update their skills, knowledge and capabilities. Where directors are involved in recruitment, they should receive appropriate training including on equality diversity and inclusion, including unconscious bias.	Addressed within appraisal and mid year review processes.

Provision	Requirement	Comply
Section C, 5.3	To function effectively, all directors need appropriate knowledge of the trust and access to its operations and staff. Directors also need to be appropriately briefed on values and all policies and procedures adopted by the trust.	Available to all.
Section C, 5.4	The chair should ensure that new directors receive a full and tailored induction on joining the board. As part of this, directors should seek opportunities to engage with stakeholders, including patients, clinicians and other staff, and system partners. Directors should also have access at the trust's expense to training courses and/ or materials that are consistent with their individual and collective development programme.	Induction programme and training offered to Board members.
Section C, 5.5	The chair should regularly review and agree with each director their training and development needs as they relate to their role on the board.	Addressed within appraisal and mid year review processes.
Section C, 5.8	The chair is responsible for ensuring that directors receive accurate, timely and clear information. Management has an obligation to provide such information but directors should seek clarification or detail where necessary.	The Chair of the Trust ensures that directors receive information in a format they require and within a timescale that will allow sufficient time to prepare for the meetings. The Chair also allows sufficient time and opportunity for clarification questions to be asked in the meeting. Directors are also encouraged to seek clarification outside of the meeting in order to assist discussion at the Board meetings. There are opportunities to input to how the reports will be presented and the information they contain.
Section C, 5.9	The chair's responsibilities include ensuring good information flows across the board and their committees; between directors and governors; and for all trusts, between senior management and non-executive directors; as well as facilitating appropriate induction and assisting with professional development as required.	As above.

Provision	Requirement	Comply
Section C, 5.10	The board of directors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. The board of directors should agree their respective information needs with the executive directors through the chair. The information for boards should be concise, objective, accurate and timely, and complex issues should be clearly explained. The board of directors should have complete access to any information about the trust that it deems necessary to discharge its duties, as well as access to senior management and other employees.	Appropriate papers and reports are presented to the Board of Directors. The Board has an annual business cycle which sets out the standard papers that will be presented to them, and the Board can also agree to receive a report on any matter if it requires. The Board of Directors will from time-to-time ask for information it requires to allow it to carry out its role and to be assured of performance. Any member of the Board of Directors can request any item to be reported to Board meetings and may also ask for this to be looked at in more detail in the Board sub-committee structure.
Section C, 5.11	The board of directors and in particular non-executive directors may reasonably wish to challenge assurances received from the executive management. They do not need to appoint a relevant adviser for each and every subject area that comes before the board of directors, but should ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis. When complex or high-risk issues arise, the first course of action should normally be to encourage further and deeper analysis within the trust in a timely manner. On occasion, non-executives may reasonably decide that external assurance is appropriate.	The Board of Directors seeks assurance directly and through its committees via assurance and escalation reports. On occasions the Board and its committees invite senior staff to provide presentations to the Board. Non-Executive Directors can request external assurance as appropriate.
Section C, 5.12	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors. The decision to appoint an external adviser should be the collective decision of the majority of nonexecutive directors. The availability of independent external sources of advice should be made clear at the time of appointment.	All directors have access to professional independent advice at the Trust's expense (including legal advice and access to auditors).
Section C, 5.13	Committees should be provided with sufficient resources to undertake their duties.	Committees are supported by the relevant executive director, senior manager/s and Trust staff.

Provision	Requirement	Comply
Section C, 5.14	Non-executive directors should consider whether they are receiving the necessary information in a timely manner and feel able to appropriately challenge board recommendations, in particular by making full use of their skills and experience gained both as a director of the trust and in other leadership roles. They should expect and apply similar standards of care and quality in their role as a non-executive director of a trust as they would in other similar roles.	This would be explored in appraisal and mid year review and be raised as a separate issue if this was not taking place. The non-executive directors will challenge the executive directors if papers are not sufficiently detailed or clear. The non-executive directors will use their skills and experience to challenge the decisions of the executive in an appropriate and professional manner having due regard to necessary standards of care required in such a role.
Section C, 5.17	The Trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Cover is renewed each year and overseen by the Company Secretary.
Section D, 2.1	The board of directors should establish an audit committee of independent non-executive directors, with a minimum membership of three or two in the case of smaller trusts. The chair of the board of directors should not be a member and the vice chair or senior independent director should not chair the audit committee. The board of directors should satisfy itself that at least one member has recent and relevant financial experience. The committee as a whole should have competence relevant to the sector in which the Trust operates.	The Trust's Audit Committee comprises three independent non-executives and is chaired by a non-executive director with recent and relevant financial experience. The Trust Chair is not a member of the Audit Committee.

Provision	Requirement	Comply
Section D, 2.2	The main roles and responsibilities of the audit committee should include: • Monitoring the integrity of the financial statements of the trust and any formal announcements relating to the Trust's financial performance, and reviewing significant financial reporting judgements contained in them. • Providing advice (where requested by the board of directors) on whether the annual report and accounts, taken as a whole, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's position and performance, business model and strategy. • Reviewing the Trust's internal financial controls and internal control and risk management systems, unless expressly addressed by a separate board risk committee composed of independent non-executive directors or by the board itself. • Monitoring and reviewing the effectiveness of the trust's internal audit function or, where there is not one, considering annually whether there is a need for one and making a recommendation to the board of directors. • Reviewing and monitoring the external auditor's independence and objectivity. • Reviewing the effectiveness of the external audit process, taking into consideration relevant UK professional and regulatory requirements. • Reporting to the board of directors on how it has discharged its responsibilities.	Evidenced in the Audit Committee annual report to June Public Board each year.
Section D, 2.3	A trust should change its external audit firm at least every 20 years. Legislation requires an NHS trust to newly appoint its external auditor at least every five years.	The Trust's external auditors were re-appointed in 2025 following a process overseen by the Auditor Panel. There are no concerns about the performance of the current auditors and there is a high level of experience of the systems in place at the Trust.

Provision	Requirement	Comply
Section D, 2.5	Legislation requires an NHS trust to have a policy on its purchase of non-audit services from its external auditor. An NHS foundation trust's audit committee should develop and implement a policy on the engagement of the external auditor to supply non-audit services.	**Explain** Although the Trust can evidence the process for appointing the external auditors through Auditor Panel and Board reports, work needs to be undertaken to develop this specific policy. However, it should be noted that the external auditors have not undertaken any non-audit work during the period of their contract with the Trust. This provision has therefore been marked as non-compliant but the intent to comply confirmed and a policy will be developed during 2024/25.
Section E, 2.1	Any performance-related elements of executive directors' remuneration should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should consider the following provisions: • Whether the directors should be eligible for annual bonuses in line with local procedures. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public and patients. • Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the trust. Consideration should be given to criteria which reflect the performance of the trust against some key indicators and relative to a group of comparator trusts, and the taking of independent and expert advice where appropriate. • Performance criteria and any upper limits for annual bonuses and incentive schemes should be set and disclosed and must be limited to the lower of £17,500 or 10% of basic salary. • The remuneration committee should consider the pension consequences and associated costs to the trust of basic salary increases and any other changes in pensionable remuneration, especially for directors close to retirement.	The Trust complies with the national guidance on VSM remuneration with respect to bonuses, and has paid these to some VSMs in some years – any decisions about this are made by the Nominations and Remuneration Committee.

Provision	Requirement	Comply
Section E, 2.2	Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	Remuneration for the Chair and NEDs set in accordance with this guidance.
Section E, 2.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination. The aim should be to avoid rewarding poor performance. Contracts should allow for compensation to be reduced to reflect a departing director's obligation to mitigate loss. Appropriate claw-back provisions should be considered in case of a director returning to the NHS within the period of any putative notice.	Has not arisen - requirement noted.
Section E, 2.5	Trusts should discuss any director-level severance payment, whether contractual or non-contractual, with their NHS England regional director at the earliest opportunity.	Comply – should this ever be required.
Section E, 2.7	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments. The committee should also recommend and monitor the level and structure of remuneration for senior management. The board should define senior management for this purpose and this should normally include the first layer of management below board level.	The Nominations and Remuneration Committee has delegated responsibility for setting all executive director remuneration, and for other senior managers not covered by the Agenda for Change terms and conditions of service. This is evidenced in the Committee's terms of reference and the Standing orders and Standing Financial Instructions.

Publicly available information

Provision	Requirement	Section in Annual Report
Section B, 2.13	The responsibilities of the chair, chief executive, senior independent director if applicable, board and committees should be clear, set out in writing, agreed by the board of directors and publicly available.	This is outlined in the Standing orders, standing financial instructions and scheme of reservation and delegation of powers which is available on the Trust's external website.

Provision	Requirement	Section in Annual Report
Section C, 4.2	Alongside this, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the trust. Both statements should also be available on the trust's website.	Statement on Board of Directors page on Trust's external website.
Section E, 2.6	The board of directors should establish a remuneration committee of independent non-executive directors, with a minimum membership of three. The remuneration committee should make its terms of reference available, explaining its role and the authority delegated to it by the board of directors. The board member with responsibility for HR should sit as an advisor on the remuneration committee. Where remuneration consultants are appointed, a statement should be made available as to whether they have any other connection with the Trust.	The terms of reference of the Nominations and Remuneration Committee are published on Board and Committee Governance page on Trust's external website.

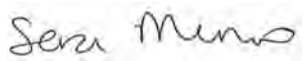
Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS England has designated that the Chief Executive should be the Accountable Officer of the Trust. The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

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

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

Signed  **Sara Munro**, Interim Chief Executive

Date 25 June 2025

Statement of Director's responsibilities in respect of the accounts

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

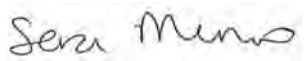
- apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- make judgements and estimates which are reasonable and prudent;
- state whether applicable accounting standards have been followed, subject to any material departures disclosed and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

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

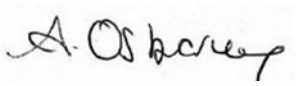
The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

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

By order of the Board

Signed  **Sara Munro**, Interim Chief Executive

Date 25 June 2025

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

Date 25 June 2025

Corporate Governance Report
Annual Governance Statement 2024/25

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**.

Selina Douglas

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 2025 and up to the date of approval of the Annual Report and Accounts.

Capacity to handle risk

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

Careful risk management is embedded within the culture of the organisation, from risk assessments in clinical practice to considering the risk in each Board decision. Risks are identified and aligned to strategic goals. Risk tolerance, i.e. the level at which risk is escalated, is clearly set out in the Risk Management Policy and Procedure.

The Chief Executive has overall responsibility for the Trust's management of risk and members of the Trust Leadership Team have been given responsibility for managing risk types:

Member of Trust Leadership Team	Risks to
Chief Executive	Staff and stakeholder engagement Integration and system change programmes
Executive Director of Finance and Resources	Efficiency Income and expenditure IT infrastructure Data security Contractual and partnership governance
Executive Director of Operations	Major change projects Business tenders Contracted activity Environmental sustainability Health and safety of staff
Executive Director of Nursing and Allied Health Professionals and Executive Medical Director	Clinical quality assessment Clinical quality improvement Clinical governance Executive Director of Nursing and Allied Health Professionals also holds operational responsibility for Risk Management
Director of Workforce	Staff capacity and capability

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

- Identify and assess risks.
- Eliminate or reduce risks to an acceptable level, in line with the Trust's approach to risk.
- Comply with policies and procedures, and statutory and external requirements.
- Maintain the Board Assurance Framework.

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

Mandatory health and safety training is delivered to managers; this incorporates risk assessment training. In addition to the mandatory training, bespoke training is provided to support teams and services with managing risk. A competency relating to risk management has been included in the managers competency framework developed by the organisational development team. Targeted training is provided where needs are identified and risk 'drop-in/Q&A sessions' have been introduced in 2024/25. There is a page dedicated to risk management on the Trust intranet, this provides access to and signposts to advice and guidance, e-learning and the policy and procedure. All training includes awareness of the Trust's approach to risk and how this should be applied in decision-making processes.

The risk and control framework

The Trust's Risk Management Policy defines the risk management framework and sets out the approach the Trust will take to the management of risk, making sure that sound risk management principles are an integral part of its governance structure and processes. It also sets out the respective responsibilities for corporate and operational risk management throughout the Trust.

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

The Trust has systems in place that contribute to the identification of risk from a number of sources for example:

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

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

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

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

The Risk Register is a record of all the risks that may affect the Trust's ability to achieve its strategic, project or operational objectives. The Trust uses an electronic risk management system to record and monitor risks. The risk register includes: a description of the risk, the risk owner, any controls currently in place, actions to be completed, and the initial, current and target risk scores. Extracts and themes from the risk register are frequently scrutinised by appropriate managers, committees, and the Board. Risk Key Performance

Indicators (KPIs) are reported to the Business Units, Trust Leadership Team, and the Board Committees in order to improve the effectiveness of the risk management process. KPIs highlight the number of risks with overdue review and risks with static scores over 12 months.

The Trust's **risk appetite** is aligned with its five strategic goals. The Trust Leadership Team defines the Trust's risk appetite and reviews this on an annual basis. Any proposed amendments are subject to review by the Audit Committee and approval by the Board. The risk appetite statement is an appendix of the Risk Management Policy, which can be found on the Trust's intranet. The risk appetite was reviewed in 2024, whereby the Trust Leadership Team included the addition of the fifth strategic goal relating to Equity. Changes were made to the risk appetite to ensure the appetite for financial risk and delivery of care supported opportunities to be taken in a controlled way.

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

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

Risk assurance process and scrutiny of risks

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

Assurance creates the bedrock of evidence which gives the Trust confidence that risk is being controlled effectively, or highlights that certain controls are ineffective or there are gaps that need to be addressed. The Trust's Board Assurance Framework (BAF) records strategic risks including risk descriptions, controls and gaps in controls, sources of assurance and gaps in sources in assurance, actions required to remedy gaps in controls or assurance.

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans are identified and the BAF has been revised during 2024, 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 BAF is reviewed on a quarterly basis and the Board receives the full BAF four times a year.

The Board receives a significant risks report at each meeting. The report details the Trust's risks scoring 15 or above (extreme), after the application of controls and mitigation measures, as well as information about risks scoring 12 (high). It provides an analysis of all risk movement, identifies themes and links these material risks to the strategic risks on the BAF. The Trust Leadership Team reviews the report in advance of the Board. The Quality Committee reviews high scoring clinical and operational risks, and the Business Committee reviews non-clinical risks, rated as high.

Assurance of risk mitigation is provided to the Board through the Quality, Audit, and Business Committees in relation to clinical and non-clinical risks. The Audit Committee also provides assurance to the Board on the risk management process.

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

Data security risks are managed through the Information Governance/Data Protection and Information Technology teams through a series of Trust Policies and technical controls.

Mitigation to Data Security risks are Implemented through a series of coordinated activities which Include:

- The ongoing and timely release of software patches to ensure our electronic devices remain as resilient as possible to the threat of cyber security risks.
- The pursuit of Cyber Essentials Plus accreditation, which has led to the introduction of improved threat detection and software patch management.
- Third party testing designed to identify vulnerabilities in the Trust security architecture are conducted regularly and any remedial actions taken.
- The development and testing of service level Business Continuity plans to ensure the Trust can respond to and maintain essential services in the event of an information security incident.
- The importance of maintaining awareness of data security, awareness to phishing emails and other cyber-risks have been highlighted to staff through yearly mandatory training, regular articles in the Trust's staff briefings and simulated Phishing Campaigns.
- The ongoing training and awareness activities for all staff.

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

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

- **Imbalance of Capacity and Demand:** Increasing demand for services (specific risks on the risk register relate to Neighbourhood Teams, CYPMHS (MindMate SPA) coupled/ reflected with increased complexity of the services required, resulting in potential

for reduced quality of patient care, delay in treatment, deterioration in health and wellbeing of patients, and additional pressure on staff, exacerbated by vacancies to some hard to recruit to roles.

- **Neurodiversity waiting times:** There is a risk of unsustainable Neurodevelopmental assessment and treatment pathways (autism and ADHD) due to demand for services surpassing the capacity resulting in unmet need of patients and long waiting lists which will cause impact to patient outcomes.

Throughout the year the Trust has focused on the controls and mitigating actions relating to the corporate risks arising from an imbalance of capacity and demand impacting on patients and staff. The Quality and Value programme and improved EQIA processes have provided focus on managing these risks.

- **IT Resilience:** The increased reliance on the Trust's IT infrastructure to support the majority of clinical and corporate processes, amplifies the risk of poor resilience, compelling resources to be allocated to cyber security tools, maintaining and investing in infrastructure to minimise legacy debt, more and better trained technical staff and letting contracts with suppliers who can supply specific expertise and capacity in the event of a significant cyber event or a major technical failure.

  An external resilience review was completed during 2024/25, with ongoing implementation of the recommendations. As a result of the actions completed to date to manage the risk, the risk has reduced from an extreme to high risk

- **Primary Care Industrial Action:** There is a risk of delays to patients having bloods taken and / delays to patients having access to medications when required. This could result in unacceptable impact on patient care. There is a further risk to implementation of Quality and Value plans involving primary care. Actions are in place to provide alternatives to primary care delivery of care and to work with primary care and the ICB in resolving the issue.

- **Finance:** The financial savings that LCH needed to achieve in 2024/25, to achieve financial balance, were significant and challenging and required significant transformation work. There was a risk that financial balance might not be achieved, resulting in loss of freedom and autonomy to act in decision making. The risk was effectively managed during 2024/25, with financial balance being achieved. A further risk will be added relating to financial balance in 2025/26.

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

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

Governance structures and accountability

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

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

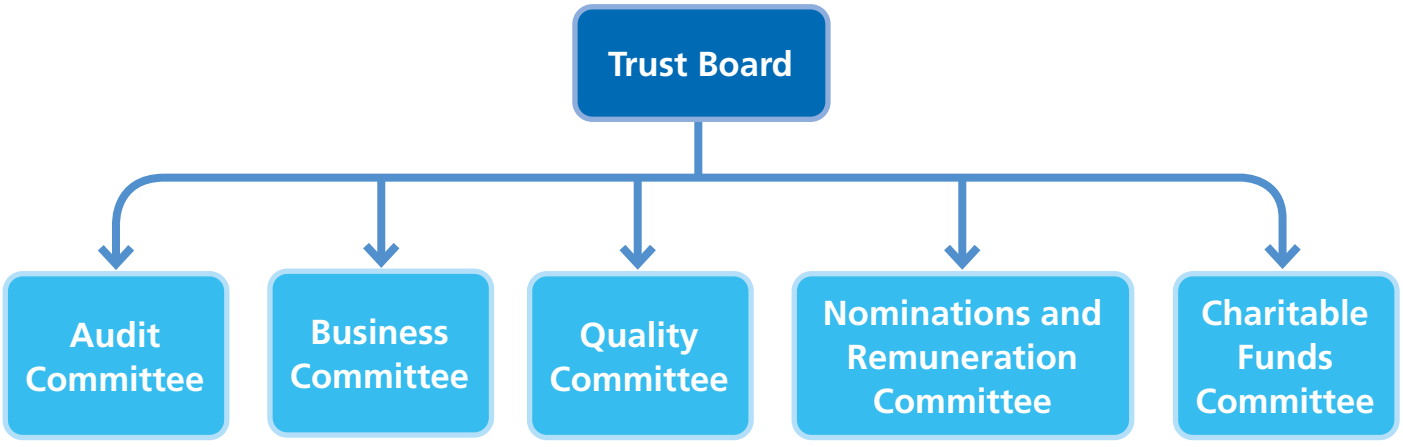
There is a clear division of responsibilities between the Chair and Chief Executive, and both have discharged their leadership functions throughout the whole of 2024/25. The division of responsibilities is set out in the Trust's standing orders and standing financial instructions (scheme of delegation section).

The Board held six formal meetings in public in 2024/25. The Annual General Meeting was held in person in September 2024. Board member attendance at Board meetings is set out in the Director's report (starting on page 90) and all meetings have been quorate.

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

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

The Board discharges its responsibilities through five Committees (see diagram below). Each committee has Board-approved terms of reference and work plans which have been reviewed during 2024/25. Each committee's minutes and assurance reports are presented at Board meetings.



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

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

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

The Board is required to carry out an independent review of governance against the **well-led framework** every three to five years. In 2024/25 following a tender exercise the Trust commissioned Mersey Internal Audit Agency to undertake a Developmental Well-Led Review to assess the leadership and governance of the Trust, in order to identify developmental actions in order to secure and sustain the Trust's future performance as part of continuous improvement.

The review was conducted from October to December 2024 and applied the updated Care Quality Commission (CQC) framework to provide a comprehensive evaluation of the Trust's capabilities, culture, and improvement opportunities.

The Independent review included:

- An overall diagnostic of the organisation's current governance arrangements including a desktop documentation review, using the CQC Well-Led KLOEs as a framework.
- Interviews with each member of the Board, key members of the senior leadership team, and an external stakeholder survey.
- Observations of key governance and assurance forums, including Trust Board, Board sub-committees, leadership forums and sub-committee groups.
- An analysis of the leadership behaviors and values as well as the governance systems, and processes.

The report concluded that there was positivity on the direction of travel of the organisation, and the compassionate and empathetic approach of Board members was evident, with the Board made up of individuals with a wide range of skills, backgrounds and experience. Committee chairing was of a good standard, and high levels of engagement and constructive contributions were observed at Committee and Board meetings. Active discussions were evident throughout the governance structure to build, challenge and enhance the Trust's equality, diversity and inclusion approach. The Trust's Board Assurance Framework was clearly visible through the governance structure and the format aligned with current good practice. External stakeholder survey results highlighted that the organisation was viewed as an active and positive system partner.

The detailed outcome of the review was presented to the Board of Directors in January 2025, and the recommendations were assigned priority ratings.

1. Overarching Strategy.
2. Board development and succession planning.
3. Governance.
4. Data Quality and Performance Management.
5. Quality and Quality Improvement.
6. Operational Risk Management.
7. Patient Voice.

An action plan has been developed with an executive lead for each developmental theme, with actions staggered over the next 24 months. The Trust Leadership Team will be overseeing progress of the implementation plan on a quarterly basis, with 6 monthly updates to the Trust Board.

The Trust has a needs-based Board development programme. In addition to the formal Board meetings, there were five Board workshops during 2024/25.

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

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

Audit Committee

Chair: Khalil Rehman

The Audit Committee comprises three non-executive directors, one of whom is a qualified accountant. The Associate non-executive director also attends the Committee. The Audit Committee met formally seven times during 2024/25 and is routinely attended by the Executive Director of Finance and Resources, the Company Secretary, Internal Audit and External Audit representatives.

The Committee provides an overarching governance role and reviews the work of the other committees which provides relevant assurance to the Audit Committee's own scope of work. It also has responsibility for overseeing the work of the Data Protection and Cyber Security Panel. 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.

Audit Committee attendance

Attendee	19 Apr	12 May (Informal)	18 Jun	12 July	11 Oct	13 Dec	11 Mar	Total (7)
Richard Gladman (until June 2024)	✔	✔	✔					3/3
Ian Lewis	✔	✔	✔	✔	✔	✔	✔	7/7
Khalil Rehman	✔	✔	✔	✔	✔	✔	✔	7/7
Rachel Booth (Associate 1 April-30 September 2024. Substantive 1 October 2024)	✗	✔	✔	✔	✔	✗	✔	5/7
Lynne Mellor (Associate Non-Executive Director 1 November 2024)						✗	✔	1/2
Andrea Osborne* (Interim from 5 February 2024. Substantive from 1 July 2024)	✔	✔	✔	✗	✔	✔	✔	6/7

*Executive Director/Interim Executive Director in attendance

Quality Committee

Chair: Helen Thomson

The Quality Committee's membership comprises three non-executive directors and three executive directors with other senior officers also attending each meeting. The Committee met on six occasions in 2024/25. Three additional informal meetings were held in the form of a joint workshop with members of the Quality Assurance and Improvement Group, which is a sub-group of the Committee.

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

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

The committee exercises these functions in the context of the Trust's Quality Strategy 2021/24 which aims to respond to challenges presented with innovation, standardisation, and a focus on improvement.

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

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

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

Quality Committee attendance

Member	28 May	22 Jul	23 Sep	25 Nov	28 Jan	25 Mar	Total (6)
Ian Lewis	✔	✔	✔	✗	✔	✔	5/6
Helen Thomson	✔	✔	✔	✔	✔	✔	6/6
Alison Lowe	✔	✔	✔	✔	✔	✔	6/6
Selina Douglas*	✔	✔	✔	✗	✗	✗	3/6
Ruth Burnett	✔	✔	✔	✔	✔	✗	5/6
Lynsey Yeomans (from 1 October 2024)				✔	✔	✗	2/3
Steph Lawrence (until 30 August 2024)	✔	✔					2/2
Sam Prince	✗	✔	✔	✔	✔	✔	5/6
Sheila Sorby (Interim Executive Director of Nursing and AHPs from 1 September 2024 - 30 September 2024 / 1 October - 31 March 2025 Deputy Director of Nursing and Quality +)	✗	✔	✔	✗	✗	✔	3/6

*CEO in attendance
+Interim Executive Director in attendance

Business Committee

Chair: Rachel Booth

The Business Committee's membership comprises three non-executive directors, the associate non-executive director, the Chief Executive and two further executives. Other

senior officers attend as required. The Business Committee held 10 meetings in 2024/25.

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 2024/25 the Committee considered recruitment and retention initiatives, proposals for a mutually agreed resignation scheme, 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 Quality and Value Board, which provides an overview of inter-connectivity for the main programmes and related projects.

Business Committee attendance

The Committee also receives twice-yearly safe staffing reports which have provided assurance that safe staffing has been maintained across the Trust's two inpatient units, Hannah House and Wharfedale Recovery Hub, during 2024/25.

Attendee	24 Apr	29 May	26 Jun	24 Jul	25 Sept	30 Oct	27 Nov	29 Jan	26 Feb	26 Mar	Total (10)
Richard Gladman (until June 2024)	✔	✗	✔								2/3
Helen Thomson	✔	✗	✔	✔	✔	✗	✔	✔	✔	✔	8/10
Khalil Rehman	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
Rachel Booth (Associate 1 April-30 September 2024. Substantive from 1 October 2024)	✔	✔	✔	✔	✔	✔	✔	✗	✔	✔	9/10
Lynne Mellor (Associate Non-Executive Director 1 November 2024)							✗	✗	✔	✔	2/4

Attendee	24 Apr	29 May	26 Jun	24 Jul	25 Sept	30 Oct	27 Nov	29 Jan	26 Feb	26 Mar	Total (10)
Selina Douglas	✔	✔	✗	✔	✔	✗	✗	✗	✗	✗	4/10
Sam Prince*	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	9/10
Andrea Osborne* (Interim from 5 February 2024. Substantive from 1 July 2024)	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
*Laura Smith/ Jenny Allen	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔	10/10
Helen Robinson+	✔	✔	✗	✔	✔	✔	✔	✔	✔	✔	9/10
Dawn Greaves+	✗	✔	✔	✔	✔	✔	✔	✔	✔	✔	9/10

*Director in attendance (job share)

+Officer in attendance

Nominations and Remuneration Committee

Chair: Brodie Clark CBE

The Nominations and Remuneration Committee's membership comprises the Chair, two further non-executive directors and the associate non-executive director. The Committee is supported by the Director of Workforce and the Company Secretary. The Committee has met six times in 2024/25.

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

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

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

The Committee ratifies and agrees any awards at the discretion of the Trust as the employer. One such duty is to review the nominations for the Clinical Excellence Awards and to encourage maximum participation from staff across the eligible consultant body.

In 2024/25 the Committee approved the recommendations for the remuneration of the interim and substantive Director of Nursing and Allied Health Professions, and substantive Director of Finance and Resources appointments, considered adjustments following Very Senior Manager benchmarking information, and continued to support various staff

financial incentive schemes which were targeted responses to the challenging workforce situation.

Nominations and Remuneration Committee attendance

Attendee	28 Jun	16 Sept	23 Oct	15 Dec	5 Feb	15 Mar	Total (6)
Brodie Clark	✗	✔	✔	✔	✔	✔	5/6
Alison Lowe	✔	✔	✔	✔	✔	✔	6/6
Rachel Booth	✔	✔	✔	✔	✔	✔	6/6
Jenny Allen/ Laura Smith+	✔	✔	✔	✔	✔	✔	6/6
Helen Robinson+		✔		✔	✔	✔	4/4

+Officer (job share) in attendance.

Charitable Funds Committee

Chair: Alison Lowe OBE

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director. The Committee is supported by the Executive Director of Nursing and met four times during 2024/25.

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

Charitable Funds Committee attendance

Attendee	18 Jun	10 Sept	17 Dec	17 Mar	Total (4)
Brodie Clark	✔	✔	✗	✔	3/4
Alison Lowe	✔	✔	✔	✔	4/4
Lynsey Yeomans (from 1 October 2024)			✔	✗	1/4
Steph Lawrence (until 30 August 2024)	✔				1/1
Sheila Sorby (Interim 1 - 30 September 2024)		✔			1/1
Andrea Osborne (Interim from 1 April - 30 June 2024 Substantive from 1 July 2024)	✔	✗	✔	✔	3/4

Changes to the Committee Structure in 2025/26

It should be noted that preparatory work has been undertaken during the latter part of 2024/25 in order to establish a new People and Culture Committee. The new Board sub-Committee will commence during May 2025 and will be reported on further in the Annual Report for 2025/26.

Incident reporting and learning from incidents

The Trust has continued to embed the Patient Safety Incident Response Framework (PSIRF) this year. The PSIRF challenges us to think and respond differently when a patient safety incident occurs. PSIRF is best considered as a learning and improvement framework with emphasis placed on the system and culture that support continuous improvement. New methodology is being applied following the undertaking of the national patient safety syllabus training levels three and four by six of our patient safety specialists this year, and this is supporting us to consider incidents from a human factor ergonomics and a systems approach.

PSIRF recognises the need to ensure we have support structures for patients and staff involved in patient safety incidents. A key part of this is fostering a psychologically safe culture, a 'Just culture' where our staff and patients feel confident to speak up when things don't go as planned. The Trust is developing robust systems for involving staff and patients in patient safety investigations and co-production of quality improvements.

A significant piece of work has been conducted in Q4 to review safety data across the organisation to inform a refresh of the Patient Safety Incident Response Plan (PSIRP) for 2025/26.

Information Governance

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

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

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

The Senior Information Risk Owner (SIRO) ensures that there is effective information governance in place. The SIRO chairs the Information Governance Approval Group which reports quarterly to the Audit Committee and in turn to the Board. The Caldicott Guardian

is the Deputy Chair of the Information Governance Approval Group, and works closely with the SIRO and the DPO, particularly where there are any identified information risks relating to patient data.

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

The Trust demonstrates compliance with the Cyber Assessment Framework, via a self-assessment through the Data Security and Protection Toolkit (DSPT). This submission is independently audited.

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

All incidents relating to a potential breach of personal data are reported, investigated and, where appropriate, remedial actions are implemented. The Trust reported two incidents to the Information Commissioner's Office (ICO) during 2024/25.

Details of the incidents are as follows:

The first breach occurred when a Leeds GP practice erroneously shared a child's full record following a Subject Access Request, including LCH data which referenced domestic violence between the parents for which the Trust was offering support, with the father of the child. The Trust approached the Data Protection Officer for the GP surgery who advised that they would carry out remedial training with the practice to prevent the error from reoccurring and would reinforce the message via information bulletins to all practices.

As such, the breach was not perpetrated by LCH, but by another organisation in error. The risk of this type of data sharing has been recognised and added to the Risk Register, however the risk of not sharing data between providers has been recognised as also being a significant risk.

The second breach happened when the Trust was made aware of a legacy staff directory from 2022 containing roughly 300 staff names and details from the Leeds Mental Wellbeing Service which was available over the internet. It had been discovered by a partner organisation when using the Bing search engine. It was only visible when using this search engine. The data disclosed included Employing organisation, Team Name, Role, Work email, Office number, Pronoun, and in some cases, there was also information regarding Sickness or maternity leave. Actions were immediately taken to remove the directory and inform all affected staff, and as the data contained details of staff working for other organisations the Data Protection Officers of those organisations were also informed. Dialogue is ongoing with affected organisations, and the Trust has provided the details of affected users.

Data Controllership of the data is being investigated as it appears the data, although maintained by LCH, was hosted on a domain owned by a partner organisation. Investigations have shown that the website used to host the data was insecure, and the Trust is advising that appropriate security certification needs to be applied.

The ICO confirmed that they were satisfied with the Trust's response to both occurrences and confirmed that no further action would be taken.

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 runs until 31 March 2026 and is aligned with the Trust's strategic goals and priorities, responding to external, internal, and cultural factors including market conditions which are currently (or anticipated) to impact on our workforce requirements. Its primary aim is to attract, develop and retain the best people in order to deliver outstanding care. The Workforce Strategy's key themes are outlined below, all of which contribute to safe, sustainable and effective staffing:

1. Resourcing

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

2. Organisation Design

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

3. Leadership

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

4. Inclusion

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

5. Wellbeing

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

6. System Partner

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

7. Foundations

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

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

The Trust's Workforce Plan supports the delivery of our operational business plan and is embedded in service needs. It is also triangulated with finance and activity data. The Plan

is updated each year and is signed off by both the Business Committee and the Board at a meeting in public.

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

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

Triangulation of data including financial, workforce and activity / performance information, takes place at the Trust Leadership Team meeting and at the Board and its subcommittees' meetings, to ensure comprehensive oversight of staffing and any issues arising.

Our services grow and develop as we deliver new pathways of care, and care for more and more people in the community. Any new service or service change is subject to a Quality Impact Assessment (QIA) which includes any new roles which create a significant change to the way care is delivered.

NHS pension obligations

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

Equality and diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Trust has a legal obligation under the Equality Act 2010 and Public Sector Equality Duty to provide equality in access to service provision and within employment.

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

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

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

The Board sets an annual budget to meet the Trust's financial obligations. For 2024/25 revenue and capital resources were agreed between the Trust and West Yorkshire ICS, the revenue plan approved was to deliver a £1m surplus. Achieving this has depended on the £15.8m efficiency programme, which represents 7.2% of income. The schemes identified to deliver the efficiencies were managed within the Quality and Value Programme, focusing on service transformation as well as a series of grip and control measures around workforce and discretionary spend.

An internal audit review in concluded an opinion of significant assurance on the design and governance framework of the Quality and Value Programme.

The Trust has worked closely with all partners within Leeds Place and across the WY ICS to ensure achievement of value for money. At the end of February, the Trust is forecasting to deliver a surplus of £1.9m.

The Trust maintained its financial governance arrangements throughout 2024/25 with the Business Committee and Board continuing to receive financial reports at each of their meetings, and the Audit Committee receiving assurances on financial governance from management, internal and external auditors.

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

On the basis of the work reported to Audit Committee in 2024/25 the external auditor has not identified any significant weaknesses in the Trust's value for money arrangements.

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

Sustainability

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

Quality Account

Quality Accounts, which are produced by providers of NHS funded healthcare, inform the public about the quality and standard of services from providers of NHS healthcare and are required by the Government to help NHS Trusts maintain focus and improve the quality of care for patients. They also provide an update on the services delivered.

Leeds Community Healthcare NHS Trust's (LCH) Quality Account looks at:

- Where our Trust is performing well and where we need to make improvements.
- Progress we have made against the quality priorities we set previously, and explains our new priorities for the next year.
- How the public, patients, carers and staff were involved in making decisions on these priorities.

By producing the Quality Account, LCH can demonstrate our commitment to continuous evidence-based quality improvement. It also explains our progress to patients and their families, the public and those who have an interest in the services that the Trust provides.

The focus of this Quality Account is to look back and celebrate our achievements and it identifies how we have and will continue to address issues that have challenged us. Our Quality Account also looks forward and highlights how we will progress and manage our ongoing priorities and challenges. Our 2024/25 Quality Account can be found on our website - **www.leedscommunityhealthcare.nhs.uk**

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.

Selina Douglas

Internal audit

Audit Yorkshire has been the provider of the Trust's internal audit services since 1 April 2022. *[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.]

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

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

* section to be updated once final Head of Internal Audit opinion received.

External audit

Forvis Mazars were re-appointed as the Trust's external auditors in 2024/25 for the 2025/26 financial year following a formal tender process carried out by the Auditor Appointment Panel and approved by Trust Board. The agreed contract period was three + one + one years.

Clinical audit

Clinical audit is a dynamic process which allows quality improvement to take place and improve outcomes for patients through systematic review of care against explicit criteria. Clinical audit can be used to identify areas for improvement and learning. When findings from clinical audit are implemented, further monitoring is used to ensure continued delivery of quality, safe, and effective care.

Clinical audit is managed at service level with the support of the clinical governance team. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the year.

During 2024/25 five national clinical audits covered the NHS services that the Trust provides, and the Trust registered in all five of these. The Trust submitted data for three out of five of these audits and are working with auditors to ensure data is able to be provided for all five in 2025/26. More information about these can be found in the Quality Account - **www.leedscommunityhealthcare.nhs.uk**

Working in collaboration

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

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

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

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

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

The WYH&CP takes a place-based approach across Bradford District and Craven; Calderdale, Kirklees, Leeds, and Wakefield that highlights the strengths, capacity, and knowledge of all those involved. This way of working is supported by West Yorkshire wide

priority programmes, such as cancer, maternity, mental health, urgent care, tackling health inequalities, children and young people. The Partnership provides greater opportunities to deliver the Five-Year Plan ambitions, ensuring that all people are given the best start in life, are able to remain healthy and age well.

Leeds Health and Care Partnership (LHCP)

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

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

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

CQC compliance

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

NHS England oversight

NHS England has assigned the Trust a segment rating of two which indicates standard oversight whereby the provider may be offered targeted support in one or more areas.

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

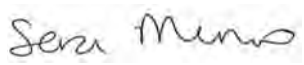
Conclusion

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

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

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

During 2024/25, no significant control issues have been identified by the Trust's systems of internal control.

Signed  **Sara Munro**, Interim Chief Executive

Date 25 June 2025

Remuneration and Staff Report

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

Three of the senior manager roles for the Trust are joint appointments with the Leeds GP Confederation; one day per week of the remuneration for the Medical Director and the Director of Workforce, Organisational Development and System Development is recharged to the GP Confederation. For five months of 2024/25 the Executive Director of Nursing and Allied Health Professionals was also a joint appointment and recharged, from September this role was no longer a joint appointment.

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

	2024 / 2025						2023 / 2024					
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**
Samantha Prince – Interim Chief Executive from 01/09/23 - 14/04/24, Executive Director of Operations from 15/04/2024	140 - 145	100	-	-	-	140 - 145	140 - 145	100	0 - 5	-	-	145 - 150
Selina Douglas – Chief Executive from 15/04/2024	155 - 160	900	-	-	-	155 - 160	-	-	-	-	-	-
Bryan Machin – Executive Director of Finance and Resources to 31/07/2023, Interim Executive Director of Finance and Resources from 01/11/2023 to 04/02/2024	-	-	-	-	-	-	65 - 70	-	-	-	-	65 - 70
Andrea Osborne – Interim Executive Director of Finance and Resources from 05/02/2024 to 30/06/2024, Executive Director of Finance and Resources from 01/07/2024*	130 - 135	-	-	-	277.5 - 280	410 - 415	20 - 25	-	-	-	-	20 - 25
Ruth Burnett – Executive Medical Director	115 - 120	300	-	-	15 - 17.5	130 - 135	110 - 115	-	0 - 5	-	-	115 - 120

	2024 / 2025						2023 / 2024					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals to 31/08/2024	35 - 40	100	-	-	-	35 - 40	95 -100	1,600	0 - 5	-	72.5 - 75	170 - 175
Sheila Sorby – Interim Director of Nursing and Allied Health Professionals from 16/08/2024 to 30/09/2024	10 - 15	-	-	-	85 - 87.5	95 - 100	-	-	-	-	-	-
Lynsey Yeomans – Executive Director of Nursing and Allied Health Professionals from 01/10/2024	50 - 55	500	-	-	32.5 - 35	85 - 90	-	-	-	-	-	-
Andrea North – Interim Director of Operations from 01/09/2023 to 14/04/2024	0 - 5	-	-	-	-	0 - 5	60 - 65	100	-	-	57.5 - 60	120 - 125
Jennifer Allen – Director of Workforce, OD and System Development	55 - 60	-	-	-	-	55 - 60	55 - 60	-	0 - 5	-	-	55 - 60
Laura Smith – Director of Workforce, OD and System Development	55 - 60	-	-	-	-	55 - 60	55 - 60	-	0 - 5	-	-	55 - 60
Brodie Clark CBE – Chair	35 - 40	400	-	-	-	40 - 45	35 - 40	400	-	-	-	40 - 45

	2024 / 2025						2023 / 2024					
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**
Richard Gladman – Non-Executive Director to 30/06/2024	0 - 5	-	-	-	-	0 - 5	10 - 15	-	-	-	-	10 - 15
Ian Lewis – Non- Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Alison Lowe – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Helen Thomson – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Khalil Rehman – Non-Executive Director	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Rachel Booth – Associate Non-Executive Director to 30/09/2024, Non-Executive Director from 01/10/2024	10 - 15	-	-	-	-	10 - 15	10 - 15	-	-	-	-	10 - 15
Lynne Mellor – Associate Non-Executive Director from 01/11/2024	5 - 10	-	-	-	0 - 2.5	5 - 10	-	-	-	-	-	-

Total remuneration for senior managers with shared responsibilities

	2024 / 2025						2023 / 2024					
Name and title	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**	**Salary** (bands of £5,000) **£'000s**	**Expense payments** (Rounded to the nearest hundred) **£'000s**	**Performance pay and bonuses** (bands of £5,000) **£'000s**	**Long term performance pay and bonuses** (bands of £5,000) **£'000s**	**All pension related benefits** (bands of £2,500) **£'000s**	**TOTAL** (bands of £5,000) **£'000s**
Ruth Burnett – Executive Medical Director	145 - 150	400	-	-	20 - 22.5	165 - 170	140 - 145	-	5 -10	-	-	145 -150
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals to 31/08/2024	45 - 50	100	-	-	-	45 - 50	120 - 125	2,000	0 - 5	-	87.5 - 90	215 - 220
Jennifer Allen – Director of Workforce, OD and System Development	70 - 75	-	-	-	-	70 - 75	65 - 70	-	0 - 5	-	-	70 - 75
Laura Smith – Director of Workforce, OD and System Development	70 - 75	-	-	-	-	70 - 75	65 - 70	-	0 - 5	-	-	70 - 75

Senior managers' remuneration – pension benefits (subject to audit)

Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2023 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Jennifer Allen – Director of Workforce, OD and System Development	0	0	25 - 30	70 - 75	566	0	597	0
Ruth Burnett – Executive Medical Director	0 – 2.5	0	25 - 30	50 - 55	405	9	465	0
Selina Douglas – Chief Executive Officer (from 15/04/2024)	0	0	5 - 10	0	289	0	129	0
Stephanie Lawrence – Executive Director of Nursing and Allied Health Professionals (to 31/08/2024)*	0	0	40 - 45	115 - 120	1,059	0	0	0
Lynne Mellor – Associate Non-Executive Director (from 01/11/2024)	0 - 2.5	0	0 - 5	0	0	1	1	0
Andrea North – Interim Executive Director of Operations (to 14/04/2024)	0	0	25 - 30	65 - 70	59	0	93	0
Andrea Osbourne – Interim Executive Director of Finance and Resources (to 30/06/2024), Executive Director of Finance and Resources (from 01/07/2024)	12.5 - 15	30 - 32.5	50 - 55	130 - 135	794	290	1,150	0

Board Member	Real increase in pension at pensionable age (bands of £2,500) £'000	Real increase in pension lump sum at pensionable age (bands of £2,500) £'000	Total accrued pension at pensionable age at 31 March 2023 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2023 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2023 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2023 £'000	Employer's contribution to stakeholder pension £'000
Laura Smith – Director of Workforce, OD and System Development	0	0	30 - 35	85 - 90	643	0	674	0
Sheila Sorby – Interim Executive Director of Nursing and Allied Health Professionals (from 16/08/2024 to 30/09/2024)	0 - 2.5	0 - 2.5	35 - 40	100 - 105	711	1	859	0
Lynsey Yeomans – Executive Director of Nursing and Allied Health Professionals (from 01/10/2024)	0 - 2.5	0	10 - 15	5 - 10	151	7	189	0

*Stephanie Lawrence left her post on 31/08/2024 and claimed all benefits on 01/09/2024. As Stephanie did not re-join the scheme, no further pensionable membership was accrued, and the values have not been proportioned for the time in post, in line with the guidance.

Information presented here is supplied by the NHS Pensions Agency.

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.

The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less, the contributions made by the individual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights. This value does not represent an amount that will be received by the individual. It is a calculation that is intended to convey to the reader of the accounts an estimation of the benefit that being a member of the pension scheme could provide. The pension benefit table provides further information on the pension benefits accruing to the individual.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement)..

Payments to past directors (subject to audit)

There have been no payments made to past directors.

Fair pay disclosures (subject to audit)

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

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

During 2024/25 the resident (junior) doctors received a multi-year pay award, however an estimate of the impact for 2023/24 was included in the pay costs reported in that year which reversed in the 2024/25 accounts and therefore the costs reported for 2024/25 are not materially affected.

Range of remuneration

Employees and agency staff annualised remuneration and salaries ranged from £16,941 to £211,222. The Trust's highest paid director was the Chief Executive whose salary was £156,984. In total six medical staff earned more than the Chief Executive, one was agency and five substantive staff.

The highest paid director for 2024/25 was the Chief Executive. No members of staff received a performance related bonus in 2024/25. Six members of staff including the Chief Executive received performance related bonus payments in 2023/24.

The percentage changes in pay of the highest paid director, the Chief Executive:

Percentage changes	2024/2025		2023/2024	
	Salary and allowances	Performance related pay and bonus	Salary and allowances	Performance related pay and bonus
Highest paid Director	10.53%	-100%	-9.5%	100%
Other employees	2.69%	-100%	2%	100%

No staff received a performance bonus in 2024/25 and therefore the change to the prior year is 100% reduction.

Total annualised remuneration and salaries for the Trust's staff including agency is shown in the tables below.

2024/2025	25th percentile	Median	75th percentile
Total Renumeration (£)	29,114	39,151	46,389
Salary component of total remumeration (£)	29,114	39,151	46,389
Pay ratio information remuneration	5.4:1	4.0:1	3.2:1
Pay ratio information remuneration	5.6:1	4.2:1	3.3:1

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

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

The banded remuneration of the highest paid director/member in Leeds Community Healthcare NHS Trust in the financial year 2024/25 was £155k - £160k (2023/24 £145k - £150k). The relationship to the remuneration of the organisation's workforce is disclosed in the table on page 113.

Year	25th percentile pay ratio		Median pay ratio		75th percentile pay ratio	
	Total remuneration	Salary	Total remuneration	Salary	Total remuneration	Salary
2024/25	5.4:1	5.6:1	4.0:1	4.2:1	3.2:1	3.3:1
2023/24	5.2:1	5.2:1	4.0:1	4.0:1	3.2:1	3.2:1

The salary of the Chief Executive was 5.6 times more than the employee who was paid the 25th percentile point in 2024/25; the median ratio is 4.2 times more than the employee in this position and 3.3 times more than the 75th percentile employee. The total remuneration includes all payments such as travel expenses not just salary; these ratios are 5.4 (25th) 4.0 (median) and 3.2 (75th). The ratios between the highest paid director and other staff have increased for all categories between 2023/24 and 2024/25. The increases reflect the move from the interim arrangements in place last year and the appointment of a substantive Chief Executive in 2024/25. The majority of staff in the Trust received a pay increase in 2024/25.

Staff Report

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

Staff costs	2024/25			2023/24		
	Permanent £k	Other £k	Total £k	Permanent £k	Other £k	Total £k
Salaries and wages	117,909	7,706	125,615	113,387	8,143	121,530
Social security costs	12,006	448	12,454	12,215	467	12,682
Apprenticeship levy	576	22	598	583	22	605
Employer's contributions to NHS pensions	25,522	953	26,475	21,084	806	21,890
Pension cost - other	21	1	22	52	2	54
Other employment benefits	0	0	0	0	0	0
Termination benefits	1,460	0	1,460	34	0	34
Temporary staff	0	2,408	2,408	0	3,793	3,793
Total gross staff costs (including seconded out)	**157,494**	**11,538**	**169,032**	**147,355**	**13,233**	**160,588**
Of which: **Costs capitalised as part of assets**	**292**	**24**	**316**	**13**	**0**	**13**

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

Average number of employees (WTE basis)	2024/25			2023/24		
	Permanent Number	Other Number	Total Number	Permanent Number	Other Number	Total Number
Medical and dental	52	25	77	50	27	77
Administration and estates	836	38	874	845	58	903
Healthcare assistants and other support staff	560	34	594	586	33	619
Nursing, midwifery and health visiting staff	884	49	933	895	54	949
Nursing, midwifery and health visiting learners	0	0	0	4	0	4
Scientific, therapeutic and technical staff	584	10	594	578	20	598
Healthcare science staff	0	0	0	0	0	0
Other	51	0	51	50	1	51
Total average numbers	**2,967**	**156**	**3,123**	**3,008**	**193**	**3,201**
Of which: **Number of employees (WTE) engaged on capital projects**	**5**	**1**	**6**	**0**	**1**	**1**

Expenditure on consultancy

The Trust has no spend on consultancy services during 2024/25 (2023/24 £Nil spend).

Off-payroll engagements

The Trust had the following off-payroll engagements as of 31 March 2025, 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 2025	22
Of which, the number that have existed:	
For less than one year at the time of reporting	9
For between one and two years at the time of reporting	7
For between two and three years at the time of reporting	
For between three and four years at the time of reporting	
For four or more years at the time of reporting	6

Six of the off-payroll appointments relate to forensic medical examiners; fifteen 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 2024/25 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 2024 and 31 March 2025, for more than £245 per day:

Number of temporary off-payroll workers engaged between 1 April 2024 and 31 March 2025	80
Of which:	
Number not subject to off-payroll legislation*	63
Number subject to off-payroll legislation and determined as in-scope of IR35*	0
Number subject to off-payroll legislation and determined as out of scope of IR35*	17
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which, number of engagements that saw a change to IR35 status following review	0

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

The Trust is required to disclose how many members of the Board or those with significant financial responsibility have been subject to off-payroll arrangements during the financial year 2024/25.

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.	18

Gender composition

*Directors here are either NEDs or individuals who have (either substantively or on an interim bases) sat on the Board of Directors at any time between April 2024 – March 2025. There are no Very Senior Managers (VSMs) below Board level.

Role	Gender	Headcount	%	FTE
Directors	Female	11	0.32%	10.02
	Male	3	0.09%	3.00
Employees	Female	2894	85.17%	2412.07
	Male	490	14.42%	454.62
	Grand total	3398	100%	2880.05

Staff turnover

	2024									2025		
Month	**04**	**05**	**06**	**07**	**08**	**09**	**10**	**11**	**12**	**01**	**02**	**03**
Headcount	3510	3508	3502	3478	3454	3474	3480	3486	3495	3519	3540	3509
Leavers Headcount	24	22	31	37	36	28	30	25	19	36	20	75
Starters Headcount	35	19	27	16	16	36	16	10	8	29	23	31
Turnover Rate (Headcount)	0.7%	0.6%	0.9%	1.1%	1.0%	0.8%	0.9%	0.7%	0.6%	1.0%	0.6%	2.2%
Turnover Rate (12m)	9.6%	9.5%	9.7%	10.1%	10.2%	9.8%	9.9%	10.0%	10.0%	10.4%	10.4%	11.1%

Engagement

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

	Engagement 2021	Engagement 2022	Engagement 2023	Engagement 2024	Morale 2021	Morale 2022	Morale 2023	Morale 2024
LCH	6.9	7.1	7.2	6.9	5.8	5.9	6.1	6.0

The Trust is proud to say it achieved another record response of 60% overall. We have consistently achieved high response rates over the last four years. For 2024 there has been a decline in our engagement and morale scores. The engagement score is significant as there are correlations between staff engagement, patient experience and patient outcomes. For this reason, it is used to compare each NHS Trust with others and is used by the CQC in their Well-Led assessments. Our scores for engagement and morale are in line with the national average (6.8 engagement and 5.9 morale) and below the community sector average (7.1 engagement and 6.2 morale).

Trade Union facility time reporting

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

Number of employees who were relevant union officials during the relevant period	8
Full-time equivalent employee number	6.69

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%	1
1-50%	7
51%-99%	0
100%	0

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

Pay bill spend	Figuress
Provide the total cost of facility time	£48,810.54
Provide the total pay bill	£169,032,000.00
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x100	0.029%

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 **= 1.92%**

Exit packages (subject to audit)

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

2024/2025

Exit package cost band (including any special payment element)	Total number of compulsory redundancies Number	Total cost of compulsory redundancies Number	Number of other departures where special payments have been made Number	Total number of exit packages Number	Total cost of exit packages Number
<£10,000	1	4,852	0	1	4,852
£10,000 - £25,000	1	22,004	0	1	22,004
£25,001 - £50,000	1	32,987	0	1	32,987
£50,001 - £100,000	2	128,850	0	2	128,850
Total number	**5**		**0**	**5**	
Total cost (£)		**188,693**			**188,693**

2023/2024

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

Staff sickness

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

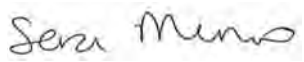
Staff sickness	2023	2024
Total days lost (WTE)	66,125	66,231
Total days available (WTE)	1,083,186	1,095,104
Sickness rate	6.10%	6.32%

Source: NHS Digital – Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse. Periods covered: January to December 2023 and January to December 2024

Staff policies applied during the financial year

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

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

Signed  **Sara Munro**, Interim Chief Executive

Date 25 June 2025

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 2025

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 2025, which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers' Equity, Statement of Cash Flows, and notes to the financial statements, including material accounting policy information.

The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards as interpreted and adapted by HM Treasury's Financial Reporting Manual 2024/25 as contained in the Department of Health and Social Care Group Accounting Manual 2024/25, 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 2025 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 2024/25; 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 for the audit of the financial statements" section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

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

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

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

Other information

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

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

We have nothing to report in this regard.

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

As explained more fully in the Statement of Directors' responsibilities in respect of the accounts, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. The Directors are required to comply with the Department of Health and Social Care Group Accounting Manual 2024/25 and prepare the financial statements on a going concern basis, unless the Trust is informed of the intention for dissolution without transfer of services or function to another public sector entity. The Directors are responsible for assessing each year whether or not it is appropriate for the Trust to prepare its accounts on the going concern basis and disclosing, as applicable, matters related to going concern..

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

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

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 considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: health and safety regulations, CQC conditions of registration and data protection regulations.

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

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

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the National Health Service Act 2006 (as amended by the Health and Social Care Act 2012).

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

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

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

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

We are also required to conclude on whether the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate. We performed our work in accordance with Practice Note 10: Audit of financial statements and regularity of public sector bodies in the United Kingdom, (Revised 2024) and Supplementary Guidance Note 01, issued by the Comptroller and Auditor General in November 2024.

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 2025.

We have nothing to report in this respect.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust, 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 November 2024.

Report on other legal and regulatory requirements

Opinion on other matters prescribed by the Code of Audit Practice

In our opinion:

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

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

We are required to report to you if:

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

We have nothing to report in respect of these matters.

Use of the audit report

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

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have received confirmation from the NAO that the group audit of the Department of Health and Social Care has been completed and that no further work is required to be completed by us.

Alastair Newall, Key Audit Partner
For and on behalf of Forvis Mazars LLP (Local Auditor)

One St Peter's Square
Manchester
M2 3DE

25 June 2025

Statement of Comprehensive Income

	Note	2024/25 £000	2023/24 £000
Operating income from patient care activities	3	223,542	212,824
Other operating income	4	14,706	14,264
Operating expenses	7,9	(237,919)	(228,206)
Operating surplus / (deficit) from continuing operations		**329**	**(1,118)**
Finance income	11	2,690	2,446
Finance expenses	12	(669)	(688)
PDC dividends payable		(239)	(343)
Net finance costs		**1,782**	**1,415**
Other gains / (losses)	13	(180)	12
Surplus / (deficit) for the year from continuing operations		**1,931**	**309**
Surplus / (deficit) for the year		**1,931**	**309**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	-	(1,307)
Revaluations	17	-	204
Total comprehensive income / (expense) for the period		**1,931**	**(794)**

Statement of Financial Position

	Note	31 March 2025 £000	31 March 2024 £000
Non-current assets			
Intangible assets	14	894	190
Property, plant and equipment	15	35,888	35,173
Right of use assets	18	56,422	60,509
Receivables	19	15	19
Total non-current assets		**93,219**	**95,891**
Current assets			
Receivables	19	9,733	9,553
Cash and cash equivalents	20	50,910	43,536
Total current assets		**60,643**	**53,089**
Current liabilities			
Trade and other payables	21	(27,910)	(24,664)
Borrowings	23	(7,736)	(7,114)
Provisions	24	(2,857)	(636)
Other liabilities	22	(1,014)	(1,220)
Total current liabilities		**(39,517)**	**(33,634)**
Total assets less current liabilities		**114,345**	**115,346**
Non-current liabilities			
Borrowings	23	(49,056)	(53,499)
Provisions	24	(349)	(354)
Total non-current liabilities		**(49,405)**	**(53,853)**
Total assets employed		**64,940**	**61,493**
Financed by			
Public dividend capital		4,042	2,526
Revaluation reserve		14,200	14,504
Income and expenditure reserve		46,698	44,463
Total taxpayers' equity		**64,940**	**61,493**

The notes on pages 131 to 177 form part of these accounts.

Name Sara Munro
Position Chief Executive
Date 25th June 2025

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	**2,526**	**14,504**	**44,463**	**61,493**
Surplus for the year	-	-	1,931	**1,931**
Other transfers between reserves	-	(304)	304	**-**
Impairments	-	-	-	**-**
Revaluations	-	-	-	**-**
Public dividend capital received	1,516	-	-	**1,516**
Taxpayers' equity at 31 March 2025	**4,042**	**14,200**	**46,698**	**64,940**

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

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

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health as the public dividend capital dividend.

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

Other reserves
Leeds Community Healthcare NHS Trust does not hold a financial assets (available for sale) reserve, a merger reserve or any other reserves not 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	2024/25 £000	2023/24 £000
Cash flows from operating activities			
Operating surplus / (deficit)		329	(1,118)
Non-cash income and expense:			
Depreciation and amortisation	7.1	10,293	9,412
Net impairments	8	-	(43)
Income recognised in respect of capital donations	4	-	(15)
(Increase) / decrease in receivables and other assets		163	4,362
Increase / (decrease) in payables and other liabilities		3,852	(2,811)
Increase / (decrease) in provisions		2,217	33
Net cash flows from / (used in) operating activities		**16,854**	**9,820**
Cash flows from investing activities			
Interest received		2,690	2,446
Purchase of intangible assets		(799)	(128)
Purchase of PPE and investment property		(3,872)	(3,456)
Initial direct costs or up front payments in respect of new right of use assets		(171)	(266)
Receipt of cash lease incentives (lessee)		-	106
Receipt of cash donations to purchase assets		-	15
Net cash flows from / (used in) investing activities		**(2,152)**	**(1,283)**
Cash flows from financing activities			
Public dividend capital received		1,516	1,748
Capital element of lease rental payments		(7,599)	(7,012)
Other interest		(2)	-
Interest paid on lease liability repayments		(664)	(688)
PDC dividend (paid) / refunded		(579)	(255)
Net cash flows from / (used in) financing activities		**(7,328)**	**(6,207)**
Increase / (decrease) in cash and cash equivalents		**7,374**	**2,330**
Cash and cash equivalents at 1 April - brought forward		**43,536**	**41,206**
Cash and cash equivalents at 31 March	20	**50,910**	**43,536**

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 2024/25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Note 1.2 Going concern

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

Leeds Community Healthcare NHS Trust Board specifically considered the matter of going concern at its Board meeting on 1 April 2025. The Trust Board concluded that after considering the matters in the paper, and having an awareness of all relevant information, that there are no material uncertainties related to events or conditions which may cast significant doubt on the ability of the Trust to continue as a going concern.

Note 1.3 Interests in other entities

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

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

Sexual Health Services - Partner: Leeds Teaching Hospitals NHS Trust

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

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

Court Liaison and Diversion Services - Partner: Community Links

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

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

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

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

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

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods / services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods / services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional, a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor, other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The main source of income for Leeds Community Healthcare NHS Trust is contracts with commissioners for health care services and is in the form of aligned payment and incentive contracts, the main form of contracting between NHS providers and their commissioners for 2024/25. Funding envelopes are set at an Integrated Care Board (ICB) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS) which replaced the National Tariff Payment System on 1 April 2023. The Trust agreed fixed element payments with commissioners, based on funding for an agreed level of activity. The fixed element also included CQUIN funding of 1.25% of the contract value.

In addition, where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received. The LVA payments schedule was provided nationally and identified those relationships where, on the basis of historical activity, the annual value of activity between the ICB and the Trust for 2024/25 is expected to be below £500,000.

In addition the Trust received non recurrent income during the financial year to reimburse specific costs incurred.

Revenue from non-NHS contracts
Revenue is recognised by Leeds Community Healthcare NHS Trust from non-NHS commissioners for health care services under IFRS 15. The revenue is recognised as and when performance obligations are satisfied.

The performance obligation relating to the delivery of the health care is satisfied over the time the healthcare is received and consumed simultaneously by the customer, as the Trust performs it. At the year end, the Trust accrues income relating to activity delivered in that year.

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

Note 1.5 Other forms of income

Grants and donations
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

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 apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.6 Expenditure on employee benefits

Short-term employee benefits
Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 Property, plant and equipment

Recognition
Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• the item has 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 (DRC) on a modern equivalent asset basis (MEA).

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 DRC on an 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, borrowing 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 and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of ‘other comprehensive income’.

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

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

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

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘held for sale’ and instead is retained as an operational asset and the asset’s useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated and grant funded assets

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Buildings, excluding dwellings	5	80
Plant & machinery	5	10
Information technology	2	5
Furniture & fittings	10	10

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets 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 where it meets recognition criteria.

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

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

	Min life Years	Max life Years
Software licences	3	5

Note 1.10 Inventories

Leeds Community Healthcare NHS Trust does not hold inventories and the cost of inventory items are expensed through the income and expenditure account.

Between 2020/21 and 2023/24 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. Distribution of inventories by the Department ceased in March 2024.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Financial assets and financial liabilities

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

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

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

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

For financial liabilities, the carrying value of short term trade and other payables is a reasonable approximation to fair value, all trade payables are considered to be short term. The nature of obligations relating to lease and other borrowings are that they are arms length transaction with values determined by contract. There is no significant difference between the carrying value and the fair value of these liabilities.

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 or assets measured at fair value through other comprehensive income, Leeds Community Healthcare NHS Trust recognises an allowance for expected credit losses.

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

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

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

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

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

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

Note 1.13 Leases

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

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

The Trust as a lessee
Recognition and initial measurement

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

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

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

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

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

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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

Finance leases

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

Operating leases

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

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2025:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

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 2025:

	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
Into perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.40% in real terms (prior year: 2.45%).

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

Non-clinical risk pooling

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

Note 1.15 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

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

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

Note 1.16 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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

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

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

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the “pre-audit” version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.17 Value added tax

Most of the activities of 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 1.18 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

Note 1.19 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2024/25.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2024/25:

IFRS 17 Insurance Contracts – The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements of Leeds Community Healthcare NHS Trust.

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

· Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

· Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

· A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.

· Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

These changes in future periods are not expected to have a material impact on these financial statements as the Trust has no assets valued on an alternative site basis.

Changes to non-investment asset valuation – Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Note 1.21 Critical judgements in applying accounting policies

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

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

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

Note 1.22 Sources of estimation uncertainty

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

Property Valuation and Asset Lives
Valuations have been undertaken by Leeds Community Healthcare NHS Trust's expert independant valuer, the District Valuer, part of the Valuation Office Agency, as at 31st March 2025. All operational assets have been valued on a current value in existing use basis. The land and building valuations are based on the Royal Institution of Chartered Surveyors valuation standards insofar as these are consistent with the requirements of HM Treasury and the Department of Health and Social Care. These valuations will therefore be subject to changes in market conditions and market values. As part of this valuation the asset lives are also estimated by the District Valuer and are subject to professional judgement. A change in the valuation of 1% would create an impact of £283k to the Statement of Financial Position, the valuation is provided by an external valuer to minimise any risk'.

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

The 2024/25 valuation was £28,349k, with Land being £8,730k and Buildings £19,619k. As the values showed no material movement compared to the net book value, no revaluation exercise has been undertaken in 2024/25 by the Trust.

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)	2024/25 £000	2023/24 £000
Mental health services		
Income from commissioners under API contracts*	34,174	32,447
Services delivered under a mental health collaborative	194	189
Community services		
Income from commissioners under API contracts*	145,565	141,017
Income from other sources (eg local authorities)	33,099	32,497
All services		
National pay award central funding**	29	22
Additional pension contribution central funding***	10,481	6,652
Total income from activities	**223,542**	**212,824**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2024/25 NHS Payment Scheme documentation.

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

**Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024/25 £000	2023/24 £000
NHS England	17,988	13,921
Integrated Care Boards	172,259	166,223
Other NHS providers	194	189
Local authorities	30,970	30,398
Non NHS: other	2,131	2,093
Total income from activities	**223,542**	**212,824**
Of which:		
Related to continuing operations	223,542	212,824

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

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

Note 4 Other operating income

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	365	-	**365**	351	-	**351**
Education and training	4,192	487	**4,679**	4,308	447	**4,755**
Non-patient care services to other bodies	61	-	**61**	73	-	**73**
Income in respect of employee benefits accounted on a gross basis	3,837	-	**3,837**	3,370	-	**3,370**
Receipt of capital grants and donations and peppercorn leases	-	-	**-**	-	15	**15**
Charitable and other contributions to expenditure	-	-	**-**	-	80	**80**
Revenue from operating leases	-	582	**582**	-	556	**556**
Other income*	5,182	-	**5,182**	5,064	-	**5,064**
Total other operating income	**13,637**	**1,069**	**14,706**	**13,166**	**1,098**	**14,264**
Of which:						
Related to continuing operations			14,706			14,264

*Other income totalled £5,182k: this includes £968k rental income, £2,107k contribution to the integrated mental wellbeing service for Leeds, £613k for First Contact Practitioners working for GPs, £371k Frontline Digitisation transformation project, £308k lease car income, £251k Local Care Partnerships income to fund projects supporting the transformation of care pathway, £160k One Adoption support to Leeds City Council, £108k Therapeutic Social Work Team support to Leeds City Council, £296k various other income.

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

	2024/25	2023/24
	£000	£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end	1,206	371

Note 6 Operating leases - Leeds Community Healthcare NHS Trust as lessor

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

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

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

Note 6.1 Operating lease income

	2024/25	2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	582	556
Total in-year operating lease income	**582**	**556**

Note 6.2 Future lease receipts

	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year;	511	495
- later than one year and not later than two years;	498	481
- later than two years and not later than three years;	485	481
- later than three years and not later than four years;	483	468
- later than four years and not later than five years;	372	465
- later than five years.	484	570
Total	**2,833**	**2,960**

Note 7.1 Operating expenses

	2024/25	2023/24
	£000	£000
Staff and executive directors costs	167,256	160,541
Remuneration of non-executive directors	124	128
Supplies and services - clinical (excluding drugs costs)	30,128	28,185
Supplies and services - general	6,350	7,280
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	979	994
Establishment	3,686	3,765
Premises	8,274	9,354
Transport (including patient travel)	1,816	2,040
Depreciation on property, plant and equipment	10,198	9,358
Amortisation on intangible assets	95	54
Net impairments	-	(43)
Movement in credit loss allowance: contract receivables / contract assets	164	61
Fees payable to the external auditor		
audit services - statutory audit	108	92
Internal audit costs	100	92
Clinical negligence	735	683
Legal fees	367	219
Insurance	119	107
Research and development	116	124
Education and training	760	1,721
Expenditure on short term leases	581	599
Expenditure on low value leases	95	96
Redundancy	1,460	34
Car parking & security	424	362
Hospitality	1	6
Losses, ex gratia & special payments	5	11
Other services, eg external payroll	1,339	1,355
Other*	2,639	988
Total**	**237,919**	**228,206**
Of which:		
Related to continuing operations	237,919	228,206

* Other expenditure includes £1,850k for external recharges, £360k for general provisions and £334k for fees and penalties.

** All expenditure includes VAT where not recoverable.

Note 7.2 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2024/25 or 2023/24.

Note 8 Impairment of assets

	2024/25 £000	2023/24 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	-	(43)
Total net impairments charged to operating surplus / deficit	**-**	**(43)**
Impairments charged to the revaluation reserve	-	1,307
Total net impairments	**-**	**1,264**

A desk top valuation was undertaken by the District Valuer, part of the Valuation Office Agency during 2024/25. This report indicated the movements in the estate values was not material since the 2023/24 full revaluation and therefore the values have not been updated for 2024/25. The 2023/24 figure relates to a net impairment gain of £43k.

Note 9 Employee benefits

	2024/25 Total £000	2023/24 Total £000
Salaries and wages	125,615	121,530
Social security costs	12,454	12,682
Apprenticeship levy	598	605
Employer's contributions to NHS pensions	26,475	21,890
Pension cost - other	22	54
Termination benefits	1,460	34
Temporary staff (including agency)	2,408	3,793
Total gross staff costs	**169,032**	**160,588**
Recoveries in respect of seconded staff	-	-
Total staff costs	**169,032**	**160,588**
Of which		
Costs capitalised as part of assets	316	13

Note 9.1 Retirements due to ill-health

During 2024/25 there were 2 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £222k (£52k in 2023/24).

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

Note 10 Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

For 2025/26 the Trust's expected pension costs are £27.3 million.

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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

Other pension costs

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

Leeds Community Healthcare NHS Trust has incurred expenditure of £22k during the year in respect of contributions for employees under the NEST scheme.

Note 11 Finance income

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

	2024/25	2023/24
	£000	£000
Interest on bank accounts	2,690	2,446
Total finance income	**2,690**	**2,446**

Note 12.1 Finance expenditure

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

	2024/25	2023/24
	£000	£000
Interest expense:		
Interest on lease obligations	664	688
Interest on late payment of commercial debt	3	-
Total interest expense	**667**	**688**
Unwinding of discount on provisions	2	-
Total finance costs	**669**	**688**

Note 12.2 The late payment of commercial debts (interest) Act 1998

	2024/25	2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	3	-

Note 13 Other gains / (losses)

	2024/25	2023/24
	£000	£000
Gains on disposal of assets	-	12
Losses on disposal of assets	(180)	-
Total gains / (losses) on disposal of assets	**(180)**	**12**
Total other gains / (losses)	**(180)**	**12**

Loss on disposal of assets relates to the disposal of lease cars held by the Trust under IFRS 16 of £40k and the disposal of Clinical and IT Equipment of £140k, following an asset verification exercise.

Note 14.1 Intangible assets - 2024/25

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2024 - brought forward	**435**	**435**
Additions	799	**799**
Valuation / gross cost at 31 March 2025	**1,234**	**1,234**
Amortisation at 1 April 2024 - brought forward	**245**	**245**
Provided during the year	95	**95**
Amortisation at 31 March 2025	**340**	**340**
Net book value at 31 March 2025	**894**	**894**
Net book value at 1 April 2024	**190**	**190**

Note 14.2 Intangible assets - 2023/24

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

Note 15.1 Property, plant and equipment - 2024/25

	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 2024 - brought forward	**8,730**	**22,194**	**-**	**2,635**	**11,379**	**1,524**	**46,462**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	1,521	-	372	1,132	35	**3,060**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	1,335	-	-	-	(1,335)	**-**
Disposals / de-recognition	-	-	-	(374)	(2,825)	(136)	**(3,335)**
Valuation / gross cost at 31 March 2025	**8,730**	**25,050**	**-**	**2,633**	**9,686**	**88**	**46,187**
Accumulated depreciation at 1 April 2024 - brought forward	**-**	**2,329**	**-**	**1,586**	**7,150**	**224**	**11,289**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	759	-	226	1,218	2	**2,205**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Reclassifications	-	36	-	-	-	(36)	**-**
Disposals / de-recognition	-	-	-	(299)	(2,761)	(135)	**(3,195)**
Accumulated depreciation at 31 March 2025	**-**	**3,124**	**-**	**1,513**	**5,607**	**55**	**10,299**
Net book value at 31 March 2025	**8,730**	**21,926**	**-**	**1,120**	**4,079**	**33**	**35,888**
Net book value at 1 April 2024	**8,730**	**19,865**	**-**	**1,049**	**4,229**	**1,300**	**35,173**

Note 15.2 Property, plant and equipment - 2023/24

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - brought forward	**9,518**	**22,072**	**729**	**2,120**	**9,033**	**189**	**43,661**
Transfers by absorption	-	-	-	-	-	-	**-**
Additions	-	242	23	515	2,346	1,335	**4,461**
Impairments	(788)	(519)	-	-	-	-	**(1,307)**
Revaluations	-	(353)	-	-	-	-	**(353)**
Reclassifications	-	752	(752)	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	-	-	**-**
Valuation / gross cost at 31 March 2024	**8,730**	**22,194**	**-**	**2,635**	**11,379**	**1,524**	**46,462**
Accumulated depreciation at 1 April 2023 - brought forward	**-**	**2,262**	**-**	**1,463**	**6,209**	**187**	**10,121**
Transfers by absorption	-	-	-	-	-	-	**-**
Provided during the year	-	667	-	123	941	37	**1,768**
Impairments	-	237	-	-	-	-	**237**
Reversals of impairments	-	(280)	-	-	-	-	**(280)**
Revaluations	-	(557)	-	-	-	-	**(557)**
Reclassifications	-	-	-	-	-	-	**-**
Disposals / de-recognition	-	-	-	-	-	-	**-**
Accumulated depreciation at 31 March 2024	**-**	**2,329**	**-**	**1,586**	**7,150**	**224**	**11,289**
Net book value at 31 March 2024	**8,730**	**19,865**	**-**	**1,049**	**4,229**	**1,300**	**35,173**
Net book value at 1 April 2023	**9,518**	**19,810**	**729**	**657**	**2,824**	**2**	**33,540**

Note 15.3 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Owned - purchased	8,730	21,384	1,120	4,079	33	**35,346**
Owned - donated / granted	-	542	-	-	-	**542**
Total net book value at 31 March 2025	**8,730**	**21,926**	**1,120**	**4,079**	**33**	**35,888**

Note 15.4 Property, plant and equipment financing - 31 March 2024

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

Note 15.5 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2025

	Land	Buildings excluding dwellings	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	14,943	-	-	-	**14,943**
Not subject to an operating lease	8,730	6,983	1,120	4,079	33	**20,945**
Total net book value at 31 March 2025	**8,730**	**21,926**	**1,120**	**4,079**	**33**	**35,888**

Note 15.6 Property plant and equipment assets subject to an operating lease (Trust as a lessor) - 31 March 2024

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

Note 16 Donations of property, plant and equipment

Leeds Community Healthcare NHS Trust has not received any donations from the Leeds Community Heathcare Charitable Trust and related Charities in 2024/25 (£15k 2023/24).

Note 17 Revaluations of property, plant and equipment

During 2023/24 a comprehensive and full valuation was undertaken by the District Valuer, part of the Valuation Office Agency, an independent RICS valuer, in accordance with RICS guidance.

The Trust commmissioned a desktop review by the District Valuer for 2024/25 and the report indicated price movements were not material since the last revaluation in 2023/24, therefore the carrying values have not been updated.

The properties at Otley and Horsforth have been identified by Leeds Community Healthcare NHS Trust as surplus with no plan to bring them back into used. These have been measured by the District Valuer as fair value and have a Land net book value of £742k and Buildings £259k.

Leeds Community Healthcare NHS Trust has a number of assets full written down to a nil value within the asset register. The gross value of these assets is £6,678k this consists of £2,252k Buildings, £1,028k Plant and Machinery, £3,100k Information Technology, £53k Fixtures and Fittings and £245k Intangible assets

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

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

Note 18.1 Right of use assets - 2024/25

	Property (land and buildings) £000	Transport equipment £000	Total £000	Of which: leased from DHSC group bodies £000
Valuation / gross cost at 1 April 2024 - brought forward	**73,426**	**825**	**74,251**	**68,897**
Additions	437	369	**806**	-
Remeasurements of the right of use asset	3,172	10	**3,182**	2,810
Movements in provisions for restoration / removal costs	(3)	-	**(3)**	-
Disposals / de-recognition	(334)	(343)	**(677)**	-
Valuation / gross cost at 31 March 2025	**76,698**	**861**	**77,559**	**71,707**
Accumulated depreciation at 1 April 2024 - brought forward	**13,431**	**311**	**13,742**	**12,636**
Provided during the year	7,682	311	**7,993**	7,094
Disposals / de-recognition	(334)	(264)	**(598)**	-
Accumulated depreciation at 31 March 2025	**20,779**	**358**	**21,137**	**19,730**
Net book value at 31 March 2025	**55,919**	**503**	**56,422**	**51,977**
Net book value at 1 April 2024	**59,995**	**514**	**60,509**	**56,261**
Net book value of right of use assets leased from other NHS providers				-
Net book value of right of use assets leased from other DHSC group bodies				51,977

Note 18.2 Right of use assets - 2023/24

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

Note 18.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in note 23.1.

	2024/25	2023/24
	£000	£000
Carrying value at 1 April	**60,613**	**56,497**
Lease additions	635	3,535
Lease liability remeasurements	3,182	7,647
Interest charge arising in year	664	688
Early terminations	(39)	(54)
Lease payments (cash outflows)	(8,263)	(7,700)
Carrying value at 31 March	**56,792**	**60,613**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.
These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.
Income generated from subleasing right of use assets is £89k and is included within revenue from operating leases in note 4.

Note 18.4 Maturity analysis of future lease payments

	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000	Total 31 March 2024 £000	Of which leased from DHSC group bodies: 31 March 2024 £000
Undiscounted future lease payments payable in:				
- not later than one year;	8,325	7,423	7,732	7,097
- later than one year and not later than five years;	31,038	28,761	29,625	27,715
- later than five years.	19,951	18,362	26,241	24,221
Total gross future lease payments	**59,314**	**54,546**	**63,598**	**59,033**
Finance charges allocated to future periods	(2,522)	(1,974)	(2,985)	(2,375)
Net lease liabilities at 31 March 2025	**56,792**	**52,572**	**60,613**	**56,658**
Of which:				
Leased from other NHS providers		-		-
Leased from other DHSC group bodies		52,572		56,658

Note 19.1 Receivables

	31 March 2025 £000	31 March 2024 £000
Current		
Contract receivables	6,280	6,252
Allowance for impaired contract receivables / assets	(296)	(132)
Prepayments (non-PFI)	1,982	2,301
PDC dividend receivable	458	118
VAT receivable	915	839
Other receivables	394	175
Total current receivables	**9,733**	**9,553**
Non-current		
Other receivables	15	19
Total non-current receivables	**15**	**19**
Of which receivable from NHS and DHSC group bodies:		
Current	1,318	1,251
Non-current	15	19

Note 19.2 Allowances for credit losses

	2024/25		2023/24	
	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	**132**	**-**	**71**	**-**
New allowances arising	296	-	132	-
Reversals of allowances	(132)	-	(71)	-
Allowances as at 31 March 2025	**296**	**-**	**132**	**-**

Note 19.3 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 Leeds Community Healthcare NHS Trust uses a provision matrix to categorise the debts and reviews historical losses over a two year period. The historical debt rates of non-NHS debt were determined by calculating invoices written off as a percentage of total non-NHS debt. Forward looking macro-economic factors were considered and the final credit losses rates were calculated.

Leeds Community Healthcare NHS Trust has a credit risk from ex-employee debt and the credit loss rate to be applied to this type of debt was calculated as 26.75%. For specific disputed debt, a credit risk of 100% has been applied and for any other outstanding debt over 6 months a credit risk has been applied at 50%. Overall a £296k credit loss allowance has been recognised for non-NHS receivables in 2024/25.

Note 20 Cash and cash equivalents movements

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

	2024/25	2023/24
	£000	£000
At 1 April	**43,536**	**41,206**
Net change in year	7,374	2,330
At 31 March	**50,910**	**43,536**
Broken down into:		
Cash at commercial banks and in hand	2	2
Cash with the Government Banking Service	50,908	43,534
Total cash and cash equivalents as in SoFP	**50,910**	**43,536**
Total cash and cash equivalents as in SoCF	**50,910**	**43,536**

Note 21 Trade and other payables

	31 March 2025 £000	31 March 2024 £000
Current		
Trade payables	9,003	5,784
Capital payables	626	1,438
Accruals	13,305	12,409
Social security costs	1,436	1,557
Other taxes payable	1,345	1,353
Pension contributions payable	2,137	2,107
Other payables	58	16
Total current trade and other payables	**27,910**	**24,664**
Non-current		
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	6,489	3,697
Non-current	-	-

Note 22 Other liabilities

	31 March 2025 £000	31 March 2024 £000
Current		
Deferred income: contract liabilities	1,014	1,220
Total other current liabilities	**1,014**	**1,220**
Non-current		
Total other non-current liabilities	**-**	**-**

Note 23.1 Borrowings

	31 March 2025 £000	31 March 2024 £000
Current		
Lease liabilities	7,736	7,114
Total current borrowings	**7,736**	**7,114**
Non-current		
Lease liabilities	49,056	53,499
Total non-current borrowings	**49,056**	**53,499**

Note 23.2 Reconciliation of liabilities arising from financing activities

	Lease Liabilities £000	Total £000
Carrying value at 1 April 2024	**60,613**	**60,613**
Cash movements:		
Financing cash flows - payments and receipts of principal	(7,599)	**(7,599)**
Financing cash flows - payments of interest	(664)	**(664)**
Non-cash movements:		
Additions	635	**635**
Lease liability remeasurements	3,182	**3,182**
Application of effective interest rate	664	**664**
Early terminations	(39)	**(39)**
Carrying value at 31 March 2025	**56,792**	**56,792**

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

Note 24 Provisions for liabilities and charges analysis

	Legal claims	Redundancy	Other	Total
	£000	£000	£000	£000
At 1 April 2024	**125**	**510**	**355**	**990**
Change in the discount rate	-	-	(4)	**(4)**
Arising during the year	944	1,390	-	**2,334**
Utilised during the year	-	(113)	-	**(113)**
Reversed unused	-	-	(4)	**(4)**
Unwinding of discount	-	-	3	**3**
At 31 March 2025	**1,069**	**1,787**	**350**	**3,206**
Expected timing of cash flows:				
- not later than one year;	1,069	1,787	1	**2,857**
- later than one year and not later than five years;	-	-	337	**337**
- later than five years.	-	-	12	**12**
Total	**1,069**	**1,787**	**350**	**3,206**

In respect of legal claims the uncertainty as to amounts and timings relates to the time taken to determine whether or not Leeds Community Healthcare NHS Trust is liable and if so, what the value of that liability will be. The provision includes an amount for Employment tribunals, a claim for a clinicians working hours dispute and a Guardians of Safe Working Hours (GoSWH) fine relating to the same incident.

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

Other provisions include a dilapidation provision for the offices at White Rose for £334k.

Note 24.1 Clinical negligence liabilities

At 31 March 2025, £269k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2024: £432k).

Note 25 Contingent assets and liabilities

	31 March 2025 £000	31 March 2024 £000
Value of contingent liabilities		
NHS Resolution legal claims	(5)	-
Redundancy	(1,642)	(1,817)
Gross value of contingent liabilities	**(1,647)**	**(1,817)**
Amounts recoverable against liabilities	-	-
Net value of contingent liabilities	**(1,647)**	**(1,817)**
Net value of contingent assets	**-**	**-**

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

Leeds Community Healthcare NHS Trust has no contingent assets in 2024/25 (£Nil 2023/24)

Note 26 Other financial commitments

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

	31 March 2025 £000	31 March 2024 £000
- not later than 1 year;	15,316	17,335
- after 1 year and not later than 5 years;	9,084	11,147
- after more than 5 years;	-	582
Total	**24,400**	**29,064**

Note 27 Financial instruments

Note 27.1 Financial risk management

In accordance with IFRS 7, Trusts should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the Trust is exposed at the end of the reporting period. Because of the continuing service provider relationship that Leeds Community Healthcare NHS Trust has with commissioners and the way those commissioners are financed, the Trust is not exposed to the degree of financial risk faced by business entities. In addition financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

Leeds Community Healthcare NHS Trust has limited powers to borrow or invest surplus funds, and financial assets and liabilities are generated by day-to-day operational activities, rather than being held to change the risks facing the Trust in undertaking its activities.

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

Currency risk

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

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

Interest rate risk

Leeds Community Healthcare NHS Trust has no borrowing in 2024/25.

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

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

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

Credit risk

The majority of Leeds Community Healthcare NHS Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2025 are in receivables from customers, as disclosed in note 19.2.

Liquidity risk

The majority of Leeds Community Healthcare NHS Trust's operating costs are incurred under contracts with Integrated Care Boards, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from depreciation and Public Dividend Capital allocated by the Department of Health and Social Care.

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

Note 27.2 Carrying values of financial assets

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through P&L	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	6,392	-	-	**6,392**
Cash and cash equivalents	50,910	-	-	**50,910**
Total at 31 March 2025	**57,302**	**-**	**-**	**57,302**

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

Note 27.3 Carrying values of financial liabilities

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through P&L	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	-	-	**-**
Obligations under leases	56,792	-	**56,792**
Trade and other payables excluding non financial liabilities	22,615	-	**22,615**
Total at 31 March 2025	**79,407**	**-**	**79,407**

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

Note 27.4 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 2025	31 March 2024
	£000	£000
- In one year or less;	30,940	27,385
- In more than one year but not more than five years;	31,038	29,625
- In more than five years.	19,951	26,241
Total	**81,929**	**83,251**

Note 28 Losses and special payments

	2024/25		2023/24	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	-	-	-	-
Fruitless payments and constructive losses	-	-	-	-
Bad debts and claims abandoned	-	-	1	1
Stores losses and damage to property	-	-	-	-
Total losses	**-**	**-**	**1**	**1**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	1	1
Extra-contractual payments	-	-	-	-
Ex-gratia payments	2	5	4	10
Special severance payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**2**	**5**	**5**	**11**
Total losses and special payments	**2**	**5**	**6**	**12**
Compensation payments received				-

Note 29 Related parties

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

Organisation and related party	Revenue from Related Party £000	Expenditure with Related Party £000	Amounts due from Related Party £000	Amounts owed to Related Party £000
Crossley Street Surgery, Wetherby		**175**		
Dr Ruth Burnett (Executive Medical Director)				
Performs unpaid GP work as part of CPD and maintaining registration				
Leeds GP Confederation	**1,206**		**511**	
Jenny Allen (Director of Workforce, OD and System Development)				
Director of Workforce, Leeds GP Confederation				
Dr Ruth Burnett (Executive Medical Director)				
Medical Director, Leeds GP Confederation				
Stephanie Lawrence (Executive Director of Nursing and Allied Health Professionals)				
Director of Nursing, Leeds GP Confederation				
Laura Smith (Director of Workforce, OD and System Development)				
Director of Workforce, Leeds GP Confederation				
Care Quality Commission		**130**		
Stephanie Lawrence (Executive Director of Nursing and Allied Health Professionals)				
Touchstone Leeds Ltd		**2,181**		
Khalil ur Rehman (Non-Executive Director)				
Consultancy / Advisory work				

The Department of Health and Social Care is regarded as a related party. During the year 2024/25 Leeds Community Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department as listed below:

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

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

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

Leeds Community Healthcare NHS Trust has also had transactions with Macmillan Cancer Support, Currys PLC and NHS Providers which the Department of Health and Social Care has deemed to be related parties of entities within the Departmental Group.

The Trust Board is a Corporate Trustee of Leeds Community Healthcare Charitable Trust. A debtor of £208k is held by the Trust in relation to the Charity for transactions made by the Trust on behalf of the charity.

Note 30 Events after the reporting date

Note 31 Better Payment Practice code

Non-NHS Payables	2024/25 Number	2024/25 £000	2023/24 Number	2023/24 £000
Total non-NHS trade invoices paid in the year	12,761	51,327	13,786	53,301
Total non-NHS trade invoices paid within target	12,131	49,634	13,140	51,857
Percentage of non-NHS trade invoices paid within target	95.1%	96.7%	95.3%	97.3%
NHS Payables				
Total NHS trade invoices paid in the year	492	25,963	300	24,982
Total NHS trade invoices paid within target	481	25,160	284	24,843
Percentage of NHS trade invoices paid within target	97.8%	96.9%	94.7%	99.4%

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

Note 32 Capital Resource Limit

	2024/25 £000	2023/24 £000
Gross capital expenditure	7,847	15,931
Less: Disposals	(219)	(42)
Less: Donated and granted capital additions	-	(15)
Charge against Capital Resource Limit	**7,628**	**15,874**
Capital Resource Limit	7,628	15,875
Under / (over) spend against CRL	**-**	**1**

Note 33 Breakeven duty financial performance

Adjusted financial performance (control total basis)	2024/25 £000	2023/24 £000
Surplus / (deficit) for the period	1,931	309
Remove net impairments not scoring to the Departmental expenditure limit	-	(43)
Remove I&E impact of capital grants and donations	12	1
Adjusted financial performance surplus / (deficit)	**1,943**	**267**

Note 34 Breakeven duty rolling assessment

	2017/18 £000	2018/19 £000	2019/20 £000	2020/21 £000	2021/22 £000	2022/23 £000	2023/24 £000	2024/25 £000
Breakeven duty in-year financial performance	4,655	5,661	2,045	1,557	507	1,042	267	1,943
Breakeven duty cumulative position	18,808	24,469	26,514	28,071	28,578	29,620	29,887	31,830
Operating income	149,526	155,640	171,312	187,920	195,550	218,532	227,088	238,248
Cumulative breakeven position as a percentage of operating income	12.6%	15.7%	15.5%	14.9%	14.6%	13.6%	13.2%	13.4%

Thank you for taking the time to read our Annual Report and Accounts for 2024-2025. You can also view this document on our website at www.leedscommunityhealthcare.nhs.uk where you can also find the full accounts.

If you would like hard copies of this report or an accessible version of the financial statements and notes on pages 125-177, please email lch.comms@nhs.net

Our Quality Account is also available on our website at www.leedscommunityhealthcare.nhs.uk

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