NHS
Leeds Community Healthcare
NHS Trust

Annual report and accounts 2017 | 2018

Inspected and rated
Good
CareQuality Commission

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Annual report and accounts 2017 I 2018

Welcome

from our Chief Executive and Chair

The scale of the challenges facing the NHS nationally and locally are well known but we have been overwhelmed by the excellent way in which all of our teams have responded and continued to deliver high quality services consistently and often in very difficult circumstances.

This is perhaps most evident through our upgraded Care Quality Commission (CQC) rating. The CQC published the results of its follow up inspection report in August 2017 and, in doing so, confirmed what we always believed to be true. That is, we have made significant improvements across our services since the CQC's last visit in 2014, a position affirmed by the Trust's upgraded CQC rating from overall 'Requires Improvement' to 'Good'.

This accolade is well-earned across our organisation. It is testament to the hard work and determination of colleagues from both corporate and clinical disciplines to provide the most effective health care to the people of Leeds and beyond. It is worthy of note that we were able to evidence this during a time of unprecedented demand across our services, not least within our Neighbourhood Teams, which were a key focus of the inspection. In doing so, adult services were rated overall Outstanding for caring - a fantastic achievement. Placed alongside the Children and dental services overall rating of 'Good' across all domains this demonstrates our shared vision to simply provide 'the best care to every community we serve.'

Over the past year we have been working to make improvements in the working lives of our colleagues here at Leeds Community Healthcare. We know great care must start with happy and fulfilled teams. It is therefore most encouraging and assuring to note that results from the NHS Staff Survey 2017 show significant increases in the confidence that colleagues have in LCH as both an employer and as a provider of services, and that they would recommend our care, without hesitation, to friends and family.

Certainly, a key Trust objective for 2018/19 will be to continue our unrelenting focus on the recruitment and retention of high quality, motivated team members.

Of course, this is still a very testing time in health care and a priority for LCH over the next 12 months must be to continue our work with key partners within the West Yorkshire and Harrogate Health and Care Partnership, and within the city of Leeds, to provide the best possible care outside of a hospital setting. We want to ensure that admissions to hospital are reduced and, similarly, discharges out of hospital are managed quickly and well, with appropriate packages of care wrapped around the patient. We'll be working with key partners including those within our teaching hospitals, Leeds City Council and GP partners to make sure we keep moving forward in this aim.

We also want to invite our patients too, to support us in this aim and become partners in their care. An important part of what we are doing across our services is rolling out a new approach known as Health Coaching. In the past, a patient may have come to a health professional with a view that they would be 'told what to do' Our expert teams are now trained to work even more closely with a patient to understand the expert knowledge they (and their family) can bring to their care. Working together with our clinicians we want patients to feel empowered to take a much more involved role in managing their care and setting goals that are meaningful for them and the lives they hope to lead.

And so, we would like to say a final thank you the individuals and teams who continue to support us in this very important work. We look forward to working with you all over the coming year with a view to providing even better care, every day.

Neil Franklin
Chair

Thea Stein
Chief Executive

Who we are and what we do

Established in 2011, Leeds Community Healthcare NHS Foundation Trust provides community healthcare services to the people of Leeds. We work with the whole family and often the city's most vulnerable people. Some of our specialist care is provided across Yorkshire and the Humber.

We work where patients live and alongside every other part of the NHS. We also work with partners in social care, the criminal justice system and the third sector.

Our services are organised into three groups: **Adult, Specialist** and **Children and Families**. These services are supported by a range of corporate teams.

Adult Services

- 13 Neighbourhood Teams (NTs)
- Neighbourhood Nights
- Community Care Beds
- Bed Bureau
- End of Life Care
- Health Case Management
- Leeds Integrated Discharge Service
- Community Geriatricians
- Continence, Urology and Colorectal Service
- Wound Prevention and Management Service
- Falls
- Pharmacy Technicians
- Single Point of Urgent Referral (SPUR)

Specialist Services

- Primary Care Mental Health/ Improving Access to Psychological Therapies (IAPT)
- Podiatry (foot health)
- Musculoskeletal and Rehabilitation Services
- Nutrition and Dietetics
- Specialist Dental Services
- Prison Health (Young Offenders Institute, Wetherby)
- Healthcare services for police custody suite across Yorkshire and the Humber
- Community Intravenous Antibiotics Service (CIVAS)
- Community Tuberculosis (TB)

Long term conditions which include:

- Neurology
- Stroke Team
- Rehabilitation Unit
- Speech and Language Therapy
- Cardiac, Respiratory and Diabetes services
- Continuing Care Neuro - Physiotherapy

Children's Services

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

- Child Development Centres
- Paediatric Neurodisability clinics and children's outpatient clinics
- Specialist child protection medical services
- Community Eye service
- Audiology and New Born Hearing
- Physiotherapy
- Occupational Therapy
- Speech and Language Therapy
- Nutrition and Dietetic Services
- Day time wetting service (from April 2018)

Child and Adolescent Mental Health Services (CAMHS)

Community Nursing Services:

- Continuing Care Nursing Team
- Hannah House

Healthy Child Pathway Early Start Service:

- Health Visiting
- School Nursing
- Sickle cell and Thalassaemia
- Watch-It weight management

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

Our vision

When providing care, our vision is simple:

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

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

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

Quality priorities

To help us achieve our vision, we worked with patients, carers and public members throughout 2017/18 to develop our quality priorities.

LCH continues to review all feedback it receives including ongoing feedback, satisfaction surveys, complaints and incidents as part of its quality improvement.

The quality priorities we have set for next year (2018/19) are aligned to these main themes:

Prevention, proactive care and self-management

Patient experience

New models of care

Our workforce

What next?

The Quality Strategy sets out the work we need to do over the next three years to support our vision and achievement of our strategic goals. This is a key enabling strategy and provides the framework for other Trust strategies that also have a fundamental role in achievement of the Trust’s vision.

Additional areas of quality improvement take place within individual services and these are managed through services’ own quality improvement plans.

You can find out more about our quality priorities in our Quality Account.

Performance report

How we're meeting our goals

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

In setting our goals we also think about the risks of not achieving them. As a Trust we have 17 strategic risks connected to our goals. These are grouped into the four following themes (also known as strategic risk 'clusters'):

Our four key goals:

1. Delivering high quality care – every time
2. Continuing to improve staff morale
3. Taking a lead in delivering New Models of Care and integrating health care
4. Ensuring services are sustainable (quality, efficiency, value for money)

Risks:

1. Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
2. Failure to engage and empower the Trust's workforce and ability to recruit and retain and develop staff
3. Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
4. Failure to maintain a viable and sustainable organisation

These risks are considered in detail at every Board meeting. More detailed information about this can be found on pg 49 of this report.

Here's how we've been working to achieve our goals throughout 2017/18

Goal 1

Delivering high quality care – every time

Our first priority is always high quality patient care. Our quality strategy sets out how we aim to achieve 'good' and 'outstanding' across our services.

To achieve this, we assess how well we are doing by using the same questions the Care Quality Commission use in their inspections:

We ask ourselves, are services:

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

The CQC published the final reports on its announced inspection, 31 January – 2 February 2017, and unannounced inspections of Hannah House, Leeds Sexual Health and the Single Point of Urgent Referral on 29th August 2017. We were delighted that the CQC rated the Trust overall as **'Good'**, the CQC's previous rating being 'Requires Improvement'.

The CQC found several areas of outstanding practice particularly within:

- Community health services for adults
- A project to improve patient flow
- The development of pharmacy technicians which had supported staff and improved patient compliance
- Speech and language therapy and musculoskeletal services.

Adult services were rated overall 'Outstanding' for caring and all other services were rated 'Good'.

Safe

- We achieved 58% of patient safety incidents being reported as 'no harm'. We are working hard to meet our 70% target.
- No cases of infections such as MRSA or Clostridium Difficile acquired by patients in our care.
- No admission of patients under 16 years of age to adult services.
- 100% of incidents applicable for Duty of Candour were dealt with appropriately (see Saying Sorry on page 10).
- We achieved a **50.0%** reduction against the target for the number of avoidable category 3 pressure ulcers.
- We aimed to have no avoidable category 4 pressure ulcers in 2017/18. There have been three in the year to date. This is improving, year on year with much focussed work and training.
- We achieved the Serious Incident Rate target consistently through the year.
- There were 4 falls in our Community Inpatient Units meaning we achieved the target to reduce falls to 12. We continue to monitor the Trust's Sign up to Safety pledge to *'reduce falls causing avoidable harm in inpatient units by 10%'* on a quarterly basis.

Sign up to SAFETY
LISTEN LEARN ACT

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

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

Saying Sorry (Duty of Candour)

If a patient is harmed as a result of a care and treatment they have received from us, or if an error is made in the care being delivered to them, we are committed to being open and honest. We would always provide the patient with an explanation of what happened, we would say sorry and we would explain what we are doing to put things right and to prevent the incident (as much as is possible) from happening again.

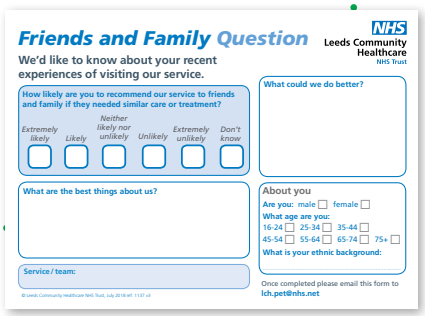
- The Trust has in place a Being Open and Duty of Candour Policy and Procedure to make sure all staff are aware of their responsibilities.
- We deliver briefing sessions at service and team meetings.
- Duty of Candour is featured in the Trust's induction day for all new starters.

The Trust is 100% compliant with the requirements placed upon it. In its report published in August 2017, the CQC were positive in its appraisal of staff understanding and the work of the Trust in this area.

What next? We continue to review incidents which trigger Duty of Candour. Currently, there is one incident where the full process has not been fully completed and this is being followed up with the service.

Caring

- The Friends and Family Test shows 100% of our inpatients would recommend our services against a target of 95%. It also shows that we achieved our target of 95% of community patients recommending LCH care.
- If things don't go as well as expected, we welcome complaints. We respond to complaints within legally set timescales most of the time, but often much quicker (see Patient Experience below).


Friends and Family Question

NHS Leeds Community Healthcare NHS Trust

We'd like to know about your recent experiences of visiting our service.

How likely are you to recommend our service to friends and family if they needed similar care or treatment?

Extremely likely | Likely | Neither likely nor unlikely | Unlikely | Extremely unlikely | Don't know

What could we do better?

What are the best things about us?

About you

Are you: male ☐ female ☐

What age are you:

16-24 ☐ 25-34 ☐ 35-44 ☐ 45-54 ☐ 55-64 ☐ 65-74 ☐ 75+ ☐

What is your ethnic background:

Service / team:

Once completed please email this form to lch.pet@nhs.net

Queries, Concerns and Complaints
Patient Experience

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

The Patient Experience Team is here to help those who have a question or want to tell us something about our services. The team is also here as an alternative to approaching the services directly.

In 2017, we began updating our approach to Patient Experience at the Trust. We moved away from using the description of Patient Advice and Liaison Service (PALS) in order to more accurately reflect the scope of services the Patient Experience Team can offer.

The Patient Experience Team works with all services in the Trust and with other health and social care partners in the city. We ensure a 'no wrong door' policy, an approach that has been agreed with *Healthwatch Leeds. This means that no matter which health or social care organisation in the city a person contacts in the first instance, the receiving organisation will pass the relevant information on. This is to make sure that a person with a complaint,

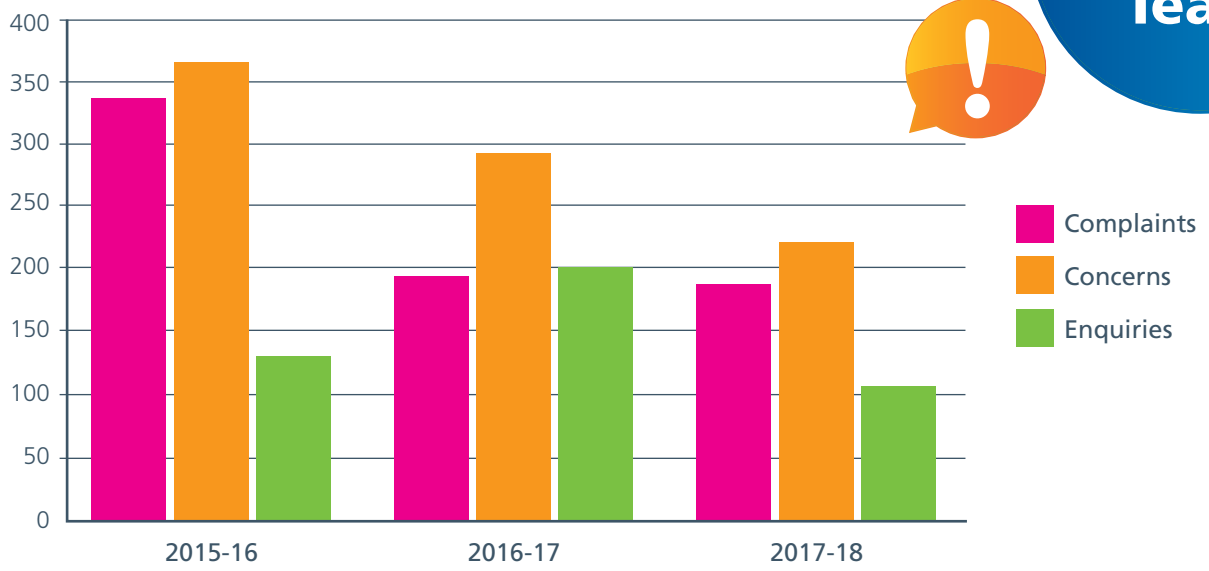
concern or question is not faced with several contact numbers or having to explain their issue over and over again.

For example: Mr S called to ask how to arrange for a piece of equipment to be collected from his home following the death of his family member. The deceased patient had not received care from LCH services but in line with our 'no wrong door' policy the Patient Experience Team called the care provider responsible for the patient's care and the Leeds Community Equipment Service to arrange for equipment to be collected.

During 2017/18 we received 188 complaints relating to services provided by Leeds Community Healthcare NHS Trust services. During the year, 11 complainants asked the Trust to re-open their complaints to look at issues again. Three referrals were made to the Parliamentary and Health Services Ombudsman; (two of the referrals were about the same complaint) none of these were upheld by the Ombudsman. There were also 221 concerns and a total of 107 enquiries recorded.

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

Patient Experience feedback received 2015-2018



The top themes for complaints in 2017/18 were:

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

We welcome all of your feedback about the services we provide; whichever way you want to tell us. You can contact us by phone, email, via the Friends and Family Test, social media, our website or even face to face.

More detailed information about the service provided by our Patient Experience Team can be found in our Quality Account available on our website: **leedscommunityhealthcare.nhs.uk**

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

Responsive

- We meet all nationally reportable and internal targets for waiting times.
- At year end the Trust was seeing 97.6% of patients on consultant-led pathways within 18 weeks, no patients waited more than 52 weeks during the year.
- Activity levels at the end of March are 6.4% less than planned for the year predominantly due to Adult Neighbourhood Teams being some 8% below the contacts target agreed with the CCG over a year ago. Significant improvements in the productivity of the Neighbourhood Teams have resulted in reduced numbers of contacts but no reduction in care.
- At year end 97.9% of patients were waiting less than 6 weeks for diagnostic tests. This was 100% from Quarter 2 and 3.
- 98.5% of patients were treated within 18 weeks of referral to Improving Access to Psychological Therapies (IAPT) and 91.8% were seen within 6 weeks.

Effective

- We have achieved the 65% target for clinical supervision, at the year-end, 72.0% of staff were compliant with clinical supervision.
- 76 clinical audits were completed in the year.
- We have achieved our Commissioning for Quality and Innovation (CQUIN) 4 goals associated with piloting outcomes measures in Musculoskeletal Services (MSK), the Neighbourhood Teams and Integrated Children's Additional Needs (ICAN).
- During 2017/18, we have put in place NICE guidance (within two years of publication) for 76% of relevant guidelines. Action plans are in place for the remaining seven guidelines.
- We are not meeting the target we set ourselves for compliance with other NICE guidance. In February 2018 we updated our NICE Guidance Policy and now allow ourselves two years to put in place complex care pathways with our patients.
- During 2017 the Trust's Learning from Deaths Policy has been written and is in the process of being put in place. The Policy is in line with national requirements and builds on the work already underway in LCH. This ensures that all deaths in the organisation, where our services were delivering direct care and case managing the patients care, are investigated appropriately to determine if there is any learning.
- We are actively involved in LeDeR (Learning disabilities mortality review programme).
- Trusts are now being asked to report and update on the 'Learning from Deaths' process that was instigated across the NHS in 2017.
- Learning is shared at our strategic mortality surveillance group. It is also shared within business units and more widely across the whole organisation if required.

Well-led

We have continued to identify challenges and make progress in meeting them as our performance assessment shows:

- We know how important it is that people using health and social care services have all their needs met. We continue to work with the local authority, other NHS and voluntary organisations in Leeds to reduce health inequalities through the Equality Delivery System2 (EDS2). We currently hold an overall EDS2 grading of 'Achieving' with an action plan in place to move us on to the next level.
- Sickness absence levels remain higher than we would like them to be.
- All staff should have an appraisal every 12 months. We have a target of 95% but we did achieve 87.1%
- We want all relevant staff to be up to date with mandatory training. The figure at the end of 2015/16 was 86.7%.
- Staff turnover remains over the target range of 9 to13% at 15.3%.
- We continuously meet the requirements for safer staffing in our inpatient services.
- We adapted our use of agency staff in year and have been compliant within the overall agency cap set by NHS improvement.
- We have sustained our staff engagement and morale through the development of 'Our 11' pledges. We also introduced our 'Working Lives Star' a practical tool that supports teams to have conversations about morale and engagement.
- We have established both a BME and disability forum and identified volunteer 'champions'.

We're proud of…

…our overall rating of 'Good' from the Care Quality Commission (CQC). The award was received in August 2017 following the CQC's inspection in January of the same year. Our adult services also received a rating of 'Outstanding' for caring as part of the same inspection.

Inspected and rated Good CareQuality Commission

We're proud of…

…our membership of the Inclusive Top 50 UK Employers, our continued membership of the Stonewall Diversity Champions programme and our improved performance in the Stonewall Workplace Equality Index.

INCLUSIVE TOP50 UK EMPLOYERS

Stonewall DIVERSITY CHAMPION

Goal 2

Continuing to improve staff morale

Continued focus for 2017/18

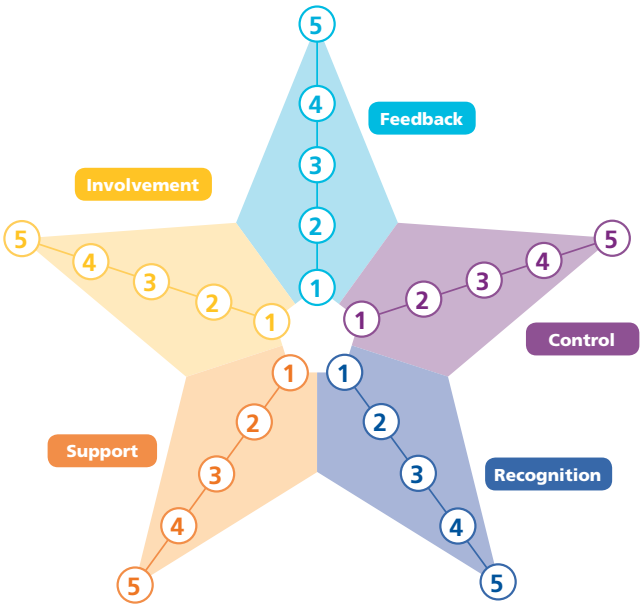
Our aim is to attract the best people… we're doing this by:

- Developing the Trust's website to promote the full range of benefits on offer. The 'Work for Us' section of the website has been redesigned to: improve the look and feel of the section; to improve navigation and ease of finding information; and to better showcase the Trust's careers, development opportunities, the full range of employment benefits and the advantages of living and working in Leeds.
- Using social media (chiefly Facebook and Twitter) to share our offer with a targeted audience, and to showcase the culture of the Trust and what it's like working here. To date over 140,000 people have seen our roles advertised on Facebook.
- Attending careers fairs and Universities in Nottingham, Bradford, Manchester, Salford, Leeds and Liverpool, to support our ability to recruit and attract high quality candidates to Leeds this year.
- Hosting a recruitment bus tour to showcase our Trust to potential applicants to our neighbourhood teams.
- Continually adapting our recruitment approach and introducing a number of initiatives aimed at improving our selection and assessment process. For example, support with relocation costs, refer a friend scheme and improving on our design of assessment centres which are used where a high number of recruits are needed.
- Further developing our preceptorship programme, to support recruitment, induction and development of newly registered and newly recruited registered nurses and therapists.

We also want to keep the best people…

We want to make sure that when we attract the best staff, we keep them happy and motivated to remain with us. Keeping good people is not about one single approach but a range of approaches that fit under the following areas:

- **Staff engagement:** Social media and the Leaders' Networks form part of this work. This is alongside discussion at local team level using the Trust's 'Engagement Star'.



- **Leadership development:** Leadership capability continues to be a focus through our coaching strategy. This supports managers via 1-2-1, team and health coaching courses as well as our 'Manager As Coach' (MAC) programme.

my e coach
• CONNECT • LEARN • GROW •

health coaching
better conversations better health

- **Career progression:** Maintaining focus on professional development and new roles for example, Preceptorship and Nurse Associate Roles and making sure people are supported with development and educational opportunities. Work will continue with our Leeds partners to develop opportunities for career progression across the health and social care system.

- **Staff wellbeing:** Supporting staff to feel psychologically and physically well at work providing opportunities for flexible working and time off for study and development.

- **Recognition and reward:** Staff feeling valued from their local management as well as the Trust forms part of this work. This can be as simple as local development opportunities for example, assignments that provide stretch and opportunities for praise. It also includes more wide ranging corporate schemes, for example, our monthly 'Thanks a Bunch' recognition scheme and the Trust's annual 'Thank You Event.'

thanks a bunch!

The Thank You Event 2017

- **Recruitment:** Ensuring opportunities are available for all staff to progress internally through secondments, apprenticeships and developmental projects.

Go Further with an **Apprenticeship**

Earn while you learn **Study while you work**

NHS National Staff Survey 2017

Every year we take part in the NHS National Staff Survey. This year 1,491 staff completed the survey compared to 1,425 in 2016, a good response rate of 54% and well above the national average of 43%. We looked at our key findings and found the following changes on last year.

Some good news:

Care of patients / service users is my organisation's top priority	+7%
I would recommend my organisation as a place to work	+6%
Communication between senior management and staff is effective	+5%
My organisation acts on concerns raised by patients / service users	+5%
I am confident that my organisation would address my concern	+5%
We are given feedback about changes made in response to reported errors, near misses and incidents	+5%
I am able to deliver the patient care I aspire to	+4%
I am satisfied with the quality of care I give to patients / service users	+4%
I am satisfied with the extent to which my organisation values my work	+4%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation	+4%
When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	+4%

Some areas of development:

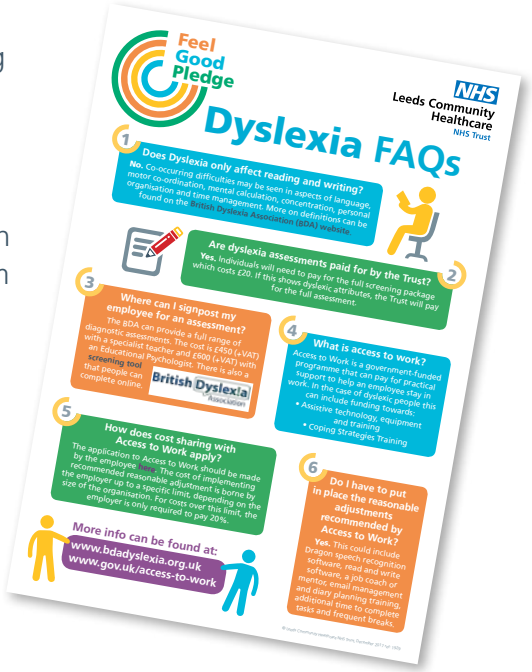
I am satisfied with my level of pay	-7%
My immediate manager can be counted on to help me with a difficult task at work	-3%
My immediate manager encourages those who work for her / him to work as a team	-2%

Health and Wellbeing

Within the last year we've launched our 'Feel Good Pledge' which further underlines our commitment to look after our staff, supporting them to remain physically healthy and mentally well, so that they can continue to provide quality care to the most vulnerable people across the City of Leeds and, in some cases, beyond.

The basis of our pledge is to develop and maintain a working environment that supports our physical mental health and wellbeing and as part of this we've developed an information hub on our intranet that brings together all the resources dedicated to staff support and wellbeing.

The resources range from access to professional Occupational Health services to comprehensive, supportive employment policies and from helping staff with dyslexia to providing new cutlery and crockery to help improve the working environment (and the lunch experience).



What next?

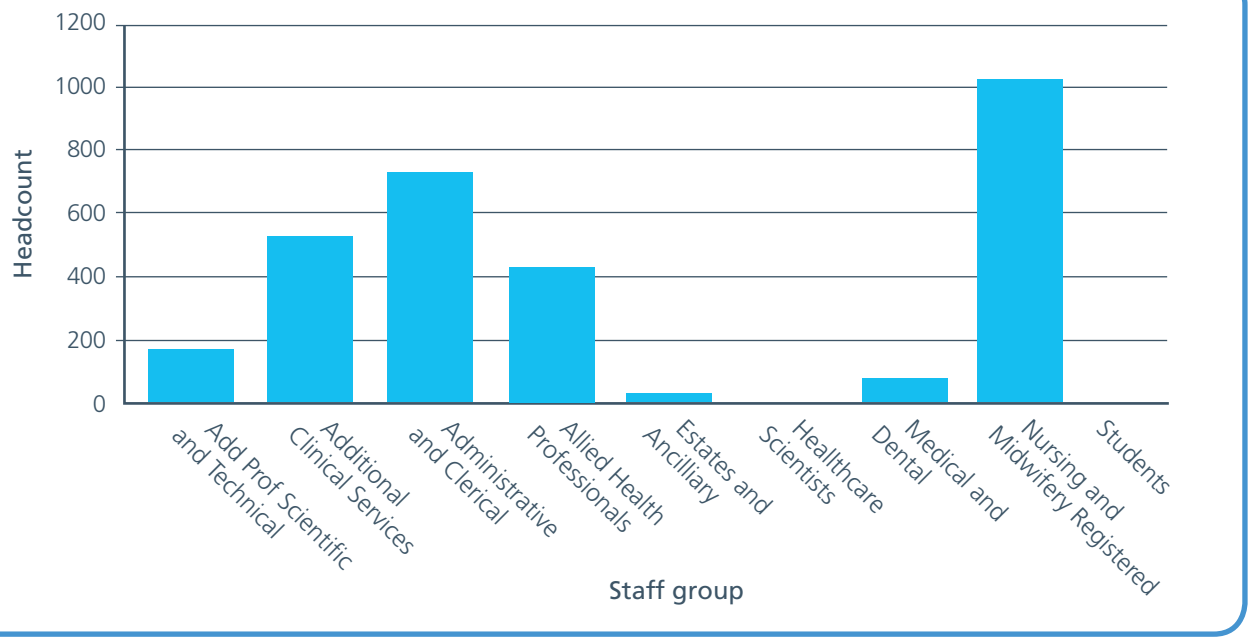
Over the coming year we intend to look closely at the responses to the health and wellbeing questions in our staff survey outcome, to examine what colleagues are telling us. We'll compare this with other local level information to see if, for example, the way some policies and processes are being interpreted and actioned is right for all concerned.

Appraisals

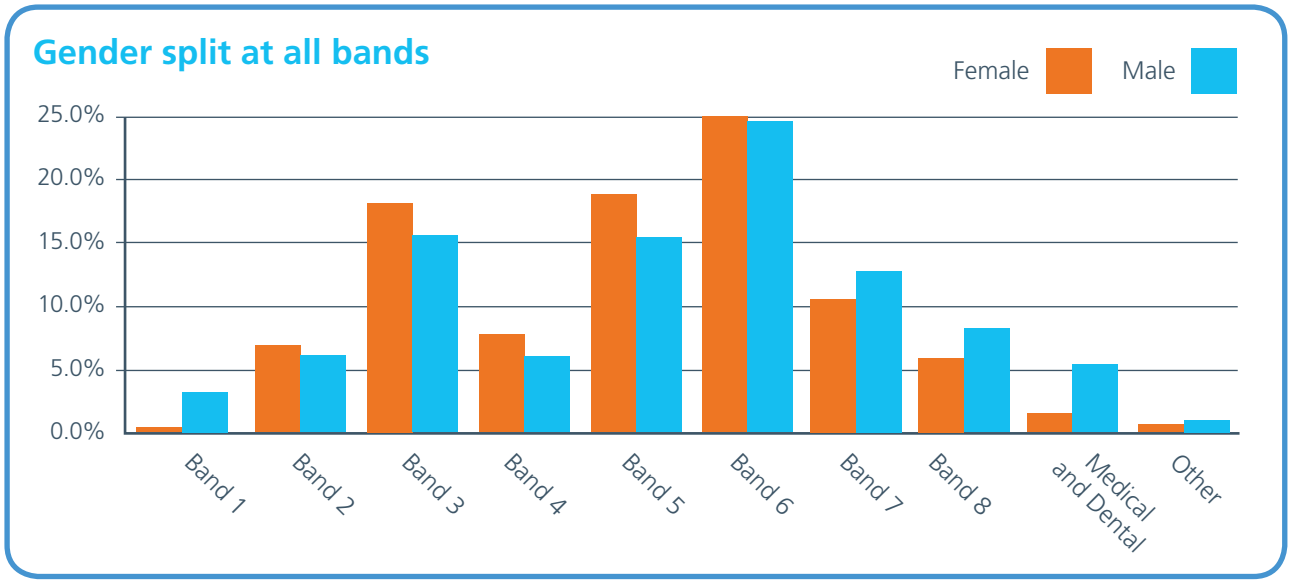
Our average appraisal percentage rate for the year is 83% but we can do better. To help us do this staff engagement data from the 2017 staff survey results will be explored further.

Workforce profile

We employ a workforce of 2,475 whole time equivalent posts which equates to 2,891 people.



Our workforce is 88% female and 12% male. The table on the opposite page demonstrates how these percentages are broken down across the pay bands.



The Trust complied with the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 and published its gender pay gap details in March 2018. The information published indicated that there is a significant gap in the top quartile with members of the female workforce being paid less than their male counterparts. Whilst this gap can be partly accounted for by the fact that this quartile contains a greater number of senior medical roles occupied by males, the Trust will undertake further action to ensure equality in recruitment and development processes.

Staff flu campaign

In September 2017, a 'cake and cuppa' drop in session marked the launch of the Trust's 2017/18 flu immunisation campaign at Trust headquarters.

Led by our Infection Prevention and Control (IPC) team, the campaign was supported by the Trust's now famous flu mascots 'Flo' and 'Frankie' who helped us hit our vaccination rate target of 70% by the beginning of December 2017.

Public Health England statistics for December 2017 showed we had the second-best vaccine uptake by frontline healthcare workers for a community trust. By the end of January 2018, 76% of patient-supporting staff had received their jab.

We're proud of…

…Our IPC team, who bring creativity and drive to this annual campaign. The team's first priority is always to make sure that the vulnerable people we treat are at a lower risk of contracting the virus. This year they also helped us achieve the associated NHS England Commissioning for Quality and Innovation (CQUIN) payment for reaching the target it set.

Jo Reynard, IPC Lead receiving NHS Employers Flu Fighter of the Year Award 2017/18

Goal 3

Leading role in delivering New Models of Care and integrating healthcare

Adult Services

We've continued our work this year to bring together adult services to provide multidisciplinary, nursing and therapy care for frail and elderly people and those with long term conditions.

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

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

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

West 1

9 **Armley**
Armley Moor Health Centre

10 **Pudsey**
Pudsey Health Centre

West 2

11 **Holt Park**
Horsforth Clinic

12 **Woodsley**
Woodsley Health Centre

13 **Yeadon**
Yeadon Community Health Centre

North 1

1 **Meanwood**
Meanwood Health Centre

2 **Wetherby**
Wetherby Health Centre

North 2

3 **Chapeltown**
Chapeltown Health Centre

4 **Seacroft**
Seacroft Health Centre

South 1

5 **Morley**
Morley Health Centre

6 **Beeston**
Beeston Hill Community Health Centre

South 2

7 **Kippax**
Kippax Health Centre

8 **Middleton**
Middleton Health Centre

- Alongside colleagues in social care we have 13 Neighbourhood Teams across the city. These are based around GP registered practices.
- Staff from Leeds Community Healthcare and Adult Social Care work together from the same base to provide seamless care.
- Staff who were previously district nurses, intermediate care nurses, community matrons and adult domiciliary physiotherapists work together as one team across the 13 neighbourhoods from 7am to 10pm.
- Each team works in caseload clusters which cover one or more practices within an area. This is to make sure care is consistent and that we work with other health and care professionals to deliver proactive joined up care to people and their families.
- Teams really get to know their community and are able to respond in a timely way.
- During the evening hours when demand reduces, Neighbourhood Teams come together to work out of 3 hubs, each covering 4 or 5 Neighbourhood Teams. The Neighbourhood Night Nursing Service then takes over from 9.30pm.
- Our Neighbourhood Teams provide 24 hours a day care, 365 days a year.

Adult Services also provide a range of services that work alongside Neighbourhood Teams. These are:

- **Health Case Management:**
  A new service which began in October 2017. It provides specialist citywide case management for people aged 18 years and over who are eligible for NHS Fast Track and Continuing Healthcare funding.
- **Leeds Integrated Discharge Service:**
  Working in partnership with Leeds Teaching Hospitals Trust, Adult Social Care and Age UK to work with people who require additional support to plan for discharge from hospital.
- **Citywide Services:**
  Continence, wound prevention and management, falls, end of life and pharmacy technicians.
- **Nursing and Therapy:**
  For some Community Care Beds (new model commissioned in 2017).
- **Citywide Bed Bureau:**
  Matches people requiring community bed provision with available beds.
- **Single Point of Urgent Referral (SPUR):**
  Manages referrals from community and hospital settings into a range of community services.

Service Development

We're always looking for ways to improve the care we offer. Here are some ways we've been doing this during 2017:

- We have developed a Clinical Care Framework for End of Life Care, Holistic Assessment and Wound Care. Clinical Care Frameworks provide best practice guidance to staff in teams. They have been developed in partnership with specialist and generalist colleagues. In 2018/19 we will work on further Clinical Care Frameworks for mental health and continence pathways.
- We are trialling some weekend clinics to understand if this will help in working more effectively and well with our weekend patient caseload. To date, feedback from patients and staff is positive. Based on this and in partnership with primary care colleagues, we are looking at if we can make this a long term addition to our offer.
- We have taken another look at our internal and external reporting processes; to make sure they work well with city-wide plans for how organisations work together during periods of pressure.
- We regularly review the reasons why people are delayed in hospital to better understand and address these delays wherever possible.
- Working together with colleagues in primary and secondary care we have launched a new template for community referrals. This is so we can organise the right care, in the right place more easily and quickly. We will continue to develop this approach in response to feedback from partners and teams.
- Regular caseload reviews to make sure they are up to date and that all our patients are appropriately reviewed and risk assessed.

Responding well under pressure

During the winter period Adult Services, along with other parts of the health and care system experienced a period of increased pressures, a further challenge was the heavy snow and ice. Our teams continued, often in very challenging circumstances, to support patients, families and each other.

We're proud of…

…Our Middleton Neighbourhood team. They pulled together to overcome challenges over the last year while continuing to manage caseloads and promote high quality.

We're proud of…

……Gemma Cannon, Neighbourhood Night service Clinical Quality Lead. Gemma goes above and beyond to ensure the delivery of high quality care every day and night across this often 'unseen' service.

We're proud of…

…Senior Nurse, Michelle Eaglen. She has shown tireless commitment, dedication and quality care for a particularly complex patient with multiple health and social problems.

We're proud of…

…Neighbourhood Team Clinical Lead Chris Richardson. Chris regularly goes the extra mile and is always prepared to support and challenge her team to improve.

The Thank You Event 2017

Children's Services

Our new children's services strategy reflects the shared ambition of LCH and individual children's services to develop a more 'joined up' way of working in order to deliver services which promote a better experience and outcome for children and young people.

Our support pyramid below shows how our care is delivered across Leeds and West Yorkshire. The base of the pyramid is where most children in Leeds will meet our teams, as this care is offered to every child. The tip of the pyramid is the support we deliver to a smaller number of children and young people as it is much more specialist.

Specialist
Eyes, ICAN, CAMHS Outreach, CAMHS Specialist Community Service, Dental, Dietetics, LD Nurses, Speech and Language Therapy, Eating Disorders Service, CAMHS Outreach Service

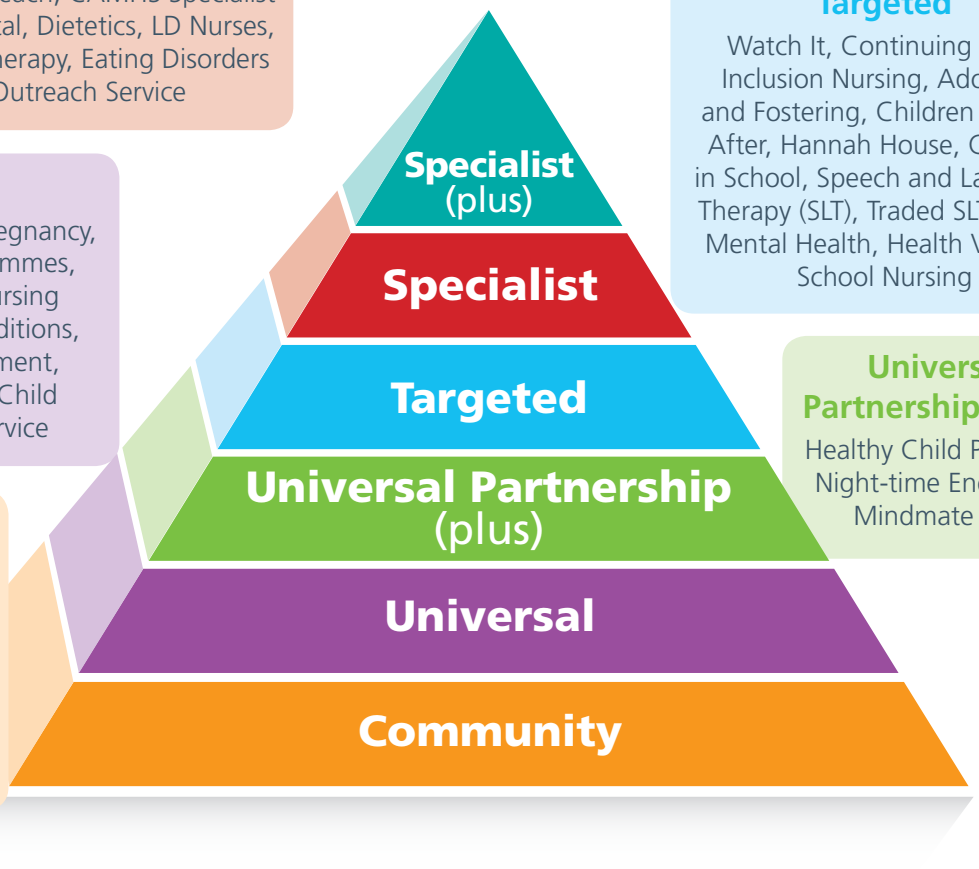
Specialist (plus)
CAMHS tier 4 in-patients

Targeted
Watch It, Continuing Care, Inclusion Nursing, Adoption and Fostering, Children Looked After, Hannah House, CAMHS in School, Speech and Language Therapy (SLT), Traded SLT, Infant Mental Health, Health Visiting, School Nursing

Universal
Healthy Child Pathway (pregnancy, birth and beyond programmes, baby clinics), School Nursing (training for medical conditions, national child measurement, hearing/vision screen), Child Health Information Service

Universal Partnership (plus)
Healthy Child Pathway, Night-time Eneuresis, Mindmate SPA

Community
Healthy Child Pathway (pregnancy, birth and beyond, family offer), School Nursing (healthy schools, health needs assessments for each school, self help resources)



Examples of some of the pathways which we will have in place include:

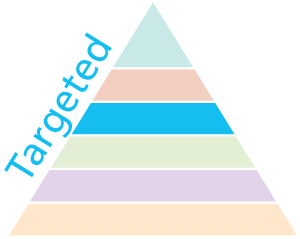
- Continence
- Communication
- Eating and drinking
- Sleep and social
- Emotional mental health

We're proud of…

…Consultant Clinical Psychologist, Sue Ranger. Sue was awarded the Association for Infant Mental Health UK Louise Emanuel award. The award is given to 'a person who has demonstrated a significant contribution to Infant Mental Health in terms of practice or through their work in research and policy'.

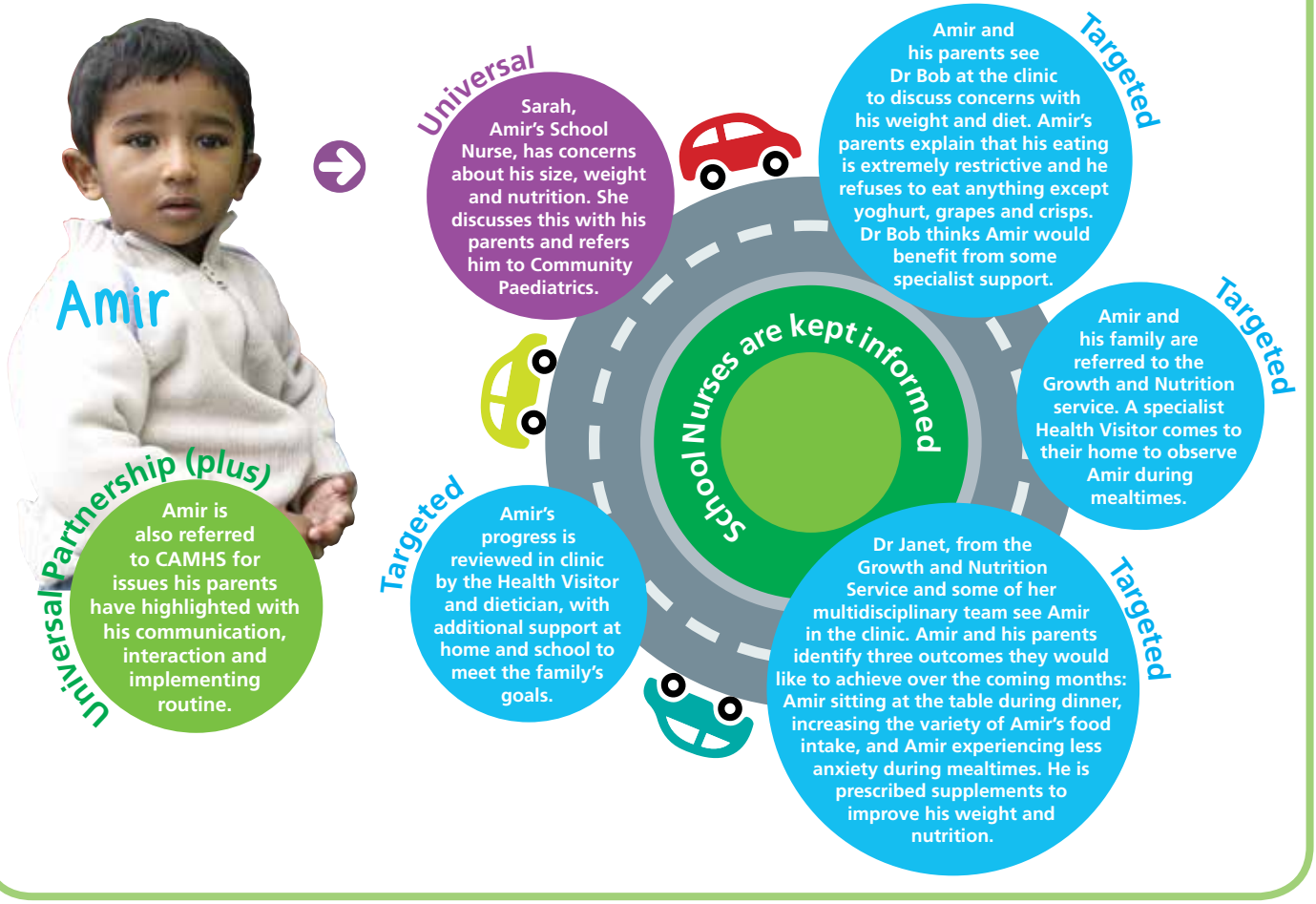
We want to place the focus on care that is wrapped around the needs of a child, with all the services a child may need working together around that child, instead of lots of different services working on their 'bit' of a child or young person's needs. **For example:**

Eating and Drinking Pathway: Amir's journey



Often people think about our services as individual teams working on their own 'part' of a patient. Many children, like five year old Amir need 'joined up' care that involves lots of different experts.

Follow Amir's journey through our eating and drinking pathway. We're reviewing this pathway, and others like it, so that Amir's journey through the system is as smooth as it can possibly be.



Next steps

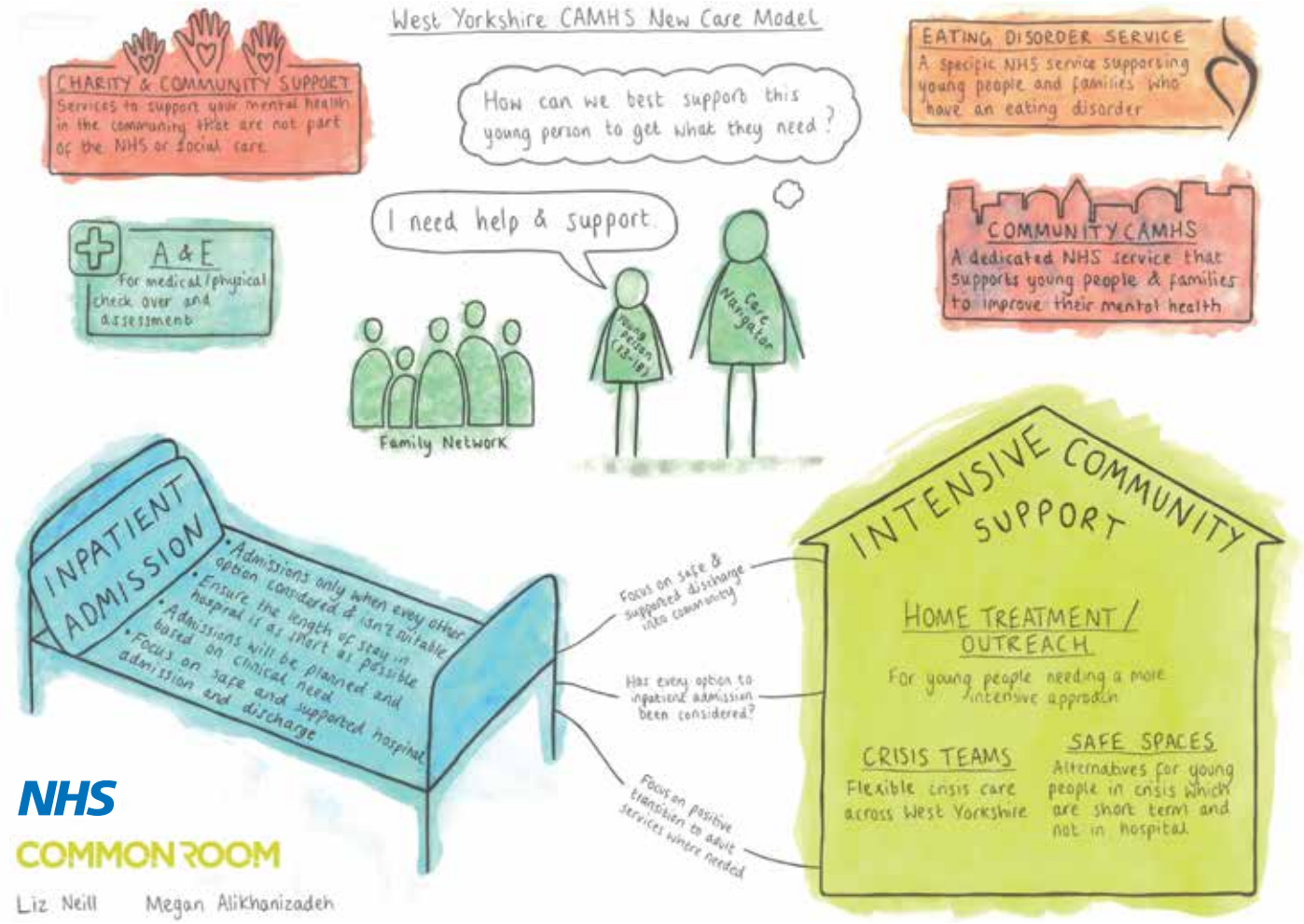
Over the course of 2018/19 we will review all our current pathways and agree the additional pathways that require development. This is so that we can create a fully comprehensive 'offer' for children and young people.

Working even more closely with key partners, commissioners, GP practices and partners at the acute trust to develop 'joined up' approaches to the delivery of care for children and young people across Leeds is really important to us.

One of the ways we'll be doing this during 2018/19 is to lead on a pioneer project to promote a new model of care. Working with *key partners in West Yorkshire, we're looking at how we can improve Child and Adolescent Mental Health Services. The main aim is to reduce the number of admissions for children and young people into inpatient beds. Where an inpatient bed is necessary we want to achieve this much closer to home in a modern, fit for purpose space.

*** West Yorkshire and Harrogate Health and Care Partnership:** Four NHS trusts that provide the region's NHS mental health services across West Yorkshire and Harrogate are working together to improve acute and specialist mental health services for local communities, as part of the wider health and care partnership. Leeds Community Healthcare NHS Trust (LCH), South West Yorkshire Partnership NHS Foundation Trust (SWYPFT), Bradford District Care NHS Foundation Trust (BDCFT) and Leeds and York Partnership NHS Trust (LYPFT).

This infographic shows how that care could be organised:



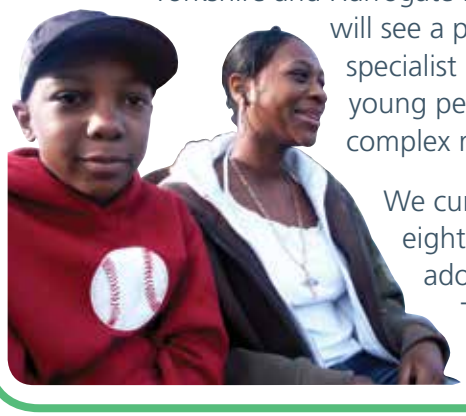
When an inpatient admission is the best option we want to make sure that a stay is as short as possible and that it takes place in a modern, fit for purpose space. Funding was announced during the year and 2018/19 will see us working with our partners to deliver the right inpatient setting for children and young people.

New child mental health unit

A £13million child and adolescent mental health unit is set to be built in Leeds.

The new unit was announced as one of 12 successful bids to receive NHS England capital funds in the Autumn Budget.

The bid, led by our Trust on behalf of a West Yorkshire and Harrogate Partnership, will see a purpose-built specialist unit supporting young people suffering complex mental illness.



We currently provide eight general adolescent beds. The new unit, proposed to be at St Mary's Hospital in Armley, Leeds will bring a significant increase - providing 18 specialist places and four psychiatric intensive care unit beds. This will see more young people being able to access specialist care closer to home, reducing the need for out of area treatment.

Thea Stein, Chief Exec, said: "Our ambition is to make sure that no child or young person within West Yorkshire goes out of area for treatment. This is better for them, their families and better for the local health and care economy.

"The next step will be to work closely with staff, patients, their families, the local community and wider partners to finalise plans and develop a modern, fit for purpose facility of which we can all be proud."

Subject to business case approval from NHS England and planning it is hoped building work will begin early 2019.

Our ambition to work even more with children and young people

We are proud of the range of work we do to involve children, young people and their carers in the development of our services. Next year we want to take this even further and plan to establish a Children and Young People's (including parents and carers) consultation group to advise us on strategy, service delivery and service developments. We will also be working with Children and Young people to co-produce a new-look website.

Meet Chris…

he's a CAMHS Participation Worker

What does your average day look like?

Each day is very different.
My role is city-wide and I work from all CAMHS bases across Leeds. My day today, involves reviewing feedback from the Friends and Family Test. I then attend a meeting with a young person and her mum with the people who 'buy our services' from us (known as a Clinical Commissioning Group). They'll be sharing their experiences of CAMHS services and how they have helped them. I then meet a young person at one of our CAMHS bases who would like to join the community CAMHS participation group for young people.

What's the best part of your role?

Involving young people! I help them to get involved in everything from projects to staff recruitment events. It is so important for our service and it's a great way of building confidence, self-esteem, developing new skills and making young people feel valued.

We're proud of…

…The School Nursing Single Point of Access team. The team has transformed the School Nursing service by developing processes to ensure all colleagues are following the same procedures, pathways and packages of care.

We're proud of…

…Our CAMHS StepUp! App, a digital innovation that takes therapy into the real world. The app offers more effective and efficient services to young people.

We're proud of…

…Our UNICEF UK Baby Friendly accreditation. The Health Visiting team received 'outstanding' status during the year, as part of the UNICEF UK process, which acknowledges high standards in infant and maternity healthcare nationally. The team is now aiming for 'Gold' status.

We're proud of…

…Paula Groves. Described as an 'outstanding role model' by colleagues, Paula cares passionately about the services we deliver and has helped colleagues in both Health Visiting and School Nursing to develop and grow.

Specialist Services

It's been a busy year in Specialist Services. Some areas have been decommissioned and others subject to investment. The issues faced are as diverse as the types of service we offer. A willingness to adapt has been important in continuing to deliver high quality services.

Both **Police Custody** and **Dental services** were subject to competitive tendering processes this year.

In January 2018 we were delighted to be awarded the new regional police custody contract for four years, with the possibility of further extension. The new service model builds on the success of the last four years and allows for further quality improvements. It will also see additional investment into frontline staffing.

The detail of the region's Community Dental Service is still being worked through, in line with this; the commissioner has withdrawn its current tender specifications. Our service is introducing planned changes in response to the original plans. We continue to work closely with commissioners to influence future developments.

In other news, new colleagues were welcomed into the **Substance Misuse Service at Wetherby Young Offenders Institute (YOI)**; having transferred into Leeds Community Healthcare from another provider. The move enhances our existing partnership with South West Yorkshire Partnership Trust (SWYPT) and supports the delivery of a holistic approach to managing the physical, mental health and substance misuse needs of young people in this setting.

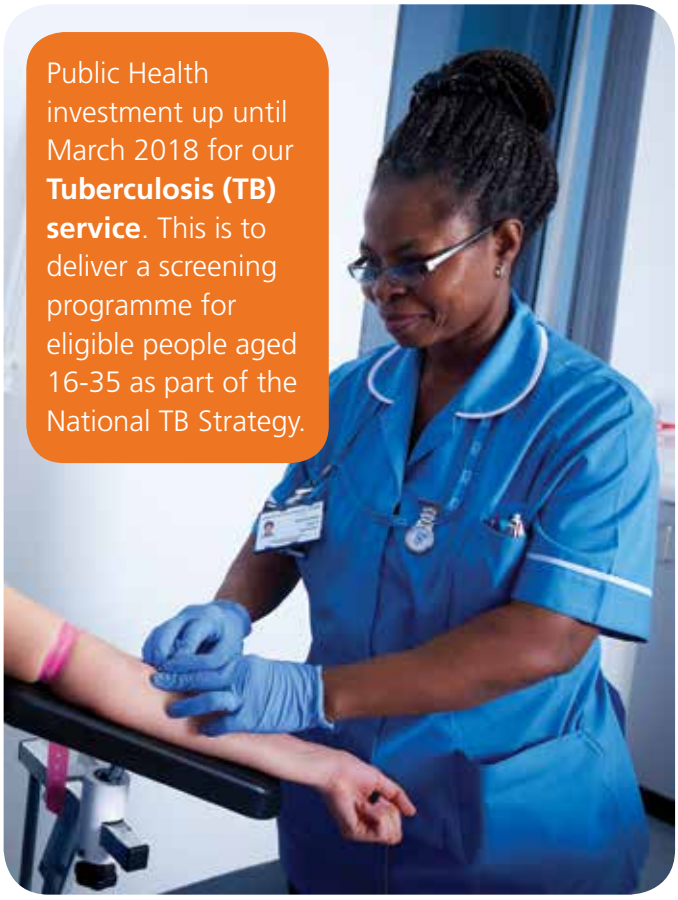
During the year we said goodbye to the **Expert Patient Programme**; a view was taken to look again at the way patients are supported through education and self-management. Whilst disappointing to lose an established service, it has presented new opportunities for the future. We also no longer provide the **Healthy Living Service**, which we lost in a competitive tendering process in October 2017. The service and its staff were transferred to a private provider and we supported colleagues through this process.

As part of adapting to change, we're always looking for opportunities for growth. A number of services have been involved in scoping out new and innovative opportunities that align to the Trust's corporate goal; to have a role in delivering New Models of Care and Integrated healthcare.

Developments include:

- Working closely with commissioners and Primary Care to introduce new ways of working, including extended roles for our **Musculoskeletal (MSK)** practitioners. We're evaluating existing pilot projects to determine a future service model for the city.
- Investment in Diabetes care, in particular Foot Protection in the **Podiatry service** and a tailor made education programme for people with Type 2 Diabetes in our **Diabetes service.**

- Funding to introduce a **'Virtual Ward'** for people with respiratory conditions. This will see us working together with health and social care partners to support people who have complex medical and social care needs as a result of their condition, particularly those at risk of an avoidable emergency hospital stay, or whose length of stay could be reduced.



Public Health investment up until March 2018 for our **Tuberculosis (TB) service**. This is to deliver a screening programme for eligible people aged 16-35 as part of the National TB Strategy.

NHS England (NHSE) investment in **Wetherby YOI** to introduce a therapeutic approach called 'Secure Stairs'.

1 year additional funding for our **Gypsy Traveller Nurse** post. We'll be looking closely at the good work we are doing with this hard to reach community to see how we could use this learning to work with other groups of people.

- Working with Leeds Teaching Hospitals NHS Trust (LTHT) a number of our services are looking at how we can deliver more 'joined up' healthcare. The services involved include:
  - Community Intravenous Antibiotics (CIVAS)
  - Neurology
  - Long Term Conditions
  - Community Gynaecology

We're looking again at some of our clinical pathways in these areas, to see how we can break down barriers and deliver services in the best way possible for patients. This provides exciting opportunities for working together, enhancing skills and following patients through their care journey.

Next steps

There has been a shift in approach from some of our commissioners with a move away from competitive tendering in support of service redesign through collaboration. This will provide the focus for much of our work in the coming year.

We're proud of…

…Caroline Senior from our Long Term Conditions Team and the healthcare team at Wetherby Young Offenders Institute (WYOI) health team, both were shortlisted for national awards.

We're proud of…

…Our new portable therapeutic space known as 'Seeds'. Based at Wetherby Young Offenders Institution, the space is used for 1:1 work, supervision, time out and private discussions.

We're proud of…

…Mark Simpson, Project Support Officer and Admin Lead. Mark's positive attitude and relentless commitment makes 'the magic happen' in our Nutrition and Dietetics team.

We're proud of…

…Dr Christine Comer, from our musculoskeletal service. Christine was awarded a Fellowship and NIHR Clinical Lectureship secondment for a research study into community based rehabilitation and improving care pathways for people with spinal stenosis.

We're proud of…

…Alyson Cawthorne, Clinical Lead Dietitian for the Diabetes service. Alyson has developed and put in place a tailor made structured education programme for people with Type 2 Diabetes.

We're proud of…

…Our Police Custody care team. They have incredibly challenging roles in very complex environments but always offer a personalised, patient-centred, holistic assessment to all individuals referred through to the service by police.

We're proud of…

…our Community Stroke Rehabilitation team. They transitioned from a 10-week service to six-week service in under two months to help reduce hospital bed days and provide higher intensity rehabilitation.

We're proud of…

…Our Leeds Improving Access to Psychological Therapies team. They have developed an online self-referral tool, to improve access to the service and increase the number of people receiving support in a timely manner.

You can find out more about our Trust services here:

www.leedscommunityhealthcare.nhs.uk

Goal 4

Ensure services are sustainable (quality, efficiency and value for money)

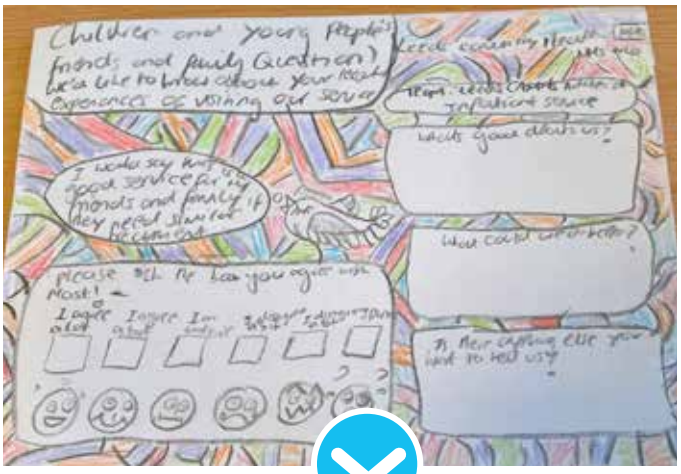
Quality

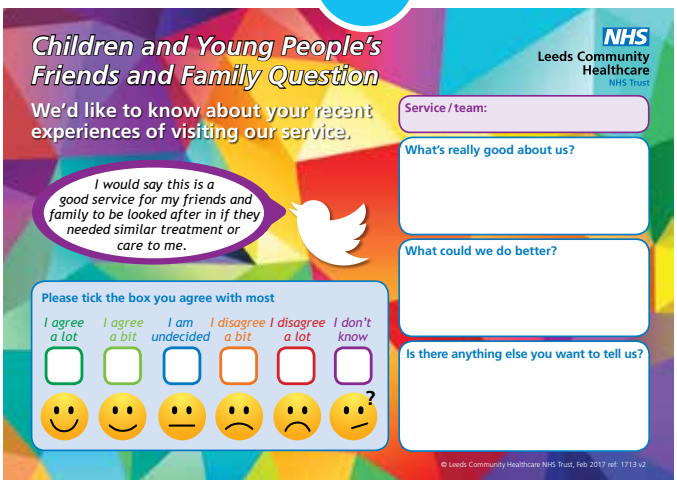
Involving people in our plans

Our commitment and approach to genuine and meaningful involvement of patients, carers and the public is one way we aim to provide quality services that are fit for the people who need them now, and in the future.

In 2017-18, some of the ways we have involved and engaged patients, carers and the public in our work included:

- For the first time, we joined up with our partners across Leeds, including Healthwatch Leeds, Leeds City Council and other NHS organisations to try out a new method of collaborative engagement. At the event we sought people's views, listened and made changes based on people's feedback to our new Patient Experience Pledge.
- Developing a new educational programme for Type 2 Diabetics, seeking feedback and incorporating suggestions.
- Involving people in judging the Trust's staff 'Thank You' awards based on our 'How we work' behaviours.
- Asking people for their feedback about changing the term 'members' to 'Friends of LCH' to describe people's relationship with us and how people can continue to be involved in the work of LCH.
- Providing opportunities for people to share their direct experience of our services at Trust Board.
- Sharing learning with new staff about what good involvement is like for patients, carers and the public, through our corporate induction programme. We also provide opportunities for people to attend corporate induction and share their own experience of LCH.
- Inviting patients and the public, supported by a training package, to take part in Safe Clean Care Project and PLACE (Patient Led Assessment of Care Environments) to continue to make a practical differences in our health centres and inpatient units.
- Developing a new Friends and Family feedback form for children and young people.





- Having information about carers' support available in our health centres.
- Launching a new parent group for Child and Adolescent Mental Health Services.
- Developing five easy read documents about the MSK service and common conditions the team supports/treats.
- Redesigning induction information for the young people of Kepple Unit at Wetherby YOI to make it more accessible.

Spotlight on CAMHS Involvement

Young people from Leeds CAMHS and West Yorkshire Playhouse help tackle Mental Health stigma

A moving play which helped to tackle young people's mental health was given added authenticity by patients from Leeds Child and Adolescent Mental Health Service (CAMHS).

Zoetrope opened at West Yorkshire Playhouse in November 2017 and followed the journey of seven very different youngsters as they navigate their way through mental health difficulties.

In preparation for their performance, Zoetrope's cast had discussions with young people from Leeds Community Healthcare's CAMHS service. CAMHS provides services for young people under 18 when mental health issues get in the way of daily life.

CAMHS young people and staff met the cast, read through scripts, and developed an understanding of what goes into putting on a production, as well as sharing their own insights and experiences.

CAMHS staff also ran a stall on show nights with information about CAMHS, additional support services available in Leeds, and ways to maintain good mental health.

Efficiency

Meeting our legal obligations

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

Here are some examples of how we do this:

Emergency preparedness and resilience

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

- Our major incident plan is regularly updated to ensure it is fit for purpose.
- We have a dedicated and trained emergency management and on-call team who lead our response to a significant event (this plan and the team are regularly tested through desk-top, situation-based training sessions and communications tests).
- Members of the emergency team, take part in regular multi-agency exercises and events to strengthen and reinforce our ability to contribute as part of a wider multi-agency response to a major incident.
- All our services have business continuity plans in place to protect against the impact a wide range of emergency situations, which may affect normal service delivery.
- We have developed a number of Operational Pressures Escalation Levels (OPEL) plans. These detail the triggers which would prompt escalation both internally and across the local health economy, and the associated actions required to mitigate and manage an incident. These OPEL plans have been developed in conjunction with and are aligned to the OPEL plans of our partner organisations.
- We continue to participate in local, regional and national exercises and events and work closely with partners in key areas to make sure our plans work well within the wider health economy.
- As an active member of the Local Health Resilience Partnership we take part in a number of associated forums and groups along with more local planning-based task groups.

What next?

In 2018/19 we will continue the development of our escalation plans, we will review the plans we have in place for severe weather situations. As part of this review, we aim to introduce Personal Business Continuity Plans for every member of staff. This will make sure that they are personally prepared for disruptive events. The Trust will also prepare for and plan to manage the impact of major regional events, for example the Tour de Yorkshire and World Triathlon.

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 accordance with the Health and Safety at Work Act 1974 and Management of Health and Safety at Work Regulations (1999).

We have a Trust Board approved Health and Safety Policy, which explicitly details roles, responsibilities, arrangement and integration with the Trust corporate governance processes.

Health and Safety in the Trust is overseen by the Health and Safety Group, which meets quarterly and is chaired by the Executive Director of Finance and Resources, with membership including staff-side representatives.

The following staff work together to ensure safety standards are met, by conducting a programme of inspections and assessments of all Trust owned or occupied buildings, providing suitable training, and offering advice and support to staff:

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

Reactive monitoring of health and safety data, in particular RIDDOR reports following serious incidents, shows a declining number of serious health and safety incidents occurring and reported to the Health and Safety Executive (HSE) in 2017/18.

There were eight events that met the criteria for reporting to the Health & Safety Executive under the provisions of the Reporting of Injuries, Diseases or Dangerous Occurrences (RIDDOR) Regulations. The Trust has continued to raise the profile of safety management during the year, and has received reports on progress at the Health and Safety Group.

In 2017/18, the HSE did not issue Leeds Community Healthcare NHS Trust with any statutory enforcement notices that require employers to take immediate action to improve health and safety risks.

Fraud

The Trust has a zero tolerance to fraud. We work hard to prevent, deter, detect and investigate fraud. Our counter fraud work is undertaken by a counter fraud specialist from our Internal Audit team and is overseen by the Executive Director of Finance and Resources. Our counter fraud work complies with that required of providers of NHS services.

Modern Slavery Act 2015

Leeds Community Healthcare meets its responsibilities under this act, as its suppliers are subject to standard NHS terms and conditions.

Disclosure of personal data related incidents

- **Incidents calculated to Level 2 or above must be reported to the Information Commissioner's Office (ICO), through the Health and Social Care Information Centre.**
- **Criteria for reporting incidents externally to the Trust (Serious Incidents Requiring Investigation – SIRI) were updated in 2015 to include cyber security.**

Three incidents have been reported to the Information Commissioner's Office (ICO) under the mandatory reporting requirements. Four incidents were regarding loss of person identifiable information and one regarding inappropriate access of information.

A fact-find has been undertaken in the wake of each incident and process improvements have been actioned, where appropriate, to prevent recurrence.

We will continue to monitor and assess information governance breaches. When weaknesses in systems or processes are identified there will be interventions undertaken at source. Low level and near-miss events will be monitored and when there are common themes we will undertake Trust-wide communications to address these themes. We will continue to support Information Governance (IG) training through the national e-learning programme and ensure staff take part in annual Information Governance training.

The Trust has a highly developed IG function and framework. It maintains effective links with the Trust's clinical teams through directorate and clinician representative delegates at the Information Governance Group meetings. The Trust's Senior Information Risk Owner (SIRO) (Executive Director of Finance and Resources) and Caldicott Guardian (Executive Medical Director) are members of this group. The group is a sub-group of the Audit Committee, thereby maintaining a reporting line to the Board of Directors as required by regulation. The group monitors IG breach incidents, maintaining oversight of breaches, as well as triggering appropriate responses to clusters of low-level incidents.

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

The Trust made a self-assessment against the Information Governance Toolkit of 'satisfactory' as at 31 March 2017, achieving Level 2 or higher for all IG requirements.

Sustainability report

As an NHS organisation, and as a spender of public funds, we need to work in a way that has a positive effect on the communities we serve. Sustainability means:

- Spending public money well.
- Smart and efficient use of natural resources.
- Building healthy, resilient communities.

By making the most of social, environmental and economic assets we can improve health, both now and in the future, even with the rising cost of natural resources.

Showing that we consider the social and environmental impact our services have means that we meet the legal requirements set out in the Public Services (Social Value) Act (2012).

We have a Sustainable Development Management Plan (SDMP), the mission statement for this plan is:

"Our Sustainable Development Plan will help us to go the extra mile and deliver quality outcomes such as:

- **Listening**
- **Taking diversity into account**
- **Service efficiencies**
- **Giving back time to staff and patients**
- **Gathering and making best use of feedback from across the board**
- **Improving conditions that surround patients and not just their healthcare need**

We will do this by working and supporting development across the sustainability spectrum."

The board approved our SDMP so our plans for a sustainable future are well known within the organisation and clearly laid out. This year we are starting to increase promotion of the need and opportunities to recycle or reduce our waste volumes.

Sustainability performance

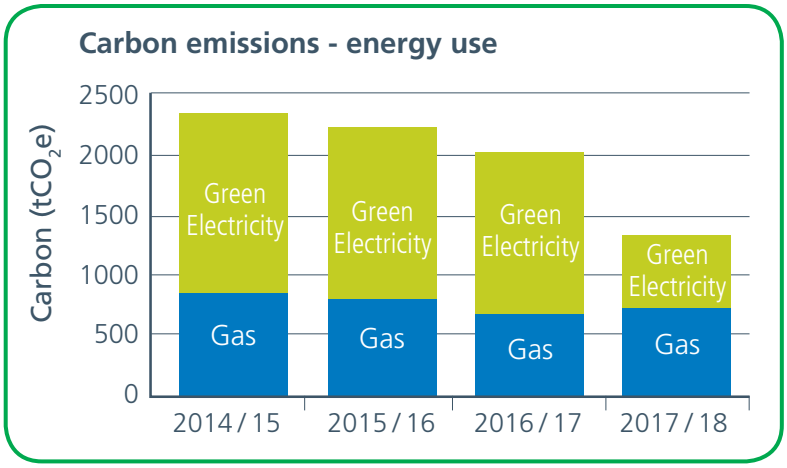
Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Here's how both the organisation and its performance on sustainability has changed over time.

Year	2014 / 15	2015 / 16	2016 / 17	2017 / 18
Floor space (m^2)	37,508	39,504	40,558	37,454
Number of staff	2,497	2,717	2,492	2,480

Energy

Energy use has shown a small reduction, due to less electricity use. Gas use is dominated by weather conditions so the much colder winter this year has increased gas consumption. Energy control systems are in place in all buildings. Currently our electricity comes from a mix of generating fuel of which renewables are 40%. In previous years this was 100% but changes in the regulatory regime required us to pay more for this type of supply and the financial position of the trust did not permit this.



Travel

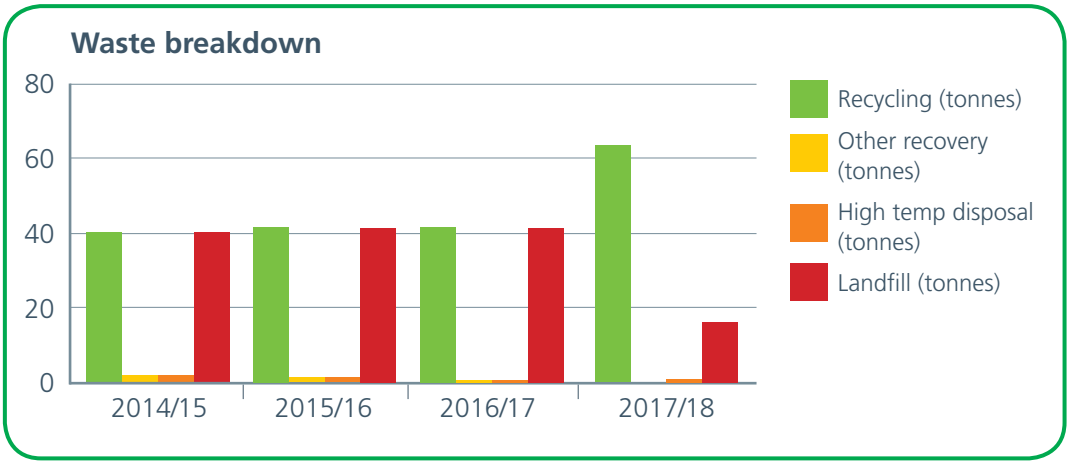
Every action counts. We are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO2e) reductions. We support a culture for active travel, to improve staff wellbeing and reduce sickness. Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Category	Mode	2014 / 15	2015 / 16	2016 / 17	2017 / 18
Staff* commute	miles	2,398,662	2,609,998	2,394,812	2,382,332
	tCO_2e	881	944	866	849
Business travel and fleet	miles	3,647,112	3,043,042	3,472,501	3,647,106
	tCO_2e	1,340	1,100	1,255	1,247
Total cost of business travel	£	133,045	138,000	142,791	145,000

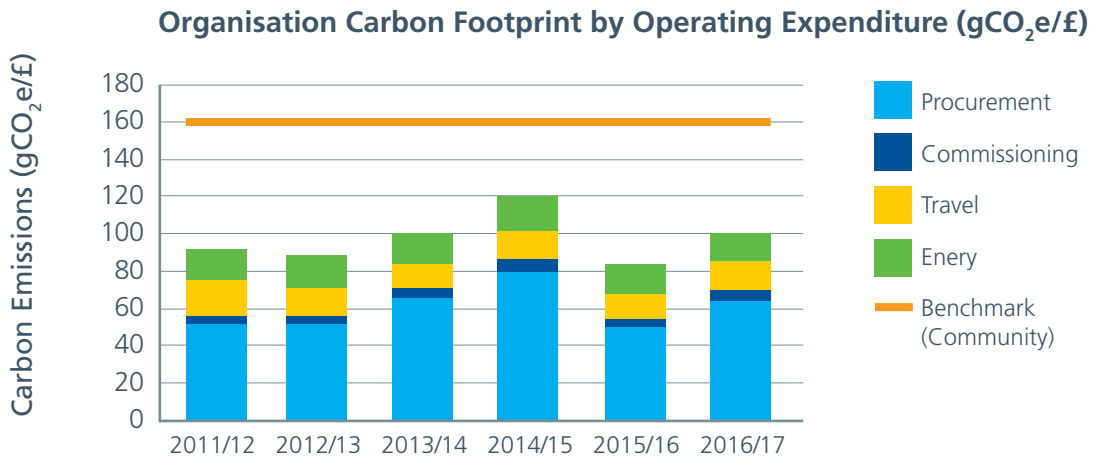
*Staff commute is a calculated result using National travel Survey data

Waste

Waste volumes remain fairly consistent however our main general waste contractor now disposes of waste by burning not landfill hence the change on the chart opposite.



Overall summary of carbon



Value for money

Financial performance summary

This is the seventh Annual Report and Accounts of Leeds Community Healthcare NHS Trust and the seventh report on our financial performance. There has been a great deal of consistency about the Trust's financial performance in that, in each and every year, the Trust has achieved its financial targets. This is not achieved by luck, but by the hard work of many, many staff; balancing their desire to continue to provide high quality care within a finite budget that requires further efficiency savings every year.

Most, if not all, NHS organisations continue to face a challenging financial environment. Many will have challenges that are specific to the services they provide or their particular circumstances. In Leeds Community Healthcare a significant proportion of the services that we provide are subject to competitive tendering. The Trust recognises that competitive tendering is one of the options open to our commissioners and, where we believe that we can deliver high quality services within the money available, we will bid to retain those services. However, there is a cost to competitive tendering, not just the cost of bidding but in the uncertainty it creates for our staff who work in the services subject to tender and the effect on them personally when a service moves to a different provider. During 2017/18 we lost a small number of services, saw a significant tender for Community Dental services aborted for the second time but we were delighted to retain the police custody service across Yorkshire and Humberside. This will put that service on a more secure financial footing from 2018/19.

Target	Target	Performance	Achieved
Planned surplus on income and expenditure	£3,034k	£4,655k	✓
Remain within External Finance Limit	(£2,941k)	(£4,140k)	✓
Remain within Capital Resource Limit	£1,816k	£1,060k	✓
Capital Cost Absorption Rate	3.50%	3.50%	✓
Agency control total	£7,386k	£6,101k	✓
Use of Resources	2	1	✓
Better Payment Practice Code:			
Non NHS invoices (number and value)	95% & 95%	96% & 97%	✓✓
NHS invoices (number and value)	95% & 95%	98% & 99%	✓✓

You may be surprised to see a target income and expenditure surplus of just over £3m and further surprised to see the Trust exceeding that by some £1.6m. The planned surplus of £3m for 2017/18 was required to achieve the "control total" set for the Trust by NHS Improvement. The additional £1.6m surplus resulted from:

£1.3m as part of a general distribution of the national 'Incentive Strategic Transformation Fund' (STF)

£150k additional surplus resulting from underspending a risk reserve held under NHS Improvement rules until the 4th quarter

£150k matching this sum as a 'bonus' from the STF

The additional funds received from the STF had to be used to increase the Trust's surplus; they do increase the Trust's cash balance which is already healthy and may, in due course, be available for investment in capital assets

The Trust's capital investment strategy continues to be one of aiming to invest all its internally generated capital resources. During 2017/18 the Trust spent just over £1.4m on communication aids for Speech and Language Therapy patients, the continuing roll-out of our Electronic Patient Record and building refurbishments.

The Trust was delighted to be allocated £13m of capital resources to develop a new in-patient facility for children and young people with mental health needs. Our plans for 2018/19 include the preparation work with a start date for construction early in the new calendar year.

In 2018/19 the Trust expects to deliver a control total of £2.5m agreed with NHS Improvement. Our cost improvement plans for the year have significantly protected front line services but there remain a number of risks, principally around the level of national funding for the 2018/19 pay award and the financial consequences of commissioning decisions by NHS Leeds CCG. This Annual Report will be published nearly half way through the financial year by which time we will know the extent to which these risks have materialised. We are proud of our reputation for providing high quality services within our financial resources; we will continue to do all we can to maintain that.

Accountability report

Corporate governance

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

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

Our Board is accountable to the public and stakeholders for:

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

The Board plays a key role in:

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

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

The Trust's Chair and Chief Executive have led these functions throughout 2017/18.

The people who sit on our Board of Directors are shown on the next page.

Changes to the Board

Elaine Taylor-Whilde stepped down as non-executive director during 2017/18 and a replacement non-executive director, Professor Ian Lewis was appointed. Professor Lewis brings considerable clinical and senior management experience, which has already been utilised in chairing the Quality Committee.

Following the secondment of Sue Ellis, Director of Workforce to another NHS post in September 2017, the post of Director of Workforce was being covered by Ann Hobson, Deputy Director of Workforce until the substantive post was filled. The Trust has now successfully recruited a job-sharing role of Director of Workforce, Organisational Development and System Development. Jenny Allen and Laura Smith will be joining the Trust's Management Team on 4 June 2018.

All directors have made a declaration that they comply with the 'fit and proper person test' that was introduced from November 2014, with the exception of one executive director who is currently on temporary leave of absence for health reasons.

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

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

Our Board of Directors during 2017/18

Neil Franklin OBE
Chair

Thea Stein
Chief Executive

Brodie Clark CBE
Non-executive Director
(Deputy Chair)

Dr Anthony Dearden
Non-executive Director

Sue Ellis
Director of Workforce*
(to 1 October 2017)

Ann Hobson
Interim Director of
Workforce*
(from 2 October 2017)

Bryan Machin
Executive Director of
Finance and Resources

Richard Gladman
Non-executive Director

Jane Madeley
Non-executive Director

Marcia Perry
Executive Director
of Nursing

Sam Prince
Executive Director
of Operations

Elaine Taylor-Whilde
Non-executive Director
(to 30 June 2017)

Professor Ian Lewis
Non-executive Director
(from 1 July 2017)

Dr Amanda Thomas
Executive Medical Director
(temp absence as of
January 2018)

Dr Phil Ayres
Interim Medical Director
(from January 2018)

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

Director's interests

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

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Area of potential conflict	Details of any hospitality or gift received within the past 12 months: £100 up to and including 7 Nov 2017. In excess of £25 from 8 Nov 2017
Neil Franklin	None	None	None	Board member (acting in an advisory capacity only), Donisthorpe Hall Care Home	Donisthorpe Hall, Care Home	None	None	None
Thea Stein	None	None	None	CQC Executive Reviewer	None	None	None	None
Jane Madeley	None	None	None	Chief Financial Officer, University of Leeds	None	None	Any contracts between the University of Leeds, Leeds Faculty of Medicine and Health, Leeds Academic Health Partnership and Leeds Community Healthcare NHS Trust	None
Tony Dearden	None	None	None	Fee paid Medical Member of First Tier Tribunal (Health, Education and Social Care Chamber), i.e. mental health tribunals. Fellow, Royal College of Psychiatrists.	None	None	None	None
Brodie Clark	None	None	None	Non-executive Director Compass	Compass (services for drug and alcohol misuse)	None	None	None

Director's interests cont'd

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Area of potential conflict	Details of any hospitality or gift received within the past 12 months: £100 up to and including 7 Nov 2017. In excess of £25 from 8 Nov 2017
Richard Gladman	None	None	None	Programme Director, Health and Social Care Information Centre (NHS Digital)	None	None	None	None
Elaine Taylor-Whilde (to 30.06.17)	CEO, Nine Health Global & Nine Health UK Ltd	Nine Health CIC	None	CEO, Nine Health CIC	Nine Health CIC	None	None	None
Ian Lewis	None	None	None	Trustee: Bone Cancer Research Trust	Occasional teaching/ facilitating for Medical Mediation Foundation	None	None	None
Bryan Machin	None	None	None	None	None	None	None	None
Amanda Thomas	None	None	None	None	None	None	Child Protection Trust Fund co-manager	None
Phil Ayres (from Jan 2018	None	None	None	Employed by Leeds Teaching Hospitals NHS Trust	None	None	None	None
Sam Prince	None	None	None	None	None	None	None	None
Marcia Perry	None	None	None	None	None	None	None	None

Director's interests cont'd

Board Member	Name of company, directorships, including non-executive directorships held in private companies or PLCs (with the exception of those in dormant companies)	Ownership or part-ownership of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS	Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS	A position of trust in a public, charity or voluntary organisation in the field of health and social care	Any connection with a voluntary or other organisation contracting for NHS services	Any other commercial interest Impacting on decision making in meetings	Area of potential conflict	Details of any hospitality or gift received within the past 12 months: £100 up to and including 7 Nov 2017. In excess of £25 from 8 Nov 2017
Sue Ellis* (to 01.10.17)	None	None	None	Governor, Greenhead College, Huddersfield (from 2 October 2015) Seconded fulltime as Programme Director for Health and Social Care Academy, hosted by Leeds Teaching Hospitals from 3/10/2017	None	None	None	None
Ann Hobson* (from 02.10.17)	None	None	None	Husband works for West Yorkshire Police –Leeds Community Healthcare provides health input into West Yorkshire Police Custody Suites	None	None	None	None

* Non-voting Board member

Board meetings and business in 2017/18

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

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

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

In addition, an annual general meeting was held in September 2017.

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

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

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

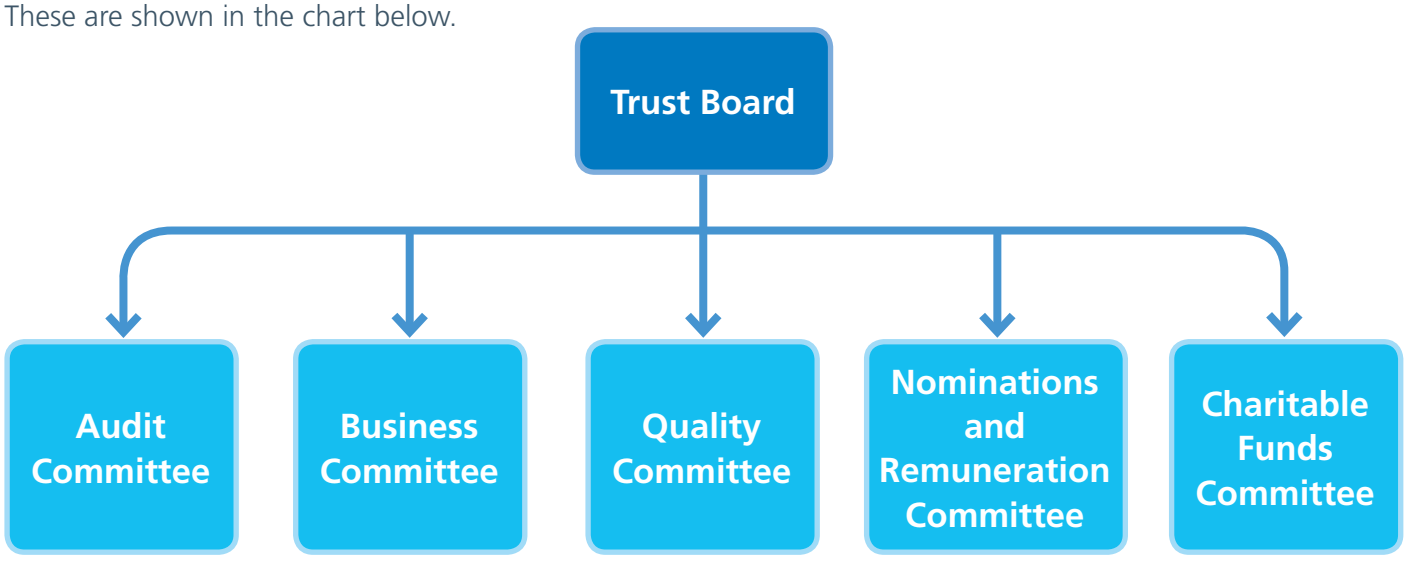
The Board receives regular updates on strategic service developments. For example:

- Enhancing integration across primary and secondary health and social care
- Rolling out new ways of working

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

The Board's committees (decision making groups)

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



Details of the functions of each committee can be found in our Annual Governance Statement 2017/18.

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

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

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

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

Signed ..... Chief Executive

Date 25 May 2018 .....

Annual Governance Statement 2017/18

Scope of responsibility

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

Thea Stein

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Leeds Community Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Leeds Community Healthcare Trust NHS Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

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

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

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

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

The Trust has a quarterly risk management newsletter to share lessons that can be learned from incidents and complaints, the latest information

about risk management, training courses available and examples of good practice across the Trust. A 'lessons learned' portal has recently been developed on the Trust's intranet, for managers to share information about incidents and improvement.

The Trust has recently completed a risk management 'health check', which surveyed service managers and clinical leads to check their knowledge of risk management policy and procedure. Overall, the response was positive. It was found that managers are generally aware of and proficient in risk management. Where scope for improvement has been identified, actions to remedy these have now been put in place.

The risk and control framework

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

The risk management procedure: supports staff to identify, assess, manage, and monitor the risks that threaten the organisation's ability to achieve its objectives. The aim of the risk management procedure is to achieve an optimum response to risk, prioritised in accordance with a consistent evaluation of the identified risk. The Trust has systems in place that contribute to the identification of risk from a number of sources; the following are examples:

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

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

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

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

The Trust's risk appetite: is aligned with its four strategic aims. Trust Board determines its appetite for risk and the senior management team review the trust's risk appetite on an annual basis. The risk appetite statement is appended to the risk management policy and procedure, which is on the Trust's internal website.

Data security risk: is managed through a system of general managers and heads of service that act as information asset owners and work with the Senior Information Risk Owner to manage data security and other information related risks.

In 2017, the Trust took part in the annual national digital maturity (DMI) review. Areas demonstrating the greatest progress since the 2016 are those that the Trust has made specific investments in, namely EPR and business intelligence. The continued delivery of the Trust's digital strategy will bring about a number of improvements and continues to make positive progress towards digital maturity.

Governance structures and accountability

Trust Board
(Chair: Neil Franklin)

The Board leads the Trust by undertaking three main roles:

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

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

There is a clear division of responsibilities between the Chair and Chief Executive. The Trust's Chair and Chief Executive have discharged their leadership functions throughout the whole of 2017/18.

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

The Board has met on thirteen occasions in 2017/18; this has comprised six formal meetings held in public, six informal meetings or strategic workshops plus an annual general meeting. Attendance at Board meetings has been good and all meetings have been quorate.

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

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

The Board has an annual work plan, which demonstrates the scheduling of required and discretionary business. The five Board committees all have terms of reference and work plans all of which have been reviewed during 2017/18.

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

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

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

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

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

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

The Trust has a needs-based Board development programme. A feature of which is a series of Board workshops taking place every two months (six events in 2017/18); senior leaders from corporate services and business units (including clinical leads) also participate in these sessions.

The individual performance of all Board members

is reviewed through a formal appraisal process and any individual development needs are identified and supported.

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

Audit Committee
(Chair: Jane Madeley)

The Committee comprises three non-executive directors. The Chair of the Committee is a qualified accountant and is a Chief Financial Officer in the higher education sector. The Executive Director of Finance and Resources, the Company Secretary, the Internal Auditor and the External Auditor attend on a routine basis. The Audit Committee met formally six times during 2017/18.

The Audit Committee provides an overarching governance role and reviews the work of the other committees, whose work can provide relevant assurance to the Audit Committee's own scope of work.

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

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

The Committee has pursued evidence of compliance with data security requirements and received regular reports concerning data security, including information about the status of serious information governance incidents reported to the Information Commissioner's Office (ICO).

The chair of each of the Board's committees produced an annual report, which provides assurance to the Audit Committee on how each committee has met its terms of reference during the year. The committees also undertook a self-assessment exercise, which was reviewed by the Audit Committee. The committees' chairs also met to discuss the outcome.

Quality Committee
(Chair: Doctor Tony Dearden until December 2017, Professor Ian Lewis from January 2018)

The Quality Committee's membership comprises the Trust's Chair, two non-executive directors, the Chief Executive and two executive directors; a number of other senior officers attend each meeting. The Committee met on 10 occasions in 2017/18.

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

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

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

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

Business Committee
(Chair: Brodie Clark)

The Business Committee's membership comprises three non-executive directors, the Chief Executive and two further executives; other senior officers attend as required. The Business Committee held 10 meetings in 2017/18.

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

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

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

The committee has assumed an extended role in terms of oversight of the Trust's main projects. At each meeting, the Committee receives an in-depth report on one aspect of the Trust's business or one area of project work for example the review of patient administration services across the Trust, which aims to provide a modern and consistent service that makes best use of digital approaches.

Nominations and Remuneration Committee
(Chair: Neil Franklin)

The Nominations and Remuneration Committee's membership comprises the Chair and two further non-executive directors; the Committee is supported by the Director of Workforce. The Committee has met three times in 2017/18.

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.

Charitable Funds Committee
(Chair: Brodie Clark)

The Charitable Funds Committee's membership is comprised of the Chair and one other non-executive director; the Committee is supported by the Executive Director of Nursing. The Committee has held three meetings during 2017/18.

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

Principal risks

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

- Failure to provide high quality, safe services, improve patient experience and measure success in terms of outcomes
- Failure to deliver integrated care and care closer to home arising from a failure to work in partnership with stakeholders to deliver service solutions
- Failure to engage and empower the Trust's workforce and the ability to recruit, retain and develop staff
- Failure to maintain a viable and sustainable organisation

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

Risks to strategic objectives contained within the Trust's clinical and service strategies and plans have been identified and the BAF was revised during 2017, in line with the Trust's annual plan. These risks are assigned to a lead executive to manage. Each of these strategic risks is also assigned to one of the Board's committees for oversight and scrutiny.

The BAF was reviewed in 2017/18 by the Trust's internal auditors. The internal auditors have confirmed that the BAF will support the Trust's overall risk management framework.

Scrutiny of risks

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

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

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

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

Incident reporting

The Trust has a strong, open incident reporting culture and is therefore a high reporter of incidents when compared to similar organisations. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident reporting is promoted through induction and training and regular communications. Learning from incidents is shared with staff through the Trust's quarterly risk management newsletter, at staff forums and new to 2017 is a learning resource on the Trust's internal website for all staff to access, which has been developed to share anonymised, learning from incidents across the organisation. When root cause analysis is undertaken, good practice in incident management is celebrated and learning shared. In addition, arrangements are in place to raise any concerns at work confidentially and anonymously if necessary.

Serious incidents are reported and managed in accordance with the Trust's incident and serious incident policy. The majority of managers have had serious incident investigation training and the Trust has a good record of reporting incidents in a timely way to NHS Improvement and to commissioners.

CQC compliance

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

The Trust received a CQC inspection in the fourth quarter of 2016/17 and the report arising from the inspection was received by the Trust in mid-2017. The Trust received an overall rating of 'Good'. The CQC described the Trust as having 'stable leadership, which appeared cohesive and worked collectively. The leadership were aware of the challenges to provide a good quality service and identify the actions needed to address these. Leaders were visible and accessible'. Following receipt of the CQC report, a quality improvement plan was produced and is monitored by the Quality Committee at each meeting.

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.

Carbon reduction delivery plans

The Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Board sets an annual budget to meet the Trust's financial obligations and through detailed monthly monitoring at the Business Committee and bi-monthly at the Board ensures that plan is adhered to. The Trust has consistently met the financial targets set by regulators. The Business Committee also receives an annual report on the Trust's reference costs, which are an indicator of the Trust's efficiency in delivering its services. Over time the Trust's overall reference cost have fallen from a maximum of 111 in 2011/12 to 97 (including IAPT) in 2016/17. As part of the internal audit cycle, the auditors, TIAA, review the Trust's approach to delivering cost improvement targets; the last report was completed in 2017/18.

The Audit Committee reviews all internal audit reports and monitors the Trust's implementation of any recommendations. Annually the Trust's external auditors are required to provide a Value for Money conclusion. In the last report available, for 2016/17 the auditors concluded that the Trust has adequate arrangements to secure economy, efficiency and effectiveness in its use of resources. The effectiveness of the Trust's services are assessed monthly by the Trust's Quality Committee and bi-monthly by the Board.

Information governance

The Trust recognises that information is an important asset, supporting both clinical and management needs and is fully committed to ensuring that personal information is protected and used appropriately. The Trust has submitted a self-assessed score of level two for the information governance toolkit.

The Trust's information governance group develops relevant policies and strategies to control data security and other information related risks. As a community trust, sharing information has been identified as an area where secure email and electronic record sharing are replacing paper based forms of communication. The introduction of data security measures has reduced the risk of data loss through the use of mobile devices. The Trust has been reviewing and revising its information governance policies and procedures to ensure compliance with the General Data Protection Regulation (in force from May 2018).

In recognition of the importance of data security, the Trust has a target of 95% of staff compliance with information governance training. Training compliance is fully monitored, and attendance is enforced where necessary.

Three incidents were reported to the Information Commissioner's Office (ICO) by the Trust during 2017/18:

Case 1 – Loss of nine staff files containing personal information. Trust reported loss to the ICO. Outcome from ICO was no further action required.

Case 2 – As part of a service tender process, a list containing details of 4000 Trust staff was sent to the service's commissioner, when only the details of staff potentially affected involved in the tender process should have been sent. Outcome from ICO was no further action required.

Case 3 – A member of staff using a system managed by another NHS trust to access a patient's notes without a legitimate reason and without consent. They shared the information with a person known to the patient. The member of staff no longer works for the Trust. A complaint was made to the ICO, who are considering their response.

Annual Quality Account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

LCH ensures that the Quality Accounts are collaborative and that services understand the potential reach and impact of the Quality Accounts.

The Trust found ways of engaging with more service users to get their input and stories to demonstrate successes and failures in context, to provide a balanced view. In particular, focus was on engagement with patients who are elderly and infirm and often housebound. The Trust strives to make the Quality Account accessible and relevant to all the communities it serves.

The Quality Account priorities have been developed in conjunction with the services and disseminated to senior managers to ensure that the priorities are aligned to both the Quality Strategy and the Trust's business objectives.

Data accuracy

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

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

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

Review of effectiveness

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

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

Internal audit

TIAA Limited has been the provider of internal audit services since 1 April 2015. This contract was recently reviewed and has been renewed. TIAA carried out 22 reviews in 2017/18, which were designed to ascertain the extent to which the internal controls in the system are adequate to ensure that activities and procedures are operating to achieve the Trust's objectives. For each assurance review, an assessment of the combined effectiveness of the controls in mitigating the key control risks was provided. The Head of Internal Audit has provided an overall opinion which concludes that, based on the work undertaken in 2017/18, reasonable assurance can be given that there are adequate and effective management and internal control processes to manage the achievement of the organisation's objectives. No emerging risks have been identified which could have an impact on the overall effectiveness of the governance, risk and internal control framework of the organisation.

In areas reviewed by internal audit where it was assessed that the effectiveness of internal control arrangements provided less than 'substantial' assurance, recommendations were made to further strengthen the control environment. There were three areas reviewed by internal audit where it was assessed that the effectiveness of some of the internal control arrangements provided 'limited'

assurance. Resultant management actions, which are monitored by the Audit Committee, have been completed or are being progressed in a satisfactory manner.

The Board commissioned an internal audit of Board and Committee effectiveness during 2017/18. The audit assessment provided reasonable assurance having found no material concerns, but outlined opportunities to advance governance arrangements.

Clinical audit

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

Clinical audit is managed at service level with the support of the quality and professional development directorate. The Quality Committee approves an annual programme of clinical audit and has oversight of progress during the course of the year. The 2017/18 programme comprised of 33 mandatory audits, 40 recommended audits and a further 44 audits which had been determined locally.

NHS Improvement oversight

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

The Trust works with a range of regulators including the CQC, HM Inspectorate of Prisons, and Ofsted. The Trust is fully compliant with the registration requirements of the CQC. During late 2016/17, the Trust was involved in an inspection by the CQC, which particularly focused on inpatient care, adult services, sexual health services and a Trust-wide review of the well-led domain and has since received an overall rating of 'Good'.

Conclusion

During 2017/18, no significant control issues have been identified by the Trust's systems of internal control.

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

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

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

Signed .....

Chief Executive

Date 25 May 2018 .....

Remuneration and staff report

Policy on senior managers' contracts

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

Name and title	Contract date	Date of Expiry	Notice period
Susan Ellis Director of Workforce	23 January 2012	External secondment from 2 October 2017	6 months
Ann Hobson Interim Director of Workforce	1 October 2017	No end date	3 months
Bryan Machin Executive Director of Finance and Resources	9 May 2011	No end date	6 months
Marcia Perry Executive (Nurse) Director of Quality	10 August 2015	No end date	6 months
Sam Prince Executive Director of Operations	4 July 2011	No end date	6 months
Thea Stein Chief Executive	1 October 2014	No end date	6 months
Dr Amanda Thomas Executive Medical Director	5 September 2011	No end date	6 months
Dr Phil Ayres Interim Medical Director	Internal secondment from LTHT 1 January 2018	31 May 2018	

Payments to past senior managers (subject to audit)

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

The Trust can confirm:

- There were no performance related payments made to senior managers in 2017/18
- There were no senior managers service contracts awarded during 2017/18
- There were no payments to past senior managers during 2017/18
- There were no payments for loss of office during 2017/18
- There was no senior off-payroll engagement during 2017/18

Number of individuals that have been deemed 'Board members, and / or senior officers with significant financial responsibility' during the financial year = 15. This figure includes off payroll and on-payroll engagement.

Senior Manager Remuneration Report (subject to audit)

	2017 / 2018						2016/ 2017					
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**
Dr Phil Ayres – Interim Executive Medical Director	35 - 40					35 - 40						
Brodie Clark – Non Executive Director	5 - 10	0.7				5 -10	5 -10	0.8				5 - 10
Dr Tony Dearden – Non Executive Director	5 - 10	0.4				5 -10	5 -10	0.5				5 - 10
Susan Ellis – Director of Workforce (to 01.10.17)	45 - 50				7.5 - 10	50 - 55	90 - 95				30 - 32.5	120 - 125
Neil Franklin – Chair	20 - 25	0.4				20 - 25	20 - 25	0.6				20 - 25
Emma Fraser – Director of Strategy and Planning (to 31.07.16)							15 - 20		0 - 5		0 - 2.5	20 - 25
Richard Gladman – Non Executive Director (from 01.04.16)	5 - 10					5 - 10	5 - 10					5 - 10
Ann Hobson – Interim Director of Workforce (from 02.10.17)	45 - 50				40 - 42.5	80 - 85						
Ian Lewis – Non Executive Director (from 01.07.17)	0 - 5					0 - 5						
Bryan Machin – Executive Director of Finance and Resources	115 - 120	0.1				115 - 120	110 - 115	0.1			52.5 - 55	165 - 170

	2017 / 2018						2016/ 2017					
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**
Jane Madeley – Non-executive Director	5 - 10					5 - 10	5 - 10					5 - 10
Paul Morrin – Director of Integration, Adult Health and Social Care (until 01.06.16)							10 - 15		0 - 5		0 - 2.5	15 - 20
Marcia Perry – Executive (Nurse Director) of Quality (from 10.08.15)	90 - 95	0.1			5 - 7.5	95 - 100	90 - 95	0.1			42.5 - 45	135 - 140
Sam Prince – Executive Director of Operations	95 - 100	0.1			15 - 17.5	110 - 115	95 - 100	0.1			30 - 32.5	125 - 130
Thea Stein – Chief Executive	140 - 145	0.1				140 - 145	140 - 145	0.1				140 - 145
Elaine Taylor Whilde – Non Executive Director (from 01.04.16)	0 - 5					0 - 5	5 - 10	1.0				5 - 10
Dr Amanda Thomas – Executive Medical Director	95 - 100		60 - 65			155 - 160	95 - 100		75 - 80			170 - 175

Pension details for senior managers
2017/18 (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 2018 (bands of £5,000) £'000	Lump sum at pensionable age related to accrued pension at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 1 April 2017 £'000	Real increase in Cash Equivalent Transfer Value £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000
Dr Phil Ayres – Interim Executive Medical Director	0	0	0	0	0	0	0
Susan Ellis – Director of Workforce (to 01.10.17)	0 - 2.5	0 - 2.5	40 - 45	130 - 135	956	34	1,039
Emma Fraser – Director of Strategy and Planning (to 31.07.16)	0	0	0	0	214	0	0
Ann Hobson – Interim Director of Workforce (from 02.10.17)	0 – 2.5	2.5 - 5	25 - 30	75 - 80	440	38	527
Bryan Machin – Executive Director of Finance and Resources*	0	0	0	0	873	0	0
Marcia Perry – Executive (Nurse Director) of Quality	0 - 2.5	0 - 2.5	35 - 40	105 -110	588	43	649
Sam Prince – Executive Director of Operations	0 - 2.5	0	35 - 40	90 - 95	558	36	613
Paul Morrin – Director of Integration, Adult Health and Social Care (to 01.06.16)*	0	0	0	0	0	0	0
Thea Stein – Chief Executive*	0	0	0	0	0	0	0
Dr Amanda Thomas – Executive Medical Director*	0	0	0	0	0	0	0

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

Cash Equivalent Transfer Values

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

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Fair pay disclosures (subject to audit)

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

The banded remuneration of the highest paid director for the Trust in the financial year 2017/18 was £159,144 (2016/17, £173,181). This was 5.5 (2016/17, 6.1) times the median remuneration of the workforce, which was £28,746 (2016/17 £28,211). The multiple is the less than last year as the highest paid director has reduced the number of clinical sessions undertaken.

In 2017/18 total remuneration ranged from £16,523 to £170,527, (2016/17, £15,251 to £173,181). Two medical staff employees were paid more than the highest paid director.

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

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

Staff costs	2017/18			2016/17
	Permanent £k	Other £k	Total £k	Total £k
Salaries and wages	77,108	2,584	79,692	79,478
Social security costs	7,353	0	7,353	7,586
Apprenticeship levy	373	0	373	0
Employer's contributions to NHS pensions	9,991	0	9,991	10,186
Pension cost - other	13	0	13	15
Other post employment benefits	0	0	0	0
Other employment benefits	0	0	0	0
Termination benefits	265	0	265	702
Temporary staff	0	6,226	6,226	8,377
Total gross staff costs (including seconded out)	**95,103**	**8,810**	**103,913**	**106,344**
Of which: Costs capitalised as part of assets	157	125	282	275

Average staff numbers in post by occupation groupings

Average number of employees (WTE basis)	2017/18			2016/17
	Permanent Number	Other Number	Total Number	Total Number
Medical and dental	53	28	81	84
Administration and estates*	628	83	711	742
Healthcare assistants and other support staff	466	40	506	540
Nursing, midwifery and health visiting staff*	877	46	923	957
Nursing, midwifery and health visiting learners	3	0	3	9
Scientific, therapeutic and technical staff	429	31	460	470
Healthcare science staff	1	0	1	1
Other	28	1	29	27
Total average numbers	**2,485**	**229**	**2,714**	**2,830**
Of which: Number of employees (WTE) engaged on capital projects	4	2	6	5

*The 2016/17 average staff numbers for administration and estates have been by increased by 23 to reflect a classification change for some staff that had previously been reported as qualified nurses. These have leadership roles within adult services and have been re-classified as managers in 2017/18. The adjustment has been made to facilitate comparisons between the two years.

On average there was 116 whole time equivalent less staff in post in 2017/18; 89 of these posts relate to services such as Family Nurse Partnership, Healthy Living, York Street, South Leeds Independence Centre, Community Intermediate Care Unit and Neonatal Hearing that the Trust has ceased to provide in 2017/18.

Expenditure on consultancy

The Trust had no expenditure on consultancy services during 2017/18.

Off-payroll engagements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last longer than six months:

Number of existing engagements as of 31 March 2018	21
Of which, the number that have existed:	
For less than one year at the time of reporting	0
For between one and two years at the time of reporting	1
For between two and three years at the time of reporting	5
For between three and four years at the time of reporting	15
For four or more years at the time of reporting	0

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

For all new off-payroll engagements or those that reached six months in durations between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than six months:

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	
Number assessed as caught by IR35	0
Number assessed as not caught by IR35	0
Number engaged directly (via PSC contracted to department) and are on the departmental payroll	0
Number of engagements reassessed for consistency/ assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

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

Exit packages

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

Exit Package cost band (including any special payment element)	Total number of compulsory redundancies Number	Total cost of compulsory redundancies £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
Less than £10,000	4	24,541	0	0
£10,000 - £25,000	0	0	0	0
£25,001 - £50,000	1	30,000	0	0
Totals	5	54,541	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of Section 16 of the Agenda for Change Handbook. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pensions Scheme. Ill-health retirements are met by the NHS Pensions Scheme and are not included in the table. There were no other departures during 2017/18.

Staff sickness

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

	Calendar Year	
	2017	2016
Total days lost	32,038	34,140
Total staff years	2,485	2,634
Average working days lost	12.9	13.0

Signed .....

Chief Executive

Date 25 May 2018 .....

Leeds Community Healthcare NHS Trust

Annual Accounts for the period

1 April 2017 to 31 March 2018

Statement of directors' responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the Trust and of the income and expenditure, recognised gains and losses 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
- 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.

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

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

By order of the Board

25/5/18 Date ..... Chief Executive

25/5/18 Date ..... Executive Director of Finance

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Leeds Community Healthcare NHS Trust ("the Trust") for the year ended 31 March 2018 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2018 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2017/18.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least twelve months from the date of approval of the financial statements. We have nothing to report in these respects.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2017/18. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2017/18.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 1, the directors are responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on Page 50 (annual report) the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

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

A fuller description of our responsibilities is provided on the FRC's website at:

www.frc.org.uk/auditors responsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 50 (annual report), the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

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

We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Leeds Community Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Clare Partridge
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
1 Sovereign Square
Sovereign Street
Leeds
LS1 4DA

25 May 2018

Statement of Comprehensive Income

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	142,243	141,955
Other operating income	4	7,283	6,699
Operating expenses	6, 8	(144,623)	(144,597)
Operating surplus / (deficit) from continuing operations		**4,903**	**4,057**
Finance income	11	70	43
Finance expenses	12	-	-
PDC dividends payable		(488)	(706)
Net finance costs		**(418)**	**(663)**
Other gains / (losses)	13	(46)	(48)
Share of profit / (losses) of associates / joint arrangements	20	-	-
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense		-	-
Surplus / (deficit) for the year from continuing operations		**4,439**	**3,346**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Surplus / (deficit) for the year		**4,439**	**3,346**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	7	(574)	-
Revaluations	18	3,428	-
Share of comprehensive income from associates and joint ventures	20	-	-
Other recognised gains and losses		-	-
Remeasurements of the net defined benefit pension scheme liability / asset		-	-
Other reserve movements		43	-
May be reclassified to income and expenditure when certain conditions are met:			
Fair value gains / (losses) on available for sale financial investments	13	-	-
Recycling gains / (losses) on available for sale financial investments	13	-	-
Foreign exchange gains / (losses) recognised directly in OCI	13	-	-
Total comprehensive income / (expense) for the period		**7,336**	**3,346**

Statement of Financial Position

	Note	31 March 2018 £000	31 March 2017 £000
Non-current assets			
Intangible assets	15	53	76
Property, plant and equipment	16	29,310	27,144
Investment property	19	-	-
Investments in associates and joint ventures	20	-	-
Other investments / financial assets	21	-	-
Trade and other receivables	24	-	-
Other assets	25	-	-
Total non-current assets		**29,363**	**27,220**
Current assets			
Inventories	23	-	-
Trade and other receivables	24	8,849	6,209
Other investments / financial assets	21	-	-
Other assets	25	-	-
Non-current assets held for sale / assets in disposal groups	26	-	165
Cash and cash equivalents	27	23,244	19,104
Total current assets		**32,093**	**25,478**
Current liabilities			
Trade and other payables	28	(11,029)	(9,757)
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	(1,361)	(1,398)
Other liabilities	30	(1,042)	(855)
Liabilities in disposal groups	26.1	-	-
Total current liabilities		**(13,432)**	**(12,010)**
Total assets less current liabilities		**48,024**	**40,688**
Non-current liabilities			
Trade and other payables	28	-	-
Borrowings	31	-	-
Other financial liabilities	29	-	-
Provisions	33	-	-
Other liabilities	30	-	-
Total non-current liabilities		**-**	**-**
Total assets employed		**48,024**	**40,688**
Financed by			
Public dividend capital		256	256
Revaluation reserve		12,032	9,496
Available for sale investments reserve		-	-
Other reserves		-	-
Merger reserve		-	-
Income and expenditure reserve		35,736	30,936
Total taxpayers' equity		**48,024**	**40,688**

The notes on pages 77 to 117 form part of these accounts.

Name

Position **Chief Executive**

Date **25 May 2018**

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

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

Statement of Changes in Equity for the year ended 31 March 2017

	Public dividend capital £000	Revaluation reserve £000	Available for sale investment reserve £000	Other reserves £000	Merger reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2016 - brought forward	**256**	**9,525**	**-**	**-**	**-**	**27,561**	**37,342**
Surplus / (deficit) for the year	-	-	-	-	-	3,346	**3,346**
Transfers by absorption: transfers between reserves	-	-	-	-	-	-	**-**
Transfer from revaluation reserve to income and expenditure reserve for impairments arising from consumption of economic benefits	-	-	-	-	-	-	**-**
Other transfers between reserves	-	(29)	-	-	-	29	**-**
Impairments	-	-	-	-	-	-	**-**
Revaluations	-	-	-	-	-	-	**-**
Transfer to retained earnings on disposal of assets	-	-	-	-	-	-	**-**
Share of comprehensive income from associates and joint ventures	-	-	-	-	-	-	**-**
Fair value gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Recycling gains / (losses) on available for sale financial investments	-	-	-	-	-	-	**-**
Foreign exchange gains / (losses) recognised directly in OCI	-	-	-	-	-	-	**-**
Other recognised gains and losses	-	-	-	-	-	-	**-**
Remeasurements of the defined net benefit pension scheme liability / asset	-	-	-	-	-	-	**-**
Public dividend capital received	-	-	-	-	-	-	**-**
Public dividend capital repaid	-	-	-	-	-	-	**-**
Public dividend capital written off	-	-	-	-	-	-	**-**
Other movements in public dividend capital in year	-	-	-	-	-	-	**-**
Other reserve movements	-	-	-	-	-	-	**-**
Taxpayers' equity at 31 March 2017	**256**	**9,496**	**-**	**-**	**-**	**30,936**	**40,688**

Information on reserves

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

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

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

Other reserves
The Trust does not hold an available for sale investment reserve, a merger reserve or any other reserves.

Statement of Cash Flows

	Note	2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating surplus / (deficit)		4,903	4,057
Non-cash income and expense:			
Depreciation and amortisation	6.1	1,724	1,565
Net impairments	7	212	-
Income recognised in respect of capital donations	4	-	-
Amortisation of PFI deferred credit		-	-
Non-cash movements in on SoFP pension liability		-	-
(Increase) / decrease in receivables and other assets		(2,331)	(91)
(Increase) / decrease in inventories		-	-
Increase / (decrease) in payables and other liabilities		1,637	(3,492)
Increase / (decrease) in provisions		(37)	(29)
Tax (paid) / received		-	-
Operating cash flows from discontinued operations		-	-
Other movements in operating cash flows		52	-
Net cash generated from / (used in) operating activities		**6,160**	**2,010**
Cash flows from investing activities			
Interest received		70	43
Purchase and sale of financial assets / investments		-	-
Purchase of intangible assets		(1)	(46)
Sales of intangible assets		-	-
Purchase of property, plant, equipment and investment property		(1,628)	(1,338)
Sales of property, plant, equipment and investment property		348	36
Receipt of cash donations to purchase capital assets		-	-
Prepayment of PFI capital contributions		-	-
Investing cash flows of discontinued operations		-	-
Cash movement from acquisitions / disposals of subsidiaries		-	-
Net cash generated from / (used in) investing activities		**(1,211)**	**(1,305)**
Cash flows from financing activities			
Public dividend capital received		-	-
Public dividend capital repaid		-	-
Movement on loans from the Department of Health and Social Care		-	-
Movement on other loans		-	-
Other capital receipts		-	-
Capital element of finance lease rental payments		-	-
Capital element of PFI, LIFT and other service concession payments		-	-
Interest paid on finance lease liabilities		-	-
Interest paid on PFI, LIFT and other service concession obligations		-	-
Other interest paid		-	-
PDC dividend (paid) / refunded		(809)	(675)
Financing cash flows of discontinued operations		-	-
Cash flows from / used in other financing activities		-	-
Net cash generated from / (used in) financing activities		**(809)**	**(675)**
Increase / (decrease) in cash and cash equivalents		**4,140**	**30**
Cash and cash equivalents at 1 April - brought forward		**19,104**	**19,074**
Cash and cash equivalents transferred under absorption accounting	41	-	-
Unrealised gains / (losses) on foreign exchange		-	-
Cash and cash equivalents at 31 March	27.1	**23,244**	**19,104**

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 2017/18 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 Accounting convention

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

Note 1.1.2 Going concern

These accounts have been prepared on a going concern basis.

The going concern concept was reviewed by the Trust's Audit Committee at its meeting on 16 March 2018.

In considering whether the Trust is a going concern the following areas were reviewed:

The Trust's financial monitoring throughout 2017/18 provides evidence that financial duties and targets will be met or exceeded. The Trust will achieve the control total set by NHS Improvement. Historically, the Trust has achieved all its financial duties.

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

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

The Trust's draft financial plan for 2018/19 demonstrates delivery of the Board approved surplus; for 2017/18 the Trust will achieve the NHS Improvement control total, for 2018/19 the plans demonstrate achievement of the control total surplus.

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

The Trust's liquidity remains very strong with £23.2m in the bank at the year end. The financial plan demonstrates the Trust has sufficient cash resources to meet its operational and capital investment commitments for 2018/19.

The Board of Directors is a stable and experienced team. The vacant Director of Workforce has been covered on an interim basis whilst substantive recruitment is undertaken and arrangements are in place for an experienced local consultant to temporarily cover the Medical Director role. A new Non-Executive Director was appointed in year to strengthen clinical input into the Board decision making.

The Board has considered the matter of the Trust as a going concern, through its ongoing assessment of sustainability and the resources needed to ensure it continues in operational existence for the foreseeable future.

Note 1.2 Critical judgements in applying accounting policies

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

With the introduction of IFRS 16 the Trust has the responsibility for ensuring the carrying value of its fixed assets reported in the Statement of Financial Position is up to date. The Trust has taken advice from the District Valuers Office, an independent expert body, on the movement in building and land values since the last full valuation was undertaken in 2014/15. The movement in the value was greater than the Trust's threshold of 10%; therefore a full revaluation of the land and buildings has been undertaken during 2017/18. This resulted in asset values increasing by £2,642k, write back of depreciation of £1,454k and a net impairment of £212k.

Note 1.2.1 Sources of estimation uncertainty
An estimate of the redundancy costs has been made and included in the Trust's expenditure for 2017/18 as required under IAS 37. The estimated value of redundancies provided for is £1,028k.

Note 1.3 Interests in other entities

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

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

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

Note 1.4 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of health care services. At the year end, the Trust accrues income relating to activity delivered in that year.

Where income is received for a specific activity which is to be delivered in a subsequent financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Income from Clinical Commissioning Groups totalled £104,059k or 70% of the total income received by the Trust. £28,444k or 19% of the Trust's income was from Local Authorities. All income is reported under a single operating segment.

Revenue grants and other contributions to expenditure
Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.5 Expenditure on employee benefits

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

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

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

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

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

Note 1.6 Expenditure on other goods and services

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

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has 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 economic lives.

Note 1.7.2 Measurement

Valuation

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

All assets are subsequently measured at their current value in existing use. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying amounts 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, modern equivalent asset basis.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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 they 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 economic lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent expenditure

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

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

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

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

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

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

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

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss 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.

Note 1.7.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:
• the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales
• the sale must be highly probable ie:
- management are committed to a plan to sell the asset
- an active programme has begun to find a buyer and complete the sale
- the asset is being actively marketed at a reasonable price
- the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.7.4 Donated and grant funded assets
Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation / grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.6 Useful economic lives of property, plant and equipment
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

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

Where material refurbishment schemes have taken place the asset lives have been reviewed and amended as appropriate.

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets
Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- the Trust intends to complete the asset and sell or use it
- the Trust has the ability to sell or use the asset
- how the intangible asset will generate probable future economic or service delivery benefits, eg the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset and
- the Trust can measure reliably the expenses attributable to the asset during development.

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

Note 1.8.2 Measurement

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

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

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

Amortisation

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

Note 1.8.3 Useful economic lives of intangible assets

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

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

Note 1.9 Inventories

The Trust has no inventories.

Note 1.10 Investment properties

The Trust has no investment properties.

Note 1.11 Cash and cash equivalents

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

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

Note 1.12 Carbon Reduction Commitment Scheme (CRC)

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

Note 1.13 Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

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

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

Classification and measurement
Financial assets are categorised as loans and receivables.

Financial liabilities are classified as other financial liabilities.

Financial assets and financial liabilities at fair value through income and expenditure
Financial assets and financial liabilities at fair value through income and expenditure are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges.

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision.

The Trust has made provision for the impairment of non-NHS receivables in excess of 90 days overdue. The Trust regularly reviews aged debts and makes referrals to a debt collection agency. Where advice from the collection agency indicates recovery is unlikely the debt is written off. Where a payment schedule is in place these debts are recovered over a longer time period.

Note 1.14 Leases

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

Note 1.14.1 The Trust as lessee

Finance leases

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

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

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

Operating leases

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

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

Leases of land and buildings

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

Note 1.14.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.15 Provisions

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

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 33.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

Note 1.16 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 34 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the Trust's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

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

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

A charge, reflecting the cost of capital utilised by the Trust, is payable as 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, except for:
(i) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
(iii) any PDC dividend balance receivable or payable; and
(iv) sustainability and transformation funding.

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

Note 1.18 Value added tax

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

Note 1.19 Corporation tax

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

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

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

Note 1.20 Foreign exchange

The functional and presentational currency of the Trust is sterling.

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

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

• monetary items (other than financial instruments measured at fair value through income and expenditure) are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

Note 1.21 Third party assets

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

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.23 Gifts

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

Note 1.24 Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

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

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

Note 1.25 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017/18.

Note 1.26 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 9 *Financial Instruments*
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 14 *Regulatory Deferral Accounts*
Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
IFRS 15 *Revenue from Contracts with Customers*
Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 16 *Leases*
Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRS 17 *Insurance Contracts*
Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
IFRIC 22 *Foreign Currency Transactions and Advance Consideration*
Application required for accounting periods beginning on or after 1 January 2018.
IFRIC 23 *Uncertainty over Income Tax Treatments*
Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

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

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

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

Note 3 Operating income from patient care activities

Note 3.1 Income from patient care activities (by nature)	2017/18 £000	2016/17 £000
Acute services		
Other NHS clinical income	692	-
Mental health services		
Block contract income	1,621	1,574
Community services		
Community services income from CCGs and NHS England	109,827	109,827
Income from other sources (eg local authorities)	29,822	30,537
All services		
Private patient income	-	17
Other clinical income	281	-
Total income from activities	**142,243**	**141,955**

Note 3.2 Income from patient care activities (by source)		
Income from patient care activities received from:	**2017/18 £000**	**2016/17 £000**
NHS England	8,079	7,997
Clinical Commissioning Groups	104,059	103,404
Department of Health and Social Care	-	-
Other NHS providers	281	2
NHS other	-	-
Local authorities	28,444	28,927
Non-NHS: private patients	-	17
Non-NHS: overseas patients (chargeable to patient)	-	-
NHS injury scheme	-	-
Non-NHS: other	1,380	1,608
Total income from activities	**142,243**	**141,955**
Of which:		
Related to continuing operations	142,243	141,955
Related to discontinued operations	-	-

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

The Trust has no overseas visitor income.

Note 4 Other operating income

	2017/18	2016/17
	£000	£000
Research and development	371	385
Education and training	1,551	1,500
Receipt of capital grants and donations	-	-
Charitable and other contributions to expenditure	-	-
Non-patient care services to other bodies	121	183
Support from the Department of Health and Social Care for mergers	-	-
Sustainability and transformation fund income	2,417	1,350
Rental revenue from operating leases	479	434
Rental revenue from finance leases	-	-
Income in respect of staff costs where accounted on gross basis	722	840
Other income*	1,622	2,007
Total other operating income	**7,283**	**6,699**
Of which:		
Related to continuing operations	7,283	6,699
Related to discontinued operations	-	-

*Other non-clincial income totalled £1,622k; of which £761k was rental income and £376k lease car income.

Note 5 Fees and charges

The Trust received no income in respect of fees and charges.

Note 6 Expenses

Note 6.1 Operating expenses

	2017/18 £000	2016/17 £000
Purchase of healthcare from NHS and DHSC bodies	-	-
Purchase of healthcare from non-NHS and non-DHSC bodies	1,345	627
Purchase of social care	-	-
Staff and Executive Directors costs	103,631	106,069
Remuneration of Non-Executive Directors	54	56
Supplies and services - clinical *	9,983	10,277
Supplies and services - general	3,537	2,435
Drug costs *	875	1,294
Inventories written down	-	-
Consultancy costs	-	25
Establishment	3,346	2,885
Premises *	12,259	11,477
Transport (including patient travel) *	1,777	1,918
Depreciation on property, plant and equipment	1,700	1,541
Amortisation on intangible assets	24	24
Net impairments	212	-
Increase / (decrease) in provision for impairment of receivables	1	51
Increase / (decrease) in other provisions	(28)	-
Change in provisions discount rate(s)	-	-
Audit fees payable to the external auditor		
audit services - statutory audit	47	52
other auditor remuneration (external auditor only)	-	13
Internal audit costs	94	92
Clinical negligence	371	265
Legal fees	84	248
Insurance	129	133
Research and development	12	58
Education and training	519	631
Rentals under operating leases *	2,244	2,414
Early retirements	-	-
Redundancy	-	-
Charges to operating expenditure for on SoFP IFRIC 12 schemes	-	-
Charges to operating expenditure for off SoFP IFRIC 12 schemes	-	-
Car parking and security *	260	226
Hospitality *	-	-
Losses, ex-gratia and special payments *	27	85
Grossing up consortium arrangements	-	-
Other services, eg external payroll *	812	835
Other **	1,308	866
Total	**144,623**	**144,597**
Of which:		
Related to continuing operations	144,623	144,597
Related to discontinued operations	-	-

* The prior year figures for these items of expenditure have been restated to reflect the additional detail in 2017/18 and to provide accurate comparative information. Operating costs for 2016/17 overall remain the same as reported last year.

** £981k of other expenditure relates to external recharges in respect of partnerships with Leeds Teaching Hospitals NHS Trust and South West Yorkshire Partnership NHS Foundation Trust.

Note 6.2 Other auditor remuneration

	2017/18 £000	2016/17 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the Trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	13
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**-**	**13**

Note 6.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2017/18 or 2016/17.

Note 7 Impairment of assets

	2017/18 £000	2016/17 £000
Net impairments charged to operating surplus / deficit resulting from:		
Loss or damage from normal operations	-	-
Over specification of assets	-	-
Abandonment of assets in course of construction	-	-
Unforeseen obsolescence	-	-
Loss as a result of catastrophe	-	-
Changes in market price	212	-
Other	-	-
Total net impairments charged to operating surplus / deficit	**212**	**-**
Impairments charged to the revaluation reserve	574	-
Total net impairments	**786**	**-**

Due to the movement in property values the Trust commissioned an asset valuation from the District Valuer as at 31 March 2018. This has resulted in impairments of £241k and the reversal of prior year impairments of £29k.

Note 8 Employee benefits

	2017/18 Total £000	2016/17 Total £000
Salaries and wages	79,692	81,316
Social security costs	7,353	7,586
Apprenticeship levy	373	-
Employer's contributions to NHS pensions	9,991	10,186
Pension cost - other	13	15
Other post employment benefits	-	-
Other employment benefits	-	-
Termination benefits	265	702
Temporary staff (including agency)	6,226	6,539
Total gross staff costs	**103,913**	**106,344**
Recoveries in respect of seconded staff	-	-
Total staff costs	**103,913**	**106,344**
Of which		
Costs capitalised as part of assets	282	275

Note 8.1 Retirements due to ill-health

During 2017/18 there were no early retirements from the Trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £0k (£197k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 9 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State 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 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the scheme actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Other pension costs

NEST (National Employment Savings Trust) is an alternative pension scheme set up to comply with new legislation which provides that employees fulfilling certain criteria must auto-enrol into a pension scheme. When they do not qualify for or wish to join the NHS Pension Scheme this is the Trust's mandatory alternative scheme. NEST Corporation is the Trustee body that has overall responsibility for running NEST. It is a non-departmental public body that operates at arm's length from government and is accountable to Parliament through the Department of Work and Pensions (DWP). The Trust has expensed £15k during the year in respect of contributions for employees under the NEST scheme.

Note 10 Operating leases

Note 10.1 Leeds Community Healthcare NHS Trust as a lessor

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

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

	2017/18 £000	2016/17 £000
Operating lease revenue		
Minimum lease receipts	479	434
Contingent rent	-	-
Other	-	-
Total	**479**	**434**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease receipts due:		
- not later than one year	453	430
- later than one year and not later than five years	1,118	1,169
- later than five years	65	80
Total	**1,636**	**1,679**

Note 10.2 Leeds Community Healthcare NHS Trust as a lessee

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

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

The Trust has no contingent rents.

	2017/18 £000	2016/17 £000
Operating lease expense		
Minimum lease payments	2,244	2,414
Contingent rents	-	-
Less sublease payments received	-	-
Total	**2,244**	**2,414**

	31 March 2018 £000	31 March 2017 £000
Future minimum lease payments due:		
- not later than one year	2,080	2,112
- later than one year and not later than five years	4,490	4,634
- later than five years	725	1,444
Total	**7,295**	**8,190**
Future minimum sublease payments to be received	-	(115)

Note 11 Finance income

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

	2017/18 £000	2016/17 £000
Interest on bank accounts	70	43
Interest on impaired financial assets	-	-
Interest income on finance leases	-	-
Interest on other investments / financial assets	-	-
Other finance income	-	-
Total	**70**	**43**

Note 12 Financing costs

Note 12.1 Finance expenditure

	2017/18 £000	2016/17 £000
Interest expense:		
Loans from the Department of Health and Social Care	-	-
Other loans	-	-
Overdrafts	-	-
Finance leases	-	-
Interest on late payment of commercial debt	-	-
Main finance costs on PFI and LIFT schemes obligations	-	-
Contingent finance costs on PFI and LIFT scheme obligations	-	-
Total interest expense	**-**	**-**
Unwinding of discount on provisions	-	-
Other finance costs	-	-
Total finance costs	**-**	**-**

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

The Trust incurred no interest payments in respect of the late payment of commercial debt.

Note 13 Other gains / (losses)

	2017/18 £000	2016/17 £000
Gains on disposal of assets	193	-
Losses on disposal of assets	(239)	(48)
Total gains / (losses) on disposal of assets	(46)	(48)
Gains / (losses) on foreign exchange	-	-
Fair value gains / (losses) on investment properties	-	-
Fair value gains / (losses) on financial assets / investments	-	-
Fair value gains / (losses) on financial liabilities	-	-
Recycling gains / (losses) on disposal of available for sale financial investments	-	-
Total other gains / (losses)	**(46)**	**(48)**

Garforth Clinic was sold in September 2017 for £362k; the carrying value was £175k less assumed costs for selling of £10k. After selling costs of £14k the Trust achieved a net profit on disposal of £193k. Other assets disposed of during the year relate to write offs of equipment no longer in use and were not saleable.

Note 14 Discontinued operations

The Trust has no discontinued operations.

Note 15 Intangible assets

Note 15.1 Intangible assets - 2017/18

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

Note 15.2 Intangible assets - 2016/17

	Software licences £000	Total £000
Valuation / gross cost at 1 April 2016 - as previously stated	**212**	**212**
Transfers by absorption	-	-
Additions	46	**46**
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to / from assets held for sale	-	-
Disposals / de-recognition	-	-
Valuation / gross cost at 31 March 2017	**258**	**258**
Amortisation at 1 April 2016 - as previously stated	**158**	**158**
Transfers by absorption	-	-
Provided during the year	**24**	**24**
Impairments	-	-
Reversals of impairments	-	-
Revaluations	-	-
Reclassifications	-	-
Transfers to / from assets held for sale	-	-
Disposals / de-recognition	-	-
Amortisation at 31 March 2017	**182**	**182**
Net book value at 31 March 2017	**76**	**76**
Net book value at 1 April 2016	**54**	**54**

Note 16 Property, plant and equipment

Note 16.1 Property, plant and equipment - 2017/18

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

Note 16.2 Property, plant and equipment - 2016/17

	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 2016 - as previously stated	**9,550**	**14,605**	**33**	**3,664**	**2,868**	**596**	**31,316**
Transfers by absorption	-	-	-	-	-	-	-
Additions	-	-	142	96	1,291	-	**1,529**
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	110	(110)	-	-	-	-
Transfers to / from assets held for sale	-	-	-	(186)	-	-	**(186)**
Disposals / de-recognition	-	-	-	(128)	-	(12)	**(140)**
Valuation / gross cost at 31 March 2017	**9,550**	**14,715**	**65**	**3,446**	**4,159**	**584**	**32,519**
Accumulated depreciation at 1 April 2016 - as previously stated	**-**	**713**	**-**	**2,222**	**665**	**488**	**4,088**
Transfers by absorption	-	-	-	-	-	-	-
Provided during the year	-	**506**	-	**386**	**622**	**27**	**1,541**
Impairments	-	-	-	-	-	-	-
Reversals of impairments	-	-	-	-	-	-	-
Revaluations	-	-	-	-	-	-	-
Reclassifications	-	-	-	-	-	-	-
Transfers to / from assets held for sale	-	-	-	(142)	-	-	**(142)**
Disposals / de-recognition	-	-	-	(101)	-	(11)	**(112)**
Accumulated depreciation at 31 March 2017	**-**	**1,219**	**-**	**2,365**	**1,287**	**504**	**5,375**
Net book value at 31 March 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**
Net book value at 1 April 2016	**9,550**	**13,892**	**33**	**1,442**	**2,203**	**108**	**27,228**

Note 16.3 Property, plant and equipment financing - 2017/18

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

Note 16.4 Property, plant and equipment financing - 2016/17

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000
Net Book Value at 31 March 2017							
Owned - purchased	9,550	13,319	65	1,081	2,872	80	**26,967**
Finance leased	-	-	-	-	-	-	-
On SoFP PFI contracts and other service concession arrangements	-	-	-	-	-	-	-
PFI residual interests	-	-	-	-	-	-	-
Owned - government granted	-	-	-	-	-	-	-
Owned - donated	-	177	-	-	-	-	**177**
Net Book Value total at 31 March 2017	**9,550**	**13,496**	**65**	**1,081**	**2,872**	**80**	**27,144**

Note 17 Donations of property, plant and equipment

The Trust has received no donations of property, plant or equipment in year.

Note 18 Revaluations of property, plant and equipment

Revaluation of property and land

- these were revalued as at 31 March 2018
- the valuation was under taken by the District Valuer
- with the exception of one property, all the Trust's buildings are specialised assets and are valued and depreciated at replacement cost. Modern equivalent assets values were used but not alternative site basis as buildings are situated in line with service requirements
- one building was valued at market value as it is not deemed to be a specialised asset
- as part of the revaluation the District Valuer updated the useful economic lives of building assets.

Revaluation of plant and equipment

- the Trust does not revalue its plant and equipment. The carrying value is depreciated annually and this is considered sufficient to ensure asset values are up to date.

Note 19.1 Investment Property

The Trust has no investment property.

Note 20 Investments in associates and joint ventures

The Trust has no investments in associates and joint ventures.

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

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

Note 22 Disclosure of interests in other entities

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

Note 23 Inventories

The Trust has no inventories.

Note 24.1 Trade receivables and other receivables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade receivables	4,272	4,157
Capital receivables (including accrued capital related income)	-	-
Accrued income	2,381	1,245
Provision for impaired receivables	(100)	(106)
Deposits and advances	-	-
Prepayments (non-PFI)	585	663
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
PDC dividend receivable	309	-
VAT receivable	1,378	220
Corporation and other taxes receivable	-	-
Other receivables	24	30
Total current trade and other receivables	**8,849**	**6,209**
Non-current		
Trade receivables	-	-
Capital receivables (including accrued capital related income)	-	-
Accrued income	-	-
Provision for impaired receivables	-	-
Deposits and advances	-	-
Prepayments (non-PFI)	-	-
PFI prepayments - capital contributions	-	-
PFI lifecycle prepayments	-	-
Interest receivable	-	-
Finance lease receivables	-	-
VAT receivable	-	-
Corporation and other taxes receivable	-	-
Other receivables	-	-
Total non-current trade and other receivables	**-**	**-**
Of which receivables from NHS and DHSC group bodies:		
Current	3,679	2,243
Non-current	-	-

Note 24.2 Provision for impairment of receivables

	2017/18	2016/17
	£000	£000
At 1 April as previously stated	**106**	**70**
Transfers by absorption	-	-
Increase in provision	59	5
Amounts utilised	(7)	(15)
Unused amounts reversed	(58)	46
At 31 March	**100**	**106**

The Trust has made provision for the impairment of non-NHS receivables in excess of 90 days overdue.

Note 24.3 Credit quality of financial assets

	31 March 2018		31 March 2017	
Ageing of impaired financial assets	**Trade & other receivables £000**	**Investments & other financial assets £000**	**Trade & other receivables £000**	**Investments & other financial assets £000**
0 - 30 days	-	-	-	-
30 - 60 days	-	-	-	-
60 - 90 days	13	-	-	-
90 - 180 days	24	-	52	-
Over 180 days	76	-	54	-
Total	**113**	**-**	**106**	**-**
Ageing of non-impaired financial assets past their due date				
0 - 30 days	3,822	-	2,535	-
30 - 60 days	29	-	72	-
60 - 90 days	71	-	32	-
90 - 180 days	2	-	2	-
Over 180 days	-	-	299	-
Total	**3,924**	**-**	**2,940**	**-**

The Trust regularly reviews aged debts and makes referrals to a debt collection agency. Where advice from the collection agency indicates recovery is unlikely the debt is written off. Where a payment schedule is in place these debts are recovered over a longer time period.

Note 25 Other assets

The Trust has no other assets.

Note 26 Non-current assets held for sale and assets in disposal groups

	2017/18 £000	2016/17 £000
NBV of non-current assets for sale and assets in disposal groups at 1 April	**165**	**165**
Transfers by absorption	-	-
Assets classified as available for sale in the year	-	44
Assets sold in year	(165)	(44)
Impairment of assets held for sale	-	-
Reversal of impairment of assets held for sale	-	-
Assets no longer classified as held for sale, other than disposal by sale	-	-
NBV of non-current assets for sale and assets in disposal groups at 31 March	**-**	**165**

During the year the Trust sold Garforth Clinic, the non-current asset held for sale.

Note 26.1 Liabilities in disposal groups

The Trust has no liabilities in disposal groups.

Note 27.1 Cash and cash equivalents movements

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

	2017/18 £000	2016/17 £000
At 1 April	**19,104**	**19,074**
Transfers by absorption	-	-
Net change in year	4,140	30
At 31 March	**23,244**	**19,104**
Broken down into:		
Cash at commercial banks and in hand	4	4
Cash with the Government Banking Service	23,240	19,100
Deposits with the National Loan Fund	-	-
Other current investments	-	-
Total cash and cash equivalents as in SoFP	**23,244**	**19,104**
Bank overdrafts (GBS and commercial banks)	-	-
Drawdown in committed facility	-	-
Total cash and cash equivalents as in SoCF	**23,244**	**19,104**

Note 27.2 Third party assets held by the Trust

The Trust does not hold cash and cash equivalents which relate to monies held on behalf of patients or other parties.

Note 28.1 Trade and other payables

	31 March 2018 £000	31 March 2017 £000
Current		
Trade payables	1,662	1,766
Capital payables	372	538
Accruals	5,674	4,112
Receipts in advance (including payments on account)	-	-
Social security costs	1,164	1,161
VAT payables	-	-
Other taxes payable	755	739
PDC dividend payable	-	12
Accrued interest on loans	-	-
Other payables	1,402	1,429
Total current trade and other payables	**11,029**	**9,757**
Non-current		
Trade payables	-	-
Capital payables	-	-
Accruals	-	-
Receipts in advance (including payments on account)	-	-
VAT payables	-	-
Other taxes payable	-	-
Other payables	-	-
Total non-current trade and other payables	**-**	**-**
Of which payables from NHS and DHSC group bodies:		
Current	2,345	1,357
Non-current	-	-

Note 28.2 Early retirements in NHS payables above

The payables note above includes amounts in relation to early retirements as set out below:

	31 March 2018 £000	31 March 2018 Number	31 March 2017 £000	31 March 2017 Number
- to buy out the liability for early retirements over 5 years	-		-	
- number of cases involved		-		-
- outstanding pension contributions	-		-	

Note 29 Other financial liabilities

The Trust has no other financial liabilities.

Note 30 Other liabilities

	31 March 2018 £000	31 March 2017 £000
Current		
Deferred income	1,042	855
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Total other current liabilities	**1,042**	**855**
Non-current		
Deferred income	-	-
Deferred grants	-	-
PFI deferred income / credits	-	-
Lease incentives	-	-
Net pension scheme liability	-	-
Total other non-current liabilities	**-**	**-**

Note 31 Borrowings

The Trust has no borrowings.

Note 32 Finance leases

The Trust has no finance leases.

Note 33 Provisions for liabilities and charges analysis

	Pensions - early departure costs £000	Legal claims £000	Re-structuring £000	Continuing care £000	Equal Pay (including Agenda for Change) £000	Redundancy £000	Other £000	Total £000
At 1 April 2017	-	372	-	-	-	818	208	1,398
Transfers by absorption	-	-	-	-	-	-	-	-
Change in the discount rate	-	-	-	-	-	-	-	-
Arising during the year	-	3	-	-	-	265	-	268
Utilised during the year	-	(11)	-	-	-	(55)	(208)	(274)
Reclassified to liabilities held in disposal groups	-	-	-	-	-	-	-	-
Reversed unused	-	(31)	-	-	-	-	-	(31)
Unwinding of discount	-	-	-	-	-	-	-	-
At 31 March 2018	-	333	-	-	-	1,028	-	1,361
Expected timing of cash flows:								
- not later than one year	-	333	-	-	-	1,028	-	1,361
- later than one year and not later than five years	-	-	-	-	-	-	-	-
- later than five years	-	-	-	-	-	-	-	-
Total	-	333	-	-	-	1,028	-	1,361

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

In respect of redundancy and other provisions the uncertainty as to amounts and timings relates to the time taken to complete the necessary workforce processes.

Note 33.1 Clinical negligence liabilities

At 31 March 2018 £657k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Leeds Community Healthcare NHS Trust (31 March 2017: £361k).

Note 34 Contingent assets and liabilities

The Trust has no contingent assets or liabilities.

Note 35 Contractual capital commitments

The Trust has no capital commitments.

Note 36 Other financial commitments

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

	31 March 2018	31 March 2017
	£000	£000
- not later than one year	876	2,100
- after one year and not later than five years	1,142	1,631
- paid thereafter	-	-
Total	**2,018**	**3,731**

Note 37 Financial instruments

Note 37.1 Financial risk management

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

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

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

The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk
The Trust currently has no borrowings.

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

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

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk
The majority of the Trust's revenue comes from contracts with other public sector bodies, therefore, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

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

The Trust is not therefore exposed to significant liquidity risks.

Note 37.2 Carrying values of financial assets

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

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available for sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non-financial assets	5,326	-	-	-	5,326
Other investments / financial assets	-	-	-	-	-
Cash & cash equivalents at bank and in hand	19,104	-	-	-	19,104
Total at 31 March 2017	24,430	-	-	-	24,430

Note 37.3 Carrying value of financial liabilities

	Other financial liabilities	Liabilities at fair value through I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non-financial liabilities	6,686	-	6,686
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2018	6,686	-	6,686

	Other financial liabilities	Liabilities at fair value through I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Embedded derivatives	-	-	-
Borrowings excluding finance lease and PFI liabilities	-	-	-
Obligations under finance leases	-	-	-
Obligations under PFI, LIFT and other service concession contracts	-	-	-
Trade and other payables excluding non-financial liabilities	6,500	-	6,500
Other financial liabilities	-	-	-
Provisions under contract	-	-	-
Total at 31 March 2017	6,500	-	6,500

Note 37.4 Fair values of financial assets and liabilities

The fair value of financial assets and financial liabilities for the Trust do not differ from the carrying value.

Note 37.5 Maturity of financial liabilities

	31 March 2018 £000	31 March 2017 £000
In one year or less	6,686	6,500
In more than one year but not more than two years	-	-
In more than two years but not more than five years	-	-
In more than five years	-	-
Total	**6,686**	**6,500**

Note 38 Losses and special payments

	2017/18		2016/17	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	1	-	2	-
Fruitless payments	2	93	-	-
Bad debts and claims abandoned	36	17	33	16
Stores losses and damage to property	1	6	9	17
Total losses	**40**	**116**	**44**	**33**
Special payments				
Compensation under court order or legally binding arbitration award	-	-	-	-
Extra-contractual payments	-	-	-	-
Ex-gratia payments	9	3	18	51
Special severence payments	-	-	-	-
Extra-statutory and extra-regulatory payments	-	-	-	-
Total special payments	**9**	**3**	**18**	**51**
Total losses and special payments	**49**	**119**	**62**	**84**
Compensation payments received		-		-

Note 39 Gifts

The Trust received no gifts during the reporting period.

Note 40 Related parties

Details of related parties transactions with indivduals are as follows:

	Expenditure with Related Party £	Revenue from Related Party £	Amounts owed to Related Party £	Amounts due from Related Party £
University of Leeds Jane Madeley (Non-Executive Director) *Chief Financial Officer, University of Leeds*	82,835	52,283	5,733	1,398
Care Quality Commission Dr A Thomas (Medical Director) *National professional advisor for Integrated Children's Service & Safeguarding* Thea Stein (Chief Executive Officer) *Executive Reviewer*	202,239	10,043	-	-
Royal College of Psychiatrists Dr Tony Dearden (Non-Executive Director) *Fellow*	2,994	-	-	-
Leeds Teaching Hospitals NHS Trust Dr P Ayres (Interim Medical Director) *Employee*	5,658,354	785,653	456,450	261,471
NHS Digital Richard Gladman (Non-Executive Director) *Programme Director*	4,575	-	-	-

The Department of Health is regarded as a related party. During the year 2017/18 the Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department as listed below:

Barnsley Hospital NHS Foundation Trust
Bradford District Care NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Bridgewater Community Healthcare NHS FT
Care Quality Commission
Central Manchester University Hospitals NHS FT
Cheshire and Wirral Partnership NHS Foundation Trust
Cumbria Partnership NHS Foundation Trust
Greater Manchester Mental Health NHS FT
Harrogate and District NHS Foundation Trust
Health Education England
Humber NHS Foundation Trust
Lancashire Care NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Lincolnshire Partnership NHS Foundation Trust
Manchester University NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
NHS Airedale, Wharfdale And Craven CCG
NHS Barnsley CCG
NHS Bexley CCG
NHS Blackburn with Darwen CCG
NHS Bradford City CCG
NHS Bradford Districts CCG
NHS Bury CCG
NHS Business Services Authority
NHS Leeds North CCG
NHS Leeds South and East CCG
NHS Leeds West CCG
NHS Lewisham CCG
NHS Resolution
NHS Liverpool CCG
NHS Milton Keynes CCG
NHS Newcastle Gateshead CCG
NHS North Cumbria CCG
NHS North of England Commissioning Support Unit
NHS North Kirklees CCG
NHS North Norfolk CCG
NHS Nottingham City CCG
NHS Sandwell and West Birmingham CCG
NHS Scarborough and Ryedale CCG
NHS Sheffield CCG
NHS Solihull CCG
NHS South Tees CCG
NHS South Tyneside CCG
NHS Vale of York CCG
NHS Wakefield CCG
NHS Waltham Forest CCG
North Tees and Hartlepool NHS Foundation Trust
Northumberland, Tyne & Wear NHS Foundation Trust
Nottingham University Hospitals NHS Trust
Oxford Health NHS Foundation Trust

NHS Calderdale CCG
NHS Doncaster CCG
NHS East Lancashire CCG
NHS East Riding of Yorkshire CCG
NHS Electronic Staff Record
NHS Enfield CCG
NHS England
NHS Fareham and Gosport CCG
NHS Greater Huddersfield CCG
NHS Harrogate and Rural District CCG
NHS Herts Valleys CCG
NHS Heywood, Middleton & Rochdale CCG
NHS Hull CCG
Pennine Care NHS Foundation Trust
Rotherham Doncaster and South Humber NHS FT
Royal Free London NHS Foundation Trust
Sheffield Children's NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Tavistock and Portman NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
West Midlands Ambulance Service NHS FT
York Teaching Hospital NHS Foundation Trust
Yorkshire Ambulance Service NHS Trust

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

Community Health Partnerships
HM Revenue and Customs
Leeds City Council
NHS Pension Scheme
Humberside Police and Crime Commissioner and Chief Constable
West Yorkshire Police and Crime Commissioner and Chief Constable
NHS Property Services
North Yorkshire County Council
Kirklees Metropolitan Council
Valuation Office Agency
North Yorkshire Police and Crime Commissioner and Chief Constable
South Yorkshire Police and Crime Commissioner and Chief Constable

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

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

Note 41 Transfers by absorption

The Trust has no transfers by absorption.

Note 42 Prior period adjustments

The Trust has no prior period adjustments.

Note 43 Events after the reporting date

With effect from 1 April 2018 the Trust will effectively become responsible for commissioning CAMHS inpatient services as part of the new models of care pilot with NHS England. The local providers of CAMHS community services; South West Yorkshire Partnership NHS FT, Bradford District Care NHS FT and the Trust will work in collaboration on this pilot. This pilot will not see a transfer of the full inpatient funding to the Trust however, any savings the Trust and its partners are able to initiate will be available to be re-invested in local services provided by the partners. Currently it is estimated the resources available for re-investment will be £0.7m.

During 2017/18 the Trust was successful in a bid to NHS England for capital funding to build a new CAMHS inpatient unit. This scheme will incur significant capital expenditure circa £13m in 2018/19 and 2019/20.

Note 44 Final period of operation as a Trust of NHS healthcare

This is not relevant to the Trust.

Note 45 Better Payment Practice Code

	2017/18 Number	2017/18 £000	2016/17 Number	2016/17 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	18,178	30,890	20,085	32,145
Total non-NHS trade invoices paid within target	17,487	29,827	19,141	30,870
Percentage of non-NHS trade invoices paid within target	96.20%	96.56%	95.30%	96.03%
NHS Payables				
Total NHS trade invoices paid in the year	935	17,588	998	19,647
Total NHS trade invoices paid within target	918	17,483	972	19,555
Percentage of NHS trade invoices paid within target	98.18%	99.40%	97.39%	99.53%
Total All Payables				
Total trade invoices paid in the year	19,113	48,478	21,083	51,792
Total trade invoices paid within target	18,405	47,310	20,113	50,425
Percentage of trade invoices paid within target	96.30%	97.59%	95.40%	97.36%

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

Note 46 External financing

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

	2017/18 £000	2016/17 £000
Cash flow financing	(4,140)	(30)
Other capital receipts	0	0
External financing requirement	**(4,140)**	**(30)**
External financing limit (EFL)	**(2,941)**	**1,336**
Under / (over) spend against EFL	**1,199**	**1,366**

Note 47 Capital Resource Limit

	2017/18 £000	2016/17 £000
Gross capital expenditure	1,463	1,575
Less: Disposals	(403)	(72)
Less: Donated and granted capital additions	-	-
Plus: Loss on disposal of donated / granted assets	-	-
Charge against Capital Resource Limit	**1,060**	**1,503**
Capital Resource Limit	**1,816**	**2,581**
Under / (over) spend against CRL	**756**	**1,078**

Note 48 Breakeven duty financial performance

	2017/18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	4,655
Remove impairments scoring to Departmental Expenditure Limit	-
Add back income for impact of 2016/17 post-accounts STF reallocation	-
Add back non-cash element of On SoFP pension scheme charges	-
IFRIC 12 breakeven adjustment	-
Breakeven duty financial performance surplus / (deficit)	4,655

Note 49 Breakeven duty rolling assessment

	2011/12 £000	2012/13 £000	2013/14 £000	2014/15 £000	2015/16 £000	2016/17 £000	2017/18 £000
Breakeven duty in-year financial performance	2,577	1,809	1,425	2,007	2,985	3,350	4,655
Breakeven duty cumulative position	2,577	4,386	5,811	7,818	10,803	14,153	18,808
Operating income	134,978	139,906	142,863	146,668	156,367	148,654	149,526
Cumulative breakeven position as a percentage of operating income	1.91%	3.13%	4.07%	5.33%	6.91%	9.52%	12.58%

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

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

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