

**AIREDALE NHS FOUNDATION TRUST  
ANNUAL REPORT AND ACCOUNTS  
2014/15**



**Airedale NHS Foundation Trust**

**Annual Report and Accounts 2014/15**

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Schedule 7, paragraph 25 (4) (a) of the  
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## CHAIRMAN'S INTRODUCTION

Having been appointed Chairman in May 2014, I am pleased to introduce Airedale NHS Foundation Trust's Annual Report and Accounts 2014/15.

### Our perspective

Our commitment to our *'Right Care'* strategy in doing what is best for our patients remains at the heart of the Foundation Trust's philosophy. In being able to achieve this we remain resolute in our aim to influence the local and national economy through continued dialogue with our stakeholders and healthcare providers. This comes at a time when the National Health Service faces many challenges. Whether concerns centre on financial sustainability, demand or activity pressures, we are pleased to say that we are working hard to provide a safe and high quality service to our local community. Our achievements in 2014/15 in terms of the recognition at a national level for our innovation in the field of telemedicine, position us well to secure a sustainable hospital for the future.

### Business overview

The Foundation Trust consolidated its position as good performing Trust and finished the year with a Monitor Continuity of Services Risk Rating (CoSRR) of 3 and an indicative 'green' Governance Risk Rating.

Our income for the year was slightly ahead of expectations at £157.7million, in the main due to increased activity. The Foundation Trust's cash position at the year end remains strong at £15.9 million. The Foundation Trust was also able to invest over £10 million during the year to improve its estate, which included significant investment in a new Emergency Department costing £6.3 million.

### Corporate reporting

During the year a number of changes were introduced by Monitor to the regulations concerning governance and reporting requirements. The approach we have adopted over recent years satisfies all of the new disclosure requirements, including having regard to Monitor's quality governance framework and the requirement from Monitor for Foundation Trusts to undertake a *'governance and capability review'*.

### The Board and governance

We have an effective Board with good and complementary skills, knowledge and experience across all directors, both executive and non-executive. The Board takes the lead in setting the tone for good governance through the Foundation Trust. As a Board we ensure that our conduct is focused on improving patient experience, driving our strategic priorities and behaving responsibly. Issues such as succession planning, performance and diversity are kept under review as a matter of course. Our Council of Governors, now in its fifth year since being constituted, continues to perform well. During 2014/15, the Council successfully appointed both a chairman and non-executive director to replace Colin Millar and David Adam respectively, who both retired after completing their terms of office. The Foundation Trust recognises the significant contributions by both Colin and David in helping to establish Airedale as a high performing Trust.

More information can be found in the Governance section of the report.

### Our people

We report on a year that has seen unprecedented demand for hospital services. Our staff responded magnificently to these enormous pressures, particularly over the winter period and my sincere thanks go to all our staff for their commitment and hard work.

**Michael I Luger**

**Chairman**

27 May 2015

## CHIEF EXECUTIVE'S OVERVIEW

Welcome to the Annual Report and Accounts for Airedale NHS Foundation Trust for 2014/15.

It has been another year of success for Airedale NHS Foundation Trust and I continue to find it a great privilege to work with such dedicated and committed staff, to provide care for the community we support.

At Airedale, we want patients to be at the heart of everything we do with health and social care providers working together to respond to patients' needs. We want patients to be in control of their health and care and to be supported in a way that is right for them and makes them feel empowered, keeps them active and retains their dignity.

The most important thing that we do all year, on each and every day, is to continue to provide treatment and care that is high quality and strives to always put the patient first – that is *'Right Care'*.

As we reflect over the events of 2014, there is much to celebrate.

It has been great to see the impact that a focus on dementia care in our ward upgrades has made. The changes to the lighting and décor on ward 4 have made such a difference, as has placing work stations much closer to patients. It has a calming atmosphere and ideas such as pictures on the internal windows have been taken into other areas, such as maternity.

The Gold Line service, run from our digital hub, for patients who are nearing the end of their lives, has been very well received by both patients and their carers alike. The staff in the hub are able to provide advice and reassurance, via either a phone or video link using an iPad, directly to the person's home and bedside. It is remarkable that simple technology can make such a big difference. The touching stories from carers about their experiences of the service really make our focus on helping patients stay at home worthwhile.

Opening the new Emergency Department last December was a momentous occasion for us all. It is a fabulous new state-of-the-art department which has been meticulously designed with special attention paid to every detail. The interactive floor in the children's area is an exciting idea, and watching children play on it really helps staff assess them, as well as it being a good distraction. The whole department has been created with patients with dementia in mind, and the specially equipped bay should help reduce distress for this most vulnerable group of patients.

I must also take this opportunity to thank all of the people who have contributed to the fund raising efforts either by being sponsored to do something extraordinary or by donating.

Again this year we were designated as a top 40 hospital by CHKS, a specialist provider of healthcare accreditation programmes, who compare the quality and safety metrics for all hospitals in England and make this award. They look at information from across the clinical specialties so it is a great indication of the high quality of all our services, which of course, reflects the dedication and efforts of staff.

We launched our Pride of Airedale reward and recognition scheme this year. It has gone down really well and we have made a number of awards to individuals and teams for their contributions.

It has also been a tough year for many, we have had, and continue to have, enormous pressure along our urgent care pathway, and this continued throughout the summer months, which was unusual. I want to thank staff who have worked tirelessly under often difficult circumstances to ensure patients are kept safe and are well cared for, particularly when we have surges in numbers of patients needing our support.

You will all be aware of the continuing issues we all have to face over at least the next five years; rising demand for care, rising expectations from the public, at a time of a squeeze on NHS finances. That means we have to work together with our partners over the next few years to ensure we can still deliver high quality care for patients. It means we will continue to strive to be different and better, to remove bottlenecks for patients where we can, and make sure everything we do adds value to patients.

We have been successful in doing this over the past few years and have been mentioned in many national documents and attracted media attention for our innovative ideas. There is a lot more we can do, which will only be possible if everyone plays their part. It is often the small things that can make the biggest difference for patients.

As we look forward to a time of significant changes in the NHS, it is vital we don't take the support of local people for granted. The loyalty of our patients and local community is one which we have to earn by involving them in decisions about their care and the services we provide. We, in turn, will work to maximise the resources we have available and embrace the new challenges and opportunities this year will bring.

Finally, I would like to thank our public and staff, our volunteers and members for their continued commitment and support as well as all our patients for choosing Airedale. We are delighted that so many members of our community wish to be involved with the hospital. I hope you agree that the future for our Foundation Trust is a very exciting one, so if you would like more regular news and information visit [www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk) or become a member and play a part in our future success.



**Bridget Fletcher**  
Chief Executive

27 May 2015

## **AN INTRODUCTION TO AIREDALE NHS FOUNDATION TRUST**

Airedale NHS Foundation Trust is a statutory body, which became a public benefit corporate on 1 June 2010, following its approval as a NHS Foundation Trust by the Independent Regulator of the NHS Foundation Trusts (Independent Regulator) authorised under the Health and Social Care (Community Health and Standards) Act 2006 (the 2006 Act).

The principal location of business of the Trust is:

- Airedale General Hospital, Skipton Road, Steeton, Keighley BD20 6TD.

In addition to the above, the Foundation Trust has registered the following location with the Care Quality Commission:

- Castleberg Hospital, Giggleswick, Settle BD24 0BN.

The Foundation Trust's head office is at:

- Chief Executive's Office, Airedale NHS Foundation Trust, Skipton Road, Steeton, Keighley BD20 6TD Tel: 01535 652511.

The Foundation Trust is registered with the Care Quality Commission without conditions and provides the following regulated activities across the stated locations:

- Accommodation for persons who require nursing or personal care;
- Treatment of disease, disorder or injury;
- Assessment of medical treatment for persons detained under the Mental Health Act 1983;
- Surgical procedures;
- Diagnostic and screening procedures;
- Transport services, triage and medical advice provided remotely;
- Termination of pregnancies;
- Nursing care; and
- Maternity and midwifery services.

Airedale NHS Foundation Trust is an award winning NHS hospital and community services Trust. We provide high quality, personalised, acute, elective, specialist and community care for a population of over 200,000 people from a widespread area covering West and North Yorkshire and East Lancashire.

We employ over 2,600 permanent and fixed term contract staff and have nearly 400 volunteers. Last year, we cared for over 31,000 elective inpatients and day cases, more than 21,000 non-elective patients, and over 162,000 outpatients. Our Emergency Department saw more than 54,000 patients and over 2,100 babies were born at the hospital last year. We have an annual budget operating income of over £157 million.

We provide services from our main hospital site, Airedale Hospital, and from community hospitals – such as Castleberg Hospital, near Settle, Coronation Hospital in Ilkley and Skipton Hospital – as well as health centres and general practices (GPs). Our health services are commissioned by the following Clinical Commissioning Groups (CCGs) - Airedale, Wharfedale and Craven; Bradford Districts; and East Lancashire – as well as regional specialist commissioners and NHS England (formerly the NHS National Commissioning Board).

In addition to partnerships with its commissioners, the Foundation Trust has also developed a range of strategic and business partnerships, including:

- A *strategic clinical partnership* with neighbouring Bradford Teaching Hospitals NHS Foundation Trust, who support us in providing sustainable services in our single handed specialties and hub and spoke arrangements for Ear Nose Throat, Ophthalmology, Oral Surgery and Orthodontics.
- A *strategic clinical partnership* with tertiary centre, Leeds Teaching Hospitals NHS Trust, which provides support in a number Paediatric services. Additionally they provide a wide range of diagnostics in Pathology and X-Ray which, by and large, is highly specialist and not available at Airedale NHS Foundation Trust.
- A *Private Finance Initiative* (PFI) with SIEMENS Medical Systems for a managed technology service to supply and maintain diagnostic x-ray equipment to the Foundation Trust.
- A *Public Private Partnership* (PPP) with Frontis Homes for the provision of staff residential accommodation on site.
- *Liaison* with Airedale, Wharfedale and Craven Clinical Commissioning Group and Local Care Direct – an independent primary care out of hours provider – to provide out of hours services in the Emergency Department.
- The Foundation Trust is a partner in a Limited Liability Partnership (Immedicare) to provide *telemedicine* services, delivering 24/7 clinical care from specialist nurses and doctors directly into nursing and residential care homes.

In addition to the above partnerships, alliances and developments, during 2014/15 the Foundation Trust also had a number of partnerships with contractors for outsourced services including car parking and security with CPP, transport with Ryder and catering with Sodexo.

## STRATEGIC REPORT

### DELIVERY OF THE 2014/15 ANNUAL PLAN

Building on the development of the vision statement from the previous couple of years, the Foundation Trust Board of Directors continued to strengthen the communication of the Foundation Trust's key values through the use of the overarching message of '*Right Care*' and by emphasising four key principles relating to patient experience:

- Nothing about me without me;
- Making every contact count;
- Through their eyes; and
- At the heart of everything we do.

The key principles underpinning the delivery of the vision in the years ahead also remain similar to those outlined over the previous couple of years. These have been further updated to reflect the progress already made by the Foundation Trust against its key milestones and to respond to the key priorities outlined both nationally and locally.

- Safety, quality, patient experience and staff engagement are at the centre of everything the organisation does;
- The need to be serious about efficiency and business control in order to be viable in the future;
- Transforming care is critical to the delivery of our strategy, through developing our existing services whilst also designing and delivering new ways of working, using diversified models of care both in and out of a hospital setting;
- Ensuring the care of the vulnerable, elderly, patients with dementia and those with nutritional needs are given priority focus;
- Ensuring a greater focus on clinical leadership, engagement and outcomes;
- Partnerships forming a significant part of the design and delivery of our services;
- Ensuring the value of the Airedale brand is retained within the community and beyond; and
- The requirement to adapt the size and shape of the workforce and estate in response to the updated service strategy.

### Putting Patients First

Overall, the vision is about an approach focused on embedding the key principles of good experience, by continually assessing the impact and outcomes for patients of the way services are provided. The next few paragraphs show the work of the Foundation Trust to improve patient experience and patient and carer communication

### Patient and Carer Communication

Engagement with patients and the public is a top priority for the Foundation Trust as a means of improving patient experience. The Patient and Public Engagement and Experience (PPEE) Steering Group and PPEE Operational Group closely monitor information about engagement and experience activity in a way that will enable the Foundation Trust to ensure it meets its commissioner contractual requirements.

The PPEE strategy is closely aligned to the Trust's '*Right Care*' principles. The Patient Experience Right Care Programme focusses on three workstreams from within the strategy's implementation plan. The whole ethos within the strategy is to ensure that patient involvement activities are embedded into all aspects of the Foundation Trust's business.

The Foundation Trust's Patient and Carer Panel is now well established. It meets monthly and is made up of a group of people who have been patients or carers who use their own personal experiences and that of friends, family and community contacts to provide the

Foundation Trust with a patient/carer perspective of care, treatment and service provision. They provide views in respect of many Foundation Trust activities, service developments and initiatives and always have some practical advice that can make such a positive difference to a patient's experience.

During 2014/15, the Panel has continued to be highly active in a whole range of diverse clinical settings and have added value to ensuring that the patient experience is at the heart of all Foundation Trust work. As well as monthly meetings they work in task groups which this year have focused on communication; discharge issues; services for dementia patients; nutrition and hydration; end of life care and reviewing Foundation Trust policies. Our overall aim is to ensure that work undertaken by our Panel and their task groups' influences real and sustained improvement in a range of services from a patient perspective.

As well as the Patient and Carer Panel, the Foundation Trust uses several other mechanisms for obtaining patient and carer feedback. Such methods include national and local patient surveys; real time survey; friends and family test; comments posted on the NHS Choices website; patient stories; mystery shopper; focus groups; Patient Advice and Liaison Service (PALS) and complaints; liaison with local Healthwatch organisations; working with Foundation Trust Members and Governors; and social media.

The following are examples of some of the engagement work staff have undertaken during the year:

- A closing evaluation when children are at the end of their speech and language therapy intervention;
- Miscarriage management patient survey;
- Setting up a parent support group for children with food allergies;
- A Foundation Trust Event on 15 May 2014 as part of Dying Matters Awareness Week;
- Mobility services footwear development forum follow up event;
- Quarterly audiology survey;
- Evaluation of patient satisfaction - enteral feeds at home and X-PERT diabetes education programme;
- Patient surveys - child development service, specialist rehabilitation clinic, Skipton Hospital/Settle Health Centre - outpatient reception survey, AIRE Unit, Radiology DXA scanning, rheumatology advice line, Bronchiectasis Group, and patient perceptions of hospital admission;
- Setting up an electronic link to enable an end of life patient on one of the wards and her husband who was in Manorlands Hospice, to see and speak to each other;
- Patient story telling within the frail elderly pathway and dementia crisis prevention teams;
- Ward 19 taking up the 'Hello my name is .....' campaign following real time survey feedback that two members of staff did not introduce themselves; and
- 'Coffee, cake and chat' a West Yorkshire wide initiative with former patients and relatives in critical care.

## Patient Stories

Individual patient stories have been presented to the Board of Directors at every meeting since 2012 and, as the first item on the agenda, set the focus for the meeting. This is a very powerful way of making sure the whole '*raison d'être*' of the Trust – the patient – is at the heart of decision making. During 2014/15, patients attending the Board either in person or via a video presentation have recounted their experience relating to the following areas:

- Personal experiences of patients with learning disabilities;
- Cancelled outpatient appointments;
- An amalgam of stories from patients and carers who have used the Gold Line service (telephone service for end of life patients);
- Staff member as a relative involving A&E, Intensive Care Unit and organ donation;

- Diagnostic services;
- Interiorised stammering;
- Stroke services and aftercare; and
- Parkinson's patients using voice/singing therapy.

## **Patient Information**

The NHS Constitution makes it clear that people have the right to reliable information to help them make choices and that good quality information will help people make confident, informed decisions about their health care. This is endorsed by the Foundation Trust and work is underway to improve how we provide patient information.

During 2014/15 Airedale Hospital's patient information service moved location in order to be more central and accessible, helping patients and visitors to find out more about healthy living, health conditions, and available services and support. There is a range of free, high quality information leaflets in stock about common health topics and conditions, including healthy eating, stopping smoking, arthritis, diabetes, cancer and heart conditions. Information can also be printed on demand from high quality health information websites. The service offers one to one advice on finding and using the best health information websites and mobile apps, and can help to source information in alternative formats and languages other than English. The service is a drop-in centre and is normally open between the hours of 9.30am and 4.00pm Mondays to Fridays.

During the year, staff worked with our local Healthwatch services to hold informal information events at local libraries to boost awareness of the service. A 'health blog' on the Foundation Trust's website continues to highlight local news and events, signpost local services and encourage discussions among local people about health issues.

The Foundation Trust has a Readers' Panel which consists of members of the public who have volunteered their time to read patient information produced by the Foundation Trust whilst it is in its draft stages. The panel is asked for its views on the type of language used, the structure of sentences and paragraphs, the style of presentation, and whether the information will be readily understood by its target audience. By asking for opinions from a sample audience, the Readers' Panel ensures publications are easily understood and resources are not wasted by producing leaflets that patients do not understand.

## **Learning Disabilities**

A strong emphasis has been placed on involving people with learning disabilities to help us introduce guidelines for our staff in order to assist in planning and identifying the care needs of patients with learning disabilities and ensure care plans take account of individual patient's needs.

We work with the regional Learning Disabilities Group, Access to Acute, for Yorkshire and Humberside, as well as the local Craven Health Task Force, to benchmark the care we provide. We are using an audit tool to help us review each episode of care and identify any aspects that are missing. The findings and any shortfalls are shared with the regional group to enhance learning and development of the service.

The group has also worked with us on improving signage around the hospital site and helped our Patient Advice and Liaison Services (PALS) team develop an easy read version of our PALS leaflet.

## **Patient Advice and Liaison Services (PALS)**

As well as providing information, advice and support to help patients, families and their carers, the emphasis within the Foundation Trust is for PALS to work closely with front-line

staff, particularly our matrons, in order to help resolve issues and queries as quickly as possible for patients.

The work undertaken by PALS is a 'real time' and continuous way of being able to respond positively to patient feedback in terms of both concerns and compliments in order to improve the delivery of our services and clinical care.

During 2014/15 there were 2,307 issues raised, from 1,797 contacts with the Patient Advice and Liaison Service (PALS), of which 2,190 issues were specifically related to Airedale NHS Foundation Trust. Of these, 359 were compliments, 286 were requests for information and 1,545 were expressions of concern, dissatisfaction and requests for action to be taken. The remaining 117 issues were related to other organisations. Further information regarding the work of the PALS is detailed in the Quality Report.

Contact details for the PALS office can be found on page 190.

## Volunteers

There are nearly 400 volunteers who undertake vital and diverse activities across the hospital. Whether it is acting as guides for patients attending appointments, assisting our patients to eat and drink during meal times; staffing the volunteer shops, taking the shop or library trolley to patients on the ward; or helping patients to attend our religious services, our volunteers are an invaluable resource for our staff and patients.

We continue to receive support from our volunteer feeding buddies, who help ward staff assist patients to eat and drink at meal times. Another key element of patient experience is the feedback we receive from our real time patient survey, in which our volunteers help by talking to patients about their stay in hospital and recording their comments and views.

Our team of nearly 30 volunteer hospital guides, who are on duty Monday to Friday, continue to provide a warm welcome to all members of the public when they attend the hospital for treatment or to visit relatives. The guides assist and direct visitors to where they wish to go and last year assisted over 20,000 patients and visitors. The hospital acknowledges and greatly values the contributions made by the volunteers, who continue to give their time unconditionally to support the hospital. It is good to know that this good work was recognised and appreciated not only by the hospital staff, patients and visitors but also by the local MP Kris Hopkins. As a result Mike Yates, Chairman of Airedale New Venture was invited to attend 10 Downing Street to represent the volunteers of Airedale Hospital for a 'Charity Champions' event.

## Progress Against 2014/15 Annual Plan

The Foundation Trust ends this challenging period in a strong position. Some highlights for 2014/15 on progress with our strategic goals and objectives include:

- Responding to the significant levels of urgent care demand, we opened a brand new £6m Emergency Department with state-of-the-art facilities and equipment. Ahead of further work to develop a co-located acute care hub, our acute medical and ambulatory care units have continued to develop clinical pathways. This has resulted in 65% of patients now being discharged within 48 hours and length of stay being reduced by 0.7 days.
- Following a substantial refurbishment to the unit and further upgrade work during the year, our endoscopy service received Joint Advisory Group ('JAG') accreditation and continues to experience increasing levels of demand.
- We continued to invest in improving the hospital environment for patients through a number of ward upgrades, which included a focus on dementia friendly initiatives.

- We have invested in further Consultant appointments across a number of specialties and have continued to increase nurse staffing where required, including using Advanced Nurse Practitioners where possible. In response to feedback from patients, families and carers we have also altered shift patterns to meet the needs of patients.
- A Reward and Recognition Scheme for staff was introduced earlier in the year, linked to the staff engagement theme. The Foundation Trust's first 'Pride of Airedale Awards' was held to reward outstanding contributions from individuals and teams.
- During the year of number service developments progressed including:
  - ✓ *Telemedicine Gold Line* for seriously ill and terminally ill patients;
  - ✓ *Intermediate Care Hub* introduced in-year;
  - ✓ *Frail Elderly Pathway* now established and in place;
  - ✓ *Dementia Crisis Prevention Team* in place;
  - ✓ *Pathology* – additional contracts secured;
  - ✓ *Surgical Developments* for example, new urology laser treatments;
  - ✓ *Obstetrics* – facilities to enable partners to stay overnight on the maternity ward; and
  - ✓ *Estate* – an additional 80 car parking spaces provided for patients and visitors.

## Service Delivery

In terms of service delivery, the Foundation Trust's focus on access times has seen a number of high profile requirements delivered including:

- Almost all patients – over 92% – treated within 18 weeks of their referral and the majority (95%) of patients admitted, treated or discharged within four hours of arriving in our Emergency Department.
- Performance on the majority of national cancer standards met or exceeded the required levels with all (100%) cancer patients receiving their first treatment within 31 days of being diagnosed and all (100%) cancer patients receiving their second or subsequent treatment within 31 days. In addition, the majority (96%) of patients with suspected cancer were seen within two weeks of their urgent GP referral. The Foundation Trust however, failed screening performance for Quarter 4 (88.9% against a threshold of 90%).
- Through contracts with our CCG Commissioners, the Foundation Trust delivered an increased level of activity in 2014/15 across non-elective, elective and outpatient work. This work reflected an increased level of demand whilst also delivering on key access waiting time targets.
- Key requirements around performance and information were met with the Foundation Trust delivering on the local clinical quality schedule and receiving the full incentive allocation associated with it.
- Progress against all the business objectives set out in the Foundation Trust's Annual Plan, are reported to the Board on a quarterly basis. The year end position showed the majority of the objectives had been delivered and for the areas not yet completed, work is ongoing that will be carried forward for completion in 2015/16. Progress against each of the objectives will be monitored via the Board Assurance Framework.

## Technology and Innovation

The Foundation Trust has continued to build its' reputation as a leader in technology and innovation. The following paragraphs show examples of the achievement and accolades the Trust has received during 2014/15.

- In 2014/15, Airedale continued to build on its already significant technological innovation in the development of telemedicine – a system whereby patients can receive medical consultations in their home via a TV link. Benefits are already being seen by our patients' with long term conditions as well as those in nursing homes, where a number of hospital admissions have been avoided by the online intervention of clinical staff working round the clock in Airedale's Telehealth Hub.
- The telemedicine Hub received visits from a wide range of people including Andy Burnham MP, Lord Willis and Earl Howe as well as a number of national and specialist media. Features on the service were also including in a range of national publications including NHS England's Five Year Forward View and the Kings Fund Digital Report.
- The telemedicine service was featured in the Healthcare Finance magazine in July and in the Guardian's healthcare supplement which included a section about the Foundation Trust's work in prisons using its telemedicine service to provide a range of on-line consultations with prisoners.
- In February 2015, the Kings Fund highlighted an example of using telemedicine to support patients with Parkinson's disease through a pilot speech and language therapy programme which can be delivered to patients in their own homes using the secure video link.
- In May 2014, Chief Executive Bridget Fletcher spoke at the Management and Clinical Innovation Forum in Barcelona on sharing leadership and innovation for healthcare improvement. And in the same month, the telemedicine service was piloted by the Queen Elizabeth Hospital, a member of the West Norfolk Alliance health team, with three care homes linked to the 24-hour telemedicine 'hub' at Airedale Hospital.
- In March 2015, a local team of partners from the NHS, local authorities, care homes, technology and academia were selected to take a national lead on transforming care for patients. The new care model, which aims to enhance health for residents in care homes, brings together more than a dozen organisations from health and social care services, care home providers, technology specialists and academics working across Airedale, Bradford, Craven, East Lancashire and Wharfedale.

Chosen from 269 groups of nurses, doctors and other health and social care staff from across the country who put forward their ideas for how they want to redesign care in their areas, a local partnership, led by the Foundation Trust, was named as one of the first 29 Vanguard areas that will share a multi-million pound transformation fund.

The so called 'Vanguard' sites will pilot plans to significantly improve patients' experiences of local healthcare by bringing home care, mental health, community nursing, GP services and hospitals together for the first time. The local scheme will use technology, such as telemedicine, to integrate services and provide immediate access to expert opinion and diagnosis, where appropriate. It will also support individual independence and improve the quality of life of residents by focusing on proactive rather than responsive care and deliver more specialist services into care homes.

For patients, this will improve their experience of health and care services and could mean, for example, fewer trips to hospital; a single point of access to health and social care services and other specialist advice day or night; access to services closer to home and a tailored personal service that is more responsive and reduces duplication.

The Foundation Trust's bid to the Health Foundation Shared Purpose programme – an independent charity working to improve healthcare in the UK – was successful. The Foundation Trust secured one of eight places on the programme which included a grant of £420k over three years. The bids aim to enhance the experience of end of life patients through the use of assistive technologies.

In November 2013, a new helpline for patients, and their carers, who have a serious illness and may be in the last year of their lives, was launched across Airedale, Wharfedale and Craven. It was extended in early 2014 for the benefit of hundreds of patients in Bradford.

The dedicated 'Gold Line' telephone number aims to provide one point of contact for patients and their carers for help and advice, 24-hours-a-day, seven-days-a-week, to support them in their preferred place of care wherever possible. Calls are answered by the team of experienced nurses based in Airedale's Telehealth Hub linked up to community-based teams, who can then visit patients if necessary. The pilot scheme is not expected to replace patients' use of their GP and other community health care services during normal working hours but aims to provide care when daytime services have closed. A formal evaluation of the service is also underway and the results will be available in 2015.

As part of our commitment to enhancing the care of end of life patients, nurses and consultants at Manorlands Hospice are using telemedicine to extend the specialist advice service they provide for staff and their patients. The charity, based in Oxenhope, now has a senior doctor or specialist nurse available between 9am and 5pm, Mondays to Friday, to have telemedicine consultations with care home staff in over 30 care homes in Airedale and Craven. Outside these times, the care homes can get advice from Airedale's Telehealth Hub. There are currently around 150 patients who receive palliative care in their own home from Manorlands and the specialists nurses also provide advice to the GPs, district nurses and practice staff who help look after them.

The development of an Electronic Patient Record (ePR) is gathering momentum and we have taken the next steps, working our technical provider TPP, towards adapting SystemOne for secondary care. Our work towards becoming a digital hospital to improve patient care and experience continues with electronic prescribing and drugs administration (EPMA) as well as electronic discharge (eDischarge) being trialed at Airedale Hospital.

Work to replace the conventional patient discharge letter with a more efficient e-discharge system is also underway. This will integrate with an electronic prescribing and administration project reducing duplication and removing the risk of transcription errors. Alongside this is an 'order-comms' project which initially will allow pathology requests to be made and results to be delivered electronically within SystemOne. Later this will be extended to other diagnostic and support functions within the Foundation Trust.

The installation of a new automated dispensing robot in the Pharmacy department at a cost of £410,000 has reduced the turnaround time for drug dispensing and the chance of dispensing errors. This has enabled pharmacy staff to spend more time on wards working directly with nurses and doctors and helping patients to understand their medicines.

## **Research and Development (R&D)**

Academic research forms part of the Foundation Trust portfolio and is regarded as an important part of the work of the Trust. Over the year, a total of 17 academic studies were open and a number of staff members were advised and guided through the research process leading to successful completion of academic degrees, predominantly at Masters level, but also included PhD studies. The key activities of the department are given below and are also shown in more detail in the R&D Annual Report published each year.

- Patient recruitment to clinical trials increased during 2014/15 compared with the previous year and had reached almost 160% of target by the end of the year.
- The research portfolio continued to broaden across specialty groups. At the end of 2012/13, almost 80% of clinical trials at Airedale were in Cancer and Stroke. Since then, more trials were opened in new specialties such as Maternity and Rheumatology.
- During 2014/15 there was an expansion in research activity in fields such as Gastroenterology, Surgery and Cardiology. At the end of 2014/15 recruitment was spread more evenly across specialty groups, illustrating the Foundation Trust's ability to offer more of our patients the opportunity to participate in clinical research. It also showed the growing research culture in the Foundation Trust and the number of clinicians who are research active.

- The Research and Development Team took part in 123 research studies during 2014/15 of which 27 were in follow-up and 90 were on the National Portfolio. A total of six commercial trials were open, of which five are on the National Portfolio. Research was actively being conducted in the following areas and includes studies with commercial sponsors:

- ✓ Oncology and Haematology;
- ✓ Surgery;
- ✓ Urology;
- ✓ Stroke;
- ✓ Paediatrics;
- ✓ Diabetes;
- ✓ Maternity/Neonatal;
- ✓ Gastroenterology;
- ✓ Obstetrics and Gynaecology;
- ✓ Critical Care;
- ✓ Rheumatology/Musculoskeletal;
- ✓ Renal/Urogenital;
- ✓ Cardiology;
- ✓ Elderly Care/Dementia; and
- ✓ Generic Health.

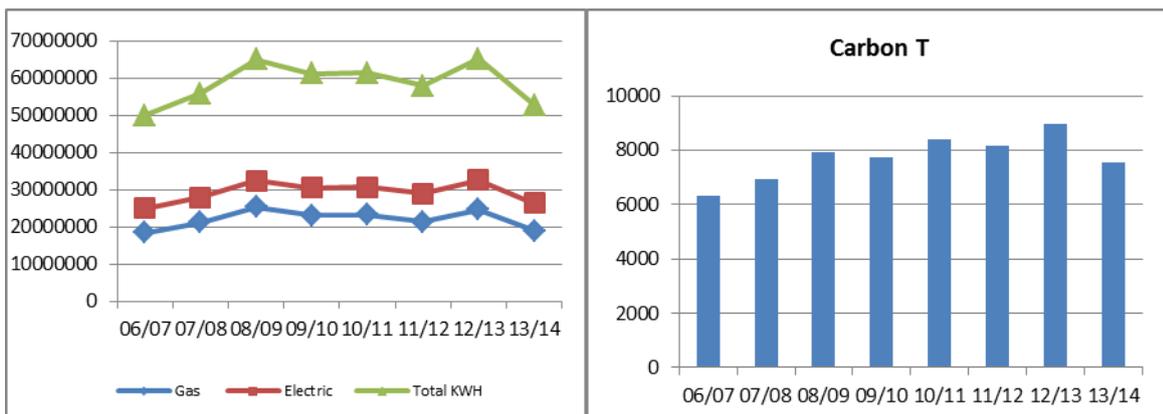
## Corporate and Social Responsibility

The Foundation Trust strives to be environmentally responsible and is aware of its social impact on the community. During the year, the Carbon Management Strategy continued to see reductions in the Foundation Trust's carbon footprint, resulting in an improved environment for patients, visitors and staff. Working closely with the Carbon Trust, energy usage was closely monitored enabling consumption to reduce and thereby energy costs.

The Climate Change Act 2008 requires carbon dioxide and greenhouse gas emission reductions of 34% by 2020 and 80% by 2050 against 1990 performance. The Foundation Trust's long-term aim is to successfully meet these targets.

The same Act established that from 2010 all Government departments, including the NHS, will receive annual carbon budgets which they must adhere to. In response to this, the Trust has developed a Carbon Management Plan (CMP) which commits it to reducing CO<sub>2</sub> by 15% by 2015 from a 2007 baseline figure. Other initiatives introduced during the year included the following:

- A new Energy Centre comprising a combined heat and power (CHP) and three new boilers. The CHP plant now produces its own electricity through a gas turbine negating the need to buy the majority of electricity from the national grid. In 2013/14 the Foundation Trust produced 8,903 tonnes of carbon and by 2015/16 should reduce by more than 50% to 4,000 tonnes of carbon.



- The Foundation Trust's EcoawAire Group continued to meet regularly throughout the year to assess sustainability as part of the Foundation Trust's external contracts or capital investments, look at potential energy efficiencies and other environmental savings. It continues to engage with and involve staff in energy and environmental issues to increase awareness.
- The Foundation Trust developed a detailed action plan to reduce the amount of waste produced by the hospital. This involved introducing new recycling waste methods, better waste segregation and more efficient waste handling.
- The Foundation Trust's energy efficiency drive completed its replacement of inefficient light fittings, replacing a total of 2800 fittings to save approximately £6,000 a month on its electricity bill. Intelligent controls were also installed incorporated in to the theatres' ventilation system so it only runs when the area is occupied.
- The promotion of the use of public transport and a Cycle2Work Scheme for staff have encouraged staff to switch from using cars to travel to and from work.

### Community Staff Engagement

Foundation Trust staff support many health related groups in both a business and voluntary capacity. We also support our staff to play a full part in the community, for example, by acting as Governors for schools. Our now well established Patient and Carer Panel ensure we involve our community in monitoring standards and in the development of services.

During the year we continued to build on our links with schools and colleges. As a result, we have successfully recruited many young people to join our Foundation Trust membership. We also developed links with local BME groups and improved membership representation from different communities.

We continued to support Sue Ryder Care, who runs our local hospice Manorlands, as the charity that the Foundation Trust staff support through a salary deduction scheme.

### Fundraising

The Trust is supported by a number of very active charities, including Friends of Airedale, Airedale New Venture and Airedale NHS Charitable Funds.

During 2014/15, the charities contributed over £400,000 to the hospital. The money was used to buy a range of new equipment for the hospital, including: various pieces of equipment and enhancements to the new Emergency Department; wheelchairs; bariatric equipment for specific wards and theatre; an endoscopy light processor kit; gym equipment for the physiotherapy department; ward enhancements to help the healing environment for patients with dementia; patient wayfinding and visitor access facilities; and a new Patient Information Point.

The 'Friendly Coffee Shop' at the main entrance of Airedale Hospital, was renovated and expanded for the benefit of patients, staff and visitors in late 2014. The £60,000 facelift was funded by the Friends of Airedale, and included a contribution from the Foundation Trust.

A new Patient Information Centre funded by Airedale NHS Charitable Funds opened during the year thanks to a £7,000 donation. The drop-in service provides high quality information to help people improve their health and wellbeing. Further information about the service is provided in the Contact Information section on page 190.

## Employee Health and Wellbeing

The Foundation Trust continues to develop the overall health and wellbeing of its workforce, and management of sickness absence. The sickness absence rate for the 2014/15 is shown below:

Statistics produced by HSCIC from ESR data		Figures converted by DoH to best estimates of required data items		
Quarterly sickness absence publications	Monthly workforce publication	FTE days available	FTE days lost to sickness absence	Average sick days per FTE
Average of 12 months (2014 calendar year)	Average FTE 2014			
4.3%	2,251	506,515	21,718	9.6

Source: Health and Social Care Information (HSCIC) – sickness absence and workforce publication – based on data from the ESR Data Warehouse

Supporting employee health and wellbeing is vital to the Foundation Trust's ambitions; enabling the workforce to deliver high standards, high quality, safe patient outcomes and experience. The Foundation Trust provides an in-house health and wellbeing service to all our employees comprising immunisation programmes, health and stress assessments, counselling, advice and guidance on back care and ergonomic advice. Staff can refer themselves to the service. Managers are also assisted with expert guidance on adjustment and back to work programmes.

The Foundation Trust's People Plan is now well established and comprises four priorities for people management and workforce development – well led, healthy and engaged, productive and skilled and talented.

The Foundation Trust has developed an Employee Wellness Programme which aims to complement the People Plan. Aligned to the delivery of the Programme, will be the establishment of a Food and Drink Strategy, which will benefit patients, visitors as well as staff. The strategy will seek to promote health and wellbeing, education, exercise, weight management and effective role modelling. Further detail regarding progress on these initiatives is given in the following paragraphs.

- In order to improve the health and well-being of staff, the Foundation Trust piloted a wellness project with Sheffield Hallam University and the Academic Health Science Network; introduced resilience training for staff and continued with Pulse Surveys and Director listening sessions to hear staff's views.
- During 2014, the Foundation Trust launched its reward and recognition scheme, with monthly Pride of Airedale Awards; bi-monthly team awards, instant rewards for one-off achievements and long service awards for those staff who have worked at the Trust for over 25 years. The Foundation Trust's first Pride of Airedale Awards Event was held in February 2015 to recognise the contributions and achievements of staff. This was very well received with 14 individual and team award winners and many other teams and individuals being commended for their achievements.
- The Foundation Trust's Rising Stars Programme has continued to go from strength to strength with new cohorts established in the year and graduates being recognised at the Pride of Airedale awards. Developing and valuing our staff and nurturing future leadership potential is key to our approach to staff engagement and organisational development. New leadership development programmes for clinical leaders and senior leaders will be launched in 2015 as the Foundation Trust develops further improves its approach to talent management.

During 2014/15 the Foundation Trust improved and modernised its approach to recruitment, with more use of social media, a focused attraction strategy, more outreach at recruitment fairs and in the community and the use of modern selection

of the future, with new roles, for example, Advanced Nurse Practitioners being deployed in the Foundation Trust during 2014.

- The Human Resources (HR) and Workforce Development Service have also focused on increasing the effectiveness of business contribution, with HR Business Partners supporting service delivery groups. The HR team and managers continue to work in partnership with staff-side and the trade unions.

### Policy in Relation to Disabled Employees

The main Foundation Trust policies which support the employment of disabled employees relate to recruitment and selection, managing attendance and equality and diversity. All human resources policies have been equality impact assessed to ensure they are non-discriminatory. Disabled employees are also supported to undertake training and development in a way in which their particular requirements can be met.

### Equality Delivery System

The Board of Directors have responded to the new requirements set out in the NHS Equality Delivery System by considering through strategic planning, Board leadership, Board support and engagement with staff; the diverse needs of the communities.

The Board of Directors currently comprises four female directors and seven male directors. The Foundation Trust employs over 2,600 staff comprising 82% female staff and 18% male staff.

### 2014/15 Resources and Risks

During 2014/15 the Foundation Trust faced a number of challenges including:

- **Workforce**  
We continued to face some significant workforce challenges in-year, particularly around the recruitment and retention of clinical staff including Consultants, Middle Grades, Junior Doctors and Clinical Support staff. In some cases, this contributed to some service development e.g. children's assessment area not being able to be taken forward in-year. The Foundation Trust ensured that national staffing level requirements were met however, for some areas this reduced workforce flexibility.
- **Financial – cost improvement and income**  
The final framework cost improvement requirements proved increasingly challenging to deliver at Group level. The Groups generally met the underlying recurrent requirements however, additional pressures to meet externally driven standards, usually at premium cost and not covered by national tariffs, had to be supported by non-recurrent schemes or contingencies. Some specialties were not able to achieve the anticipated income levels due to a number of reasons e.g. ability to increase capacity at affordable cost, case mix complexity and the impact of emergency work on capacity. The cost improvement gaps will therefore be added back to the 2015/16 requirements thereby adding further pressure for the year ahead.
- **Activity and demand for services**  
The Foundation Trust has continued to face significant peaks in demand, resulting in the need to open up an additional 50 beds (14% increase on core bed base) during the year, resulting in significant additional staffing costs.
- **Transformation**  
The work to transform services and provide the *'Right Care'* for our local community has started in a number of areas however, the pace and scale of change needs to be developed further. The Foundation Trust is keen to build on the progress made to

date and take a greater role across the health economy in driving through the required transformation.

The year-end position showed a variance to the original five year plan submitted in 2014/15, due to a number of assumptions changing since submission. The Foundation Trust has however achieved its planned position for 2014/15 and achieved above planned cash levels. Despite this position, significant increased costs in relation to gaps in medical staffing, as well as increased costs to service additional activity and support for the A&E target have been absorbed. During the year, the Foundation Trust received additional support of £1.3m of Systems Resilience Funding which supported the additional costs.

We continued to maintain a Continuity of Services Risk Rating (CoSRR) of 3 and strong levels of liquidity. The Governance Risk Rating has been maintained as planned. The Foundation Trust also received a Band 6 classification from the Care Quality Commission (6 being the highest rating).

## LOOKING FORWARD TO 2015/16 – PRINCIPAL RISKS AND UNCERTAINTIES

The environment against which the Foundation Trust operates is extremely fluid. Looking forward to 2015/16, there are a number of external challenges facing the Foundation Trust which are outlined below:

- **National Tariff 2015/16**

Along with the vast majority of NHS Providers, the Foundation Trust has now accepted the Enhanced Tariff Option for 2015/16. There will be changes to the emergency care marginal rate, headline efficiency requirement and improvement to clinical negligence premiums, which will impact on the Foundation Trust's financial position.

- **Transformation**

The Foundation Trust's 2014/15 Annual Plan highlighted the need for radical transformation at pace and scale across the local health economy. Whilst some progress is being made there is still a significant amount of work to do.

- **Local Commissioning Assumptions and Affordability**

The Foundation Trust's main commissioning CCG's allocation reduction is a significant pressure and concern remains about the resulting activity estimates given current demand.

The underlying levels of urgent and emergency work continues to be a financial risk which could result in increased costs and a level of overtrade on the CCG contract for 2015/16 as is the ability to achieve 18 weeks at specialty level as set out in the 2015/16 Standard National Contract.

The Foundation Trust is continuing to work with commissioners and provider colleagues to design a model for stroke care across patch, and it is anticipated that this work will continue in to 2015/16.

- **NHS England Specialist Services**

Any potential risks regarding future service configuration plans for specialised services will be monitored during 2015/16.

- **Workforce**

The impacts of the Safer Staffing Nurse Tool audit are still being evaluated. The potential increased requirement for additional investment in nursing staff will be a contributing factor to the overall deficit plan for 2015/16.

The demand on services from an ageing local population who require integrated, long-term health and social care and the location of the current workforce require multi-skilled staff to work across professional boundaries to ensure patients are provided with right care. The Foundation Trust's ability to respond is dependent upon a number of factors including changing the workforce to meet a number of competing pressures.

The Trust's *Forward Operational Plan 2015/16* sets out in more detail the risks and contingency plans developed to ensure the Foundation Trust's ongoing sustainability.

Progressing the delivery of the Foundation Trust's '*Right Care*' Strategy will be key to success and in response to the Five Year Forward View 'New Models of Care', the Foundation Trust will be leading on the Vanguard Enhanced Health in Care Homes. The Foundation Trust recognises that it is essential to continue to progress its own internal transformation and efficiency programmes, and therefore other initiatives to improve patient care are being and have been developed focussing on urgent and emergency care, maternity, cancer and specialist services.

## Statement on quality from the Chief Executive

*We continue to prioritise the delivery of the “Right Care” and treatment for our patients and their families. We aim to provide services that are safe, clinically effective, compassionate and responsive to needs. Our aspiration is for provision to integrate around the individual patient rather than the organisations providing care. To achieve this it is important that we both listen and work with local people and representative bodies, including commissioners, local authorities, Healthwatch and voluntary agencies. In this way integration plans can align across the local health and social care economies to offer a continuum of care. I continue to be encouraged by how many of you wish to be involved in our work and future plans.*

*As a small healthcare provider, operating in a stringent economic climate and serving a largely ageing population, many with long-term health conditions, we must look to re-configure services and maximise efficiency without compromising the clinical quality of our care. In 2014, Airedale NHS Foundation Trust was, for the third successive year, judged as one of the top 40 performing hospitals in England for quality and safety by CHKS, the independent provider of healthcare intelligence and quality improvement.*

*The Trust has a well-deserved reputation for innovation, but more importantly we are able to demonstrate tangible outcomes for our patients and families. With direct access to electronic GP records, accurate information is available and risks minimised. Our long-term goal is a shared electronic patient record across primary, secondary and ultimately social care. The deployment of telemedicine and other assistive technologies into patient homes, nursing homes and GP surgeries continues to offer the opportunity for personalised treatment and support. Significant recent developments, overseen by our Telehealth Hub, are the Gold Line Service – where patients and carers can call for help 24/7 when they or their loved ones are terminally ill – and the Integrated Care Hub, which co-ordinates health and social rehabilitation or recovery care after, for example, a stroke.*

*In recent years our Emergency Department (ED) has been extremely busy in the face of unrelenting, incremental demand. In December 2014, following a significant infrastructure investment, we opened a state of the art Emergency Department. This enables us to better address patient dignity; upscale our ability to assess patients; support the management of the frail and elderly and treat more patients in a timely way. At national and regional levels, there is an intention to create a new model of urgent and emergency care, a drive towards seven day working with an expectation of a reduction in emergency admissions. Our new ED means the organisation is well placed to meet these not insignificant challenges, but we remain reliant on a cohesive local response to reduce avoidable admissions.*

*In establishing the new ED, staff worked tirelessly to maintain current provision whilst ensuring training and orientation were effective in order to seamlessly deliver the “Right Care”. Staff and volunteers are pivotal to ensuring a sustainable future for Airedale NHS Foundation Trust. I would like to take this opportunity to thank them all – clinical and support – for their commitment, talent and professionalism in helping us to improve quality and performance across all service areas.*



*We seek to foster a culture of transparency, accountability and challenge. It is important that our Quality Account is accurate and presents an open and honest picture of our care. The information used and published in the Quality Account is, to the best of my knowledge, accurate and complete. In describing our quality improvements, I hope you recognise our genuine commitment to putting patients’ needs first, providing safe, effective and innovative services.*

*Bridget Fletcher*

**Bridget Fletcher, Chief Executive, 27<sup>th</sup> May 2015**

## 1.1 Current view of Airedale NHS Foundation Trust's position and status on quality

### Introduction

**“Right Care”:** Our intention over the next five years is to integrate services around the patient. Demarcating care between primary care, community services and hospitals hinders co-ordinated and personalised health services for patients and families. This vision extends beyond healthcare to include social care and mental health partners. *“A patient with cancer needs their mental health and social care coordinated around them. Patients with mental illness need their physical health addressed at the same time.”*<sup>1</sup> We aim to truly place patients – whether in the community or as a hospital inpatient – at the centre of care and in doing so deliver better outcomes.<sup>2</sup>



To align with this forward view, the Trust's **Quality Strategy** has been revised and a **Quality Improvement Framework** developed in consultation with patients, staff, Board of Directors, and Governors. Focusing on the system and underpinned by three supporting domains – patient experience, patient safety and the clinical effectiveness of care and treatment – we have looked at what we can actively do to improve quality. The *2014/15 Quality Account* seeks to provide accurate, timely, meaningful and comparable measures to allow you to evaluate how successful we have been.

**Our partners:** we continue to seek and listen to the views of partners to help us understand what is important and ensure services are responsive to needs. For the first time, the annual *Quality Account* public engagement event was held off-site, at Keighley Civic Centre. Hosted by the Board of Directors as part of its wider initiative to improve openness, the event had a varied programme of presentations and workshops based on the “Right Care” vision. The event explored both the opportunities – the delivery of care closer to home – and also the challenges – meeting the needs of an ageing population. Invitations were extended to commissioners, the local authorities and the three Healthwatch organisations, covering the Bradford, North Yorkshire and Lancashire locality, as well as to the public, local community groups and Foundation Trust members.

The elderly, those with learning and physical disabilities and black and minority ethnic (BME) groups are often the most vulnerable and least likely to attend this kind of event, but it is important that we understand what matters to all groups. As a response, a series of meetings have been held over the last eighteen months, including with representatives from local learning disability groups and for those advocating for the elderly, to ensure we are responsive and inclusive.

We recognise the importance of a collaborative approach in working through new models of care and we continue to regularly meet with commissioners (Clinical Commissioning Groups), local GPs, patient groups and social care and mental health providers to discuss how we can improve quality and deliver better outcomes for patients. It is also vital to engage and consult with our workforce: regular events are held by the Chief Executive to canvass opinion of all staff and a biannual volunteer event solicits the views of this group.

<sup>1</sup> NHS England (2014), *Five Year Forward View*. NHS England.

<sup>2</sup> Airedale NHS Foundation Trust (2014), *Forward Plan Strategy 2014-15 to 2018-19*.

Such engagement events guide and inform a shared vision for quality improvement, whilst supporting the work of the *Quality Account* Steering Group.

## Domain 1: The patient experience

We continue to embed the ***Patient and Public Engagement and Experience Strategy*** whilst consulting on a five year plan to take forward the principal of the “*right care, in the right place, the first time*”.<sup>2</sup> A key objective is prioritising patient experience across the organisation. At the monthly Board of Directors’ meeting, the first agenda item is by agreement, a **patient story** told from the perspective of patients and families. Feedback is a potent and reflective tool. Sometimes staff are on the receiving end of our services. The following was recounted in person and is used with permission. This is an abridged version



### ***Louise's story***

*As a Sister in the Emergency Department [ED], I deal with trauma and critical care on a daily basis. Whilst off duty on a June evening, I received a phone call from my 20 year old daughter, Patsy. Her father and my ex-partner, Matthew was in the ED, experiencing a severe headache.*

*“He’s always having headaches Mum.”*

*Patsy and I made our way to the ED which I remember seemed busy, noisy, “the air stifling”. In the Relatives’ Room were some of Matthew’s family. Although on good terms with Matthew, I found myself with a family I had not had contact with for many years, and uncertain of my reception. Feeling relief, I was welcomed and the situation explained. An ambulance had been called after Matthew showed stroke like symptoms. On the way to Airedale he started to fit and lost consciousness.*

*On entering the resuscitation area and seeing Matthew and my colleagues caring for him, I felt stunned. Matthew was intubated, a tube inflating his lungs and his body artificially paralysed to protect his brain and preserve life.*

*“Suddenly it felt like there was just our family here, it [the ED] became quiet and the heat was no longer obvious.”*

*The CT [computerised tomography] scan revealed a massive bleed from a burst vessel in his brain. Matthew was transferred to the ICU.*

*Throughout this time colleagues explained what was happening with honesty, sensitivity and always with the opportunity to ask questions. Whilst these conversations are never easy for staff, the fact that they knew me can only have made this all the more difficult. As more family arrived, and Matthew’s family is large, needs were accommodated for and information and explanations “pitched” at appropriate levels so informed choices could be made. “Looking back, this empowered us to be in control of the choices being made.”*

*By morning it was clear to all that Matthew would not recover from his brain injury.*

*I asked Patsy if her Dad had ever mentioned organ donation. The Organ Transplant Nurse was able to confirm that Matthew was on the organ donation register. After much discussion with family and professionals, it was agreed to proceed.*

*Through this period, staff supported the family to say our goodbyes in our own ways, “understanding that there is no right or wrong” in this and fully respecting our individual needs for privacy and time.*

*The machines keeping Matthew alive were switched off and he was taken to theatre to retrieve his organs.*

*“The care given to the family did not stop with Matthew’s heart”, but continued in the immediate aftermath and the following days, when the Organ Transplant Nurse contacted Patsy with information of the recipients. She rang ahead suggesting I was with Patsy for the phone call. There were to be many other such thoughtful actions and kindnesses.*

*Matthew became the fifth person in five years at Airedale to donate his organs. Patsy felt “intense” comfort from knowing people had benefited from her father’s death.*

*“Matthew was someone always fixing things and I think he would have been delighted to mend some people’s lives by agreeing to use his organs... I am proud to say that I am now on the organ donation register.”*

Source: Board of Directors’ Meeting September 2014.

**End of Life Care:** the quality of care we provide to patients who are dying and their relatives is one of our main priorities. Following an independent national review, the Trust formally withdrew its use of the **Liverpool Care Pathway** in July 2014. Our new approach, *One Chance to get it Right* (NHS England, 2014) focuses on the needs and wishes of those dying and the people closest to them. Key to the delivery of “a good death” is effective **communication**. This is the responsibility of all staff. For Matthew’s family we got it right, but this is not always the case.

**Royal College of Physicians: National care of the dying audit for hospitals (2014)**<sup>3</sup>: Based on the audit of 6,500 patient records, the national report found that doctors recognised in nine out of ten cases when terminally ill patients were close to death, but in more than half of these circumstances, failed to tell patients. Airedale is one of the providers highlighted where communication – both with patients and their relatives – and recording (in patient case notes) needs to improve. Since the audit was undertaken, the Trust has focussed on ways to better identify those coming to the end of their lives. Extra training has been delivered to over 150 staff to improve communication skills for sensitive and difficult conversations, with more in-depth training rolled out to senior medical and nursing staff. The training, SAGE and THYME, reminds staff how to listen and to respond in ways designed to empower the patient. In May 2014, led by the Trust’s Patient and Carer Panel, visitors and staff were encouraged to talk about their own death as part of the Dying Matters organisation’s awareness week, run in collaboration with local public and voluntary organisations, including Age UK, Manorlands Hospice, Carers’ Resource, Cruse Bereavement Care, various faith groups, Organ Donation and Transplantation Directorate and law firms.

Our Palliative Care Team continues to support staff, patients and families with information, including the principles of the **Gold Standard Framework**. This is a nationally recognised and a systematic, evidence based approach to improve the quality of care for people considered to have a life expectancy of less than 12 months. Since January 2014, the Trust has had a Specialist Palliative Care Nurse available seven days a week. Access to advice through the innovative **Gold Line** telephone service – a central point of contact for terminally ill patients and carers offered 24 hours a day, seven days a week, via the Telehealth Hub – is also available. (See section **2.1.3** for more detail.) We recognise that there is always more work to be done, for example in exploring spiritual needs.

Effective care and treatment extends beyond technical skills and knowledge; it is also about demonstrating genuine compassion and respect for people’s individuality. The **Patient and Carer Panel** has identified communication and end of life care as priority work streams. The Panel is composed of unpaid lay volunteers who have been patients or carers, and acts as a critical friend. In the last year, the Panel has focussed on staff training and development, using individual experiences – patient stories – to inform the Trust’s “*Right Care*” Customer Care training programme for staff.

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<sup>3</sup> Royal College of Physicians (2014), *National care of the dying audit for hospitals, England*. Available at: [https://www.rcplondon.ac.uk/sites/default/files/nccdah\\_national\\_report.pdf](https://www.rcplondon.ac.uk/sites/default/files/nccdah_national_report.pdf) [Accessed: 11/012/14].



With an ageing local population and the growing prevalence of **dementia** across the country, caring for this group of patients remains a core priority. The environment can have an impact on how those with dementia function and often simple alterations can improve cognition. The *Enhancing the Healing Environment* audit tool, developed by The King's Fund, is used to evaluate how dementia-friendly our wards and departments are and informs the Estate Department's project upgrades and refurbishment work. The recently opened Emergency Department (ED) includes an assessment and treatment room

which specifically considers the needs of those with dementia. (See section **2.1.1** for more information on developments in dementia services over the last year.) Improvements to **access and wayfinding** for visitors, outpatients and inpatients are important patient experience elements of the "Right Care" vision. This work includes: improved signage, the provision of ramps and lifts to the main entrance points and public areas and ensuring that bathing and toilet areas are disability compliant. Wheelchairs are located in key areas for visitors to transport patients, including in the Chapel.

Each year the Trust takes part in **national patient surveys** to learn about the experience of people who use our services. Findings are used to help us understand how to improve the quality of service provision.

**Accident and Emergency Survey<sup>4</sup>:** In March 2014, 800 people aged 16 years and over who went to our ED were sent a questionnaire from the CQC focusing on the care, treatment and support provided; 29 per cent responded. The national average response rate was 34 per cent. Compared to 142 other trusts, patients told us we were above average for: length of time spent in our Emergency Department; *"doctors and nurses acknowledging patients and not talking as if they weren't there"*; and receiving test results before leaving the department. There were no areas where we were judged to be performing below average, in spite of the fact that the survey was undertaken whilst the ED was in temporary accommodation. A similar survey was undertaken in 2012. There is a limit to how accurately the data can be compared across years, particularly in the context of ED activity rates, but no change in how patients rated the overall standard of care received was noted.



**Adult Inpatient Survey<sup>5</sup>:** during August 2014, 396 people aged 16 or over, who had spent at least one night in hospital, were asked a range of questions about their care and treatment. In general, the Trust performed consistently across the survey domains. The survey highlighted many positive aspects of the patient experience, including being treated with respect and dignity, having confidence and trust in doctors, and wards being clean. Areas where improvement could be made included insufficient privacy when being examined and treated in the ED. (The survey was conducted before the new department opened and whilst the ED was in temporary accommodation.) The Patient and Public Engagement and Experience Operational Group oversees a patient survey action plan to look at ways to improve areas of shortfall.

<sup>4</sup> Care Quality Commission [CQC] (2014), *Accident and Emergency Survey 2014*. Picker Institute. Europe.

<sup>5</sup> CQC (2014), *Survey of Adult Inpatients*. Available from 21<sup>st</sup> May 2015: [www.cqc.org.uk/inpatientsurvey](http://www.cqc.org.uk/inpatientsurvey).

The ***National Cancer Patient Experience Survey 2014***<sup>6</sup> involved 153 acute providers of cancer services across thirteen cancer groups. Of 438 eligible Airedale patients, 65 per cent of questionnaires were returned; the national response rate was 64 per cent. A comparison of results with the previous year's survey indicates a reduction in the number of responses where patients ranked the Trust in the top 20 per cent in England. One patient experience response is placed in the bottom 20 per cent: patients "*always given enough privacy when discussing condition treatment*". In 2013 we were rated in the lowest 20 per cent for: "*staff failing to inform patients about free prescriptions*". An improvement in this return is observed, but performance remains below the national average.

***Friends and Family Test (FFT)***: Since April 2013, patients have been asked whether they would recommend hospital wards and EDs to friends and family if they needed similar care or treatment: on average 94 per cent of our inpatients and 87 per cent of those using the ED are either likely or extremely likely to recommend services.<sup>7</sup> The FFT expanded to cover Maternity Services in October 2013 and Community Services in January 2015. At national level the FFT is due to include Outpatients and Day Case Surgery from 1<sup>st</sup> April 2015. The Trust has been surveying these areas since October 2014. This means patients have the opportunity to give feedback on the quality of the care they receive and provides us with a better understanding of the needs of our patients to enable improvement. For example, following feedback, ear plugs have been added to the Acute Medical Unit stores. It is planned to include children and young people under the age of 16 within the FFT from April 2015.

The ***Inquiry into Mid Staffordshire NHS Foundation Trust*** detailed sobering failings in care which caused unnecessary harm. As a consequence, a series of measures were implemented across the NHS to deliver a culture of harm free and patient centred care. One such action was a national review of complaint management systems. Following an extensive appraisal, the Trust has revised its *Complaints Policy* and re-aligned procedural standards. Whilst a summary of complaints activity is included in the *Quality Account*, more detailed quantitative and qualitative analysis is provided in the Trust's complementary statutory annual ***Complaints and Concerns Report 2014/15***.<sup>8</sup>

In 2014/15 there were 2307 issues raised, from 1797 contacts with the Patient Advice and Liaison Service (PALS), of which 2190 were specifically related to Airedale General Hospital: 359 were compliments, 286 were requests for information and 1545 were expressions of concern, dissatisfaction and requests for action to be taken. The remaining 117 issues were related to other organisations. Evaluation focuses on recurring themes and on specialities or wards with a persistent profile of concern. Seventeen of the PALS contacts became a formal complaint during 2014/15. This is often due to the complexity of the concern which requires a formal investigation, undertaken on the instruction of the complainant. Whilst the number of complaints arising from PALS contacts is stable and comparatively few, there is a discernible increase in the number of formal complaints in the last year. This is being closely monitored.

In 2014/15 a total of 103 formal complaints were received, compared to 73 in the previous reporting period. The Trust has three outstanding complaints that are undergoing investigation by the Parliamentary Health Service Ombudsman (PHSO) with a further complaint under initial review. Over the last year, one complaint received by the PHSO was not investigated whilst a further one was investigated and not upheld.

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<sup>6</sup> NHS England (2014), *The National Cancer Patient Experience Survey*. Airedale NHS Foundation Trust. Quality Health. Crown Copyright. England.

<sup>7</sup> Due to a NHS England change in the calculation of this indicator, figures are based on the period October 2014 to February 2015.

<sup>8</sup> The annual Airedale NHS Foundation Trust *Complaints and Concerns Report 2014/15* will be available in June 2015 at: [www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk)

The Trust takes complaints extremely seriously and is committed to learning how we can improve. Hospital discharge is one such area.

**Your concern...** *“Why was there no palliative care discharge planning for my father?”*

**Our response...** To address this shortfall, the Clinical Nurse Specialist for Palliative Care attended the Surgical Group meeting to update the membership on palliative care good discharge planning. Other clinical areas have been involved in cascade planning.

**Your concern...** *“The information regarding my father’s social situation at home was not considered when planning his discharge and this impacted on him when he returned home.”*

**Our response** ...The Matron shared with ward staff how the lack of documentation of social situation affected the patient. The importance of documenting social circumstances was emphasised.

Source: Airedale NHS Foundation Trust Complaints Team 2014.

Local Healthwatch organisations carry out announced **Enter and View** visits of health and social care services. In November 2014, six representatives of Healthwatch North Yorkshire carried out a visit of Airedale General Hospital with a particular focus on the patient experience of **hospital discharge** and post hospital support arrangements. Over 40 current and previous patients provided feedback; Healthwatch also interviewed a senior Pharmacist and the Appointments Manager. Areas visited included: Medical Admissions, Acute Elderly Medicine, the Stroke Ward, Ward 6, Outpatients and the Telehealth Hub. Healthwatch found that in response to patients’ concerns about protracted discharge, a target of *“Home by 1pm”* has been implemented. Changes to prescribing routines and the greater provision of ward-based Pharmacists have been made.

*“Patients who had been previously discharged talked about their experiences to us. They described an experience which was “joined up” with admission and diagnosis being timely. Treatment, even at another hospital, being arranged promptly and after discharge community care being as previously arranged. There will be of course other contrary experiences, but we could not find patients with an alternative view.”<sup>9</sup>*

## Domain 2: Patient safety

In October 2013, the **Care Quality Commission** (CQC) inspected services at Airedale General Hospital, finding services safe, effective, well-led and responsive to the needs of patients. As the process was in its pilot stage, the CQC did not formally rate the hospital and we therefore anticipate a further inspection before the end of 2015. In support of its regulatory model, the CQC publishes a quarterly *Intelligent Monitoring Report* on each acute provider. Key quality indicators are selected to evaluate the level of risk. In the July 2014 report on Airedale NHS Foundation Trust, no areas were deemed to be a risk; in the December 2014 publication the Trust was banded in the lowest category of risk with a score of three out of a maximum possible risk score of 190.<sup>10</sup>



The CQC is to introduce new fundamental standards of care in the next fiscal year. However, two regulations which form part of these came into force in November 2014: **fit and proper persons**, whereby Trust Directors are responsible for overall quality and safety,

<sup>9</sup> Healthwatch North Yorkshire (2014), *Enter and View Report Airedale NHS Foundation Trust November 2014*. Page 2.

<sup>10</sup> CQC *Intelligent Monitoring Reports* are available at the following link: <http://www.cqc.org.uk/provider/RCF/reports>.

and **duty of candour**. Duty of candour explains what we should do to make sure we are open and honest with people when something goes wrong with their care and treatment. A transparent reporting and learning culture enables areas of concern to be identified and targeted. **Incident monitoring systems** help us to understand where problems are occurring so that preventative actions can be taken.

We reported a serious incident in July 2012 following an inpatient fall and subsequent significant head injury. In 2013 a cluster of four similar incidents was identified with some commonality in location. Regrettably, three of the five patients involved died following the fall; all were on anti-coagulants. To address these events, a multi-disciplinary Head Injury from Falls Task and Finish Group was set up and a clinical audit commissioned to assess adherence with head injury standards. The following describes some of the interventions made to target patient safety: review of head injury pathway for inpatients that have fallen, with a further update following the release of specific National Institute for Health and Care Excellence (NICE) guidance; amendment of internal referral for urgent and non-urgent CT head scans; revision of neurosurgical referrals; and a programme of training in the use and application of the Glasgow Coma Scale. To ensure a sustained improvement, a re-audit of clinical and training standards has taken place in recent months. There have been no ensuing inpatient deaths following a significant fall since these measures were introduced.

This year the Trust recorded a **Never Event** within Maternity Services. This is a serious, largely preventable, patient safety incident that should not occur if the available pre-emptive measures are applied. This incident concerned a retained swab, post operation. In accordance with our **Being Open Policy**, the patient was informed and chose not to be involved in the investigative process. The Trust apologised to the patient. An immediate review of practice was undertaken with a root cause analysis meeting convened and chaired by the Chief Executive to review and mitigate the causes and identify learning. The following changes to processes include the: development of multi-disciplinary guidance on action to be taken when a swab is missing, clarification of unit guidelines for perineal repair and re-assessment of how swab count is recorded.

Clear and visible leadership is a key component in promoting a safety culture. In 2014 the Trust commissioned an **independent review of our Maternity Services** by the Royal College of Obstetricians and Gynaecologists. The visit took place over three days and involved interviews, focus groups, walk-rounds and case note review. The evaluation confirmed that the service is safe, but identified improvements in governance systems, including improved monitoring information of processes and outcomes. There is a need to ensure Board and executive members “*walk the journey*” of women, patients and staff to view the environment with fresh eyes.

**Patient safety walk-rounds:** continue on a fortnightly basis with 22 walk-rounds carried out in 2014 and 26 planned for 2015, including Community Services. The team includes a staff member and Board representatives – executive and non-executive. Using the principle of the *15 Steps Challenge*, an initiative developed by the NHS Institute for Improvement and Innovation, emphasis is on engagement with patients, including family and front-line clinical staff. The objective is to evaluate clinical areas from the perspective of the patient. Feedback concentrates on good practice and areas of improvement, with staff given the task to target areas of shortfall.

**Freedom to Speak Up<sup>11</sup>:** A positive and transparent culture that supports staff to do “*the right thing*” for patients depends on listening to staff and understanding that achieving targets and financial balance can never be at the expense of acceptable standards of care. New this year is a Trust-wide **Quality and Safety Forum**. Open to all staff, this is an opportunity to express views and ideas on quality and safety directly to the Medical Director and the

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<sup>11</sup> Francis R. (2015), *Freedom to Speak Up Review -An independent review into creating an open and honest reporting culture in the NHS*. Available at: [https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU\\_web.pdf](https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf) [Accessed 13/02/15].

Director of Nursing. Staff often know when things are not working well. We want staff to feel supported so that they are willing to challenge decisions or actions they perceive to be wrong or harmful.

We continue to review incident reporting systems to promote an effective safety culture and we plan to switch fully to electronic online reporting in the next year. (See section 2.3.9 for more in depth analysis.) The 2014 *NHS National Staff Survey* indicates that the percentage of staff witnessing potentially harmful errors, near misses or incidents is in the lowest 20 per cent of acute trusts in England whilst the fairness and effectiveness of incident reporting procedures is better than average.<sup>15</sup> Low and no harm incidents account for 97.9 per cent of all incidents that occur.<sup>12</sup>

**Safe Staffing:** In order to comply with the commitments set out in *Hard Truths: The Journey to Putting Patients First* (Department of Health, 2014), trusts are required to publish<sup>13</sup> and submit nursing, midwifery and care staff staffing levels as part of a national reporting system which launched officially in June 2014. Monthly staffing reports of capability and capacity on a shift by shift basis, actual against planned, with an overall average fill rate are distilled and reviewed at the monthly Board of Directors' meeting. Where staffing levels are less than 90 per cent of those planned, key risks are detailed and contingency planning and actions taken are provided: for example recruitment campaigns in pressurised areas. Incident reporting is used to inform this process. NICE has announced plans to develop guidance to support hospitals understand ratios for other staffing groups, including doctors.



The Royal College of Physicians (2014), *Sentinel Stroke National Audit Programme (SSNAP)*<sup>14</sup> published reports show that despite steady progress in the care of stroke patients across the country, there are significant shortages of both nurses and doctors. The SSNAP organisational audit measures the staffing levels, resources and facilities available in every hospital that cares for stroke patients acutely. In the period April to June 2014, Airedale was assigned Level E – elevated risk. The Trust experienced significant workforce pressures in this period. A series of short and longer-term solutions linked to organisational and local health transformational plans have been put in place to ensure consistent high quality and safe services for patients, including access to emergency care and specialist rehabilitation support. The annual 2013/14 patient care audit provides answers to questions about whether or not patients are being treated quickly enough, receive adequate therapy, and whether they get the anti-coagulants required. Airedale's overall banding is Level C – no evidence of risk.

The annual anonymous *National NHS Staff Survey*<sup>15</sup> helps us to improve the working lives of all our staff. Previous surveys have revealed issues around work pressure, work related stress, satisfaction with the quality of work and patient care, and staff motivation at work. The latest survey shows a statistically significant deterioration from 2013 in staff scores around: work pressure, job satisfaction and the Trust as a place to work or receive treatment. The following areas show a statistically significant improvement in scores on the preceding

<sup>12</sup> Based on incidents occurring between 1<sup>st</sup> October 2013 and 31<sup>st</sup> March 2014 and reported to the NRLS by 30<sup>th</sup> May 2014.

<sup>13</sup> Available at: <http://www.airedale-trust.nhs.uk/patient-outcomes/> [Link checked 16/04/15]

<sup>14</sup> These reports are available at: <https://www.strokeaudit.org/results/National-Results.aspx> [Accessed 18/12/14].

<sup>15</sup> *NHS Staff Survey 2014* is available from: [http://www.nhsstaffsurveys.com/Caches/Files/NHS\\_staff\\_survey\\_2014\\_RCF\\_full.pdf](http://www.nhsstaffsurveys.com/Caches/Files/NHS_staff_survey_2014_RCF_full.pdf) [Accessed 6/03/15].

reporting period: appraisal rates and the numbers experiencing physical violence. (See section [2.3.5 Staff recommendation](#) form more detail, including actions taken.)

**Supporting and developing our workforce:** Recent years have seen workforce re-design in response to the integration of the Trust's services with local health and social care partners, alongside the need to deliver increased efficiencies. This creates both challenges and opportunities for staff. Valuing and nurturing staff is crucial to engagement and organisational development. The Trust has implemented a new **reward and recognition scheme** with a suite of awards – long service, team, annual and instant. *The Pride of Airedale Award* is given to those staff members recognised by peers for providing outstanding care or supporting others to do so. As an organisation, we have a responsibility to foster the expertise required to develop and empower individuals and teams to focus on quality and service development. The Trust was awarded the bronze **Investors in People** national quality standard in 2014. Leadership potential and talent spotting continue to be actively promoted, with appropriate access to leadership and line-management development programmes, including the *Rising Stars* initiative. The staff appraisal scheme has been revamped to ensure our workforce is adaptable, resilient and flexible and that staff are supported through transition and re-design.

Infections that are acquired as a result of healthcare interventions (**healthcare associated infections**) remain a high priority for the Trust. The last reported hospital acquired MRSA bacteraemia case occurred in February 2014 and we have met the Department of Health (DH) target of zero cases for the 2014/15 fiscal year. There were eleven cases of *C.difficile* in the same period; root cause analysis indicates that of these, seven cases were unavoidable. The DH target of nine cases for 2014/15 is met. (See sections [3.2.1 Infection prevention](#) and [2.3.8 Rate of C. difficile](#) for further review.)

**“Think like a patient and act like a taxpayer”<sup>16</sup>:** In the face of rising demand and reduced budgets, it is important that the focus on efficiency savings is not at the expense of patient safety. All cost improvement plans are risk assessed for their impact on quality and safety by the Medical Director and the Director of Nursing. Only cost improvement schemes with manageable levels of risk go ahead. In March 2015 Pharmacy welcomed an automated dispensing robot. The robot will mean new ways of working in support of efficiency and quality. The objective is to speed up prescription turnaround time, minimise dispensing errors, reduce drug stock holding and release more Pharmacy staff to be deployed to clinical areas.

### Domain 3: Clinical effectiveness

**Mortality ratios:** In the key mortality measures – Hospital Standardised Mortality Ratio (HSMR), Summary Hospital-level Mortality Indicator (SHMI) and deaths in low-risk conditions – Airedale's ratios are lower than expected or within the expected range. The SHMI for the period April 2013 to March 2014 is 0.87 where 1.0 represents the national average. For this measure, the Trust is one of 17 providers across England with lower than expected mortality; this is an improvement on the same period in 2012/13. (See section [2.3.1](#) for more analysis of this indicator.) The Trust level HSMR for the same period is 82.00 where 100.00 is the national average. The weekday HSMR is 77.31 and the weekend 95.93; deaths in low risk diagnosis groups is 0.33 compared to a national rate of 0.61.<sup>17</sup> In 2013 death rates in a number of surgical specialties, broken down by individual surgeon, were published; further specialties have been added in the last year.<sup>18</sup> The data derives from national clinical audits

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<sup>16</sup> Stevens Simon (2014), Chief Executive NHS England. International Centre for Life. Newcastle. 01/04/2014. Full text of speech available at: <http://www.england.nhs.uk/2014/04/01/simon-stevens-speech/> [Accessed 12/12/14].

<sup>17</sup> Dr Foster Intelligence published April 2015 for the period July 2013 to June 2014: HSMR = 82.83 [lower than expected]; Weekday HSMR = 77.97 [lower than expected]; Emergency weekend HSMR = 96.69 [within expected]; Deaths in Low Risk Diagnosis Groups = 0.41 [within expected].

<sup>18</sup> Surgeons' outcome data is available from: <http://www.hqip.org.uk/consultant-surgeons-data-published-for-2014?source=CHAINmail>. [Accessed 12/12/14].

which the Trust participates in. These crude rates are based on small numbers, are not adjusted for case-mix and take no account of care systems. The *Quality Improvement Programme* developed by our new Medical Director, seeks to build on the work of the Trust's Mortality Review Group and the use of standardised case note review to identify those aspects of the process that are important to mortality and thereby maximise clinical outcomes.

Across the country increasing pressure is being experienced by health services: growing waiting lists, pressures in EDs and on out-of-hours services. According to the National Audit Office, emergency admissions have risen by 47 per cent over the last 15 years<sup>19</sup>; a pattern that is repeated at Airedale. Since December 2014, the Trust has been providing care from a cutting edge **Emergency Department**, to a standard our community and staff should be able to expect. We have embedded new pathways of assessment and care for urgent medical and surgical patients to enable timely patient review. To avoid unnecessary admissions, we provide GP access to specialist consultants. Although we are better able to manage the increased numbers of patients, in the last year there have been occasions where we have not met the required level of performance i.e. patients receiving treatment within the four hour standard. Despite additional winter capacity and a continual process of evaluating staff resilience, we have also had to cancel a number of elective operating lists when demand for beds has exceeded supply. This has a detrimental impact on patient experience. The Trust is working with our commissioners, who have been tasked with developing a system-wide urgent and emergency care strategy, to agree realistic and deliverable ED targets to reduce activity. Without radical transformation across the whole health and care system – treating patients in “*the right place, at the right time, the first time, in all care settings*”<sup>2</sup> – the achievement of national targets will continue to be a challenge. ED activity is declared as a risk in planning submissions and declarations to the regulator, Monitor.



**Transformation and Integration:** In 2011 we established a **Telehealth Hub** on the Airedale General Hospital site. Working with local health and social care partners, the Hub supports patients to self-care, delivers care closer to home and closes the gap between primary, community, social and secondary care.<sup>20</sup> This work continues to attract interest from the media, think tanks and policy advisors. An aspect of the Telehealth Hub service was featured as a new model of care case study in *NHS England's Five Year Forward View*.<sup>21</sup>

*“In Airedale, nursing and residential homes are linked by secure video to the hospital allowing consultations with nurses and consultants both in and out of normal hours - for everything from cuts and bumps to diabetes management to the onset of confusion. Emergency admissions from these homes have been reduced by 35% and A&E attendances by 53%. Residents rate the service highly.”<sup>21</sup>*



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<sup>19</sup> Department of Health (2013), *Emergency admissions to hospital: managing demand*. National Audit Office. TSO. Page 4.

<sup>20</sup> The King's Fund (2015), *The Future is Now*. Available at: <http://www.kingsfund.org.uk/reports/thefutureisnow/> [Accessed 06/03/15].

<sup>21</sup> NHS England (2014), *NHS Five Year Forward View*. Available at: <http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf>. Page 16. [Accessed 12/12/14].

The Trust and its partners were invited in 2014 by NHS England to participate in a series of workshops to explore new clinical care pathways and models of health and social care. Subsequently Airedale, Wharfedale and Craven locality has been identified as an “*accelerator site*” to progress and pilot pioneering initiatives. One example being a new **Intermediate Care Hub (IC\_HUB)** that went live in November 2014. Based within the Trust’s Telehealth Hub, it provides health and social care colleagues with a single point of referral for adults needing rehabilitation or recovery care after an illness, such as a stroke. It offers quick interventions to prevent major health problems developing should a patient’s long-term condition deteriorate. The approach seeks to prevent unnecessary admissions into hospital where patients can be more effectively cared for in community settings. This is an example of an organisational and district wide approach to the integration of health and social care, involving Airedale, Wharfedale and Craven CCG, Bradford Metropolitan District Council, North Yorkshire County Council and the voluntary group, Carers’ Resource.

As reported in last year’s *Quality Account*, we now have shared primary and secondary healthcare access via **SystemOne**, the information technology used by GPs. This exchange of patient information has improved communication across boundaries with clear benefits for patients. For example, a butterfly alert allows prompt identification of those patients with a diagnosis of dementia and ensures the correct support is initiated throughout the inpatient episode of care. Work to scope the next phase of our plans for a shared and integrated electronic patient record across primary, intermediate, secondary and social care communities has begun. In February 2015, we piloted Electronic Prescribing and Medicines Administration and eDischarge on SystemOne on two Orthopaedic surgical wards.

Being smarter with technology is not the only means to achieve the “*Right Care*” for our community. A multi-disciplinary **Frail Elderly Pathway Team** and a **Dementia Crisis Response and Prevention Service** offer early intervention to avoid unnecessary hospital admission and more cohesive co-ordination of care. Advanced Community Nurse Practitioners, working in the ED can focus on frail patients and deliver care in the community, rather than the acute sector. Implementations of ambulatory care pathways provide an alternative to hospital admission, for example, through the administration of intravenous antibiotics in community. In the Craven locality, community services have been expanded to include a Community Cardiac Rehabilitation Nurse, Heart Failure Specialist Nurse and Respiratory Specialist Nurse. A Parkinson’s Disease Specialist Nurse commenced in 2014, serving Airedale, Wharfedale and Craven.

Complementing innovation is Airedale’s strong health research culture, designed to promote the best use of available evidence in the advancement of clinical effectiveness. The Trust takes part in a broad portfolio of clinical trials, including research into long-term conditions (diabetes, dementia), cardiology, stroke and cancer. In the last 18 months, the Trust’s participation in trials has broadened across new specialties, including Maternity, Rheumatology and Surgery, affording greater opportunity to patients to take part. The Trust is participating in research into the medical genetics of disease, notably a University of Cambridge study of primary biliary cirrhosis. We continue to meet the national trial approval target timescales, with recruitment to trials steadily increasing. Dissemination of findings is essential so staff are encouraged to publish work and present at conferences.<sup>22</sup>

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<sup>22</sup> Airedale NHS Foundation Trust (2014), *Research and Development Annual Report 2013/14*.

## Research in action

Carl Booth, Lead Pharmacist for Oncology and Clinical Trials, won the British Oncology Pharmacy Association (BOPA) travel scholarship for the second time in three years, for his presentation at the BOPA symposium on venous thrombolism risk in chemotherapy outpatients. Carl is now Chair of the BOPA Research and Audit Committee and is hoping to continue to improve safety for patients on chemotherapy.



Source: Airedale NHS Foundation Trust (November 2014) *Research Newsletter*.

(For more on clinical research at Airedale see section [2.2.3](#).)

## In conclusion

In 2014, Monitor published a report on the future of smaller acute providers. Findings were based on analysis of data related to patient experience, safety and clinical effectiveness. It concluded that there was no evidence of poor quality of care in small hospitals.<sup>23</sup> The regulator did observe that there is indication that smaller hospitals are under greater financial constraint. By looking at how and where we provide care, innovative use of technology and prudent financial oversight, we believe we can work in partnership to address challenges and ensure patients and families receive quality healthcare.

Delivering high quality evidence-based care depends on measuring outcomes, including the experience of those using our services, so we can understand if we are protecting patients from harm, treating patients efficiently with good clinical results and meeting personal needs. It allows others to assess and reflect on our approach to safety and quality improvement and reinforces public accountability. It is therefore important that our *Quality Account* is accurate, transparent and presents an unbiased view of the quality delivered by Airedale NHS Foundation Trust. There is always opportunity for improvement and we are committed to working with and listening to staff, expert bodies, including royal colleges, and other partner organisations to identify, monitor and improve services and ensure that all our patients and carers receive high quality, compassionate and responsive care.



**Mr Karl Mainprize,  
Medical Director**



**Rob Dearden,  
Director of Nursing**

27<sup>th</sup> May 2015

<sup>23</sup> Monitor (2014), *Facing the future: small acute providers*. London.

## 2 Priorities for improvement and statements of assurance from the Board

### 2.1 Priorities for improvement: current and future

#### Current Priorities 2014/15

In last year's *Quality Account*, we identified our three key local quality priorities for this fiscal year:

- 1: Patient experience:** *improving nutritional care for patients with dementia;*
- 2: Patient Safety:** *reduction of slips, trips and falls sustained by patients admitted to our hospital wards; and*
- 3: Clinical Effectiveness:** *the use of telemedicine to improve the overall quality of healthcare for people with long-term conditions.*

We report on our progress against these in section 2 of this report and also present a core set of national quality statements and metrics to allow comparative understanding of performance.

Our progress and performance during 2014/15 in other local quality improvement work is reported in section 3 of this *Account* and within the three domains of quality:

- Section 3.1:** *privacy and dignity; creating a customer service culture;*  
**Section 3.2:** *infection prevention; management of pressure area care; and*  
**Section 3.3:** *management of the number of Caesarean sections; Enhanced Recovery Programme; fractured neck of femur improvement project.*

We also report on our performance against national key priorities.

#### Future priorities 2015/16

Over the last year, the Medical Director has developed a Trust-wide *Quality Strategy and Quality Improvement Framework*, underpinned by the Trust's *Forward Plan Strategy 2013-14 to 2015-16*,<sup>2</sup> as approved by the Board of Directors. The quality improvement priorities for 2015/16 are as follows. (See **Section 1.1 – Introduction and Patient Experience** – for how the views of patients, the wider public and staff have been taken into account in selection.)

**1: Patient experience:** *improving the quality of care for people in the last days of life in Airedale General Hospital.* In line with *One Chance to get it Right* (NHS England, 2014), this initiative focuses on five principles: recognition, sensitive communication, involvement, the needs of families and individual care plans. Progress will be monitored by the multi-disciplinary End of Life Operational Group via: evaluation of staff training uptake, staff assessment of its usefulness and patient outcomes; feedback from the annual *Bereaved Relatives Survey*; and on-going local clinical audit.

**2: Patient Safety:** *management of pressure area care* is an existing priority which we now seek to build upon as pressure ulcers are a significant source of harm. We recognise that pressure ulcers originate across and outside of the health and social care system and, as part of our "*Right Care*" vision understand that we need to work with partners to address the causes of pressure ulcers and reduce prevalence, regardless of source. Using the NHS Safety Thermometer pressure ulcer Commissioning for Quality and Innovation (CQUIN) methodology to measure progress, the initiative's progress will be monitored by the Nursing and Midwifery Leadership Group.

**3: Clinical Effectiveness:** *management of sepsis: sepsis six bundle.* In last year's *Account*, we reported a serious incident in relation to the management of sepsis. Sepsis is caused

when the body's immune system overreacts to infection. Severe sepsis claims around one in three patients' lives; in septic shock the chances of survival are one in two.<sup>24</sup> Some of these deaths may be avoided by early recognition and immediate intervention using therapies that are widely available. Through the sepsis six bundle, the Trust seeks to embed consistent recognition and rapid treatment. Progress will be measured through the 2015 national CQUIN indicators and monitored by the Medical Delivery Assurance Group.

Other local prioritised quality improvement work identified for inclusion in the 2015/16 *Quality Account* is:

**Domain 1: Patient experience:** *improving care for patients with dementia; privacy and dignity.*

**Domain 2: Patient Safety:** *infection prevention; reduction of slips, trips and falls sustained by patients admitted to our hospital wards; and*

**Domain 3: Clinical Effectiveness:** *the use of telemedicine to improve the overall quality of healthcare for people with long-term conditions; Caesarean section; and fractured neck of femur improvement project.*

The *Enhanced Recovery Programme* is now judged to be embedded with progress monitored through clinical governance and performance reporting systems. As such, it will no longer be reported in future publications. *Creating a customer service culture* is to be included in future privacy and dignity priority updates.

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<sup>24</sup> <http://survivesepsis.org/about-us/> [Accessed 02/03/15].

## 2.1.1 Priority 1 patient experience: *improving nutritional care for patients with dementia*

**Lead Executive Director**

*Rob Dearden, Director of Nursing*

**Clinical Lead and Implementation Lead**

*Elaine Andrews, Assistant Director Patient Safety*

*Jane McSharry, Senior Nurse Practice Development*

*Katherine Jones, Dietetics Professional Lead*

*Maria Moloney, Safeguarding Sister*

### **Rationale and aim**

*“An estimated 25 per cent of hospital beds are occupied by people with dementia. People with dementia also stay in hospital for longer, are more likely to be re-admitted and more likely to die than patients admitted for the same reason.”*<sup>25</sup> Refusal to eat, loss of appetite, forgetting to chew and swallow and being distracted are all frequently observed in this vulnerable group.<sup>26</sup> Through focusing on developing the skills and expertise of our workforce in the care of patients with dementia, the Trust seeks to meet the complex needs of those living with dementia, including improved nutrition.

### **Process for monitoring progress**

This priority is part of the wider *“Right Care”* programme. The multi-disciplinary and agency *Here to Care* Project Management Group co-ordinates the key dementia priorities: training, environment, admission avoidance, patient flow and elective pathway. Membership includes patient and carer representatives. This area remains a key work stream of the Patient and Carer Panel. The Nutrition and Hydration Group meets regularly to agree what is best practice in all aspects of nutrition and hydration and provides quarterly updates on progress to the Quality and Safety Operational Group.

Complaints are one of a series of quality markers used to provide measurement of the effectiveness of initiatives. Complaints feedback is received on a monthly, quarterly and annual basis at ward level and through to Board. The annual *Airedale NHS Foundation Trust Complaints and Concerns Report*<sup>8</sup> provides a summary of the Trust’s mechanisms for measurement and learning.

### **Current status**

The Trust is an *“Ambassador Trust”* for the Butterfly Scheme with mandatory training for Nurses, Health Care Support Workers, Phlebotomists, Physiotherapists, Occupational and Speech and Language Therapists, Doctors, and Dietitians. Provision was extended in January 2015 to include all staff – clinical and non-clinical – including volunteers and bank staff.

*The Butterfly Scheme was developed by a carer, Barbara Hodgkinson, from observations of her mother’s dementia care whilst she was in hospital recovering from a knee operation. The scheme is designed to:*

- *Highlight the unique needs of patients whose memory is permanently affected by dementia by displaying (with appropriate consent) a butterfly symbol.*
- *Provide staff with simple, practical guidance towards meeting the needs of these patients such as the REACH response: Remind, Explain, Arrange, Check, History.*



<sup>25</sup> Department of Health (2014), *Dementia . A state of the nation report on dementia care and support in England*. William Lea.

<sup>26</sup> Watts, V.et al., (2007), *Feeding Problems in dementia* Geriatric Medicine 37:8 –pp.15-19.

- *Alert staff to the use of carer information via the “All about Me” form which offers helpful information to enable staff to better engage and create a more positive experience for the patient. In completing the form, input from relatives and carers is encouraged to ensure a patient’s care plan reflects preferences and dislikes, including food and drink. This can improve nutrition, hydration and the mealtime experience.*

By the end of March 2015 60 per cent of the workforce had achieved competency in privacy and dignity training (which incorporates the Butterfly Scheme). We have developed a *Training Strategy for Dementia* to ensure *all* staff members have knowledge and skills in caring for people with dementia. In 2013 the University of Bradford’s Dementia Group invited the Trust to participate in its Person Centred Care Programme. Twelve staff members were selected to receive intensive training; a cascade of learning to colleagues with direct contact with this group of patients is now on-going. The training covers: effective communication, how to focus on the individual, and the impact of the environment. Staff working with dementia patients are also encouraged to undertake the Social Care Institute for Excellence dementia e-learning programme.

Last year, following a successful bid to the Department of Health, work to improve four wards and a garden area at Airedale General Hospital was completed to create positive therapeutic dementia environments.



A fifth ward has subsequently been refurbished and there is a rolling capital programme to update two hospital wards each year. A scheme to upgrade Harden Ward at Castleberg to mirror the main site work is planned. Research indicates that changes in the physical surroundings can encourage greater independence, lessen anxiety, improve nutrition and reduce the number of falls. Access to safe social spaces and dining areas, with eye-catching colour contrasting schemes and signage, help patients find their way around, reduces distress and has a positive impact on dietary intake. These innovations have been adopted across the Foundation Trust, most notably in the new ED. With input

from clinical experts, the Alzheimer Society, patient and carer representatives, there is a strong awareness of dementia in its design with a specially equipped bay – The Butterfly Room. Window artwork and nature murals make bays seem less clinical. Colour selection is designed to promote relaxation and minimise visuo-spatial problems. A sky ceiling – back-lit tree canopy – soothes and minimises anxiety.

In line with NICE recommendations, the Malnutrition Universal Screening Tool (MUST) is used for all inpatient admissions to establish nutritional risks. Completion of this tool is audited on a monthly basis, using nursing key performance record keeping indicators, and scrutinised by the Trust’s Nursing and Midwifery Leadership Group. In 2014, a 12 month seconded Nutrition Nurse post permitted concerted training for nurses on the effective use of the tool. Following the training of 103 nurses, clinical audit shows considerable improvement – on the baseline data – in the identification of malnourished patients. However, there remains scope for supplementary improvement.

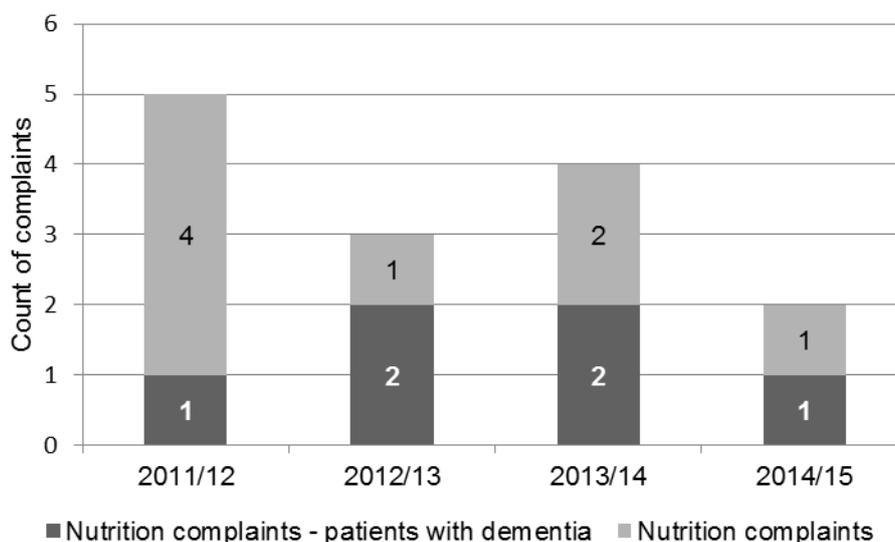
### **Initiatives and progress in 2014/15**

- To ensure prompt and appropriate referral to specialist services, all patients aged 75 and over admitted as an emergency are screened for dementia or delirium.
- A one-to-one nursing project – the Butterfly Support Team – is available for those patients with dementia who are distressed and or may have more challenging behaviours. Staff are specifically trained to support this patient group and work with carers and families. The project is supplemented by multi-disciplinary “Dementia Champions”. The next stage is to ensure sufficient expertise is available on the nursing bank.
- A monthly qualitative *Dementia Carers Survey* is undertaken to monitor carers’ perceptions of care. This work has been enhanced by feedback from Healthwatch

Bradford and District's focus group's conversations with carers of people living with dementia between November 2013 and January 2014.<sup>27</sup> A process to capture the experience of black minority ethnic groups within the monthly survey is under consideration.

- As dementia advances, it can cause behavioural changes which can be difficult for carers and family. In support of carers we:
  - Provide information boards related to the Butterfly Scheme on applicable wards;
  - Facilitate a ward based Carer's Resource Support Worker; and
  - Offer access to high quality health information for patients, carers (and staff) via the Patient Information Specialist. This includes publications from the Alzheimer's Society.
- Photographs of food menus have been piloted to help in mealtime choices.
- Protected mealtimes and the Red Tray system – which alerts staff that additional assistance is required – are amongst initiatives designed to promote nutritional intake.
- The feeding buddy scheme continues to support patient mealtimes with 20 volunteers (including staff members) on the rota. Family and carers are encouraged to visit and assist.
- Daily monitoring reports –underpinned by a SystmOne localised alert – to Matrons of the number of patients who require assistance to eat allows support staff to be assigned to those wards requiring greater assistance to help patients to eat and drink.

**Figure 1: Stacked bar chart of nutrition complaints by dementia diagnosis**



Data source: *Complaint Team Ulysses database*

It is important that we are able to monitor the effectiveness of these measures. Complaints provide valuable quantitative and qualitative information. There were two complaints involving nutritional matters in 2014/15, one of which involved a patient with dementia. In addition, slip, trip and fall and violence and aggression incidents are closely scrutinised to understand the effectiveness of training and environmental enhancements. In 2014, the Nutrition Nurse conducted pilot mealtime audits based on what are considered the 12 essential standards of good care for a positive mealtime experience in order to understand how consistently processes are followed: on one ward, ten standards were met; on a second ward, nine were met and on a third ward, seven were met. The standards include:

<sup>27</sup> The full report is available from Healthwatch at the following link:- [http://www.healthwatchbradford.co.uk/sites/default/files/ev\\_visit\\_19th\\_aug\\_final\\_report.pdf](http://www.healthwatchbradford.co.uk/sites/default/files/ev_visit_19th_aug_final_report.pdf) [Accessed 02/03/15].

- Have patients who require assistance been identified with a red tray?
- Have patients been made ready for their meal?
- Have bedside tables been cleared of items not conducive to mealtimes?
- Were any non-clinical duties carried out during the mealtime?
- Did all those requiring assistance receive this in a timely manner?
- Did food charts accurately reflect amount eaten?

### Initiatives in 2015/16 to achieve progress:

- Consideration of a finger food menu, allowing patients to graze; this has been shown to better suit some patients' dietary patterns.
- Finalisation of plans for afternoon tea parties" on Ward 4 to fully utilise social spaces. This is to be facilitated by volunteers.



- Consolidation of the Community Crisis Response and Prevention Team for Dementia with the aim to try to support patients in their home environment wherever it is safe to do so and facilitate timely hospital discharge. This is a multi-disciplinary team of Community and Mental Health Nurses, Occupational Therapists, Healthcare Support Workers and Dementia Support Workers.
- Accreditation as a dementia friendly organisation with the Dementia Action Alliance.

### *Improving the patient environment: Ward 4 case study*

*The outside garden area has been re-designed and a "reflections" room created, with comfortable furnishings. A reel of pictures from the 1950s is displayed on a loop to prompt recollection. A family room means that relatives and carers can spend longer periods of time and alleviate possible anxiety in their loved one.*

### **2.1.2 Priority 2 patient safety: reduction of slips, trips and falls sustained by patients admitted to our hospital wards**

**Lead Executive Director**  
 Rob Dearden, Director of Nursing  
**Clinical Lead and Implementation Leads**  
 Debra Fairley, Deputy Director of Nursing  
 Elaine Andrews, Assistant Director Patient Safety  
 Noel McEvoy, Senior Nurse Safeguarding Adults  
 Tracy Kershaw, Quality and Safety Lead

#### **Rationale and aim**

Whilst patients of all ages fall, the occurrence is greater in older people: one in three people over the age of 65, and half of those over 80 will fall each year.<sup>28</sup> For hospital inpatients the risk is compounded by factors such as delirium and cognitive impairment; medical diagnosis/condition which can be multi-factorial; disabilities for example, poor eyesight, hearing and mobility; and other problems associated with continence. Slips, trips and falls are collectively our most reported patient safety related incident, a finding consistent across England.<sup>29</sup> With inpatient falls being a common cause of injury, pain, distress, delay in

<sup>28</sup> Department of Health [DH] (2009), *Falls and fractures: effective interventions in health and social care*. Crown copyright: COI for DH.

<sup>29</sup> NHS England (2014), <http://www.england.nhs.uk/ourwork/patientsafety/falls-prevention/> [Accessed 29/12/15].

discharge and loss of independent living, the effective management to reduce their number is an important priority. The Trust aims to demonstrate a year on year reduction in the number of falls sustained by inpatients. This is not without challenges: staff must continually balance duty of care with patient independence and rehabilitation.

## Process for monitoring progress

The multi-disciplinary Trust's Falls Management Steering Group co-ordinates the work to deliver a sustained reduction in falls. An overarching action plan is in place detailing key areas of focus: falls risk assessment, care and management of patients following a fall, discharge, patient and family information, equipment and training and education. Incident monitoring systems support measurement of progress; occurrences of slips, trips and fall events and the level of harm are reported and reviewed on a monthly, quarterly and annual basis at ward level through to Board. In the last 18 months, multi-disciplinary Missed Fracture Working Group and Head Injury task and finish groups were established to specifically address learning from incidents with an emphasis on education and training, national guidance and pathways or care. The annual position statement – *Falls within Airedale NHS Foundation Trust* - provides a summary of progress against this priority.

## Current status

**Table 1: Airedale NHS Foundation Trust rate of inpatient falls per 1000 bed days**

Fiscal year	Bed days* [Y]	Reported Falls [X]	Reported falls per 1000 bed days	*Reported falls resulting in fracture	Reported falls resulting in fracture per 1000 bed days
2014/15	109842	1203	11.0	25	0.2
2013/14	112289	1254	11.2	25	0.2
2012/13	113315	1287	11.4	15	0.1
2011/12	101078	1100	10.9	32	0.3
2010/11	123529	1197	9.7	25	0.2
2009/10	127983	1089	8.5	26	Not available
2008/09	128740	777	6.0	15	Not available

\*A bed day is a day during which a person is confined to a bed and in which the patient stays overnight in a hospital (OECD Health Data 2013. June 2013).

Data source: bed days – Airedale NHS Foundation Trust Information Services; patient safety incidents – Airedale Quality and Safety Team [Ulysses database].

### \*Methodology:

Bed occupancy is calculated from data from Wards 1,2,3,4,5,6,7,9,10,13,14,15,17,18,19,21, High Dependency, Intensive Care and Coronary Care. Supplied by the Trust's Information Services Department. Falls comparable with National Reporting and Learning System [NRLS] calculations are calculated as follows:

X= the total number of all patient falls reported in your hospital/unit in the most recent year for which data are available. Include falls in day units and outpatients.

Y= the total number of occupied bed days in your hospital/unit in the most recent year for which data are available, divided by 1000.

X divided by Y gives the number of falls per 1000 occupied bed days.

Taken from: *The Third Report from the Patient Safety Observatory, Slips, Trips and Falls in Hospital* (NPSA, 2007).

In evaluating our performance, it should be noted that the data is not adjusted for age or case-mix. The proportion of Airedale's population aged 75 and over is nine per cent of our admitted patients.<sup>30</sup> As explained, this is a vulnerable group with an increased likelihood of falling. With age comes an increased risk of developing osteoporosis, which in the event of a fall, increases the risk of sustaining a fracture.

<sup>30</sup> Yorkshire and Humber Public Health Observatory (2012), *Calculating catchments*. Available at: <http://www.yhpho.org.uk/> [Accessed 20/01/14].

All slips, trips and falls (including those that might be deemed a minor incident such as a graze) are included in the dataset. A sign of a strong safety culture is that whilst the rate of reported incidents should increase, the number of incidents resulting in severe harm should reduce. Of the 2014/15 inpatient falls: 14 resulted in a fractured neck of femur, eleven in other fractures and 17 in significant harm. The eleven other fractures relate to nine patients.

Based on incident reporting, in 2014/15 the overall proportion of Airedale General Hospital inpatient falls, against inpatient admissions was 1.96 per cent of which falls resulting in fracture was 0.04 per cent. (This compares to 2.09 per cent in 2013/14 with 0.04 of these resulting in fracture.)<sup>31</sup>

Falling is not an inevitable part of ageing and we remain committed to safeguarding patients from this occurrence. All falls that result in significant injury (fracture, head injury) are considered as a serious incident. A two day information gathering process is instigated with a report then presented to the Medical Director and the Director of Nursing for consideration, including the remedial measures to prevent similar incidents. For those cases not deemed a serious incident, an internal root cause analysis is carried out; a standardised tool is used to support this process. Patients and relatives are kept fully informed of on-going findings. Information is aggregated with other similar episodes to maximise potential learning. The Trust's Safeguarding Adults Team is fundamental to supporting this process.

#### **Initiatives and progress in 2014/15:**

- The Trust's *Policy for the Prevention and Management of Slips, Trips and Falls for Patients* is subject to annual review, takes account of NICE guidance and encompasses community services. This appraisal included development of a:
  - Screening tool for all patients admitted to hospital to the risk of falling;
  - Integrated multi-factorial individual risk assessment into existing nursing documentation; and
  - Post fall review form with a focus on review of medications.
- Establishment of a multi-disciplinary Head Injury from Falls Task and Finish Group for falls, with a focus on head injury.
- Commissioning of a clinical audit of compliance with NICE guidance for head injury, originating from a cluster of incidents resulting in subdural haematoma. A re-audit was conducted in November 2014 with findings widely shared.
- Development of a Glasgow Coma Scale and vital signs action plan to improve nursing competency in the care of patients with a head injury. An e-learning package is available and training compliance is closely monitored. The Acute Care Team has supported this work.
- Inclusion of guidance for patients who suffer head injury in the *Essential Care of Inpatient Falls*.
- The Hospital at Night – H@N –iPod handover bleep escalation system now prompts medical review within 30 minutes for actual or suspected head injury.
- Implementation of an email falls alert to the Safeguarding Team for those patients who sustain a significant injury.
- A higher number of falls occur between the hours of 04.00 - 08.00. Environments have been changed so that satellite staff stations are placed along the sides of wards to bring staff closer to the patient with the aim of reducing safety incidents.
- Dementia friendly refurbishments are designed to promote patient safety: matt flooring minimises the risk of slips, trips and falls – shiny surface can be perceived as slippery. (See before and after changes opposite.)
- Establishment of a multi-disciplinary Frail Elderly Pathway Team in January 2014 to improve the co-ordination and management of care for older people. Composed of Physiotherapists, Occupational Therapists, Case Managers, Support Workers and a Senior Nurse, the team is based on the Acute Medical and Ambulatory Care Unit with ED in reach. The objectives are to: commence rehabilitation at the earliest stage to

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<sup>31</sup> Based on the inpatient admissions of 61,223 in 2014/15 and 59,867 in 2013/14.

optimise recovery; act as an interface with community teams to avoid unnecessary re-/admission; and provide integrated joined up holistic care and treatment.

- The Community Crisis Response and Prevention Team for Dementia (described in the preceding section) is a service designed to reduce the risk of secondary complications, including falls and fractures.
- Thirteen floor-level beds for patients at high risk of falling out of bed are being successfully utilized. An electronic hospital tracking system is available to support tracking.
- Monitoring reports are now requested to ensure bed (and chair alarms) for those patients at high risk of falling are available and functional.
- The Trust is an active member of the district wide Falls Pathway Development Group.



### **Initiatives in 2015/16 to achieve progress:**

- Continue to develop education and training in falls management and prevention for Registered Nurses, Allied Health Professionals and Health Care Support Workers, drawing upon the use of e-learning packages such as that developed by the Royal College of Physicians. Emphasis is on challenging attitudes away from the inevitability of falling.
- Undertake further audit to evaluate the recent ward refurbishments and the impact on falls reduction. This will involve analysis of the number of falls before and after changes.
- Enhance links with health, social care and voluntary providers to encourage continuity of care and services for patients who have fallen. For example, the Trust is working with the Yorkshire Ambulance Service to ensure that mobility aids used at home are transferred with the patient to hospital.
- Develop the Frail Elderly Pathway Team to include: six day week, review of extended hours, and greater focus on ED.
- In reach by Community Advanced Nurse Practitioners from the Collaborative Care Teams into the ED and Acute Medical Unit, focussing on patients presenting with frailty or falls who with benefit from intermediate care rather than hospital admission.



### 2.1.3 Priority 3 clinical effectiveness: *quality of healthcare for people with long-term conditions – telemedicine technology*

**Lead Associate Director**  
*Stacey Hunter, Director of Operations*  
**Implementation Lead**  
*Marie Buchan, Telemedicine Manager*

#### **Rationale and aim**

There is evidence to suggest that people, particularly those with long-term conditions, want to have control over decisions about their care, desire to live a normal life and do not wish to spend time in hospital unnecessarily.<sup>32</sup> Feedback from a series of engagement events as well as satisfaction surveys of patients and staff endorse this finding. Assistive technologies, such as telemedicine, can allow patients to manage their conditions and avoid time-consuming and costly trips either to hospital or outpatient clinics. An approach integrated around the needs of individual patients offers the potential for greater collaboration and efficiency across health and social care. Airedale's Telehealth Hub aims to care for patients closer to home whenever it is safe to do so; people with chronic illness can avoid emergency treatment and admission if their condition is well-managed.<sup>33</sup>



#### **Process for monitoring progress**

The multi-disciplinary and agency Telemedicine Operational Group is responsible for the delivery of this priority. Meeting monthly, the group monitors activity levels, the roll out of telehealth technology and reviews avoided admissions in those with long-term conditions. To provide a more complete understanding of quality, qualitative feedback is also considered. Monitoring is on-going both internally and externally to support assessment of the impact of the innovation and inform future initiatives and strategy.

Following on from an evaluation in 2013 of the impact of telemedicine on the use of health care resources for older people, Airedale NHS Foundation Trust asked the Yorkshire Health Economics Consortium to undertake further analysis in care homes, using a more substantial dataset. Results of a retrospective before and after observational study of 27 care homes with telemedicine were published in December 2014.<sup>34</sup> Post code data for people 65 and over was gathered on: non-elective admissions, ED visits and ambulance journeys for a period from July 2009 to July 2014. This was compared with similar post code data collected from care homes without telemedicine (although without an obvious before and after measure) for the period February 2011 to July 2014. All care homes were in the Airedale Wharfedale and Craven locality.

Analysis primarily focused on: changes in activity (episodes) and healthcare costs. Results found that in care homes with telemedicine there was:

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<sup>32</sup> Department of Health (2011), *Whole System Demonstrator Programme*. Available from:- [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/215264/dh\\_131689.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215264/dh_131689.pdf) [Accessed 06/12/13].

<sup>33</sup> Dr Foster Intelligence (2013), *Dr Foster Hospital Guide 2013*. Dr Foster Limited. p.10.

<sup>34</sup> York Health Economic Consortium, *Airedale NHS Foundation Trust, Evaluation of Telehealth Interventions for Care Homes in Airedale, Wharfedale and Craven* [December 2014], page iv.

- a reduction in non-elective admissions of 37 per cent compared to the same period before its introduction; this equates to a 39 per cent reduction in healthcare costs; and
- a reduction in ED visits by 45 per cent .

In those care homes without telemedicine there was:

- a reduction of 32 per cent in non-elective admissions; this equates to a 31 per cent reduction in healthcare costs after November 2012 compared to the equivalent period before; and
- a reduction in ED visits by 31 per cent.

The authors conclude that whilst an effect in non-elective admissions and ED visits is observed, a similar, if less striking result, is discernible in the care homes without telemedicine. There are known limitations in this type of study design as well as challenges in gathering and analysing the available data. The authors could not be certain its control or comparator group (the care homes without telemedicine), *“had similar numbers, demographic and disease profiles to the residents of the care homes with telemedicine.”*<sup>34</sup> Factors, other than the telemedicine intervention may be responsible for the changes observed. It is difficult therefore to make inference from this study and the Consortium recommend a prospective, matched care home study.

### Current status

As previously described, there are currently across Airedale, Wharfedale and Craven, six patients with chronic heart failure, 40 patients living with chronic obstructive pulmonary disease (COPD) and 25 patients with diabetes who have secure access, via a set top box, to the Telehealth Hub at Airedale General Hospital. A new initiative in 2014 for patients living in the Craven locality with long-term conditions – COPD and heart failure – will see 65 iPads rolled out in support of multi-way contact. In addition 30 iPads have been deployed in the homes of those who are near end of life. The Hub is staffed 24 hours a day, seven days a week (24/7), by highly skilled Senior Nurses. In the last twelve months, the team has developed to include Acute Care, Urgent Care and District Nurses, Fall Practitioners and Occupational Therapists. If required, escalation to a Consultant is available. Via the Hub, the team are able to offer medication advice, can review on-going clinical observations. Access to the SystmOne GP record has made available care plans and patient medication information in support of clinical decision-making. It also means a patient’s GP is kept apprised of consultations. If a patient needs to come to hospital, staff can communicate with the ambulance service to ensure a direct admission to the Medical Assessment Unit. The Hub regularly receives in excess of 300 video calls each month from patients in their own homes as well as nursing and residential homes across England.



A new Intermediate Care Hub (IC\_HUB) went live in November 2014. Intermediate care describes the care needed when a patient is not ill enough for hospital treatment, but cannot cope at home following, for example, a stroke or the deterioration of a chronic condition. Based within the Trust’s Telehealth Hub, health and social care colleagues are provided with a single point of referral for adults needing rehabilitation, recovery or re-ablement care to support people to live independently again. Within

three weeks of operation, 187 referrals had been received with an average of 23 daily calls. As described in section 1.1, this is a joint health and social care approach, and the result of organisational and district wide integration work between: Airedale Wharfedale and Craven CCG, Bradford Metropolitan District Council, North Yorkshire County Council, the voluntary group, Carers’ Resource, and Airedale NHS Foundation Trust.

In 2012/13 we reported that the Trust secured a three year grant from the Health Foundation Shared Purpose Programme to enhance the experience of end of life patients through the use of assistive technologies. The Gold Line service provides a single point of contact for patients and their carers to be able to access 24/7 help and advice via the Hub. The initial pilot commenced in November 2013 across Airedale, Wharfedale and Craven and was extended to the remainder of the Bradford district and its metropolitan populations in March 2014. A combined total of approximately 850 patients are registered and there are in excess of 400 telephone calls each month. The pilot is being independently evaluated – quantitatively and qualitatively – by the University of Bradford. The Gold Line service is as much about the carers as it is for the patients; the pressure and stress in these circumstances can be overwhelming and the Gold Line can be a source of emotional support. The following is used with permission.

### ***Patient Story - Sarim and Samina***

*Sarim looks after her mother, Samina who is terminally ill. Sarim tends to ring the Gold Line whenever there is a symptom change, if Samina won't settle or if she becomes agitated. The Gold Line Nurse recognised that the calls were more about Sarim's own fears about her mother's condition. The Nurse would advise remedies for the changed symptoms such as providing warm water with peppermint for cramps in the tummy, or to move Samina on to her side. There were several calls of this nature, but it has never, as yet, been necessary to call out the GP or the community team or admit Samina to hospital.*

*Sarim continues to ring the Gold Line for a chat to be given reassurance she is doing the right thing, sometimes just for a couple of minutes to make sure the Gold Line is still there if needed.*

*"I don't know what I would have done without you."*

*Source: Board of Directors' Meeting April 2014.*

### **Initiatives and progress up to 2014/15:**

- Over 5000 nursing and residential patients are linked to the Telehealth Hub; this compares to 1000 in 2012/13.
- There are now 37 nursing and residential homes across the Airedale, Wharfedale and Craven district using this technology – this compares to a total of 17 in 2012/13 – with a further 49 homes live in the Bradford area.
- Calderdale and Huddersfield Foundation Trust has commissioned Hub access in support of 18 nursing homes across its locality.
- In East Lancashire there are 25 nursing and residential homes accessing our services with work being undertaken with several other homes.
- Areas with care homes access to the Hub include: Cumbria, Coventry, Rugby, Dartford, King's Lynn, Lincoln and Rochdale.

### **Initiatives in 2015/16 to achieve progress:**

- Develop an initiative to provide GP triage Monday to Friday for the homes across the Pendle locality.
- Relocate to a new Telehealth Hub site within the hospital to enable growth of services.
- Support the "Right Care" outpatient work stream by facilitating new models for delivery of clinics.
- Extend and develop the IC- Hub to include: 24/7 collaboration, mapping of the patient journey and evaluation of data to support patient outcomes and resource allocation.
- Forge relationships with Bradford District Care Trust to explore the opportunities and understand the risks in bringing telehealth to mental health patients.
- Continue to monitor patient feedback and satisfaction regarding the telemedicine service.

## 2.2 Statements of assurance from the Board

The following statements serve to offer assurance that the Trust is measuring clinical outcomes and performance, is involved in national projects aimed at improving quality and is performing to essential standards.

### 2.2.1 Review of services

*During 2014/15 Airedale NHS Foundation Trust provided and/or sub-contracted 76 relevant health services [as per Monitor's Provider License].*

*Airedale NHS Foundation Trust has reviewed all the data available to them on the quality of care in 76 of these relevant health services.*

*The income generated by the relevant health services reviewed in 2014/15 represents 90 per cent of the total income generated from the provision of relevant health services by Airedale NHS Foundation Trust for 2014/15.*

### 2.2.2 Participation in clinical audits and national confidential enquiries

Clinical audit measures the quality of care and services against agreed national and local standards and recommends improvements where necessary. National confidential enquiries into patient outcomes and death are conducted by specialists with the aim of improving patient care and safety.

*During 2014/15, 36 national clinical audits and 5 national confidential enquiries covered relevant health services that Airedale NHS Foundation Trust provides.*

*During that period Airedale NHS Foundation Trust participated in 89 per cent of national clinical audits and 100 per cent of national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.*

*The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust was eligible to participate in during 2014/15 are as follows: see table 2 and 3.*

*The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in during 2014/15 are as follows: see table 2 and 3.*

*The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in, and for which data collection was completed during 2014/15, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.*

**Table 2: National clinical audits undertaken by Airedale NHS Foundation Trust**

Ref.	Title	Applicable to ANHSFT	ANHSFT participation	Per cent eligible patients submitted
1	Elective surgery – knee replacement (Patient Reported Outcome Measures [PROM])	✓	✓	115
2	Elective surgery – hip replacement (PROM)	✓	✓	110.1
3	Elective surgery – hernia (PROM)	✓	✓	107.5
4	Acute coronary syndrome or acute myocardial infarction (MINAP)	✓	✓	100
5	Bowel cancer (NBOCAP)	✓	✓	100
6	Cardiac rhythm management (CRM)	✓	✓	100
7	Case mix programme (CMP) (care provided in intensive care)	✓	✓	100
8	Epilepsy 12 audit (childhood epilepsy)	✓	✓	100
9	Lung cancer (NLCA)	✓	✓	100
10	National prostate cancer audit	✓	✓	100
11	National joint registry (NJR)	✓	✓	100
12	Neonatal intensive and special care (NNAP)	✓	✓	100
13	Oesophago-gastric cancer (NAOGC)	✓	✓	100
14	Sentinel stroke national audit programme (SSNAP)	✓	✓	100
15	Diabetes (Paediatric) (NPDA)	✓	✓	100
16	Diabetes (Adult) (NDA) pregnancy	✓	✓	100
17	National chronic obstructive pulmonary disease audit programme (COPD)	✓	✓	100
18	Fitting child (care provided in emergency departments)	✓	✓	100
19	Mental health (care provided in emergency departments)	✓	✓	100
20	Older people (care provided in emergency departments)	✓	✓	100
21	Plural procedures	✓	✓	100
22	Falls and fragility fractures audit programme (FFFAP) (now incorporates National Hip Fracture Database [NHFD])	✓	✓	99
23	Elective surgery – varicose veins (PROM)	✓	✓	94.6
24	National emergency laparotomy audit (NELA)	✓	✓	92
25	National heart failure audit	✓	✓	87
26	Rheumatoid and early inflammatory arthritis	✓	✓	80
27	Inflammatory bowel disease (IBD) - Biologics	✓	✓	67
28	Patient information and consent (National Comparative Audit)	✓	✓	58
29	Severe trauma (TARN)	✓	✓	55.9
30	Adult community acquired pneumonia	✓	Underway	-
31	National audit of dementia	✓	Underway	-
32	Patient blood management in adults undergoing scheduled surgery (National Comparative Audit)	✓	Underway	-
33	National audit of intermediate care	✓	*	
34	National cardiac arrest audit (NCAA)	✓	*	
35	Diabetes (Adult) (NDA)	✓	x	
36	Diabetes (Adult) (NDA) foot care	✓	x	
37	Non-invasive ventilation - adults	N/A	Did not proceed	
38	Diabetes (Adult) inpatient	N/A	Did not proceed	
39	Congenital heart disease(CHD) (Paediatric cardiac surgery)	x	Not Applicable	
40	Coronary angioplasty	x	Not applicable	
41	Head and neck oncology (DAHNO)	x	Not Applicable	
42	National adult cardiac surgery audit	x	Not Applicable	
43	National vascular registry	x	Not Applicable	
44	Paediatric intensive care (PICANet)	x	Not Applicable	
45	Prescribing observatory for mental health (POMH)	x	Not Applicable	
46	Pulmonary hypertension (specialist centres)	x	Not Applicable	
47	Renal replacement therapy (renal registry)	x	Not Applicable	

Data source: Airedale NHS Foundation Trust Clinical Audit Department.

\* Not adopted by the Trust for 2014/15

### **Clarification for variation from 100 per cent submission rate:**

Ref: 1, 2, 3 & 23: There are known issues regarding participation rates for PROM data including: patients getting better, patients refusing surgery, cancelled operations (in these cases the pre-operative questionnaire may be counted but not mapped to an episode), coding issues, sub-contracting activity and the timing of questionnaires.

Ref 29: published data is based on the anticipated number of patients. This is a provisional figure.

Ref 35: on-going data extraction difficulties (primary/secondary care interface). Work is underway to resolve.

Ref 36: There has been a delay in the gathering and inputting of this data. An action plan to address this shortfall is in place.

**Table 3: National Confidential Enquiries (NCEPOD) undertaken by Airedale NHS Foundation Trust**

<b>Ref.</b>	<b>Title</b>	<b>Applicable to ANHSFT</b>	<b>ANHSFT participation</b>	<b>Per cent eligible patients submitted</b>
1	<i>Sepsis (National Confidential Enquiry into Patient Outcome and Death [NCEPOD])</i>	✓	✓	100
2	<i>Gastrointestinal Haemorrhage (NCEPOD)</i>	✓	✓	100
3	<i>Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)</i>	✓	✓	100
4	<i>Lower Limb Amputation (NCEPOD)</i>	✓	✓	100
5	<i>Tracheostomy Care (NCEPOD)</i>	✓	✓	100
6	<i>Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)</i>	x	Not Applicable	

Data source: Airedale NHS Foundation Trust Clinical Audit Department.

*The reports of 25 national clinical audits were reviewed by the provider in 2014/15 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.*

This is a sample.

### **Major Trauma: The Trauma Audit & Research Network (TARN)**

This audit is primarily aimed at large Trauma Centres. Local actions for improvement include the following:

- *New facilities in the cutting edge ED department, including new trauma transfer mattresses and badges to identify trauma staff.*
- *An increase in staff Advanced Trauma Life Support training.*
- *Improved collaborative working between the ED and Radiology departments to advance the accessibility and reporting of computed tomography (CT).*
- *Out-of-hours ED Radiographers undergoing training in CT head and neck trauma so that it can be performed by onsite radiographers within minutes, with a performance reporting target of 60 minutes.*
- *Review of trauma pathways at the Major Trauma Centre (Leeds General Infirmary) for local adoption.*

### **Severe Sepsis and Septic Shock**

The management of severe sepsis and septic shock in the Emergency Department continues to improve. It is important to ensure the timeliness of measuring vital signs and administering treatments. A local education programme is underway to raise recognition of the symptoms of sepsis amongst nursing staff. Increased clinical membership of the Sepsis Working Group is also being sought.

### *Epilepsy12 (Childhood Epilepsy)*

Good results were achieved overall. Local actions for improvement include the following:

- *An appointment of an Epilepsy Nurse. This has been agreed.*
- *Ensuring magnetic resonance imaging (MRI) is conducted where there are defined indications.*
- *Consideration of electrocardiogram (ECG) in children presenting with a first convulsive seizure.*
- *Development of documentation for advice on water safety.*

### *Patient Information and Consent for Infusion (National Comparative Audit)*

The numbers submitted to this audit are small. However, the results have highlighted the following areas for improvement:

- *Raise awareness regarding the use of patient information leaflets.*
- *Change the wording of the transfusion prescription chart regarding provision of the patient leaflet.*
- *Promote the Consent for Transfusion e-learning module as part of local training requirements.*

### *Sentinel Stroke National Audit Programme (SSNAP)*

Monthly stroke strategic meetings have been established to look at all aspects of stroke service delivery, including improvement indicators within SSNAP reports where outcomes fall below the national average.

### *Lung Cancer (NLCA)*

An overall improvement in data quality and clinical outcomes continues to be reported year on year. Although the audit has not made any specific local recommendations, a separate piece of work is underway to respond to the results of the *National Cancer Patient Experience Survey 2014*. Performance against *All cancers - 62 day wait for first treatment* continues to be closely monitored. Monthly performance reports to clinical teams are being introduced.

### *National Joint Registry (NJR)*

The Trust continues to achieve excellent results and no action for improvement has been identified.

### *Neonatal National Audit Programme (NNAP)*

The Trust scored well on temperature measurement, screening for retinopathy of prematurity and antenatal steroids for mothers. The breast feeding rates in preterm babies are variable. There are on-going plans to support breast feeding. Issues with data collection were highlighted: time of first consultation between parents and a senior doctor. The Trust has already identified this prior to the audit being published and actions have been implemented to improve the quality of data.

*The reports of 117 local clinical audits were reviewed by the provider in 2014/15 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.*

This is a sample.

### *Audit ID 13/6156: Speech and Language Therapy Record Keeping Audit*

*Aim:* To monitor compliance with both Trust and Royal College standards of record keeping and clinical decision making.

*Conclusions:* Overall the standard of Speech and Language Therapy record keeping is good, particularly in relation to assessment, problem identification and treatment planning. However there are elements which can be improved upon.

<i>Actions:</i>	<i>Outcome</i>
i Re-issue record keeping guidance and include a copy in the induction pack.	Complete
ii Staff to review record keeping as part of peer case review.	Complete
iii Use goal planning sheets to document and date the agreement of identified goals. Document as not applicable where appropriate.	In progress [Paediatric Speech and Language Service Team – complete.]

#### *Audit ID 14/6273: Malnutrition Universal Screening (MUST) Tool Re-audit*

*Aim:* To assess MUST scoring and nutritional care following the additional recommended training.

*Conclusions:* There is an improvement in the percentage of fully completed MUST scores. However, there remains scope for further progress. Nutritional care can vary between wards and this could be improved upon by the inclusion of a comprehensive nutritional care plan.

<i>Actions:</i>	<i>Outcome</i>
i Validation audits of MUST completion to be undertaken on all the wards; results to be fed back to Sisters and Matrons.	Complete
ii The Nutrition Nurse post to formally commence 1 <sup>st</sup> April 2015.	Complete
iii MUST training to continue on all adult inpatient areas and on the Haematology Oncology Day Unit.	In progress

#### *Audit ID 14/6300: Vancomycin audit*

*Aim:* To monitor compliance against standards adopted by the Scottish Antimicrobial Pharmacists Network. There are currently no England NHS standards.

*Conclusions:* Prescribing practice is good but the weight of patients on vancomycin is not always clearly displayed on the prescription chart.

<i>Actions:</i>	<i>Outcome</i>
i Develop and implement a Vancomycin prescription chart to be used in those patients requiring intravenous vancomycin	Document complete and going through the approval process
ii Provide clear guidance for Pharmacists in interpreting Vancomycin levels.	Document complete and going through the approval process

#### *Audit ID 13/6110: NICE Clinical Guidance 50 Acutely Ill Adults in Hospital*

*Aim:* To monitor compliance with NICE Clinical Guideline 50

*Conclusions:* Overall, the results of this audit were positive: 92 per cent of patients audited had clear written management plans as recommended by NICE. However, on occasion plans did not state which vital signs should be recorded or the frequency of monitoring required.

<i>Actions:</i>	<i>Outcome</i>
i Medical staff to be reminded that if deterioration occurs, a written management plan must be provided, and include: interventions, frequency of vital sign recordings and resuscitation status.	Complete
ii Ward staff to be reminded that vital signs should be recorded at least 12 hourly unless documented otherwise.	Complete

#### *Audit ID 14/6310: Airedale General Hospital Compliance with British Orthopaedic Association Standards for Trauma (BOAST) 7 Guidelines for Fracture Clinic*

*Aim:* To assess our current compliance with the new BOAST 7 guidelines.

*Conclusions:* The Trust is compliant on most points. The following actions have been agreed to address deficiencies.

<i>Actions:</i>	<i>Outcome</i>
i Chronic regional pain management plan.	In progress
ii Review of information sheets.	Complete
iii Extra post-weekend-on-call fracture clinics arranged.	Complete

#### *Audit ID 13/6160 Crash Trolley Audit*

*Aim:* To monitor compliance with crash trolley standards.

*Conclusions:* All crash trolleys were recorded as safe, although some required de-stocking.

<i>Actions:</i>	<i>Outcome</i>
i Improve and standardise portable suction	Complete
ii Add anaphylaxis kit	Complete
iii Rationalisation of drugs on the crash trolleys.	Complete

#### *Audit ID 13/6118 Paediatric Stabilisation Audit*

*Aim:* To establish whether stabilisation care service is provided in a timely fashion.

*Conclusions:* Timely transfer of patients to the Bradford Royal Infirmary Paediatric Intensive Care Unit is achieved. However, there are minor issues around the documentation of arrival times and airway management. A full set of vital observations are taken at the point of patient deterioration.

<i>Actions:</i>	<i>Outcome</i>
i Contact audit team regarding missing data.	In progress
ii Devise discharge checklist for deteriorating patients.	In progress

### **2.2.3 Participation in clinical research**

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same Doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. Research is a core part of the NHS, enabling it to improve the current and future health of the people it serves.

*The number of patients receiving relevant health services provided or sub-contracted by Airedale NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethics committee was 586.*

*Participation in clinical research demonstrates the commitment of Airedale NHS Foundation Trust to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes. National systems are being used to manage the studies in proportion to risk and the Trust is participating fully in the central sign-off process (CSP) for National Portfolio studies and has fully signed up to the Research Passport system.*

*Airedale NHS Foundation Trust was involved in conducting 83 clinical research studies across all specialties during 2014/15 of which 53 were on the National Portfolio.*

*There were 34 senior clinical staff participating in research approved by a research ethics committee at Airedale NHS Foundation Trust during 2014/15. These staff participated in research across 16 different medical specialties. The Trust is committed to expanding research into new specialties to improve the quality of care for our patients. The primary motivation for conducting research within the Trust is for the advancement of knowledge and promotion of evidence-based practice within clinical care. This is reflected in the number of non-commercial studies undertaken during 2014/15 which represent 95 per cent of the total.*

*As well, in the last three years, 20 publications have resulted from our involvement in National Institute for Health Research studies, which show our commitment to transparency and desire to improve patient outcomes and experience across the NHS.*

*Our engagement with clinical research also demonstrates the commitment of Airedale NHS Foundation Trust to testing and offering the latest medical treatments and techniques.*

## **Research in action: Focus4 Study – colorectal cancer study**

Chief Investigator: Dr Shazza Rehman  
Research Nurse: Sharron Parkinson  
Clinical Trials Co-ordinator: Ellie Waldon

*This is a programme of studies which aim to recruit patients with colorectal (bowel) cancer which is inoperable or that has spread elsewhere in the body. Patients will be offered the very latest treatments; this will involve biomarker testing of the original tumour specimens to determine the type of drug to be prescribed. Follow up will focus on how patients respond to these treatments.*

*Source: Airedale NHS Foundation Trust Research and Development Newsletter, July 2014.*

### **2.2.4 Use of Commissioning for Quality and Innovation framework**

Commissioners are responsible for ensuring that adequate services are available for their local population by assessing needs and purchasing services. A proportion of a provider's income is conditional on the achievement of quality and innovation as set out in the Commissioning for Quality and Innovation (CQUINS) payment framework.

#### ***Use of CQUINS payment framework***

*A proportion of Airedale NHS Foundation Trust's income in 2014/15 was conditional on achieving quality improvement and innovation goals agreed between Airedale NHS Foundation Trust, and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.*

*Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at: <http://www.england.nhs.uk/wp-content/uploads/2014/02/sc-cquin-guid.pdf>*

*As part of the drive to improve quality, an amount of funding to be paid to the Trust during 2014/15 for the delivery of services to our patients was dependent upon achieving a range of quality markers. This scheme (CQUIN) linked £2,857,848 of our funding to the delivery of the agreed quality indicators. [This is based on the indicative outturn value for 2014/15.]*

*During 2014/15 Airedale NHS Foundation Trust delivered CQUINs to the value of £2,433,370 to the satisfaction of our commissioners.*

*The monetary total of funding conditional to the delivery of agreed quality indicators in 2013/14 was £2,931,750.00.*

## 2.2.5 Registration with the Care Quality Commission

The Care Quality Commission (CQC) is the independent regulator of health and social care in England.

### **Statements from the Care Quality Commission**

*Airedale NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is without conditions. Airedale NHS Foundation Trust has no conditions on registration.*

*The Care Quality Commission has not taken enforcement action against Airedale NHS Foundation Trust during 2014/15.*

*Airedale NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.*

All CQC inspection reports are publically available at: <http://www.cqc.org.uk/directory/RCF>

## 2.2.6 Information on the quality of data

The Secondary Uses Service (SUS) is designed to provide anonymous patient-based data for purposes other than direct clinical care such as healthcare planning, commissioning, public health, clinical audit and governance, benchmarking, performance improvement, medical research and national policy development.

### **NHS Number and General Medical Practice Code Validity**

*Airedale NHS Foundation Trust submitted records during 2014/15 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data – which included the patient's valid NHS number was:*

*99.87 per cent for admitted patient care;  
99.97 per cent for out patient care; and  
99.33 per cent for accident and emergency care.*

*– which included the patient's valid General Practitioner Registration Code was:*

*99.83 per cent for admitted patient care;  
99.91 per cent for out patient care; and  
99.24 per cent for accident and emergency care.*

### **Information Governance Assessment Report**

Information governance (IG) ensures necessary safeguards for, and appropriate use of patient and personal information; the IG toolkit is a system which allows NHS organisations and partners to assess themselves against Department of Health information governance policies and standards. The assessment provides an overall measure of the quality data systems, standards and processes within an organisation.

*Airedale Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 71 per cent and was graded green.*

## **Clinical Coding error rate**

*Airedale NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during the 2014/15 by the Audit Commission.*

However, an independent statutory Clinical Coding Audit for Information Governance was undertaken during the reporting period and the diagnoses and treatment coding (clinical coding) error rates reported in that report were as follows:

Primary Diagnoses Incorrect 9.0 per cent;  
Secondary Diagnoses Incorrect 5.0 per cent;  
Primary Procedure Incorrect 4.9 per cent; and  
Secondary Procedure Incorrect 3.2 per cent.

The report stated that: *“The percentage of correct primary diagnoses, secondary diagnosis, primary procedures and secondary procedures sits comfortably within the recommended Information Governance level 2 target requirements with only the primary diagnosis being 4 per cent off achieving level 3 status”*. The report also stated that: *“The coding was found to be robust with good depth of coding and the majority accurately reflected the care the inpatients received”*.

Results for clinical coding should not be extrapolated further than the actual sample audited. The following services were reviewed in the sample: General Surgery, Respiratory/Thoracic, Trauma and Orthopaedic, Urology, Cardiology, General Medicine, Oral, Oral Maxillo Facial, Geriatric Medicine, Gynaecology, Gastroenterology, Rheumatology, Ophthalmology, Paediatrics, Acute Internal Medicine and Nursing.

Airedale NHS Foundation Trust will be taking the following actions to improve data quality:

- Review of the ratio of coding episodes per coder as activity increases year on year;
- Collaborate with Cardiology to review the clinical record to improve the interpretation of information for coding; and
- Undertake training in respect of the coding of female prolapse.

## 2.3 Reporting against core indicators

To provide a better understanding of comparative performance, the *Quality Account* includes a core set of statutory national quality indicators aligned with the Department of Health's *NHS Outcomes Framework* for 2014/15 and reflects data that the Trust reports nationally. The measures are robust, conforming to specified data quality standards and prescribed standard national definitions and is subject to appropriate scrutiny and review.<sup>35</sup>

To understand whether a particular number represents good or poor performance, the national average, outlier intelligence and a supporting performance commentary is included where available. *Unless indicated, the data source for the following indicators is the NHS Health and Social Care Information Centre (HSCIC). In line with national guidance, information for (at least) the last two reporting periods is provided.*<sup>36</sup>

*Domain 1 – Preventing people from dying prematurely*

*Domain 2 – Enhancing the quality of life for people with long-term conditions*

### 2.3.1. Summary hospital-level mortality indicator (SHMI)

#### **Rationale**

The SHMI is not an absolute measure of quality but is a useful indicator for supporting organisations to ensure they properly understand their mortality rates across services.

The SHMI is based on all primary diagnoses, with deaths measured which take place in or out of hospital for 30 days following discharge. The SHMI value is the ratio of observed deaths in the Trust over a period of time divided by the expected number given the characteristics of patients treated (where 1.0 represents the national average). Depending on the SHMI risk adjusted value, trusts are banded between 1 and 3 dependent on whether their SHMI is low (3), as expected (2) or high (1) compared to other trusts. Banding uses a 95 per cent control limit; there is a one in 20 chance that an organisation is an outlier.

The SHMI takes account of underlying illnesses such as diabetes and heart disease. By including a measurement of the potential impact of providing palliative care on hospital mortality, additional context to the SHMI value and banding is offered.

<b>Table 4: SHMI</b>	<b>Oct 12 - Sep 13</b>	<b>Jan 13- Dec 13</b>	<b>Apr 13- Mar 14</b>	<b>Jul 13- Jun 14</b>
	Pub: Apr 14	Pub: Jul 14	Pub: Oct 14	Pub: Jan 15
Airedale NHS Foundation Trust SHMI value	0.92	0.89	0.87	0.89
National average	1.00	1.00	1.00	1.00
The highest value for any acute trust	1.19	1.18	1.20	1.20
The lowest value for any acute trust	0.63	0.62	0.54	0.54
Airedale NHS Foundation Trust SHMI banding [2 = as expected; 3 = low]	2	2	3	2

<sup>35</sup> Definitions are based on Department of Health guidance, including the *NHS Outcomes Framework 2014/15 Technical Appendix*.

<sup>36</sup> To ensure consistency in understanding of these indicators, NHS England publishes a data dictionary for the quality accounts (see the *Quality Accounts* area of the NHS Choices website).

	Oct 12 - Sep 13	Jan 13- Dec 13	Apr 13- Mar 14	Jul 13- Jun 14
	Pub: Apr 14	Pub: Jul 14	Pub: Oct 14	Pub: Jan 15
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for Airedale NHS Foundation Trust	23.9	24.0	25.9	25.9
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level average for England	20.9	22.0	23.6	24.6
The highest value for any acute trust	44.9	46.9	48.5	49.0
The lowest value for any acute trust	0.0	1.3	0.0	0.0

### **Statement**

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

- Trust mortality data is submitted in accordance with established information reporting procedures.
- To date, the SHMI for the Trust has remained constant and not subject to significant variation. The Trust continues to view this in line with internal scrutiny of data quality.
- To assure the quality of information submitted, the Trust undertakes periodic audits of data quality including audits of the use of the palliative care code on discharge and when patients are deemed to have died with a palliative care code. The palliative care code indicates that the patient has had access to specialist palliative care services.
- SHMI data is provided through NHS Indicators and is formally signed off by the Medical Director.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:*

- Exhibiting notable practice: all mortality cases are routinely reviewed by a well-established, Consultant-led Trust Mortality Group, chaired by the Consultant Microbiologist. Themes and trends are highlighted and have led to demonstrable service quality improvements, including a focus on pressure ulcers, fluid balance and antibiotic prescribing and the development of a specialist Falls subgroup to improve the care of frail susceptible older people.
- Examining mortality risk during periods of high activity or raised areas of concern within speciality by means of a comprehensive review of corroborative data, discussion at the Clinical Specialties Assurance Committee and the specialty governance meetings.
- Holding periodic multi-disciplinary mortality meetings where all clinicians can learn from mortality events.
- Receiving SHMI performance at the Board and publishing trends in the quarterly public *Quality Improvement Account*.

## Domain 3 – Helping people recover from episodes of ill health or following injury

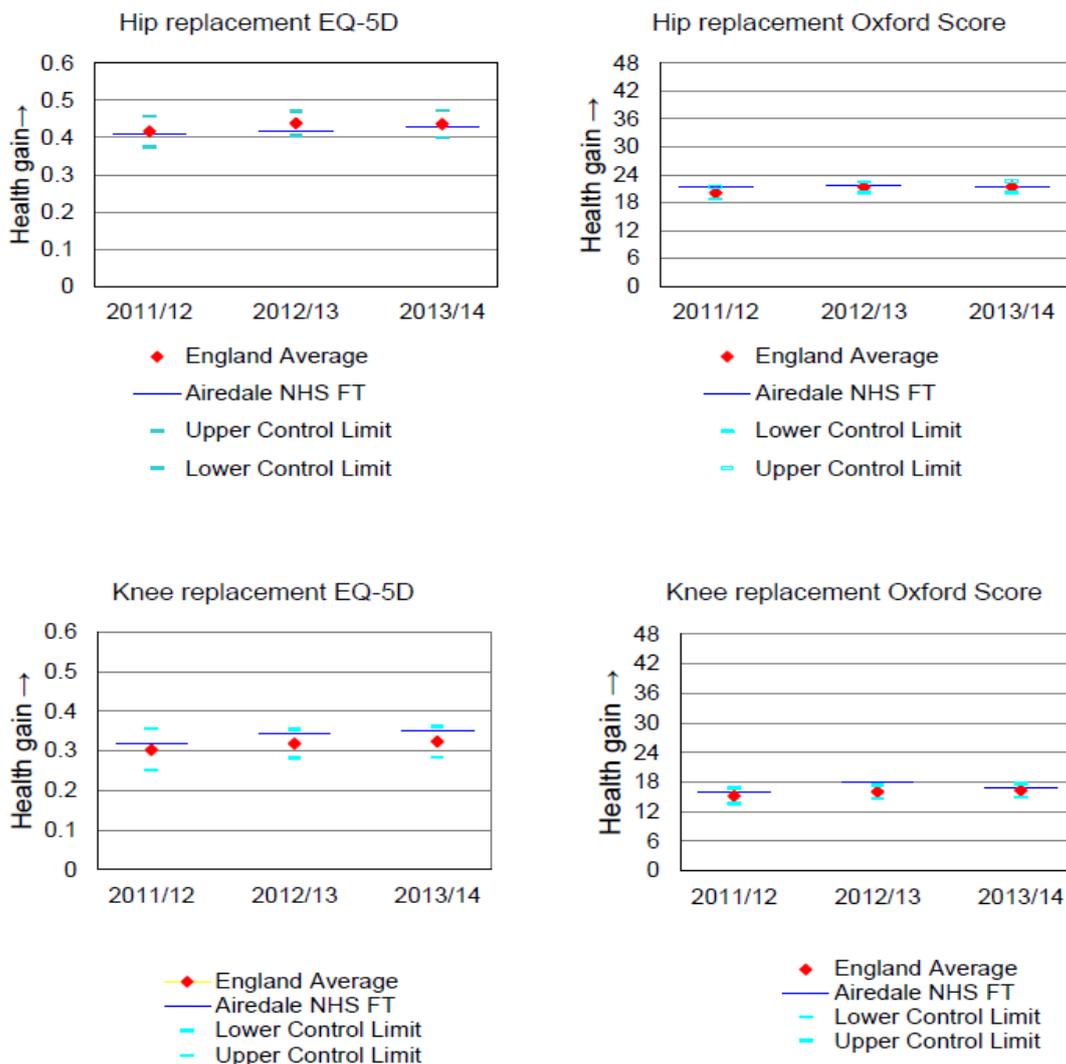
### 2.3.2 Patient Reported Outcome Measures (PROMS)

#### Rationale

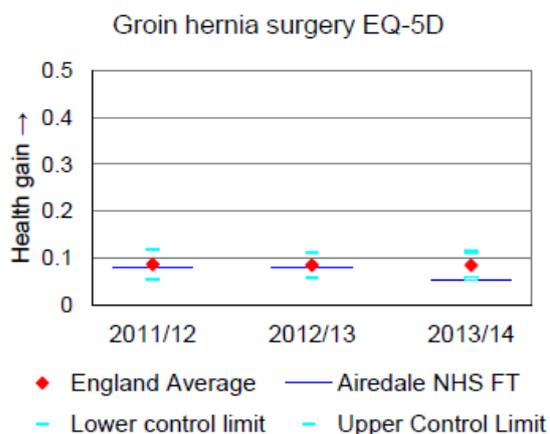
PROMs indicate patients' health status or health-related quality of life from their perspective, based on information gathered from a questionnaire that they complete before and after surgery. PROMs offer an important means of capturing the extent of patients' improvement in health following ill health or injury.

Airedale's adjusted average health gain is presented alongside the national average and control limits. An average adjusted health gain allows fair comparison as the demographics of the patient and level of complexity is accounted for. It is a measure of outcomes in the sense of how much a patient has improved as a result of the surgery. A high health gain score is good.

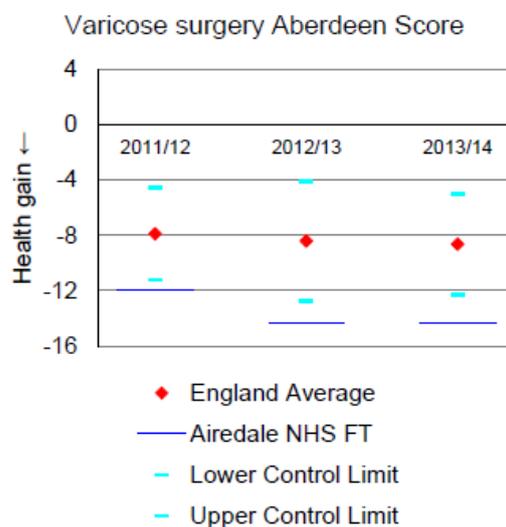
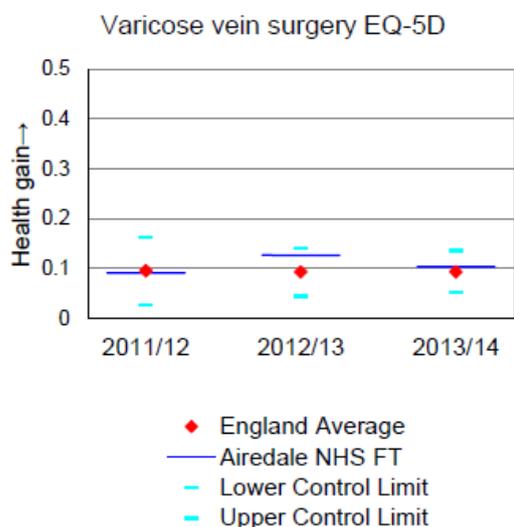
Datasets for 2013/14 are provisional and will not be finalised until August 2015. As in previous years, the 2014/15 dataset is not included as there is limited response data at this stage, particularly for hip and knee procedures where the post-operative questionnaires are not sent to Orthopaedic patients until six months after the procedure is carried out. The standardised EQ-5D measure is given as this applies to all elective conditions. However, this is less sensitive than condition specific measures and for a more complete analysis, the Oxford Score is provided for hip and knee replacement and the Aberdeen score for varicose vein surgery. Control limits are set at 95 per cent. A high health gain score is good.



The Trust is a positive outlier for the finalised 2012/13 knee replacement Oxford Score for average adjusted health gain.



For procedures such as groin hernia and varicose vein surgery, patients may actually feel worse than before the surgery e.g. from pain, mobility. As stated, the EQ-5D measure tends to be less sensitive than the condition specific measures.



Please note, in the Aberdeen Varicose Vein Surgery Score, the scale is reversed. A score is generated from the questionnaire whereby 0 is the best score (no evidence of varicose veins) and 100 is the worst possible. Therefore if the patient has improved following surgery, the health gain will be a minus number and the larger the minus number, the greater the health gain. Based on the data published in February 2015 for the 2013/14 fiscal year, Airedale is a positive outlier (outside of the upper control limit) . This is consistent with our performance in the two preceding years

## **Statement**

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

The Trust is outside the lower 95 per cent control limit for the 2013/14 EQ-5D average adjusted health adjusted measure for groin hernia surgery, but within the more cautious 99.8 per cent control limit. The dataset remains provisional. Case note review of two subsets within this group – those reporting further surgery on the affected area and those with better than expected health gains – has been undertaken by the Clinical Director. Although the sample size was small, a significant degree of recall bias/error was observed.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve the score and so the quality of its services, by:*

- Continuing to monitor our rate of participation for each procedure and, although we have less direct influence, response rates are similarly reviewed. The Trust continues to raise awareness of the importance of returning the questionnaires at pre-operative assessment and in the ward environment at discharge.
- Reviewing special interest topic features issued by the HSCIC, at local level to inform discussion: Directly Standardised Rates of Episodes (published November 2014); and Patient engagement with PROMs by demographic characteristics, procedure type and self-reported pre-operative health (published February 2015).
- Analysis of our own data extract from the HSCIC, notably the groin hernia surgery 2013/14 provisional dataset.
- The Trust continues to actively participate in review of its results and work with the HSCIC and others to understand the data in order to inform understanding of patient outcomes.

### 2.3.3 Percentage emergency re-admissions to Airedale NHS Foundation Trust within 28 days of discharge

#### Rationale

Whilst some emergency re-admissions following discharge from hospital are an unavoidable consequence of the original treatment, others could potentially be avoided through ensuring the delivery of optimal treatment according to each patient's needs, careful planning and support for self-care. The following is standardised to allow comparison with other organisations and is presented in age groups: 0 to 15 and 16 years and over. A low percentage score is good.

	2010/11	2011/12	2012/13
<b>Table 5: Emergency re-admissions</b>		Pub: Dec 13	
Airedale NHS Foundation Trust percentage 0 to 15 years	11.70	11.32	No update for 2012/13 is currently available from the HSCIC
National percentage average [England] 0 to 15 years	10.01	10.01	
The <i>highest</i> * percentage return by small acute trust 0 to 15 years	12.61	14.87	
The <i>lowest</i> * percentage return by small acute trust: 0 to 15 years	6.19	5.74	
Airedale NHS Foundation Trust percentage 16 years or over	10.30	10.04	
National percentage average [England] 16 years or over	11.43	11.45	
The <i>highest</i> * percentage return by small acute trust 16 years or over	12.69	12.69	
The <i>lowest</i> * percentage return by small acute trust 16 years or over	7.14	8.73	

\* The highest and lowest rates are taken from comparable trusts [small acute]. Indirectly age, sex, method of admission, diagnosis and procedure standardised per cent.

#### Statement

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

The figures presented are from the Health and Social Care Information Centre website and are derived from information provided by Airedale and other trusts. Elements of this information are subject to commissioner scrutiny and a variety of external audits.

The 2014/15 rate is not currently available from the HSIC. Using the methodology (see 4.6.3 for the technical detail), the Trust's Information Service has calculated the percentage of emergency admissions occurring within 28 days of the last and previous discharge from the Trust in 2014/15 (for all ages) as: 12.45%.

0 to 15 years: the re-admission rate is above average, but has fallen in the last (available) year. As part of Trust strategy to get patients home as soon as possible, we frequently discharge them and then offer open access. This allows the patient to be readmitted directly to the ward if the parents or carers feel there is any deterioration in the patient or if they are struggling with caring for the patient for any other reason. Clearly this will impact on the re-admission rate.

16 years or over: the re-admission rate is below average and has fallen in the last year. A number of actions have had an impact, including a target for urgent referrals to community of 95 per cent of patients being seen within 24 hours of discharge from hospital.

During the data collection period the Trust will have coded some of the patients attending the ambulatory care unit (ACU) as admissions. These would be patients who in the past would have been admitted to a hospital bed for treatment (for example, deep vein thrombosis, pulmonary embolism patients). The referrals (mainly from GPs) are now triaged by a Consultant who will assess suitability for ambulatory care instead of an admission. It is likely that in the data period 2011/12 and 2013/14 some of the patients attending ACU will have been classified as a re-admission if they had had an admitted spell within 28 days. Data collection changed in March 2015.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this percentage, and so the quality of its services, by:*

0 to 15 years:

- Consider the integration of “open access” into our ambulatory paediatric service, which we are currently developing so that patients can be allowed home without being formally discharged.

16 years or over:

- Medical re-admissions by Consultant are incorporated into performance metrics, circulated to colleagues and discussed at the monthly General Internal Medicine meeting. A similar process is in place within Surgical Services and provides the opportunity to discuss, understand the rationale and accuracy of clinical coding and ensure re-admissions are correctly captured on the Trust’s patient administrations system.

## Domain 4 – Ensuring that people have a positive experience of care

### 2.3.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients

#### Rationale

An organisation's responsiveness to patients' needs is regarded as a key indication of the quality of patient experience and care. The score for the inpatient setting is used in the *NHS Outcomes Framework* (indicator 4b: Ensuring that people have a positive experience of care).

This measure is based on the overall average percentage score for answers covering five domains: access and waiting; safe, high quality, coordinated care; better information, more choice; building closer relationships; and clean, comfortable, friendly place to be. The scores are presented out of 100 with a high score indicating good performance.

	2013	2014
<b>Table 6: Responsiveness to patient needs</b>	403	396
	replies;	replies;
	808	850
	surveyed	surveyed
Airedale NHS Foundation Trust overall percentage score	76.6	76.9
National percentage score	76.9	76.6

#### Statement

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

The Trust sample varies from year to year and difference in outcomes is to be expected unlike the national score which is, by definition, adjusted data. These factors should be considered when making comparison between years.

Improvements or deterioration of patient experience continue to be monitored via our real-time inpatient survey and Friends and Family Test so that remedial actions can be introduced in a timely way.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this score and so the quality of its services, by:*

- Monitoring of local and national patient survey results by the Trust's Patient and Public Engagement and Experience Operational and Steering Groups.
- Continued implementation of the Patient and Public Engagement and Experience Strategy with key focus areas of: access points to the organisation, "Right Care" training for staff and enhancing the experience of patients within urgent care.
- Listening and learning from patient experiences via the Friends and Family Test and the real-time inpatient survey and taking action where necessary.

### 2.3.5 The percentage of staff employed by, or under contract to the Trust during the reporting period, who would recommend Airedale NHS Foundation Trust as a provider of care to their family or friends

#### Rationale

How members of staff rate the care that their employer organisation provides can be a meaningful indication of the quality of care and a helpful measure of improvement over time.

The following is the percentage of staff that agree or strongly agree with the statement “*If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust*” and is based on the annual *NHS Staff Survey* (question 12d).

The scores are presented out of 100 with a high score indicating good performance.

Table 7: Staff recommendation	2012	2013	2014
	341 replies; 775 surveyed	1146 replies; 2480 surveyed	1047 replies; 2504 surveyed
	Pub: Feb 2013	Pub: Feb 2014	Pub: Feb 2015
Airedale NHS Foundation Trust percentage	67	73	69
National median percentage acute trusts [England]	60	64	65

#### Statement

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

The Trust’s response rate in 2014 is 42 per cent which is average for acute trusts in England and compares with a response rate of 46 per cent in the 2013 survey. The results of the 2014 *NHS Staff Survey* are less positive than our locally conducted *Staff Pulse Survey*. This appears to be due to more staff reporting a neutral response (neither agreeing nor disagreeing) in the *NHS Staff Survey*.

Overall staff engagement was 3.72 in the 2014 *NHS Staff Survey*, compared to 3.77 in 2013 and is below the average for acute trusts of 3.74. Possible scores range from one to five, with one indicating that staff are poorly engaged (with their work, team and organisation) and five indicating staff are highly engaged.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this score and so the quality of its services, by:*

In November 2014, the Trust published a *People Plan* with the aim of improving staff experience and supporting the “*Right Care*” portfolio. Actions in response to the 2014 *NHS Staff Survey* will be incorporated into the *People Plan*, as applicable, and include:

- Work pressure – this is a key element of the Trust’s “*Right Care*” portfolio, including service reviews and the development of new models of care. Workforce redesign will support staff health and well-being.
- Line management – the 2014 *NHS Staff Survey* indicates that an improvement is needed in the quality and consistency of line management. Line managers will be encouraged to attend *Line Management Essentials* training or *Skills for Great Line Management* with improvement monitored via the appraisal process.
- Building the confidence of non-clinical staff to speak up about unsafe clinical practice.
- Senior management communication with staff, embedding the “*Right Care*” communications plan and supporting senior managers with communications in teams.

- Addressing the different experiences of some staff groups, using listening sessions and focus groups sponsored at senior levels with action planning.

## *Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm*

### **2.3.6 Percentage of patients admitted to hospital and were risk assessed for venous thromboembolism (VTE)**

#### **Rationale**

VTE can cause death and long-term morbidity. According to NICE many cases of VTE acquired in healthcare settings are preventable through effective risk assessment and prophylaxis. A high percentage score is good.

<b>Table 8: Risk assessment for VTE</b>	<b>Apr-Jun 2014</b>	<b>Jul-Sep 2014</b>	<b>Oct-Dec 2014</b>
	Pub: Nov 2014	Pub: Oct 2014	Pub: Apr 2015
Airedale NHS Foundation Trust percentage	95.1	95.2	96.0
National percentage average [England]	96.0	96.0	96.0
The highest percentage return for any acute trust	100.0	100.0	100.0
The lowest percentage return for any acute trust	87.2	86.4	81.0

Source: NHS England.

#### **Statement**

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

- The Trust has maintained a consistently high standard of compliance with the national VTE risk assessment priority.
- Data is provided weekly to all managers and lead clinicians. Broken down by clinical area, this allows those which are under reporting to be identified and supported with improvement and restorative actions.
- The VTE risk assessment tool is embedded in the clinical areas and features prominently in clinical decision making, ensuring vigilance in completing risk assessments.
- Thromboprophylaxis prescription rates are benchmarked against other NHS providers, using data from the NHS Safety Thermometer. These compare favourably and indicate that clinicians are completing VTE risk assessments with appropriate VTE prophylactic measures.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this percentage, and so the quality of its services, by:*

- Continue to benchmark Airedale's performance against other providers in England and report on a monthly basis through the Trust dashboard.
- Regular discussion of VTE assessment data with clinical directors to educate and improve rates in all directorates.
- The Trust continues to embed the processes of root cause analysis for reported VTE with the dissemination of results to learn lessons and improve overall VTE care.

### 2.3.7 Rate of *C. difficile* infection per 100,000 bed days in Airedale NHS Foundation Trust patients aged 2 or over

#### **Rationale**

Hospital associated *C. difficile* can be preventable. There are issues around reporting cases of *C. difficile*, resulting from differences in the tests and algorithms used in the NHS for determining whether patients have a *C. difficile* infection. In March 2012, the Department of Health issued revised guidance on a new clinical testing protocol; this aims to bring about more consistent testing and reporting of cases of *C. difficile* infection.

The rate provides a helpful measure for the purpose of making comparisons between organisations and tracking improvements over time. A low rate is good.

<b>Table 9: Rate of <i>C. difficile</i></b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>
Airedale NHS Foundation Trust rate per 100,000 bed days	18.7	15.0	6.2
National average rate [England] rate per 100,000 bed days	22.2	17.3	14.7
The highest rate for any acute trust rate per 100,000 bed days	58.2	30.8	32.2
The lowest rate for any acute trust rate per 100,000 bed days	0.0	0.0	0.0

*Figures based on Trust apportioned cases for specimens taken for patients aged 2 or over.*

Source: Public Health England.

#### **Statement (please read in conjunction with section 3.2.1)**

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons:*

- The Trust has a rigorous diagnostic testing protocol to identify cases. All confirmed cases are monitored through internal processes and reported to Public Health England, Monitor and commissioners.
- Performance is reflective of: a robust antibiotic policy closely scrutinised by Pharmacy staff, high standards of staff and patient hand hygiene, environmental cleanliness and the continued vigilance and awareness of staff.
- Root cause analysis on all hospital acquired cases is undertaken to ensure opportunities to improve practice are identified and enacted.
- All cases are reviewed with Community Service staff to assess which are unavoidable.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:*

- Implementing further strategies during the forthcoming year, including:
  - Early detection of all cases;
  - Environmental monitoring and sampling;
  - The use of different antibiotic agents for patients with penicillin allergy; and,
  - Working with community colleagues through the Joint Infection Prevention and Control Strategy Group and the execution of NHS England guidance.
- Recruitment of a new Consultant Microbiologist.
- Implementation of changes to the Trust's antibiotic policy in relation to Orthopaedic surgery.

**Domain 5 - Treating and caring for people in a safe environment and protecting them from avoidable harm**

**2.3.8 Reported number and rate of patient safety incidents per 100 admissions reported within the Airedale NHS Foundation Trust and the number and percentage that resulted in severe harm or death**

**Rationale**

Patient safety incidents are adverse events where either unintended or unexpected incidents could have led or did lead to harm for those receiving NHS healthcare. Based on national evidence about the frequency of adverse events in hospitals, it is likely that there is significant under reporting. An open, transparent culture is important to readily identify trends and take timely, preventative action.

This indicator is designed to measure the willingness of an organisation to report incidents and learn from them and thereby reduce incidents that cause serious harm. The expectation is that the number of incidents reported should rise as a sign of a strong safety culture, whilst the number of incidents resulting in severe harm or death should reduce. (Severe denotes when a patient has been permanently harmed as a result of the incident.)

**Table 10: Patient safety incidents**

Apr 2014 – Sep 2014 [Issue: Apr 2015]						
	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 1000 bed days]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	2038	37.49	3	0.1	3	0.1
National position [acute non specialist n=140]	587,483	35.1	2168	0.4	683	0.1
The highest value [acute non specialist n=140]	12020	74.96	74	74.3	27	8.6
The lowest value [acute non specialist n=140]	35	0.24	0	0.0	0	0.0

Oct 2013 – Mar 2014 [Issue: Sep 2014]						
	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 100 admissions]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	2357	8.84	1	0.0	2	0.1
National position [small acute trust n=28]	61184	8.77	358	0.6	70	0.1
The highest value [small acute trust n=28]	3790	15.53	59	3.1	9	0.7

The lowest value  
[small acute trust n=28]

301

1.19

0

0.0

0

0.0

## **Statement**

*Airedale NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has in place:*

- The National Reporting and Learning System (NRLS) has changed cluster groups in the most recent release of data as well as the method used for benchmarking. Rate is now calculated by bed days for all acute non specialist trusts rather than per admissions by small acute trust. The re-calculated rate for the previous reporting period i.e. October 2013-March 2014, is 40.7. Whilst no national benchmark has been made available for the latter period, the Trust is above the median reporting rate and within the inter quartile range for all organisations in the period April to September 2014. Both returns indicate that we are unlikely to be under-reporting patient safety incidents.
- Consistent reporting of all patient safety incidents to the NRLS against each of the required six month periods.
- Due to issues with the Trust uploading process, the number of reported incidents is lower than the actual return for the period April to September 2014. (The manual uploading process has consequently been reviewed and strengthened.)
- An open and engaged culture to learn from incidents and improve the quality and safety of services, hence the lower than average number of cases of severe harm.

*Airedale NHS Foundation Trust intends to take /has taken the following actions to improve this rate, and so the quality of its services, by:*

- Maintaining and improving an open and transparent reporting culture, one which encourages all healthcare staff to report all incidents and adhere to the principles of the duty of candour.
- Full introduction of the on-line reporting model over the next year. This will enable staff to provide more accurate information and further streamline the process by ensuring that all incidents including near misses are reported in a timely and comprehensive manner.
- Promotion of attendance at training and education sessions/events in order to raise the awareness and importance of reporting and risk rating incidents by all staff, across the whole organisation.
- Identifying trends and themes that can be triangulated with other measures of quality and safety, to ensure that immediate actions and shared learning takes place for quality improvement.
- Acting on areas of concern, aimed at improving patient outcomes and shared learning across the Trust.

## 3 Other information

As well as the selected improvement projects detailed in section 2.1, the *Quality Account* takes the opportunity to outline other local priority work in the three areas of quality: patient experience, safety and clinical effectiveness. Metrics or measures are included and where possible, historical and benchmarking data is provided to support interpretation.

### 3.1 Patient experience

The Trust is committed to the principle that all patients and the public are treated as individuals with dignity and respect, that cultural and ethnic diversity are valued, and that vulnerable and hard to reach groups have equal opportunity to be fully involved in all aspects of their care.

#### 3.1.1 Privacy and dignity

**Lead Executive Director**  
*Rob Dearden, Director of Nursing*  
**Clinical Lead and Implementation Lead**  
*Noel McEvoy, Senior Nurse Safeguarding Adults*  
*Karen Dunwoodie, Patient Experience Lead*

In recent years, high profile reports and inquiries have shown a failure at individual and organisational level to deliver care with compassion and dignity. We care for people, often when they are at their most vulnerable, and it is important that we continually reflect on and challenge the way in which we, as a hospital and community, treat and care for our patients, their relatives, friends and carers.

A series of training initiatives encourage staff to reflect on how compassionate care can be embedded into practice. (See section **3.1.2** for an update on *Customer care training – “Right Care”*.)

Funded by Health Education Yorkshire and Humber, the Trust has worked with the University of Bradford to train 12 peer facilitators. This is in support of the national mandate for 80 per cent of patient-facing staff to receive foundation level dementia training by March 2018. Feedback suggests training is high quality and relevant, and the model sustainable. The approach recognises that e-learning is not always appropriate and instead utilises case scenarios to maximise its impact. *“It’s about good care, being decent, treating people as people. The training is so valuable.”*<sup>37</sup> Here, a Dementia Peer Facilitator reflects upon engaging with a dementia patient:



*“I walked into the bay (in the Coronary Care Unit) and I didn’t meet a 93 year old dementia patient who was aggressive and resisting care... rather I met [his younger self] Tom, a 29 year old joiner and Burnley Football Club supporter, who was worried about what was happening.”*

Source: *Dementia Peer Facilitator, Airedale NHS Foundation Trust.*<sup>37</sup>

SAGE and THYME training is designed to improve skills and confidence in supporting patients, relatives and carers in distress, including where an individual is near the end of life. Based on a mnemonic device, clinical and non-clinical staff are encouraged to hold back on

<sup>37</sup> Crossland J. and Collins L (2015), *The experience of the peer facilitator: confidence to cascade?* PowerPoint presentation at the Bradford Dementia Group, 5th January 2015.

giving advice, using a structured framework, in order to empower the person concerned to consider their own solutions.



**Setting:** create some privacy – sit down. “You seem upset – would you like to talk about it?”

**Ask:** “Can I ask what you are concerned about?”

**Gather:** gather all the concerns – not just the first few. “Is there something else?”

**Empathy:** respond sensitively. “You have a lot on your mind.”

**Talk:** “Who do you have to talk to or help you?”

**Help:** “How do they help?”

**You:** “What do you think would help?”

**Me:** “Is there something you would like me to do?”

**End:** summarise and close. “Can we leave it there?”

In the period June 2013 to December 2014, of the 315 clinical and non-clinical attendees, 98 per cent recommended training to others.

The following metrics have been selected to measure improvement in our patients’ experience. We know that there is some work for us to do to improve the quality of information provided for patients and their relatives, particularly around discharge planning. The metrics have been selected with this in mind.

**Table 11: Patient experience – performance against selected metrics at Airedale NHS Foundation Trust**

	2012/13	2013/14	2014/15
[Q66] Did you feel you were treated with respect and dignity while you were in hospital?	8.8	8.8	8.8
[Q50] Did you feel you were involved in decisions about your discharge from hospital?	7.1	7.0	6.9
[Q62] Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.9	5.8	6.2
[Q68] Overall, how would you rate the care you received?	7.8	7.9	8.0

Data source: Care Quality Commission National NHS In-Patient Survey 2014.

People are asked by the CQC about different aspects of their care and treatment. Based on these responses, trusts receive scores out of ten. A higher score is better.

**GREEN** = best 20 per cent performing trusts.

**AMBER** = trusts within the middle 60 per cent; about the same

**RED** = worst 20 per cent performing trusts.

In 2015/16 the following inpatient survey questions will be reported:

- [Q32] Were you involved as much as you wanted to be in decisions about your care and treatment?
- [Q33] Did you have confidence in the decisions made about your condition or treatment?
- [Q34] How much information about your condition or treatment was given to you?
- [Q66] Did you feel you were treated with respect and dignity while you were in hospital?
- [Q67] During your time in hospital did you feel well looked after by hospital staff?
- [Q68] Overall, how would you rate the care you received?

In recent years a number of estate refurbishment and development projects have been undertaken that serve to ensure that people are cared for in a modern hospital environment with privacy and dignity. The newly refurbished Ward 4 has specific facilities to enable families to stay with distressed and/or end of life patients, as does the Children’s Ward. A self-contained bereavement suite was a key feature of the 2013 upgrade of the Midwifery-led unit; similar provision is now available in the new ED to allow families and carers privacy in what can be a noisy and busy environment. In the coming year, it is planned to increase hospital car parking provision and access points, with a particular focus on those living with disabilities. The roll out of electronic smart boards in clinical areas will support confidentiality. Following patient feedback, Craven community sites – Skipton Hospital and Settle Health Centre – have been refurbished in the last twelve months with reception areas and clinical rooms now affording greater privacy for patients.

In June 2013, the Patient-Led Assessment of the Care Environment (PLACE) was introduced by the Department of Health and an assessment carried out. The aim of PLACE is to provide a snapshot of how an organisation is performing against a range of non-clinical indicators which impact on the patient experience of care: cleanliness; the condition, appearance and maintenance of healthcare premises; the extent to which the environment supports the delivery of care with privacy and dignity; and the quality and availability of food and drink. A second PLACE assessment was carried out in April 2014; results were published in September 2014. To ensure the needs and expectations of patients are met, an action plan detailing how we expect to improve our services, particularly in the area of privacy and dignity through the provision of internet, telephone, radio and television access, is being implemented.



**Table 12: Airedale General Hospital and Castleberg 2014 PLACE results compared to the England average**

Domain	Airedale General Hospital % score	Castleberg % score	National % average score
Cleanliness	98.74 ↑	99.06	97.25 ↑
Food	88.92 ↑	93.06	88.79 ↑
Privacy, Dignity & Wellbeing	84.72↑	79.29	87.73 ↓
Condition, Maintenance and Appearance	93.55 ↑	92.25	91.97 ↑

↑ Performance against 2013 returns. No audit of Castleberg was conducted in 2013.

Source: NHS England 2014: Health and Social Care Information Centre.

### 3.1.2 Creating a customer service culture

**Lead Executive Director**  
*Rob Dearden, Director of Nursing*  
**Clinical Lead and Implementation Lead**  
*Debra Fairley, Deputy Director of Nursing*  
*Karen Dunwoodie, Patient Experience Lead*

Research suggests that compassion declines the more staff are exposed to clinical practice.<sup>38</sup> To instil core values and challenge opposing attitudes, the Trust created its own customer care training module – “*Right Care*” – for clinical and non-clinical staff. The package refreshes key messages of who our customers – patients, carers, relatives – are and the importance of treating people as individuals. Training is aligned with line management standards, the NICE patient experience standard (QS15) and the *NHS Constitution*.<sup>39</sup> Drawing on the real experiences of patients, the training is supported by members of the Patient and Carers Panel. Examples of good and inadequate customer care form its basis with the objective to reinforce four principles of patient experience:

1. “*Through your eyes.*”
2. “*Making every contact count.*”
3. “*No decision about me without me.*”
4. “*The patient at the heart of everything we do.*”

A throw-away comment by staff can have a profound and resonating effect on a patient and make an already stressful situation, much worse. Being told you are “lucky” to have a quick referral appointment, after receiving a life changing diagnosis weighed heavily on one patient. Similarly, being greeted by doctors and nurses, along with a box of tissues, made another patient erroneously fear the worse. Conversely crouching down to talk at eye level was less intimidating to a patient as was being given a detailed explanation of what would take place – during an operation – and what to expect afterwards.

Patients and their carers must feel welcome and safe when receiving our care and services. Listening to particular groups can ensure that the patient journey is made easier and more comfortable. To understand the experiences of those with learning disabilities, a series of surgeries were held in 2014 with three learning disability groups. “*Freddy’s Story*” is now used as a teaching aid for nursing staff. Told from the perspective of a patient with learning disabilities, it seeks to highlight the difficulties faced in performing basic tasks like sitting, walking, eating and drinking. We continue to reflect on how to involve other groups – carers, relatives, older patients and the experiences of cancer patients – to understand where improvements can be made in the quality of our communication. In addition, the Learning and Development Department are working with a number of disciplines to explore in detail specific issues relating to communication and customer care to develop specific interventions and strategies. A further investment has been made in developing Customer Care Champions across the Trust with staff purposefully working towards a recognised customer qualification.

“*Right Care*” is supported by a series of initiatives developed in recent years to reinforce a culture of kindness, compassion, courtesy and respect. These include:

- *Dignity and Respect in Care* project (described in detail in the 2013/14 *Quality Account*);
- *The Patient and Public Engagement and Experience Strategy*;

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<sup>38</sup> Department of Health and National Commissioning Board (2012), *Developing the Culture of Compassionate Care*. London: Crown Copyright.

<sup>39</sup> Department of Health (2013), *The NHS Constitution*. Available from:- <http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution/Documents/2013/the-nhs-constitution-for-england-2013.pdf> [Accessed 20/01/14].

- “Right Care” - Nursing and Midwifery Strategy 2013 – 2015; and
- Monitoring via the real-time inpatient survey (a previous *Quality Account* priority).

As of March 2015, 2,654 staff, including community staff, had received an element of “Right Care” training, including community service teams. As well as the number of staff who have received “Right Care” training, the following are useful metrics to measure progress:

- In 2014/15 the number of times patients have had cause to formally complain about the attitude and behaviour of staff during the course of their experience of care and services was seven times: four complaints were raised regarding nursing staff, two medical staff and one allied healthcare professions.
- A number of complaints refer to the attitude and behaviours of staff. It is not always possible to identify staff, but where possible an apology is offered and individuals encouraged to reflect on their behaviour.



## 3.2 Patient safety

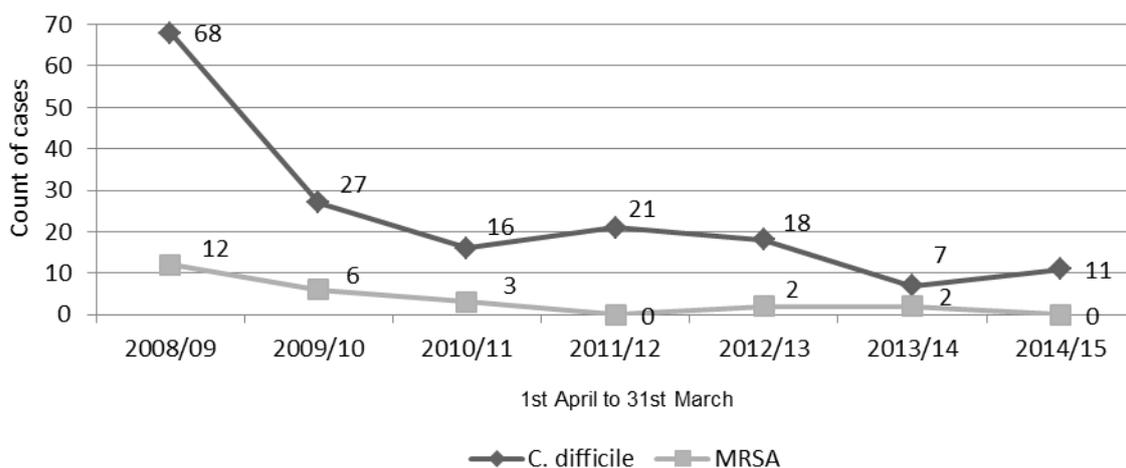
Together with the reduction of inpatient falls, infection prevention and the reduction in unavoidable pressure ulcers remain as specific areas of focus for the Trust for 2014/15.

### 3.2.1 Infection prevention

**Lead Executive Director**  
*Rob Dearden, Director of Nursing*  
**Clinical Lead and Implementation Lead**  
*Allison Charlesworth, Matron Infection Prevention*

Healthcare associated infections (HCAI) are infections that are acquired as a result of healthcare interventions. There are a number of factors that can increase a patient's risk of acquiring an infection, but high standards of infection control practice minimise the risk of occurrence (Health Protection Agency [HPA] 2013). This fiscal year the Trust reported no hospital acquired MRSA bacteraemia. Eleven *C. difficile* cases developed in hospital. Root cause analysis showed that seven of these were unavoidable. (Please also see section **2.3.2 Rate of *C. difficile*** which provides a national comparator.)

**Figure 2: MRSA bacteraemia and *C. difficile* cases at Airedale General Hospital in the last seven years**



Data source: Airedale NHS Foundation Trust Infection Prevention.



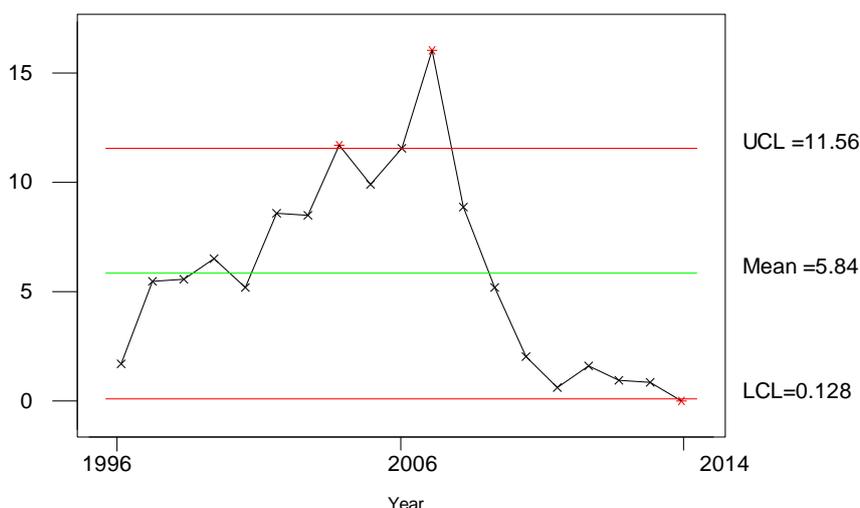
To prevent HCAI, we continue to monitor closely the rates of infection; strengthen infection control measures; and learn from best practice. Key measures include:

- Senior Sisters/Charge Nurses provide updates and assurance on measures implemented to reduce HCAI through the Infection Prevention Implementation Group.
- All hospital acquired MRSA, MSSA and Ecoli bacteraemia and *C. difficile* infections are subject to root cause analysis with learning points cascaded immediately to clinical teams.
- Infection alerts are in place on SystmOne to ensure staff are aware of patients with a history of MRSA, *C.difficile* and multi-resistant infections.

- Anti-microbial selection and usage is reviewed by the Antibiotic Pharmacist and Director of Infection Prevention; treatment choice is closely monitored as part of the analysis of *C. difficile* infection prevention.
- Environmental sampling continues to be carried out to establish if *C. difficile* can be detected in the immediate environment of patients with *C. difficile* infection.
- The district wide Infection Prevention Team and the Joint Infection Prevention Control Strategy Group continues to support an integrated approach to *C. difficile* prevention work.
- Systems are in place to identify patients at risk of carrying Carbapenemase producing Enterobacteriaceae (CPE) through exposure at other hospitals in prevention of further transmission.
- Executive hand hygiene walk rounds, led by the Matron for Infection Prevention, continue to promote compliance with “bare below the elbows” and hand hygiene guidelines.
- The monthly hand hygiene audit reports a Trust aggregated compliance average of 97 per cent for 2014/15. This is part of a robust and on-going infection prevention clinical audit programme.
- Quarterly newsletters are issued to maintain the profile of infection prevention. Topics in the last year have included: *C. difficile*, flu, CPE, Ebola and Norovirus.
- A peripherally inserted central catheter (PICC) and midline service has been introduced to provide patients with more appropriate intravenous access. Staff are being trained to care for and manage these devices.
- Domestic Services undertake routine cleanliness audits whilst the Enhanced Cleanliness Team maintains its work programme.

Rigorous efforts including hand washing, screening cultures to detect patients (and in some cases staff) colonised with MRSA and the use of contact precautions and alerts for colonised patients who are re-admitted all seek to help reduce the transmission of MRSA within hospitals. The Trust’s inpatient MRSA carriage rate remains low (reported as 0.03 in December 2014) and, as illustrated below, demonstrates a sustained downward shift in recent years. Sample size in 2014 was 321.

**Figure 3: Special process control chart of the relative frequency of Airedale General Hospital inpatients carrying MRSA 1996–2014**



Data source: Airedale NHS Foundation Trust Infection Prevention.

### 3.2.2 Management of pressure area care

**Lead Executive Director**

*Rob Dearden, Director of Nursing*

**Clinical Lead and Implementation Lead**

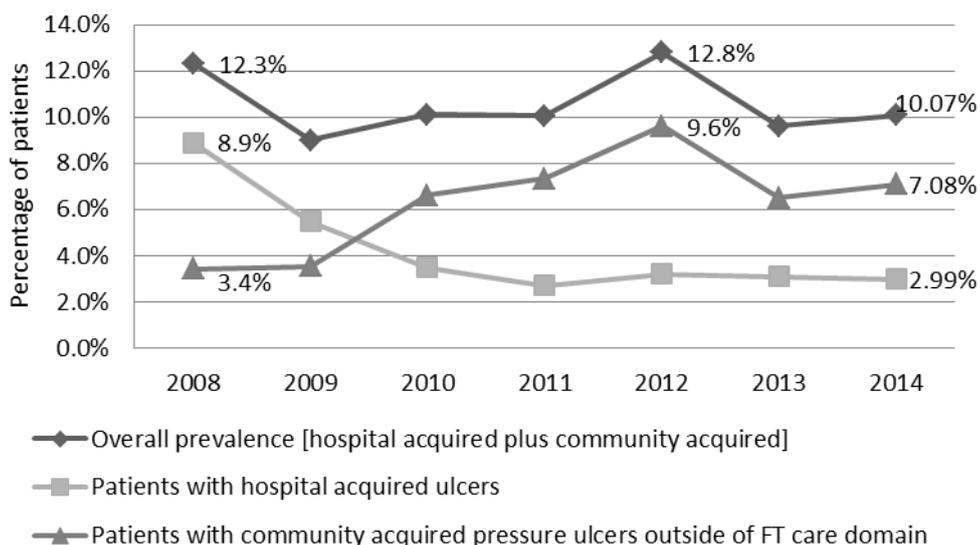
*Elaine Andrews, Assistant Director Patient Safety*

*Janine Ashton, Tissue Viability Nurse*

The prevention of hospital acquired pressure ulcers and improved treatment and management of acquired ulcers (both community and hospital) reduces the risk of associated complications such as infection, pain and disability, as well as reducing the length of hospital stay. Improved nursing care and management of pressure ulcers have resulted in a reduction in the prevalence of hospital acquired pressure ulcers from 8.9 per cent reported in 2008 to 2.99 per cent in 2014 as measured in the annual pressure ulcer audit conducted in November. Of an overall sample of 268, eight patients were recorded as having Trust acquired pressure ulcers. Of these, five had category 2 (superficial injury) and one patient had the most severe form of pressure ulcer (category 3, 4 or suspected deep tissue injury).

The Trust sees and treats a significant number of inherited pressure ulcers that develop outside of the clinical care of Airedale General Hospital or our community services: patients who are admitted from nursing homes, residential care or their own homes. Of the 27 (10.07 per cent) of patients with pressure ulcers, 19 patients (7.08 per cent) were admitted with tissue damage. Many of these may be considered largely preventable and represent a significant human and financial cost. Inherited pressure ulcers are followed up with the referring agency.

**Figure 4: Airedale NHS Foundation Trust pressure ulcer point prevalence 2008–2014**

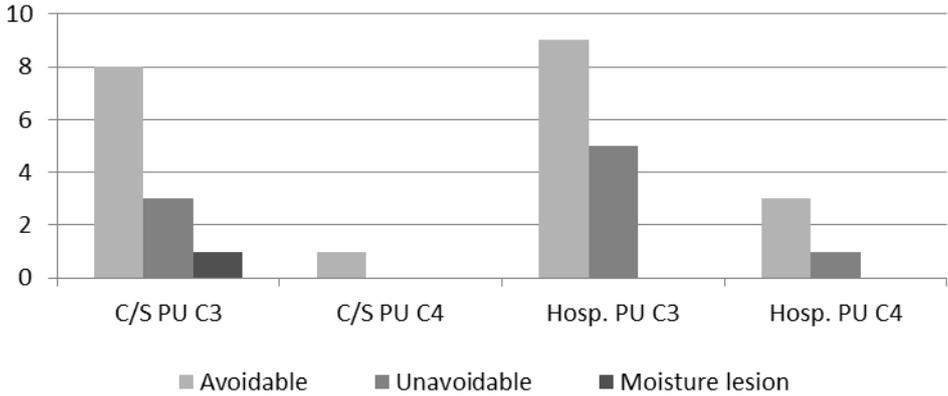


Data source: ArjoHuntleigh Getinge Group (2014) *Airedale NHS Foundation Trust Pressure Ulcer Assessment Preventative Care and Outcomes*

Between 1st April 2014 and 31st March 2015, there were: 32 category 3 and six category 4 pressure ulcers reported as developing in acute hospital care; and 17 category 3 and one category 4 pressure ulcer reported as developing within community services (C/S). The Trust has a robust incident investigation process to determine the root causes of significant pressure ulcers (category 3 and 4) acquired in hospital and within our Community Services. This is an on-going process with 31 reviews currently complete (as shown in figure 5). All key issues are investigated with learning and actions for improvement set out in an action plan which is monitored via the Trust's governance systems. Part of this process determines whether the pressure ulcer is preventable (avoidable) or inevitable in development

(unavoidable). The following figure illustrates the outcome of root cause analysis of category 3 and 4 pressure ulcers since March 2014; C/S includes Castleberg Hospital. Moisture associated skin damage or moisture lesions are defined as inflammation and erosion of the skin caused by prolonged exposure to a source of moisture, including urine, perspiration and wound exudate. Where a common theme in care or treatment is identified by the review, the Trust voluntarily refers itself to the local authorities' Adult Protection Team.

**Figure 5: Pressure ulcer review : root cause analyses of category 3 and 4 pressure ulcers (1st April 2014 to March 31st 2015)**



Data source: Tissue Viability Database.

The NHS Safety Thermometer, a national improvement tool used to monitor and analyse patient harm including that relating to pressure ulcers, has been embedded within the organisation over the last 18 months. A point prevalence tool, it surveys 100 per cent of in hospital patients and a sample of community patients one day per month, but, unlike incident reporting, records only the most serious category rather than each single incident. This can result in under reporting of prevalence. There is variation within the Safety Thermometer data which makes it unsuitable for like for like comparison. This is due partly to case mix and local interpretation of the measures which can vary from one collector to the next. Over the last twelve months returns have demonstrated a sustained downward trend in prevalence of pressure ulcers (categories 2 to 4), attributable to targeted quality improvement work.

A series of initiatives have been introduced in the past twelve months including: review of the pathway to prevent tissue damage under plaster casts; the development of a plaster cast core plan; introduction of off-loading technique training programmes to prevent pressure ulcer development to the heels. The Trust has employed a further Tissue Viability Nurse to support the promotion of pressure ulcer prevention. All inpatients with category 2 pressure damage are reviewed to ensure the correct preventative action is taken. The *Intentional Safety Care Bundle* has been adopted in the acute setting with accuracy of completion closely monitored.

The Trust continues to work with Airedale Wharfedale and Craven CCG in support of collaborative working with Bradford District Care Trust via a Project Group with the overarching aim of establishing a Tissue Viability in-reach model. A review of risk assessment tools has taken place to ensure consistency in approach. The CCG has funded three Pressure Ulcer Nurses to provide additional training, education and support to the nursing and residential care homes across the district. Working with the Pressure Ulcer Team, the Craven Virtual Ward Team Leader has introduced the community SKIN bundle into the residential care homes to avert pressure damage in care. Whilst access to equipment has been a persistent theme within Craven, Trust staff are working closely with the North Yorkshire equipment service provider and commissioners and the situation is improving.

### 3.3 Clinical effectiveness

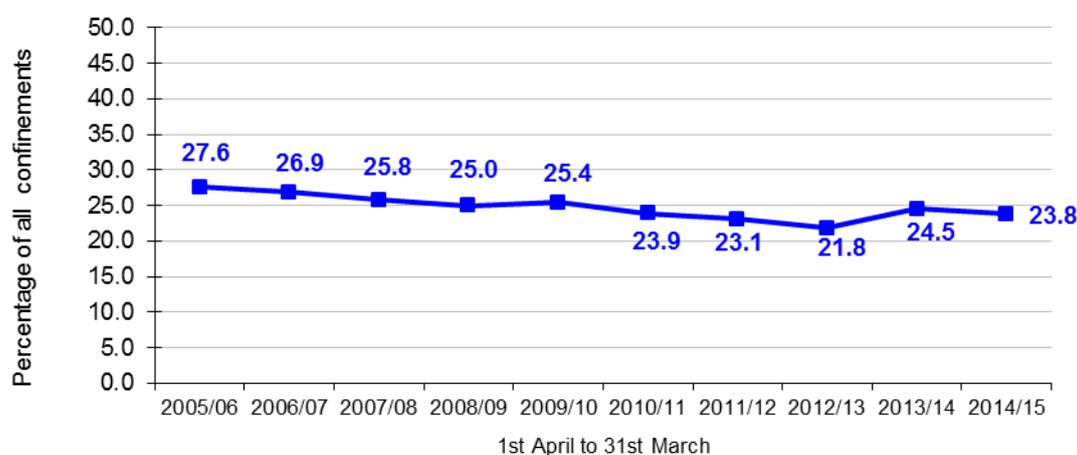
The following projects focus on the delivery of clinical excellence in care and treatment.

#### 3.3.1 Management of the number of caesarean sections

**Lead Executive Director**  
*Mr Karl Mainprize, Medical Director*  
**Clinical Lead and Implementation Lead**  
*Mr Stephen Porter, Clinical Director Obstetrics and Gynaecology*  
*Julie Hincliffe, Interim Head of Midwifery*

Work has continued within Maternity Services to reduce the number of caesarean sections over the last year. There are a number of risks associated with caesarean section, both for the mother and the baby, in the immediate and longer-term.

**Figure 5: Caesarean section rate for Airedale NHS Foundation Trust since 2005/06**



Data Source: *Evolution Maternity System.*

The latest England percentage of caesarean hospital deliveries has slightly increased to 26.2 per cent for 2013/14 with a national incremental trend in caesarean birth sustained. Although the Trust's overall caesarean section rate is below the national mean, analysis has identified that the elective section rate is above the England mean. It is important to point out that an elective caesarean is not an adverse outcome and in many cases is the most appropriate action to take to ensure that there is no preventable loss or morbidity. Case note review by senior staff shows adherence with guidance and recommendations surrounding elective sections. The Maternity Unit is committed to optimising opportunities for normal birth and to reducing intervention rates.

Initiatives and progress up to 2014/15:

The following build on the major investment in the birthing environment of the previous year.

- The bespoke Midwifery led Unit provides a homely environment. With access to a private outdoor space, it aims to offer a relaxing place to give birth. The Unit's primary focus is on normality and active birth from the onset of labour. The aim is to promote normal birth and a reduction in the number of interventions, including caesarean section. Both Medical and Midwifery staff are fully committed to this philosophy of care. At the time of this report, almost six per cent of all births occur in water with water labour rates increasing by over a third to 15 per cent of all births. Feedback from patient surveys and evaluations is positive.

- Women who have had one previous caesarean section for a non-recurring reason and who are not at increased risk of uterine rupture in labour are actively encouraged to aim for vaginal birth in the subsequent pregnancy. The service aims reduce the number of second caesarean sections through the implementation of the following:
  - Introduction of a Patient Decision Aid (PDA) to ensure that all women eligible for vaginal birth after caesarean section (VBAC) receive, and have the opportunity to discuss essential information upon which to base their decision about method of delivery. An audit of case notes in November and December 2014 shows that the PDA is embedded within the antenatal system.
  - Implementation of a Midwife led VBAC clinic in May 2014 to allow those women who are undecided about VBAC following discussion with an Obstetrician, to have a further opportunity to discuss all options prior to a final decision. Those women with tocophobia or extreme anxiety can be referred to the Healthcare Psychology Service.
  - Commencement in April 2014 of a new system of care, High risk antenatal care, low risk intrapartum care (HALO). This system allows women with antenatal risk factors, but no intrapartum risk factors to be cared for in labour by a Midwife on the Midwife led Unit, reducing the risk of obstetric intervention and offering the best opportunity for a vaginal birth.
  - External Cephalic Version (ECV) is offered to women with a baby in the breech position and for whom it is safe. At the time of this report, 25 women had attended for ECV in 2014/15.
  - Launch in February 2014 of the pilot community team, My Airedale Midwife (MAM), focused on delivering services and continuity of care-giver for vulnerable women, those requesting home birth and women who have had a previous caesarean. During this period the home birth rate rose from 1.1 per cent in the previous two years to 1.5 per cent of all births.

### 3.3.2 Enhanced Recovery Programme

#### **Lead Executive Director**

*Mr Karl Mainprize, Medical Director*

#### **Implementation Leads**

*Mr Chris Newman, Clinical Director Surgery*

*Mr Alex Acornley, Clinical Director Trauma and Orthopaedics*

*Mr Basit Khan, Consultant*

*Mr Stephen Porter, Clinical Director Obstetrics and Gynaecology*

*Miss Claire Murphy, Consultant Oncoplastic Breast Surgeon*

*Denise Todd, Matron Surgical Services*

*Nona Toothill, Clinical Nurse Specialist Urology*

*Denise Parker, Clinical Nurse Specialist Breast Care*

*Julie Blackburn, Senior Nurse Endoscopy*

*Phil Brown, Interim General Manager, Surgical Services*

Enhanced recovery is an effective way of improving the experience and wellbeing of patients who need planned elective surgery. Funded by the Department of Health and endorsed by the National Cancer Action Team, the principles of the Trust's Enhanced Recovery Programme are to ensure that patients are in a favourable clinical condition prior to surgery; they have optimal management during their operation; and have the best post-operative rehabilitation.

*The programme focuses on delivering key principles of care:*

- *Pre-surgery education diminishes anxiety and increases the knowledge and understanding of the patient.*
- *Admission on the day of surgery reduces length of stay.*
- *A standardised anaesthetic protocol helps pain management and recovery.*
- *Multi-professional patient records support the sharing of information and reduce risk of complications.*
- *Orthopaedic physiotherapy and occupational therapy is promoted to ensure effective rehabilitation.*
- *Criteria-based discharge: a checklist that helps to reduce error in the discharge process, reducing the risk to the patient.*
- *A telephone call to the patient in the 48 hours following discharge helps to reduce risk to the patient and re-admission to hospital.*

The Trust initially selected Orthopaedic and Colorectal clinical specialties to implement the programme. All Colorectal specialty patients are routinely entered onto the enhanced recovery pathway. Orthopaedic services have built on their successful implementation with a dedicated Orthopaedic Ward for the sole purpose of elective joint replacement surgery. An integrated service pathway is aimed at reducing infection and early supported discharge from hospital. Most patients can now expect to go home on average two days after their operation compared to the four days prior to this initiative.

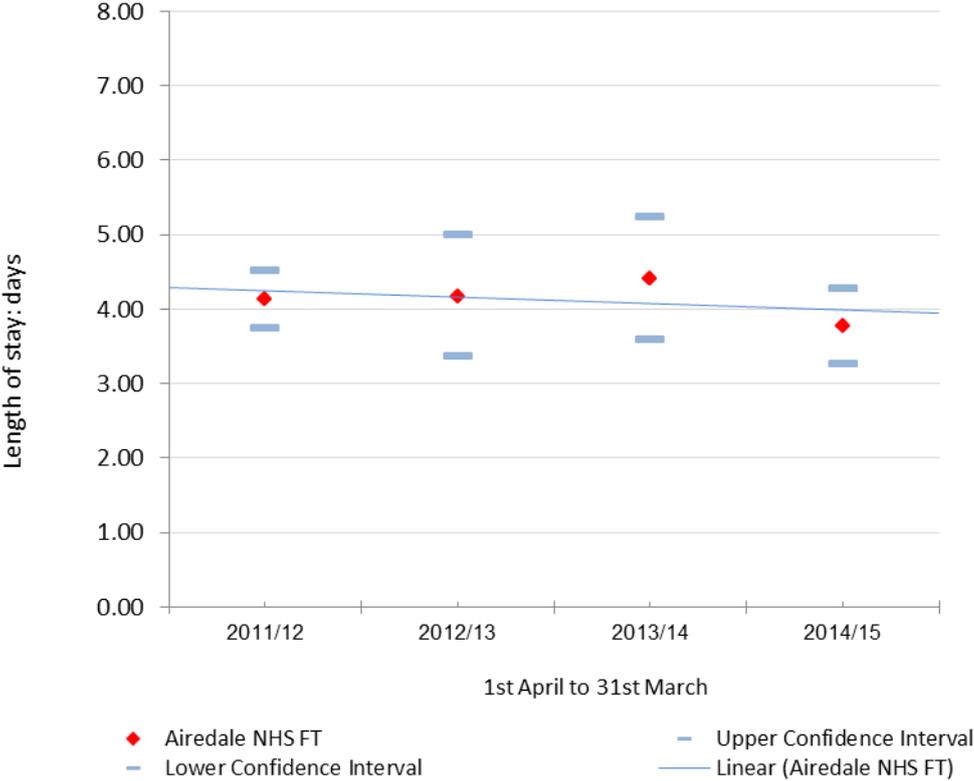
In 2011/12 the Enhanced Recovery Programme was successfully extended to Gynaecology whilst, more recently, the principles have been adopted in Urology and Breast surgery. In Urology, on some occasions, day surgery (laser treatment) is undertaken. Ward staff have had enhanced training to improve post-operative recovery and minimise complications. In most instances Urology patients are now being discharged a half to one day earlier.

Within Breast surgery, joint working with community teams and improved training has been spearheaded by the Clinical Nurse Specialist for Breast Care and underpinned by a revised integrated care pathway. In most circumstances and with the support of Community staff, breast care patients are now discharged half a day to one day after surgery, with a surgical drain in place. With the appointment of a Consultant Oncoplastic Breast Surgeon, day case Breast surgery has been introduced to meet the national standard of 23 hours discharge following mastectomy.

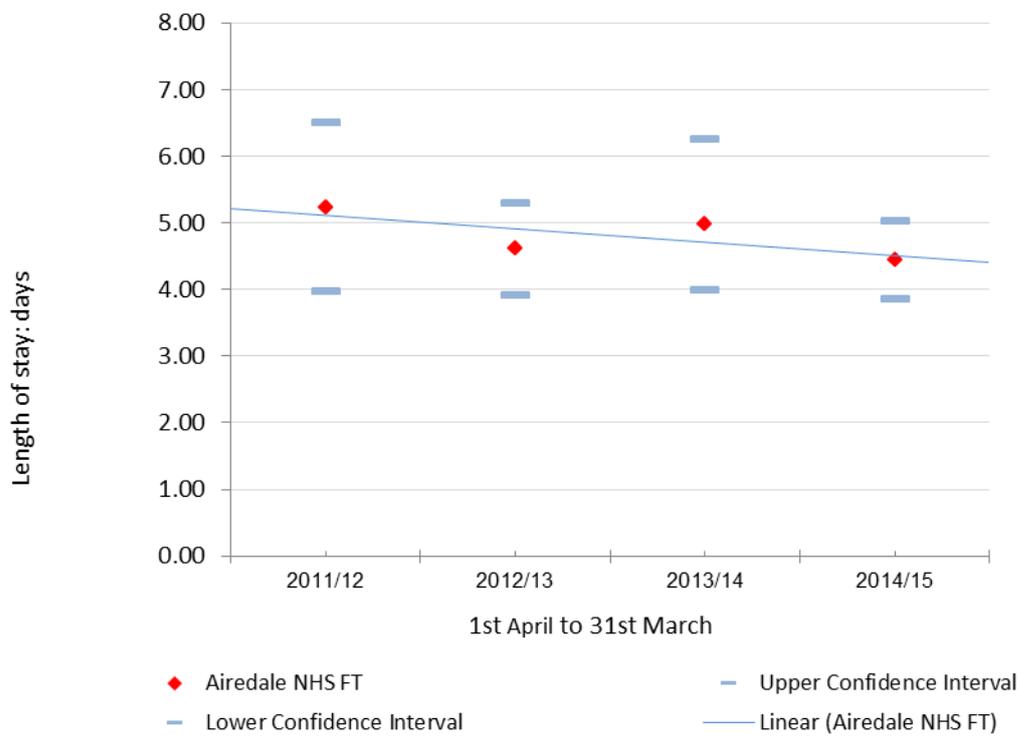
As previously described in 2013/14, the success of the programme, has led to its adoption within the Medical Division, specifically within the Cardiac Pacemaker Programme and Endoscopic Retrograde Cholangiopancreatography (ERCP). ERCP is a procedure that uses an endoscope and X-rays to look at the bile duct and the pancreatic duct. In the last year, the ERCP pathway has been reviewed in collaboration with the Radiology team. ERCP is now performed in the morning rather than the afternoon to improve patient experience. In the coming year, it is planned to introduce the programme to the caesarean section pathway within the Maternity service.

Overall a third of the patients going through the Enhanced Recovery Programme are discharged on the first day after their operation with the vast majority being home within two to three days. Figures 6 to 8 present the mean length of stay for joint replacement and abdominal hysterectomy at Airedale in the last four fiscal years. Confidence intervals are set at 95 per cent, meaning there is a one in 20 chance that the true value lays outside this range. Not all 2014/15 episodes are complete; the sample return covers the period April 2014 to January 2015.

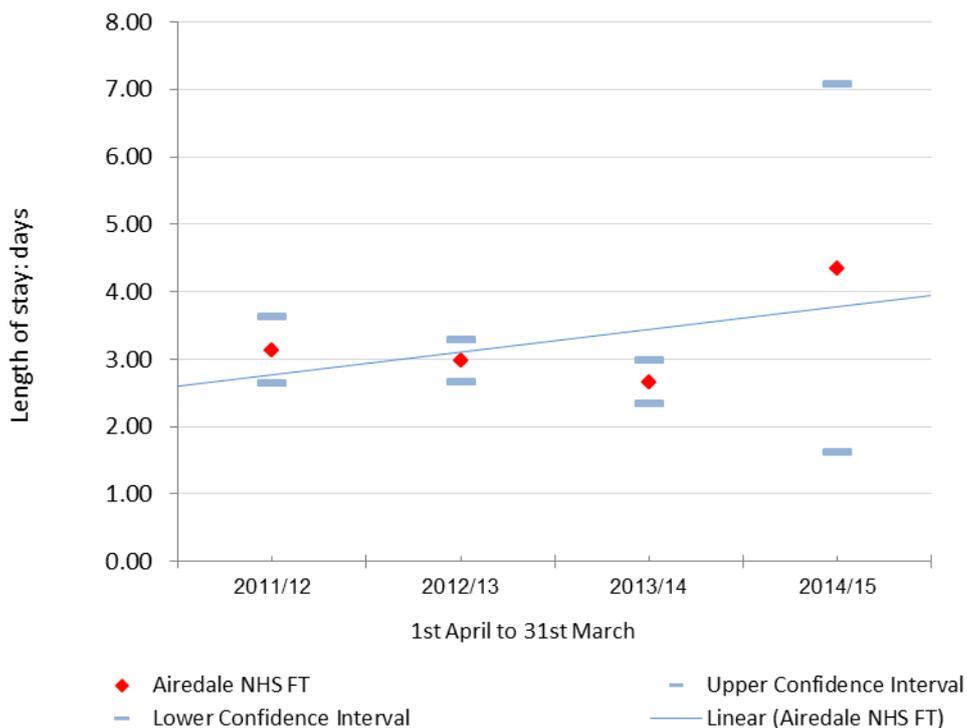
**Figure 6: Airedale NHS Foundation Trust hip replacement mean length of stay over the last four fiscal years with linear trend line**



**Figure 7: Airedale NHS Foundation Trust knee replacement mean length of stay over the last four fiscal years with linear trend line**



**Figure 8: Airedale NHS Foundation Trust abdominal hysterectomies mean length of stay over the last four fiscal years with linear trend line**



Data source: Airedale NHS Foundation Trust Information Services.

On average, there are between eight and thirteen abdominal hysterectomies undertaken each month. In December 2014, there were six procedures and of these, one patient with complex needs stayed for 21.25 days. As a consequence, the mean length of stay for December 2014 was 15 days compared to just over three days (95 per cent confidence interval 2.6 to 3.9) for the other nine months in the 2014/15 sample.

### **3.3.3 Fractured neck of femur improvement project**

**Lead Executive Director**

*Mr Karl Mainprize, Medical Director*

**Implementation Lead**

*Alex Acornley, Clinical Director Trauma and Orthopaedics*

*Mr Gethin Thomas, Consultant*

*Ian Segovia, Orthopaedic Nurse Practitioner*

*John Logue, Matron Critical Care Unit*

*Phil Brown, Interim General Manager, Surgical Services*



A broken hip, also known as a fractured neck of femur, is the most serious consequence of a fall, with the risk of occurrence increasing with age. According to NICE, the majority of fractured neck of femurs happen in elderly patients with osteoporosis; mortality is high although most deaths are from associated conditions and not the fracture itself.<sup>40</sup> For those who recover, there is a possibility of a loss in mobility and independence. Hip fracture is attributable to a number of factors (age, underlying conditions, sex and ethnicity), but research suggests that organisational factors in a patient's treatment can affect outcomes.

In the last year, the Acute Trauma and Elective Orthopaedic wards have benefited from the *Here to Care* dementia friendly upgrade. The Orthopaedic-Geriatric ward rounds continue. The multi professional disciplinary team support all Orthopaedic patients with the appropriate advice, rehabilitation services, aids and adaptations to promote mobility and independence both in and out of hospital. As described in the preceding section, the Enhanced Recovery Pathway continues to be successful with elective patients and we now use some of the principles in the care and treatment of Acute Trauma Ward patients. In the coming year our Orthopaedic Nurse Practitioner will undertake a period of training to enhance his skills to become an Advanced Nurse Practitioner. This will further strengthen the Orthopaedic team.

In 2014/15, 288 patients were diagnosed with a fractured neck of femur:

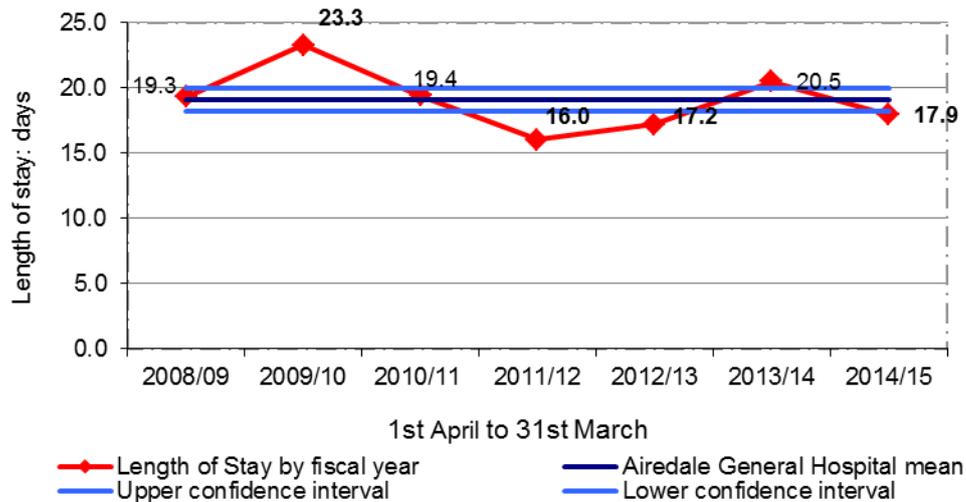
- 95 per cent were clerked in using the jointly agreed proforma;
- 75 per cent went to Theatre within 36 hours of presentation (it is thought that the maximum any one trust can achieve is approximately the 80-85% mark); and
- 90 per cent were seen by an Orthogeriatrician within 72 hours of presentation.

A further marker of the quality of care that patients receive is the total length of NHS care following a fractured neck of femur with a shorter length of stay associated with less risk.

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<sup>40</sup> NICE (2011), Hip Fracture. *The management of hip fracture in adults*. NICE clinical guideline 124. NICE: Manchester.

**Figure 9: Fractured neck of femur mean length of stay [day] for Airedale General Hospital patients over the last seven fiscal years**



Data source: Airedale NHS Foundation Trust Information Services.

The figure above describes our performance in the last seven years in the reporting period 1<sup>st</sup> April to 31<sup>st</sup> March: mean length of stay is 19 days with upper and lower confidence interval (of 95 per cent) ranging from 18 to 20 days. These intervals help to identify positive and negative special cause variation which falls outside the expected limits (an outlier) and support understanding of performance. The return for 2009/10 is classed as a negative outlier, meaning that the length of stay is worse than expected. In the subsequent five years, three returns – 2011/12, 2012/13 and 2014/15 – demonstrate better than expected performance with an average length of stay in the last year of 18 days. Between 1<sup>st</sup> January and 31<sup>st</sup> December 2013, the overall acute hospital mean length of stay for England was 19.8 days with trusts' performance varying from as little as nine days to as much as 39 days.<sup>41</sup>

<sup>41</sup> Royal College of Physicians (2014), *Falls and Fragility Fracture Audit Programme. The National Hip Fracture Database Extended Report 2014*. Health Quality Improvement Partnership.

### 3.4 Performance against key national priorities

The following indicators support the national priorities as set out in the Department of Health's *NHS Operating Framework 2014/15* and include performance against relevant indicators and performance thresholds set out in Appendix B of Monitor's *Compliance Framework 2014/15*. The return conforms to specified data quality standards and prescribed standard national definitions<sup>35</sup> and is subject to third party scrutiny and review.

Indicator	Threshold	2012/2013	2013/2014	2014/2015
Clostridium difficile – meeting the Clostridium difficile objective	9	18	7	4
All cancers: 31-day wait for second or subsequent treatment, comprising either:				
surgery	94%	100%	100%	100%
anti-cancer drug treatments	98%	100%	100%	100%
radiotherapy	94%	N/A	N/A	N/A
All cancers: 62-day wait for first treatment, comprising either:				
from urgent GP referral to treatment	85%	93.9%	89.8%	 90.2%
from Cancer screening service referral	90%	95.8%	94.1%	95.7%
Maximum 18 week waits from referral to treatment in aggregate – admitted	90%	93.1%	91.8%	90.0%
Maximum 18 week waits from referral to treatment in aggregate – non-admitted	95%	97.3%	95.9%	96.0%
Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway	92%	92.5%	92.6%	 92.4%
All cancers: 31-day wait from diagnosis to first treatment	96%	100%	100%	99.5%
Cancer: two week wait from referral to date first seen, comprising either:				
all cancers	93%	96.5%	97.8%	97.9%
for symptomatic breast patients (cancer not initially suspected)	93%	98.9%	98.4%	97.6%
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	95.9%	95.8%	95.6%
Data Completeness: Community Services comprising:				
Referral to treatment information	50%	100%	100%	100%
Referral information	50%	71.7%	99.9%	92.7%
Treatment activity information	50%	89.6%	92.6%	99.8%

Green = achievement against the target.

 = subject to third party audit by PriceWaterhouse Coopers on behalf of the financial regulator, Monitor. See page 68 for detail of data testing.

Data source: Airedale NHS Foundation Trust Information Services.

## 4. Annex

### 4.1 Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG)

The draft *Quality Account* 2014/15 was circulated to the Airedale, Wharfedale and Craven Clinical Commissioning Group and the following feedback received in May 2015:

  
**Airedale, Wharfedale and Craven  
Clinical Commissioning Group**

Millennium Business Park  
Airedale, Wharfedale and Craven CCG Col  
Station Road  
Steeton  
West Yorkshire  
BD20 6RB

19th May 2015

Dear Bridget,

#### **Airedale NHS Foundation Trust Quality Accounts 2014/15 Feedback from Airedale, Wharfedale and Craven CCG (AWC CCG)**

Thank you for sending through the Airedale NHS Foundation Trust (ANHSFT) 2014/15 Quality Accounts for review. AWC CCG has also shared this with our associate commissioning colleagues from East Lancashire, Bradford City and Bradford Districts CCGs and this letter reflects our collective thoughts.

Overall, the ANHSFT Quality Account provides a detailed, open and honest reflection on the activities undertaken throughout 2014/15. It shows clear evidence of continuous improvement in the quality of services delivered. The Account is comprehensive and clear to the reader and the design layout successfully links the quality agenda to the NHS Outcomes Framework. This provides an assurance to the reader that the national drive to improve quality is deeply embedded in the culture and overall direction of travel of ANHSFT.

Throughout the report, the use of statements and action plans provides in depth quality detail, resulting in an informative document.

AWC CCG support the priorities put forward for 2015/16 and notes good progress has been made against the priorities of 2014/15.

Patient experience continues to feature high in the Government's agenda. The use of 'Louise's story' within the document illustrates one example of a moving and powerful reflection of the challenges staff face and the professionalism and conduct displayed to ensure our patients are treated in a caring and compassionate manner whilst being fully informed in difficult and upsetting circumstances.

In a culture of being open, honest and transparent, it is commendable that the Trust has provided details of recognised failures within the organisation, such as communications with patients, and is addressing these to improve our patients' experience.

One area which is slightly misleading concerns the 'Home by 1pm' discharge arrangements. The reader assumes that this was introduced as a direct result of patients' concerns. Whilst this is true and patient feedback constantly tells us this is an issue, what the document fails to reference in this section is the AWC CCG CQUIN of 2014/15 'home by 2pm' goal and the subsequent failure to achieve this target. It is expected that this will feature as a high priority of the Trust going forward in 2015/16.

It is pleasing to note the enthusiasm of the Board members undertaking patient safety quality walk rounds. In order to highlight partnership working, it would have been advantageous to mention that the CCG Executive Nurse also conducts monthly quality walk rounds and shares these reports with the Trust to aid improvements and highlight good working practice.

Following on from this, other opportunities to demonstrate partnership working with external organisations have been missed. The Pressure Ulcer Steering Group is one such example, which develops initiatives to reduce pressure ulcer incidence with the CCGs, other NHS Trusts and Local Authorities.

Centred on a strong organisation is an effective workforce and it is pleasing to read that initiatives are in place, such as the Reward and Recognition scheme, to empower and value staff.

The Trust is to be congratulated on the transformational Telemedicine scheme. This has been nationally recognised and also features in the NHS England's Five Year Forward View. The evaluation has shown interesting findings in Care Homes with Telemedicine with a reduction of non elective hospital admissions and A&E attendances. It is, however, also acknowledged that as a result of additional developments introduced, we have seen a similar trend for those Care Homes without access to Telemedicine.

The CCG commends the Trust on being an 'Ambassador Trust' for the Butterfly Scheme and acknowledges the initiatives put in place throughout 2014/15 such as a 12 month seconded Nutrition Nurse and the Butterfly Support Team to provide one-to-one nursing for distressing or challenging behaviours. The CCG is pleased to see developments included for 2015/16 are in line with the 5 year forward view.

The Trust is an active member of the Falls Pathway Development group. Unfortunately there has not been a huge reduction in the number of falls in 2014/15 but a number of initiatives have been put in place such as the changing of satellite staff stations to bring staff closer to patients. The CCG recognises the continued development of education and training planned for 2015/16.

ANHSFT have conducted a number of clinical audits throughout 2014/15 with areas for improvement being addressed by the Trust.

ANHSFT have achieved 83% of their CQUIN schemes for 2014/15 with failure to achieve stretch targets of the Safety Thermometer and Friends and Family Test response rate of 40% for inpatients and 20% for A&E attenders. Dementia diagnostic assessments and A&E admitted patients >75 years known to have dementia also fell short of the 90% target. Integrated discharge CQUIN indicator to increase the number of discharges before 2pm was 26.4% against a trajectory of 35% at Q4.

Data quality targets on NHS Number and General Practice Code Validity were high with none falling below 99%. Information governance was rated green with an overall score of 71%.

Reported safety incidents rate per 1000 bed days is slightly above the national position although those resulting in severe harm is better than the national position at 0.1%. Unfortunately the Trust recorded a Never Event within Maternity Services and learning has been implemented resulting in a change to processes to prevent this happening again. The CCG acknowledges the Trust followed their Being Open policy throughout the investigation on this incident.

The CCG is pleased to note ANHSFT reported no hospital acquired MRSA bacteraemia during 2014/15. Equally pleasing are the Clostridium Difficile figures which remain within the trajectory of 9 for the year with 4 attributable to the trust.

The CCG recognise the commitment of ANHSFT to improving quality and ensuring a safe and effective environment. Overall, the Trust has had a very positive twelve months and there is very clear evidence of the continued commitment to improved quality of care for patients. We hope that you agree that this summary provides an objective review and is accepted in the spirit intended.

Kind regards



**Dr Phil Pue**  
Chief Clinical officer



**Steph Lawrence**  
Executive Nurse

## 4.2 Overview and Scrutiny Committee

The draft *Quality Account 2014/15* was circulated to Bradford Metropolitan District Council Health Overview and Scrutiny Committee and North Yorkshire County Council Overview and Scrutiny Committee for comment. Both acknowledged receipt and the following feedback received.

City of Bradford MDC

[www.bradford.gov.uk](http://www.bradford.gov.uk)

### Department of Legal and Democratic Services

Bridget Fletcher  
Chief Executive  
Airedale NHS Foundation Trust  
Airedale General Hospital  
Skipton Road  
Steeton, Keighley  
West Yorkshire BD20 6DT

c/o Overview & Scrutiny Team  
Bradford Metropolitan District Council  
Room 149, City Hall  
Bradford BD1 1HY

Tel: (01274) 432313  
Email: [caroline.coombes@bradford.gov.uk](mailto:caroline.coombes@bradford.gov.uk)

Date: 26 May 2015

Dear Bridget Fletcher

#### **ANHSFT Quality Account 2014/15**

Thank you for asking me for comments on your 2014/15 Quality Account.

I am pleased to note the progress your Trust has made over the last year. I was also very glad to have attended the opening of your new Emergency Department in December 2014, which as you state, should enable you to provide an improved service to the community.

As you will be aware, the Health and Social Care Overview and Scrutiny Committee (the Committee) has recently received a presentation from commissioners and acute trusts on stroke services in Bradford District. I am aware of, and concerned by, the current challenges facing the provision of the acute stroke and thrombolysis service at Airedale Hospital and the Committee will be scrutinising this closely over the coming months.

The Committee has also received a presentation on the Enhanced Health in Care Homes Vanguard for Bradford, Airedale, Whafedale and Craven and looks forward to hearing about the results of that work, in particular any impact on hospital admissions, A&E attendance rates and length of stay in hospital. Related to this, I have noted your priority around the use of telemedicine technology to support people with long term conditions. I will be proposing that the Committee looks at the use of telemedicine (alongside the use of telecare) to support people in their own homes over the coming twelve months.

The Committee will also continue to scrutinise the integration of health and social care and I welcome your report recognising the pressing need for continued collaboration with the focus always on delivering the best possible care, treatment and quality of life for people in Bradford District.

I look forward to working with you over the next year.

Yours sincerely

Cllr Vanda Greenwood  
Chair – Health and Social Care Overview and Scrutiny Committee



City of Bradford  
Metropolitan District Council



### 4.3 Healthwatch

The draft *Quality Account 2014/5* was circulated to HealthWatch Bradford and District, HealthWatch North Yorkshire and HealthWatch Lancashire and the following feedback received in May 2015. All acknowledged receipt.

Healthwatch Bradford acknowledged the willingness and transparency of Airedale NHS Trust and other health providers to include Healthwatch in their quality work and the production of *Quality Accounts*. Due to national pressures on public finances, the group has had to prioritise its work and regrettably it finds itself no longer able to offer comment on NHS providers' *Quality Accounts*. It will, however, continue to work with all providers and commissioners, including whenever possible the Joint Quality Committee, on a range of other issues within its available capacity.

### 4.4 How to provide feedback on the Quality Account and Report

We welcome your views on our *Quality Account*, specifically:

- Where you think the biggest improvements on our quality priorities can be made?
- How to engage our partners in our work to improve the quality of services?
- Do you have any comments or suggestions on the format of our *Quality Account*?
- Your suggestions for quality priorities.

The Annual report and *Quality Account* will be available on our website at:

[www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk)

A summary of the *Quality Account* is available in *The Airedale Annual Record 2014/15*.

If you need a copy in a different format, such as **large print** or in another language, then please contact our Interpreting Services on telephone: 01535 292811 or email interpreting at [interpreting.services@anhst.nhs.uk](mailto:interpreting.services@anhst.nhs.uk)



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AiredaleNHSFT

#### 4.5 Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

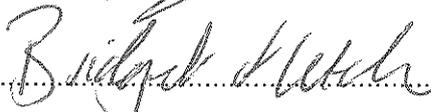
- the content of the quality report meets the requirements set out in the *NHS Foundation Trust Annual Reporting Manual 2014/15*;
- the content of the quality report is not inconsistent with internal and external sources of information including:
  - Board minutes for the period April 2014 to March 2015 (the period);
  - Draft minutes from the Board Meeting on 29 April 2015;
  - Papers relating to Quality reported to the Board over the period April 2014 to March 2015;
  - Feedback from the Airedale Wharfedale and Craven CCG dated 19 May 2015;
  - Feedback from Governors dated 21 May 2015;
  - Feedback from Overview & Scrutiny Team Bradford Metropolitan District Council dated 26 May 2015
  - The draft trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for the period April 2014-March 2015, dated May 2015;
  - The 2014 CQC inpatient survey published in May 2015 ;
  - The 2014 national staff survey published in February 2015;
  - Care Quality Commission Intelligent Monitoring Reports dated July 2014 and November 2014 and a draft version dated May 2015;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2015.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

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

By order of the Board

NB: sign and date in any colour ink except black.

27<sup>th</sup> May 2015 .....  ..... Deputy Chairman

27<sup>th</sup> May 2015 .....  ..... Chief Executive

## Independent Auditors' Limited Assurance Report to the Council of Governors of Airedale Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Airedale Hospital NHS Foundation Trust to perform an independent assurance engagement in respect of Airedale Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and specified performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2015 subject to limited assurance (the "specified indicators"); marked with the symbol **A** in the Quality Report, consist of the following national priority indicators as mandated by Monitor:

<b>Specified Indicators</b>	<b>Specified indicators criteria</b> (exact page number where criteria can be found)
<i>Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.</i>	<i>Criteria can be found on page 95-96 of a signed Annual Report and Accounts 2014/15</i>
<i>Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.</i>	<i>Criteria can be found on page 95-96 of a signed Annual Report and Accounts 2014/15</i>

### Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports 2014/15" issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the "Detailed requirements for quality reports 2014/15";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the "2014/15 Detailed guidance for external assurance on quality reports".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports 2014/15; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2014 to March 2015 (the period);
- Draft minutes from the Board Meeting on 29 April 2015;
- Papers relating to Quality reported to the Board over the period April 2014 to March 2015;
- Feedback from the Airedale Wharfedale and Craven CCG dated 19 May 2015;
- Feedback from Governors dated 21 May 2015;
- Feedback from Overview and Scrutiny Committee; Overview & Scrutiny Team Bradford Metropolitan District Council dated 26 May 2015
- The draft trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 for the period April 2014-March 2015, dated May 2015;
- The 2014 CQC national patient survey published in May 2015;
- The 2014 national staff survey published in February 2015;
- Care Quality Commission Intelligent Monitoring Reports dated July 2014 and November 2014 and a draft version dated May 2015;
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 21 May 2015.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales ("ICAEW") Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Airedale Hospital NHS Foundation Trust as a body, to assist the Council of Governors in reporting Airedale Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Airedale Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

### **Assurance work performed**

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and "Detailed requirements for quality reports 2014/15";
- reviewing the Quality Report for consistency against the documents specified above;

- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

### **Limitations**

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM the “Detailed requirements for quality reports 2014/15 and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different [NHS Foundation Trusts/organisations/entities].

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Airedale Hospital NHS Foundation Trust.

### **Conclusion**

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2015,

- The Quality Report does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM and the “Detailed requirements for quality reports 2014/15”;
- The Quality Report is not consistent in all material respects with the documents specified above; and
- the specified indicators have not been prepared in all material respects in accordance with the Criteria and the six dimensions of data quality set out in the “Detailed guidance for external assurance on quality reports 2014/15”.

PricewaterhouseCoopers  
PricewaterhouseCoopers LLP

Leeds

Date 28/5/15

The maintenance and integrity of the [name of entity]'s website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

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## 4.6 Monitor guidance for data quality assurance on Quality Reports

Monitor requires foundation trusts to obtain external assurance on its quality reports. Set out below is the detailed 2014/15 guidance for auditors to enable review and testing of data quality.

### **4.6.1 Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways**

#### *Source of indicator definition and detailed guidance*

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at [www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf](http://www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf)

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at <http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/>

#### *Detailed descriptor*

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

#### *Numerator*

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

#### *Denominator*

The total number of patients on an incomplete pathway at the end of the reporting period

#### *Accountability*

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: [www.england.nhs.uk/wp-20](http://www.england.nhs.uk/wp-20)

### **4.6.2 Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers**

#### *Detailed descriptor*

PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

#### *Data definition*

All cancer two-month urgent referral to treatment wait

#### *Numerator*

Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

#### *Denominator*

Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

#### *Accountability*

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: [www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf) (see Annex B: NHS Constitution Measures).

### **4.6.3 Emergency re-admissions within 28 days of discharge from hospital**

#### *Indicator description*

Emergency re-admissions within 28 days of discharge from hospital.

#### *Indicator construction*

Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.

#### *Numerator*

The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or *in situ*) or chemotherapy for cancer coded anywhere in the spell.

#### *Denominator*

The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to 31 March within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.

#### *Indicator format*

Standard percentage

#### *More information*

Further information and data can be found as part of the HSCIC indicator portal. This definition is adapted from the definition for the 30 days re-admissions indicator in the *NHS Outcomes Framework 2013/14: Technical Appendix*. Trusts are required to report 28 day emergency re-admissions rather than 30 days to be consistent with the mandated indicator requirements of the NHS (Quality Accounts) Amendment Regulations 2012 (S.I. 2012/3081).

## 4.7 Glossary

**Acute trust** An acute trust provides hospital services; mental health hospital services are provided by a mental health trust.

**Board of Directors** The Board of Directors is responsible for the effective governance of the organisation by setting the corporate strategy, supervising the work of the executive directors, setting the organisation's culture, taking those decisions that the Board reserves to itself and being accountable to its stakeholders. Executive directors are responsible for the management of the foundation trust and are accountable to the Board of Directors, of which they are part, for the performance of the foundation trust. The Board of Directors is accountable to the Council of Governors via the non executive directors.

**Care Quality Commission (CQC)** The independent regulator of health and social care in England.

**CHKS** A provider of healthcare improvement services, including analytic tools. It is part of the Capita plc. group.

**Commissioning for Quality and Innovation (CQUIN scheme)** A proportion of a healthcare provider's income is conditional on quality and innovation through the CQUIN payment framework.

**Clinical Commissioning Groups (CCG)** From April 1<sup>st</sup> 2013, a CCG is the local NHS organisation responsible for making sure that appropriate health services are in place to meet local people's needs.

**Dr Foster** The Dr Foster Unit at Imperial College London has developed methodologies to support organisations to improve quality and efficiency through the use of data. It adheres to a code of conduct that prohibits political bias and requires it to act in the public interest.

**Foundation Trust** A type of NHS trust in England created to devolve decision-making from central government control to local organisations and communities to ensure they are responsive to the needs and wishes of their local people. NHS foundation trusts members are drawn from patients, the public and staff and are governed by a Board of Governors comprising people elected from and by the membership base.

**Gold Standard Framework** A nationally recognised systematic, evidence-based approach to improve the quality of care for people considered to have a life expectancy of less than 12 months. The framework is widely used in primary care and nursing homes.

**Health Foundation** An independent, charitable foundation working to improve the quality of healthcare in the UK and beyond.

**Healthwatch England** An independent consumer champion for health and social care in England. Working with a network of 152 local Healthwatch, it ensures that the voices of consumers reach the ears of the decision makers.

**Health and Social Care Information Centre (HSCIC)** The national provider of information, data and IT systems for health and social care.

**Institute for Innovation and Improvement** The Institute supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership.

**Monitor** The independent regulator responsible for authorising, monitoring and regulating NHS Foundation Trusts.

**NHS Constitution** The Constitution sets out the rights of NHS patients and staff. These rights cover how patients access health services, the quality of care, confidentiality, information and the right to complain if things go wrong.

**NHS England** is empowered to make informed decisions, spend taxpayers' money wisely and provide high quality services through the mechanism of the clinical commissioning groups (CCGs).

**The National Institute for Health and Clinical Excellence (NICE)** An independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health.

**NHS Outcomes Framework 2014/15** Sets out the national outcome goals and indicators that the Secretary of State uses to monitor progress of the NHS.

**Overview and Scrutiny Committees (OSC)** These are committees made up of locally elected lay members which provide a mechanism by which the local authority or population can scrutinise the NHS.

**Patient Advice and Liaison Service (PALS)** PALS ensures that the NHS listens to patients, carers and friends, answers their questions and resolves concerns as quickly as possible.

**Parliamentary Health Service Ombudsman (PHSO)** The role of the PHSO is to provide a service to the public by undertaking independent investigations into complaints where the NHS in England has not acted properly or fairly or has provided a poor service.

**Patient Safety Thermometer** A tool developed to check basic levels of care. In order to identify where things are going wrong and take action. It is being used by frontline healthcare workers to measure and track the proportion of patients in their care with pressure ulcers, urinary tract infections, venous thromboembolisms and falls.

**Patient safety walk rounds** are scheduled visit by an Executive Director and Non-Executive Director to a ward or department to meet with staff and discuss good practice and safety issues. Where issues are highlighted, corrective actions are suggested and the individuals concerned are assigned responsibility to act upon them.

**Primary Care** The first point of contact for most people, for example, services provided by local GPs and their teams.

**Providers** The organisations that provide NHS services, for example NHS trusts and their private or voluntary sector equivalents.

**Registration** From April 2009, every NHS trust that provides healthcare directly to patients has to be registered with the Care Quality Commission (CQC).

**Secondary Care** A service provided by medical specialists who generally do not have first contact with patients.

**Special Review** A review carried out by the CQC to look at themes in health and social care. Reviews focus on services, pathways of care or groups of people.

**The 15 Steps Challenge** The 15 Steps Challenge encourages patients and staff to work together to identify improvements which may enhance the patient experience, highlighting what is working well and what might be done to increase patient confidence.

**The King's Fund** An independent charity working to improve health and health care in England. It shapes policy and practice through research and analysis; development of individuals, teams and organisations; and promoting understanding of the health and social care system.

## DIRECTORS' REPORT

The Director's Report has been prepared under direction issued by Monitor, the independent regulator for Foundation Trusts, as required by Schedule 7 paragraph 26 of the NHS Act 2006 and in accordance with:

- Section 415, 416 and 418 of the Companies Act 2006 (section 415(4) and (5) and section 418 (5) and (5) and section 418 (5) and (6) do not apply to Foundation Trusts;
- Regulation 10 and schedule 7 of the Large and Medium-sized Companies and Groups (Accounts and Reports) Regulation 2008 ('the Regulations');
- Additional disclosures as required by the FReM; and
- Additional disclosures as required by Monitor.

## COMPOSITION OF THE BOARD

Airedale NHS Foundation Trust is headed by a Board of Directors with responsibility for the exercise of the powers and performance of the NHS Foundation Trust.

**Chairman** Professor Michael Luger  
**Chief Executive** Miss Bridget Fletcher

**Executive Directors**

Mr Andrew Copley	<i>Director of Finance</i>
Mr Robert Dearden	<i>Director of Nursing</i>
Mr Karl Mainprize	<i>Medical Director</i>
Mrs Ann Wagner	<i>Director of Strategy and Business Development</i>

**Non-Executive Directors**

Mr Ronald Drake	<i>Deputy Chairman</i>
Mrs Sally Houghton	<i>Senior Independent Director</i>
Mr Jeremy Cross	
Professor Anne Gregory	
Dr Michael Toop	

## QUALITY AND PERFORMANCE AGAINST MANDATORY STANDARDS

To provide a better understanding of comparative performance, the Foundation Trust's Quality Accounts includes a core set of statutory national quality indicators aligned with the Department of Health's *NHS Outcomes Framework* for 2014/15 and reflects data that the Foundation Trust reports nationally. Information of performance against the core indicators and performance thresholds is given in the Quality Report 2014/15 in section 3 of the Annual Report.

### Care Quality Commission: Essential standards of quality and safety

The Foundation Trust has a rigorous assessment process against all applicable outcomes of the Care Quality Commission (CQC)'s essential standards. This process tests compliance across all Trust's services.

This is complemented by a corporate process led at executive director level, whereby each of the essential standard's self-assessments are scrutinised to ensure compliance and consistency of approach. Comparison against the service's own self-assessment is undertaken, and where recommendations are made, action plans are produced and monitored where necessary. The Foundation Trust's Audit Committee reviews the assessment process and reports.

The Foundation Trust is registered with the Care Quality Commission without conditions.

In September 2013, the Foundation Trust underwent an inspection as a pilot of the CQC's new inspection process. As a pilot site the Foundation Trust did not receive a rating as a result of this

inspection but on publication of the report, the CQC stated that Inspectors concluded that the Foundation Trust's services were well managed; benefitted from a stable, experienced board and had a clear governance structure. A number of areas of good practice were highlighted including the introduction of the Telehealth Hub; direct access to electronic information held by community services, including GPs and the valued use of volunteers within the hospital.

The full report can be accessed from the CQC's website at [www.cqc.org.uk](http://www.cqc.org.uk)

## Quality Governance

During 2014/15, the Foundation Trust, led by the Medical Director, reviewed the Foundation Trust's quality governance arrangements by using the Quality Governance Framework developed by Monitor, the Foundation Trust regulator. From this the senior management team, clinical directors, governors and the executive directors were instrumental in the development of a Quality Improvement Strategy (QIS) and a Quality Assurance Framework (QAF). The QIS and QAF were reviewed and approved using the Foundation Trust's governance assurance reporting arrangements, namely the Trust's risk management group, Audit Committee and Board of Directors.

Further details about the Foundation Trust's quality governance arrangements are included within the Annual Governance Statement on page 110 and the Quality Report in section 3 of the Annual Report.

## National NHS Staff Survey 2014

The 2014 annual survey of NHS staff was conducted in October to December 2014. A summary of performance is as follows:

The Foundation Trust compared most favourably with other acute Trusts in terms of:

- Percentage of staff appraised in the last 12 months (best 20%) – 93% compared to an average of 85%;
- Percentage of staff experiencing physical violence from patients, relatives and the public in the last 12 months (best 20%) – 11% compared to 14% average;
- Percentage of staff believing the Foundation Trust provides equal opportunities for career progression and promotion (best 20%) – 91% compared to an average of 87%;
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in the last month (best 20%) – 30% compared to 34% average; and
- Percentage of staff having equality and diversity training in the last 12 months – 72% compared to 63% average.

The Foundation Trust also compared favourably with other acute Trusts in terms of the fairness and effectiveness of incident reporting procedures; staff experiencing harassment, bullying or abuse from patients, and staff experiencing discrimination at work.

The Foundation Trust compared least favourably with other acute Trusts in relation to:

- Work pressure felt by staff (worst 20%) – 3.21 compared to an average of 3.07;
- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver (worst 20%) – 73% compared to 77% average;
- Percentage of staff agreeing that they would feel secure raising concerns about unsafe clinical practice – 64% compared to 67% average;
- Percentage of staff agreeing their role makes a difference to patients – 89% compared to 91% average; and
- Support from immediate managers – 3.58 compared to 3.65 average.

Each Trust received an overall indicator of staff engagement. The Foundation Trust's score in 2014 was 3.72 compared to 3.77 in 2013. This score is average when compared with Trusts of a similar type. Possible scores range from 1 to 5, with 1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged.

In response to the findings of the staff survey, an action plan has been developed to address the areas scoring worse than last year and/or when benchmarked against other Trusts, and the next steps included in the Foundation Trust's People Plan.

### Monitor standards

Monitor is the sector regulator for health services in England with the role of protecting and promoting the interests of patients by ensuring that the whole sector works for their benefit.

As part of its responsibilities, Monitor makes sure foundation hospitals, ambulance trusts and mental health and community care organisations are well led and are run efficiently, so they can continue delivering good quality services for patients in the future.

Monitor measures and assesses the actual performance of each NHS Foundation Trust, against each Foundation Trust's annual plan (as approved by Monitor). From the third quarter of 2013/14, Monitor published two ratings, as set out in Monitor's Risk Assessment Framework (replacing the Compliance Framework): the ratings are Continuity of Services and Governance:

- **Continuity of Services** rating (rated 1-4, where 1 represents the highest risk and 4 the lowest risk).
- **Governance** rating (Trusts are rated green if no issues are identified and red where enforcement action is being taken).

The Foundation Trust achieved a financial risk rating of 3 at the end of 2014/15. The tables below summarise the rating performance throughout the year and provide a comparison to the previous year.

2014/15	Annual Plan	Q1	Q2	Q3	Q4
<b>Continuity of service rating</b>	3	3	3	3	3
<b>Governance risk rating</b>	Amber with declared risks A&E and C.diff standards	Green	Green	Green	Green*

\*To be confirmed by Monitor as part of the quarterly review process

2013/14	Annual Plan	Q1	Q2	Q3	Q4
<b>Under the compliance framework</b>					
<b>Financial risk Rating</b>	3	3	3		
<b>Governance risk rating</b>	Amber/ Red	Amber/ Green	Green		
<b>Under the risk assessment framework</b>					
<b>Continuity of service rating</b>				3	3
<b>Governance risk rating</b>				Green	Green

## National Patient Surveys

The Foundation Trust welcomes the opportunity to take part in a range of annual national patient surveys that are initiated by the Care Quality Commission. This is an ideal way of obtaining regular patient feedback as a means of seeking to improve our patient experience.

- **Cancer Patient Experience Survey**

The results of National Cancer Patient Experience Programme were published in September 2014. A total of 118,081 patients nationwide receiving treatment for cancer from 153 acute Trusts during September to November 2013, were invited to take part in the survey including 438 patients from Airedale Hospital. A total of 252 patients completed the questionnaire giving a response rate of 65% against a national response rate of 64%.

The survey highlighted a number of positive findings with the hospital being rated as one of the best 20% in the country for the following survey questions:

- ✓ Patient thought they were seen as soon as necessary;
- ✓ Staff gave complete explanation of purpose of tests;
- ✓ Staff explained completely what would be done during test;
- ✓ Given easy to understand written information about test;
- ✓ Given complete explanation of test results in understandable way;
- ✓ Patient completely understood the explanation of what was wrong;
- ✓ Patient given written information about side effects;
- ✓ Patient definitely involved in decisions about care and treatment;
- ✓ Patient finds it easy to contact their CNS;
- ✓ Hospital staff gave information about support groups;
- ✓ Hospital staff gave information about impact cancer could have on work/education;
- ✓ Hospital staff gave information on getting financial help;
- ✓ Staff gave complete explanation of what would be done;
- ✓ Staff explained how operation had gone in understandable way;
- ✓ Nurses did not talk in front of patient as if they were not there;
- ✓ All staff asked patient what name they preferred to be called by;
- ✓ Staff definitely did everything to control side effects of chemotherapy;
- ✓ Staff definitely did everything they could to help control pain;
- ✓ Patient offered written assessment and care plan; and
- ✓ Patient did not feel that they were treated as a `set of cancer symptoms.`

- **Accident and Emergency Survey**

The findings from the National Accident and Emergency (A&E) Survey for 2014, for Airedale NHS Foundation Trust, were published by the CQC in December 2014. The survey involved 142 acute and specialist NHS Trusts with major accident and emergency departments in England and received almost 40,000 responses.

The independent survey asked the views of patients, aged 16 years and over, who attended the Emergency Department during March 2014 their thoughts about different aspects of the care and treatment they received.

A number of positive findings were highlighted in the survey including an overall satisfaction with the length of time patients' visits to the Emergency Department lasted and that the doctors and nurses did not talk to each other as if they were not there. The report also showed that patients said they received the results of their tests before leaving the Emergency Department and that staff explained the results of the tests in a way they could understand.

The areas highlighted for improvement were in the main connected to the environment and facilities, for example, not having enough privacy when discussing their condition with

reception staff. It is therefore anticipated that the new Emergency Department opened in December 2014, will have made a huge difference to patients' experience.

- **Adult Inpatient Survey**

The results from the survey of adult inpatients for 2014 were published by the Care Quality Commission at the end of May 2015. The Quality Report in section 3 of the Annual Report provides a detailed analysis of the findings.

- **Friends and Family Test**

The Friends and Family Test (FFT) began on 1 April 2013 and involves asking the question of all inpatients at the time of discharge and all patients who have attended the Emergency Department "How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

The first public results were published on the NHS Choices website on 30 July 2013 and now appear on a monthly basis. The FFT became operational in maternity services on 1 October 2013 and expanded to include community services in January.

To see how Airedale NHS Foundation Trust has scored, click on the following link to the NHS Choices website: – [www.nhs.uk](http://www.nhs.uk).

In April 2014, to improve the uptake of the Friends and Family Test, the Foundation Trust introduced questionnaire cards in five different languages and Easy Read to help patients complete test. They are produced in Polish, Slovakian, Urdu, Bengali and Mandarin and can be produced in other languages on request.

- **Real-Time Inpatient Survey**

The Foundation Trust implemented its own real time inpatient survey in 2013/14 as a means of helping staff make improvements to the care and services that are provided to patients. The survey is undertaken on a daily basis, Monday to Saturday, supported by the Foundation Trust's volunteers who assist patients being discharged that day to complete the survey.

The project is overseen by a steering group whose members continually monitors progress and include volunteer representatives. The survey has now expanded into other areas and now also covers the endoscopy unit as well as maternity services, physiotherapy and paediatrics.

- **Patient-Led Assessments of the Care Environment**

April 2013 saw the introduction of Patient-Led Assessments of the Care Environment (PLACE), which is the new system for assessing the quality of the patient environment, replacing the old Patient Environment Action Team (PEAT) inspections. The assessments apply to hospitals, hospices and day treatment centres providing NHS funded care. The assessments take place every year, with results reported publicly to help drive improvements in the care environment. The results aim to show how hospitals are performing nationally and locally.

The Foundation Trust's second PLACE inspection took place at Airedale Hospital in April 2014 and the results published in September 2014.

*Airedale General Hospital and Castleberg Hospital 2014 PLACE results compared to the England average*

Domain	Airedale General Hospital % score	Castleberg Hospital % score	National % average score
Cleanliness	98.74 ↑	99.06	97.25
Food	88.92 ↑	93.06	88.79
Privacy, dignity and wellbeing	84.72 ↑	79.29	87.73

Condition, maintenance and appearance	93.55 ↑	92.25	91.97
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Source: NHS England 2014: Health and Social Care Information Centre

Key: % score out of 100

↑ Performance against 2013 return. No audit of Castleberg was conducted in 2013

The Foundation Trust has continued to make improvements in reducing healthcare acquired infections. During 2014/15, the Foundation Trust had no cases of hospital acquired MRSA bacteraemia compared to two cases in 2013/14. Eleven Clostridium Difficile cases developed in the hospital. Root cause analysis showed that seven of these were hospital acquired cases.

Further information regarding patient experience surveys can be found in the Quality Report in Section 3 of the Annual Report.

## STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF AIREDALE NHS FOUNDATION TRUST

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS Foundation Trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by Monitor.

Under the NHS Act 2006, Monitor has directed Airedale NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Airedale NHS Foundation Trust and of its income and expenditure, total recognized gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgments and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements;
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; and
- Prepare the financial statement on a going basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the Monitor's *NHS Foundation Trust Accounting Officer Memorandum*.



**Bridget Fletcher**  
Chief Executive

27 May 2015

## ANNUAL GOVERNANCE STATEMENT

### Scope of Responsibility

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

### The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Airedale NHS Foundation 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 Airedale NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the Annual Report and Accounts.

### Capacity to Handle Risk

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Foundation Trust and for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management.

The Foundation Trust has a risk management strategy, which is reviewed and endorsed by the Board of Directors annually. The Risk Management Strategy was reviewed as part of the Monitor Governance and Capability Review and is currently being reviewed to take account of the new Duty of Candour. There is a clearly defined structure for the management and ownership of risk through the development of the risk register and assurance framework. The 'high level' risks and board assurance framework are monitored at Executive level and in the Board's sub committees and by the Board of Directors.

Some aspects of risk are delegated to the Foundation Trust's Executive Directors:

- The Medical Director is responsible for clinical governance, and has overall lead for risk management and patient safety with support from the Assistant Director, Healthcare Governance. The Medical Director is, with support from the Assistant Director, Healthcare Governance, also responsible for reporting to the Board of Directors on the development and progress of the quality and patient safety strategy and for ensuring that the strategy is implemented and evaluated effectively;
- The Medical Director is also the executive lead (with management support provided from the Assistant Director, Healthcare Governance) for ensuring a fully integrated and joined up system of risk and control management is in place on behalf of the Board;
- The Director of Nursing is responsible for infection prevention and control;
- The Director of Operations is responsible for health and safety;

- The Director of Finance provides the strategic lead for financial and performance risk and the effective coordination of financial controls throughout the Foundation Trust. The Director of Finance is also the SIRO and has responsibility for information governance;
- The Head of HR and Workforce is responsible for workforce planning, staffing issues, education and training. Responsibility for organisational development is incorporated in to Executive Directors combined objectives both on an individual basis and collectively as the executive team; and
- All heads of service, Clinical Directors and managers have delegated responsibility for the management of risk and patient safety in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each individual Group produces a divisional/directorate patient safety and risk register, which is consistent and mirrors the Foundation Trust's patient safety and risk register requirements and is in line with the risk management strategy.

All members of staff have responsibility for participation in the risk/patient safety management system through:

- Awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments;
- Compliance with all legislation relevant to their role, including information governance requirements set locally by the Foundation Trust;
- Following all Foundation Trust policies and procedures;
- Reporting all adverse incidents and near misses via the Foundation Trust incident reporting system;
- Attending regular training as required ensuring safe working practices;
- Awareness of the Foundation Trust patient safety and risk management strategy and their own Group patient safety and risk management strategy; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Foundation Trust recognises the importance of supporting staff. The risk management team act as a support and mentors to Foundation Trust staff who are undertaking risk assessments and managing risk as part of their role. Risk assessment training is available to all members of staff and includes:

- Corporate induction training when staff join the Foundation Trust;
- Mandatory update training for all staff at specified intervals;
- Targeted training with specific areas including risk assessment, incident reporting and incident investigation; and.
- Training and mentoring support for a new electronic adverse event reporting system to be introduced from 1 April 2015, targeted at managers of wards, departments and non-clinical areas.

The Foundation Trust seeks to learn from good practice and will investigate any serious incidents, complaints and SIRI's (Serious Incidents Requiring Investigation) using Root Cause Analysis methodology. The findings are reviewed by the Foundation Trust's Assurance Panel to ensure learning points are implemented. Assurance is gained by presenting reports to the Foundation Trust's Executive Assurance Group and summary reports to the Board of Directors. Any learning points are taken to the Trust's Quality Safety and Operational Group chaired by the Medical

Director and Director of Nursing and whose membership comprises Clinicians, Matrons and Senior Managers. A wider distribution of learning points for staff is disseminated via a Quality and Safety Newsletter and staff briefings.

In addition to the Foundation Trust reviewing all internally driven reports, the Foundation Trust adopts an open approach to the learning derived from third party investigations and audits, and/or external reports. The Foundation Trust actively seeks to share learning points with other health organisations, and pays regard to external guidance issued. This learning approach is supported by implementing a *'true for us'* test which seeks to test the Foundation Trust's systems and processes against the findings and recommendations of external reports and reviews. Accordingly, the Foundation Trust will undertake gap analyses and adjust systems and processes as appropriate in line with best practice. The Foundation Trust has also adopted a pro-active approach to seeking independent reviews as evidenced by the commissioning of Royal College reviews to examine maternity services following concerns raised. A number of external reports including the *'Freedom to Speak Up'* review led by Sir Robert Francis QC, and the *Hard Truths: Putting Patients First* published by the Department of Health, have also been considered and the recommendations arising from those reports reviewed and acted upon.

### **The Risk and Control Framework**

The Board approved Risk Management Strategy has defined the Foundation Trust's approach to risk throughout the year. The strategy determines the requirements for the identification and assessments of risks and for control measures to be identified and how risks should be managed and the responsibilities of key staff in this process. As an organisation seeking to develop its innovative work in the field of telemedicine, the Foundation Trust is risk aware, and adopts a risk management approach.

The Risk Management Strategy assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. The process populates the risk register and board assurance framework, to form a systematic record of all identified risks. All risks are evaluated against a common grading matrix, based on the Australia/New Zealand risk management standard to ensure that all risks are considered alike. The control measures, designed to mitigate and minimise identified risks, are recorded within the risk register and board assurance framework.

The board assurance framework sets out:

- What the organisation aims to deliver (corporate/strategic objectives);
- Factors which could prevent those objectives being achieved (principal risks);
- Processes in place to manage those risks (controls);
- The extent to which the controls will reduce the likelihood of a risk occurring (likelihood); and
- The evidence that appropriate controls are in place and operating effectively (assurance).

The board assurance framework provides assurance, through ongoing review, to the Board, that these risks are being adequately controlled and informs the preparation of the Statement on Internal Effectiveness and the Annual Governance Statement. The board assurance framework and risk register have identified no significant gaps in control/assurance.

### **Quality Governance Arrangements**

The Board reviews performance data each month against Monitor and CQC standards and outcomes via a series of integrated dashboards focusing on quality, safety, patient experience and clinical outcomes; staff engagement and workforce development; finance and performance; service

developments and transformation and business development. A quality account report has been developed and designed specifically to support the triangulation of data across the organisation, and is reviewed by the Board in conjunction with the integrated dashboards.

The Foundation Trust's risk management processes have identified a number of risks. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

The Foundation Trust's financial position is subject to a number of risks. Its position is dependent on delivering productivity and efficiency improvements. This is set against a difficult national economic background and changing NHS landscape. The strategy of focusing on partnership working to deliver system change at pace is therefore continuing and will continue in to 2015/16 and beyond. This change is also dependent upon the Foundation Trust's ability to secure and retain the right workforce at clinician level as well as being able to influence widespread change in clinical practice. The clinical management structure has undergone significant changes during the current and previous year in order to equip clinicians with the skills and resilience to meet the challenges of the changing NHS landscape. The further development of the clinician workforce and structure remains key to the success of the Foundation Trust and therefore this work will also continue in to the coming year.

The Foundation Trust is mitigating these risks through rigorous budgetary control and management of significant productivity and efficiency improvements. Outcomes are being measured by monthly review of financial performance information by the Board, in addition to scrutiny of the impact of efficiency savings on patient safety and quality of service.

The Board has delegated scrutiny of the quarterly Corporate Governance Statement Monitor return to the Audit Committee prior to review by the Board. In conjunction, the Board receives the quality account, integrated governance dashboards and the finance and performance report on a monthly basis. This process provides assurance to the Board that the Corporate Governance Statement is a valid reflection of the Foundation Trust's performance over the previous quarter(s), whilst allowing the Board opportunity for scrutiny of compliance.

In addition to the standard reporting and assurance process, the Foundation Trust undertook an external independently evaluated Board Governance and Capability Review ('Review') during the early part of 2014 as part of the Monitor pilot scheme. The Review examined the effectiveness of governance structures; the responsibilities of Directors and subcommittees; the capability at Board level to provide organisational leadership; reporting lines and accountabilities between the Board, its subcommittees and the executive team; the assessment of risks and the risk management process; and the degree and rigour of oversight the Board has over the Foundation Trust's performance. The outcome of the evaluation assessed the Foundation Trust's governance arrangements to be strong with no major areas of weakness identified. In the spirit of learning, the Board considered the Review and formed a response to the findings which have been taken forward through its governance processes. The most significant output from the Review was a root and branch evaluation of the Trust's quality governance arrangements. Arising from this was the formulation of a Quality Assurance Strategy and a Quality Improvement Framework, which received Board approval in March 2015.

Discussion has been ongoing throughout the year with Commissioner colleagues to ensure all key access targets are being met from within available resource. There have been regular contract management meetings with the Foundation Trust's lead commissioning cluster – Airedale, Wharfedale and Craven Clinical Commissioning Group (CCG) and other reviews with Bradford Districts and East Lancashire Clinical Commissioning Groups.

The Foundation Trust successfully registered, without conditions, with the Care Quality Commission in 2010, and continues to be fully compliant with the registration requirements of the Care Quality Commission. Assurance against the requirements of the CQC registrations is

monitored on an ongoing basis throughout the year by the Executive Lead responsible for ensuring compliance for each of the CQC outcomes.

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 in to 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.

Control measures are in place to ensure all organisations' obligations under equality, diversity and human rights legislation are complied with. This is evidenced by the response to the Equality Act 2010 in which the Foundation Trust built on the work undertaken in reviewing the Single Equality Scheme at Board level and the inclusion and completion of equality impact assessments on all the Foundation Trust's policies. Accordingly, the Board approved the proposed approach, objectives and action plan for delivering the Equality Delivery System, and nominated a Non-Executive Lead. The Foundation 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 Foundation Trust has a comprehensive system that sets strategic and annual objectives. The Board of Directors sets these objectives with regard to the economic, efficient and effective use of resources.

The objectives set reflect national and local performance targets for standards of patient care and financial targets to deliver this care within available resources. Within these targets, the Foundation Trust includes specific productivity and efficiency improvements. These are identified from a range of sources including internal review such as internal audit, external audit and external organisations including benchmarking agencies.

The Foundation Trust has a robust monitoring system to ensure that it delivers the objectives it identifies. Ultimate responsibility lies with the Board which monitors performance through reports to its meetings of the Board of Directors. Underpinning this is a system of monthly reports on quality and safety, financial and operational information to the Foundation Trust's executive management group, and clinical management groups. The information received by the Board is supplemented with integrated governance dashboards and a summary dashboard mapping movements during the previous quarter. The reporting at all levels includes detail on the achievement against productivity and efficiency targets and is derived through a bottom-up approach to management reporting.

The Foundation Trust operates within a governance framework of Standing Orders, Standing Financial Instructions and other processes. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets;
- Delegation of authority;
- Performance management; and
- Achieving value for money in procurement.

The governance framework is subject to scrutiny by the Foundation Trust's Audit Committee and internal and external audit.

## Information Governance

Maintaining the security of the information that the Foundation Trust holds provides confidence to patients and employees of the Foundation Trust. To ensure that its security is maintained an Executive Director has been identified – the Foundation Trust’s Director of Finance – to undertake the role of Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data held and a review of information flows to underpin the Foundation Trust’s information governance assurance statements and its assessment against the information governance toolkit.

As part of the Foundation Trust’s assurance mechanism, the internal audit work plan includes an annual review of the Information Governance Toolkit submission. Following the identification of a number of areas of weakness in the 2012/13 submission, a rigorous and robust review of the information governance toolkit process took place and a number of improvements were implemented. I can report that for 2014/15, the information governance toolkit submission process was given a ‘significant assurance’ opinion by the Foundation Trust’s internal auditors.

During 2014/15, the Foundation Trust reported one Serious Information Governance Reportable Incident. The incident involved the disclosure of one patient’s clinical data, in error, to a third party. The disclosed data was recovered by the Trust. The incident was logged and managed via the Trust’s internal process. In addition it was graded at level 2 in accordance with the national IG Serious Incident Requiring Investigation (SIRI) tool and reported externally to the Information Commissioner’s Office (ICO) and Department of Health. No further action was taken against the Trust.

## 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. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The Foundation Trust has continued to build on the extensive work undertaken to develop the Quality Account and has drawn on the various guidance published in-year in relation to the Quality Account.

The Foundation Trust has developed its vision, values and priorities through wide involvement and in consultation with patients, carers, staff, external stakeholders and Governors. The consultation process for the Quality Account included presentations to the Board of Directors, Council of Governors and informally to Governors at their network meetings, workshop sessions with representatives from the Council of Governors, Healthwatch and Patient and Carer Panel as well as members of the public. In addition, Foundation Trust members were canvassed for their opinions on the Foundation Trust’s quality improvement plans via a number of Foundation Trust member events as well as the hospital’s open day.

Through this engagement the Foundation Trust has been able to ensure the areas chosen provided a balanced view of the organisations priorities for 2014/2015. In preparing the Quality Account, the Foundation Trust had a Quality Account project lead to develop the Quality Account, reporting direct to the Medical Director, and the Quality Account Steering Group with Governor and Patient Carer Panel membership continued. A formal review of the process was established, involving a presentation of the Foundation Trust’s initial draft account to its external stakeholders (Overview and Scrutiny Committee’s, Healthwatch and Commissioners). The draft Quality Account was formally reviewed through the Foundation Trust’s governance arrangements (formal management group, Board sub-committee and Board of Directors). The Foundation Trust set priorities for 2014/15 were patient safety – reduction of slips, trips and falls, patient experience – improving nutritional care for patients with dementia and clinical effectiveness – quality of

healthcare for people with long term conditions using TMed technology and also included a Governor led priority. Priorities were then developed to embed and monitor quality improvement processes, set against the needs of patients in the delivery of the Foundation Trust's services.

The Foundation Trust has utilised Group performance reports, governance and quality reports, clinical outcome measures, mortality reports, Dr Foster and CHKS benchmarking data and a range of key national targets to govern the work associated with these priorities. The data used to report the Foundation Trust's quality performance in 2014/2015 was taken from national data submissions, CHKS and national patient surveys. The quality and safety metrics were reported on a monthly basis to the Board through the performance and governance reports, including the Quality Account Report. The process by which the quality of care, including the quality and accuracy of elective waiting time data, is monitored at management and executive level is achieved through the triangulation of data from patient and staff surveys as well as internal and external data sources. Any deviations to expected performance levels are reported on an exception basis to the Board via the Trust's Executive Assurance Group. External assurance of performance was gained by sharing the Quality Account with the Foundation Trust's Commissioners, Healthwatch and OSCs as required by national regulation.

The Foundation Trust's external auditor, PwC, have undertaken a review of the arrangements in place at the Foundation Trust to secure the data quality of information included in the Quality Account. The report prepared by PwC will be submitted to Monitor by the end of May 2015.

## Review of Effectiveness

As Accounting 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, the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to 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, the Audit Committee, and the Executive Assurance Group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The board assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by the major sources of assurance on which reliance has been placed during the year. These sources included reviews carried out by PwC, Care Quality Commission, Internal Audit, NHS Litigation Authority and the Health and Safety Executive.

The following groups and committees are involved in maintaining and reviewing the effectiveness of the system of internal control:

- The Board of Directors has overall accountability for delivery of patient care, statutory functions and Department of Health requirements;
- The Audit Committee oversees the maintenance of an effective system of internal control and reviews the statement on internal effectiveness and Annual Governance Statement;
- The Executive Assurance Group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the Risk Management Strategy;
- 
- The Assistant Director of Healthcare Governance through the Executive Assurance Group ensures that a fully integrated approach is taken when considering whether the Foundation

Trust has in place systems and processes to support individuals, teams and corporate accountability for the delivery of safe patient centered, high quality care;

- The Assistant Director of Healthcare Governance also manages the clinical audit programme through a dedicated audit team. The audit work programme is reviewed by the Executive Assurance Group and is overseen by the Audit Committee;
- The Clinical Specialty Assurance Committee provide the Board of Directors with assurances of clinical effectiveness and compliance with best practice in the specialties reviewed, through scrutiny of patient quality and safety, patient experience, medicines management, staffing, activity and service line reporting;
- The key group in the management of health and safety is the Joint Health and Safety Committee. This comprises management, staff side representatives and reports into the Executive Assurance Group. The Committee ensures that the Trust meets its legal requirements to consult with staff on matters that affect their health and safety, and has the responsibility of promoting and developing health and safety arrangements across the organisation, by ensuring compliance with the Health and Safety at Work Act 1974 (and related regulations). The Committee is chaired by the Director of Operations, whose role includes being the designated lead director for health and safety for both the Trust's Executive Directors Group and the Board. The Director of Operations is supported in this role by the Resilience and Governance Manager; and
- Internal audit is provided by the Mersey Internal Audit Agency (MIAA). MIAA present the internal audit work plan at the Audit Committee for approval which is then monitored by both the Audit Committee and the Executive Assurance Group. The Head of Internal Audit presents an annual opinion on the overall adequacy and effectiveness of the Foundation Trust's risk management, control and governance processes. This is achieved through a risk based plan of work, agreed with management, approved by the Audit Committee and subsequently reviewed by the Board of Directors.

Review and assurance mechanisms are in place and the Foundation Trust continues to develop arrangements to ensure that:

- Management, including the Board, regularly reviews the risks and controls for which it is responsible;
- Reviews are monitored and reported to the next level of management;
- Changes to priorities or controls are recorded and appropriately referred or actioned;
- Lessons which can be learned, from both successes and failures, are identified and circulated to those who can gain from them; and
- Appropriate level of independent assurance is provided on the whole process of risk.

During 2014/15 the internal auditors undertook ten full audits of the Foundation Trust's systems and processes and 13 follow-up reviews, from which the internal auditors did not identify any significant internal control issues and/or gaps in control.

We acknowledge however that the Foundation Trust is in a period of significant change and will therefore continue to adapt to the changing NHS landscape through an iterative process of review of governance arrangements.

## Conclusion

My review confirms no significant internal control issues have been identified for the year ended 31 March 2015.



**Bridget Fletcher**  
**Chief Executive**

27 May 2015

## GOVERNANCE AND ORGANISATIONAL ARRANGEMENTS

Each NHS Foundation Trust has its own governance structure. The basic governance structure of all NHS Foundation Trusts includes:

- Membership
- Council of Governors *and*
- Board of Directors

This structure is established and well developed at Airedale NHS Foundation Trust, as set out in the Foundation Trust's constitution that is published at [www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk) and in the NHS Foundation Trust directory on Monitor's website at [www.monitor-nhsft.gov.uk](http://www.monitor-nhsft.gov.uk)

In addition to this basic structure, the Foundation Trust also makes use of board committees and sub-groups, comprising directors and/or governors, as a practical way of dealing with specific issues.

### FOUNDATION TRUST MEMBERSHIP

The Foundation Trust has two membership constituencies:

- A public member constituency; and
- A staff member constituency

The number of members and the number of members in each constituency at 31 March 2015 is shown below.

<b>Member Constituency</b>	<b>Number of Members</b>
Bingley	806
Bingley Rural	426
Craven	907
Ilkley	538
Keighley East	925
Keighley Central	818
Keighley West	712
Wharfedale	466
Worth Valley	612
Skipton	1,063
Settle and Mid-Craven	769
South Craven	593
West Craven	366
Pendle East and Colne	588
Rest of England	1,301
Staff	2,821
<b>Total number of foundation trust members</b>	<b>13,728</b>

### Public Member Constituency

We have 15 public member constituencies, split in to the neighbourhood wards of Bradford Council, Craven Council and Pendle Council. A further constituency covering out of area members was established at authorisation to reflect the large number of members living outside the immediate catchment area of the hospital.

All members of the public who are over 14 years of age, living in one of the following public constituencies can become a member by making an application for membership to the Foundation Trust.

- Bingley
- Bingley Rural
- Craven
- Ilkley
- Keighley East
- Keighley Central
- Keighley West
- Wharfedale
- Worth Valley
- Skipton
- Settle and Mid-Craven
- South Craven
- West Craven
- Pendle East and Colne
- Rest of England

As of 31 March 2015 the Foundation Trust had 10,907 public constituency members.

### **Staff Member Constituency**

An individual who is employed by the Foundation Trust under a contract of employment (which includes full and part time contracts of employment) may become a member of the Foundation Trust provided:

- He or she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- He or she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

Individuals who exercise functions for the purposes of the Foundation Trust, otherwise than under a contract of employment with the Foundation Trust, may become members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months. The staff constituency also includes registered Trust volunteers with at least one year's service.

The staff constituency is divided into the following constituencies:

- Doctors and dentists who are registered with their regulatory body to practice;
- Nurses and midwives who are registered with their regulatory body to practice;
- Allied health professionals and scientists who are registered with their regulatory body to practice;
- All registered volunteers (with a minimum of 12 months service); and
- All other staff.

All eligible staff and volunteers are automatically made members in the staff constituency unless they inform the Foundation Trust they do not wish to do so.

As at 31 March 2015, the Foundation Trust had over 2,800 staff members. Six members of staff had chosen to opt out of membership.

### **Constitution Changes**

During 2014, the 'Lower Wharfe Valley' constituency, which included Rawdon, Guiseley, Otley and Yeadon, was merged with the 'Wharfedale' constituency to create a single 'Wharfedale' constituency.

The Lower Wharfe Valley Governor seat had remained vacant since 2011 and as part of the major revision of the Foundation Trust's constitution in 2013; a consultation with members in the Lower Wharfe Valley constituency took place in which members were asked for their views regarding the proposed merger. The response received was overwhelmingly in favour of the merger.

The revised Monitor Model Election Rules were adopted by the Council of Governors and approved in February 2015. The new rules allow members to vote for Foundation Trust Governors using e-voting technology. The Foundation Trust is now able to offer members the option of voting by internet, telephone and text communication. It is anticipated that this change will encourage younger members to vote and increase overall turn-out. In order to achieve this and to simplify the voting process the ballot method was also changed from the system of 'single transferable vote' system to 'first past the post' system.

## **Membership Strategy**

The Membership Development Strategy covering the period 2014/15 is reviewed and approved by the Membership Development Group and the Council of Governors on an annual basis.

The strategy, along with the communications plan and patient and public involvement strategy, will ensure that the membership and the public are:

- Fully represented at all levels;
- Clearly informed; and
- Used appropriately in decision making around service provision.

The strategy aims to:

- Ensure public membership is representative of the community it serves (in terms of nationality, gender, disability, ethnic origin, age, social background, geographical spread and social deprivation)
- Ensure that all staff groups are given equal opportunity to become involved
- Identify levels of involvement and participation within the membership according to the wishes and needs of individuals
- Ensure a continuous approach to the development of the membership in terms of both numbers and level of engagement

In 2015/2016, our plan is to continue the work of engaging with members and the public and collecting specific feedback from the public, and members, including staff and to present that feedback to the board of directors. Collecting feedback will also to facilitate the future development of the Foundation Trust's services as part of the annual planning process help Governors to fulfil their role of engaging with their community and membership.

## **Membership Development Group**

This Group is responsible for developing the membership by recruitment, retention, communication and engagement. The Group meets monthly and was involved in the following membership activities, amongst others, in 2014/15:

- assisting in planning the public open event
- contributing ideas to the member newsletters
- contributing to the involvement of members and the public in the annual plan
- collating feedback from members and the public and sharing this with the board and providing a response back to the members and public
- raising the profile of Governors and membership at hospital events and other recruitment activities;
- engaging with members and the public in the community via community events.

## Membership Recruitment

Recruitment of new members is an ongoing activity to ensure membership numbers are maintained and that membership is representative of the local community. In 2014/2015 the strategy's aim was to ensure overall membership numbers were maintained, whilst focussing on those areas where membership was under represented ie. working age membership.

## Membership Engagement

This year has also seen a number of key developments with regard to membership engagement, development and communications:

In August 2014, we delivered a very successful annual open event, which attracted over 700 visitors in total. The open event provided over 50 displays from hospital departments and was also supported from other organisations such as Bowel Cancer Screening, Slight Airedale, Learning disabilities organisations and local sports disability partnerships. Members and the public were also given the opportunity to share their views with Governors and give their feedback on their experiences and future plans.

The annual members' meeting was held on 31 July 2014.

The annual theatres and endoscopy open day was held in October. This popular event gave our patients and the public the opportunity to tour the departments and meet the staff and Governors.

Our 'Focus on' events are presentations and demonstrations in response to a number of different health topics, and tailored to the interests expressed by our members. They provide all members with opportunities to gain more of an insight into how our services operate. The programme ran throughout 2014/15 and included talks on:

- The Gold Line and caring for people at the end of their life;
- How anaesthetics work;
- Applying for medical school;
- Dementia;
- Multiple sclerosis;
- New emergency department; and
- Bladder problems;

Each member is asked to complete a feedback form and to make suggestions for future events. From feedback received following each event, over 90% of members rated the events as 'excellent'.

We also continued to hold drop-in sessions before each 'Focus on' event where members are able to meet their Governors and find out more about their role, and have the opportunity to ask questions or give feedback about our services. We also advertise the Governor email addresses on our website and bi-annually with the newsletter and encourage our members to contact their Governor with any feedback.

Our 'Interested in becoming a Governor?' events are an opportunity for members to find out about the role of a Governor in more detail. We held two of these events during 2014/15 with a talk from the membership manager and current Governors on the role and responsibilities of a Governor, the election process and what happens once Governors are elected.

This year we sent our regular quarterly communications newsletter to all our membership households. These communications, sent by post and email, are exclusive to our members and provide updates on new developments at the Foundation Trust, information on membership activities, useful patient information, and health advice.

All this information is also available on the Foundation Trust section of our website.

This year we have continued our engagement with young people via local colleges and by holding events for young people such as:

- Applying for medical school;
- Theatres and endoscopy open day; and
- Annual open day.

We have continued to produce our Young Members newsletter, specifically aimed at our members aged 14-21 years, giving them health information and invites to our events.

This year we continued our aim to have an increasingly representative membership by targeting our recruitment in specific areas and with specific groups in the community.

### **Membership Involvement**

The 'Welcome' information mailing members receive, also includes a form for members to record their areas of special interest.. This is returned to the Foundation Trust and allows us to create a database of interests where members would be interested in contributing, for example by completing a survey or participating in a focus group. Members have also been invited to events specific to their interests.

In 2014/15, Governors continued their focus on collecting member and public feedback and ensuring those views were included in the preparation of the Foundation Trust annual plan. Feedback and views were collected via Governor drop-in sessions, Governor attendance at community events, member events, annual open day, staff and volunteer's days and events hosted by Governors and via direct contact with Governors. These views were collated and presented to the Board by the Governors in December 2014 to ensure their consideration as part of the annual planning process. The Board responded to the views of Governors, members and the public at a board to council meeting in February 2015. Governors will feedback to members and the public to explain how those views have been incorporated into the Foundation Trust's future plans.

We have also agreed an additional route for sharing feedback on a bi-monthly basis. All feedback is collated by the membership office and then presented by a Governor to the bi-monthly Patient and Public Engagement and Experience Group so the Foundation Trust can action the feedback and respond.

Governors provide an update to members via the Foundation Trust newsletter, which details the work the Governors have been involved in during the year.

Members are also invited, via their newsletter and the website, to meet Governors at drop-in sessions before every member talk, held throughout the year. Governors also take part in the annual public open day, volunteer and staff events and the theatres open day, giving members an opportunity to meet with them and discuss any issues or questions.

### **Contacting the Foundation Trust Office**

The Foundation Trust office continues to be a central point of contact for all members to make contact with the Trust and the Council of Governors. It can be contacted during office hours, Monday to Friday on 01535 294540 (24 hour answerphone also available) or by email to [members@anhst.nhs.uk](mailto:members@anhst.nhs.uk)

A list of Governor contact email addresses is published on the Foundation Trust website in the Council of Governors section.

## COUNCIL OF GOVERNORS

The Council of Governors comprises 31 Governors – the majority, elected – who play a vital role in the governance of the Foundation Trust, working closely with the Board of Directors. They represent the interests of the Foundation Trust’s public and staff constituencies as well as its members and partner organisations in the local community including healthcare, universities, voluntary organisations and local authorities under the terms of the Foundation Trust’s Constitution. The Council has a number of statutory duties as defined in the Constitution which include:

- The appointment (and removal) of the Chairman and Non-Executive Directors of the Foundation Trust and approval of the appointment of the Chief Executive;
- Deciding on the pay and allowances, and other terms and conditions of office, of the Chairman and Non-Executive Directors;
- Appointing the Foundation Trust’s auditors;
- Holding the Non-Executive Directors, to account, individually and collectively, for the performance of the Board of Directors;
- Approving changes to the Constitution of the Foundation Trust;
- Being consulted on future plans of the Foundation Trust and having the opportunity to contribute to the planning cycle;
- Scrutinising the Annual Plan and receiving the Annual Report and Accounts; and
- Developing the membership of the Foundation Trust.

We have 25 Governors elected by our members (including staff members) who represent the following constituencies (groups):

- **Bradford Metropolitan District Council (ten Governors)**
- **Craven District Council (five Governors)**
- **Pendle Borough Council (three Governors)**
- **Rest of England (one Governor)**
- **Staff and Volunteers (six Governors)**

Of the remaining six nominated Governors, these represent the interests of partner organisations in the local community including universities, voluntary organisations and local authorities.

During the year, the Council of Governors reviewed the Foundation Trust Constitution and approved a change to the election system by which Governors are elected. The Foundation Trust has adopted the ‘first past the post’ system and is now able to offer members e-voting as a means of casting their vote. Following consultation with members, the merger of the Lower Wharfe Valley with the Wharfedale constituency was approved by the Council of Governors at the 2014 annual general meeting; thereby reducing the number of public governors from 20 to 19.

The annual ballot of Governors for the appointment of a Lead Governor and Deputy Lead Governor was held during the year. Mrs Anne Medley, Governor for Keighley West, was duly elected as Lead Governor, and Mr John Roberts, Governor for Worth Valley was elected as Deputy Lead Governor.

A joint meeting with the Board of Directors is held twice yearly to review progress on the Foundation Trust’s Annual Plan and to consider priorities for the forthcoming year. In preparation for the Annual Planning process, the Council of Governors canvassed the opinion of its members and the public by attending local shows and member events, holding drop-in sessions at the hospital, meeting the public and members at GP surgeries, having a dedicated exhibition stand at the hospital open day as well as informal networking. During the year, Governors were fully engaged in different activities and working groups and continued to familiarise themselves with the complexities of such a large organisation. To help support newly elected Governors, the Foundation Trust has developed a bespoke induction programme which existing Governors are

also invited to attend. Other training sessions are organised on a monthly basis to provide further development opportunities for Governors utilising the Foundation Trust's in-house staff as well as extending invitations to external organisations to speak at Governor network meetings. Governors have also developed, with support from the Trust, an informal buddying system whereby in the first few months, new governors are supported by other experienced governors. The Foundation Trust has also provided funding for several of its Governors to attend national training events organised by the Foundation Trust Network.

We value the contribution our Governors make and the different perspectives they bring to the development of services

In consultation with the Council of Governors, the Board appointed Mrs Sally Houghton, Non-Executive Director, as the Senior Independent Director following Mr David Adam's retirement as Non-Executive Director and Senior Independent Director. Mrs Houghton is available to Governors if they have concerns, which contact through the normal channels of Chairman, Chief Executive or Director of Finance have failed to resolve or for which contact is inappropriate.

Elections are held each year for those seats either vacated due to resignations or because Governors have reached the end of their three year term of office. Governors can serve no more than three consecutive terms of office (resulting in a maximum of nine years' tenure). The overall make-up of the Council of Governors, together with their attendance at Council of Governors meetings in 2014/15 is shown on pages 126 and 127.

### **The Board of Directors' Relationship with the Council of Governors and Members**

The Board works closely with the Trust's Council of Governors. The full Board of Directors has met formally with the Council of Governors during the year, to seek and consider the views of the Governors in considering the Foundation Trust's Annual Plan for the coming year. The emphasis was again placed on ensuring Governors were engaged fully in planning for the 2015/16 Annual Plan; this was achieved by holding Board to Council meetings in which Governors fed back the views and comments received throughout the year from Foundation Trust members and members of the public. Regular meetings are held with Governors, attended by Directors, in which specific topics chosen by Governors are discussed. The Chairman, who chairs both the Board of Directors and the Council of Governors, ensures synergy between the two Boards through regular meetings and briefings.

In addition, Governors and Directors, including the Chairman, attend members' events that are held regularly at the hospital on subjects requested by members.

The Directors (both Executive and Non-Executive) meet regularly with Governors during their day to day working through committee meetings, network sessions, Chairman's briefings, consultations and information sessions. Examples include participation in Foundation Trust committees and working groups, and consultations about the Annual Plan and Quality Account. The Foundation Trust has established a buddying system in which each of the Executive and Non-Executive Directors meet informally with a number of Governors to provide briefings and up to date information about the Foundation Trust. The Trust's Stakeholder Governors also meet on a regular basis with the Director of Strategy and Business Development to exchange information about their organisation's developments which might be of mutual interest.

Although meetings of the Board of Directors are held in public and Governors can and do attend, the Chairman provides a Board of Directors feedback session for Governors at their monthly network meetings. The Chairman describes the matters discussed and decisions made within the public and private session of the Board meetings, and responds to any questions or concerns Governors may have.

The following table summarises Governor and Director attendance at Council of Governor's meetings:

**Attendance of Governors and Directors at Council of Governors meetings 2014/15**

<b>Public Governors</b>	<b>Tenure</b>	<b>Constituency</b>	<b>Meetings attended</b>
<b>Public Elected Governors</b>			
Janet Ackroyd	Defeated at election 31.5.14 Replaced at election by Cath Wilson	South Craven	1/1
Peter Allen	Elected 1 June 2013	Skipton	4/4
Peter Beaumont	Elected 1 June 2013	Wharfedale	4/4
John Bootland	Elected 1 June 2014	Keighley Central	3/3
David Child	Elected 1 June 2013	Bingley	3/4
Steve Coakley	Removed 31.10.14 Seat currently vacant	Pendle East and Colne	0/3
Alan Davies	Elected 1 June 2012	Craven	3/4
Jean Hepworth	Elected 1 June 2013	Keighley East	3/4
Peter Jackson	Elected 1 June 2014	Rest of England	2/3
Valerie Kimberley	Elected 1 June 2014	West Craven	3/4
Christine Johnson	Elected 1 June 2014	Skipton	3/3
Anne Medley	Elected 1 June 2014	Keighley West	4/4
Adrian Mornin	Resigned 31.7.14 Seat currently vacant	Keighley Central	0/2
Chris Nolan	Elected 1 June 2012	West Craven	2/4
Alan Pick	Elected 1 June 2012	South Craven	3/4
John Roberts	Elected 1 June 2013	Worth Valley	4/4
Pat Taylor	Elected 1 June 2013	Settle and Mid Craven	4/4
Pat Thorpe	Elected 1 June 2013	Bingley Rural	3/4
Bryan Thompson	Elected 1 June 2013	Ilkley	3/4
Cath Wilson	Elected 1 June 2014	South Craven	2/3
Vacant	Seat merged with Wharfedale on 31 July 2014	Lower Wharfe Valley	-

<b>Stakeholder Governors</b>	<b>Tenure</b>	<b>Constituency</b>	<b>Meetings attended</b>
<b>Appointed Governors</b>			
Prof Anne Forster	Appointed 1 June 2013	University of Leeds	3/4
Cllr Robert Heseltine	Appointed 1 June 2013	North Yorkshire County Council	4/4
Naz Kazmi	Appointed 1 June 2013	Voluntary Sector	2/4
Cllr Ken Hartley	Appointed 16 June 2013	Pendle Borough Council	4/4
Pauline Sharp	Appointed 1 June 2013	Bradford Metropolitan District Council	3/4
Cllr Marcia Turner	Appointed 1 June 2013	Craven District Council	3/4
<b>Staff Elected Governors</b>			
<b>Staff Governors</b>	<b>Tenure</b>	<b>Constituency</b>	<b>Meetings attended</b>
<b>Staff Elected Governors</b>			
Rachel Binks	Elected 1 June 2014	Nurses and Midwives	2/3
Annette Ferrier	Elected 1 June 2013	Allied health professionals and scientists	4/4
Valerie Henson	Elected 1 June 2012	Nurses and Midwives	2/4
Tom Hollins	Elected 1 June 2014	Doctors and Dentists	1/3
Rebecca Malin	Elected 1 June 2014	All other staff	1/3
Naren Samtaney	Resigned 31.5.14 Replaced at election by Tom Hollins	Doctors and Dentists	1/1
Mike Yates	Elected 1 June 2014	Volunteers	3/3
In addition the Council of Governors meetings were attended by the following Directors:			
<b>Non-Executive Directors</b>	<b>Job Title</b>	<b>Meetings attended</b>	
Colin Millar	Chairman (retired 30 April 2014)	0/0	
Michael Luger	Chairman (appointed 1 May 2014)	4/4	
David Adam	Non-Executive Director (retired 30 September 2014)	1/2	
Ronald Drake	Non-Executive Director	3/4	
Prof Anne Gregory	Non-Executive Director	3/4	
Sally Houghton	Non-Executive Director	4/4	
Dr Mike Toop	Non-Executive Director	3/4	
Jeremy Cross	Non-Executive Director (appointed 1 October 2014)	1/2	
<b>Executive Directors</b>			
Bridget Fletcher	Chief Executive	4/4	
Karl Mainprize	Medical Director (from 3 June 2014)	2/3	
Dr Harold Hosker	Interim Medical Director (from 1 April 2014 to 2 June 2014 )	1/1	
Andrew Copley	Director of Finance	3/4	
Robert Dearden	Director of Nursing	2/4	
Ann Wagner	Director of Strategy and Business Development	4/4	

## BOARD OF DIRECTORS

The Board of Directors is responsible for exercising all the powers of the Foundation Trust and is the body that sets the strategic direction, allocates the Foundation Trust's resources and monitors its performance.

Its role is to:

- Set the organisation's values;
- Set the strategic direction and leadership of the Foundation Trust;
- Ensure the terms of the Provider Licence are met;
- Set organisational and operational targets;
- Assess, manage and minimise risk;
- Assess achievement against the above objectives;
- Ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives;
- Ensure that the highest standards of corporate governance are applied throughout the organization; and
- Note advice from, and consider the views of, the Council of Governors.

The Board has an annual schedule of business which ensures it focuses on its responsibilities and the long-term strategic direction of the Foundation Trust. It meets ten times a year to conduct its business and at quarterly intervals to discuss matters requiring strategic debate. Board members also attend seminars and training and development events throughout the year.

Since becoming a Foundation Trust, the Board has undertaken a rigorous evaluation of its own performance and of individual Directors. The aim is to conduct a full performance evaluation every three years supplemented by more frequent baseline assessment of skills, experiences and competencies. In 2014, the Foundation Trust was invited by Monitor to participate in the pilot for the new Governance and Capability Review. The Review, undertaken by an external evaluation company, Foresight Partnership/Capita concluded in March 2014 and the Report findings shared with the Board. The company has no other connection with the Foundation Trust.

The Review concluded that; the Foundation Trust had a competent Board with a strong team in terms of composition and capabilities; that the Board's commitment and focus on quality was evident; and, that the Board was seen as demonstrating an open and non-defensive culture with a strong commitment to learning and development. The Review identified scope for some fine tuning to further strengthen the quality governance arrangements. Since then a longer term over-arching quality strategy has been developed and will be fully in place during the year.

The Board is made up of five Executive Directors and six Non-Executive Directors including the Chairman. It also has an Associate Director – the Director of Operations.

The balance of the Board of Directors meets the provisions of the Foundation Trust Code of Governance requirements for at least half of the directors being independent Non-Executive Directors. The Non-Executive Board Directors possess a wide range of skills and experience essential for an effective Foundation Trust board of directors. These skills enable them to provide independent judgment and advice on issues of strategy, vision, performance, resources and standards of conduct and constructively challenge, influence and help the executive team develop proposals on such strategies.

The Board of Directors works as a unitary board and directors have been selected to ensure the success of the organisation as a Foundation Trust, with an appropriate balance of clinical, financial, business and management background and skills. Should it be necessary to remove either the Chairman or any Non-Executive Director, this shall be undertaken by the Council of Governors in accordance with the Foundation Trust's Constitution.

The Board may delegate any of its powers to a committee of Directors or to an Executive Director. These matters are set out in the Foundation Trust's Scheme of Decisions Reserved to the Board and the Scheme of Delegation. Decision making for the operational running of the Foundation Trust is delegated to the Executive Directors Group, which comprises all of the Executive Directors, Associate Director, Head of HR and the Company Secretary.

Responsibility for the appointment of the Chairman and Non-Executive Directors resides with the Council of Governors. The Appointments and Remuneration Committee, which comprises five members of the Council of Governors and two Non-Executive Directors plus the Chairman, is responsible for bringing recommendations for non-executive appointments to the Council. The Company Secretary and Head of HR attend each meeting in an advisory capacity. The Committee also has the option to commission an independent adviser if appropriate.

A separate committee, the Board Appointments, Remuneration and Terms of Service Committee, comprising Non-Executive Directors and the Chief Executive is established with responsibility for the recruitment and selection of Executive Directors and the remuneration and terms of service of Executive Directors.

The composition of the Board for the year of the report is set out on the following pages. It also includes details of each director's background, committee membership and attendance at meetings.

An annual appraisal process for Non-Executive Directors is in place and is reviewed on an annual basis by the Appointments and Remuneration Committee ('ARC'). The Chairman appraises the performance of the Non-Executive Directors and provides a detailed report to the Appointments and Remuneration Committee; whilst the Senior Independent Director leads the Chairman's appraisal and provides a summary report also to the ARC. In preparing the appraisals, both the Chairman and Senior Independent Director consult with Executive Directors and via the Lead Governor, take in to account the views of Governors in their appraisal reports. Executive Directors also have detailed appraisals of their performance and an annual appraisal process is in place with regular reviews of objectives set by the Chief Executive, and in the case of the Chief Executive by the Chairman. A summary report of the Executive Director appraisals is presented to the Board Appointments, Remuneration and Terms of Service Committee ('BART') by the Chief Executive, and by the Chairman in the case of the Chief Executive.

Non-Executive Directors are involved in regular development activities including Board workshops, and attendance at seminars and conferences. The Foundation Trust considers it has the appropriate balance and completeness in the Board's membership to meet the ongoing requirements of an NHS Foundation Trust.

Disclosures of the remuneration paid to the Chairman, Non-Executive Directors and senior managers are given in the Remuneration Report on page 137. The Board of Directors who served during the year comprised the following Executive and Non-Executive Directors are shown below.

## **Biographies of the Board of Directors**

### **Non-Executive Directors**

#### **Colin Millar, Chairman (retired 30 April 2014)**

Colin was appointed Chairman in 2005 and retired after serving a second term of four years. His early career was in marketing with an international consumer goods company, principally in the UK. Subsequently he held senior marketing appointments in the financial services sector. Latterly, he owned and ran a market research company supplying information to companies and trade organisations throughout the world. Up to his retirement he was also a Non-Executive Director of a regional building society and a Trustee of a hospice in Leeds.

**Michael Luger, Chairman (appointed 1 May 2014)**

Michael was appointed Chairman in May 2014 following the retirement of Colin Millar. Michael formerly served as Dean of Manchester Business School for seven years, retiring from that post in December 2013. Prior to that he was a professor of public policy, business and planning at the University of North Carolina and taught economics at Duke University and the University of Maryland. In addition to university leadership roles, Michael has served on numerous public sector and not-for-profit boards, commissions, and task forces. He has worked as a professional planning officer in the USA and for the Greater London Council, as a consultant and advisor to national, state, regional and local governments throughout the world, and to major multi-national corporations. His expertise in public finance, infrastructure, and economic development has been used in the health care sector in both the USA and UK. Michael is currently a Non-Executive Director at the Office of Rail Regulation and is a part-time professor at Manchester Business School. He also acts as a business consultant for a limited company. As well as being chairman of the Board of Directors and Council of Governors, Michael chairs the Appointments and Remuneration Committee and is a member of the Board Appointments, Remuneration and Terms of Service Committee.

**David Adam, Non-Executive Director (retired 30 September 2014)**

David was appointed a Non-Executive Director in February 2007. David is a chartered accountant with almost 40 years financial management experience, including 13 years as a PLC Finance Director with two publicly listed companies. He previously worked as Finance Director in a number of large UK plc subsidiaries and has also held the post of Chief Executive of a large educational supply company. He also held Non-Executive Director roles in three UK companies as well as being a Pension Fund Trustee for over 20 years.

**Jeremy Cross, Non-Executive Director (appointed 1 October 2014)**

Jeremy was appointed a Non-Executive Director following the retirement of David Adam. Jeremy is a Chartered Accountant and is currently working as a self-employed consultant. He is also a Non-Executive Director with Mansfield Building Society. Jeremy's previous roles include Director of Personal Current Accounts with Halifax Plc and Bank of Scotland. Prior to this he held various commercial and strategic senior roles with Asda and Boots. Jeremy is a member of the Audit Committee.

**Ronald Drake, Non-Executive Director and Deputy Chairman**

Ronald was appointed a Non-Executive Director in February 2007. His term of office will end in 2015/16. Ronald has over 36 years as a qualified solicitor since being admitted to the Roll in 1978. He retired as Partner with a national legal practice in 2012 having worked previously in Birmingham, Bradford and for the last 25 years in Leeds. He has also been a part-time employment tribunal Judge since 1997. Ronald is a member of the Clinical Specialty and Assurance Committee, Board Appointments, Remuneration and Terms of Service Committee and the Appointments and Remuneration Committee.

**Professor Anne Gregory, Non-Executive Director**

Anne was appointed a Non-Executive Director in June 2012. Anne has 30 years of experience in public relations and is currently employed at University of Huddersfield. Prior to that Anne was employed at Leeds Metropolitan University where she also served a term as pro-vice chancellor. For eight years Anne was a Non-Executive Director of South West Yorkshire Partnership NHS Foundation Trust and previously served eight years on the board of Bradford Community NHS Trust. Ann is chair of the Board Appointments and Remuneration Committee and is a member of the Clinical Specialty and Assurance Committee.

**Sally Houghton, Non-Executive Director and Senior Independent Director**

Sally was appointed a Non-Executive Director in February 2006 and is currently serving a third term, which is due to end in July 2015. Sally is a qualified accountant and has over twenty years experience in multi-national manufacturing and engineering companies, some of which at Finance Director level. She is currently employed at a local firm of solicitors on an accountancy basis.

Sally chairs the Audit Committee and Airedale NHS Foundation Trust Charitable Funds Sub-Committee and is a member of the Appointments and Remuneration Committee.

#### **Dr Michael Toop, Non-Executive Director**

Michael was appointed a Non-Executive Director in February 2013. He is a retired consultant in chemical pathology and previously managed the chemical pathology department at Harrogate Hospital for 25 years until his retirement in 2011. Michael also worked in various specialties at Leicester Royal Infirmary and then as registrar in Birmingham. Throughout his career Michael has held a number of formal positions including with the Royal College of Pathologists and Association for Clinical Biochemistry. Michael is chair of the Clinical Specialty and Assurance Committee.

The Board considers all the Non-Executive Directors to be independent.

### **Executive Directors**

#### **Bridget Fletcher, Chief Executive**

Bridget was appointed Chief Executive in November 2010. She was previously Chief Operating Officer/Chief Nurse and prior to this Director of Nursing for 5 years having joined Airedale in 2005. Before joining Airedale, Bridget was Assistant Director, Quality Assurance at The Royal Marsden NHS Foundation Trust. Prior to this she was at West Middlesex University Hospital NHS Trust and Salford Royal NHS Trust where she held a number of senior management roles with responsibility for acute health services and professional nursing services.

#### **Rob Dearden, Director of Nursing**

Rob joined Airedale NHS Foundation Trust as Interim Director of Nursing in August 2011 and was appointed to the substantive role of Director of Nursing on 1 August 2012. Prior to this, he was Deputy Director of Nursing at Calderdale and Huddersfield NHS Foundation Trust. He qualified as a Registered General Nurse in 1987 at Manchester Royal Infirmary and then as a Registered Mental Nurse at Wigan Infirmary in 1990. He later specialised in Care of Older People and Rehabilitation Medicine in Manchester, Wirral and Halifax. Rob has a significant background in Practice Development.

#### **Andrew Copley, Director of Finance**

Andrew was appointed Director of Finance in January 2013. Andrew is a Fellow of the Association of Chartered Certified Accountants with nearly 20 years financial management experience. He joined the Airedale in 2008 as Deputy Director of Finance from Calderdale and Huddersfield NHS Foundation Trust. Andrew initially trained as a radiographer at Pinderfields and Pontefract hospitals and later joined St Luke's hospital, Bradford.

#### **Dr Harold Hosker, Interim Medical Director (to 3 June 2014)**

Harold was Interim Medical Director from 1 March 2014 to 3 June 2014. Following the appointment of Karl Mainprize, Harold returned to his substantive role as Deputy Medical Director with the Foundation Trust. Harold joined Airedale in 2007 as Consultant in General and Respiratory Medicine having previously held the same position at Burnley NHS Trust. His early career was spent at Newcastle as a medical SHO/Registrar before going on to research lung cancer. Harold has also worked as a Specialist Registrar in Leeds and Hull.

#### **Mr Karl Mainprize, Medical Director (appointed 3 June 2014)**

Karl was appointed Medical Director on 3 June 2014, having previously been Deputy Medical Director at York Hospitals NHS Foundation Trust. Prior to this he worked at Scarborough Hospital as Consultant Colorectal Surgeon for almost 10 years where he was instrumental in developing the first ever community endoscopy service. Having qualified in 1989 he spent his early career based at Oxford, Reading and London.

#### **Ann Wagner, Director of Strategy and Business Development**

Ann joined the Airedale NHS Foundation Trust in 2006 as Director of Corporate Development taking on responsibility for securing Foundation Trust status, which was achieved in 2010. Since

then she has taken the lead for strategy and business development. Prior to joining Airedale, Ann held a number of senior strategic roles including Executive Director of Service Improvement at West Yorkshire SHA, National Programme Director for the Department of Health Integrated Service Improvement Programme, Programme Director for the West Yorkshire Choice Pilot and Director of Performance Management at Bradford Health Authority. Prior to joining the NHS, Ann worked in the private sector as a PR consultant managing a range of business to business accounts; and before that worked in Local Authorities and the North of England in a number of marketing related posts.

## Committees of the Board of Directors

The Foundation Trust Board of Directors and Council of Governors have discharged their functions throughout the year through a number of sub-committees as outlined below. The Board receives regular reports from the Committee Chairperson as well as the minutes in order to evaluate the performance and effectiveness of its sub-committees. A description of the work of the nominations committees are detailed in the Remuneration Report.

## Audit Committee

The Audit Committee is chaired by a Non-Executive Director – Mrs Houghton, and has a further two Non-Executive Director members, Mr Cross and Dr Toop. The Director of Finance and other senior managers including the Company Secretary and the Assistant Director, Healthcare Governance, attend each committee meeting. Also in attendance is a Governor representative.

The Committee's terms of reference are approved by the Board of Directors. The Committee has an annual work plan which shows how it plans to discharge its responsibilities under its terms of reference. Minutes of each meeting are reported to the Board along with any recommendations by the Chair of the Audit Committee. Committee members carry out a self-assessment each year. The Committee reports to the Board of Directors through its annual report on its work in support of the Annual Governance Statement. This specifically comments on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the Foundation Trust, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission outcomes.

Its main duties throughout the year were:

- **Financial reporting** – The Audit Committee monitors the integrity of the financial statements of the Foundation Trust, including scrutinising the quarterly corporate governance statement to Monitor, and any formal announcements relating to the Foundation Trust's financial performance, reviewing significant financial reporting judgments contained in them. The Committee received and approved the Foundation Trust accounts and the Annual Governance Statement for 2014/15.
- **Governance, risk management and internal control** – The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Foundation Trust's activities (both clinical and non-clinical) that support the achievement of the Foundation Trust's objectives. The Audit Committee ensures that the review of the effectiveness of the system of internal control is undertaken and its findings reported to the Board. The Committee received the Foundation Trust's Board Assurance Framework and various audit reports concerning these matters, during this period. The Committee received reports outlining the progress made in planned counter fraud work and general issues concerning the NHS Counter Fraud Service (CFS). The Committee also reviewed as appropriate the findings of other relevant significant assurance functions, both internal and external to the Foundation Trust and considered the implications to the governance of the Foundation Trust.

- **Internal audit** – The Committee ensures that there is an effective internal audit function established by management that meets mandatory internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. The Committee received the internal audit plan, internal audit annual report and progress reports in this period and also received the review of the internal audit function by external audit and the Director of Finance. The internal audit contract with Mersey Internal Audit Agency was extended by the Foundation Trust for a further two years beyond its initial term of three years.
- **External audit** – The Audit Committee reviews and monitors the external auditor's independence and objectivity and the effectiveness of the audit process. The Committee received and reviewed external audit plans and regular routine reports, along with holding regular private discussions with the external auditors and internal audit. The external auditor attends each Audit Committee meeting. The external audit contract with PricewaterhouseCoopers was extended by the Council of Governors for a further year beyond its initial contract term of three years.
- **Counter fraud** – The Audit Committee ensures that there are appropriate fraud prevention and detection measures in place. It receives an annual report from the Foundation Trust's Local Counter Fraud Specialist and reviews and approves the annual work plan each year.

The Company Secretary was the formal secretary for the Committee and ensured that co-ordination of papers and minutes were produced in accordance with the Chair of the Committee. The Foundation Trust has a process agreed by Governors for the agreement of non-audit services provided by external audit. No additional non-audit services were required during the period.

### Clinical Specialty Assurance Committee

The Clinical Specialty Assurance Committee, chaired by Dr Toop, Non-Executive Director, provides the Board of Directors with assurance that high standards of care are provided by the Foundation Trust by reviewing clinical specialties, focussing on the following service quality areas:

- Patient experience;
- Quality;
- Safety;
- Medicines Management
- Staffing
- Activity; and
- SLR performance.

It also provides support to the Board of Directors in developing an integrated approach to governance by ensuring clinical effectiveness and compliance with best practice in each of the clinical specialties areas reviewed

### Charitable Funds Sub-Committee

The Charitable Funds Sub Committee, chaired by Mrs Houghton, Non-Executive Director, acts on behalf of the Board of Directors in its capacity as Corporate Trustee of the Airedale NHSFT Charitable Funds (charity number 1050730). Other committee members include the Director of Strategy and Business Development, Director of Operations, a senior matron and a senior clinician.

The purpose of the committee is to give additional assurance to the Corporate Trustee that its charitable activities are within the law and regulations set by the Charity Commission for England and Wales and to ensure compliance with the charity's own governing document. The committee meets at least four times a year and provides advice to the Corporate Trustee on matters such as investment strategy and fundraising strategy.

The annual report and accounts of the Airedale NHSFT Charitable Funds are available from either contacting the Company Secretary or via the Foundation Trust's or Charities Commission website.

### Director attendance at Board and Sub-Committee meetings 2014/15

Directors	Board of Directors	Audit Committee	BART	Charitable Funds Sub-Committee	CSAC
Colin Millar (retired 30 April 2014)	1/1	-	-	-	-
Professor Michael Luger (appointed 1 May 2014)	9/9	-	1/1	-	-
David Adam (retired 30 September 2014)	5/5	2/3	5/5	-	-
Jeremy Cross (appointed 1 October 2014)	4/5	1/2	-	-	-
Ronald Drake	9/10	-	4/5	-	6/6
Professor Anne Gregory	9/10	-	5/5	-	5/6
Sally Houghton	8/10	5/5	-	5/5	-
Dr Mike Toop	9/10	5/5	-	-	5/6
Bridget Fletcher	10/10	-	5/5	-	-
Andrew Copley	10/10	5/5	-	3/3	-
Dr Harold Hosker (from 1 April to 2 June 2014)	1/2	-	-	-	-
Rob Dearden	10/10	-	-	-	3/6
Mr Karl Mainprize (appointed 3 June 2014)	8/8	-	-	-	6/6
Ann Wagner	10/10	-	-	1/2	-

### Register of Director Interests

The Board of Directors undertakes an annual review of its Register of Declared Interests. At each meeting of the Board of Directors a standing agenda item also requires all Executive and Non-Executive Directors to make known any interest in relation to the agenda, and any changes to their declared interests. There are no interests which may conflict with their management responsibilities as per the requirements of the Monitor Code of Governance. It is reported that the Chairman had no other significant commitments that affected his ability to carry out his duties to the full and was able to allow sufficient time to undertake those duties.

The Register of Declared Interests for the Board of Directors is held by the Foundation Trust's Company Secretary and is available for public inspection on request.

### Political and Charitable Donations

Airedale NHS Foundation Trust made no political or charitable donations during the year. The Foundation Trust does however continue to benefit from the receipt of charitable donations which are monitored and allocated separately through the charitable funds sub-committee. We are extremely grateful to members of the public for their continued support in providing these donations.

### Counter Fraud

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy the Foundation Trusts financial position at any time to enable them to ensure the accounts comply with requirements outlined in Secretary of State Directions. They are also responsible for safeguarding the Foundation Trust's assets and taking reasonable steps for the prevention and detection of fraud and other irregularities.

## **Additional Disclosures Required by the NHS Foundation Trust Annual Reporting Manual**

Accounting policies for pensions and other retirement benefits are set out in Note 1.3 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

### **Responsibility Statement**

The Directors are responsible for preparing the Annual Report and the financial statements in accordance with applicable law and regulations.

The Directors are also responsible for keeping adequate accounting records that are sufficient to show and explain the Foundation Trust's transactions and disclose with reasonable accuracy at any time the financial position of the Foundation Trust and enable them to ensure that the financial statements comply with applicable law and regulations. They are also responsible for safeguarding the assets of the Foundation Trust and hence taking reasonable steps for the prevention of fraud and other irregularities.

The Directors confirm that to the best of their knowledge, the Annual Report and financial statements taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

### **Statement of Disclosure to Auditors**

For each individual who is a director at the time that the Annual Report is approved;

- So far as each director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and
- The directors have taken all the steps they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the NHS Foundation Trust's auditor is aware of that information.

### **Statement on Going Concern**

After making enquiries, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

## **ASSESSMENT AGAINST THE MONITOR NHS FOUNDATION TRUST CODE OF GOVERNANCE**

Airedale NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a '*comply or explain*' basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors has established governance policies that reflect the principles of the NHS Foundation Trust Code of Governance, these include:

- Corporate Governance Framework Manual, incorporating the Standing Orders of the Board of Directors, Standing Orders of the Council of Governors, Scheme of Reservation and Delegation of Powers and Standing Financial Instructions;
- Established role of Senior Independent Director;
- Private meeting between the Chair and Non-Executive Directors;

- Performance Appraisal Process for all Non-Executive Directors, including the Chairman, developed and approved by the Council of Governors;
- Formal induction programme for Non-Executive Directors and Executive Directors;
- Attendance records for Directors and Governors at key meetings;
- Comprehensive induction programme for Governors;
- Register of Interest for Directors, Governors and senior staff;
- Council of Governors' Policy for Raising Serious Concerns;
- Established roles of Lead and Deputy Lead Governor;
- Monthly private meeting between the Chair and Governors to review matters discussed at the Board of Directors' meetings;
- Comprehensive briefing report provided to all meetings of the Council of Governors by the Chief Executive and Director of Finance;
- Effective Council of Governors' sub-committee structure;
- Council of Governors' agenda setting process;
- Collective performance evaluation mechanism for the Council of Governors;
- Membership Development Strategy, Implementation Plan and Key Performance Indicators;
- Nominations, Remuneration and Terms of Service Committee of the Board of Directors;
- Nominations, Remuneration and Terms of Service Committee of the Council of Governors;
- Agreed recruitment process for Non-Executive Directors;
- Provision of high quality reports to the Board of Directors and Council of Governors;
- Tri-annual Board evaluation and development plan;
- Council of Governors' presentation of performance and achievement at Annual Members Meeting;
- Code of Conduct for Governors;
- Going Concern Report;
- Robust Audit Committee arrangements;
- Governor-led process for the appointment of External Auditor; and
- Whistleblowing Policy and Counter Fraud Policy.

In considering the provisions of the Monitor Code of Governance for Foundation Trusts, the Board is satisfied that all the requirements have been complied with and consequently there are no departures from the Code of Governance requiring disclosure.



**Bridget Fletcher**  
Chief Executive

27 May 2015

# REMUNERATION REPORT

## Annual Statement on Remuneration

The Foundation Trust has established two committees responsible for the remuneration, appointments and nomination of Board directors: the Appointment and Remuneration Committee and the Board Appointments, Remuneration and Terms of Service Committee. Through these two committees, the Board ensures that a robust and thorough process of performance evaluation of Executive and Non-Executive Directors is undertaken and remuneration levels are set accordingly.

## Appointments and Remuneration Committee

The Appointments and Remuneration Committee (the 'Committee') is established for the purpose of overseeing the recruitment and selection processes to secure the appointments of Non-Executive Directors (including the Chairman) being cognisant of the Board of Directors knowledge, skills and experience. The Committee also oversees the review of remuneration levels of the Chairman and Non-Executive Directors. The Committee makes recommendations to the Council of Governors on the appointment of Non-Executive Directors (including the Chairman) of the Foundation Trust and the Chairman and Non- Executive Directors remuneration levels.

The process in which the Non-Executive Directors are evaluated is managed by the Committee and involves Governors and Board directors. The Chairman conducts the Non-Executive Director appraisals, whilst the Senior Independent Director conducts the appraisal of the Chairman. The Council of Governors receives a report each year outlining the process undertaken.

During the year, the Committee undertook a remuneration review of Non-Executive Director fees. In doing so, the Committee was cognisant of the pay and employments conditions elsewhere in the Foundation Trust and in particular the increase in salary levels for staff, which for 2014/15 comprised a 1% 'national uplift'. Also taken in to account was the benchmarking of Non-Executive Director fees with neighbouring Foundation Trusts and the contracted days compared with those Foundation Trusts. Following a robust review of fees, the Committee recommended an uplift in fees of 1% applicable from 1 April 2014. The increase was duly approved by the Council of Governors.

The Committee's other work during the year included reviewing its terms of reference; ensuring the Foundation Trust's preparedness for the new CQC regulation regarding the Fit and Proper Person requirements; and, initiating a candidate search in readiness for the retirement of Mrs Sally Houghton, Non-Executive Director in July 2015.

The process of appointing a successor Chair commenced prior to the 2014/15 financial year. Following a rigorous selection process in which a preferred candidate had been selected, the candidate opted to withdraw from the process due to other external work commitments. The Committee re-commenced the appointment process and commissioned a different external recruitment consultant to source suitable candidates. The search produced a strong field of candidates. The Committee involved a number of Governors in reviewing the person specification and role description as well the recruitment process – all of which were presented and approved by the Council of Governors. The Committee as part of a robust selection process undertook a series of long listing and short listing meetings prior to conducting interviews. The interview process involved the assistance of an independent assessor who conducted a one to one interview with each of the candidates. In addition to this, the Chief Executive and the Lead Governor together with the Deputy Chairman also conducted one to one interviews. The Council of Governors was also invited to take part in a discussion forum with each of the candidates – of which a number of Governors took part in. Also contributing to the selection process was the Board of Directors who also took part in a discussion forum with the candidates of which a number of Executive and Non-Executive Directors participated in. Finally, the selection panel comprising the Senior Independent Director, Deputy Chairman, Lead Governor, Stakeholder Governor, Staff Governor and a Public

Governor conducted a series of interviews with each of the candidates. Each element of the selection process then fed back their comments to the Committee, following which a preferred candidate was nominated for approval by the Council of Governors. An Extraordinary Council of Governors meeting was convened on 2 April 2014 for the purpose of approving the preferred candidate recommendation by the Committee. The recommendation was approved and the successor Chairman – Mr Michael Luger was appointed with effect from 1 May 2014.

The previous Chairman, Mr Colin Millar, did not take an active role in the recruitment and selection process but provided advice and guidance on the role of the Chairman in order to assist the Committee in its deliberations.

As a consequence of the delay in appointing a successor Chair and in order to manage the refreshing of the Board, the succession plan was reviewed and it was considered by the Committee appropriate to extend the term of office of Mr David Adam, Non-Executive Director and Senior Independent Director to September 2014. This was duly considered and approved by the Council of Governors. The appointment process for a successor Non-Executive Director was undertaken during 2014 following the same robust process as had been undertaken for the successor Chair appointment. The appointment of Mr Jeremy Cross was duly approved by the Council of Governors and Mr Cross appointed with effect from 1 October 2014.

During 2014/15, the Committee met to consider the process for the replacement of Mr Colin Millar as Non-Executive Director and Chairman and Mr David Adam as Non-Executive Director. The Committee also considered the Board succession plan for Non-Executive Directors and conducted a remuneration review of Non-Executive Directors

### **Board Appointments and Remuneration and Terms of Service Committee**

The Committee is established for the purpose of overseeing the recruitment and selection process for Executive Directors and the appointment of formal Board positions, for example the Senior Independent Director. The Committee's second purpose is to determine the remuneration and terms of service of Executive Directors and Associate Directors as well other senior managers covered by NHS Agenda for Change or the Consultant Contract.

The Committee also reviews current and future requirements applicable to the performance and setting of salaries for the posts covered by the committees remit and in addition the Foundation Trust's senior management succession planning arrangements and talent management process. The Executive Directors appraisals conducted by the Chief Executive and in the case of the Chief Executive by the Chairman are reported to the committee. The evaluation process involves input from other Executive Directors as well as Non-Executive Directors. The committee's report to the Board of Directors includes the reporting of the Chief Executive's annual objectives.

The Committee met to consider the selection process for the appointment of a Medical Director to replace Dr Andrew Catto who left the organisation at the end of February 2014. Following a rigorous selection process, the Foundation Trust successfully appointed Mr Karl Mainprize as Medical Director to take office with effect from 3 June 2014. The Committee also met to consider the interim arrangements for Medical Director and allocated responsibilities, and included the appointment of Dr Harold Hosker as Interim Medical Director to cover the period from March to June 2014. The Committee considers the interim arrangements to have been appropriate and robust.

The Committee also met during the year to consider the latest independent benchmarking information for Director's remuneration and to agree the appropriate level of remuneration. The Committee followed a previously agreed formal Executive Pay Framework, the purpose of which is to provide a level of remuneration linked to performance, role weight, and pay of other staff in the Foundation Trust and in the context of wider public sector considerations.

As part of the review of remuneration, the Committee considers a report from the Chief Executive which summarises the performance of individual Directors (including the Company Secretary and

Head of Human Resources and Workforce), against their agreed objectives. In the case of the Chief Executive, the Chairman presents the performance report. The Committee then makes a decision about each director's salary review, linked to their performance. In determining any decisions relating to Executive pay, the Committee has regard to the Monitor Code of Governance in relation to the remuneration of Executive Directors and is particularly sensitive to the pay and conditions of other staff within the Foundation Trust. Accordingly, the level of increase applied to directors salaries were limited to the maximum increase that staff employed under Agenda for Change could have received for 2014/15.

## Senior Managers' Remuneration Policy

In 2013/14 the Foundation Trust adopted an Executive Director Pay and Rewards Framework ('Framework') developed in line with the recommendations contained in the Hutton Report (March 2011) and Fair Pay Code. The Framework was reviewed again in 2014/15 to determine Executive Director pay.

The Foundation Trust's main principles are that Executive Director's remuneration should fairly reward an individual's due desert and contribution to the Foundation Trust's success; and should be sufficient to recruit, retain and motivate executives whilst providing value for money.

Underpinning this, the Foundation Trust ensures that:

- Pay and reward are linked to the weight of the role based on accountability, job responsibilities and the knowledge and skills required;
- Pay is proportional to an individual's performance based on achievement of individual and Foundation Trust objectives and enables progression as Directors develop in role;
- Base pay and reward follow a robust performance appraisal process with objectives and final assessment of pay awards delegated to the Board Appointment, Remuneration and Terms of Service Committee;
- Pay and reward reflects pay developments and awards in the wider public sector and takes in to account the level of general pay increases for other staff within the Foundation Trust, ensuring value for money; and
- Executive pay ranges are published to staff and the public in the Foundation Trust's Annual Report.

## Key Components of remuneration

### Executive Directors

Remuneration Component	How this component relates to Foundation Trust strategy	How this component operates in practice	Performance measures and maximum potential value
Base salary	Base salary helps to attract, reward and retain the right calibre of executive to deliver the leadership/management needed to execute the Foundation Trust's vision and plan	Base salary reflects the role, the executive's skills and experience and market level. To determine market level, the BART committee reviews remuneration data on executive positions against NHS benchmarks using the 'IDS publication' <i>NHS Boardroom Pay Report</i> . On appointment an executive director's base salary is set at the market level or below if the executive is not fully experienced at this level. Where base salary on appointment is below market level to reflect experience, it will over time be increased to	The base salaries of Executive Directors in post at the start of the policy period and who remain in the same role throughout the policy period will not usually be increased by a higher percentage than the average annual percentage increase in salaries of all other employees in the Foundation Trust. The only exceptions are where an executive director has been appointed at below market level to reflect experience. The BART committee has the discretion to award increases above the maximum point or non-consolidated performance payments to reward exceptional performance.

		align with the market level subject to performance. In exceptional cases the BART committee has the discretion to appoint above the maximum pay point in order to recognise outstanding experience, skills and knowledge. Base salaries of all Executive Directors are reviewed once each year. Reviews cover individual performance, experience, development in role and market comparisons.	
Annual performance related bonus	No performance related pay scheme is in operation within the Foundation Trust. All other staff are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.		
Long term performance related bonus	No long term performance related scheme is in operation within the Foundation Trust. All other staff are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.		
Pension related benefits	Pension provision is one of the components to attract, reward and retain the right calibre of Executive Director's in order to ensure delivery of the leadership and management needed to execute the Foundation Trust's vision and plan	Executive Directors are entitled to join the NHS Pension Scheme. The employer's contributions are 14% of base salary. Alternatively, at their option and with agreement, Executive Directors may receive cash in lieu of pension at the stated rate and subject to normal statutory deductions.	Maximum is 14% of base salary

### Non-Executive Directors

Remuneration Component	How this component operates in practice
Annual fee	<p>The remuneration of the Chair and Non-Executive Directors is determined by the Appointments and Remuneration Committee. Members of the Committee conflicted by the Committees' recommendations are excluded from the decision making process. These are determined in the light of:</p> <ul style="list-style-type: none"> <li>➤ Fees of Chairpersons and Non-Executive Directors of other Foundation Trusts selected for comparator purposes on the same basis as for Executive Directors;</li> <li>➤ The responsibilities and time commitments; and</li> <li>➤ The need to attract and retain individuals with the necessary skills and experience.</li> </ul> <p>The Chair and Non-Executive Directors receive an annual base fee. Additional fees are paid:</p> <ul style="list-style-type: none"> <li>➤ To the Chair of the Audit Committee; and</li> <li>➤ To the Chair of the Clinical Specialty and Assurance Committee.</li> </ul> <p>Non-Executive Directors' fees are reviewed annually against market comparators. They were last reviewed in June 2014. Current fee levels are shown in the annual report on remuneration.</p>
Travel expenses	Non-Executive Directors are entitled to reimbursement of travel and accommodation expenses at the same rates as applicable to Executive Directors and other staff.
Other benefits	Non-Executive Directors are not entitled to receive any other fees or benefits in kind other than their annual remuneration.

For Executive Directors, appointments are not time limited and the period for serving notice, whilst historically has been six months, is now three months for new appointees. Executive Director contracts have reflected this change as new directors are appointed. Contractual provision for early termination is not appropriate as the contracts are not fixed term. Liability for early termination is therefore not calculated. No significant termination payments have been made since the organisation became a Foundation Trust. The Foundation Trust's remuneration reports are subject to a full external audit.

Details of person information and remuneration are detailed on pages 129 and 142 respectively.

## Annual Report on Remuneration

### Service Agreements

The following table shows for each person who was a director of the Foundation Trust at 31 March 2015 or who served as a director of the Foundation Trust at any time during the year ended 31 March 2015, the commencement date and term of the service agreement or contract for services, and details of the notice periods.

Director	Contract start date	Contract term (years)	Unexpired term at the date of publication (months)	Notice period by the Trust (months)	Notice period by the director (months)
David Adam	31 October 2013	11 months*	Retired on 30 September 2014	3 months	3 months
Jeremy Cross	1 October 2014	3 years	2 years and 5 months	3 months	3 months
Andrew Copley	1 January 2013	Indefinite term	Not applicable	3 months	3 months
Robert Dearden	1 August 2011	Indefinite term	Not applicable	3 months	3 months
Ronald Drake	31 July 2014*	2 years*	1 year and 2 months	3 months	3 months
Bridget Fletcher	3 October 2005	Indefinite term	Not applicable	6 months	6 months
Anne Gregory	1 June 2012	3 years	1 month	3 months	3 months
Harold Hosker	1 March to 3 June 2014	Indefinite term	Not applicable	3 months	3 months
Sally Houghton	1 February 2013*	2 years 5 months*	2 months	3 months	3 months
Michael Luger	1 May 2014	3 years	2 years	3 months	3 months
Karl Mainprize	3 June 2014	Indefinite term	Not applicable	3 months	3 months
Colin Millar	31 October 2013*	6 months*	Retired on 30 April 2014	3 months	3 months
Mike Toop	1 February 2013	3 years	8 months	3 months	3 months
Ann Wagner	1 September 2006	Indefinite term	Not applicable	6 months	6 months

Notes:

\*Term of office extended for a specific time period for succession planning purposes

### Committee Membership

The members of the Board Appointments, Remuneration and Terms of Service Committee comprises the Senior Independent Director (Committee Chair) Chairman (appointed 31 July 2014), Deputy Chairman, Chief Executive (or another Executive Director when considering the appointment of the Chief Executive) and one other Non-Executive Director. The Company Secretary and Head of Human Resources and Workforce also attended in an advisory capacity.

During the year, the Committee met on five occasions, with the Chief Executive attending all meetings. The meeting attendance of committee members is shown on page 134.

The members of the Appointments and Remuneration Committee comprise the Chairman (Committee Chair), Deputy Chairman, Senior Independent Director, two elected Governors, one

stakeholder Governor, one staff Governor and the Lead Governor. The Company Secretary and Head of Human Resources and Workforce also attended in an advisory capacity.

The number of meetings and attendance by committee members can be found on page 130.

The information subject to audit, which includes senior manager's salaries, compensations, non-cash benefits, pension compensation and retention of earnings for Non-Executive Directors, is set out below and included in Note 5.5 to the accounts.

### Salaries and Allowances (for the period 1 April to 31 March)

Name and title	2014/15 (12 months)					
	Salary (bands of £5000)  £000	Taxable benefits (total to the nearest £100)  £00	Annual performance related bonuses (bands of £5000)  £000	Long term performanc e related bonuses (bands of £5000)  £000	All pension related benefits (bands of £2500)  £000	Total (bands of £5000)  £000
Mr Andrew Copley, Director of Finance	105-110	1	0	0	5-7.5	115-120
Mr Robert Dearden, Director of Nursing	100-105	1	0	0	7.5-10	110-115
Miss Bridget Fletcher, Chief Executive	175-180	3	0	0	40-42.5	215-220
Dr Harold Hosker, Interim Medical Director*	0-5	0	0	0	0	0-5
Mr Karl Mainprize, Medical Director*	120-125	0	0	0	7.5-10	130-135
Mrs Ann Wagner, Director of Strategy and Business Development	110-115	3	0	0	2.5-5	115-120
Mr David Adam, Non-Executive Director*	5-10	2	0	0	0	5-10
Mr Jeremy Cross, Non-Executive Director*	5-10	1	0	0	0	5-10
Mr Ronald Drake, Non-Executive Director	10-15	0	0	0	0	10-15
Prof Anne Gregory, Non-Executive Director	10-15	6	0	0	0	10-15
Mrs Sally Houghton, Non-Executive Director	15-20	1	0	0	0	15-20
Prof Michael Luger, Chairman*	35-40	8	0	0	0	40-45
Mr Colin Millar, Chairman*	0-5	1	0	0	0	0-5
Dr Mike Toop, Non-Executive Director	15-20	8	0	0	0	15-20

Name and title	2013/2014 (12 months)					
	Salary (bands of £5000)  £000	Taxable benefits (total to the nearest £100)  £00	Annual performance related bonuses (bands of £5000)  £000	Long term performance related bonuses (bands of £5000)  £000	All pension related benefits (bands of £2500)  £000	Total (bands of £5000)  £000
Dr Andrew Catto, Medical Director*	20-25	0	0	0	0	20-25
Mr Andrew Copley, Director of Finance	100-105	0	0	0	2.5-5	105-110
Mr Robert Dearden, Director of Nursing	100-105	3	0	0	5-7.5	115-120
Miss Bridget Fletcher, Chief Executive	165-170	2	0	0	27.5-30.0	195-200
Dr Harold Hosker, Interim Medical Director	0-5	0	0	0	0	0-5
Mr Karl Mainprize, Medical Director*	0	0	0	0	0	0
Mrs Ann Wagner, Director of Strategy and Business Development	110-115	14	0	0	0-2.5	115-120
Mr David Adam, Non-Executive Director*	10-15	2	0	0	0	10-15
Mr Jeremy Cross, Non-Executive Director*	0	0	0	0	0	0
Mr Ronald Drake, Non-Executive Director	10-15	0	0	0	0	10-15
Prof Anne Gregory, Non-Executive Director	10-15	0	0	0	0	10-15
Mrs Sally Houghton, Non-Executive Director	15-20	1	0	0	0	15-20
Prof Michael Luger, Chairman*	0	0	0	0	0	0
Mr Colin Millar, Chairman*	40-45	5	0	0	0	40-45
Dr Mike Toop, Non-Executive Director	10-15	10	0	0	0	15-20

Notes:

Mr David Adam, Non-Executive Director to 30 September 2014

Dr Andrew Catto, Medical Director to 28 February 2014 (Medical Director pay only – excludes pay as a Consultant)

Mr Jeremy Cross, Non-Executive from 1 October 2014

Dr Harold Hosker, Interim Medical Director from 1 March 2014 to 2 June 2014 (Medical Director pay only – excludes pay as a Consultant)

Dr Karl Mainprize, Medical Director from 3 June 2014

Professor Michael Luger, Chairman from 1 May 2014

Mr Colin Millar, Chairman to 30 April 2014

No Executive Directors are Non-Executive Directors of any other organisation

No former senior manager received compensation in the period 1 April 2014 to 31 March 2015

The pension related benefits are calculated by taking the inflated increase in pension entitlement (2.7% for 2014/2015) less the employee contribution. Assuming pension is paid for a period of 20 years.

The increase in entitlement is calculated as  $((20 \times PE) + LSE) - ((20 \times PB) + LSB)$ .

Where:

PE is the annual rate of pension that would be payable to the director, if they became entitled to it at the end of the financial year.

PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year.

LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

As Bridget Fletcher withdrew from the pension scheme in 2013/2014, she has no contributions to offset against the inflationary increase which shows a higher than expected increase in 2014/2015.

## Pension Benefits as at 31 March 2015

Name and title	Real increase in pension at age 60  (bands of £2500 £000)	Real increase in pension lump sum at age 60  (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2014  (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2014  (bands of £5000) £000	Cash equivalent transfer value at 31 March 2015)  £000	Cash equivalent transfer value at 31 March 2014)  (bands of £5000) £000	Real increase in cash equivalent transfer value  £000	Employers contribution to stakeholder pension  (to nearest £100) £00
Mr Andrew Copley Director or Finance	0-2.5	5-7.5	35-40	105-110	640	586	54	0
Mr Robert Dearden Director of Nursing	0-2.5	0-2.5	35-40	115-120	659	637	22	0
Miss Bridget Fletcher Chief Executive	0	0	65-70	195-200	1322	1322	0	0
Dr Harold Hosker* Interim Medical Director	0-2.5	5-7.5	55-60	175-180	1210	1138	72	0
Mr Karl Mainprize* Medical Director	40-42.5	125-127.5	40-45	125-130	767	0	767	0
Mrs Ann Wagner Director of Strategy and Business Development	0-2.5	0-2.5	30-35	100-105	677	647	30	0

\*Dr Hosker appointed Interim Medical Director 1 March 2014 to 2 June 2014

Mr Mainprize appointed Medical Director with effect from 3 June 2014

As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

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 pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures,

and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV – This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

## Expenses paid to Governors 2014/15

During the financial year, a number of Governors were paid expenses to reimburse their travel costs incurred whilst attending meetings at the Foundation Trust and at external training and development events.

	2014/15	2013/14
Number of Governors in office	29	30
No of Governors receiving expenses	12	9
Total expenses paid to Governors	£1800	£1600

## Fair Pay Information

The HM Treasury FReM requires the disclosure of the median remuneration of the Foundation Trust's staff and the ratio between this and the mid-point of the banded remuneration of the highest paid Director. The calculation is based on full-time equivalent staff of the Foundation Trust at the end of 2014/15 on an annualised basis. This information, with comparatives for last year, is shown below.

	2014/15	2013/14
<b>Median remuneration of staff</b>	£24,799	£23,825
<b>Mid-point of highest paid Director</b>	£177,200	£167,500
<b>Ratio</b>	7.15:1	7.03:1

## The NHS Pension Scheme

Pension benefits are provided through 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 the Secretary of State, in England and Wales.

Contribution Tier	Pensionable Pay	Contribution Rate
1	Up to £15,279.99	5%
2	£15,432.00 to £21,387.99	5.6%
3	£21,388.00 to 26,823.99	7.1%
4	£26,824.00 to £49,472.99	9.3%
5	£49,473.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

Employer contributions are 14% of salary.

The Scheme is a 'final salary' scheme. Annual pension are normally based on 1/80<sup>th</sup> for the 1995 section and of the best of the last three years of pensionable pay for each year of service, 1/60<sup>th</sup> for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service. Members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules.

Annual increases are applied to pension payments at rates defined by the Pensions (increase) Act 1971, and are based on changes in consumer prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable. Members can purchase additional service in the NHS Scheme and contribute to money purchase AVCs run by the Scheme's approved providers or by other Free Standing AVC providers.

For early retirements other than those due to ill health, the additional pension liabilities are not funded by the Scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

Full details of the pension scheme can be found on the NHS Pensions website at [www.pensions.nhsbsa.nhs.uk](http://www.pensions.nhsbsa.nhs.uk)

### Off-Payroll Engagements

PES (2012)17 requires the Foundation Trust to seek assurance from off-payroll engagements, that all their tax obligations are being met. This is required for existing engagements who at the 31 March 2015 cost in excess of £58,000 per annum or for new engagements during the period between the 1 April 2014 and 31 March 2015 cost more than £220 per day and were engaged for more than six months.

The Foundation Trust is required under the reporting requirements published by the HM Treasury in relation to PES (2012)17, to report that it has one engagement which meets the disclosure requirements. The Foundation Trust has received the required assurance for the engagement that the tax obligations are being met as per the terms of their contract.

#### Off-Payroll Engagements as of 31 March 2015, for more than £220 per day and that last longer than six months

Number of existing engagements as of 31 March 2015	1
Of which.....	
Number that have existed for less than one year at time of reporting.	1
Number that have existed for between one and two years at time of reporting.	0
Number that have existed for between two years and three years at time of reporting.	0
Number that have existed for between three and four years at time of reporting.	0
Number that have existed for four or more years at time of reporting.	0

#### Off-Payroll Engagements of Board Members, and/or, senior officials with significant responsibility, between 1 April 2014 and 31 March 2015

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed 'board members and/or senior officials with significant responsibility' during the financial year.	11

*The Foundation Trust has a number of doctors who meet the financial criteria but have no significant financial responsibility and therefore fall outside the scope of the reporting requirement.*

## Information Subject to Audit

The information subject to audit, which includes senior manager's salaries, compensations, non-cash benefits, pension compensation and retention of earnings for Non-Executive Directors, is set out below and included in Note 5.5 to the accounts.

A handwritten signature in black ink, appearing to read "Bridget Fletcher". The signature is written in a cursive, flowing style.

**Bridget Fletcher**  
**Chief Executive**

27 May 2015

# ***Independent auditors' report to the Council of Governors of Airedale NHS Foundation Trust***

## ***Report on the financial statements***

### **Our opinion**

In our opinion, Airedale NHS Foundation Trust's ("the Trust's") Group and Parent Trust's financial statements (the "financial statements"):

- give a true and fair view of the state of the Group's and of the Parent Trust's affairs as at 31 March 2015 and of the Group's and Parent Trust's income and expenditure, and Group's cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

### **What we have audited**

The Group and Parent Trust's financial statements comprise:

- the Consolidated and Parent Trust's Statement of Comprehensive Income for the year ended 31 March 2015;
- the Consolidated and Parent Trust's Statement of Financial Position as at 31 March 2015;
- the Consolidated and Parent Trust's Statement of Changes in Taxpayer's Equity for the year then ended;
- the Consolidated Statement of Cash Flows for the year then ended; and
- the notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Airedale NHS Foundation Trust Annual Report (the "Annual Report"), rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements is the NHS Foundation Trust Annual Reporting Manual ("ARM") 2014/15 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

### **Our audit approach**

#### *Overview*



- Overall materiality: £3,147,000 which represents 2% of total revenue.
- In establishing our overall approach we assessed the risks of material misstatement and applied our professional judgement to determine the extent of testing required over each balance in the financial statements.
- We performed our audit of the financial information for the group which included the parent Airedale NHS Foundation Trust and its subsidiary, Airedale NHS Foundation Trust Charitable Fund.
- The audit was undertaken at Airedale General Hospital, based in Steeton, Keighley which is where the finance function and Trust's Headquarters are based.
- Management override of control and fraud in revenue / expenditure recognition;
- Financial sustainability and going concern; and
- Property, Plant and Equipment revaluation.

#### ***Airedale NHS Foundation Trust context***

Airedale NHS Foundation Trust provides acute, elective, specialist and community care for a population of over 200,000 people from West Yorkshire, North Yorkshire and East Lancashire and the surrounding areas.

Services are provided from the Airedale General Hospital site, as well as a number of other community hospital sites such as Castleberg Hospital, near Settle, Coronation Hospital in Ilkley and Skipton Hospital.

The Trust's primary Clinical Commissioning Group ("CCG") commissioner is NHS Airedale, Wharfedale & Craven CCG. However a significant proportion of the Trust's income comes from the NHS East Lancashire CCG, NHS Bradford Districts CCG and NHS England.

### *The scope of our audit and our areas of focus*

We conducted our audit in accordance with International Standards on Auditing (UK and Ireland) ("ISAs (UK & Ireland)").

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatement that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as "areas of focus" in the table below. We have also set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

<i>Area of focus</i>	<i>How our audit addressed the area of focus</i>
<p><b>1) Management override of control and fraud in revenue / expenditure recognition</b></p> <p>See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes two to five for further information.</p> <p>Under ISA (UK&amp;I) 240 there is a rebuttable presumption that there are risks of fraud in revenue recognition. We have extended this presumption to the recognition of expenditure. We focussed on this area because there is a heightened risk, due to:</p> <ul style="list-style-type: none"> <li>• the pressures surrounding the financial position and sustainability of the Trust in future years, hence an incentive to defer revenue and recognise as much expenditure as possible in 2014/15;</li> <li>• the Trust's principal source of income is from Clinical Commissioning Groups ("CCGs"). A contract reconciliation is negotiated with each CCG after the end of the financial year and is, therefore, subject to management judgement regarding its value;</li> <li>• the inherent complexities in a number of contractual arrangements entered into by the Trust;</li> <li>• the timing and complexity of the intra-NHS balance reconciliation process; and</li> <li>• a number of areas of expenditure involving estimation such as provisions.</li> </ul> <p>The Trust's income contracts with commissioners include a Commissioning for Quality and Innovation ("CQUIN") element. The Trust's entitlement to this income is contingent on it meeting its targets for these indicators. As such there was a potential risk of income being included in the financial statements which may have been subject to clawback by commissioners for breach of targets.</p> <p>The Trust's Statement of Financial Position at 31 March 2015 includes a material balance for provisions of £7.0m. These provisions are for a variety of matters, including; staff restructuring schemes, employment costs, holiday pay for part-time staff, and potential clawback of income. Provisions are a form of estimate and therefore include a level of judgment from management. The risk was therefore that the assumptions and judgements of management could be outside of acceptable ranges.</p>	<p><b>Income and expenditure</b></p> <p>We evaluated the accounting policy for income and expenditure recognition of the Trust to ensure that it is consistent with the requirements of the Monitor ARM and noted no issues in this respect.</p> <p>We tested a sample of revenue transactions recognised after the year end to check that the amount of revenue recognised was accurately and appropriately recognised in 2014/15. For transactions close to the year-end we tested a sample to check that they had been recorded in the correct accounting period.</p> <p>We also tested a sample of revenue transactions recognised during the year to check the amount was recognised accurately and the Trust had received the cash for those transactions.</p> <p>Our testing did not identify any exceptions.</p> <p><b>Intra-NHS balances</b></p> <p>We obtained the Trust's mismatch reports received from Monitor, which identified balances (debtor, creditor, income or expenditure balances) that were disputed by the counterparty. We then checked that management had investigated all disputed amounts and discussed with them the results of their investigation and the resolution.</p> <p>We read correspondence with the counterparties, which was consistent with the results management reported to us. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact.</p> <p><b>CQUINs</b></p> <p>We examined the Trust's contracts with all its material commissioners, in particular understanding the performance targets attaching to those which can result in fines or lost CQUIN payments. We have then compared the year end performance against those targets to assess whether there are any other areas of potential fine or clawback of income – none were noted.</p> <p><b>Provisions</b></p> <p>In assessing provisions we have confirmed that:</p> <ul style="list-style-type: none"> <li>• the recognition criteria of IAS 37 'Provisions, Contingent Liabilities and Contingent Assets' had been met; and</li> <li>• the assumptions underpinning the provisions are</li> </ul>

reasonable.

### Journals

We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure. We used data analysis techniques to focus in particular on those journals with a material net debit or credit to the Statement of Comprehensive Income.

We traced these journal entries to the supporting documentation (for example, invoices, goods received notes and cash receipts and payments).

Where revenue or expenditure was recorded through journal entries outside of the normal business process, we traced the journal to patient records or invoices on a sample basis to establish whether a service had been provided or a sale occurred.

Our testing did not identify any issues.

### 2) Financial sustainability and going concern

In 2014/15 this was a heightened area of focus due to the general pressures on demand for the trust's services and healthcare funding, as well as reductions in some of the Trust's income contracts.

The Trust's overall position at 31 March 2015 is a deficit of £2.8m, against the planned breakeven position. The Trust's balance sheet at 31 March 2015 also shows a ratio of current assets to current liabilities of 0.91 (2013/14: 1.13)

The Trust's financial plans forecast a deficit of £1.2m in 2015/16 and a breakeven position in 2016/17.

There is an increased cost improvement requirement for 2015/16 and beyond which represents a more significant challenge for management.

In considering the financial performance of the Trust we have:

- confirmed that the Foundation Trust has complied with all covenants with lenders;
- tested material balances owing to and from other health bodies through the national balance agreement exercise at 31 March 2015; and
- confirmed that the going concern principle applied to the financial statements by the Directors is appropriate, through assessment of the Trust's budget, cash flow forecasts and levels of reserves.

We have also performed the following to inform our assessment of the Trust's financial position and performance:

- assessed the reasonableness of assumptions within the Trust's financial forecasts against assumptions provided by Monitor and those we have seen at other Trusts;
- performing targeted audit procedures to gain comfort over the recognition of revenue; and
- assessment of key areas of accounting judgement including deferred income and provisions.

Our work on the above areas indicates that the going concern basis is appropriate.

### 3) Property, Plant and Equipment revaluation

We focussed on this area because Property, Plant and Equipment ("PPE") represents the largest balance in the Trust's statement of financial position and the Trust has continued to invest in its estate during 2014/15. PPE is valued at £62.8m as at 31 March 2015.

All PPE assets are measured initially at cost, with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and are required to be performed with sufficient regularity to ensure that the carrying value is not

We obtained and read the relevant sections of the valuation report provided by the Trust's Valuers. We used our own valuations expertise to evaluate and challenge the assumptions and methodology applied in the valuation exercise. We found the assumptions and methodology applied to be reasonable and in accordance with RICS guidelines.

We confirmed that the valuer had a UK qualification and was registered with an appropriate professional body and was not connected with the Trust.

We considered, based on our knowledge of the Trust obtained during our audit, whether the Trust had any future plans that would impact on the usage (and, hence, valuations) of the properties. Our testing did not identify any

## Area of focus

materially different from fair value at the reporting date.

A full valuation of the Trust's portfolio of land and buildings (including dwellings) was undertaken during 2014/15 by the Trust's valuation expert, with a valuation date of 31 March 2015.

The specific areas of risk are:

- accuracy and completeness of detailed information on assets provided to the valuation expert – most significantly the floor plans, on which the valuation of properties is routinely based;
- the methodology, assumptions and underlying data used by the valuation expert; and
- the processing of accounting transactions resulting from this valuation.

## How our audit addressed the area of focus

such matters.

We tested the underlying data upon which the valuation was based back to floor plans for a sample of properties. We found the valuation to have been based on appropriate and up to date floor space data.

We tested a sample of new additions in the year to confirm they had been appropriately valued – this involved agreement back to supporting invoice. Our testing did not identify any such matters.

We physically verified a sample of assets across all classes of asset to confirm existence and in doing so considered whether there was any indication of physical obsolescence which would indicate potential impairment. Our testing did not identify any such indicators.

We confirmed that the change in valuation was appropriately disclosed in the annual report and correctly reflected in management's workings and general ledger.

## How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the trust, the accounting processes and controls, and the environment in which the Group operates.

## Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, consistent with last year, we determined materiality for the financial statements as a whole as follows:

<b>Overall materiality</b>	£3,147,000 (2014: £2,921,000).
<b>How we determined it</b>	2% of revenue
<b>Rationale for benchmark applied</b>	We have applied this benchmark, which is a generally accepted measure when auditing not for profit organisations, because we believe this to be the most appropriate financial measure of the performance of a Foundation Trust.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £146,000 (2014: £140,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

## Other required reporting in accordance with the Audit Code for NHS foundation trusts

### Opinions on other matters prescribed by the Audit Code for NHS foundation trusts

In our opinion:

- the information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements; and
- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

### Consistency of other information

Under the Audit Code for NHS foundation trusts we are required to report to you if, in our opinion:

- information in the Annual Report (the "Annual Report") is: We have no

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>- materially inconsistent with the information in the audited financial statements; or</li> <li>- apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit; or</li> <li>- otherwise misleading.</li> </ul>  | <p>exceptions to report arising from this responsibility.</p>            |
| <ul style="list-style-type: none"> <li>• the statement given by the directors in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group and Parent Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Group and Parent Trust's acquired in the course of performing our audit.</li> </ul> | <p>We have no exceptions to report arising from this responsibility.</p> |
| <ul style="list-style-type: none"> <li>• the section of the Annual Report as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.</li> </ul>   | <p>We have no exceptions to report arising from this responsibility.</p> |
| <ul style="list-style-type: none"> <li>• the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.</li> </ul>   | <p>We have no exceptions to report arising from this responsibility</p>  |

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### Economy, efficiency and effectiveness of resources and Quality Report

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- |  |   |
|--|---|
| <ul style="list-style-type: none"> <li>• we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.</li> </ul> | <p>We have no exceptions to report arising from this responsibility</p> |
| <ul style="list-style-type: none"> <li>• we have qualified, on any aspect, our opinion on the Quality Report.</li> </ul>   | <p>We have no exceptions to report arising from this responsibility</p> |

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## Responsibilities for the financial statements and the audit

### Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Airedale NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

### What an audit of financial statements involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of:

- whether the accounting policies are appropriate to the Group and Parent Trust's circumstances and have been consistently applied and adequately disclosed;
- the reasonableness of significant accounting estimates made by the directors; and
- the overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both.

In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

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## Certificate

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We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.



Ian Looker (Senior Statutory Auditor)  
for and on behalf of PricewaterhouseCoopers LLP  
Chartered Accountants and Statutory Auditors  
Leeds

28 May 2015

- (a) The maintenance and integrity of the Airedale NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.
  - (b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.
-

## **FINANCIAL SUMMARY**

The Foundation Trust had a deficit of £2,777,000 for 2014/15. This position included a technical impairment of £2,834,000. The impairment arose out of the Foundation Trust's annual revaluation of its land and buildings by the District Valuer. The year end surplus outturn, excluding the technical impairment, was £59,000 for the year.

The accounts included in the annual report reflect both the financial position of the Foundation Trust and a group position which consolidates the Foundation Trust and Airedale NHS Foundation Trust Charitable Funds accounts. Airedale NHS Foundation Trust Charitable Funds accounts had a negative movement of £1,000 in the year 2014/2015.

The underlying surplus position was in line with plan. The Foundation Trust was unable to make a more significant surplus due to increasing agency costs related to continuing increases in emergency activity and difficulties to recruit.

### **Income and Expenditure**

Total income from continuing activities for 2014/15 was £157.7 million. An analysis of this is shown on pages 174 and 176.

### **Cash**

The Foundation Trust had a cash balance of £15.9 million at the close of the financial year.

The Foundation Trust managed its cash by recovering debts in a timely manner, paying creditors within contractual terms and only investing within the Government banking system.

### **Borrowing Limit**

The Foundation Trust no longer uses the borrowing limit; it is regulated by the terms of the Licences agreement with Monitor which is subject to a detailed financial risk assessment.

The analysis below shows the Foundation Trust's financial position against key performance indicators.

Details of any post balance sheet events are provided in note 24 of the accounts.

### **Financial Outlook**

In our financial planning for 2015/16 we have considered a range of severe financial possibilities given the current economic climate. The Foundation Trust is planning for a deficit of £1.2m, however due to the strong cash position this will still achieve a Continuity of Services Risk Rating of 3.

The Foundation Trust is continuing to invest in increased nursing staff over 2015/16; has a challenging cost improvement target to achieve; and, expects the continuation of increased demand. Notwithstanding these challenges, the Board remains determined to deliver efficiency improvements to ensure the long term sustainability of the Foundation Trust.

### **Capital Investment Activity**

The Foundation Trust's capital programme invested over £10.2 million in 2014/15, to improve its buildings and equipment.

The Foundation Trust has completed a significant investment in a new state-of-the-art Emergency Department at Airedale Hospital at a cost of £6.3 million.

A £400,000 refurbishment of Airedale Hospital's pathology department during 2014 provided extra space for the team to be able to cope with an increase in business and work more efficiently. The new layout separates the laboratories from administrative areas, improving the flow of work and includes a more welcoming entrance, with a waiting area for visitors.

The Foundation Trust has also invested £3,259k from the Safer Hospital Safer Wards fund to implement advanced technology into the hospital. The funding supports the delivery of the district's Integrated Care for Adults Programme (ICAP) which focuses on the patient's holistic needs and is designed to deliver 'right care, in the right place, first time', for local people.

### Accounting Policy

There has been a change in accounting policy in respect of preparation of the Annual Accounts, as the charitable Funds accounts are now consolidated with the Foundation Trust accounts to produce Group accounts.

### Investments

The Foundation Trust made no investments in 2014/15. The Charitable fund had a stockholding of £590,000 as at 31 March 2015.

### Private Patient Income

Section 164(3) of the Health and Social Care act removes condition 10 (which restricts income from private charges), from the Foundation Trust Terms of Authorisation. The Foundation Trust is now required by the Act and the Foundation Trust's Constitution (rather than by the terms of Authorisation) to ensure that income derived from activities related to the Foundation Trusts principle purpose of delivering goods and services for the purpose of the NHS exceeds income derived from other activities. To increase this income in any financial year by 5% or more, the Foundation Trust is required to seek approval from the Council of Governors. In 2014/15 the Foundation Trust had not increased the percentage beyond the 5% threshold. The private patient income for 2014/15 was £188,000.

### Cost Improvement Programme

A formal cost improvement programme (CIP) was approved for 2014/15, which set targets and actions plans aimed at improving efficiency. The CIP was monitored monthly and achieved £5.8 million within the financial year. Examples of the higher value schemes achieved during the year are:

- Staffing and skills mix review £734,000;
- Savings from procurement cost reductions £800,000;
- New pathways £1,369,000; and
- Growth and repatriation £857,000.

### Auditors and Audit Fee

The Foundation Trust's external auditor is PwC. Disclosure of the cost of work performed by the auditor in respect of the reporting period is shown below.

<b>Audit Area</b>	<b>Audit Fee 2014/15 (£)</b>
Statutory Audit	<b>£49,078*</b>
Quality Report	<b>£8,400*</b>

\* All the above figures exclude VAT

**FOREWORD TO THE ACCOUNTS**

**AIREDALE NHS FOUNDATION TRUST**

The accounts for the year ended 31 March 2015 are set out on the following pages and comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the Notes to the Accounts.

These accounts for the year ended 31 March 2015 have been prepared by Airedale NHS Foundation Trust in accordance with paragraph 24 and 25 of schedule 7 to the National Health Service Act 2006 and in accordance with directions given by Monitor, the sector regulator for health services in England.

Signed: ..... *Bridget Fletcher* ..... Bridget Fletcher - Chief Executive  
Date: *27/05/2015*

**STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE AIREDALE NHS FOUNDATION TRUST**

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officers' Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Airedale NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Airedale NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance,
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:  Bridget Fletcher - Chief Executive

Date: 27/05/2015

## **NATIONAL HEALTH SERVICES ACT 2006**

### **DIRECTIONS BY MONITOR IN RESPECT OF NATIONAL HEALTH SERVICES FOUNDATION TRUSTS' ANNUAL ACCOUNTS**

Monitor, the Independent Regulator of NHS Foundation Trusts, with the approval of HM Treasury, in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National Health Services Act 2006, hereby gives the following Directions:

#### **1. Application and interpretation**

(1) These Directions apply to NHS foundation trusts in England.

(2) In these Directions "The Accounts" means

for an NHS foundation trust in its first operating year since authorisation, the accounts of an NHS foundation trust for the year from authorisation until 31 March

for an NHS foundation trust in its second or subsequent operating year following authorisation, the accounts of an NHS foundation trust for the year from 1 April

"the NHS foundation trust" means the NHS foundation trust in question

#### **2. Form of Accounts**

(1) The accounts submitted under paragraph 25 of Schedule 7 of the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's gains and losses, cash flows and financial state at the end of the financial year.

(2) The accounts shall meet the accounting requirements of the 'NHS Foundation Trust Annual Reporting Manual' (FT ARM) as agreed with HM Treasury, in force for the relevant year.

(3) The statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation Trust.

(4) The Annual Governance Statement shall be signed and dated by the chief executive of the NHS foundation Trust.

#### **3. Statement of accounting officer's responsibilities**

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

#### **4. Approval on behalf of HM Treasury**

(1) These directions have been approved on behalf of HM Treasury

**Signed by the authority of monitor, the independent Regulator of NHS foundation trusts**

**CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR TO  
31 March 2015**

	Note	2014/15		2013/14	
		Group £000	Foundation Trust £000	Group £000	Foundation Trust £000
Operating income from continuing operations	3	157,701	157,391	146,963	146,069
Operating expenses of continuing operations:	4				
- Operating expenses		(159,342)	(158,991)	(145,279)	(144,818)
Operating (Deficit)/Surplus) before Finance costs		(1,641)	(1,600)	1,684	1,251
<b>FINANCE COSTS</b>					
Finance income		78	65	70	53
Finance expense - financial liabilities		(128)	(128)	(152)	(152)
Finance expense - unwinding of discount on provisions	16.2	(15)	(15)	(22)	(22)
Movement in fair value of investment property and other investments		27		18	-
Public Dividend Capital - dividends payable		(1,098)	(1,098)	(1,131)	(1,131)
<b>NET FINANCE COSTS</b>		<b>(1,136)</b>	<b>(1,176)</b>	<b>(1,217)</b>	<b>(1,252)</b>
<b>(DEFICIT)/SURPLUS FOR THE YEAR</b>		<b>(2,777)</b>	<b>(2,776)</b>	<b>467</b>	<b>(1)</b>

		Group	Foundation Trust	Group	Foundation Trust
	Note	2014/15 £000	2014/15 £000	2013/14 £000	2013/14 £000
<b>(DEFICIT)/SURPLUS FOR THE YEAR</b>		<b>(2,777)</b>	<b>(2,776)</b>	<b>467</b>	<b>(1)</b>
Share of profit/ (loss) of associates/ joint arrangements		-	-	-	-
Gain/(loss) from transfer by absorption from demising bodies		-	-	350	350
Impairments	6	3,936	3,936	(661)	(661)
Revaluations	6	150	150	295	295
Other Reserve Movements		-	-	-	-
<b>total other comprehensive income</b>		<b>4,086</b>	<b>4,086</b>	<b>(16)</b>	<b>(16)</b>
<b>TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR</b>		<b>1,309</b>	<b>1,310</b>	<b>451</b>	<b>(17)</b>
<b>Allocation of Surplus/(Deficit) for the year</b>					
(a) Surplus/Deficit for the year attributable to					
- Minority interest		-	-	-	-
- Owners of parent		(2,777)	(2,776)	467	(1)
<b>Total</b>		<b>(2,777)</b>	<b>(2,776)</b>	<b>467</b>	<b>(1)</b>
(b) Total comprehensive income/(expense) for the year attributable to					
- Minority interest		-	-	-	-
- Owners of parent		1,309	1,310	451	(17)
<b>Total</b>		<b>1,309</b>	<b>1,310</b>	<b>451</b>	<b>(17)</b>

All operations are continuing.

The notes on pages 8 to 35 form part of these accounts.

The operating deficit for 2014/2015 in respect of the Foundation Trust includes a net loss on impairment of the Trusts Property ,plant and equipment resulting from modern equivalent asset valuation of £2,834k

The impairment of £2,834k is made up £3,654 reversal of previous impairments shown as income and £6,488k of expenditure. The expenditure figure also includes £3,083k depreciation and a £26k loss on disposal of PPE.

**CONSOLIDATED STATEMENT OF FINANCIAL POSITION**  
as at 31 March 2015

	Note	31 March 2015		31 March 2014	
		Group	Foundation Trust	Group	Foundation Trust
		£000	£000	£000	£000
<b>Non-current assets</b>					
Property, plant and equipment	6	62,800	62,800	54,282	54,282
Other Investments	19.4	590		467	-
Trade and other receivables	9.1	922	922	813	813
<b>Total non-current assets</b>		<b>64,312</b>	<b>63,722</b>	<b>55,562</b>	<b>55,095</b>
<b>Current assets</b>					
Inventories	8	2,511	2,511	2,602	2,602
Trade and other receivables	9.1	4,593	4,591	4,485	4,480
Cash and cash equivalents	10	16,331	15,866	17,319	16,660
<b>Total current assets</b>		<b>23,435</b>	<b>22,968</b>	<b>24,406</b>	<b>23,742</b>
<b>Current liabilities</b>					
Trade and other payables	11	(18,024)	(17,962)	(15,255)	(15,120)
Borrowings	13	(635)	(635)	(622)	(622)
Provisions	16	(5,902)	(5,902)	(5,181)	(5,181)
Other liabilities	12	(674)	(674)	(139)	(139)
<b>Total current liabilities</b>		<b>(25,235)</b>	<b>(25,173)</b>	<b>(21,197)</b>	<b>(21,062)</b>
<b>Total assets less current liabilities</b>		<b>62,512</b>	<b>61,517</b>	<b>58,771</b>	<b>57,775</b>
<b>Non-current liabilities</b>					
Borrowings	13	(3,033)	(3,033)	(3,668)	(3,668)
Provisions	16	(1,136)	(1,136)	(1,189)	(1,189)
Other liabilities	12	(4,185)	(4,185)	(4,324)	(4,324)
<b>Total non-current liabilities</b>		<b>(8,354)</b>	<b>(8,354)</b>	<b>(9,181)</b>	<b>(9,181)</b>
<b>Total assets employed</b>		<b>54,158</b>	<b>53,163</b>	<b>49,590</b>	<b>48,594</b>
<b>Financed by (taxpayers' equity)</b>					
Public Dividend Capital		49,535	49,535	46,276	46,276
Revaluation reserve		10,513	10,513	6,576	6,576
Income and expenditure reserve		(6,885)	(6,885)	(4,258)	(4,258)
Charitable funds reserves	19.4	995		996	-
<b>Total taxpayers' equity</b>		<b>54,158</b>	<b>53,163</b>	<b>49,590</b>	<b>48,594</b>

The notes on pages 8 to 35 form part of these accounts.

The financial accounts on pages 1 to 35 were approved by the Board of Directors on

Signed on its behalf by:  Bridget Fletcher - Chief Executive

Date:

27/05/2015

**CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED**  
31 March 2015

GROUP	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Charitable Funds Reserve	Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2014	46,276	(4,258)	6,576	996	49,590
Public Dividend Received	3,259	-	-	-	3,259
(Deficit) for the financial year	-	(2,776)	-	(1)	(2,777)
Other reserve movements	-	149	(149)	-	-
Impairments	-	-	3,936	-	3,936
Revaluations	-	-	150	-	150
transfer by Modified accounting	-	-	-	-	-
Balance at 31 March 2015	<u>49,535</u>	<u>(6,885)</u>	<u>10,513</u>	<u>995</u>	<u>54,158</u>
	£000	£000	£000	£000	£000
Balance as at 1 April 2013	44,319	(4,615)	6,950	528	47,182
Public Dividend Received	1,957	-	-	-	1,957
(Deficit)/Surplus for the financial year	-	(1)	-	468	467
other reserve movements	-	8	(8)	-	-
Impairments	-	-	(661)	-	(661)
Revaluations	-	-	295	-	295
transfer by Modified accounting	-	350	-	-	350
Balance at 31 March 2014	<u>46,276</u>	<u>(4,258)</u>	<u>6,576</u>	<u>996</u>	<u>49,590</u>

The notes on pages 8 to 35 form part of these accounts.

The statement of changes in taxpayers' equity is for the Group, the consolidated Charitable fund balances are identified separately in the table.

Foundation Trust	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total
	£000	£000	£000	£000
Balance as at 1 April 2014	46,276	(4,258)	6,576	48,594
Public Dividend Received	3,259	-	-	3,259
(Deficit) for the financial year	-	(2,776)	-	(2,776)
Other reserve movements	-	149	(149)	-
Impairments	-	-	3,936	3,936
Revaluations	-	-	150	150
transfer by Modified accounting	-	-	-	-
Balance at 31 March 2015	<u>49,535</u>	<u>(6,885)</u>	<u>10,513</u>	<u>53,163</u>
	£000	£000	£000	£000
Balance as at 1 April 2013	44,319	(4,615)	6,950	46,654
Public Dividend Received	1,957	-	-	1,957
(Deficit)/Surplus for the financial year	-	(1)	-	(1)
other reserve movements	-	8	(8)	-
Impairments	-	-	(661)	(661)
Revaluations	-	-	295	295
transfer by Modified accounting	-	350	-	350
Balance at 31 March 2014	<u>46,276</u>	<u>(4,258)</u>	<u>6,576</u>	<u>48,594</u>

**CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED**  
**31 March 2015**

		2014/15	2013/14
	Note	£000	£000
<b>Cash flows from operating activities</b>			
Operating (deficit)/surplus from continuing operations		<u>(1,641)</u>	<u>1,684</u>
		(1,641)	1,684
<b>Non-cash income and expense</b>			
Depreciation and amortisation	4/6	3,083	3,920
Impairments		6,488	1,165
Reversal of Impairments		(3,654)	(576)
Non-cash donations/grants credited to income		(211)	(86)
Loss on disposal		26	101
PDC Dividend Accrued		-	-
(Increase) in trade and other receivables		(255)	(264)
Decrease/(Increase) in inventories		91	(280)
Increase in trade and other payables		2,606	2,149
Increase/(Decrease) in other liabilities		396	(140)
Increase in provisions		653	2,986
Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		<u>(68)</u>	<u>100</u>
<b>NET CASH GENERATED FROM OPERATIONS</b>		<u><b>7,514</b></u>	<u><b>10,759</b></u>
<b>Cash flows from investing activities</b>			
Interest received		65	53
Purchase of Property, Plant and Equipment	6	(9,931)	(7,450)
Sales of Property, Plant and Equipment		-	29
Charitable funds - net cash flows(used in)/from investing activities	19.4	<u>(85)</u>	<u>18</u>
<b>Net cash used in) investing activities</b>		<u><b>(9,951)</b></u>	<u><b>(7,350)</b></u>
<b>Cash flows from financing activities</b>			
Public dividend capital received		3,259	1,957
Loans repaid		(505)	(505)
Other Capital receipts		(117)	(105)
Interest Paid		(63)	(77)
Interest element on Finance lease		(62)	(75)
PDC dividend paid		<u>(1,063)</u>	<u>(1,087)</u>
<b>Net cash generated from financing activities</b>		<u><b>1,449</b></u>	<u><b>108</b></u>
<b>Net (decrease)/increase in cash and cash equivalents</b>	10	<u><b>(988)</b></u>	<u><b>3,517</b></u>
Cash and cash equivalents at 1 April 2014	10	<u><b>17,319</b></u>	<u><b>13,802</b></u>
Cash and cash equivalents at 31 March 2015	10	<u><u><b>16,331</b></u></u>	<u><u><b>17,319</b></u></u>

The notes on pages 8 to 35 form part of these accounts.

**Note 1 Accounting Policies and Other Information**

Monitor has directed that the accounts of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following accounts have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and the HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. The Accounts are prepared on a going concern basis.

These accounts have been prepared under the historic 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 Consolidation**

These accounts are for Airedale NHS Foundation Trust .The Trust has a joint venture, with a 50% equity investment in Immedicare LLP, in partnership with Involve .

The Trust has no subsidiaries except Airedale NHS Charitable Trust Funds, for which the Trust acts as Corporate Trustee. As per note 1.17 the Trust has consolidated in 2013/14 due to materiality. Previously HM Treasury granted dispensation of IAS27 solely in relation to the consolidation of NHS Charitable funds. From 2014 /2015 this dispensation is no longer available , therefore the Trust has consolidated these accounts with the accounts of the Foundation Trust. The financial accounts have been restated to include the current and prior year , in line with the accounting policies of the Foundation Trust and IAS8.Comparative accounts for the Chartable Funds have been included in note 19.4.

**Note 1.2 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 received or receivable in the normal course of business, net of discounts and, where appropriate, other sales related taxes. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

The figures quoted are based upon income received in respect of actual activity undertaken within each category. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Airedale NHS Foundation Trust contracts with NHS commissioners following the Department of Health's Payment by Results methodology. The income associated with incomplete inpatient spells (spells which begin in one financial year but are incomplete at the year end date) is matched to the appropriate financial year. The value of incomplete spells of care has been calculated using estimation techniques and has been included in NHS receivables for the current year.

**Note 1.3 Expenditure on Employee Benefits**

**Short Term Employee Benefits**

Salaries, wages and employment related payments 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 year is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

### **Pension Costs**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website: [www.nhsbsa.uk/pensions](http://www.nhsbsa.uk/pensions).

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting year.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme is subject to full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:-

#### **a) Full actuarial (funding) valuation**

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution rates to be paid by employers and scheme members. The last such disclosed valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. The 2008 valuation has been undertaken, the report has yet to be disclosed to individual organisations.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6% with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pensions Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 14.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

#### **b) Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting year by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2015 is based on detailed membership data as at 31 March 2008 (the latest mid-point) updated to 31 March 2015 with summary global member and accounting data.

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

#### **c) Scheme provisions**

In 2008-09 the NHS Pension Scheme provided defined benefits, which are illustrated below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained.

#### **Annual Pensions**

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and on the best of the last three years pensionable service and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

#### **Pensions Indexation**

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in consumer prices in the twelve months ending 30 September in the previous calendar year.

#### **Lump Sum Allowance**

A lump sum is payable on retirement which is normally three times the annual pension payment.

#### **Ill Health Retirement**

Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

#### **Death Benefits**

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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Members can purchase additional service in the NHS scheme and contribute to money purchase AVCs run by the schemes approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

#### **Transfer between Funds**

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

**Preserved Benefits**

Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

**Compensation for Early Retirement**

Where a member of the scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

**National Employment Savings Trust ( Nest) Pension Scheme**

Following the Pensions Act 2008 the NHS Foundation trust has a duty in the financial year ending 31 March 2015 to provide a pension scheme for employees who are in eligible to join the NHS Pension Scheme. The NHS Foundation Trust has selected NEST as it's partner to meet the duty. The scheme operated by Nest on the NHS Foundation Trust's behalf is a defined contribution scheme, employers contributions are charged to operating expenses as and when they become due.

**Note 1.4 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 these goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a current asset such as a prepayment or a non-current asset such as property, plant and equipment.

**Note 1.5 Property, Plant and equipment**

Property, plant and equipment is capitalised where:-

- a) It is held for use in delivering services or for administrative purposes;
- b) It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- c) It is expected to be used for more than one financial year; and
- d) The cost of the item can be measured reliably.

In addition, property, plant and equipment is capitalised if it:-

- a) individually has a cost of at least £5,000; or
- b) Forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control, or
- c) Forms part of the initial setting up of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

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

**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. Thereafter they are stated at cost less accumulated depreciation and any recognised impairment loss.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Land and buildings are valued at fair value in accordance with the revaluation model set out in IAS 16. Land and buildings are revalued at least every five years. More frequent valuations are carried out if the Foundation Trust believes that there has been a significant change in value.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors Valuation standards. The last asset valuations were undertaken by the Valuation Office Agency with a prospective valuation date of 1 April 2015 a full revaluation exercise of the estate has been carried out.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and fair value for non-specialised operational property.

For non-operational properties including surplus land, the valuations are carried out at open market value

Assets in the course of construction are valued at cost and are revalued by professional valuers when they are brought into use.

Operational equipment is valued at net historic cost.

#### **Subsequent Expenditure**

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the capital recognition criteria as above. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

#### **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.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by professional valuers appointed by the Trust.

Property, plant and equipment is depreciated on a straight line basis over the estimated lives which are:-

- a) Engineering plant and equipment:- 5 - 15 years - Plant and Machinery
- b) Vehicles:- 7 years -Transport Equipment
- c) office equipment, furniture and soft furnishings:- 5 - 10 years - Furniture and Fittings
- d) Medical and other equipment:- 5 - 15 years - Plant and Machinery
- e) IT equipment:- 3 - 6 years -Information Technology
- f) Buildings, installations and fittings:- 15 - 80 years -Buildings including Dwellings

The assets residual values and useful lives are reviewed, and adjusted if appropriate, at each statement of financial position date. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the classification. Assets under the course of construction are not depreciated until the asset is brought into use.

#### Disposals

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sale proceeds and the carrying amount of the asset and is recognised in the Statement of Comprehensive income.

#### 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 FT ARM, impairments that are due to a loss of economic benefits or 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 (1) the impairment charged to operating expenses and (2) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic or 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 income 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.

#### Derecognition

Assets intended for disposal are classified as 'Held for Sale' once all the following criteria are met:-

a) The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

b) The sale must be highly probable i.e.:-

- 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'

- 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 and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are derecognised 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 assets economic life is adjusted. The asset is derecognised when scrapping or demolition occurs.

#### **Protected Assets/Commissioner Related Services**

Assets are no longer defined as protected/un-protected assets. Where assets are used in the provision of Commissioner Requested Services have been disposed of during the year, a narrative disclosure is required. An explanation of the means by which the NHS foundation trust will continue to meet its obligations to provide Commissioner Related Services is required. Commissioner Requested Services are services that will be considered by the commissioner for protection should a provider fail.

#### **Donated Assets**

Donated fixed assets are capitalised at their current value on receipt and this value is credited to income, 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 is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. Donated fixed assets are valued and depreciated as described above for purchased assets.

#### **Note 1.6 Government Grants**

Government grants are grants from Government bodies other than income from NHS England and Clinical Commissioning Groups or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is taken to the statement of comprehensive income, 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 grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. Grant assets are valued and depreciated as described above for purchased assets.

#### **Note 1.7 Inventories**

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

#### **Note 1.8 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 Trusts normal purchase sale or usage requirements, are recognised when, and to the extent which performance occurs i.e. when receipt or delivery of the goods or services is made.

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

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

#### **Derecognition**

All financial assets are derecognised 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 derecognised 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'

#### **Loans and Receivables**

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

The Trusts loans and receivables comprise; cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value. In all cases the fair value is the transaction value. Any long term receivables that are financial instruments require discounting to reflect fair value.

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

#### **Financial Liabilities**

All financial liabilities are recognised initially at fair value. In all cases the fair value is the transaction value.

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 (loans and receivables) 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.

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account for credit losses.

**Note 1.9 Leases**

**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 payment, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are derecognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income.

**Operating Leases**

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

**Note 1.10 Provisions**

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate of 1.30% in real terms for pension liabilities (1.80% 2013/14). All other provisions are discounted at the General discount rate short term -1.50%, (6 to 10 years) -1.05% and long term (more than 10 years) (-0.65% 2013/2014).

**Clinical Negligence Costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried out by the NHSLA on behalf of the Trust is disclosed at Note 16

**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 the NHSLA 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 1.11 Contingencies**

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed on Note 14 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 14, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:-

- a) Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or
- b) 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 1.12 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 Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge reflecting the cost of capital utilised by the Trust is payable as PDC Dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets, average daily cash balances held with the Government Banking Service (GBS) and National Loans Fund Deposits (NLFS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets. In accordance with the requirements laid down by the DOH, the dividend for the year is calculated on the 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 adjustments to net assets occur as a result of the audit of the annual accounts.

**Note 1.13 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 1.14 Corporation Tax**

The Trust is a Health Service body within the meaning of s519 ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is power for the Treasury to dis-apply the exemption in relation to the specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988), but as at 31 March 2015 this power has not been exercised. Accordingly the Trust is not within scope of Corporation Tax.

**Note 1.15 Foreign Exchange**

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange rate gains and losses are taken to the Statement of Comprehensive Income.

**Note 1.16 Third Party Assets**

Assets belonging to third parties (such as money held on behalf of patients) are banked and shown within cash and creditors in the Trust's accounts.

**Note 1.17 Dispensation from the Application of Accounting Standards**

Assets have been transferred under the Modified Absorption Costing.

**Note 1.18 Critical Accounting Judgements and Key Sources of Estimation Uncertainty**

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

**Note 1.18.1 Critical Judgements in Applying Accounting Policies**

The following are the critical 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 accounts:-

a) HM Treasury requires Trusts to value their land and buildings on a Modern Equivalent Asset (MEA) basis. IAS 16 requires Trusts to ensure that a fixed assets are shown in their accounts at a fair value. To ensure compliance a 'desk top' review of land and buildings values was undertaken. The Trust commissioned the Valuation Office Agency (VOA) to conduct this piece of work and the Trust has recorded the revised valuation figures in these accounts.

**Note 1.18.2 Key Sources of Estimation Uncertainty**

The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting year, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:-

a) In measuring income for the year management has taken account of all available information. Income estimates that have been based on actual information related to the financial year.

Included in the income figure is an estimate for incomplete spells, patients undergoing treatment that is only partially complete at year end. The number of incomplete spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which relates to the current year.

Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is often not received until future periods, when claims have been settled, an estimate must be made as to the collectability.

b) In estimating expenses that have not yet been charged for, management has made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

c) The Trust's accounting policy for property, plant and equipment is detailed in Note 1.5 . The carrying value of property, plant and equipment as at 31 March is detailed in Note 6.As stated above the VOA has provided an MEA valuation of land and buildings, whilst on an annual basis management estimates the useful economic lives of equipment based on management's judgement and experience. When management identifies that actual useful lives differ materially from the estimates used to calculate depreciation, that charge is adjusted prospectively.

d) The Trust has a number of provisions, the largest of which relates to the early retirement costs of former staff. The valuation of the provision in respect of each former member of staff is based on guidance issued by the Department of Health at the point of retirement. As this valuation is based on average life expectancy actual costs are likely to differ from the estimated provision figures.

**Note 1.19 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 Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

**Note 1.20 Transforming Community Services (TCS)**

The 2014/15 FReM required that all transfers between public sector bodies be accounted for using Modified absorption accounting. Airedale NHS Foundation Trust had no transfers in 2014/2015 .

**Note 1.21 Exceptional Items**

Exception items, are items of income or expenditure which are non-operational in nature, either due to a technical accounting adjustments, arising from the revaluation of the Estate(Impairments) or one off significant costs arising from the restructuring of an element of the service (Redundancy).

**Note 1.22 Accounting Standards and amendments issued but not yet adopted**

IFRS 9 Financial Instruments  
IFRIC 21 Levies

**To be adopted from 2015/2016**

IFRS 13 Fair Value Measurement  
IAS 36 (amendment)-recoverable amount disclosures  
Annual Improvement 2012  
Annual Improvement 2013  
IAS 19 (amendment) -employer contributions to defined benefit pension schemes

## 2 Operating segments

The Trust's core activities fall under the remit of the Chief Operating Decision Maker ("CODM") as defined by IFRS 8 'Operating Segments', which has been determined to be the Board of Directors. These activities are primarily the provision of NHS healthcare, the income for which is received through contracts with commissioners. The contracts follow the requirements of Payment by Results where applicable and services are paid for on the basis of tariffs for each type of clinical activity. The planned level of activity is agreed with our main commissioners for the year, and are listed in the related party disclosure (see Note [19.2]).

The Trust manages the delivery of healthcare services across a total of 5 Clinical Groups. Performance is reported at Clinical Group level to the Trust Board, although this is not the primary way in which financial matters are considered by the Board.

The Trust has applied the aggregation criteria from IFRS 8 Operating Segments because the Clinical Groups provide similar services, have homogenous customers, common production processes and a common regulatory environment. The overlapping activities and interrelation between the groups also suggests that aggregation is appropriate. The Clinical Groups report to the CODM, and it is the CODM that ultimately makes decisions about the allocation of budgets, capital funding and other financial decisions.

On this basis the Trust believes that there is one segment. The overall deficit reported to the Trust Board under the Clinical Group reporting structure was £2,776k excluding the NHS Foundation Charitable Funds (2013/14: deficit of £1k, excluding the NHS Foundation Charitable Funds), which is the same as the position reported in the Statement of Comprehensive Income.

### 2.1 Statement of Cash Flow

NHS Charitable funds activities included to account for consolidation.

## 3 Operating Income from continuing operations

### 3.1 Analysis operating income

	2014/2015 12 Months	2013/2014 12 Months
	£000	£000
<b>Income from activities by classification:</b>		
Elective income	22,607	22,299
Non elective income	38,193	37,733
Outpatient income	17,367	16,724
Accident and Emergency income	5,529	5,475
Community Services	5,031	5,042
Other NHS clinical income	41,978	41,421
Private patient income	188	361
Other non-protected Clinical income	8,299	6,681
<b>Total income from activities</b>	<b>139,192</b>	<b>135,736</b>
<b>Income from activities by source:</b>		
NHS Foundation Trust	661	459
NHS Trusts	951	638
CCGs and NHS England	136,247	133,077
Department of Health - other	-	-
Local Authorities	168	171
NHS Other	28	33
Non NHS: Private Patients	188	361
Non NHS: Overseas visitors	4	(2)
NHS injury scheme (see below*)	526	618
Non NHS: Other	419	381
<b>Total income from activities</b>	<b>139,192</b>	<b>135,736</b>
<b>Other operating income:</b>		
Research and development	1,981	1,291
Education and training	4,843	4,445
Charitable and other contributions to expenditure	211	87
Non-patient care services to other bodies	1,983	1,424
Profit on disposal fixed asset	-	-
Reversal of Impairments on Property, Plant & Equipment	3,654	576
Rental revenue from operating leases	10	15
Staff Recharges	171	132
Other (see note 3.2)	5,346	2,363
Charitable Funds: Incoming Resources excluding investment income	310	894
<b>Total other operating income before exceptional item</b>	<b>18,509</b>	<b>11,227</b>
Transitional investment	-	-
<b>Total other operating income</b>	<b>18,509</b>	<b>11,227</b>
<b>Total operating income</b>	<b>157,701</b>	<b>146,963</b>

\*NHS injury scheme income is subject to a provision for doubtful debts of 18.9% (2013/14 15.8%) to reflect expected rates of collection.

**3.2 Analysis of Other Operating Income: Other**

	2014/2015 12 Months £000	2013/2014 12 Months £000
Car Parking	857	817
Estates maintenance	52	86
Pharmacy Sales	34	28
Staff Accommodation rental	69	6
Crèche services	467	458
Catering	2	56
Clinical Tests	732	702
Clinical Excellence	60	60
Property Rentals	6	10
Reversal of provisions	1,377	(1,853)
Other income (see below)	1,690	1,993
	<u>5,346</u>	<u>2,363</u>

The "Other" other income is made up of a wide variety of items, including items such as course fees income and sales of non patient services to other organisations. Clinical Tests include the provision of Telemedicine services. Reversal of Provisions for reductions in income relating to 2013/2014 activities rechargeable in 2014/2015 have been charged to other income as per note 16.

**3.3 Analysis of income from activities**

(mandatory and non-mandatory services replaced with commissioner requested services)

	2014/15 12 Months £000	2013/14 12 Months £000
Commissioner requested services	130,705	128,694
Non-commissioner requested services	8,487	7,042
<b>Total</b>	<u>139,192</u>	<u>135,736</u>

**3.4 Private patient income**

Section 164(3) of the Health and Social Care act removes condition 10, (which restricted income from private charges), from the Trusts Terms of Authorisation. The Foundation Trust are now required by the Act and constitution (rather than by the terms of Authorisation), to ensure that income derived from activities related to the Trusts principle purpose of delivering goods and services for the purposes of the NHS exceeds income derived from other activities. To increase this income in any financial year by 5% or more, the Trust is required to seek approval from the Council of Governors. In 2014/2015 the Trust has not increased the percentage beyond the 5% threshold.

**3.5 Overseas visitors (relating to patients charged directly by the Trust)**

	2014/15 12 Months £000	2013/14 12 Months £000
Income recognised this year	4	(2)
Cash payments received in year	2	4
Amount written off in -year	3	6

## 4. Operating Expenses from continuing operations

## 4.1 Operating expenses comprise:

	2014/2015 12 Months	2013/14 12 Months
	£000	£000
Services from NHS Foundation Trusts	263	397
Services from NHS Trusts	855	871
Services from CCGs and NHS England	-	-
Services from other NHS bodies	10	-
Purchase of healthcare from non NHS Bodies	30	75
Employee Expenses - Executive directors	764	593
Employee Expenses - Non-executive directors	125	123
Employee Expenses - Staff	103,662	98,673
NHS Charitable funds - employee expenses	55	119
Supplies and services - clinical	13,195	11,840
Supplies and services - general	3,041	3,114
Establishment	875	1,043
Research & Development	-	1
Transport (Business travel only)	458	420
Transport (other)	105	109
Premises	7,219	6,369
Premise- business rates payable to local authorities	391	335
Increase in provision for irrecoverable debts	81	(48)
Inventories write down	123	30
Inventories consumed	-	-
Drug costs	10,450	9,150
Rentals Under Operating Leases	1,328	1,603
Impairment of Plant, Property and Equipment	6,488	1,165
Depreciation on property, plant and equipment	3,083	3,920
Audit services- statutory audit	69	63
Audit services- statutory audit charitable funds	5	5
NHS Litigation Authority contribution - Clinical Negligence	2,478	2,467
Loss on disposal of property, plant and Equipment	26	101
Legal fees	474	196
Consultancy costs	530	126
Training, courses and conferences	502	448
Patients travel	4	4
Redundancy	1,304	1,109
Hospitality	26	30
Insurance	111	113
Losses, ex gratia and special payments	49	30
Other	872	403
NHS Charitable funds: Other resources expended	19.4 291	282
<b>Operating expenses</b>	<b>159,342</b>	<b>145,279</b>

The external audit liability is limited to a maximum of £1 million

## 4.2 Operating leases as lessee

The Trust has an operating lease in place with Siemens for the provisions of Radiology equipment. The value of lease payments for the year 2014/15 was £1,169.1k (2013/14 £1,210k). This lease arrangement commenced on 22 October 2001 and is scheduled to run for 15 years, this was subsequently extended for 4 years with a possible additional extension of a future 4 years. A review of the lease arrangements has determined that this should be treated as an operating lease under IFRS. Siemens invested £1.73 million at the start of the contract and it is envisaged that a total of £6.35 million will be spent on new equipment during the period of the contract. At the end of the contract, the Trust has the option to purchase the equipment at its market value or may require the operator to remove it. The annual charge for the service is fixed and includes an amount for maintenance.

The balance of lease payments relates to small operating leases in respect of Pathology analysers, photocopiers and cars. In all these cases the Trust has the option to purchase the equipment at its market value at the end of the lease or can require the operator to remove them.

## 4.2.1 Operating expenses include:

	2014/15 12 Months	2013/14 12 months
	£000	£000
Other minimum operating lease rentals	1,328	1,603
	<u>1,328</u>	<u>1,603</u>

## 4.2.2 Total future minimum operating lease payments due:

	2014/15 12 Months	2013/14 12 months
	£000	£000
Within 1 year	1,328	1,546
Between 1 and 5 years	4,858	943
After 5 years	8	-
	<u>6,194</u>	<u>2,489</u>

## 4.3 Operating leases as lessor

The trust has operating leases in place with Local Care Direct Ltd relating to the use of accommodation on the Airedale General hospital site. The value of the lease payments from Local Care Direct in 2014/15 was £10k

	2014/15 12 Months	2013/14 12 months
	£000	£000
Rents recognised in year	10	15
	<u>10</u>	<u>15</u>
<b>Total future minimum operating lease income due:</b>	<b>£000</b>	<b>£000</b>
Within 1 year	-	-
	<u>-</u>	<u>-</u>

## 5. Employee expenses and numbers

## 5.1 Employee expenses

	2014/15 12 Months			2013/14 12 months		
	Total £000	Permanently Employed £000	Other £000	Total £000	Permanently Employed £000	Other £000
Salaries and wages	80,649	79,192	1,457	78,983	77,817 #	1,166
Social Security Costs	5,924	5,924	-	5,814	5,814	-
Employer contributions to NHS Pensions Agency	9,530	9,530	-	9,323	9,323	-
Termination benefits	1,304	-	1,304	1,109	1,109	-
Agency/contract staff	8,633	-	8,633	5,310	-	5,310
NHS Charitable funds staff	55	55	-	119	119	-
	<u>106,095</u>	<u>94,701</u>	<u>11,394</u>	<u>100,658</u>	<u>94,182</u>	<u>6,476</u>

## 5.2 Average number of employees (WTE basis)

	Total 2014/15 Number	Permanently Employed Number	Other Number	Total 2013/14 Number	Permanently Employed Number	Other Number
Medical and dental	245	245	-	238	238	-
Administration and estates	493	493	-	492	492	-
Healthcare assistants and other support staff	446	446	-	436	436	-
Nursing, midwifery and health visiting staff	709	709	-	697	697	-
Scientific, therapeutic and technical staff	380	380	-	372	372	-
Bank and agency staff	158	-	158	124	-	124
Other	3	3	-	3	3	-
Total	<u>2,434</u>	<u>2,276</u>	<u>158</u>	<u>2,362</u>	<u>2,238</u>	<u>124</u>

WTE = Whole time equivalents

**5.3 Retirement due to ill health**

During 2014/15 from the 1/4/2014 to the 31/3/15 there was 2 early retirements from the NHS agreed on the grounds of ill health (2013/14: 0). The estimated additional pension liabilities of these ill-health retirements will be £279k (2013/14: £0k). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

**5.4 Exit packages**

The following is the breakdown of the 2014/15 Exit packages

Exit Packages Cost Band	2014/2015		2013/2014	
	Number of agreed departures	Cost of departures £000	Number of agreed departures	Cost of departures £000
<£10,000	3	20	-	-
£10,000-£25,000	7	114	4	73
£25,001-£50,000	11	358	5	186
£50,001-£100,000	2	118	-	-
<b>TOTAL</b>	<b>23</b>	<b>610</b>	<b>9</b>	<b>259</b>
<b>Addition Analysis</b>				
Contractually Agreed Resignation Scheme	23	610	9	259
Voluntary redundancy	0	0	0	0
<b>TOTAL</b>	<b>23</b>	<b>610</b>	<b>9</b>	<b>259</b>

There were no compulsory Redundancies

**5.5 Directors Remuneration**

	Year ended 31 March 2015 £000	Year ended 31 March 2014 £000
Aggregate emoluments to Executive Directors	703	573
Remuneration to Non-Executive Directors	125	125
Pension Costs	61	48
	<b>889</b>	<b>744</b>

No directors have emoluments in excess of £200k  
There has been no compensation or exit packages paid for directors resigning in the year  
The highest paid director is £177k and has no share options

## 6. Property, plant and equipment (Group and Foundation Trust)

## 6.1 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	2,700	37,716	5,880	2,712	10,239	125	10,897	118	70,387
Additions - purchased	-	7,556	-	(2,497)	1,358	9	3,662	79	10,167
Additions - donations of physical assets (non-cash)	-	71	-	-	102	-	-	38	211
Additions - grants / donations of cash to purchase:	-	-	-	-	-	-	-	-	-
Impairments charged to operating expenses	-	-	-	-	-	-	-	-	-
Impairments charged to the revaluation reserve	-	(1,069)	-	-	-	-	-	-	(1,069)
Reversal of impairments credited to operating income	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to the revaluator	-	4,915	90	-	-	-	-	-	5,005
Reclassifications	-	-	-	-	-	-	-	-	-
Revaluations	(320)	(4,711)	607	-	-	-	-	-	(4,424)
Disposals	-	-	-	-	(547)	-	(16)	-	(563)
<b>Cost or valuation At 31 March 2015</b>	<b>2,380</b>	<b>44,478</b>	<b>6,577</b>	<b>215</b>	<b>11,152</b>	<b>134</b>	<b>14,543</b>	<b>235</b>	<b>79,714</b>
Depreciation at 1 April 2014	-	-	-	-	6,488	45	9,538	34	16,105
Provided during the year	-	1,604	136	-	764	19	546	14	3,083
Reclassifications	-	-	-	-	-	-	-	-	-
Impairment charged to expenses	320	6,168	-	-	-	-	-	-	6,488
Reversal of impairments	-	(2,985)	(669)	-	-	-	-	-	(3,654)
Revaluations	(320)	(4,787)	533	-	-	-	-	-	(4,574)
Disposals	-	-	-	-	(521)	-	(13)	-	(534)
<b>Depreciation at 31 March 2015</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>6,731</b>	<b>64</b>	<b>10,071</b>	<b>48</b>	<b>16,914</b>
<b>Net book value</b>	<b>2,380</b>	<b>44,069</b>	<b>1,100</b>	<b>215</b>	<b>3,645</b>	<b>30</b>	<b>4,472</b>	<b>144</b>	<b>56,055</b>
- Purchased at 31 March 2015	-	-	-	-	499	-	-	-	499
- Finance Lease as at 31 March 2015	-	-	-	-	-	-	0	-	-
- PFI as at 31 March 2015	-	-	5,477	-	-	-	-	-	5,477
- Donated at 31 March 2015	-	409	-	-	277	40	-	43	769
<b>Total at 31 March 2015</b>	<b>2,380</b>	<b>44,478</b>	<b>6,577</b>	<b>215</b>	<b>4,421</b>	<b>70</b>	<b>4,472</b>	<b>187</b>	<b>62,800</b>
<b>Asset Financing</b>									
Owned	2,380	44,069	1,100	215	3,645	30	4,472	144	56,055
Finance lease	0	0	0	0	499	0	0	0	499
Private finance initiative	0	0	5,477	0	0	0	0	0	5,477
Donated	0	409	0	0	277	40	0	43	769
<b>Total at 31 March 2015</b>	<b>2,380</b>	<b>44,478</b>	<b>6,577</b>	<b>215</b>	<b>4,421</b>	<b>70</b>	<b>4,472</b>	<b>187</b>	<b>62,800</b>

## 6.2 Current year analysis of property, plant and equipment:

In 2014/15, equipment previously used in the provision of services were disposed off and replaced as necessary in order to continue to meet the Foundation Trust's obligations to provide Commissioner Related Services.

At 31 March 2015, the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by David Curtis MRICS, Senior Surveyor DVS, Valuation Office Agency, Leeds Valuation Office, 42 Eastgate, Leeds. The Valuation Office Agency has confirmed that the valuation has been undertaken with regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition. The finance lease in this section relates to the provision of Catering services from Sodexo to the Trust. The arrangement commenced in May 2009 and has a life of 10 years.

## 6. Property, plant and equipment (Group and Foundation Trust)

## 6.3 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	2,660	35,036	5,458	2,438	10,603	121	10,695	54	67,065
Transfer by Absorption - modified	-	-	-	-	16	-	334	-	350
Additions - purchased	62	5,613	-	274	928	-	426	64	7,367
Additions - donations of physical assets (non-cash)	-	14	-	-	58	14	-	-	86
Impairments charged to revaluation reserve	-	(763)	(23)	-	-	-	-	-	(786)
Reversal of impairment credited to the revaluation reserve	-	85	40	-	-	-	-	-	125
Revaluations	(22)	(2,269)	405	-	(16)	-	(334)	-	(2,236)
Disposals	-	-	-	-	(1,350)	(10)	(224)	-	(1,584)
<b>Cost or valuation At 31 March 2014</b>	<b>2,700</b>	<b>37,716</b>	<b>5,880</b>	<b>2,712</b>	<b>10,239</b>	<b>125</b>	<b>10,897</b>	<b>118</b>	<b>70,387</b>
Depreciation at 1 April 2013	-	-	-	-	6,904	36	8,616	26	15,582
Provided during the year	-	1,768	174	-	806	18	1,146	8	3,920
Reclassifications	-	-	-	-	-	-	-	-	-
Impairment charged to expenses	22	793	(285)	-	16	-	334	-	1,165
Reversal of Impairment	(22)	(291)	111	-	(16)	-	(334)	-	(576)
Revaluations	-	(2,270)	111	-	(1,222)	(9)	(224)	-	(2,531)
Disposals	-	-	-	-	(1,222)	(9)	(224)	-	(1,455)
<b>Depreciation at 31 March 2014</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>-</b>	<b>6,488</b>	<b>45</b>	<b>9,538</b>	<b>34</b>	<b>16,105</b>
<b>Net book value</b>	<b>2,700</b>	<b>37,432</b>	<b>484</b>	<b>2,712</b>	<b>2,905</b>	<b>29</b>	<b>1,359</b>	<b>77</b>	<b>47,698</b>
- Purchased at 31 March 2014	-	-	-	-	616	-	-	-	616
- Finance Lease as at 31 March 2014	-	-	-	-	-	-	-	-	-
- PFI as at 31 March 2014	-	-	5,396	-	-	-	-	-	5,396
- Donated at 31 March 2014	-	284	-	-	230	51	-	7	572
<b>Total at 31 March 2014</b>	<b>2,700</b>	<b>37,716</b>	<b>5,880</b>	<b>2,712</b>	<b>3,751</b>	<b>80</b>	<b>1,359</b>	<b>84</b>	<b>54,282</b>
<b>Asset Financing</b>									
Owned	2,700	37,432	484	2,712	2,905	29	1,359	77	47,698
Finance lease	0	0	0	0	616	0	0	0	616
Private finance initiative	0	0	5,396	0	0	0	0	0	5,396
Donated	0	284	0	0	230	51	0	7	572
<b>Total at 31 March 2014</b>	<b>2,700</b>	<b>37,716</b>	<b>5,880</b>	<b>2,712</b>	<b>3,751</b>	<b>80</b>	<b>1,359</b>	<b>84</b>	<b>54,282</b>

## 6.4 Prior year analysis of property, plant and equipment:

Disclosure relating to protected assets is no longer required. In 2013/14, equipment previously used in the provision of services were disposed off and replaced as necessary in order to continue to meet the Foundation Trust's obligations to provide Commissioner Related Services.

At 31 March 2014, the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by David Curtis MRICS, Senior Surveyor DVS, Valuation Office Agency, Leeds Valuation Office, 42 Eastgate, Leeds. The Valuation Office Agency has confirmed that the valuation has been undertaken with regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition. The finance lease in this section relates to the provision of Catering services from Sodexo to the Trust. The arrangement commenced in May 2009 and has a life of 10 years.

**6.5 Revaluation of Plant, Property and Equipment (Group and Foundation Trust)**

Note 1.5 of the accounting policies defines the accounting treatment required by the Trust following a revaluation. In 2014/2015 the net book value of the Property has changed. In year there has been additions £10.2m, disposals of £0.6m and depreciation £3.1m. This would have resulted in an increase of the value of the Asset value of £61.5m. After revaluation, the accounting treatment required a reversal of the 2014/2015 impairments of £8.6m, a revaluation surplus of £0.2m and impairment of £7.5m which resulted from a net increase in the property valuation. £.3.9m has been reflected in revaluation account and £.2.8m through the Income and expenditure account, and net movement of £1.3m. The 2014/2015 net book value is £62.8m.

**6.6 Donors of property, plant and equipment:**

	2014/15 12 Months £000
Conversion of former photographic room into office- Airedale NHSFT Charitable Funds	7
Interactive Projector- Airedale NHSFT Charitable Funds	8
Sky ceiling and virtual windows- Airedale NHSFT Charitable Funds	30
Airedale General Hospital main entrance refurbishment- Friends of Airedale	64
BeneView T1 patient monitor- Airedale NHSFT Charitable Funds	2
BeneView T8 patient monitor- Airedale NHSFT Charitable Funds	48
BeneView T1 patient monitor- Part funded by Airedale New Venture	26
BeneView T1 patient monitor- Part funded by Friends of Airedale	26
	<u>211</u>

For the year 2013/2014 donated Assets were £86k

No restriction or conditions were placed on the donated asset by the donor

Donated assets are valued at the cost paid by the donor which reflects their fair value.

**6.7 Legacy Assets Transfers**

As at the 31/3/2015 no further assets have been transferred other NHS bodies.

**6.8 Public Dividend Received**

	2014/15 £000
Additional Public Dividend Capital (PDC) has been received, to fund capital projects	
	3259
	<u>3259</u>

**7. Current year intangible fixed assets (Group and Foundation Trust)**

The trust had no intangible fixed assets at the 31 March 2015

**8. Inventories****8.1 Analysis of inventories**

	31 March 2015 £000	31 March 2014 £000
	Group and Foundation Trust	Group and Foundation Trust
Drugs	648	685
Consumables	1,805	1,850
Energy	58	67
Total	<u>2,511</u>	<u>2,602</u>

## 8.2 Inventories recognised in expenses

	2014/15 12 Months £000	2013/14 12 months £000
	Group and Foundation Trust	Group and Foundation Trust
Inventories recognised as an expense in the year	22,993	20,948
Write-down of inventories (including losses)	123	30
<b>Total</b>	<b>23,116</b>	<b>20,978</b>

## 9. Trade and other receivables

## 9.1 Trade and other receivables are made up of:

	31 March 2015 £000	31 March 2014 £000
	Group and Foundation Trust	Group and Foundation Trust
<b>Current</b>		
NHS receivables	2,089	2,600
Receivables with other related parties	-	-
Provision for the impairment of receivables	(252)	(177)
Prepayments	551	384
VAT Receivables	336	225
PDC Dividend receivable (Department of Health)	4	39
Other receivables	1,863	1,409
Charitable Funds Trade and other receivables	19.4	5
<b>Total</b>	<b>4,593</b>	<b>4,485</b>
<b>Non-Current</b>		
Accrued income	891	746
other receivables	31	67
<b>Total</b>	<b>922</b>	<b>813</b>

The majority of the NHS foundation trust's trade is with Clinical Commissioning Groups, as commissioners for NHS patient care services. As Clinical Commissioning Groups are funded by the government to buy NHS patient care services, no credit scoring for them is considered necessary.

## 9.2 Movements in the provision for impairments of receivables

	31 March 2015 £000	31 March 2014 £000
	Group and Foundation Trust	Group and Foundation Trust
Balance at 1 April 2014	177	229
Increase in allowance recognised in income statement	88	52
Amounts utilised	(6)	(4)
Unused amounts reversed	(7)	(100)
<b>Balance at 31 March 2015</b>	<b>252</b>	<b>177</b>

NHS Injury Benefit Scheme income is subject to a provision for impairment of 15.8% to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

## 9.3 Ageing of non-impaired receivables past their due date

	31 March 2015 £000	31 March 2014 £000
	Group and Foundation Trust	Group and Foundation Trust
0-30 Days	1	61
30-60 Days	12	6
60-90 Days	72	106
<b>Total</b>	<b>85</b>	<b>173</b>

## 10. Cash and cash equivalents

	31 March 2015		31 March 2014	
	£000	£000	£000	£000
	Group	Foundation Trust	Group	Foundation Trust
Balance at 1 April 2014	17,319	16,660	13,802	13,694
Net change in year	(988)	(794)	3,517	2,966
Balance at 31 March 2015	<u>16,331</u>	<u>15,866</u>	<u>17,319</u>	<u>16,660</u>
Made up of:				
Cash with Government Banking Service	16,325	15,860	17,285	16,654
Cash at commercial banks and in hand	6	6	34	6
Cash and cash equivalents	<u>16,331</u>	<u>15,866</u>	<u>17,319</u>	<u>16,660</u>

## 11. Trade and other payables

	31 March 2015	31 March 2014
	£000	£000
<b>Current</b>		
Receipts in advance	-	720
NHS payables- Capital	18	67
NHS payables- Revenue	2,183	1,180
Amounts due to other related parties revenue	-	-
Non-NHS trade payables-capital	1,081	796
Non-NHS trade payables-revenue	1,039	1,035
Accruals	5,211	1,539
VAT payable	45	-
Social Security Costs	912	987
Other taxes payable	988	914
Other Payables	6,485	7,882
Charitable Funds - Trade and other payables	19.4	
TOTAL	<u>18,024</u>	<u>15,255</u>

## 12. Other liabilities

	31 March 2015	31 March 2014
	£000	£000
<b>Current</b>		
Deferred income	674	139
<b>Non-Current</b>		
Deferred income	4,185	4,324
	<u>4,859</u>	<u>4,463</u>

The figures in this section relate to the deferred income balance resulting from bringing the PFI arrangements with FRONTIS onto the Statement of Financial Position as required by Department of Health Guidance on PFI under IFRS. The residences came into use in May 2005 and the deferred income credit balance is set to reduce in equal instalments over a period of 40 years from that date, whereupon ownership will transfer to the Trust. (Note 21)

## 13. Borrowings (Group and Foundation Trust)

## 13.1 Finance Trust Financing Facility Loan

	31 March 2015	31 March 2014
	£000	£000
<b>Current</b>		
Obligations under Loan	505	505
<b>Non-Current</b>		
Obligations under Loan	2,528	3,033
	<u>3,033</u>	<u>3,538</u>

The Trust obtained a loan from the Foundation Trust Financing Facility on the 12/7/2011 repayable over 10 years, in the sum of £4.8 millions to support capital developments. The Trust repaid on the £505k of the loan in 2 instalments in 2014/2015k.

## 13.2 Finance lease obligations

	31 March 2015	31 March 2014
	£000	£000
<b>Current</b>		
Obligations under finance leases	130	117
<b>Non-Current</b>		
Obligations under finance leases	505	635
	<u>635</u>	<u>752</u>

The Trust has one finance lease in place at 31 March 2015. This is with Sodexo and relates to the provision of equipment as part of the catering service provided to the Trust, which commenced in May 2009. The lease is set to run for 10 years from that date, when £1.174 million worth of capital expenditure was incurred by Sodexo in establishing the catering facility. At the end of the contract the Trust will have the option to purchase all equipment and fixtures for £1. In the 2014-15 financial year the annual finance charge was £63k and the annual lease liability was £117k.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease payments	
	March 2015	March 2014	March 2015	March 2014
	£000	£000	£000	£000
	Group and Foundation Trust	Group and Foundation Trust	Group and Foundation Trust	Group and Foundation Trust
Within one year	79	180	130	117
Between one and five years	564	719	505	610
After five years	0	25	0	25
Less future finance charges	(108)	(172)	0	0
Present value of minimum lease payments	<u>535</u>	<u>752</u>	<u>635</u>	<u>752</u>

**14. Contingencies (Group and Foundation Trust)**

The NHS Foundation Trust has £31k contingent liability for legal expenses, which is based upon information provided by the NHS Litigation Authority.

**15. Third Party Assets ( Group and Foundation Trust)**

Airedale NHS Foundation Trust did not hold any monies on behalf of patients at the 31st March 2014 or the 31st March 2015.

**16. Provisions****16.1 Provisions current and non-current**

	Current		Non-current	
	31 March 2015 £000	31 March 2014 £000	31 March 2015 £000	31 March 2014 £000
	Group and Foundation Trust	Group and Foundation Trust	Group and Foundation Trust	Group and Foundation Trust
Pensions relating to the early retirement of staff pre 1995	128	129	1,136	1,189
Legal claims	55	52	-	-
Other	5,719	5,000	-	-
	<u>5,902</u>	<u>5,181</u>	<u>1,136</u>	<u>1,189</u>

**16.2 Provisions by category**

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2014	1,318	52	5,000	6,370
Arising during the year	93	33	4,535	4,661
Utilised during the year	(128)	(30)	(860)	(1,018)
No longer required	(34)	-	(2,956)	(2,990)
Unwinding of discount	15	-	-	15
At 31 March 2015	<u>1,264</u>	<u>55</u>	<u>5,719</u>	<u>7,038</u>

**Expected timing of cash flows:**

Within one year	128	55	5,719	5,902
Between one and five years	513	-	-	513
After five years	623	-	-	623
	<u>1,264</u>	<u>55</u>	<u>5,719</u>	<u>7,038</u>

The Pensions relating to other staff provision is expected to be fully utilised within the next 13 years. This statement is based on information provided by the NHS business Services Authority - Pensions Division. As the provision was established before the existence of 'back to back' arrangements, no reimbursement is expected.

The legal claims have a probability factor of 10% ,50%, 75% and 94% and are expected to settle within the next year. This Statement is based on information provided by the NHS Litigation Authority .Full reimbursement of these provisions is expected from the NHS Litigation Authority for amounts above the excess. No amounts have been 'back to backed' with other NHS organisations.

The other provisions column comprises provisions in respect of a number of issues which are expected to be settled within 12 months. They comprise of MARS scheme to support the Right Care programme, unresolved contractual issues relating to the income of the Foundation Trust, and a small number of employment cases which were outstanding at the end of the financial year.

£21,840,916 is included in the provisions of the NHS Litigation Authority at 31 March 2015 in respect of clinical negligence liabilities of the Trust (31 March 2014 - £18,546,273).

**17. Losses and special payments (Group and Foundation Trust)**

	31 March 2015				31 March 2014			
	Number of cases	Total number of cases	value of cases £	Total value of cases £	Number of cases	Total number of cases	value of cases £	Total value of cases
<b>Losses</b>								
loss of Cash	6		328		4		140	
Bad Debts	93		8,308		35		10,071	
Stores losses	4		122,734		3		30,497	
Damages to Premise		103		131,370		42		40,708
<b>Special payments</b>								
Compensation under legal obligation	9	-	79,720	-	14	-	42,606	-
Loss of personal effects	15	-	5,382	-	23	-	5,184	-
Other		24	1,393	86,495		37		47,790
<b>Total losses and special payments</b>	<u>127</u>	<u>127</u>	<u>217,865</u>	<u>217,865</u>	<u>79</u>	<u>79</u>	<u>88,498</u>	<u>88,498</u>

The NHS foundation trust's losses and special payments include uncollectable private patient/other debts and ex gratia payments in respect of the loss of personal items. The payments are recorded on a cash basis rather than an accruals basis.

**18. Contractual Commitments**

Commitments under capital expenditure contracts at 31 March 2015 were £32k

## 19. Related Party Transactions

## 19.1 Transactions with Key Management Personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS as "those persons having authority and responsibility for planning, direction and controlling the activities of the entity, directly or indirectly, including any director (whether executive or otherwise) of that Entity". The trust has deemed that its key management personnel are the board members (directors and non-executive directors) of the Trust.

The transactions with board members are as follows

	£000
2014/15	889

The expenditure above, is key management personnel compensation which is analysed as follows

	£000
Short term employment benefits	828
Post-employment benefits	61
Termination benefits	0
	889
	889

Short term benefits employer benefits include salaries, employer's social security contributions and benefit in kind  
Post-employment benefits include employer's contribution to NHS Pension Scheme

The remuneration of individual Board members is disclosed with in the Trust's. annual report. There were no outstanding balances with directors as 31 March 2015

Other than key management personnel compensation as shown above, none of the board members or parties to them has undertaken any material transactions with the NHS Foundation Trust

## 19.2 Transactions with other related parties

Airedale NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year the NHS foundation trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000	Expenditure £000
NHS Airedale, Wharfedale & Craven CCG	91,725	26
NHS East Lancashire CCG	13,604	-
NHS Bradford Districts CCG	16,713	5
Bradford Teaching Hospitals NHS Foundation Trust	659	-
Health Education England	4,495	-
Bradford District Care Trust	2,376	311
NHS England, CSU,LAT	11,987	99
Leeds Teaching Hospitals NHS Trust	78	987
NHS Litigation Authority	-	2,578
Other NHS bodies	5,045	2,796
	<b>146,682</b>	<b>6,802</b>
HMRC	-	5,924
NHS Pension Scheme	-	9,530
Bradford Metropolitan Council	85	423
Other	-	-
	<b>85</b>	<b>15,877</b>
Joint Venture	<b>526</b>	<b>791</b>

In addition, the NHS foundation trust has had a number of transactions with other Government Departments and other central and local Government bodies.

## 19.3 Transactions with Joint Venture

The Foundation Trust has a 50% equity share in Immedicare .The company holds no capital assets. Under the terms of the joint venture agreement, the Foundation Trust is not liable for any losses in the first year of trading, therefore as Immedicare has made a deficit in 2014/2015, the Foundation Trust has not reflected any entries in the statement of Comprehensive Income. The loss is for 2014/2015 was £348k

19.4 Summary statement of Financial activities with Airedale NHS Foundation Trust Charitable Funds

Charity's Statement of financial activities	2014/15 12 Months £000	2013/14 12 months £000	
Incoming activities excluding investment income	310	894	
Expenditure			
Employee Costs with ANHSFT	0	(55)	
Other Employee Costs	(55)	(119)	
other Expenditure			
Other resources Expended	(291)	(282)	
Audit Fee	(5)	(5)	
Total Operating Expenditure	<u>(351)</u>	<u>(461)</u>	
Investment Income	13	17	
Fair value movements on investments properties and other investments	27	18	
Net incoming/(outgoings) resources before other recognised gains and losses	<u>(1)</u>	<u>468</u>	
Charity's Balance Sheet/Statement of Financial Position	2014/15 12 Months £000	2013/14 12 months £000	
Investments	590	467	
Current Assets			
Trade and other receivables	2	5	
Cash and Cash Equivalents	<u>465</u>	<u>659</u>	
	467	664	
Current Liabilities			
Trade and other payables	(62)	(135)	
Net Assets	<u>995</u>	<u>996</u>	
Funds of Charity			
Restricted Funds	4	3	
Unrestricted Funds	991	993	
	<u>995</u>	<u>996</u>	
Movements on Reserves	Total	Restricted	Unrestricted
Balance At 1 April 2014	996	3	993
Net incoming	(1)	1	(2)
Balance at 1 March 2015	<u>995</u>	<u>4</u>	<u>991</u>

## 20. Financial instruments.

	31 March 2015 £000	31 March 2014 £000
<b>Financial assets</b>		
NHS Trade and other receivables excluding non financial assets	2,089	2,600
Non-NHS Trade And other receivables excluding Non-financial assets	2,058	1,333
Cash and cash equivalents at bank and in hand	15,866	16,660
NHS Charitable funds: financial assets	1,057	1,130
<b>Total</b>	<u>21,070</u>	<u>21,723</u>

The NHS foundation trust's financial assets all fall under the category 'loans and receivables'.

<b>Financial liabilities</b>		
Borrowings excluding Finance leases and PFI liabilities	3,033	3,538
Obligations under Finance leases	635	752
NHS Trade and other payables excluding non financial liabilities	2,183	1,247
Non-NHS Trade and other payables excluding Financial Liabilities	10,935	9,686
NHS Charitable funds: financial liabilities	62	135
<b>Total</b>	<u>16,848</u>	<u>15,358</u>

The NHS foundation trust's financial liabilities all fall under the category 'other financial liabilities'.

<b>Maturity of financial liabilities</b>		
In one year or less	13,815	11,563
In more than one year but less than two years	648	634
In more than two year but less than five years	1877	1946
in more than five years	508	1214
<b>Total</b>	<u>16,848</u>	<u>15,357</u>

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial accounts approximate to their fair value.

Because of the continuing service provider relationship that the NHS foundation trust has with the Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the NHS foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The NHS foundation 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 NHS foundation trust in undertaking its activities.

**Liquidity Risk**

The Foundation Trust's net operating costs are incurred under 3 year rolling contracts with local Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Foundation receives such contract income in accordance with Payment by Result (PBR), which is intended to match the income received in year by reference to the National Tariff procedure cost. The Foundation Trust receives cash each month based on an annually agreed level of contract activity, and there are monthly corrections made to adjust for the actual income due under PBR, to minimise the effects on cash flow.

The foundation Trust Currently finances its capital expenditure from internally generated funds, no use of the Foundations Borrowing limit is currently been made.

**Interest Rate Risk**

With the exception of cash balances, the Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust monitors the risk but does not consider it appropriate to purchase protection against it.

**Foreign Currency Risk**

The Foundation Trust has negligible foreign currency income, expenditure assets or liabilities.

**Credit Risk**

The Foundation Trust receives the majority of its income from Clinical Commissioning Groups and Statutory bodies and so the credit risk is Negligible. The Foundation Trusts treasury management policy minimises the risk of loss of cash invested by limiting its investments to

- the government banking service and the National Loans Fund
- Banks registered directly regulated by the FSA

The policy limits the amounts that can be invested with any one non-government owned institution and the duration of the investment to £3m and 3 months.

All banks are subject to risk based on the credit ratings of these institutions

**Price Risk**

The Foundation Trust is no materially exposed to any price risks through contractual arrangements.

## 21. Private Finance Initiative contracts

### 21.1 PFI schemes off-Statement of Financial Position

The Trust has no off-statement of Financial Position PFI schemes.

### 21.2 PFI schemes on-Statement of Financial Position

Since May 2005 residential services have been provided to the Trust by FRONTIS, a registered social landlord. This involved FRONTIS constructing an accommodation block and mews houses. FRONTIS are responsible for the maintenance of the accommodation and management of residential accommodation services, including the collection of rents from tenants. The Trust guarantees an occupancy level of 90%, but FRONTIS remits a share of any rents received for occupancy over 90%.

The accounting treatment of this arrangement was covered in a DH publication called 'Accounting for PFI under IFRS'. In this publication it was recognised that such arrangements involved the operator receiving all or most of its income from individual users rather than the Trust. The arrangement falls within the scope of IFRIC 12 and such is recognised as an item of Property, Plant & Equipment on the Statement of Financial Position at its fair value. The opposite entry at the point at which the asset was recognised was as a deferred income balance.

The arrangement is set to run for a period of 40 years from May 2005, but does not involve any cash flows between the Trust and FRONTIS. As such there is no imputed finance lease and service charges. During this period FRONTIS are responsible for maintaining the property, but at the end of the 40 year period ownership will revert to the Trust.

**22. Prudential Borrowing Limit (PBL)**

With effect from 1 April 2013, the NHS foundation trust is no longer required to comply with, and remain within, a total prudential borrowing limit. This requirement has been repealed by the Health and Social Care Act 2012. The Financial disclosures that were provided previously are no longer required.

The NHS foundation trust has a £10 million approved working capital facility. This is in place but has not been used during the year.

The NHS foundation trust does have borrowing which arise out the Finance lease obligations in respect of the Catering lease with Sodexo with a current value of £635k. The contract commenced in May 2009 and has a life of 10 years.

**23. Intra-Government Balances ( Group and Foundation Trust)**

	Receivables amounts falling due within one year £000	Receivables amounts falling due after more than one year £000	Payables amounts falling due within one year £000	Payables amounts falling due after more than one year £000
English NHS Foundation Trusts	282	-	742	-
English NHS Trusts	434	-	298	-
Department of Health	4	-	-	-
Public Health England	-	-	3	-
Health Education England	17	-	-	-
NHS England & CCGs	1,010	-	647	-
RAB Special Health Authorities	-	-	-	-
NHS Whole Government Accounting bodies	337	-	445	-
Other Whole Government Accounting bodies	345	-	2,011	-
As at 31 March 2015	<u>2,429</u>	<u>-</u>	<u>4,146</u>	<u>-</u>

**24. Events after the Reporting year**

There are no adjusting or non-adjusting events requiring after the reporting year requiring disclosure.

**Annual accounts of -**

**Airedale NHS Foundation Trust  
Airedale General Hospital  
Steeton  
Keighley  
Yorkshire  
England**

Airedale NHS Foundation Trust is an NHS provider of Healthcare

## CONTACT INFORMATION

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STEETON  
KEIGHLEY  
WEST YORKSHIRE  
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**Tel: 01535 652511**

**[www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk)**

This annual report and accounts is available on our website at [www.airedale-trust.nhs.uk](http://www.airedale-trust.nhs.uk)

If you need a copy in a different format, such as large print, audio, braille or in another language, then please contact our Interpreting Services on Tel: 01535 292811 or email [interpreting.services@anhst.nhs.uk](mailto:interpreting.services@anhst.nhs.uk)

### **Governors**

Governors can be contacted via the Company Secretary or FT Membership Office at the above address Tel: 01535 284541 Email: [members@anhst.nhs.uk](mailto:members@anhst.nhs.uk)

### **Patient Advice and Liaison Service (PALS)**

The PALS team at Airedale NHS Foundation Trust offer support, information and advice to patients, relatives and visitors. The PALS office is located at the entrance to Ward 18 and is open weekdays from 8.00 am to 4.00 pm. Tel: 01535 294019. Email: [pals.office@anhst.nhs.uk](mailto:pals.office@anhst.nhs.uk)

### **Readers Panel**

The Readers Panel, whilst being popular, always needs to recruit new members. If you would be interested in joining this group, please contact Karen Dunwoodie, patient experience lead. Tel: 01535 294027. Email: [helene.roberts@anhst.nhs.uk](mailto:helene.roberts@anhst.nhs.uk)

### **Volunteers**

New volunteers are always welcome and if you are interested in becoming a volunteer at Airedale NHS Foundation Trust, please contact Gurmit Jauhal, voluntary services manager. Tel: 01535 295316. Email: [gurmit.jauhal@anhst.nhs.uk](mailto:gurmit.jauhal@anhst.nhs.uk).



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