Airedale
NHS Foundation Trust

AIREDALE NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS
2018/19

Airedale NHS Foundation Trust

Annual Report and Accounts 2018/19

Presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006

CONTENTS

CHAPTER 1
PERFORMANCE REPORT

SECTION 1: Overview of Performance

Chief Executive's Statement

Welcome to our Annual Report for 2018/19.

I joined Airedale as Chief Executive in June 2018, so this is my first annual report here at the Trust. What struck me on joining was what a welcoming place Airedale is, and what a special place the Trust occupies in the heart of its community. There is enormous pride in this organisation, both from the people who work and volunteer here, and our patients, visitor, carers and partners. 2018 was also the year that we celebrated the 70th anniversary of the NHS and national pride in this beloved institution was at an all-time high.

The year has, in my view, been a successful year for the Trust, despite a tough national backdrop. The context in which we operate has never been more challenging: winter pressures that have continued all year round; staff shortages across our professions, particularly nurses and medics; tight financial control; and ongoing political uncertainty as the country navigates its most significant political, economic and social change since 1945.

All we can do in the midst of this turbulence is to continue to focus on what we are here for: to provide the best possible care to our patients. It is to the enormous credit of our people that we have continued to provide high quality, compassionate care to our communities in line with our values and the principles of our Right Care Strategy, despite external pressures and uncertainty.

The last twelve months have seen some tremendous achievements here at Airedale, with patient care at the heart of them. An excellent example is the launch of our Mobile Cancer Care Unit, the first in the north of England, in partnership with the Hope For Tomorrow charity. The unit takes chemotherapy treatment out to our communities, rather than necessarily expecting our patients – some of whom live in remote parts of the Dales – to come to Airedale. The 'cancer care bus' as it has become known, was the result of the vision and hard work of our Lead Clinical Nurse Specialist for Haematology, Oncology and Chemotherapy and it has become a familiar and popular sight locally.

This is just one example of a variety of service improvement and transformation projects that have taken place this year. I have been pleased to see that quality improvement is at the heart of the work that takes place here at Airedale and, combined with our leadership development work, makes the Trust a consistent player on the local and regional stage. A significant piece of improvement work has been taking place across stroke services this year in the shape of the Bradford and Airedale stroke collaboration work. At both trusts our stroke teams have challenged themselves and embraced new ways of working across our organisational boundaries and have already made improvements for patient outcomes, as evidenced by improved patient and quality outcomes data. This sets a great precedent for the Airedale and Bradford Acute Provider Collaboration Programme which is focusing on our 30+ shared services to make them sustainable for the future, and ensure good outcomes for our patients.

System working as a whole has moved forward at pace this year. The West Yorkshire and Harrogate Health and Care Partnership has continues to stride forward this year and we are seeing progress being made in several areas, in particular in the development of the single vascular service for West Yorkshire. The Partnership's current *'Looking Out For Our Neighbours'* campaign has been adopted and supported across the patch, and services such as pathology and radiology are beginning to see strong collaboration work. Closer to home, my role also includes leadership of the Airedale Wharfedale and Craven Health and Care Partnership which has recently formalised its governance and partnership arrangements between all partners and is now beginning to make headway in removing artificial organisational boundaries for our patients to help them to stay happy, healthy and at home.

Our year at Airedale ended with two separate but closely linked highlights. The first was receiving our combined rating of Good from the Care Quality Commission inspections and NHS Improvement Use of Resources review which took place in November and December. While there remains more to do to get our quality and well-led elements to where they should be, I am pleased that the work of our people and the tight grip on our resources has been recognised. I was also gratified to see that the CQC commented repeatedly on the positive culture at Airedale, a direct reflection of the enthusiasm, commitment and professionalism of our people.

The second - the day after our CQC announcement - was the fifth Annual Pride of Airedale Awards which rounded off the year by celebrating the achievements of individual and teams from across the organisation. Over 270 nominations were made this year, a testament to the supportive, encouraging ethos towards colleagues that typifies Airedale.

Looking forward, we have a busy year ahead. The national context remains challenging; but we will continue to focus on what we need to do to support the NHS Long Term Plan, and await the supporting workforce plan and social care green paper.

Locally, we have welcomed some new executive colleagues to Airedale who will help to develop and shape our direction, and we will continue to play our part as a partner in the AWC Health & Care Partnership. We will also in the summer welcome several new governors to the Trust, following elections in May. Priorities for us over the next year continue to be the prevention of falls, prevention and treatment of sepsis, wound care, the care and support of patients with mental illness and end of life care; the continued digitisation of our patient records; and consolidating a Good rating for quality and well-led as part of our next CQC inspection. Internally we will see a strong focus on developing leaders in every seat and pushing forward the Great Place To Work programme. This year also sees the reopening of our intermediate care facility at Castleberg Hospital in Settle and we will be beginning preparations for our 50th birthday celebrations in July 2020.

I started by talking about the enormous pride that there is in Airedale. I am proud too of our people, our volunteers, our governors, non-executive directors, and my executive colleagues, and would like to thank them for the support they have all shown to me and to the organisation over the past year. I am proud to belong to the Airedale community and look forward to a good year.

Brendan Brown
Chief Executive, Airedale NHS Foundation Trust
28 May 2019

Our history, purpose and activities

The principle purpose of the Trust is the provision of goods and services for the purpose of health care in England. 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 Foundation Trust is: Airedale General Hospital, Skipton Road, Steeton, Keighley BD20 6TD.

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

- Castleberg Hospital, Giggleswick, Settle BD24 0BN.
- Skipton General Hospital, Skipton BD24 2RJ

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

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening services
- Management of supply of blood and blood derived products
- Maternity and midwifery services
- Nursing care
- Surgical procedures
- Termination of pregnancy
- Transport services, triage and medical advice provided remotely
- Treatment of disease, disorder or injury

Castleberg Hospital was closed temporarily in April 2017 on patient safety grounds and is due to open in autumn 2019.

Airedale NHS Foundation Trust is an award winning integrated 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 2,470 permanent staff and have over 350 volunteers. Last year, we cared for over 35,000 elective inpatients and day cases, more than 30,000 non-elective patients, and over 150,000 outpatients. Our emergency department saw more than 62,000 patients and over 2,100 babies were born at the hospital last year. We have an annual budget operating income of over £180 million.

We provide services from our main hospital site, Airedale Hospital, and from community hospitals, 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.

Key issues and risks

As part of good governance, the Trust continues to identify potential risks to achieving its strategic developments.

During 2018/19 the Trust continued to embed its risk management processes with a review of the risk management arrangements and the risk management strategy. These will be further strengthened in 2019/20 with the development of the Board's risk appetite statement in summer 2019. The Trust also reviewed and implemented refreshed governance arrangements, with a more focused Quality and Safety Committee and the introduction of a People Committee. All committees have non-executive director membership. An internal of committee effectiveness received significant assurance.

There is a regular review of the Board Assurance Framework and the high level risk register at the Board and its sub-committees. A description of the principle risks and uncertainties facing the Trust is set out in the Annual Governance Statement on p88.

In April 2018 the Board of Directors agreed the annual plan setting out its key areas of delivery. The risks to the achievement of the goals are described in the Board Assurance Framework as:

Deliver high quality patient care and experience

- Failure to deliver patient safety, quality and productivity whilst delivering efficiencies
- Failure to respond to the CQC Annual Inspection Report findings in a timely and robust manner
- Failure to meet NHS Improvement Single Oversight Framework and/or Sustainability and Transformation requirements and CCG Contract Standard requirements
- Failure to ensure continuity plans can respond to loss of digital infrastructure including from cyber attacks
- Failure to provide safe care due to Brexit implications

Deliver better care through the most effective and efficient way of using resources

- Failure to respond to national funding issues, acute provider efficiencies, CCG QUIP programme, cuts to LA budgets
- Failure to fund the 10 Year Plan
- Failure of system transformation at pace
- Failure to secure non-NHS income growth

Be the employer of choice

- Failure to respond to external factors influencing availability of workforce
- Failure to develop organisational culture/staff values/behaviours and morale
- Significant changes in the composition of the Board resulting in an impact on decision making and governance
- Failure to embed Leadership and Accountability Framework

The issues below describe the risks that the Board of Directors considers to be of particular significance. There may be other risks or uncertainties not yet identified by the Foundation Trust that could impact on future performance.

Key risks to the Trust during 2018/19 were:

- **Availability of workforce**
  The Trust has continued to experience significant challenges in being able to recruit nurses and doctors. This has had a significant impact on patient flow and the provision of safe staffing levels across wards, particularly over the winter period. It has been an ongoing balance to ensure that safety and quality was not compromised while managing agency expenditure. This will continue to be a challenge in 2019/20.

- **Demand for services**
  During 2018/19 the Trust saw a significant increase in the numbers of people attending Accident and Emergency. This also resulted in increased admissions, acuity, and patients who had delays in their discharge arrangements. As a result there had been at times significant escalation beds opened, over and above the planned additional winter beds. This also placed additional pressure on the staffing levels across the Trust.

- **Financial position**
  The Trust continues to operate in a difficult financial environment being shaped by the national financial picture with the on-going need to reduce the public deficit and bring NHS finances at a national level back into balance. This sits alongside the continued challenges of ensuring safe staffing levels in the context of shortages in the available clinical workforce; delivering year on year efficiency savings; investing in developing technology and maintaining facilities; and responding to increasing demand and seasonal pressures. The Trust has also agreed a fixed income contract with its commissioners and there are risks of increasing activity as a cost to the Trust.

- **Regulatory Control**
  In December 2018 the Trust underwent a new ‘well led’ inspection by the Care Quality Commission alongside the Use of Resources inspection by NHS Improvement. This resulted in a rating of ‘requires improvement’ for Quality of Care; ‘requires improvement’ for Well Led; ‘good’ for Use of Resources; and ‘good’ overall. The inspection highlighted a number of areas for improvement and it is important that the Trust addresses these areas while maintaining high quality care across all of its services.

- **Performance**
  Generally, the Trust performance well across the national mandatory performance standards, however, maintaining this level of performance remains challenging for a variety of reasons including, increasing demand, system wide transformation developing, but not at the pace or scale to keep in line with demand, commissioner affordability and in some cases available capacity. The Trust must keep a close grip on its performance, while responding to the expected changes in performance measures during the year.

- **Transformation and partnership**
  During 2018/19 the Trust has seen significant steps forward in the development of its transformation and partnership on a local; district; and regional level. The Chief Executive has a dual role as both Chief Executive of the Trust and system leader across Airedale, Wharfedale and Craven and Chairs the local Health and Care Partnership. He is also a member of the Bradford District and Craven Integration and Change Board. In addition, members of the Executive team along with counterparts in Bradford Teaching Hospitals Foundation Trust, form the Strategic Collaboration Board, looking at efficient pathways of care between the two Trusts. At a regional level the Trust is represented at the West Yorkshire Association of Acute Trusts in support of the West Yorkshire and Harrogate Health and Care Partnership. All of these partnership arrangements require significant attention and commitment. It is important that these are balanced against the needs of the Trust to ensure that work is progressed at pace on a partnership level to deliver the needed changes in activity and patient care, while keeping a focus on performance and quality of services within the Trust.

Going concern disclosure

Airedale NHS Foundation Trust has prepared its 2018/19 annual accounts on a going concern basis. After making enquiries, the directors have a reasonable expectation that Airedale 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. The accounts have been prepared under a direction issue by NHS Improvement under the National Health Service Act 2006.

SECTION 2 - PERFORMANCE ANALYSIS

How we measure performance

Like all Trusts, Airedale NHS Foundation Trust is under enormous pressure to meet the health care needs of a growing and diverse population, alongside great changes to the infrastructure of the NHS and a difficult financial climate.

The Trust's performance against a range of national targets and standards is assessed and reported externally. These measures include the 4-hour emergency care standard; cancer referral targets; infection control standards; 18-week waiting times and staffing levels.

For most of the objectives or indicators, a rating of either Green or Red is applied based on the position to date against the threshold set. In some cases an Amber rating is applied for reasons such as the objective/indicator area being currently on hold or as an early warning that an area being measured on a quarterly or annual basis is currently behind plan. Supporting commentary is provided together with trend charts showing the position over the previous five quarters or fifteen months, depending on the frequency of the measurement period.

The Board considers an Integrated Performance Report at each meeting which describes performance against these targets and any action being taken to address dips in performance. This is informed by detailed review at a group and executive level prior to the Board meeting. There is also detailed scrutiny of the different elements of the Integrated Performance Report through the Board sub-committees: Finance, Performance and Digital Committee; Quality and Safety Committee; and the People Committee. Each quarter the Board confirms the position of each of these metrics to NHS Improvement.
Details of the Trust's performance during the year can be seen below.

Performance overview

The Trust's NHS Improvement Single Oversight Framework Governance rating was Segment 2 (on a scale where 1 is highest and 4 is lowest) during 2018/2019 due to non-achievement of the 95% target for the A&E 4 hour standard and, at certain points during the year, pressures around the Cancer 62 Day and Diagnostics 6 Week Standards. All other standards were achieved or within agreed limits.

The Trust has not achieved the requirements for the A&E element of the Sustainability and Transformation Funding. This has in year been affected by a 5% increase in A&E attendances and 6% increase in Non-Elective activity.

Key performance indicators

Indicator	Target	Q1	Q2	Q3	Q4
Total time in ED under 4hrs	**95%**	92.9%	90.6%	91.2%	88.0%
Referral to Treatment Time, 18 wks.	**92%**	92.7%	92.2%	92.9%	92.9%
Diagnostics 6 Week Wait	**99%**	92.6%	97.9%	98.7%	96.7%
Cancer 2 week wait	**93%**	93.9%	93.9%	94.1%	94.3%
Cancer 2 week wait (breast symptomatic)	**93%**	93.1%	97.5%	92.3%	91.0%
Cancer 31 days from diagnosis to first treatment	**96%**	100%	100%	100%	100%
Cancer 31 days for second or subsequent treatment – surgery	**94%**	100%	100%	100%	100%
Cancer 31 days for second or subsequent treatment – drug treatment	**98%**	100%	100%	100%	100%
Cancer 62 day wait for first treatment (urgent GP)	**85%**	85.1%	85.5%	86.8%	86.1%
Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	**90%**	90.9%	95.8%	90.2%	80%

Development and performance of the foundation trust

The Trust starts the challenging period ahead from a strong position. Some highlights for 2018/2019 on progress with our strategic goals and objectives include:

External recognition

- The ACE2 cancer project at Airedale has been highlighted as one of 10 new 'one stop shops' designed to speed-up cancer diagnosis and help save lives.

- Liz Thwaite is the second of our community nurses to be awarded the prestigious title of Queen's Nurse, in recognition of her high standards of practice and patient care. Liz is Clinical Lead for Community Nursing and oversees the district nursing teams within Craven and the specialist nursing and community advanced practitioner teams that work across Airedale, Wharfedale and Craven.

- We have been named as one of the top 5 trusts for the CHKS Top Hospitals programme national patient safety award 2018. The patient safety award is a national award for outstanding performance in providing a safe hospital environment for patients.

- The stammering therapy team were shortlisted for a prestigious HSJ award for their innovative service offered UK-wide for patients who stammer. The project, which has already won a Guardian Public Service Award, offers a specialist speech therapy service to adults across the UK via videolink to patients' laptops, tablets and even mobile phones.

- Physiotherapist Rachael Sharples, who is therapy team leader at Manorlands hospice, was given a 'Yorkshire women of achievement' award for her outstanding contribution to Manorlands. Rachael is part of a team of two physiotherapists and two occupational

therapists and they have introduced palliative rehabilitation to the hospice which is about allowing people with life-limiting and terminal conditions to live as independently and fully as possible.

- We launched our new mobile cancer care unit which will provide treatments in the community and will visit Settle, Grassington, Colne, Wilsden, Ilkley, Wharfedale, Skipton and Keighley.

- The Procurement and Supplies team at AGH Solutions Ltd have been named in the top 25% of all Acute Trusts in the country by NHS Improvement for the efficient way it runs its procurement process and how effectively it gets best prices for its products.

- Our first cohort of Nurse Associates received their registration from the NMC in January. Airedale was one of 11 sites to take part in the national pilot for the role and the first cohort of 7 students started their 2-year training in January 2017.

- Our Endoscopy team were awarded full accreditation by the Joint Advisory Group (JAG) of the Royal College of Physicians. The assessors were particularly impressed by the innovative team with strong leadership, the cleanliness of the unit, the paging system, and the clear and informative patient information.

- Our Maternity team got excellent results from new parents in the Care Quality Commission's Maternity 2018 survey. In 8 areas Airedale performed really well, particularly around communications, support, advice and respecting decisions

Working with our communities

- The organisation celebrated Dementia Action Week in May 2018 raising awareness of support available within the trust and in the community. This involved a number of stalls on the top landing and a presentation to staff about the acute dementia pathway.

- The digital health team organized a workshop to involve staff, patients and carers in developing a strategy for digital services at Airedale. The event was attended by a number of students from South Craven College to offer a younger person's perspective on what the trust's priorities for digital workstreams should be.

- The theatres and endoscopy unit held their ever popular Theatres Open Day. Hundreds of people attended to have a go at fixing broken bones and see how staff replace hip, knee and shoulder joints and to use a kit for practicing keyhole surgery during the event. In the endoscopy unit visitors could use cameras to look inside a stomach, bowel, lungs and bladder and see information stands from organisations such as the Crohn's and Colitis society and the bowel cancer screening programme.

- A Death Café was organised by the palliative care team as part of the national Dying Matters Awareness Week. Visitors and staff were invited to join the team in the café area for discussion about dying and bereavement.

- An Eid celebration was held to give staff the opportunity to join together with colleagues, eat some delicious food and to wish one another 'Eid Mubarak'. It was organised by Hospital Chaplain Ron Mulligan and Organisational Learning team. It was held after the start of the Eid celebrations, to include those staff who had taken leave to be with their families and friends.

- A Patient and Public Engagement project was conducted by members of the Dietetics team. The project explored the model for Diabetes Structured Education in order to better understand the needs of the local population and to factor recommendations into strategies aiming to increase uptake of structured education. Thoughts were gathered from 25 local healthcare professionals and 118 local patients and members of the public from a range of demographic groups, via interviews, focus groups and questionnaires, and considered alongside national guidelines and research in order to identify key themes and priorities and make recommendations.

- The trust has hosted and organised events for members in partnership with other local providers. In April 2018 we ran a session for raising awareness of pathways to services for Eating Disorders. In October 2018 we hosted a play about stammering in partnership with a local theatre company. Both events were well attended and evaluated by members of the public.

- The trust has hosted a number of nurse recruitment events to attract student nurses and those who wanted to return to practice.

- Our allied health professionals helped to organise an event in collaboration with staff in Bradford as part of an AHP celebration event. It was a great opportunity for AHPs across the district to get together, and featured key note speaker Suzanne Rastrick, as well as a whole host of information stalls and innovative discussion huddles on the day.

- The inaugural maternity open day was a great success with 100s of people coming to meet staff and find out more about the service. The open day was enjoyed by new parents, mums-to-be and families, as well as those interested in pursuing a career as a midwife.

Performance

- An incredible 97% of the patients surveyed over the last year as part of the friends and family test said that they were likely or extremely likely to recommend Airedale's services, which include outpatient clinics, inpatient services, maternity and community services.

- Our clinical research and development team saw a record increase in the number of patients taking part in clinical research. The Trust took part in 73 studies in 2017/18 with over 1,000 patients taking part.

- The vast majority of staff at Airedale Hospital would recommend the Trust to their family and friends for treatment according to the results of the national NHS Staff Survey which also showed that staff are positive about working at the Trust. Overall our results make positive reading. We are better than average in areas such as health and wellbeing, line

managers, morale, inclusion, working in a safe environment, safety culture and staff engagement. Staff have also reported improvements (compared to last year) in relation to support from line managers, staff engagement and developing a safety culture.

- Our infection prevention has been excellent this year. The Trust also has had one case of MRSA to date during 2018/2019 and no avoidable cases of clostridium difficile. Over 75% of staff were given the flu vaccination in year.

Financial Overview

The Trust achieved a surplus of £3,362k for 2018/19. This improvement was mainly achieved by meeting the control total set by NHS Improvement and subsequent allocation of STF funding of £6,789k. This position also included a technical adjustment of £3,8181k. The adjustment arose out of the Trust's annual revaluation of its land and buildings by the District Valuer.

The year-end surplus outturn, excluding the technical adjustment and STF funding, was £391k for the year.

Total income from continuing activities for 2018/19 was £185.7 million. The Trust had a cash balance of £15.3 million at the close of the financial year, which included £2,179k of STF funding. An analysis of this is shown in the Consolidated Statement of Cash flows in Chapter 4.

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 £163k in the year 2018/19.

The Trust's external auditor is Grant Thornton. Disclosure of the cost of work performed by the auditor in respect of the reporting period is provided in note 4.1 of the accounts.

The analysis below shows the Trust's financial position against key performance indicators.

In our financial planning for 2019/20 the Trust is planning for an underlying surplus of £3,236m. In 2019/20 the Trust has been given a control total to achieve by NHS Improvement of £6,398m of which £3,162m will again be supported by Provider Sustainability Funds (PSF) Sustainability Transformation Funds subject to the Foundation Trust delivering an agreed performance trajectory. The control total is a stretch target for the Trust and will be challenging to deliver.

The Trust is continuing to invest in increased nursing staff over 2018/19; 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 Trust.

The Trust's capital programme invested over £4.5 million in 2018/19 to improve its buildings and equipment. Examples of the higher value capital expenditure schemes included: construction of a new car park at £0.815 million.

A formal cost improvement programme (CIP) was approved for 2018/19, which set targets and actions plans aimed at improving efficiency. The CIP was monitored monthly and achieved £7,232m within the financial year. Examples of the higher value schemes achieved during the year were:

- Non- recurrent pay savings.
- SPV savings
- Procurement savings.
- Income growth.

In terms of service delivery, the Trust's focus on access times has seen a number of high profile requirements delivered in 2017/2018 including:

- Most patients were treated within 18 weeks of their referral
- Despite unprecedented system wide pressures for urgent care, a large proportion of patients were admitted, treated or discharged within four hours of arriving in our emergency department.
- We continue to have one of the lowest infections rates in the country for Clostridium difficile.
- There was one hospital acquired MRSA case during the year.
- Performance on the majority of the national cancer standards met or exceeded the required levels.

Supported through contracts with our CCG Commissioners, the Trust delivered an increased activity income in 2018/2019 across a number of points of delivery. This work reflected an increased level of demand whilst also delivering on key access waiting time targets.

Key requirements around clinical quality were met with the Foundation Trust delivering on the local quality schedule.

Service developments and initiatives

We have continued to develop the ambulatory care model at the front end and have seen a 25% increase in patients who are being treated as same day emergency care (SDEC). We now see 37% of patients as same day emergency care.

We have successfully developed strong partnership working across health and social care to improve the MAID (Multi-Agency Integrated Discharge) team who support patients who require further support on discharge. This has been especially important when supporting peaks in demand for services through the winter months.

Airedale NHS Foundation Trust, Bradford District Care Trust and Bradford Teaching Hospitals Foundation Trust worked collaboratively to jointly redesign the autism assessment

and diagnosis service in line with the requirements of NICE guidance NG128 *"Autism spectrum disorder in under 19s: recognition, referral and diagnosis"* and Quality Standard 51. This work required a number of professionals from across the 3 organisations to reach a consensus on the most effective pathway to reduce waiting times from referral to diagnosis and address increasing demand for the service. In July 2018 the new pathways were piloted and proved to be very effective reducing the waiting time from up to 2 years to 13 weeks.

Research and Development

Clinical research is fundamental to creating an evidence-based decision making culture in healthcare and is now an established part of core NHS business. Research is essential to generate new knowledge for the benefit of patients, the modernisation and promotion of services in the NHS and the development of evidence-based patient care. Recent studies have demonstrated that active participation in research leads to better outcomes for patients (Ozdemir, et.al. 2015; Downing, et al. 2017). Also, a correlation was found between clinical trial activity in NHS trusts and Care Quality Commission ratings as found in a recent study (Jonker L, Fisher SJ, 2018).

Airedale NHS Foundation Trust receives National Institute for Health Research (NIHR) funding to support National Portfolio research. During 2018/19 the organisation took part in more than 70 clinical research studies of which 60 were on the National Portfolio and three were commercial contract trials. More than 1,000 patients were recruited to NIHR portfolio studies during the year. Research is actively being conducted in 19 clinical specialty groups and we are now able to offer more patients than ever the opportunity to participate in clinical research. A total of 46 senior clinical staff are involved in research which is an indication of the growing culture of research and evidence-based practice within the organisation. As a relatively small organisation, the Foundation Trust continues to perform to a high standard and manages to consistently achieve the high-level objectives set by the NIHR.

Academic research forms an important part of the Foundation Trust portfolio and is integral to staff development within the organisation. Over the year a number of staff members have been advised and guided through the research process leading to successful completion of academic degrees; predominantly at Masters level and also for PhD. Clinical staff have published in peer-reviewed journals and publications include Cochrane Systematic Reviews. Over the past 3 years 33 publications have been declared. Airedale has also been formally acknowledged as a contributor to studies reported in 40 publications due to the Foundation Trust's involvement in NIHR portfolio studies. In addition to this there have been conference posters and oral presentations.

During 2018/19 there were a number of notable achievements in research:

- We took part in the national 100,000 Genomes Study which is groundbreaking translational research and will provide vital information that will transform patient care for individuals with cancer or rare diseases;
- A Research Education Day was held in the education centre which celebrated research in the Trust and featured a number of our clinicians;
- A legacy received in the will of a patient enabled us to set up a new Airedale-sponsored ovarian cancer study which is expected to provide new and more reliable diagnostic information for women with suspected ovarian cancer;

- The Research team received commendations for being amongst the highest patient recruiters for a number of different clinical trials;
- Other events during the year included research 'roadshows' at local venues and the collection of food and groceries for a 'food mile' in aid of Skipton Food Bank.

Partnership working

The Trust has continued to strengthen its partnership working arrangements during 2018/19 at a local, district and regional level.

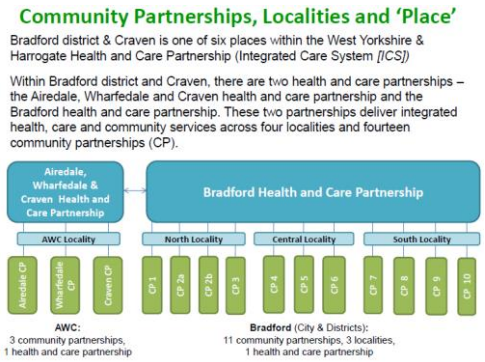
Airedale, Wharfedale and Craven Health and Care Partnership

The Trust's Chief Executive is also the system lead for the Airedale, Wharfedale and Craven Health and Care Partnership (AWC HCP). The AWC HCP board agreed to formally operate from 1 April 2019. The ambition of the HCP is to deliver the vision of 'Happy, Healthy at Home' and ensure:

- Every neighbourhood will be a healthy place – with better prevention and earlier intervention – live longer in good health, be happy, 'demand' less, contribute more
- Services will be planned and delivered based on the needs of communities underpinned by clear expectations of the responsibility of individuals
- Everyone with long term conditions will have support to self-care
- People will have fewer assessments and contacts, continuity of care supported by shared records and professional trust
- Everyone with multiple needs will have a team that works together with them and their family/carers
- Local hospitals will be networked with each other and with services in communities

This is being delivered through:

- System & Partnership Working - Starting new partnership arrangements for holding system commissioning and budget conversations, ensuring greater transparency on how local money is spent and mutual efficiencies are achieved.
- Approval of a Strategic Partnering Agreement (SPA) - a framework that sets out how we work together & our agreed system approach to shared decision making and accountability
- Working with the Community Partnerships - creating new models of care that increasingly focus on prevention, reducing health inequalities, improving the experience of the workforce and that deliver financial and workforce sustainability.
- A different planning approach 2019/20 – System commissioning intentions through community partnerships and programmes.



West Yorkshire and Harrogate Health and Care Partnership

West Yorkshire and Harrogate Health and Care Partnership (WY&H HCP) was formed in 2016 as one of 44 Sustainability and Transformation Partnerships (STPs). It brings together all health and care organisations in our six places: Bradford District and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield to meet the needs of people as close to home as possible.

Our organisation is one of the partners which make up this unique Partnership

In order to realise the ambitions of the Partnership we need to recruit, train, develop and retain our skilled and caring workforce so that health and social care services are fit for the future - for generations to come. The Partnership's workforce plan 'A healthy place to live, a great place to work' can be found here. This document describes the challenges we face and the work we will be doing together to address them.

All partner organisations have now formally approved the Partnership's Memorandum of Understanding. A new Partnership Board will also bring NHS, councils and communities closer together. The first meeting in public will take place in June 2019.

The NHS Long Term Plan

The NHS Long Term Plan for the NHS gives formal backing to systems like West Yorkshire and Harrogate Health and Care Partnership. It gives a further boost to the priorities that we have been working on locally and the help we need to deliver reductions in health inequalities and unwarranted care variation (often referred to as the post code lottery). For example, the focus on mental health services, cancer, preventing ill health, and primary care (GPs, district nurses and occupational therapists) will build on our approach and the progress we have already made. The recognition of workforce challenges is welcome and we are keen to understand how the full workforce plan will further support local efforts to secure a workforce for the future. This is perhaps our biggest single challenge.

Alongside the NHS long-term plan we will need additional resources and support for social care and for local government. Without these we cannot deliver our ambitions.

West Yorkshire Association of Acute Trusts

The West Yorkshire Association of Acute Trusts (WYAAT) is a collaboration of NHS acute hospitals from across the region to drive forward the best possible care for our patients. It also includes Harrogate as the town and it services are covered by the clinical commission groups based in West Yorkshire.

Our vision is to create a region-wide efficient and sustainable healthcare system which embraces the latest thinking and best practice so we can consistently deliver the highest quality of care and outcomes for our patients in the WYAAT area.

The WYAAT six acute trusts are:

- Airedale NHS Foundation Trust (FT)
- Bradford Teaching Hospital NHS FT
- Calderdale and Huddersfield NHS FT

• Harrogate and District NHS FT
• Leeds Teaching Hospitals NHS Trust
• Mid Yorkshire Hospitals NHS Trust.

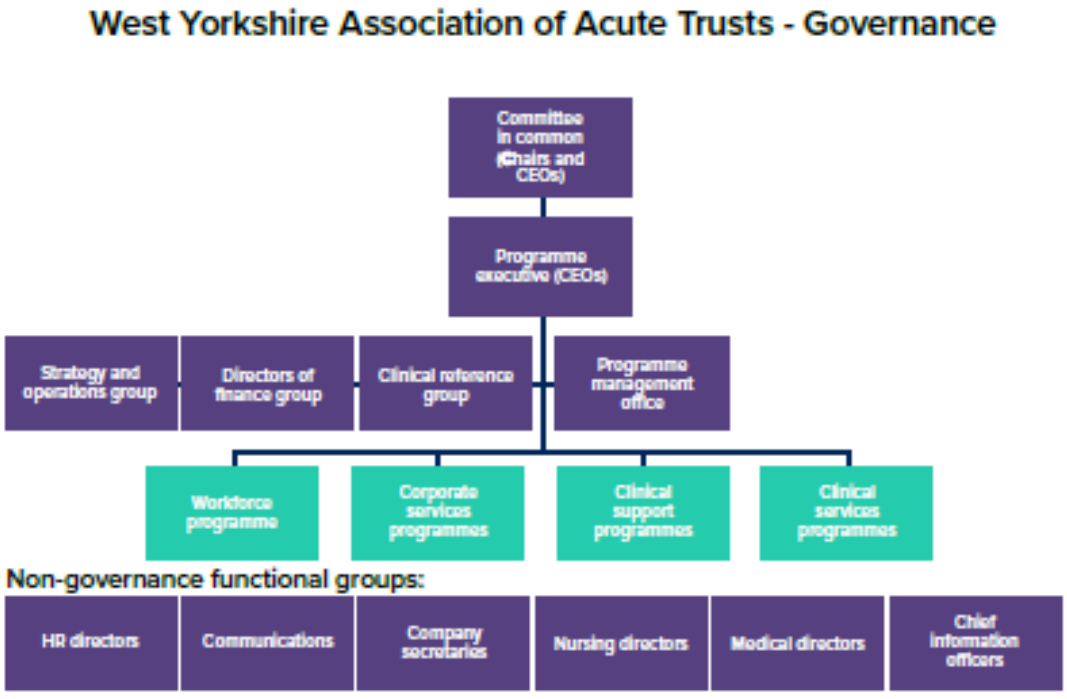
Our patients across the region are the focus of all WYAAT's work. Improving their experience and outcomes is at the heart of our work and brings us together.
We cover a population area of 2.3 million people and for them WYAAT is aiming to make the most of our resources and expertise and provide:

- The highest quality of services and care
- Improved access to healthcare services
- Better and more coordinated pathways of care
- Access to a wider range of clinical specialists
- The best NHS care with local healthcare working as efficiently as possible.

Our priority areas during 2018/19 were:

1. Corporate: procurement; estates and facilities; information management and technology; and workforce
2. Support services: scan 4 safety implementation; pharmacy; pathology services; radiology transformation; and radiology technology.
3. Clinical services: service sustainability; elective surgery; and vascular services.

There are clear governance arrangements in place, with decisions going back to each individual trust board for approval.



Some of the successes of WYAAT during the year have been:

- Improved how we share x-ray and scan images through a shared Picture Archive and Communication system so all WYAAT hospitals can see images to prevent delays in care and treatment.
- Begun the implementation of Scan 4 Safety, an electronic recording system to enable our hospitals to record and track the products used to treat our patients.

- Introduced better information supporting our patients ahead of surgery to ensure they are better prepared about what will happen before, during and after surgery.

Sustainability and sustainable development

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, the Trust has created a sustainable development management plan (SDMP).

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34% (from a 1990 baseline) equivalent to a 28% reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions 0% by using as the baseline year.

Policies
In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. An update to our SDMP is required because it has not been approved by the board in the last 12 months.

- SME opportunities currently 35% on new spend
- Local opportunities offered currently 37% on new spend
- Number of deliveries are monitored and have decreased by 7% since last year
- Paper consumption is continuously monitored and has decreased 9.5% since 2012
- 83% of purchase transactions are completed through NHS Supply Chain and enhanced information on how carbon intensity of goods has been addressed by NHS Supply Chain (through the tender process and supplier engagement)
- Information on energy efficiency of Electro-medical equipment is collated and available to customers
- Reduced CO2e emissions from NHS Supply Chain buildings by 2.5% year on year
- Reduced direct CO2e emissions from NHS Supply Chain transport by 2.5% year on year
- Reduction in business travel and related direct CO2e emissions
- Removal of packaging material and reduced supplier transport
- Enhance sustainable practice of suppliers within specific categories

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc.

Our board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events

One of the ways in which we measure our impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (https://www.sduhealth.org.uk/sdat/) (SDAT) tool. The last time we used the SDAT self-assessment was in 2019-04 scoring 34%.

As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Our organisation is *starting* to contribute to the following Sustainable Development Goals (SDGs).

Our organisation is *clearly* contributing to the following Sustainable Development Goals (SDGs).

We have not assessed the social and environmental impacts for the organisation.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

Strategic partnerships are already established with the following organisations: Councils, Universities and Hospitals across Leeds, Airedale, Bradford, Calderdale and Huddersfield, Harrogate and Mid Yorks. (STP footprint).

For commissioned services here is the sustainability comparator for our CCGs; please note this is published a year in arrears:

Organisation name	**SDMP**	**SDAT**	**SD reporting score**
NHS Bradford Districts CCG	No	n/a	Good
NHS Airedale, Wharfedale and Craven	No	n/a	Good

CCG			
NHS East Lancashire CCG	No	n/a	Minimum
NHS Morecambe Bay CCG	No	n/a	Poor
NHS Bradford City CCG	No	n/a	Good
NHS England	n/a	n/a	n/a

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx
http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp annual-reporting.aspx

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

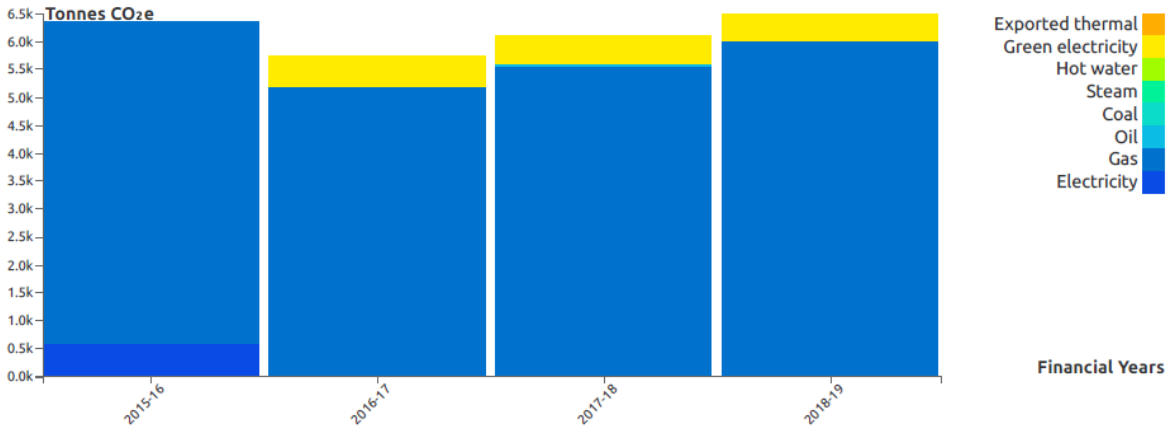
	2015/16	**2016/17**	**2017/18**	**2018/19**
Total gross internal floor space	64,929	60,808	60,808	61,517
Total number of staff employed	2,300	2,445	2,447	2,657

The 2014-2020 Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS by 28% (from a 2013 baseline) by 2020. We have supported this ambition as follows:

Energy

The Trust has spent £711,031 on energy in 2018-19, which is a 1.84% decrease on energy spend from last year.

Energy Consumption (kWh	**2015/16**	**2016/17**	**2017/18**	**2018/19**
Gas consumed	27,616,731	24,767,816	26,206,733	28,292,549
Oil consumed	0	0	121,836	10,310
Coal consumed	0	0	0	0
Steam consumed	0	0	0	0
Hot water consumed	0	0	0	0
Electricity consumed	1,020,295	1,093,147	1,166,728	0
Green electricity	0	1,071,284	1,143,393	1,305,440
Total	28,637,026	26,932,247	28,638,690	29,608,299



Carbon Emissions (tCO2e)	2015/16	2016/17	2017/18	2018/19
Electricity	587	11,3	0	0
Gas	5,780	5,176	5,556	6,009
Oil	0	0	39.8	3.29
Coal	0	0	0	0
Steam	0	0	0	0
Hot Water	0	0	0	0
Green	0	554	510	461
Exported thermal	0	0	0	0
Total	6,367	5,741	6,106	6,473

Paper

The movement to a Paperless NHS can be supported by staff reducing the use of paper at all levels, this reduces the environmental impact of paper, reducing cost of paper to the NHS and can help improve information security.

Paper Consumed	2015/16	2016/17	2017/18	2018/19
Paper spend (£)	0	0	31,000	27,790
Paper products used (tonnes)	0	0	200,874	201

Travel

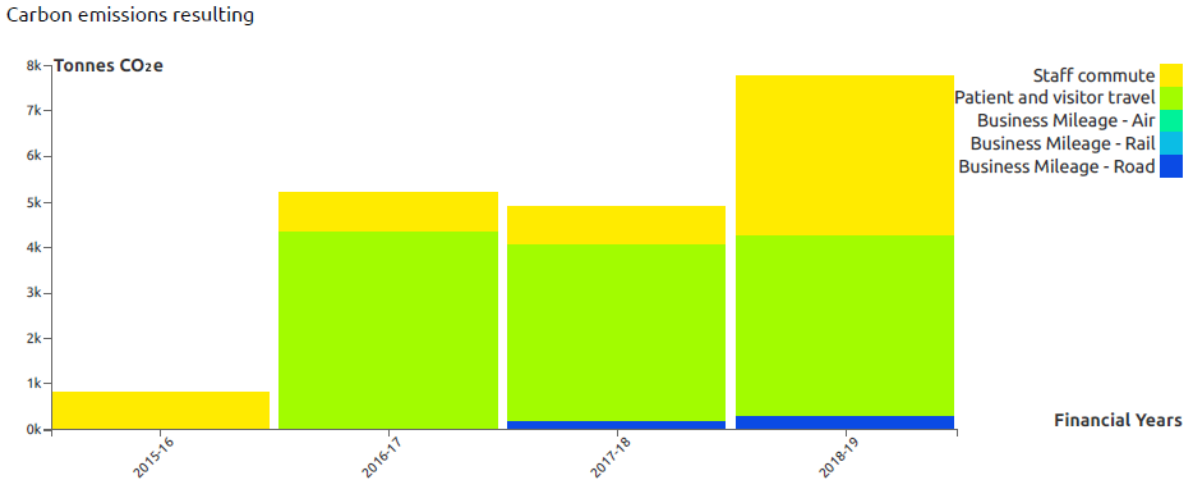
We recognise that a Healthy Transport Plan is a foundational part of our Travel Policy and we have completed that and keep it under review.

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services.

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

We have used the SDU Health Outcomes of Travel Tool and we have identified the hotspots and will look to reduce these impacts.

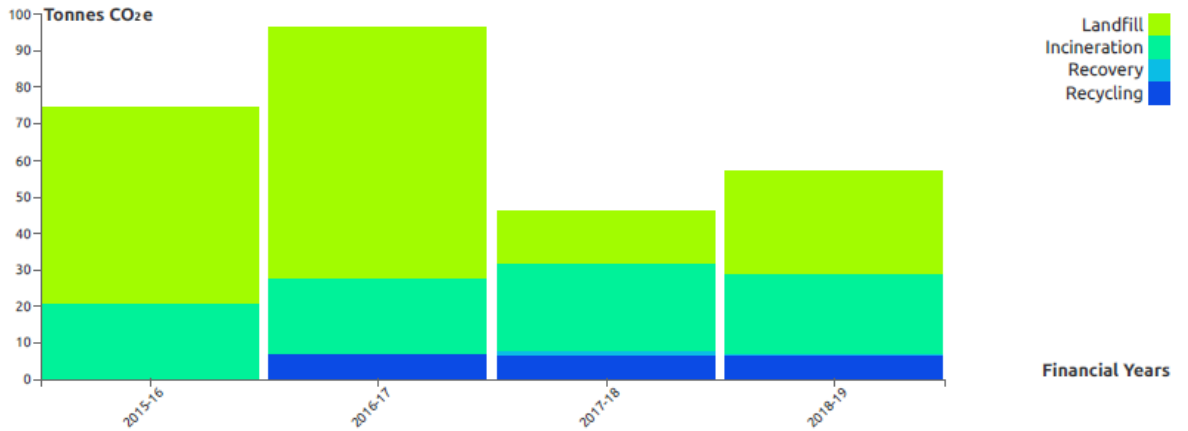
Travel Undertaken (miles)	2015/16	2016/17	2017/18	2018/19
Patient and visitor travel	0	11,989,396	10,847,993	10,728,465
Business travel and fleet	0	16	547,837	856,285
Staff commute	2,210,300	2,349,645	2,351,567	9,454,240
Total	2,210,300	14,339,057	1,374,739	21,038,990



Carbon Emissions (tonnes)	2015/16	2016/17	2017/18	2018/19
Business mileage – road	0	0	195	316
Business mileage – rail	0	0	0	0
Business mileage – air	0	0	0	0
Patient and visitor travel	0	4,333	3,865	3,956
Staff commute	799	849	838	3,486
Total	799	5,182	4,899	7,757

Waste

Waste Produced (tonnes)	2015/16	2016/17	2017/18	2018/19
Waste recycling weight	0	335	294	319
Other recovery weight	0	0	65	9
Incineration disposal weight	95	95	110	101
Landfill disposal weight	220	220	41	81
Total	315	650	510	510

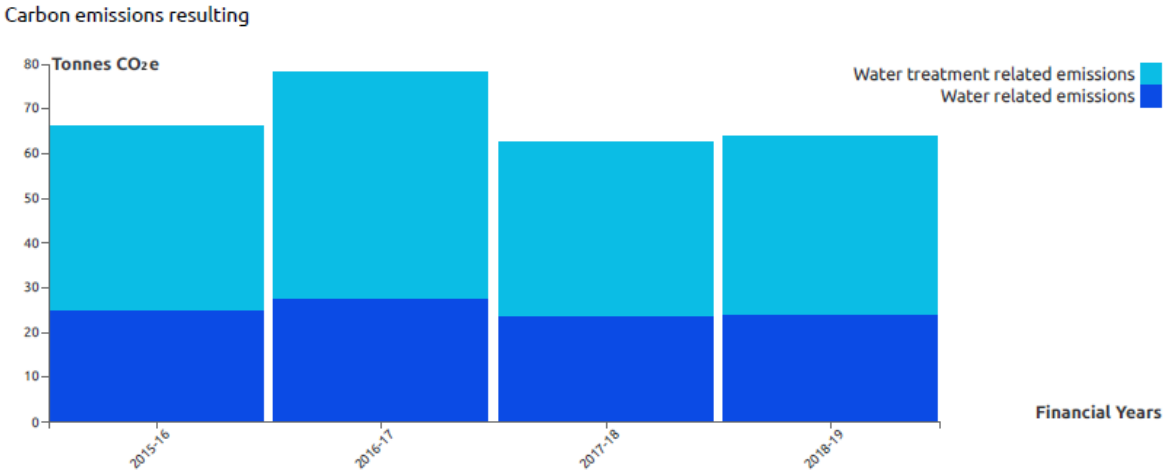


CO2 Emissions (tCO2e)	2015/16	2016/17	2017/18	2018/19
Recycling	0	7	6	7
Recovery	0	0	1	0

Incineration	21	21	24	22
Landfill	54	68	14	28
Total	75	96	45	57

Finite Resource Use – Water

	2015/16	2016/17	2017/18	2018/19
Water volume (m³)	72,479	80,148	68,610	70,161
Waste water volume (m³)	57,983	71,377	54,888	56,129
Water and sewage cost (£)	176,314	201,891	214,806	203,469

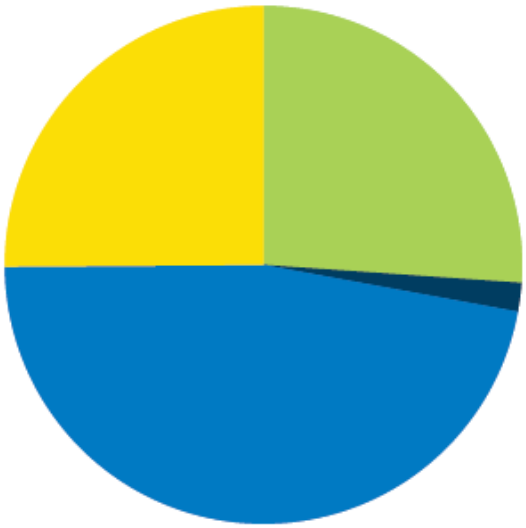


CO2 Emissions (tCO2e)	2015/16	2016/17	2017/18	2018/19
Water related emissions	25	28	24	24
Waste treatment related emissions	41	51	39	40
Total	66	79	63	64

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report used the Estate Returns Information Collection ('ERIC') returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our expenditure.

More information is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx (http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx)



	2018/19
Core emissions	26%
Commissioning	2%
Procurement	47%
Community	25%
Total	100%

SDU whole organisation carbon profile

Information calculated from operating expenditure of £180,587 of which £56,045 is non-pay spend based on typical values for an Acute Trust organization.

	2015/16	2016/17	2017/18	2018/19
Patient and visitor travel	0	4,333	3,865	3,965
Staff commute	799	849	838	3,486
Business Services	2,133	1,981	2,312	1,706
Capital spending	994	994	1,808	1,368
Construction	744	691	807	2,193
Food and catering	777,295	1,450	1,692	252
Freight transport	824	765	893	613
Information and communication technologies	328	305	355	728
Manufactured fuels, chemicals and gasses	878	816	952	566
Medical instruments / equipment	4,557	4,233	4,940	3,446
Other manufactured goods	754	700	817	2,185
Paper products	620	576	672	131
Pharmaceuticals	1,802	1,674	1,953	758
Coal	0	0	0	0
Electricity (net of any exports)	587	11	0	0
Gas	5,780	5,176	5,556	6,009
Oil	0	0	39	3
Thermal energy (net of any exports)	0	0	0	0
Leased Assets Energy Use (Upstream - Gas, Coal & Electricity)	0	0	0	0
Business travel and fleet	0	0	195	430

Anaesthetic Gases	1,801	1,522	1,175	1,179
Waste and Water	141	174	109	121
Commissioning	484	450	525	530
Total	800,518	26,700	29,504	29,660

Social Value

Collectively as an organisation we recognise the contribution that commissioning, procurement and commercial can have in delivering sustainability and social value, and our duty under the Public Services Value Act.

Our statement on Public Services (Social Value) Act is: As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of by making the most of social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources. Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. This is monitored through the Trust Board and through our annual report.

Using the Social Value Calculator we have been to calculate the social value created from some specific activities:

	2015/16	**2016/17**	**2017/18**	**2018/19**
Total Social Value	0	0	0	0
Total reported investment	0	0	0	0

Adaptation

Events such as heatwaves, cold snaps and flooding are expected to increase as a result of climate change. To ensure that our services continue to meet the needs of our local population during such events we have developed and implemented a number of policies and protocols in partnership with other local agencies.

Biodiversity Action Plan

At Airedale we encourage wards, teams and organisations to adopt a courtyard and create green spaces for the enjoyment of staff, patients and visitors. This improves the access to green space and also encourages team building and gardening, many positive comments have been received regarding this project. The gardening team have also created a wildlife walk around the gardens and staff frequently use the green space and enjoy the wonderful views at Airedale NHS Foundation Trust.

Social, Community and Human Rights Issues

Our 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 or local charities.

During the year we continued to build on our links with schools and colleges. We also developed links with local BME groups and improved membership representation from different communities.

The Trust participated in the Takeover Challenge, a national event led by the Children's Commissioner for England – Bradford District has for the last 3 years been a flagship provider giving 100's of children and young people (ages 13-19) the opportunity to be involved in decision making by working alongside adults at all levels and across all sectors. This year's event took place on Friday 23rd November 2018. The objective of Takeover Day is for children and young people to broaden their knowledge and skill set. There are benefits to organisations through opportunity to directly talk with young people, allowing them to constructively question, challenge and give a different or new insight into how services are designed and delivered – evidencing youth voice at its best. Two students had a packed agenda with us and the day was very positively evaluated by all involved

Following a bid application process, Airedale has been awarded £65,000 from the Pears Foundation for a two year project (January 2019- January 2021) to recruit young people into volunteer placements across the hospital. The vision is to train up lead volunteers to deliver ward based social activities for patients. We will work with a local charity training provider called 'Pioneer Projects' to help us deliver this work.

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.

The Foundation Trust was supported during the year by a number of very active charities, including Friends of Airedale and Airedale NHS Charitable Funds.

During 2018/19, the Airedale NHS FT Charitable Funds contributed nearly £490,000 to the hospital. The money was used to buy a variety of equipment and services for the Foundation Trust including the following:

- ✓ Overchair tables for the Stroke Unit
- ✓ Electronic chemotherapy chair for HODU
- ✓ Concerts provided by Music in Hospitals and Care on the Critical Care Unit
- ✓ Treadmill for the Physiotherapy Department
- ✓ Portable pulse oximeters for the Paediatric/NeoNatal department
- ✓ Installation of new double doors for Wards 18 and 19
- ✓ Contribution towards work carried out on Ward 5
- ✓ Contribution towards new Theatres

Modern Slavery Act 2015

The Trust has a Board approved anti-slavery and human trafficking statement which is published on its website at www.anhst.nhs.uk

Important events since the end of the financial year 31 March 2019

Details of any post balance sheet events are provided in note 23 of the accounts

Overseas Operations

The Trust does not operate outside of the UK.

CHAPTER 2
ACCOUNTABILITY REPORT

SECTION 1 - DIRECTORS' REPORT

The Director's Report has been prepared under direction issued by NHS Improvement, 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 NHS Improvement.

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. The Board of Directors at the year-end is shown below.

Chair	Andrew Gold
Chief Executive	Brendan Brown

Executive Directors

Jill Asbury	Director of Nursing
Andrew Copley	Director of Finance
Stacey Hunter	Chief Operating Officer*
Karl Mainprize	Medical Director

Non-Executive Directors

Jeremy Cross	Chair of the Finance, Performance and Digital Committee
Anne Gregory	Senior Independent Director and Chair of the Board Appointments, Remuneration and Terms of Service Committee
Maggie Helliwell	Chair of the Quality and Safety Committee
Mark Lam	Chair of the Audit and Risk Committee
Lynn McCracken	Deputy Chair and Chair of the People Committee.

The gender balance of the Board as at 31 March 2019:

	Female	Male
Non-Executive Directors	3	2
Executive Directors	2	3

The age profile of the Board as at 31 March 2019:

Age range	Number of Directors
18 – 39	0
40 – 49	3
50 – 59	4
60 - 69	3
70 +	0

* Stacey Hunter, left the post of Chief Operating Officer on 31 March 2019 and Rob Aitchison began in the role from 1 April 2019.

Register of Directors' 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 NHS Improvement Code of Governance. The current and previous Chair who held office during the year ended 31 March 2019, both declared they had no other significant commitments that affected their ability to carry out their duties to the full and were able to allow sufficient time to undertake those duties.

The Register of Declared Interests for the Board of Directors and the Council of Governors is held by the Foundation Trust's Company Secretary and is available for public inspection on the Foundation Trust's website at www.anhst.nhs.uk .

Airedale NHS Foundation Trust made no political or charitable donations during the year. The 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 donations.

Meetings of the 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 organisation; 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 nine times a year to conduct its business and at quarterly intervals to discuss matters requiring strategic debate. The Board also meets on other occasions to discuss matters requiring Board consideration. 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. The Board intended to commission an external review in 2018/19 but this will now take place in 2019/20 to enable the refreshed governance structure (implemented with effect from January 2019) has time to embed. .

At the year end, the Board consisted of the chief executive plus four executive directors, three associate directors and six non-executive directors, including a non-executive chair. The associate directors do not have voting powers which ensures the balance of power on the board rests with the non-executive directors.

The non-executive 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, legal, business and management background and skills. Should it be necessary to remove either the chair 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 and associate directors (one of which is also the company secretary).

Responsibility for the appointment of the chair 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 chair, is responsible for bringing recommendations for non-executive appointments to the Council. The company secretary and associate director of human resources and workforce attend the meetings 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 those 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 chair 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 Chair's appraisal and provides a summary report also to the ARC. In preparing the appraisals, both the chair and senior independent director consult with executive directors and take into 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 chair. 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 chair 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 and continues to monitor this balance through its Board Appointments, Remuneration and Terms of Services and Appointments and Remuneration committees.

Disclosures of the remuneration paid to the chair, non-executive directors and directors are given in the Remuneration Report on page 62. The Board of Directors who served during the year comprised the following executive and non-executive directors:

Biographies of the Board of Directors

Non-Executive Directors

Andrew Gold, Non-Executive Chair
Appointment: June 2016
Andrew was appointed Chair on 19 January 2018. Andrew is a qualified accountant and has a wide range of Board experience from a career in regulated financial services, mainly with member owned organisations. Until spring 2016, Andrew was the Group Director Risk, Audit and Compliance of a locally based regulated financial service group. Since May 2014 Andrew has been NED of the Ecology Building Society who are based in Silsden and are a mutual who demonstrate strong ethical values. Living in Skipton, Andrew is also directly involved in a number of activities that support the local community. Andrew Chairs the Trust Board and the Appointments and Remuneration Committee. He is also a member of the Board Appointments, Remuneration and Terms of Service Committee. Additionally, he is a member of the West Yorkshire Association of Acute Trusts' Committee in Common and the West Yorkshire and Harrogate Health and Care Partnership Board.

Jeremy Cross, Non-Executive Director
Appointment: October 2017
Jeremy is a Chartered Accountant and is currently working as a self-employed consultant. He is also non-executive chairman of Mansfield Building Society, a Director at Leeds Grammar School and Treasurer of Care and Repair (Leeds) Limited, a Leeds based charity aimed at helping older people maintain their independence and quality of life at home. 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 chair of the Finance, Performance and Digital Committee and the Airedale NHS Charitable Funds Sub-Committee and is a member of the Board Audit and Risk Committee. Jeremy has also been appointed as non-executive chair of the Trust's wholly owned subsidiary, AGH Solutions Limited.

Professor Anne Gregory, Non-Executive Director and Senior Independent Director
Appointment: April 2012
Anne was re-appointed as a non-executive director on 1 June 2015. 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. Anne is chair of the Board Appointments, Remuneration and Terms of Office Committee, a member of the Appointments and Remuneration Committee and the Quality and Safety Committee.

Dr Maggie Helliwell, Non-Executive Director
Appointment: June 2016.
Maggie started her career at Airedale hospital as a junior doctor in the 1970's before becoming a GP at Ling House, in Keighley, a role she held for over 35 years. Maggie became chair of the Worth Valley Health Consortium in the 1990's, while working part-time as a GP. She was later appointed Medical Director of Airedale Primary Care Trust (PCT) and clinical governance lead when four PCT's across the district merged. Maggie returned to Airedale Hospital in 2007 prior to retirement. Maggie is a member of the Audit Committee and chairs the Quality Committee.

Lynn McCracken, Non-Executive Director and Deputy Chair
Appointment: October 2016.
Lynn McCracken, Non-Executive Director and Deputy Chair Appointment: October 2016. Lynn is an MBA-qualified solicitor with many years' legal and governance experience. She began her legal career in private practice in Manchester before moving in-house, working initially for a national rail freight operator, and later as Director of Governance & Legal Services at The Riverside Group. Prior to that Lynn had a short service commission in the Royal Navy specialising in telecommunications. Lynn is currently a trustee board member at Manchester MIND, a mental health charity, and a non-executive director in Calico Group's health, care and support charity. She previously served as a trustee board member at Manchester MIND, a mental health charity; and on the board of Community Seven, a provider of social housing in Liverpool; and chaired the National Housing Federation's Governance Forum. Lynn is a member of the Appointments and Remuneration Committee, Board Appointments, Remuneration and Terms of Service Committee and Quality and Safety Committee. Lynn has also served as Chair of the newly established People Committee since January 2019.

Mark Lam. Non-Executive Director
Appointment: July 2018.
Mark has extensive global experience in telecommunications and information technology.
He is the Chief Technology and Information Officer of Openreach, a BT Group business, and has previously held management positions at Siemens, Carphone Warehouse and Deutsche Telekom. His experience of global business spans Europe, the USA, and Asia, where he has led major contracts and operations. Mark chairs the Trust's Audit and Risk Committee and is a member of the Finance, Performance and Digital Committee.

The Board considers all the non-executive directors to be independent in character and judgement and there are no relationships or circumstances which could affect or appear to affect, the director's judgment.

Executive Directors

Brendan Brown, Chief Executive

Appointed: June 2018

Brendan was appointed to the joint position of Chief Executive, Airedale NHS Foundation Trust and Partnership Lead, Airedale, Wharfedale & Craven Partnership. Brendan previously held the position of Executive Director of Nursing/Deputy Chief Executive at Calderdale & Huddersfield NHS Foundation Trust. Prior to this he was Director of Nursing/Deputy Chief Executive at Burton Hospitals and has previously held Board positions at Chief Nurse, Chief Operating Officer and Acting Chief Executive level. Brendan trained as a nurse in Derby and has a background in both acute hospital and community nursing and senior management positions. He has a Masters with Distinction from the University of Nottingham.

Bridget Fletcher, Chief Executive

Appointment: November 2010 to 3 June 2018.

Bridget 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.

Jill Asbury, Director of Nursing

Appointed: July 2017

Jill joined Airedale as Deputy Director of Nursing in January 2016 and was appointed Director of Nursing following a period as Interim Director of Nursing. She qualified as a nurse in 1986 and has spent most of her career working at Leeds Teaching Hospitals NHS Trust where she was Head of Nursing for Education and Workforce before joining Airedale. Prior to this she worked in various roles including Divisional Nurse Manager, Matron and Clinical Nurse Specialist at Leeds Teaching Hospital and as a Nurse Manager at Killingbeck Hospital in Leeds.

Andrew Copley, Director of Finance

Appointed: 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.

Stacey Hunter, Chief Operating Officer

Appointment: August 2015 to 31 March 2019.

Stacey qualified as a nurse in 1990 and spent over 10 years in various nursing roles in Hull and Leeds prior to moving into general management in 2001. Since then Stacey has spent

most of her career at Leeds Teaching Hospitals NHS Trust progressing from clinical services manager to general manager prior to joining Airedale in 2013. Her other professional roles have included Council Membership of the RCN from 2003 to 2011. Stacey is also trustee of a Leeds based children's hospice.

Mr Karl Mainprize, Medical Director
Appointed June 2014
Prior to joining the Trust, Karl had 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.

Committees of the Board of Directors

The Board of Directors and Council of Governors have discharged their functions throughout the year through a number of sub-committees as outlined below with the exception of:

- Remuneration and nominations committees – detailed in the Remuneration Report
- Council of Governors – detailed in Section 4 – Assessment against the NHS Improvement Foundation Trust Code of Governance

The Board receives regular reports from the Committee chair as well as the minutes in order to evaluate the performance and effectiveness of its sub-committees.

The Board reviewed its Governance structure at the September and October 2018 Board meetings and the November Board Strategy meeting. The revised governance structure was implemented in January 2019 and the changes are highlighted below.

Audit and Risk Committee
The Audit Committee was renamed the Audit and Risk Committee in January 2019 in order to make the Committee's focus on risk more explicit. This Committee is chaired by a Non-Executive Director – Mark Lam, and has a further two non-executive director members, Jeremy Cross and Dr Maggie Helliwell. The director of finance and other senior managers including the company secretary and the assistant director, healthcare governance, attend Audit Committee meetings. Also in attendance is a governor representative.

The Committee's refreshed terms of reference were approved by the Board of Directors in November 2018. 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 and Risk Committee. A self-assessment of the Committee's performance will be undertaken in 2020. 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, and any formal announcements relating to the Foundation Trust's financial performance, reviewing significant financial reporting judgments contained in them. The Committee received and recommended to the Board the approval of the Foundation Trust accounts and the Annual Governance Statement for 2018/19.

- Integrated 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), including its subsidiaries, that support the achievement of the Foundation Trust's objectives. The 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 work plan, annual report and progress reports in this period. The internal audit function was provided by Mersey Internal Audit Agency (MIAA) until June 2018 and, following a robust process led by the Audit Committee, with input from the Director of Finance and Assistant Director of Finance, a three year contract was awarded to Audit Yorkshire commencing on 1 July 2018.

- 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 function is provided by Grant Thornton.

- 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.

Quality and Safety Committee

The Quality Committee became the Quality and Safety Committee in January 2019 and continues to be chaired by Dr Maggie Helliwell, Non-Executive Director. Membership also includes Anne Gregory, non-executive director, Lynn McCracken, non-executive director, the Foundation Trust's director of nursing, medical director and associate director of human resources and workforce.

The committee provides the Board of Directors with assurance that there is continuous and measurable improvement in the quality of the services provided. It achieves this by ensuring governance, performance and internal control systems support the delivery of safe, high quality patient care. The Committee also ensures that the risks associated with the quality of the delivery of patient care are identified and managed appropriately.

Charitable Funds Sub-Committee

The Charitable Funds Sub Committee, chaired by Jeremy Cross, 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 an executive director, a senior matron and a senior clinician.

The purpose of the committee is to give additional assurance to the Board of Directors as 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 Charity Commission website.

Finance, Performance and Digital Committee

The Board Finance Committee became the Finance, Performance and Digital Committee in January 2019. This Committee provides the Board with an independent and objective review of, and assurances, in relation to financial, performance and digital matters which

may impact on the financial viability and sustainability of the Trust. The committee is chaired by Jeremy Cross, non-executive director and also comprises non-executive directors Mark Lam. Another non-executive director will be joining the membership following appointments of two new non-executive directors in May 2019. The membership also comprises the Finance Director, the Chief Operating Officer and the Associate Director of Strategy, Planning and Partnerships.

The Committee also provides detailed scrutiny of financial and performance information, including performance against the cost improvement and capital investment programmes, the control total target and the cashflow position. Additionally, it reviews business cases for major initiatives.

People Committee

Established in January 2019, this Committee provides assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. This includes reviewing: recruitment and retention; training; employee health and wellbeing; employee engagement levels; workforce matters; and employee culture, diversity and inclusion. This Committee has been chaired by non-executive director, Lynn McCracken and will be chaired by one of the newly appointed non-executive directors from May 2019 onwards. The other newly appointed non-executive director will also become a member in May 2019. Additionally, Mark Lam is a member of the Committee. The Associate Director of Human Resources and Workforce and the Chief Operating Officer are also Committee members.

Director attendance at Board and Committee meetings 2018/19

Directors	Board of Directors	Audit Committee	BART*	Charitable Funds Committee	Quality and Safety Committee	Finance Committee	People Committee
Jeremy Cross	9/9	5/5	-	4/4	-	5/5	-
Andrew Gold	9/9		14/14	-	4/4	4/4	-
Professor Anne Gregory	9/9	1/2	10/14	-	0/3	-	-
Dr Maggie Helliwell	8/9	5/5	-	-	5/7	1/2	-
Lynn McCracken	9/9	-	13/14	-	6/7	-	2/2
Mark Lam	5/6	2/3	-	-	-	2/3	1/2
Bridget Fletcher	1/2	-	1/3	-	-	1/1	-
Brendan Brown	7/7	-	11/11	-	-	0/3	-
Andrew Copley	9/9	5/5	-	-	-	5/5	-
Jill Asbury	9/9	-	-	-	7/7	-	-
Karl Mainprize	9/9	-	-	-	6/7	-	-
Stacey Hunter	9/9	-	-	4/4	-	3/5	2/2

*BART – Board Appointments, Remuneration and Terms of Service Committee

Directors' Statements

Better Payment Practice Code

The table below reports the Foundation Trust compliance with the better payment practice code in respect of invoices received for non-NHS and NHS trade creditors. The target is to pay all non-NHS trade creditors within 30 calendar days of receipt of the goods or a valid invoice (whichever is later) unless other payment terms have been agreed.

Non-NHS Trade Creditors Summary of Position 2018/2019		
Year to 31 March 2019	**Numbers**	**Year to 31 March 2018**
42,377	Number of bills paid to date	37,215
7,359	Number of bills paid in 30 days	8,684
17.37%	Percentage of bills paid in 30 days	23.33%

Year to 31 March 2019	Values	Year to 31 March 2018
£134,385k	£k Value of bills paid to date	£102,789k
£75,125k	£k Value of bills paid in 30 days	£66,739k
55.90%	Percentage of bills paid in 30 days	65.03%

NHS Trade Creditors Summary of Position 2018/2019		
Year to 31 March 2019	**Numbers**	**Year to 31 March 2018**
1,790	Number of bills paid to date	1,946
58	Number of bills paid in 30 days	179
3.24%	Percentage of bills paid in 30 days	9.20%

Year to 31 March 2019	Values	Year to 31 March 2018
£6,342,837k	£k Value of bills paid to date	£5,363,644k
£1,850,295k	£k Value of bills paid in 30 days	£280,290k
29.17%	Percentage of bills paid in 30 days	5.23%

The Trust complied with the prompt payment code for most of the year, however, due to technical issues during Q4 2018/19 the Foundation Trust was unable to achieve the payment terms for a number of ledger payments

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 Trust's 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 2017/18 the Foundation Trust had not increased the percentage beyond the 5% threshold. The private patient income for 2018/19 was £210k (2017/18 £166k).

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 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 Trust's auditor is aware of that information.

Details of political donations

The Board confirmed that no political donations have been made during the year.
Compliance with HM Treasury cost allocation and charging guidance

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.

Preparation of the Annual Report and Accounts

All directors understand that it is their responsibility to prepare the annual report and accounts, and that they consider the annual reports and accounts, taken as a whole, to be fair, balanced, understandable, and to provide the information necessary for patients, regulators and other stakeholders to assess the performance of Airedale NHS Foundation Trust, including our business model and strategy. 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.

Our accounts, which begin on in Chapter 4 of this document, have been prepared under a direction issued by NHS Improvement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012).

Our patients - Enhanced quality governance reporting

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 2015/16 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 2018/19. The Directors' Report, Quality Governance section of the Annual Report references where this information can be found in the Quality Report.

Overview

The Foundation Trust is registered with the CQC without conditions. The CQC has not taken any enforcement action against the Foundation Trust during 2018/19.

The Foundation Trust participated in special reviews or investigations by the CQC, details of which can be found in the Quality Report 2018/19 section 2.2.5.

In February 2018 the Care Quality Commission carried out a local systems review in Bradford, where they looked at the flow of over 65-year-olds through the health and social care system. The type of review does not result in a rating, but is designed to understand where improvements can be made. Published in June 2018, the report is generally positive, highlighting how different agencies work collaboratively to keep people safe at home, how we all have a shared purpose, vision and strategy and how well information-sharing is working. There are areas for improvement: access to GPs, better signposting and medicines management after leaving hospital, and quality of domiciliary care. The Bradford and Airedale Health and Wellbeing Board is leading on the identified actions to address areas of shortfall.

In November 2018, the Care Quality Commission undertook its Core Services Inspection and returned during December 2018 to conduct their annual Well-led Inspection. The final report was published in March 2019; and the rating for the safety and well-led domain is "Requires improvement" as is the overall Quality summary rating for the Trust.

Ratings for Airedale General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Medical care (including older people's care)	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Surgery	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Critical care	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Maternity	Good Sept 2017	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Sept 2017	Good Sept 2017
Services for children and young people	Good Sept 2017	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Sept 2017	Good Sept 2017
End of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Diagnostic imaging	Requires improvement Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients & diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Use of resources	Good
Combined rating	Good

The Trust developed and submitted a detailed Quality Improvement Plan in response to the inspection report to both the Care Quality Commission and the Commissioners. It is anticipated the Trust will be requested to attend the Bradford Health and Social Care Overview and Scrutiny Committee to discuss the findings.

The Quality Improvement Plan was developed in response to the CQC Quality Report of March 2019 and will be monitored during 2019/20 with added rigor in relation to embedding for consistent and sustained improvements. In addition the Trust has taken the opportunity to review previous CQC reports to identify any outstanding aspects that will be included within the current improvement plan. The Quality Improvement Plan has been submitted to the Care Quality Commission and the Trust Commissioners. An overview of the ratings is shown in the Quality Report 2018/19 section 2.2.5. The full report, can be accessed from the CQC's website at www.cqc.org.uk

The Trust will maintain active communication with the CQC during a programme of relationship meetings and continue to extend invitations to the CQC to attend events and visit clinical areas.

In February 2019 the Care Quality Commission performed a Review of Services for looked after children in Bradford. The Trust was involved and was subjected to a 2-day on-site visit by the inspection team; at the time of reporting there has been no outcome published.

Quality Governance

With the arrival of a new Chief Executive in June 2019, he along with the Medical Director and Director of Nursing reviewed the quality governance arrangements by using the Quality Governance Framework developed by NHS Improvement, the Trust regulator. Following this review the Quality Assurance Framework (QAF) was amended to reflect the refreshed and strengthened arrangements. A strengthened reporting structure was implemented and the revised quality governance structure is becoming more embedded.

Further details about the Foundation Trust's quality governance arrangements are included within the Annual Governance Statement in Section 7 of the Annual Report and in section 3 of the Quality Report. Information about patient care activities and stakeholder relations can be found in the Quality Report in the following sections:

Activity	Disclosure	Section Reference
Patient Care	Descriptions of how the Foundation Trust is using its Foundation Trust status to develop its services and improve patient care	Quality Report section 1 Statement on Quality from the Chief Executive.
	Performance against key health care targets	Quality Report section 3.4 – Performance Against Key National Priorities.
	Arrangements for monitoring improvements in the quality of healthcare and progress towards meeting any national and local targets, incorporating CQC assessments and reviews and the Foundation Trust's response to any recommendations made	Quality Report sections 2 and 3 covering priorities for improvement, statements of assurance from the Board, performance against core national indicators and other quality information.
	Progress towards targets as agreed with local commissioners, together with details of other key quality improvements	section 2.2.4 of the Quality Report Use of the Commissioning for Quality and Innovation Framework
	Any new or significantly revised services	Quality Report section 1 Statement on Quality from the Chief Executive.
	Service improvements	Quality Report sections:

	following staff or patient surveys/comments and CQC reports	1. Statement on quality from Chief Executive 2. Priorities for improvement - future priorities: 2.2.5 Registration with the Care Quality Commission 2.2.12 Workforce Race Equality Standard. 2.3.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients 2.3.5 Staff who recommend Airedale NHS Foundation Trust as a provider of care to family or friends. 2.3.6 Friends and Family Test - Patient
	Information on complaints handling	Quality Report section 1 Statement on Quality from the Chief Executive. See also annual statutory Airedale NHS Foundation Trust Complaints and Concerns Annual Report 2018/19
Activity	**Disclosure**	**Section Reference**
Patient Experience	Information on patient experience surveys	Quality Report sections: 2.3.4 Responsiveness of Airedale NHS Foundation Trust to the personal needs of patients 2.3.6 Friends and Family Test - Patient 3.1 Privacy and dignity: Table 11 : CQC *Inpatient Survey 2017* (published June 2018) and patient survey results for: *National Cancer Patient Experience Survey 2017* *CQC Emergency Department Survey 2017* *CQC Maternity Survey 2018*
Activity	**Disclosure**	**Section Reference**
Stakeholder Relations	Descriptions of significant partnerships and alliances entered into by the NHS Foundation Trust to facilitate the delivery of improved healthcare	Quality Report with specific reference to section 1: 3.2.3 Frail Elderly Pathway Team initiative (to identify frailty and enhance the care planning between health and social care); 3.3.1 Quality of healthcare for people with long-term conditions describing the Airedale Digital Care Hub and the Vanguard programme. Annual Report - Performance Report: Purpose and Activities section.
	Development of services involving other local services/agencies and involvement in local initiative	See above plus: Quality of wound care for patients both in hospital and the community – CQUIN
	Any other public and patient involvement activities	Part 2 – How we engage with others in developing quality goals
	Consultation with local groups and organisations, including the overview and scrutiny committees of local authorities covering the membership areas.	Section 1 - Statement on Quality from the Chief Executive Section 4 - Annex

SECTION 2 - 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 chair) being cognisant of the Board of Directors knowledge, skills and experience. The Committee also oversees the review of remuneration levels of the chair and non-executive directors. The Committee makes recommendations to the Council of Governors on the appointment of non-executive directors (including the chair) of the Foundation Trust and the chair and non- executive directors remuneration levels.

The process through which the non-executive directors are evaluated is managed by the Committee and involves seeking feedback from governors and Board Directors, as well as directly from governor members of the Appointments and Remuneration Committee. The chair conducts the non-executive director appraisals, whilst the senior independent director conducts the appraisal of the chair. The Council of Governors receives an assurance report each year outlining the process undertaken.

During the year, the Committee undertook a review of the payments made to non-executive director in recognition of additional responsibilities over and above the core non-executive director role. This reflected the changes in the governance arrangements across the sub-committees of the Board. Payments are reflective of the frequency of meetings. The Committee also considered an HMRC change effective 6 April 2019 relating to the taxation of expenses payable to NEDs and a resultant proposal on the NED mileage rate. In both cases the Committee made recommendations which were approved by the Council of Governors.

The Committee also undertook a remuneration review of Non-Executive Director fees. In doing so, the Committee was cognisant of the pay and employment conditions elsewhere in the Trust and the national pay award for very senior managers and other employees... Also taken in to account was the benchmarking of Non-Executive Director fees with neighbouring Foundation Trusts and the contracted days compared with those Trusts. Following a robust review of fees the Committee recommended a 1.7% cost of living

increase for NEDs for 2018/19 with a backdated adjustment to 1 April 2018, which the Council of Governors' approved.

The Committee's other work during the year included reviewing its terms of reference and reviewing the role descriptions for the chair and non-executive directors to ensure they remained relevant and appropriate. The Committee also commissioned a skills review which would inform future recruitment to non-executive director vacancies. It also conducted a candidate search two non-executive posts: a replacement for Professor Anne Gregory when her term completes at the end of April; and a new non-executive post with a focus on people to chair the newly established People Committee. The Committee used the in-house services of the Trust's HR department. The search method included on-line advertising through NHS Jobs and NHSI as well as seeking candidates via networking. The candidate search concluded successfully with the appointment of Melanie Hudson and Nadira Mirza who joined the Trust on 7 May 2019.

The Council of Governors also approved the re-appointment of Maggie Helliwell as a non-executive director for a further year, and Andrew Gold as Chair for a further three-year term, noting that both had received an appraisal within the previous three months and were deemed to have met the performance standard requirement, the independence test and fit and proper person criteria.

At the time of writing this report, the Committee had commenced a candidate search to appoint a non-executive director to address two upcoming non-executive director vacancies: one post with financial expertise and one with a focus on IT and digital.

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 and Board Committee chairs. The Committee's second purpose is to determine the remuneration and terms of service of Executive Directors and Associate Directors.

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 outcome of the executive directors' appraisals, conducted by the chief executive, and in the case of the chief executive, conducted by the chair, 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.

As part of the review of remuneration, the Committee considered a report from the chief executive which summarised the performance of individual directors. In the case of the chief executive, the chair presented the performance report. The Committee also made a

decision on director pay. In determining any decisions relating to executive pay, the Committee has regard to the NHS Improvement 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 did not exceed the maximum increase that staff employed under Agenda for Change would have received for 2018/19.

The Committee led the appointment of four executive posts: Associate Director of Strategy, Planning and Partnerships; Associate Director of Corporate Affairs / Group Company Secretary, Associate Director of Quality and Safety, and the Chief Operating Officer.

The BART considered recommendations from the appointment panel and agreed the preferred candidates for each role. As a result Stuart Shaw was appointed as Associate Director of Strategy, Planning and Partnerships from November 2018; Victoria Pickles was appointed to the post of Associate Director of Corporate Affairs / Group Company Secretary and joined the Trust on 15 February 2019; Rob Aitchison was appointed as Chief Operating Officer from 1 April 2019; and Amanda Stanford will join the Trust as Associate Director of Quality and Safety in June 2019.

At the time of writing this report, the Committee had commenced a candidate search to appoint a Director of People and Organisational Development, as the current post holder is due to leave the Trust at the end of June.

The Committee also met during the year to consider the skills matrix for executive directors and to review the Committee terms of reference.

Senior Managers' Remuneration Policy

In 2013/14 the 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 2018/19 to determine executive director pay. For the Trust, this Framework applies to Executive Directors and Associate Directors, collectively referred to as Very Senior Managers (VSM).

The Trust remains committed to the principle of fair pay and is mindful of that in determining remuneration levels which attract, retain and motivate executives whilst providing value for money.

In response to the directive issued by the Secretary of State in June 2015 (and subsequent guidance issued in February 2017), regarding Very Senior Manager remuneration, the Foundation Trust confirms that, via the Board Appointments, Remuneration and Terms of Service Committee ('BART),' the policy on executive remuneration (the Framework) is, and will continue to be, reviewed on an annual basis. BART reviewed executive director

remuneration levels in 2018 in accordance with the Framework, and considered these to be necessary and publicly justifiable.

Underpinning this, the Trust ensures that in regard to senior managers:

- 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 Trust's Annual Report.

These principles are specifically scrutinised in the case of all senior managers earning more than £150,000.

Salary and pension contributions of all executive and non-executive directors
Information on the salary and pensions contributions of all executive and non-executive directors is provided in the tables on the following pages. The information in these tables has been subject to audit by our external auditors Grant Thornton. Additional information is available in notes from p8 of the accounts.

Key Components of remuneration

Executive Directors

Remuneration Component	***How this component relates to the 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 'NHS Boardroom Pay Report.* 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 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.	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 maximum incremental uplift applicable to the highest paid staff on Agenda for Change. 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.
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

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. The current chief executive, who retires on 3 June 2018, is the only remaining executive director with a six month notice period. 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.

Non-Executive Directors

Remuneration Component	**How this component operates in practice**
Annual fee	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: ➢ Fees of Chairpersons and Non-Executive Directors of other Foundation Trusts selected for comparator purposes on the same basis as for Executive Directors; ➢ The responsibilities and time commitments; and ➢ The need to attract and retain individuals with the necessary skills and experience. The Chair and Non-Executive Directors receive an annual base fee. Additional fees are paid to: ➢ Deputy Chair; ➢ Senior Independent Director; ➢ Chair of the Audit Committee; ➢ Chair of the Quality Committee; ➢ Chair of the Charitable Funds Sub-Committee, and ➢ Chair of the Trust's wholly owned subsidiary. Non-Executive Directors' fees are reviewed annually against market comparators. They were last reviewed in July 2017. Current fee levels are shown in the annual report on remuneration.
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.

The Trust's remuneration reports are subject to a full external audit.

Details of remuneration and pension information are detailed on pages 62 and 64 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 2018 or who served as a Director of the Foundation Trust at any time during the year ended 31 March 2019, 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 Foundation Trust (months)	Notice period by the director (months)
Non-Executive Directors					
Jeremy Cross	1 October 2017	3 years	18 months	3 months	3 months
Andrew Gold	1 June 2016	3 years	2 months	3 months	3 months
Anne Gregory	1 June 2015	3 years	1 month	3 months	3 months
Maggie Helliwell	1 June 2016	3 years	2 months	3 months	3 months
Mark Lam	1 July 2018	3 Years	27 months	3 months	3 months
Lynn McCracken	1 October 2016	3 years	6 months	3 months	3 months
Executive Directors					
Jill Asbury	11 January 2016	Indefinite term	Not applicable	3 months	3 months
Brendan Brown	4 June 2018	Indefinite term	Not applicable	6 months	6 months
Andrew Copley	1 January 2013	Indefinite term	Not applicable	3 months	3 months
Stacey Hunter	8 July 2013	Indefinite term	Not applicable	3 months	3 months
Karl Mainprize	3 June 2014	Indefinite term	Not applicable	3 months	3 months

*Professor Gregory's term of office was extended for one year from 1 June 2018

A non-executive director's term of office may be terminated immediately if they commit a material breach of their obligations under their terms of appointment or under the following circumstances:

- commit any serious or repeated breach or non-observance of their obligations to the Foundation Trust (which include an obligation not to breach their duties to the Foundation Trust, whether statutory, fiduciary or common-law); or
- are guilty of any fraud or dishonesty or acted in a manner which in the opinion of the Foundation Trust acting reasonably brings or is likely to bring them or the Foundation Trust into disrepute or is materially adverse to the interests of the Foundation Trust; or
- have been convicted within the preceding 5 years of any offence if a sentence of imprisonment for a period of not less than 3 months has been imposed; or
- have been adjudged bankrupt or their estate sequestrated and (in either case) has not discharged; or

- are disqualified from acting as a director in accordance with the Airedale NHS Foundation Trust Constitution.

In such circumstances the process for termination by the Council of Governors would be in accordance with the Fit and Proper Persons Regulations and accompanying operating procedure.

Nominations Committee Membership

The Trust has two nominations committees. The Board Appointments, Remuneration and Terms of Service Committee is established for the purpose of overseeing the appointment of executive directors. The Appointments and Remuneration Committee oversees the selection process for the appointment of non-executive directors.

The members of the Board Appointments, Remuneration and Terms of Service Committee comprises the senior independent director (Committee chair), chair, chief executive (or another executive director when considering the appointment of the chief executive) and one other non-executive director. The company secretary and associate director of HR and Workforce also attended in an advisory capacity. During the year, the Committee met on ten occasions, with the chief executive attending all (or part) meetings. The meeting attendance of committee members is shown on page 46.

The members of the Appointments and Remuneration Committee comprise the Chair (Committee chair), senior independent director, non-executive director, two elected Governors, one stakeholder Governor, one staff Governor and the Lead Governor. The Associate Director of Corporate Affairs and Associate Director of Human Resources and Workforce also attended in an advisory capacity.

Expenses paid to Governors 2018/19

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.

	2018/19	2017/18
Number of Governors in office	22	24
Number of Governors receiving expenses	2	5
Total expenses paid to Governors	£402	£700

Salaries and Allowances (for the period 1 April 2018 to 31 March 2019) (subject to audit)

Information relating to senior manager's salaries, compensations, non-cash benefits, pension compensation and retention of earnings for Non-Executive Directors payments is set out below.

Salaries and Allowances
(For the period 1 April 2018 to 31 March 2019)

Name and Title	2018-19 (12 months)					
	Salary (bands of £5000) £000	Taxable benefits (total to the nearest £100)	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
Miss Bridget Fletcher - Chief Executive	40-45	0	0	0	-2.5-0	40-45
Mr Brendan Brown- Chief Executive	120-125	1	0	0	-15--10	105-110
Mr Andrew Copley - Director of Finance	140-145	0	0	0	17.5-20	160-165
Ms Jill Asbury- Director of Nursing	105-110	0	0	0	82.5-85	190-195
Dr Karl Mainprize - Medical Director	165-170	1	0	0	67.5-70	230-235
Ms Stacey Hunter - Director of Operations	135-140	2	0	0	25-27.5	160-165
Prof Michael Luger- Chair	0	0	0	0	0	0
Mr Andrew Gold - Chair	40-45	8	0	0	0	40-45
Mr Jeremy Cross - Non-Executive Director	10-15	12	0	0	0	10-15
Prof Anne Gregory-Non -Executive Director	10-15	3	0	0	0	10-15
Dr Maggie Helliwell - Non-Executive Director	10-15	0	0	0	0	10-15
Mr Mark Lam- Non-Executive Director	10-15	0	0	0	0	5-10
Mrs Lynn McCracken-Non-executive	10-15	0	0	0	0	10-15
Mr Mohammed Sarwar-Non-Executive Director	0	0	0	0	0	0

Salaries and Allowances (for the period 1 April 2017 to 31 March 2018) (subject to audit)

Information relating to senior manager's salaries, compensations, non-cash benefits, pension compensation and retention of earnings for non-executive directors payments is set out below.

Name and Title	2017-18 (12 months)					
	Salary	Taxable benefits	Annual performance-related bonuses	long-term performance-related bonuses	All pension related benefits	Total
	(bands of £5000) £000	(total to the nearest £100)	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000
Miss Bridget Fletcher - Chief Executive	195-200	2	0	0	0	195-200
Mr Brendan Brown- Chief Executive	0	0	0	0	0	0
Mr Andrew Copley - Director of Finance	135-140	1	0	0	62.5-65	200-205
Ms Jill Asbury- Director of Nursing	100-105	0	0	0	135-137.5	240-245
Dr Karl Mainprize - Medical Director	160-165	1	0	0	32.5-35	195-200
Ms Stacey Hunter - Director of Operations	130-135	2	0	0	57.5-60	185-190
Prof Michael Luger- Chair	25-30	7	0	0	0	25-30
Mr Andrew Gold - Chair	20-25	4	0	0	0	20-25
Mr Jeremy Cross - Non-Executive Director	10-15	6	0	0	0	15-20
Prof Anne Gregory-Non -Executive Director	10-15	3	0	0	0	10-15
Dr Maggie Helliwell - Non-Executive Director	10-15	0	0	0	0	10-15
Mr Mark Lam - Non-Executive Director	0					
Mrs Lynn MCCraken-Non-executive	10-15	0	0	0	0	10-15
Mr Mohammed Sarwar-Non-Executive Director	0-5	1	0	0	0	0-5

Michaeal Luger until December 2017
Mohammed Sarwar until June 2017
Bridget Fletcher to June 2018
Brendan Brown from June 2018
Mark Lam from July 2018
No executive directors are non-executives of any other Organisation
No former senior manager received compensation in the period 1/4/2018 - 31/3/2019

The pension related benefits are calculated by taking the inflated increase in pension entitlement (1% for 2018/2019) less the employee contribution. Assuming pension is paid for a period of 20 years.
The increase in entitlement is calculated as ((20 x PE) + LSE) -((20 X PB +LSB)
Where PE is the annual rate of pension that would be payable to the director, if the director 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 the director 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
Bridget Fletcher withdrew from the pension scheme in 2013/2014,

Pension Benefits as at 31 March 2019 (subject to audit)

Name and title	Real Increase in Pension at Age 60 (bands of £2500) £000	Real Increase in Pension Lump Sum at Pension age (bands of £2500) £000	Total accrued pension at Pension age at 31 March 2019 (bands of £5000) £000	Lump Sum at pension Age Related to Accrued Pension at 31 March 2019 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2019 £000	Cash Equivalent Transfer Value at 31 March 2018 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Miss Bridget Fletcher - Chief Executive	0	-10-5	65-67.5	195-200	1335	1335	0	0
Mr Brendan Brown- Chief Executive	0-2.5	0	7.5-10	0	109	93	13	0
Dr Karl Mainprize - Medical Director	2.5-5	0-2.5	65-67.5	100-105	1077	905	172	0
Ms Jill Asbury - Director of Nursing	2.5-5	5-10	40-45	125-130	922	763	159	0
Mr Andrew Copley - Director of Finance	0-2.5	-5-0	55-57.5	140-145	1113	974	139	0
Ms Stacey Hunter - Director of Operations	2-2.5	-2.5-0	35-40	80-85	668	566	101	0

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.

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 £15,431.99	5%
2	£15,432.00 to £21,477.99	5.6%
3	£21,478.00 to 26,823.99	7.1%
4	£26,824.00 to £47,845.99	9.3%
5	£47,846.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

Note: Employer contributions are 14% of salary.

The Scheme is a 'final salary' scheme. Annual pension are normally based on 1/80th for the 1995 section and of the best of the last three years of pensionable pay for each year of service, 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. 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

Fair Pay Information (subject to audit)

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 2018/19 on an annualised basis. This information, with comparatives for last year, is shown below.

	2018/19	**2017/18**
Median remuneration of staff	£21,089	£26,614
Mid-point of banded remuneration of the highest paid Director	£167,500	£242,500
Ratio	8:1	9.1

The Medical Director is the highest paid director. In 2017/18, the highest paid director was the Chief Executive.

SECTION 3 - STAFF REPORT

Employee information

Analysis of Staff Costs (subject to audit)

An analysis of staff costs is shown below. The information is split between permanently employed, defined as staff with a permanent (UK) employment contract directly with the Foundation Trust and other staff, defined as staff engaged on the objectives of the entity that do not have a permanent (UK) employment contract with the Foundation Trust. This information includes employees on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities.

	2017/18 12 months			2018/19 12 months		
Employee expenses	**Total**	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	87,910	86,809	1,101	97,508	97,163	345
Social security costs	8,447	8,447	0	8,651	8,651	0
Employers contributions to NHS Pensions Agency	10,873	10,873	0	11,603	11,603	0
Other pensions	-	-	-	37	37	-
Apprenticeship levy	462	462	0	447	447	0
Agency/contract staff	3,327	0	3,327	6,571	0	6,571
NHS Charitable Funds staff	0	0	0	0	0	0
TOTAL	107,641	101,062	6,579	111,160	87,399	4,441

Analysis of Staff Numbers (subject to audit)

An analysis of staff numbers is shown below. The average number of employees is calculated as the whole time equivalent number of employees under contract of service in each week in the financial year, divided by the weeks in the financial year

	2017/18			2018/19		
Average number of employees*	**Total Number**	**Permanently employed Number**	**Other Number**	**Total Number**	**Permanently employed Number**	**Other Number**
Medical and Dental	276	251	25	295	263	32
Administration and Estates	537	537	0	609	584	25
Healthcare assistants and other support staff	624	587	37	682	608	74
Nursing, midwifery and health visiting staff	751	680	71	705	675	30
Scientific, therapeutic and technical staff	412	412	0	442	442	0
Other	0	0	0	0	0	0
TOTAL	2600	2467	133	2733	2572	161

***WTE = whole time equivalent

The Trust employed 2,633 (primary assignment only, permanent and fixed term contracts) staff comprising 2,205 female staff and 428 male staff.

Analysis of Sickness Absence

The Trust continues to support employees' health and wellbeing and attendance. The sickness absence rate for 2018/19 is shown below. The average annual sick days per full time equivalent (FTE) for 2018/19 was 9.88 days.

Average FTE 2018	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Day per FTE	FTE-Days Available	FTE-Days Lost to Sickness Absence
2,554.50	25,232.63	9.88	932,393	40,933

Source: Health & Social Care Information Centre (HSCIC) using data drawn for January 2018 to December 2018 from the ESR data warehouse. Underlying figures have been converted to the Cabinet Office measurement base by applying a factor of 225/365 to convert form calendar days to working days lost.

Employee Policies and Actions

Supporting employee health and wellbeing remains a key priority for the Foundation Trust to enable the delivery of high standards, high quality, and safe patient outcomes in an environment which provides a positive experience for all our patients and visitors. The Foundation Trust has an established Employee Health and Wellbeing service that provides direct support to employees and their services can be accessed through either a management or self-referral route. There is a range of services available for employees, including employee health advice, occupational therapy and mental health support and

immunization programmes. The Flu Vaccine Programme had over 75% uptake from front line colleagues.

The Foundation Trust actively promotes an employee assistance programme (EAP), that offers a multichannel service including 24 hour 7 days a week telephone helpline which is supported by a dedicated website and direct email access to their specialist advisors. Within this service employees can seek mental health support; be signposted to other local services and receive if appropriate up to six sessions of telephone counselling and/or face to face counselling.

Mental health has become a significant cause of absence for the Trust. In order to support employees the Trust has introduced a day one referral service for anyone experiencing mental health or work related stress issues; and has introduced mental health first aiders to identify the early signs of mental health and promote support. There is also a partnership with Remploy to provide access to a Work Mental Health Support Service directly from their facility. This support is available to individuals who are experiencing difficulties at work due to depression, anxiety, stress and/or other mental health conditions and complements the services provided by the Employee Health and Wellbeing team.

The Foundation Trust continues to provide an Employee Wellness Programme as part of the People Plan.

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

The Trust has invested in leadership development with a comprehensive programme of development for senior leaders, new leaders and rising stars. This has been supplemented by the development of in-house coaching capability with 19 colleagues undertaking ILM Level 5 training, with a planned extension in 2019/20.

In October 2018, the Trust launched its first intake of supported interns in partnership with Keighley College. The programme aims to enhance employment opportunities for local young people with learning and physical disabilities through direct experience of the work place through placement rotation between different departments including Sterile Services, Laundry, Mobility Services and Human Resources. This is part of the Trust's commitment to employing a more diverse workforce.

The Trust has a well- established apprenticeship programme in place with Keighley College for Apprentice Health Care Support Workers; and has plans for 25 Nurse associates, as well as supporting apprenticeships in other areas, for example Pathology, Pharmacy and corporate services.

In order to respond to the well documented workforce supply challenges, the Trust has been at the forefront in deploying new roles and new workforce models, including ACPs, Nurse Associates, Pharmacy Assistants and Discharge coordinators. The Trust is currently working with Huddersfield University, sponsored by the LWAB, to evaluate the deployment of these new roles within the Acute Assessment Unit.

In November 2018, applications opened for a reciprocal mentoring programme for board members and BAME colleagues. The programme has attracted 14 BAME colleagues to each mentor a member of the board on their experience of being an employee at Airedale, in return BAME colleagues receive personal development support from the board member. Plans to extend this programme to other protected characteristics including LGBT+ and Disability will be implemented in 19/20

In October 2018, 400 colleagues attended positive psychology training from The Art of Brilliance team. 60 attendees had further training in November, resulting in the trial of the Great Place to Work methodology from January 2019. The approach is owned by teams to agree improvements in their own areas.

In May 2018, a piece of development work was designed with leaders in diagnostics to respond to levels of morale reported in 2017 staff survey. This has resulted in leadership development being provided for 40 leaders and planned for another 40 at all levels of seniority and roles.

The Trust's Reward and Recognition Scheme is now embedded with 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 Foundation Trust for over 25 years. The Trust's fifth Annual Pride of Airedale Awards Event was held in March 2019 to recognise the contributions and achievements of employees. This was very well received with over 231 nominations and 11 individual and team award winners and many other teams and individuals being commended for their achievements.

The Human Resources (HR) and Workforce Directorate has continued to develop focusing on increasing the effectiveness of its business contribution, employee engagement and organizational learning and improvement. The HR team and managers continue to work in partnership with staff-side and the trade unions through the Airedale Partnership Group.

Equality and Diversity

Policy in Relation to Disabled Employees

The main Trust policies which support the employment of disabled employees relate to recruitment and selection, managing attendance and equality and diversity. All HR policies have been equality impact assessed. The director of human resources and workforce facilitated the establishment of a disability focus group to identify and take action to improve the experience of disabled staff. This group organised the first Trust Disability Awareness

Week to raise awareness of disability and workplace support and has developed and published a reasonable adjustments toolkit for managers. The work of the group is now well established and is beginning to pay dividends in terms of improved experience being reported in the NHS Staff Survey. The head of employee health and wellbeing has also taken on a wider role to support managers and employees make timely reasonable adjustments to the workplace environment.

Equality Delivery System

The Foundation Trust is committed to being an inclusive provider and employer.

In October around 500 employees took part in an employee event at Airedale Hospital which celebrated difference. Some highlights from the event were:

- Promotion of Right Care Behaviours
- Diversity stands and presentations
- Storytelling and presentations from employees and external partners

The Foundation Trust is fully committed to meet its core requirements under the Equality Act 2010 and has published an Inclusion Strategy to enable it to become more inclusive in terms of patient experience and as an employer. The commitment to the NHS Equality Delivery System and delivering actions as part of the Workforce Race Equality Standard are key elements of this strategy.

The establishment of several focus groups to promote awareness of equality in the workplace has enabled employees to share their experiences of working at Airedale and as resulted in the development of actions plans relating to the Workforce Race Equality Standard and disability. The focus groups, each sponsored by a non-executive director are themed around the Foundation Trust's Right Care values and aim to give BAME, LGBT and disabled employees a voice in helping shape the Foundation Trust's approach to improving employee experience. A Gender Focus Group has also been established to address issues relating to the gender pay gap reports and employee experience. All this work is overseen by an Inclusion Implementation Group chaired by the director of nursing and director of human resources and workforce.

Employee Engagement and Relations

The Foundation Trust recognises that a high level of employee engagement is crucial to improving patient care and experience. The Foundation Trust has a formal partnership agreement in place with the unions and staff organisations representing employees. There are also consultation mechanisms through the Joint Local Negotiating Committee for medical staff and the Airedale Partnership Group for all employees.

The Foundation Trust currently has four staff governor seats, which represent the views of staff on the Council of Governors and Trust working groups.

Local employee surveys – called 'pulse surveys' are distributed throughout the year to measure employee satisfaction and monitor specific issues. The results inform action plans drawn up following the annual staff survey, which are monitored at group level and by the executive management team.

The executive directors conduct 'listening sessions' to meet with employee groups on a regular basis. The programme of visits is intentionally flexible to enable a rapid response to any areas of concern highlighted by the results of the pulse survey or staff survey. Feedback is reported to and monitored by the executive directors group.

The executive directors also do regular walkrounds to front-line ward and support service areas. Feedback is presented to executive colleagues enabling any concerns to be addressed as soon as practicable.

Staff Survey

The 2018 annual survey of NHS staff was conducted in October to December 2018. The format of the survey report has changed this year, so that areas of employee experience are grouped into ten key themes. The National Staff Survey Centre has aligned previous results, where possible with the new format and scoring mechanisms.
The table below presents the results of significance testing conducted on this year's theme scores and those from last year*. It details the Trusts theme scores for both years and the number of responses the each of these are based on.

The final column contains the outcome of the significance testing: an up arrow indicates that the 2018 score is significantly higher than last years, whereas a down arrow indicates that the 2018 score is significantly lower. If there is no statistically significant difference, you will see 'Not significant'. When there is no comparable data from the past survey year, you will see 'N/A'.

Theme	2017 score	2017 respondents	2018 score	2018 respondents	Statistically significant change?
Equality, diversity & inclusion	**9.3**	1213	**9.4**	1145	Not significant
Health & wellbeing	**6.3**	1233	**6.3**	1164	Not significant
Immediate managers	**6.8**	1234	**7.0**	1166	↑
Morale		0	**6.3**	1145	N/A
Quality of appraisals	**5.5**	1084	**5.4**	1084	Not significant
Quality of care	**7.3**	1050	**7.3**	1036	Not significant
Safe environment - Bullying & harassment	**8.3**	1206	**8.4**	1147	Not significant
Safe environment - Violence	**9.6**	1202	**9.6**	1143	Not significant
Safety culture	**6.8**	1224	**7.0**	1152	↑
Staff engagement	**7.1**	1247	**7.2**	1182	Not significant

The table below details the Trusts theme scores for 2018 compared to the Avergae Acute Trusts theme score and whether the Trust scored above, below or no change.

Theme	2018 Trust score	2018 Average Acute Trust score	Above/Below Average Acute Trust 2018 score
Equality, diversity & inclusion	**9.4**	**9.1**	Above
Health & wellbeing	**6.3**	**5.9**	Above
Immediate managers	**7.0**	**6.7**	Above
Morale	**6.3**	**6.1**	Above
Quality of appraisals	**5.4**	**5.4**	_
Quality of care	**7.3**	**7.4**	Below
Safe environment - Bullying & harassment	**8.4**	**7.9**	Above
Safe environment - Violence	**9.6**	**9.4**	Above
Safety culture	**7.0**	**6.6**	Above
Staff engagement	**7.2**	**7.0**	Above

In response to the findings of the staff survey, areas of focus have been agreed with the Board of Directors, though many of the key actions needed are included in the Foundation Trust's People Plan.

SECTION 4 - ASSESSMENT AGAINST THE NHS IMPROVEMENT NHS FOUNDATION TRUST CODE OF GOVERNANCE

The 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:

- 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;
- Regular private meetings between the Chair and Non-Executive Directors;
- Performance appraisal process for all Non-Executive Directors, including the Chair, 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 Interests for Directors, Governors and senior staff;
- Annual declaration of compliance with the 'fit and proper' persons test described in the provider licence, for the Board of Directors;
- Council of Governors' Policy for Raising Serious Concerns;
- Established roles of Lead Governor 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;
- Council of Governors' agenda setting process;
- Collective performance evaluation mechanism for the Council of Governors;
- Governor Involvement Group, Implementation Plan and Key Performance Indicators;
- Board Appointments, Remuneration and Terms of Service Committee for Executive Directors;
- Appointments, Remuneration and Terms of Service Committee for Non-Executive Directors;
- 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 the 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 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.

Each NHS Foundation Trust has its own governance structure. The basic governance structure of all NHS Foundation Trusts includes:

- Foundation Trust Members;
- 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 and in the NHS Foundation Trust Directory on NHS Improvement's website at www.improvement.nhs.uk

In addition to this basic structure, the Foundation Trust also has Board committees and sub-groups, comprising directors and/or governors, which are a practical way of dealing with specific issues.

Our Membership

The Foundation Trust has two membership constituencies:

- A public member constituency; and
- A staff member constituency

The number of members in each constituency at 31 March 2019 is shown below.

Member Constituency	Number of Members
Bingley	756
Bingley Rural	422
Craven	878
Ilkley	499
Keighley East/Central	1749
Keighley West	716
Wharfedale	381
Worth Valley	587
Skipton	1016

Settle and Mid-Craven	577
South Craven	748
West Craven	556
Pendle East and Colne	443
Rest of England	1785
Staff	2745
Total number of Foundation Trust members	**13858**

Public Member Constituency

The Foundation Trust has 14 public member constituencies, split into the neighbourhood wards of Bradford Council, Craven Council and Pendle Council. A constituency covering out of area members (Rest of England) 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 aged 14 or over and living in one of the public constituencies shown above can become a member by making an application for membership to the Foundation Trust.

As of 31 March 2019 the Foundation Trust had 11,113 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 or continue as a member of the 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 is currently 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; and
- All other staff.

All eligible staff are automatically made members of the staff constituency unless they inform the Foundation Trust they do not wish to become a member.

As at 31 March 2019, the Foundation Trust had over 2,700 staff members.

Constitution Changes

A review of the Constitution was undertaken during the 2016/2017 financial year. This followed a self-assessment by Governors of the performance of the Council. The main changes included a reduction in the size and composition of the Council.

As part of the consultation process with Governors, it was agreed to implement the changes on a phased approach as shown below.

2017 Removal of duplicated (vacant) seats – Keighley Central, Skipton, West Craven and Nurses & Midwives
Removal of Volunteers, Craven DC and University of Leeds

2018 Removal of duplicated seat – South Craven
Merger of Keighley Central and Keighley East seats

2019 Merger of Keighley West and Worth Valley seats
Merger of Ilkley and Wharfedale seats

Membership Development Strategy

Both the Board of Directors and Council of Governors agree that an active and engaged membership and public will continue to enhance the development of the Trust's strategic objectives in delivering high quality care, working with partners to deliver integrated care and to ensure clinical and financial sustainability.

The Membership Development 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; and
- Ensure a continuous approach to the development of the membership in terms of both numbers and level of engagement.

In 2018/2019, our plan was to continue the work of engaging with members and the public and collecting feedback from the public, and members, including staff and to present that feedback to the Board of Directors. The aim of the Membership Development Strategy was to continue to support the Foundation Trust's engagement strategy by enabling Governors to participate fully in the hospital's events. Collecting feedback through these events facilitates the future development of the Foundation Trust's services as part of the annual planning process and helps the Governors to fulfil their role of engaging with their community and membership.

Governor Involvement Group (formerly the Membership Development Group)
This Group is responsible for developing the membership by recruitment, retention, communication and engagement. The Group meets monthly (formerly bi-monthly) and was involved in the following membership activities, amongst others, in 2018/19:

- attending open events at the hospital including theatres and staff open days;
- 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; and
- engaging with members and the public in the community via community events.

A Membership report is presented at the Annual Members Meeting. This incorporates information regarding membership age, ethnicity and gender by constituency and details the level and effectiveness of member engagement.

Membership Recruitment
Recruitment of new members is an ongoing activity to ensure that membership is representative of the local community. In 2018/2019 the strategy's aim was to ensure overall membership numbers were maintained, whilst focussing on those areas where membership was under represented.

Membership Engagement
During 2018/19, members were engaged in the work of the Trust through the following activities:

- The annual members' meeting, held on 26 July 2018.
- A number of events and open days organised by the hospital. These included a talk on Stammering and open days focussing on the work of our Theatres Department and Staff Open Day. These activities provide members with opportunities to gain more of an insight into how our services operate. At each of these events members were able to meet their governors and find out more about their role, and had the opportunity to ask questions or give feedback about our services.

In September 2018 a number of our staff represented the Trust at a Health Awareness Day held within the community in Ilkley. This event was arranged by the local GP practice and supported by local organisations. Those people attending this event were given the opportunity to provide feedback about the Trust's services to a Governor.

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 membership application form includes an area where members record how they would like to get involved. This 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 2018/19, 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 through governor involvement in events and via direct contact with governors. These views were collated and presented to the Board by the governors in December 2018 to ensure their consideration as part of the annual planning process.

All feedback is collated 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.

Members are also invited, via the website and electronic mailings, to meet governors before every member talk, held throughout the year. Governors also take part in various open days taking place throughout the year at the hospital, for example showcasing the work of the Theatres and Maternity departments. The annual staff event also gives staff an opportunity to meet with the staff governors and discuss any issues or questions.

Our Council of Governors

The Council of Governors currently comprises 22 governor seats – 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 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.

During 2018/19, five governors were elected by our members (including staff members) who represent the following constituencies:

- Keighley Central/East
- Keighley West
- Pendle East and Colne
- West Craven
- Staff All Other

Elections are held each year for those seats either vacated due to resignations or because governors have reached the end of their 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 2018/19 is shown under 'Attendance of Governors and Directors at Council of Governors meetings 2018/19'.

The size and composition of the Council of Governors changed with effect from 1 June 2018 as outlined in the section of this report titled *'Constitution Changes'*.

The annual ballot of governors for the appointment of a lead governor and deputy lead governor was held during the year. Mr Jerry Stanford, governor for Pendle East and Colne, was duly elected as lead governor, and Mr Paul Maskell, governor for West Craven was elected as deputy lead governor.

A joint meeting with the Board of Directors is normally held twice yearly to review progress on the Foundation Trust's Annual Plan and to consider priorities for the forthcoming year. The Council of Governors presented their feedback to the Board at a Board to Council meeting in December 2018. The Board responded to the Council of Governors on that feedback at a meeting in March 2019. This gave the Board of Directors the opportunity to reflect on the governor feedback and present the draft Annual Plan prior to the submission in April 2019.

In preparation for the Annual Planning process, the Council of Governors canvassed the opinion of its members and the public by attending local events 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 staff open days 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 Trust has developed a bespoke induction programme which existing governors are also invited to attend. A combined Induction performance evaluation event was held in June 2018.

The Trust has provided opportunities for its governors to attend the national Governwell training programme organised by NHS Providers. Governors have also participated in seminars and workshop sessions organised by the West Yorkshire and Harrogate Health Care Partnership.

Governors are invited to attend Audit and Risk Committee and Charitable Funds Committee. In 2018/19 David Child was the governor representative on both of these committees. The Board of Directors has agreed that a governor will be invited to attend each of the committees as an observer going forward.

We value the contribution our governors make and the different perspectives they bring to the development of services.

The Board of Directors' and Council of Governors

Detailed below is a summary of the key roles and responsibilities of the Council of Governors and a description of how the Board of Directors and Council of Governors work together in the best interests of the Foundation Trust.

The Council of Governors is constituted in accordance with the Foundation Trust's Constitution and Standing Orders. The Council of Governors complies with the NHS Foundation Trust Code of Governance in which the Governor statutory duties are set out. The Council of Governors does not undertake the operational management of the Foundation Trust; rather they act as a link between members, patients, the public and the Board of Directors, providing an ambassadorial role in representing and promoting the Foundation Trust

The Foundation Trust's governance structure is established to ensure the Council of Governors meets its statutory duties. The Council of Governors primary statutory duties are to hold the non-executive directors individually and collectively to account for the performance of the Board; and to represent the interests of the members of the Foundation Trust as a whole and the interests of the public. Examples of governors fulfilling their statutory duties during the year include approving the appointment of three non-executive directors, deciding the remuneration of the non-executive directors, receiving the annual accounts, external auditor's reports and annual reports and providing their views to the Board of Directors on the Foundation Trust's forward plans. Governors also commenced a

process of appointing the Trust's external auditor and the appointment will be made in the 2019/20 financial year.

The Council of Governors has agreed a Code of Conduct setting out their role and responsibilities as well as their individual personal conduct. A separate dispute resolution procedure exists for the purpose of resolving any disputes that may arise between the Board of Directors and Council of Governors, which could ultimately be referred to NHS Improvement for adjudication.

The Council of Governors represents the interests of the Foundation Trust members and the general public. They have an important role to play in acting as the eyes and ears of these groups of people, and providing feedback about the Trust's services and plans.

The Council of Governors meets four times a year for the purpose of receiving briefings from the executive directors on matters of strategic importance, finance and performance and quality and safety. Additional meetings are also called if there are matters requiring approval by the Council of Governors e.g. non-executive director appointments, for which a delay may be detrimental to the process. The non-executive directors attend Council of Governors meetings to report on the work of each of the committees they chair; the purpose of which is to support Governors in their role of holding non-executive directors to account for the performance of the Board.

The full Board of Directors meet 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 Annual Plan 2019/20. This was achieved by the governors feeding back the views and comments received throughout the year from Foundation Trust members and members of the public.

The chair, who chairs both the Board of Directors and the Council of Governors, ensures synergy between the two governing bodies through regular meetings and briefings.

The directors (both executive and non-executive) meet regularly with governors during their day to day working through committee meetings, working group meetings, network sessions, chair's briefings, consultations and information sessions. Examples include participation in the Appointments and Remuneration Committee and consultations about the Annual Plan and Quality Account. .

The Governors have established a monthly Governor Involvement Group meeting whereby executive and non-executive directors meet informally with a number of governors to provide briefings and up to date information about the Foundation Trust.

Although meetings of the Board of Directors are held in public and governors can and do attend, the chair provides a Board of Directors feedback session for governors at their

monthly Governor Involvement Group meetings. The chair 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.

Governors have received training in the past regarding their holding to account duties and this training will be delivered to newly elected Governors in June 2019.

The Board of Directors is collectively responsible for exercising all of the powers of the Foundation Trust; however, it has the option to delegate these powers to senior management and other committees as set out in the Scheme of Delegation. . The Board's role is to provide active leadership within a framework of prudent and effective controls which enable risk to be assessed and managed. The Board is responsible for the allocation of resources to support the achievement of organisational objectives, ensure clinical services are safe, of a high quality, patient focused and effective.

The Board of Directors ensure high standards of clinical and corporate governance and, along with the Council of Governors, engages members and stakeholders to ensure effective dialogue with the communities it serves.

The Board is accountable to stakeholders for the achievement of sustainable performance and the creation of stakeholder value through development and delivery of the Foundation Trust's long term *'Right Care'* vision and strategy. The Board ensures that adequate systems and processes are maintained to deliver the Foundation Trust's annual plan, deliver safe, high quality healthcare, measure and monitor the Foundation Trust's effectiveness and efficiency as well as seeking continuous improvement and innovation.

The following table summarises governor and director attendance at Council of Governor's meetings:

Attendance of Governors and Directors at Council of Governors meetings 2018/19

Public Governors	Tenure	Constituency	Meetings attended
Public Elected Governors			
Peter Allen	Re-elected 1 June 2016	Skipton	1/4
Peter Beaumont	Re-elected 1 June 2016	Wharfedale	4/4
Margaret Berry	Elected 1 June 2016	South Craven	4/4
John Bootland	Re-elected 1 June 2017	Keighley Central	4/4
Martin Carr	Elected 1 June 2016	Craven	3/4
David Child	Re-elected 1 June 2016	Bingley	4/4
Linda Dobson	Elected 2 June 2015 (to May 2018)	Keighley East	1/1
Vacant seat	-	Rest of England	-
Paul Maskell	Re-elected 1 June 2018	West Craven	2/4
Christine Highley	Elected 1 June 2018	Keighley West	3/4
David Pearson	Elected 2 June 2015 (to May 2018)	South Craven	1/1
John Roberts	Re-elected 1 June 2016	Worth Valley	4/4

Jerry Stanford	Re-elected 1 June 2018	Pendle East and Colne	4/4
Pat Taylor	Elected 1 June 2016	Settle and Mid Craven	4/4
Pat Thorpe	Re-elected 1 June 2016	Bingley Rural	4/4
Bryan Thompson	Elected 1 June 2016	Ilkley	4/4
Stakeholder Governors	**Tenure**	**Constituency**	**Meetings attended**
Appointed Governors			
Cllr Robert Heseltine	Re-appointed 2 June 2016	North Yorkshire County Council	4/4
Naz Kazmi	Re-appointed 2 June 2016 (to September 2018)	Voluntary Sector	0/2
Shamim Akhtar	Appointed 6 December 2018	Voluntary Sector	0/1
Cllr Ken Hartley	Re-appointed 2 June 2016 (to May 2018)	Pendle Borough Council	0/1
Cllr Margaret Foxley	Appointed 1 June 2018	Pendle Borough Council	2/4
Cllr Caroline Firth	Appointed 1 June 2018	Bradford Metropolitan District Council	2/4

Staff Governors	**Tenure**	**Constituency**	**Meetings attended**
Staff Elected Governors			
Annette Ferrier	Elected 1 November 2017	Allied health professionals and scientists	3/4
Richard Jackson	Elected 1 November 2017	Doctors and Dentists	4/4
Denise Todd	Elected 1 November 2017 (to October 2018)	Nurses and Midwives	0/1
Michael Smith	Elected 1 June 2018	All other Staff	3/4
In addition the Council of Governors meetings were attended by the following Directors:			
Non-Executive Directors	**Role Title**		**Meetings attended**
Andrew Gold	Chairman		4/4
Jeremy Cross	Non-Executive Director		1/4
Prof Anne Gregory	Non-Executive Director		4/4
Dr Maggie Helliwell	Non-Executive Director		4/4
Lynn McCracken	Non-Executive Director		4/4
Mark Lam	Non-Executive Director (from 1.07.18)		2/2
Executive Directors			
Bridget Fletcher	Chief Executive (to 31.05.18)		1/1
Brendan Brown	Chief Executive (from 4.06.18)		3/3
Jill Asbury	Director of Nursing		2/4
Andrew Copley	Director of Finance		3/4
Stacey Hunter	Chief Operating Officer		4/4
Karl Mainprize	Medical Director		2/4
Nick Parker	Associate Director of HR and Workforce		2/4
Stuart Shaw	Associate Director of Strategy, Planning and Partnerships		1/1

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 Foundation 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

A list of governor contact email addresses is published on the Foundation Trust website in the Council of Governors section.

SECTION 5 – NHS IMPROVEMENT'S SINGLE OVERSIGHT FRAMEWORK

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A Foundation Trust will only be in segments 3 or 4 where it has found to be in breach or suspected breach of its licence.

NHS Improvement has placed the Foundation Trust in segment 2 as part of its Single Oversight Framework. This segmentation information is the Foundation Trust's position as at 28 May 2019. Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. The Foundation Trust has not been subject to any enforcement action by NHS Improvement (Monitor).

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Foundation Trust disclosed above might not be the same as the overall finance score here.

Area	**Metric**	**2017/18 scores**				**2016/17 scored**	
		Q 4	**Q 3**	**Q 2**	**Q 1**	**Q4**	**Q3**
Financial sustainability	Capital service capacity	1	1	2	4	1	1
	liquidity	1	2	2	1	1	1
Financial efficiency	I & E margin	1	1	3	4	1	1
Financial controls	Distance from financial plan	1	1	1	1	1	2
	Agency spend	1	1	1	1	2	2
Overall scoring		**1**	**1**	**2**	**3**	**1**	**1**

SECTION 6 – STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which requires Airedale NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. 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 *Department of Health Group Accounting Manual* and in particular to:

- observe the Accounts Direction issued by NHS Improvement, 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 (and the Department of Health Group Accounting 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 *NHS Foundation Trust Accounting Officer Memorandum.*

Brendan Brown
Chief Executive

28 May 2019

SECTION 7 - 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 2019 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 Trust and for meeting all statutory requirements and adhering to guidance issued by NHS Improvement in respect of governance and risk management.

The Board of directors provides leadership on the overall governance agenda including risk management. It is supported by a number of subcommittees that scrutinise and review assurances on internal control. These include:

- Audit and Risk Committee
- Quality and Safety Committee
- Finance, Digital and Performance Committee
- People Committee

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit & Risk Committee. Additional assurance on the effectiveness of the systems for ensuring clinical quality is given by the Quality and Safety Committee. The Board of directors routinely receives the minutes of these Committees alongside the Board Assurance Framework and the corporate risk register. Special Board meetings are convened from time to time to discuss key areas and provide assurance within on how the risks associated are being managed and mitigated.

The Risk and Compliance Group oversees all risk management activity to ensure:

- that the correct strategy is adopted for
- managing risk;
- controls are present and effective;
- action plans are robust for those risks that are
- being actively managed; and
- that high risks are scored appropriately.

The Risk and Compliance Group is chaired by the Executive Director of Nursing and comprises other executive colleagues. Other senior managers and specialist leads routinely attend each meeting. While the Risk and Compliance Group reports directly to the Audit and Risk Committee, it also provides a regular report on the high level risks and mitigating actions to the Board and works with other committees of the Board in order to triangulate material issues in accordance with the Board's appetite for taking risk and ensure a coordinated approach to effective risk management.

The Chief Executive has overall responsibility for the management of risk. Other members of the Director Team exercise lead responsibility for the specific types of risk as follows:

- The medical director and director of nursing are jointly responsible for clinical governance, risk management and patient safety, and whilst each have been allocated specific duties and responsibilities there are clear lines of accountability. The medical director is 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 director of nursing is the executive lead 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 also responsible for infection prevention and control, and safeguarding children and adults;

- The chief operating officer is responsible for health and safety and for overall risks to operational performance;

- The director of finance provides the strategic lead for financial and performance risk and the effective coordination of financial controls throughout the Trust. The director of finance is also the SIRO and has responsibility for information governance;

- The associate director of human resources and workforce is responsible for workforce planning, staffing issues, education and training. Responsibility for organisational development is incorporated into executive directors' combined objectives both on an individual basis and collectively as the executive team.

- The associate director of corporate affairs is responsible for the management of the board assurance framework and ensuring that strategic risks are identified and reported to the board of directors.

In addition, there are clear responsibilities for risk identified across trust. 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 risk register, which is consistent and mirrors the Trust's risk register requirements, 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 Trust;
- Following all Trust policies and procedures;
- Reporting all adverse incidents and near misses via the Trust incident reporting system;
- Attending regular training as required ensuring safe working practices;
- Awareness of the 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 Trust recognises the importance of supporting staff. The risk management team act as a support and mentor to 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 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 the electronic adverse event reporting system that is targeted at managers of wards, departments and non-clinical areas.

The Board has set out the minimum requirements for staff training required to control key risks through a clear mandatory training programme including infection control, fire safety, safeguarding adults and children, information governance and manual handling. During 2018/19 we achieved 90% compliance against this programme. We also have a health & safety training programme from Board to ward. The mandatory training framework describes the requirements for each staff group and the frequency of training in each case. In addition there is training in incident investigation, including documentation, root cause

analysis, serious incidents and steps to prevent or minimise recurrence and reporting requirements.

Incidents, complaints, claims and patient feedback are routinely analysed to identify lessons learned and to help improve internal control and are reported to the Board through the Quality Report.

The Trust has in place counter fraud arrangements through Audit Yorkshire from the NHS Counter Fraud Authority and has a named Local Counter Fraud Specialist. In order to ensure that counter fraud resources are effectively there is a Counter Fraud Plan and Annual Counter Fraud Report which outlines the proactive, reactive and strategic counter fraud work undertaken for the Trust in 2018/19.

I have ensured that all risks of which I have become aware are reported to the Board of directors and to the Risk and Compliance Group. All new significant risks are escalated to me as Chief Executive and the executive team. They are reviewed and validated by the Risk and Compliance Group. The risk score determines the escalation of risks. There is a regular programme of review of risks on the Board Assurance Framework which enables the Board of directors to scan the horizon for emergent threats and opportunities and consider the nature and timing of the response required in order to ensure risk is kept under appropriate control at all times.

The Risk and Control Framework

The Trust has a Risk Management Strategy (titled Risk Management Policy), which is reviewed and endorsed by the Board of directors. The Strategy provides a framework for managing risks across the organisation which is consistent with best practice and Department of Health guidance. The Strategy provides a clear, systematic approach to the management of risks to ensure that risk assessment is an integral part of clinical, managerial and financial processes across the organisation.

The Strategy is regularly reviewed and was updated to reflect the changes in the governance structure implemented during the year. There is a clearly defined structure for the management and ownership of risk through the development of the risk register and assurance framework. The Strategy sets out the role of the Board and its sub-committees together with individual responsibilities of the chief executive, executive directors, other senior managers and all staff in managing risk.

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 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;
- The evidence that appropriate controls are in place and operating effectively (assurance); and,
- Risk rating pre and post mitigation and 12 month target rating.

In conjunction with the Board Assurance Framework, a 'heat map' and 'risk matrix' has been developed. The aim of these documents is to identify those risks presenting the greatest threat to the Trust achieving its strategic objectives, and the likelihood of those risks increasing sufficiently to require assurance and/or action.

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.

The Board has assessed its risk appetite and this is reviewed annually. It is taken into account when considering the tolerance level of any risk.

The Board sub-committees support the Board in carrying out its responsibilities. During 2018 the Trust's governance arrangements were reviewed and refreshed. The new committee structure provides assurance to the Board that the areas within their terms of reference and any risks are being managed appropriately. This change of emphasis enables the Board to focus on matters of strategic importance or those risks requiring escalation. The main changes to the governance structure were:

- The Audit Committee was re-named Audit and Risk Committee to reflect its role in overseeing risk management arrangements for the Trust. A Risk and Compliance Group was established reporting in to the Audit and Risk Committee. The Audit and Risk Committee ensures that the systems and processes in place to ensure the triangulation of information are robust, as evidenced by external and internal audit reviews. The Board has also delegated authority to the Committee to oversee the risk management arrangements for the newly established wholly owned subsidiary – AGH Solutions Limited.
- The Quality Committee changed to oversee and monitor the Trust's quality and safety metrics and strengthen quality governance. As a result the Committee was re-named Quality and Safety Committee and moved to a monthly basis.
- The Finance Committee terms of reference changed to incorporate oversight of the Trust's performance and digital strategy.

- A new People Committee was established. Meeting on a bi-monthly basis, this committee focuses on workforce, resourcing, organisational development, engagement and workforce systems and provides assurance to the board that staffing processes are safe, sustainable and effective.

Each committee receives a quarterly report on the strategic risks relating to their particular area, for example the Finance, Performance and Digital Committee will review the risks associated with the achievement of the financial plan or with digital transformation.

CQC Registration requirements

The Trust is registered with the Care Quality Commission and systems exist to ensure compliance with the registration requirements. A process of self-assessment is in place and is undertaken annually. Areas of concern are risk assessed and applied where necessary to the local and corporate risk registers. The Trust's last inspection in December 2018 included a Well Led review and Use of Resources review as well as the inspection of core services, with the report published in March 2019. The Trust was given a combined rating of Good, with Requires Improvement for Quality of Care and Well Led. To ensure robust implementation of the must and should do actions identified by the CQC new governance arrangements are in place based on NHS Improvement methodology for challenged trusts whereby all actions are monitored through a Blue, Red, Amber, Green (BRAG) rating. In order for an action to become green, robust evidence will be required as assurance that:

- The action has been completed
- The action will achieve the intended impact
- Any identified risks are captured on the risk register
- There is a plan in place to monitor the effectiveness of the actions, including the impact for patients / staff

In order for an action to become blue, a period of monitoring / measuring must be completed which demonstrates a sustained delivery of the expected outcome. A CQC Response Group has been established which will oversee the delivery of the plan, monitor progress, sign off actions, agree submission of sustained position to the Quality and Safety Committee, (must and should do actions). The Board will approve the movement from a rating of Green to Blue in line with the recommendations from the Quality and Safety Committee. This is a proven system of assurance of sustained improvement in the quality of care provided to patients and ensures that the Board of directors have a clear line of sight of the improvement changes in the organisation.

Performance information

The Board reviews performance data each month against NHS Improvement 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; and business development. A '*patient safety scorecard'* 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. To support the Board in this process, the medical director also reports the learning from deaths.

The Trust adopts a bottom-up approach to performance management. The process of assessing performance at specialty level is monitored on a monthly basis at the directorate Integrated Performance Groups led by the director of finance. These inform the monthly Integrated Governance Report and associated performance reports which are reviewed through the committee structure and then at the Board. As part of the monitoring process, performance targets are set which are then RAG rated to identify those areas requiring scrutiny at executive or board level. The Board requires exception reports to be presented should the nationally mandated performance standards not be met. Examples of exception reports presented to the Board in 2018/19 include the 4 hour emergency care standard, mortality and the cancer screening standards.

Data security

The Trust takes a robust approach to ensuring data security is managed and any risks are assessed in a timely manner. Data quality and data security risks are managed and controlled via the risk management system. Risks to data quality and data security are continuously assessed and added to the IM&T risk register. In addition, independent assurance is provided by the Information Governance Toolkit self-assessment review by internal audit. During 2017/18 the Board directed the Audit and Risk Committee to assess the Trust's preparedness for the General Data Protection Regulations ('GDPR') in May 2018. The final report was received at the Audit and Risk Committee in April 2018 which provided assurance that the Trust was overall in a good position to meet the requirements of General Data Protection Regulation; this is due to the continued annual compliance of the IG Toolkit (IGT).

Incident Reporting

Incident reporting and investigation is recognised as a vital component of risk and safety management and is key to being a learning organisation. An electronic incident reporting system is operational throughout the organisation and is accessible to all colleagues. Incident

reporting is promoted through induction and training programmes, regular communications, patient safety walk rounds or other visits and inspections that take place. There is an escalation process for incidents and the executive team are alerted when a new incident is reported.

- Adverse incident reporting - The Trust promotes a culture of openness and transparency and staff are advised on the Trust's approach to this through the Being Open / Duty of Candour Policy.
- Serious incident reporting – An assurance panel reviews the reports from serious incidents to ensure that actions taken are embedded and effective. Learning from these is reported to the Board quarterly.

- Never events - The Trust experienced three never events during 2018/19 (two in 2017/18 and one in 2016/17). So far in 2019/20 there have been two reported never events. When there is a never event it is investigated in detail to identify areas of learning. The results of these investigations are reported to the Quality and Safety Committee and the Board of directors.
- Claims – The Trust has robust processes in place for dealing with both Clinical Negligence and Employers Liability Claims. When necessary we seek legal representation. A summary of any settled claim is disseminated where appropriate to:
    - involved clinician(s)
    - Relevant Clinical Director
    - Directors
    - Health and Safety Team

Quarterly reports on claims are presented to the Risk and Compliance Group.

The Trust's risk management processes have identified a number of risks. A number of system-wide risks relating to unprecedented challenges in achieving financial sustainability and controlling costs whilst maintaining patient safety, quality and productivity, responding to transformational change at pace and responding to staffing shortages whilst controlling bank and agency spend have been considered and reflected in the Board Assurance Framework. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

As at 31 March 2019 Airedale NHS Foundation Trust had identified a number of risks, which are being managed and mitigated, scoring 15 or above on the corporate risk register which could impact on the achievement of corporate objectives, compliance with its licence or Care Quality Commission in the following areas:

- Nurse staffing levels
- Pathology Laboratory information system
- Controlling costs
- CCG Affordability
- Adverse governance rating as part of the NHS Improvement Single Oversight Framework
- Financial obligations
- Failure to achieve cost improvement programmes
- Inability to change responsible consultant for pathology test results
- NHS Locum consultant beyond 12 months
- Failure to deliver contract income
- Impact on services provided to the Trust due to financial delays in invoice payments

The Trust's financial position is subject to a number of inherent 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 Trust has over the past five years delivered the majority of its national mandatory performance standards.

Over the last 12 months this has become increasingly challenging for a variety of reasons, including increasing demand, system wide transformation developing but not at the pace or scale to keep in line with demand, and commissioner affordability. There has been a number of recent developments across the system to mitigate these including the move to an Aligned Incentive Contract, the implementation of the Airedale, Wharfedale and Craven Health and Care Partnership chaired by the Chief Executive of the Trust in his role as system lead, and the introduction of an Acute Provider Collaboration board between the Trust and Bradford Teaching Hospitals Foundation Trust (BTHFT). The Trust also has a joint venture with BTHFT to provide a pathology service for both organisations and opportunities are being explored to extend this partnership to another trust. Further opportunities for collaboration are also being explored to potentially share other functions and these will be actively pursued during 2019/20.

Availability of workforce remains a significant risk to the clinical safety and operation of the Trust. As part of the refresh of the governance arrangements in 2018/19, a People Committee was introduced. The purpose of the Committee is to provide assurance to the Board on the quality and impact of people, workforce and organisational development strategies and the effectiveness of people management in the Trust. The Trust Board has approved a People Plan which describes how the Trust recruits, retains and develops its people. The implementation of this Plan is monitored through the People Committee. The People Committee receives the workforce plan and will be considering this against the 'NHS Improvement Developing Workforce Safeguards' standards. These have also been incorporated in the Trust's Annual Plan for 2019/20. The People Committee will also receive an update on each specific staff group at each of its meetings. The first discussion focused on medical workforce.

There is a Medical Workforce Group, chaired by a Deputy Medical Director and reporting to the People Committee, which ensures that medium and long-term strategies are in place to address the current and future gaps in the medical workforce.

Each month the Board receives the Nursing and Midwifery Staffing Report which includes fill rates, ratios, vacancies, safety and the impact on the nursing workforce. There is a clear process of review of nurse staffing levels and escalation throughout the Trust. The Trust has continued to undertake significant nursing recruitment both nationally and internationally. This has been successful; however, the need to open to additional capacity over the winter period placed pressure on nurse staffing which had to be addressed through bank and agency use.

The Board receives a number of quality and safety reports (for example, patient safety scorecard and CQC Insight Report, mortality scorecard and learning from deaths report), which enable the board to monitor the impact of gaps in workforce.

The 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.

The Trust has published an up-to-date register of interests for decision-making staff within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS'* guidance. In January 2019 the Trust implemented a new system for declaring interests, gifts and hospitality which will require all decision-making staff to make a positive or nil return. This will provide a more comprehensive and robust register going forward.

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 that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust has 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 Trust's financial plan is approved by the Board and submitted to NHS Improvement. The plan, including forward projections, is monitored on a monthly basis and scrutinised by the Board Finance, Performance and Digital Committee. The Board reviews the financial plan at each Board of directors' meeting.

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 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 Trust pays regard to its reference costs, a nationally mandated collection of cost data for delivering services in the NHS. The Board Finance, Digital and Performance Committee terms of reference also includes scrutiny of the Foundation Trust's cost improvement plans ('CIP') and receives presentation of the CIP tracker from the director of finance.

The 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 Trust's Audit and Risk Committee and internal and external audit. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

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 – the Trust's director of finance – undertakes the role of Senior Information Risk Owner (SIRO). The SIRO supports the chief executive and the Board in ensuring compliance with appropriate standards and managing information risks. 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 Trust's Information Governance assurance statements and its assessment against the Data Security and Protection Toolkit (DSPT). The Clinical Director, digital care and telemedicine is the Trust's Caldicott Guardian. Freedom of Information compliance is managed by the Head of Information Governance and Data Protection Officer, (a shared appointment with BTHFT) with responsibility for ensuring that procedures and processes are in place. The Information Governance Manager provides support for the day to day management of Information Governance. There is an established Information Governance Group (IGG) which oversees compliance, issues and incidents, receives assurance and reports on action plans and projects. The Head of Information Governance chairs the IGG. Membership includes the SIRO, Caldicott Guardian, Information Governance Manager, Head of IT and other senior representatives from across the Foundation Trust. The IGG is accountable to the Finance, Performance and Digital Committee. The IGG regularly reports and informs on progress and compliance with the Toolkit and the SIRO signs off the 31st March annual submission.

As part of the Foundation Trust's assurance mechanism, the internal audit work plan includes an annual review of evidence against the Toolkit submission. I can report that for 2018/19, the DSPT submission process was given a 'significant assurance' opinion by the Trust's internal auditors.

During 2018/19, the Trust had no serious information governance reportable incidents ('SIRI') that required noting as breaches in the Data Security and Protection Toolkit.

Annual Quality Report

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. NHS Improvement (in exercise of the powers conferred on 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*.

Our Board of directors takes an active leadership role on quality. The quality of our services is an integral part of our discussions on business matters and business decisions and the Board receives updates regularly. The Quality and Safety Committee terms of reference were reviewed and strengthened to focus on providing assurance on quality of services to the Board, supported by its revised governance structure. The Committee is a formal committee of the Trust Board and is chaired by a Non-Executive Director and includes two other Non-Executives, one of which has a clinical background. The Executive Director of Nursing, Executive Medical Director, Assistant Director, and Healthcare Governance also attend the Committee.

The Quality Committee scrutinises the Integrated Governance Report each month with a focus on the quality information within the report. There is clear clinical leadership for the development of the Annual Quality Report each year by the Executive Director of Nursing, in close collaboration with the Executive Medical Director. Both the Quality and Safety Committee and the Council of Governors receive assurance on the progress against the priorities and outcomes highlighted within the Annual Quality Report. The Quality Committee is responsible for overseeing the production of the Annual Quality Report and for overseeing monitoring indicators and data quality. The Trust has engaged with the Governors to develop the shortlist of quality priorities for 2019/20 and then tested these further with partner organisations, including HealthWatch and the Clinical Commissioning Groups. The draft Quality Report was formally reviewed through the Trust's governance arrangements (Risk and Compliance Group, Board sub-committee and Board of directors).

A limited assurance report was provided by external audit on the content of the quality report. They audited two mandated national indicators:

1. The percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge; and,
2. the maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

and gave a unqualified opinion. External audit also looked at one local indicator – Summary Hospital-level Mortality Indicator (SHMI) and reported a number of recommendations. The local indicator does not form part of the Audit Opinion.

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 and Risk Committee, Quality and Safety Committee and the Risk and Compliance Group. 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 Grant Thornton (external audit), Care Quality Commission, Internal Audit, NHS Resolution 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:

Board of directors
The Board has set out the governance arrangements including the committee structure within the Standing Orders and its Constitution. The Chairs of the Board's subcommittees report to the Board at the first available Board meeting after each Committee meeting. Urgent matters are escalated by the Committee Chair to the Board as appropriate. The Board has agreed, in conjunction with the Council of Governors, the strategic objectives for the Trust. The Executive Directors have assessed the risks to their achievement, along with risk controls and assurance mechanisms. As part of this risk assessment process, gaps in controls and assurances have been highlighted. This information is incorporated in the Trust's Board Assurance Framework document reviewed regularly by the Board of directors.

Audit and Risk Committee
The Audit and Risk Committee is responsible for establishing an effective system of internal control and risk management and provide an independent assurance to the Board. The Committee takes an overview of the organisation's governance activity supported by the internal auditors who provide opinions on compliance with standards and the systems of internal control. The Committee ensures that any recommendations from these audits are implemented. The Committee also reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework. The Committee has oversight of, and relies on the work of the Risk and Compliance Group to monitor the risk management process and risk registers. The Committee has oversight of expressions of concern and whistleblowing arrangements and also receives assurance on the arrangements for

counterfraud activity within the Trust, including the outcome of any referrals and investigations.

Quality and Safety Committee
The Quality and Safety Committee monitors selected quality metrics, and ensures that the Trust has robust systems in place to learn from experience. It receives reports on areas of risk e.g. Safeguarding: Information Governance; Patient Safety, Serious Incidents and assures itself that Group Governance is assuring themselves on the quality of their services. The Quality Committee is chaired by a Non- Executive Director and reports to the Board of directors.

People Committee
The People Committee has been newly established and scrutinises work to manage and mitigate the risks relating to the recruitment, retention, support and development of our people. The Committee is chaired by a non-executive director and reports to the Board of directors.

Finance Digital and Performance Committee
The Finance, Digital and Performance Committee scrutinises the financial risks and targets and any significant risks to activity and performance. The Committee is responsible for ensuring that there are robust financial control procedures in place. The Finance and Performance Committee is chaired by a Non-Executive Director and reports to the Board of directors.

Joint Health and Safety Committee
The Committee includes management and staff side. 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 chief operating officer, whose role includes being the designated lead director for health and safety. The chief operating officer is supported in this role by the resilience and governance manager.

Internal Audit
The Internal Audit reports issued in the year have given significant assurance that there is a generally sound system of internal control. However, some weakness in the design and/or inconsistent application of controls put the achievement of certain objectives at risk.

There were 18 completed internal audit reports in 2018/19. There were 12 reports with significant or high assurance and five where an opinion was not required. One internal audit received limited assurance - Asset Utilisation – Radiology. Action plans and progress is reported in detail to each subsequent Audit and Risk Committee meeting as part of Internal Audit's follow-up process. For the finalised reports there has been significant progress has

been made in implementing the action plans in many of the individual audit report areas. Any areas where there has not been sufficient progress are called in for review by the Audit and Risk Committee. There have been no ‘Low Assurance’ reports this year.

External Audit
External audit provides independent assurance on the accounts, annual report, Annual Governance Statement and on the Annual Quality Report. These documents and internal and external audits of specific areas of internal control provide the Board of directors with the information it requires to gain assurance that the Trust is meeting its objectives to protect patients, staff the public and other stakeholders against risks of any kind: which allows the Board to support me in signing this Annual Governance Statement. The Auditor provided a clean unqualified audit opinion on 28 May 2019.

Review and assurance mechanisms are in place and the 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.

Conclusion
The system of internal control has been in place in Airedale NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

In summary I am assured that the NHS foundation trust has an overall sound system of internal controls in place, which is designed to manage the key organisational objectives and minimise the NHS foundation trust's exposure to risk. There are however weaknesses in the system which are being addressed. The Board of directors is committed to continuous improvement and enhancement of the system of internal control.

I am assured that:
- The Board, executive director and senior management have identified and are managing the risks facing the trust, with the escalation of risk events, an effective process for keeping risks scores up to date and flagging any risk and control concerns;
- There is an appropriate risk management framework embedded in the trust;
- The internal auditors and other independent assurance providers to the trust, including external audit, have identified no major concerns from their risk focused programme of independent assurance.

My review therefore confirms no significant internal control issues have been identified for the year ending 31 March 2019.

Brendan Brown
Chief Executive

28 May 2019

CHAPTER 3
QUALITY REPORT

NHS
Airedale
NHS Foundation Trust

Quality Report

2018-19

About Airedale NHS Foundation Trust

Airedale NHS Foundation Trust provides acute and community services to a population of over 220,000 from an area covering some 700 square miles across West and North Yorkshire and East Lancashire. Care and treatment is provided from our main site at Airedale General Hospital. Community services are provided from locations which include Coronation Hospital in Ilkley and Skipton Hospital as well as health centres and general practices. We employ over 2,500 staff, including a community based workforce and have approximately 400 volunteers.

Contents

Part 1: Statement on quality from the Chief Executive

1.1 Introduction

I am proud to have the opportunity to introduce the annual Quality Report, my first as Chief Executive of Airedale NHS Foundation Trust. The report explains the quality of care we offer and how we are seeking to improve this. Our ambitions, achievements and the challenges that we face are reflected in this report.

Against a backdrop of financial constraint and unprecedented demand linked to increasing numbers of older people with complex health and care needs, collaboration between health and social care organisations is vital if we are to deliver high quality, personalised and join-up care that meets individual circumstances – the "Right Care". The last year has seen us working as part of the West Yorkshire Association of Acute Trusts and the West Yorkshire and Harrogate Health and Care Partnership to bring the contributions of GPs, district nurses, social workers, mental health providers, care homes, voluntary organisations and local hospitals into a single integrated care system which meets the national ambitions of the NHS Ten Year Plan. We have scrutinised services where we already work collaboratively with Bradford Teaching Hospitals NHS Foundation Trust – such as stroke and vascular services – to provide a basis in the future to make patient pathways more clinically effective and sustainable.

Before I joined the Trust I was aware of the Airedale Digital Hub's well-deserved reputation for innovation and its tangible outcomes for patients and families. Through assistive technologies the Hub provides a single point of access to all aspects of specialist health and social care advice, for example, to care homes and those patients at the end of life via our Gold Line Service.

Part of our goal of making treatment and care seamless across primary, secondary and ultimately social care is through the effective use of an electronic patient record. Our Digital Hub can access GP records – SystmOne – to ensure information about a patient is up to date, avoiding delays and minimising risk. From April 2018 SystmOne became the primary record in the hospital setting.

Delivering modern healthcare from a hospital over 40 years old can be a challenge. This year has seen the completion of a new £7 million Acute Assessment Unit – an integrated Acute Medical, Surgical Assessment, and Ambulatory Care Unit. This follows on from other dynamic infrastructure projects in recent years which endeavour to optimise clinical decision-making and patient flow whilst supporting safe and dignified standards of care.

In establishing the new Acute Assessment Unit staff worked tirelessly to maintain the provision of care and treatment for our community whilst ensuring training and orientation were effective. With recognised national shortages within staffing groups and specialisms it has never been more important to cherish our most valuable asset – our staff. Across services I have been impressed by the commitment of staff and volunteers to quality improvement and would like to take this opportunity to thank them all for their resilience and professionalism.

The Care Quality Commission undertook its annual Well-led and Core Service Inspection at the close of 2018, selecting Critical Care, Medical Care, Surgery and Urgent and Emergency Care and Diagnostics for review. We were rated as "Good" for the 'Responsive', 'Caring', and 'Effective' domains, and "Requires Improvement" for 'Safe' and 'Well-led'. Overall our quality rating stayed the same – "Requires improvement". Inspectors recognised that we have made progress since our last inspection, but identified areas where further and more rapid improvement is required, including nurse and medical staffing levels and skill mix, and how well leaders improve the quality of services and safeguard high standards of care. Steps are being taken to address all required actions and recommendations, many of which are detailed in this report.

I hope the Quality Report provides you with a clear picture of how important quality improvement, patient safety and patient and carer experience are to us all at the Foundation Trust. Although we have further work to do there is much to be proud of as highlighted at our annual Pride of Airedale awards and recognised at a national level. The Trust was named for the seventh time one of the top 40 performing hospitals by CHKS. This is a national patient safety award by an independent provider of healthcare intelligence.

Other quality achievements and initiatives over the last twelve months include:

- *97% of inpatients rated our care as excellent or very good and 99% across Community Service.*
- *Appointment of a Head of Collaboration for Stroke to improve stroke services for the population of Bradford and Airedale.*
- *Opening in August 2018 of a new pathology blood sciences laboratory as part of a complete renovation of Pathology to meet increasing demand for services across Airedale and Bradford.*
- *Extended funding for the ACE2 cancer pilot site to establish a "one stop shop" designed to give patients with cancer symptoms rapid access to diagnostic tests.*
- *Provision of a mobile cancer care unit. Funded as part of a partnership with the Hope for Tomorrow charity, the unit is the first of its kind in the North of England and offers treatment – such as chemotherapy – in remote areas thereby avoiding lengthy travel time for patients who may feel unwell.*
- *Successful achievement of Joint Advisory Gastrointestinal Endoscopy Accreditation.*
- *The Trauma and Resuscitation Team Skills (TaRTS) course – evidence based resource developed at Airedale and now being implemented in other hospitals – singled out by the CQC as outstanding practice.*
- *Running of Diabetes made easy educational sessions across the district with a particular area of focus on engagement with the South Asian community.*
- *National Midwifery Council registration of the first cohort of nursing associates in January 2019. We are a national pilot site for this programme.*

1.2 Signed declaration

It is important that our Quality Report is accurate and presents an honest picture of our care. We seek to foster an open and transparent culture so we can understand where improvements are needed. I am pleased to confirm that the Board of Directors has reviewed the 2018/19 Quality Report. As Chief Executive of Airedale NHS Foundation Trust, I can confirm that the information used and published in the Quality Report is, to the best of my knowledge, accurate and complete.

Brendan Brown,
Chief Executive
Airedale NHS Foundation Trust
30th May 2019

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

We remain committed to providing the *"Right Care"* – high quality care that is safe, clinically effective, compassionate and responsive to the needs of individual patients and their families – as set out in our *Quality Improvement Strategy* and the Trust's *Annual Plan*. The following provides a brief review of quality outcomes against our quality and safety aims.

Harm free care

We have been named as one of the top five hospitals for patient safety in the CHKS Top Hospitals programme 2018 – the only trust in the North of England. This is in recognition of our performance in providing a safe hospital environment for patients and is based on a range of 16 indicators, including rates of hospital-acquired infections and mortality.

Harm occurs when care is sub-optimal either as the result of something we did or did not do for the patient. According to the NHS Safety Thermometer indicator around 94 per cent of our patients receive harm free care. Regrettably however, this year the Trust reported three Never Events: wrong site surgery (wrong site block); retained guidewire in a central line; and, wrong site interventional radiology procedure.

Never Events are serious, largely preventable patient safety incidents that should not occur, with a high potential for severe harm or death. In collaboration with NHS Improvement these events have been reviewed and key objectives to improve system reliability and underpinning processes are being enacted: the consistent application of *Five Steps to Safer Surgery*; the roll out of *Steps to Safer Interventional Procedures*, simulation testing to embed practice; and, the introduction of human factors training across the organisation. To further communicate key messages, three Quality Summits have been held over the year bringing together clinical and non-clinical staff groups across the organisation and our wider partners in recognition of the responsibility we all have in delivering a safe healthcare environment for patients, visitors and colleagues.

Of the incidents reported in the period April to September 2018, 98.8 percent were categorized as low or no harm. Open forum discussions on quality and safety are held regularly by the Medical and Nursing Directors where staff can offer personal insight and raise concerns. Having a safety culture is dependent on an open culture. The Freedom to Speak up Guardian offers an important means for staff to voice patient safety concerns.

The 2018 *NHS National Staff Survey* indicates that Trust's safety culture has significantly improved since the previous survey. Scores for staff confidence and security in reporting and addressing unsafe clinical practice are better than the national average with staff reporting that our organisation treats those involved in an incident fairly. According to the 2018 Care Quality Commission inspection report, there is a strong focus within the organisation on learning and improvement. However, the 'Safe' domain was rated as "*Requires improvement*" with the following issues highlighted for attention:

- Staffing levels and skill mix;
- Initial assessment of patients and review of inpatient risk assessments;
- Mandatory training compliance for medical staff;
- Adherence to the Safer Surgery checklist;
- Record keeping (including document control and storage); and,
- Assessment and management of patients with mental health needs.

Inspectors were not assured services had adequate oversight of these concerns. This is not what we aspire to for our patients and key findings have been incorporated into an overarching *Quality Improvement Action Plan* for progression.

Infections as a result of healthcare interventions for the fiscal year are: one case of hospital acquired MRSA bacteraemia and five cases of C.*difficile* (all of which were found upon investigation to be unavoidable). C.*difficile* infection per 100,000 bed days in Trust patients aged 2 or over is below the England average based on available figures.

Patient Safety Alerts are published by NHS England regularly, warning hospitals about practices that are potentially unsafe. The warnings recommend a date by which changes to practice should be implemented. The Trust has closed all alerts issued in the preceding twelve months in the applicable time frames.

Patient complaints can offer insight into safety related problems which may not be identified via incident reporting or case note review. In the last year we reported 56 formal complaints compared to 59 in the preceding period. This is the lowest number reported in the last five years. Across England in the preceding fiscal year, hospital and community services saw a decrease in formal complaints of 3.3 per cent with Yorkshire and Humber recording a reduction of almost one per cent. Over the last year no complaints were either upheld or partially upheld by the Health Service Public Ombudsman.

Through monitoring complaints, the Trust aims to support managers to make swift improvements. A newsletter – *Quality and Safety Matters* – highlighting learning from complaints and incidents is circulated to staff each month to reinforce learning.[1] For example:

You said … *"Planned surgery was cancelled due a failure to ensure the availability of appropriately trained staff."*

We did ... To prevent further re-occurrence, specialist teams are now fully involved in the planning meetings.

You said … *"Lighting around payment meters in the car park is poor. With the shorter winter days, visitors felt vulnerable and potentially at risk."*

We did ... *Installed additional lighting."*

The latest CQC inspection highlighted that we do not always respond to and close complaints within our target of 40 days; action is being taken to ensure our service is responsive. In October 2018 Healthwatch Bradford and the Independent Published Complaints Advocacy Team undertook a survey to investigate the experience and views of 97 people regarding the healthcare complaints process across the Bradford district. Whilst it is not possible to determine within the report specific issues that relate to Airedale NHS Foundation Trust, the report recommendations are being worked through.

No avoidable mortality

Key mortality measures – Summary Hospital-level Mortality Indicator and the Hospital Standardised Mortality Ratio – show performance for the Trust within the expected range.

The Trust has responded to the recommendations from NHS England's (2017) *National Guidance on Learning from Deaths* which highlighted variable responses across the country as to how deaths are investigated and families treated. Led by the Medical Director, processes continue to be reviewed and encapsulated in a dedicated *Responding to and Learning from Deaths Policy*. This year we have drawn on national guidance to evaluate how we care for and involve bereaved families and carers following a patient's death. The guidance complements a broader programme of work – the implementation of the Duty of Candour, evaluation of organisational systems when families seek to address their concerns – to ensure engagement is meaningful and individualised.

Under Regulation 28, the Coroner has a legal duty to issue a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. The Trust received one such notification over the last year in which the Coroner directed that

[1] Detailed analysis and learning from complaints can be found in the complementary statutory annual *Complaints and Concerns Report 2018/19* available in June 2019 at: http://www.airedale-trust.nhs.uk/about-us/publications/complaints-report/ [accessed 28/02/19].

procedures at hospital discharge for those patients neurologically assessed with head injuries are reviewed. An action plan has been developed and shared with the Coroner.

Innovative real-time quality intelligence

To drive forward and monitor improvement, meaningful patient information and clinical intelligence is essential. Alongside other acute services across Yorkshire and Humber, the Trust was successful in a joint bid to become a Local Health and Care Record Exemplar (LHCRE) site. Each partnership will receive up to £7.5 million to fully develop inter-operability between the various distinct clinical information technology (IT) systems.

From April 2018 SystmOne became the principal record in the hospital setting. Through the use of SystmOne shared primary and secondary healthcare record access, information can be accessed securely across care settings to obtain a tailored view of an individual's health information. This development is part of our goal for a shared electronic patient record across primary, secondary and ultimately social care which will improve the accuracy of clinical information and services to patients.

Developments in the last year include:

- Collaboration with TPP, the software supplier of SystmOne, to:
    - Transfer the Maternity Service primary patient record to SystmOne; and,
    - Enable the recording of observations for inpatient calculation of early warning scores (NEWS2) and automated escalation for deteriorating patients.
- Permitting of prescriptions recorded in the Emergency Department (ED) to be automatically transferred to the inpatient chart via the Electronic prescribing and medicine administration (EPMA) system.
- Implementation of a SystmOne ED e-triage.
- E-observations pilot project to use smart devices and apps as part of care.
- Switching from paper referrals to e-referrals to allow greater flexibility for patients to book, change and cancel appointments.
- Roll out across wards and departments of an e-QUIP Asset Management system as a repository for recording medical device training and compliance.

No avoidable delays in care

NHS England has indicated that instances of delayed transfers of care from hospital to other care settings are increasing across the country. This has an impact on the flow of patients through the hospital. The *Improving Patient Co-ordination and Flow Programme* is part of our transformational work to focus on the *"whole system flow".* That is, to look beyond the hospital setting, to redesign pathways of care to avoid unnecessary admissions whilst improving hospital throughput. Emphasis is placed on the integration of the contributions of district nurses, social workers, mental health professionals, GPs, care homes and voluntary organisations into one cohesive system.

In 2018 the CQC reviewed 20 local health and care systems to understand how older people move between the health and social care system. The Bradford locality, including our services, was invited to participate.[2] Many of the following initiatives are highlighted in the published report.

The work of the Airedale Digital Care Hub in using enabling technology to provide a single point of access to all aspects of specialist health and social care advice provides the opportunity to reduce unnecessary hospital attendance and GP visits where clinically appropriate. The Multi-Agency Integrated Discharge Team (MAID) is located on the Digital Care Hub; the team brings together the Case Management Team and the Intermediate Care Hub and focuses on a systematic and planned approach to discharge.

[2] CQC (2018) Beyond Barriers: How older people move between health and social care in England. Available at: https://www.cqc.org.uk/publications/themed-work/beyond-barriers-how-older-people-move-between-health-care-england [Accessed 25/08/18]

Allied to these services, a series of initiatives have been implemented to improve patient flow and prevent unnecessary waiting for patients including the SAFER patient bundle, recruitment of Flow Facilitators to manage discharge and the "*End PJ Paralysis*" campaign. The latter aims to mobilise patients and where appropriate, encourage inpatients to dress in normal day wear to keep patients active and reduce the risk associated with bed rest such as muscle atrophy. The *2017 CQC Adult Inpatient Survey* results show significant improvement in patients' experience of the time between arrival at the hospital and getting a bed on a ward. However, there remains aspects around leaving hospital where patient experience could be improved though better dialogue between healthcare professionals and patients and carers and greater support and information on how to manage health conditions.

In partnership with commissioners, the innovative Red Bags Pathway was launched in 2018. The bags contain key paperwork, medication and personal items all of which travel with patients from care homes to hospital. The aim is to ensure care home residents who attend hospital attend with vital information that could help healthcare professionals make informed decisions. Such initiatives are part of our wider partnership work with care home providers and local authority services.

The new Acute Assessment Unit opened in spring 2018 and allows rapid access to appropriate staff, diagnostic tests, clinical treatments and enhanced multi-disciplinary working. This vision and how it has helped patient flow has been showcased in NHS Improvement's *Action on A&E*, a yearbook illustrating achievements across the North of England.[3]

In spite of this and other initiatives including seven day opening of the Ambulatory Care Unit, appointment of a Patient Flow Matron, *"Get Me Home"* multi-agency meetings every day to review complex discharges and the establishment of a Winter Room during the busiest months, multiple pressures across the whole health and care system continue to affect the delivery of services. In the last 12 months, we have not been able to consistently deliver national standards including the six week diagnostic standard and ED maximum waiting time of four hours from arrival to admission, transfer or discharge. We apologise for not achieving these important quality standards. We know that sustaining a low wait time remains a key factor in providing high quality and responsive care. However, in this measure and other key standards – waiting times for cancer and referrals to treatment – the Trust regularly performs better that the England average.[4]

People – workforce

Having the right number and mix of staff with the appropriate skills, at all times, is integral to providing safe, high-quality care. The 2018 Care Quality Commission inspection has highlighted concerns about nurse and medical staffing levels with unfilled shifts for registered nurses in some clinical areas and gaps in medical cover in the ED and out of hours within Critical Care.

The care of patients is of the utmost importance and a series of robust mechanisms monitor nurse, midwifery and medical staffing levels. Actual and planned staffing rates are cross-referenced with key quality markers, patient acuity and bed occupancy, to ensure patient safety is maintained. However, there are recognised national and local workforce shortages and not exclusively amongst nurses and doctors. There is a national deficit in, for example, trained sonographers and in other clinical roles. The situation is further compounded by increasing demands on services by an ageing population. We are therefore keen to address the supply challenges and the findings in the CQC inspection by continuing to take all possible actions to recruit, retain and mitigate for medical and nursing staff vacancies.

Where possible unstaffed capacity is proactively filled with locum and bank staff to

[3] Available at: http://intranet.anhst.nhs.uk/TeamCentre/Communications/Misc/Yearbook%20-%202018%20(LR).pdf [Accessed 23/11/18]

[4] BBC NHS Performance Tracker [current at 13/12/18]

ensure that safe staffing levels and staffing skill mix is maintained across clinical areas at all times. A priority in the coming year is to review the process for booking bank and agency staff. Active recruitment of additional doctors, nurses and allied health professionals remains ongoing. In collaboration with colleagues across the health and social care and through our *People Plan* we continue to review staff roles and responsibilities and evaluate different ways of clinical working. For instance and as part of the Stroke Collaboration Project, our medical, nursing and therapy staff and those from Bradford Teaching Hospitals NHS Foundation Trust have undertaken shifts at each other's sites. The Trust is participating in Health Education England's Nursing Associate Programme to build capability, offer an improved career pathway and strengthen workforce retention.

Other initiatives to release nursing time include: Acute Assessment Flow Co-ordinator, Discharge Liaison Officers, and Pharmacy Assistants to support the administration of medication to patients. The responsibilities of Healthcare Support Workers (HCSW) have been reviewed to enhance nursing support through, for example, the taking and recording of vital signs. An apprentice HCSW quarterly cohort scheme has been introduced.

There is a team of Advanced Clinical Practitioners working across the Acute Assessment Unit and on specialist wards to provide advanced clinical skills to the level of a junior doctor. The training is comprehensive and clinically supervised by consultant medical staff. Post-graduate Physician Associates are being recruited to support doctors in the diagnosis and management of patients.

The introduction of an electronic staff roster supports the utilisation of staff in the most clinically effective and efficient way possible. A Guardian of Safe Working ensures junior doctor trainees are protected against protracted working hours and receive the training, supervision and support required.

In terms of doctors the Trust is: exploring the potential for further international recruitment to fill gaps at consultant and middle tier level; has introduced Trust grade doctors to fill junior doctor gaps; and is implementing the Associate Specialist Grade and other senior level appointments to attract and retain key employees. However, it is equally important that we respond to workforce supply challenges in other areas. So in healthcare science we are recruiting graduate scientists, supporting the provision of training of the Healthcare Scientist to undertake extended and advanced roles whilst also developing and nurturing talent within the existing Healthcare Scientists.

We are also taking similar actions with Allied Health Professionals, in Pharmacy and across corporate services, with a focus on enhancing skills in role and developing new roles supported by effective recruitment strategies. In Community Services we offer student placements in support of longer-term employment. This work is captured in the Trust's *People Plan*. By involving employees in decision making, valuing diversity and inclusion, looking after the health and well-being of people, and developing and nurturing their talent we aim to make the Trust a great place to work.

It is important to acknowledge that for existing staff there is an increased level of pressure with the potential to affect staff morale and well-being. Staff must feel valued and have the ability to progress and maintain skills, through for example attendance at mandatory training. Effective leadership to ensure there is ongoing support is seen as fundamental. With the arrival of the new Chief Executive, governance has been identified as a key area of immediate focus.

Governance and Leadership

In the 2018 CQC inspection the 'Well-Led' domain was rated as "*Requires improvement*". In order to provide clarity to those individuals working within an organisation, it is vital there is effective and robust leadership with a common vision and purpose, supported by clear governance arrangements and accountability.

Over the last year the leadership team has overseen a series of improvements, not least

in the organisational culture and in the visibility of management. A key area of focus has been our complex governance structure which is not always understood within the organisation. The assessment and escalation of risk has been evaluated to ensure all work is ultimately overseen by one of the Board committees. These committees act to assure the Board of Directors that the organisation is running effectively and safely.

Strategic leadership, previously strengthened through the establishment of a triumvirate for each service group composed of a Clinical Director, Head of Nursing or Midwifery and Assistant Director of Operations, has been further augmented through the appointment of two Deputy Medical Directors for Integrated Care and Children's Services and Surgery, Critical Care, Diagnostics and Women's Services. The aim is to align Trust strategy as set out in the *Annual Plan*, to specific service group ambitions and ensure objectives share a common purpose.

Our *People Plan*, which offers practical guidance to managers through a leadership and coaching programme – *Consistently Good Line Manager Conversations Toolkit* –, has been refreshed. Much focus in the last year has been on the annual appraisal process to ensure everyone has an effective review aligned to our ambitions and "*Right Care*" values and behaviours. In relation to medical staff, the Trust continues to report high appraisal completion rates.[5] Our goal remains to develop leaders with the required skills at every level of the organisation.

Open communication and a common purpose is encouraged through the promotion of a learning culture. Quality and Safety Walk-round programme is part of a dynamic cycle of improvement, promoting dialogue between staff, patients and the senior executive team with the aim of increasing openness and communication.

The annual anonymous *National NHS Staff Survey*[6] (published by NHS England) helps us to improve the working lives of all our staff. On the basis of last year's survey results, we have focussed in the last 12 months on improving:

- The quality of appraisals and non-mandatory training and development;
- The experience of staff in Estates and Facilities, Pharmacy, Radiology, Theatres and new administration teams;
- Improving leadership and line management;
- Addressing the experience of disabled colleagues; and,
- Responding to concerns relating to bullying, harassment and abuse.

Results from the 2018 *NHS Staff Survey* indicate improvements across a range of questions. Overall the Trust is above average compared to other acute providers across England in eight of the ten key themes, which cover areas such as health and wellbeing, line managers, morale, inclusion, working in a safe environment, safety culture and staff engagement. Statistically significant improvement was reported by staff when compared to last year in relation to immediate managers and safety culture.

The Trust scored above the national average as a place to work and for the standard of care for friends and relatives. There are some areas where staff would like to see further improvements. We know that almost everyone had an appraisal this year, but that the quality of appraisals is inconsistent. Some staff reported that they are not satisfied with the quality of care or work they are able to deliver. This appears to be due to system and workforce pressures, but we need to understand this better and ensure staff are either involved in, or understand, ongoing initiatives across the system and at Airedale to respond to these challenges. Results are reviewed at the People Committee, which is a sub-committee of the Trust Board, for them to consider and agree areas of focus for the year ahead. Trust-wide actions will be included in our refreshed *People Plan*.

[5] *Medical Revalidation and Responsible Officer Annual Report* to NHS England July 2018 Board of Directors public meeting
[6] NHS *Staff Survey 2017* is available from: http://www.nhsstaffsurveys.com/Page/1064/Latest-Results/2018-Results/ [Accessed 26/02/19]

Part 2: Priorities for improvement and statements of assurance from the Trust Board

How we engage with others in developing our quality goals

At the monthly Board of Directors' meeting, the first agenda item is, by agreement, a patient story told from the perspective of patient and family. The 2018 *NHS Staff Survey* places the Trust above average amongst acute providers for the number of staff reporting the effective use of patient/service user feedback. According to the recent findings of the CQC inspection, there is *"positive engagement with patients, staff, public and local organisations to seek feedback as a way to improve services*."[7]

The views of our patients, staff and local partner organisations are important and we receive feedback via a number of methods including: surveys such as the Friends and Family Test, patient and staff stories, compliments, complaints and concerns, social media, Patient Safety and commissioner Quality Walk rounds, listening events and Healthwatch enter and view visits. This feedback provides us with vital information with which to improve services.

Our volunteers and the Council of Governors play an invaluable role in representing the views and interests of the local community; their engagement work informs and guides our "*Right Care*" vision. Where a patient group is not well represented, efforts are made to seek feedback. Our Youth Forum now meets regularly to offer a young person's perspective on our services. For those patients or individuals who have complex communication needs and/ or whose views are seldom heard, specific engagement events and focus groups are arranged for example, the Diabetes Made Easy education sessions. Our Maternity Service is part of a new partnership – Maternity Voices Partnership – bringing together health professionals and women in Bradford District and Craven to give voice to local people and groups, including the black, Asian and minority ethnic (BAME) communities.

The Board of Directors continues to work closely with colleagues at neighbouring providers, local commissioning groups, Healthwatch and local authorities as well as across the wider region – via the West Yorkshire and Harrogate Health and Care Partnership – to make sure we listen to our local communities and provide health and social care that meets the needs of the Airedale, Wharfedale and Craven population. The last year has seen us working with the voluntary community group Exclusively Inclusive which works to reduce social isolation. The group presented to the Board of Directors in November 2018.

2.1 Priorities for improvement 2018/19

Selected quality priorities reflect national and local goals as well as current performance and have been approved by the Board of Directors. In last year's *Quality Report*, we identified our three key local quality priorities for this fiscal year. These are listed below with detailed information on how we performed set out in this section of the *Quality Report*:

2.1.1 Patient experience: *improving the quality of wound care for patients both in hospital and the community;*

2.1.2 Patient Safety: *improve the prevention, early identification and management of Acute Kidney Injury; and,*

2.1.3 Clinical Effectiveness: *the management of sepsis.*

We also committed to reporting on a number of aspects of improvement work within the three domains of quality. Our progress and

7 CQC Airedale NHS Foundation Trust Inspection Report available from: https://www.cqc.org.uk/sites/default/files/new_reports/AAAH9765.pdf [Accessed 18/03/19].

performance over the last year for the following quality goals is reported in **Part 3** of this report:

3.1 Patient experience:

- *Improving care for patients living with dementia;*
- *Privacy and dignity:*
  - *Promotion of a customer services culture; and,*
  - *A patient-led care environment.*

3.2 Patient safety:

- *Infection prevention and control;*
- *Reduction of slips, trips and falls sustained by patients admitted to our hospital wards; and,*
- *Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care).*

3.3 Clinical effectiveness:

- *Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions;*
- *The monitoring of Caesarean section rates through the optimisation of opportunities for physiological birth; and,*
- *Fractured neck of femur improvement project.*

Future priorities for 2019/20

1. **Patient experience:** *improving the care and support for people with mental health needs*

The latest CQC inspection highlights concerns about the assessment and management of patients with mental health needs, particularly within the Emergency Department. Gaps in out of hours mental health liaison meant some patients who arrived in the night (ED and as an inpatient) were still waiting next morning. Quality improvement work will focus on how we can ensure the needs of this vulnerable patient group are considered and delivered through an improved and integrated service. Progress including performance metrics will be set out in a Mental Health Strategy currently under development and monitored by the Quality and Safety Committee.

2. **Patient Safety:** *fall prevention* (formerly Reduction of slips, trips and falls sustained by patients admitted to our patient wards).

3. **Clinical Effectiveness:** *management of sepsis.*

Other local quality improvement work identified for inclusion in the 2019/20 Quality Report is as follows:

3.1 Patient experience:

- *Improving the quality of wound care for patients both in hospital and the community;*
- *Improving care for patients living with dementia*; and,
- *Privacy and dignity: promotion of a customer services culture.*

3.2 Patient safety:

- *Infection prevention and control;*
- *Improve the prevention, early identification and management of Acute Kidney Injury; and,*
- *Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care).*

3.3 Clinical effectiveness:

- *Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions;*
- *The monitoring of Caesarean section rates through the optimisation of opportunities for physiological birth; and,*
- *Fractured neck of femur improvement project.*

Following review, the creation of a patient-led care environment is judged to be a fundamental aspect of all the above priorities and will therefore be encompassed in future updates. Thus dementia environmental adaptations will be contained in the priority 'Improving care for patients living with dementia'.

2.1.1 Priority 1 patient experience: improving the quality of wound care for patients both in hospital and the community

The challenge and our aim

The care we provide to patients who have or develop wounds can fundamentally improve the quality of their lives. According to the National Institute for Health Research, there are approximately 79,500 people in England who have a complex wound at any one time; healing can take months, years or never happen at all. Research evidence demonstrates that over 30 per cent of chronic wounds – identified as wounds that have failed to heal for four weeks or more – do not receive a full wound assessment. This can contribute to ineffective treatment and further delay wound healing for patients. Through the provision of standardised care based on research and best practice, patients have the greatest opportunity for healing.

Working collaboratively between primary care, community and the hospital setting the Trust, alongside commissioners and partner organisations, aims to ensure there is an integrated and individualised programme of treatment to support wound healing and garner the associated benefits. Selection of this priority builds on patient feedback on quality improvement initiatives across the local health and social care system to prevent and effectively manage pressure area care.

How we monitor progress

Key actions and milestones are monitored via the Community Services' Quality and Safety meeting and reported through the Integrated Performance Review meeting. Progress is measured through the 2017-19 national CQUIN - Improving the assessment of wounds – with the objective being to increase the number of patients who have a full assessment of chronic wounds.

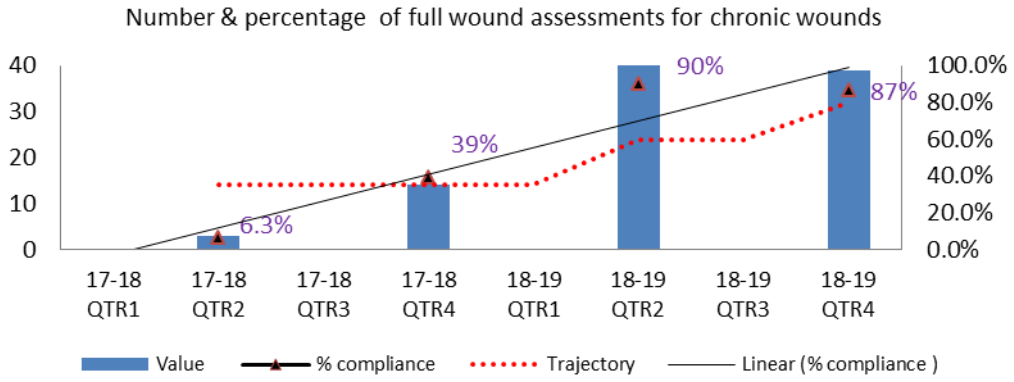
Current status

Over the last two years Community Services in collaboration with Bradford District Care Foundation NHS Trust has undertaken an audit of the number of wounds that have failed to heal within four weeks and the number of wound assessments completed. This initial review conducted in 2017 found 6.3 per cent of the Trust's district nursing applicable patient group had a full wound assessment. An incremental trajectory for improvement has been agreed: namely, that by March 2019, 80 per cent of wounds that have failed to heal within four weeks will have a comprehensive wound assessment. Progress is illustrated in the following chart and indicates the target was met six months ahead of schedule with latest results showing 87 per cent of the Craven patient group receiving a full wound assessment.

The number of full wound assessments undertaken is denoted by the blue bar for each audit of a district nursing caseload of patients meeting the chronic wound criteria. The black triangle indicates the percentage compliance achieved. The red broken line designates the threshold target of 35 per

cent in 2017/18, stretching to 60 percent at by the end of September 2018 and 80 per cent by March 2019. The service gained and has maintained compliance from March 2018.

Figure 1: Number and percentage of full wound assessments for chronic wounds



Data source: *Performance Team – national CQUIN submission.*

In tandem with above, review of patient case notes registered within the Airedale, Wharfedale and Craven locality to evaluate the quality of care and treatment has highlighted areas requiring greater consideration: the effect of medication on wound healing, the impact on quality of life, including social isolation, and, greater attention to potential systemic infection.

Initiatives and progress in 2018/19

Baseline review and ongoing audit inform the local strategies adopted across providers and the Airedale, Wharfedale and Craven locality to reduce this burden of harm, and include the following key actions:

- Delivery of holistic wound assessment training across all relevant Community Service teams.
- Evaluation of the SystmOne configuration to improve the quality of data capture. A SystmOne wound assessment template has been developed based on best practice. Following an initial delay in access experienced by Community Services, this is now available across the district. Limitations of the system have been identified e.g. inclusion of those patients with more than one wound. To support compliance, it is not possible to proceed through the assessment without completing all relevant stages.
- Review of wound associated templates in use across district providers to address completion of each component of the comprehensive wound assessment.
- Uniform and consistent approach to using photography to monitor progress.
- Systematic dissemination of findings at various meetings and forums.

To improve the delivery of holistic skin and wound assessment within the acute setting, the following work has been undertaken:

- A Skin Assessment and Wound Care Plan is now embedded on the ward areas.
- Establishment of a joint wound care Formulary aligned with Community Services and Bradford District Care Foundation NHS Trust.
- Implementation of a Skin Tear Pathway to support accurate assessment and appropriate treatment.
- The acute wound care Formulary is currently under review.

The overall objective is to ensure continuity in the use of creams and dressings, a more accurate assessment of a wound and ultimately increased healing time. In support of this, quarterly wound care study days are available to all staff as is bespoke training for specific departments.

Next steps

- Configuration of SystmOne to ensure a seamless transfer of care at the point of admission and/or discharge.
- Link the findings and recommendations with other quality improvement work streams, such as the management of sepsis and the completion of the Malnutrition Universal Screening Tool (MUST) score.
- Continue to work to achieve nationally set absolute levels of performance based on the assessment of national data returns and review of the latest evidence.
- Planning is underway to develop a Tissue Viability Nurse cupboard which will stock specialist dressings to ensure patients have appropriate and timely care to prevent dressing wastage and improve overall patient experience.

2.1.2 Priority 2 patient safety: improve the prevention, early identification and management of Acute Kidney Injury

The challenge and our aim

Acute kidney injury (AKI) is a sudden episode of kidney failure or kidney damage that happens within a few hours or days, usually as a complication of another serious illness. AKI causes a build-up of waste products in the blood making it difficult for the kidneys to correct the balance of fluid in the body. It usually occurs without symptoms making it difficult to identify. It is estimated that one in five emergency admissions into hospital are associated with AKI and that up to 40,000 excess deaths per year in hospital are due to AKI.[8] Up to 30 per cent of these deaths may be potentially avoidable.[9] Whilst there has not been any local patient engagement as such in the local prioritisation of this work, patients have fed into the national initiatives with our staff participating in in the National Confidential Enquiry.

In recognition that early detection and management has a profound effect upon patient outcomes we seek in collaboration with our "*Right Care*" partners to raise awareness with the aim of reducing the number of patients who develop AKI across the locality. More specifically within the hospital the aim is a reduction in preventable hospital acquired acute kidney injury.

How we monitor progress

[8] Wang H, E, Muntner P, Chertow G, M, Warnock D, G, Acute Kidney Injury and Mortality in Hospitalized Patients. Am J Nephrol 2012;35:349-355

[9] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [2009] Adding Insult to Injury

A multi-disciplinary AKI Task and Finish Group has been established, chaired by a Consultant in Acute Medicine, to measure the quality improvement, co-ordinate the work streams and consider where additional work is required. Progress is monitored by the clinical groups and reported across the Trust's Integrated Performance Review meeting.

Current status

The primary aim of NHS England's acute kidney programme "*Think Kidneys"* is to reduce the risk of acute kidney injury. To do so, establishing local and national data collection and audit is paramount.

- A standardised data flow via the implementation of a nationally agreed algorithm for laboratory information management systems for the early detection of AKI has been established. Our Pathology Service is one of the 72 per cent of laboratories across England reporting AKI warning stage test results to the UK Renal Registry.
- A patient outcome baseline review for the period February to April 2017 was undertaken by the clinical lead. Of the total number of acute admissions, eight per cent of admitted patients (sample 522) had a diagnosis of AKI. Differentiating patients with a hospital acquired AKI from patients that had an AKI on arrival to hospital is more complex than first appreciated, in part as the hospital code *"hospital acquired"* is seldom used. As a result we have not been able to identify a robust informatics solution to quickly and reliably assess progress. Currently it is necessary to access individual patient records via the pathology reporting system.
- A mortality case note review undertaken over the last year by the Mortality Review Group highlighted the challenge of identifying patients with a hospital acquired AKI from patients with AKI on arrival, making assessment of care and treatment difficult. Of the five AKI deaths reviewed, it was noted that the AKI 8 tool was appropriately completed. Themes identified related to the End of Life pathway and communication with relatives and between specialists.

Initiatives and progress in 2018/19

Following the introduction of a care bundle – AKI 8 – in September 2017 (planned to align with the junior doctor changeover), and an underpinning education programme, a pilot commenced on the Acute Medical Unit in October 2017. In response to clinician feedback the AKI8 tool was re-designed this year and re-formatted as the AKIR3. It was re-launched on the Acute Assessment Unit with support from consultants. Although a snap audit showed reasonable uptake with completing the form to some degree, compliance with action points was poor and informal feedback remains that clinicians see the form as cumbersome and unhelpful. It has not been rolled out further.

Detailed review of AKI within the trust showed no evidence of benefit following introduction of either the AKI8 or AKI R3. The evidence base for AKI care bundles leading to a measurable improvement in either AKI incidence or clinical outcome remains weak.

The setting up of "sick day rules" on SystmOne i.e. guidance on temporary cessation of medicines to patients deemed at high risk of AKI based on an individual risk assessment.

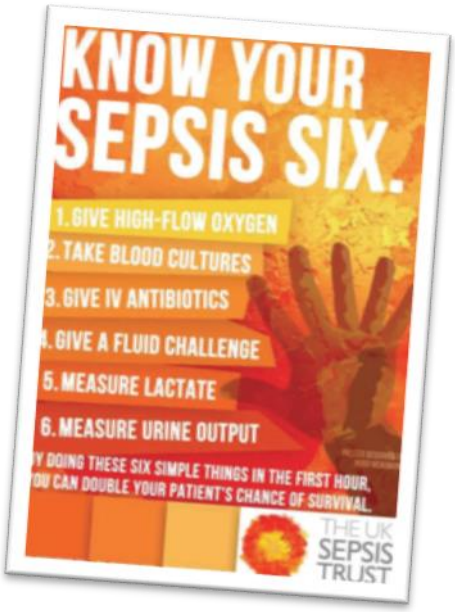
.

Next steps

It is thought that two of every three cases of AKI are already present before hospital admission. In those cases that develop in hospital there may be factors that link to primary care such as a delayed admission with acute illness or inappropriate prescribing. The GP Clinical Director has taken on the AKI clinical lead to progress initiatives in the coming year. Through working with community partners it is hoped a preventative approach can be fostered to improve clinical practice and patient outcomes.

2.1.3 Priority 3 clinical effectiveness: management of sepsis

The challenge and our aim



Sepsis is a common and potentially life-threatening condition where the body's immune system overacts to an infection. Affecting all age groups, sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 35,000 deaths attributed to sepsis annually.[10] Reports by the Parliamentary and Health Service Ombudsman have highlighted problems in the detection and treatment of sepsis. [11] Sepsis is a key national priority for NHS England and local commissioning groups. Whilst there has not been any local patient engagement as such, patients have fed into the national toolkit and staff have participated in the Healthcare Quality Improvement Partnership as part of the Clinical Outcome Review Programme's *Sepsis Study*.

The Trust seeks to embed identification and treatment of sepsis in line with national guidance for the Commissioning for Quality and Innovation (CQUIN).

How we monitor progress

Progress is measured and reported through the joint CQUIN *Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)* indicator. NHS England and NHS Improvement believe that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint CQUIN supports a coherent approach within provider organisations towards reducing the impact of serious infections whilst at the same time reducing the likelihood of the development of strains of bacteria that are resistant to antibiotics. Key actions and milestones are monitored by the Clinical Groups and reported at the Integrated Performance Review meeting.

Current Status

A range of actions are recommended for rapid implementation when a patient presents with sepsis known as the Sepsis Six Bundle. The UK Sepsis Trust and others have developed the concept of the 'Sepsis Six' – a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring – to be instituted within one hour by non-specialist practitioners at the front line.[12] It is the prompt administration of antibiotics which is regarded as the most crucial action in the prevention of morbidity and mortality. The Trust has adopted tools for the screening and initial management of sepsis. The national CQUIN has four components. (The fourth arm concerns the reduction in use of antibiotics and is discussed in section *3.2.1 Infection Prevention and Control*.) The first three components are:

---

[10] Royal College of Physicians (2014) Acute Care Toolkit 9: Sepsis https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_9_sepsis.pdf. [Accessed 23/10/18]

[11] Parliamentary and Health Service Ombudsman, *Time to Act. Severe sepsis: rapid diagnosis and treatment saves lives sepsis.* Available at: https://www.ombudsman.org.uk/publications/time-act-severe-sepsis-rapid-diagnosis-and-treatment-saves-lives-0 [Accessed 23/10/18]

[12] http://www.survivingsepsis.org/bundles/Pages/default.aspx [Accessed 23/10/18]

1. Screening for sepsis (Emergency Department and hospital inpatients)

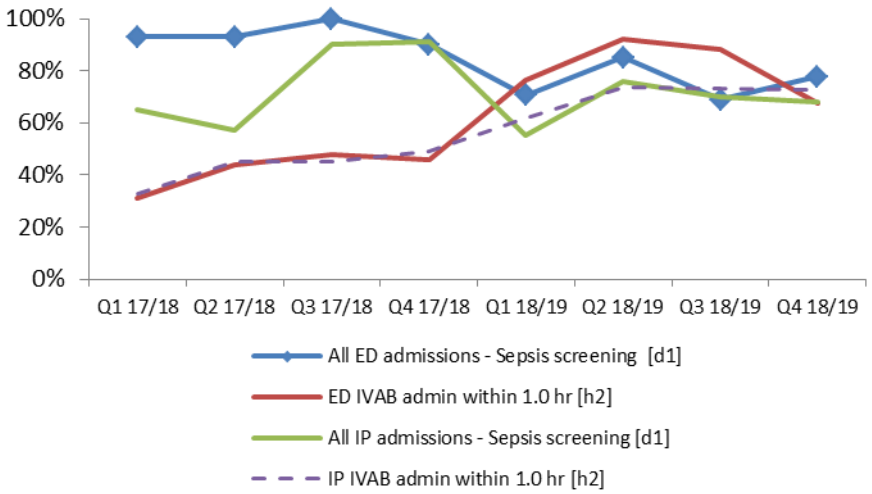
Each month a random sample of ED patients – adult and children – and inpatients who present with symptoms associated with sepsis are reviewed to assess the proportion that are screened.

2. Administration of antibiotics (Emergency Department and hospital inpatients)

Retrospective case note review of a random sample of ED and acute adult inpatients where clinical codes indicate sepsis are reviewed each month. One of its purposes is to understand the level of compliance with the one hour local protocol for the administration of intravenous antibiotics.

The chart below shows ED and hospital inpatient performance against these measures. It must be noted that t the CQUIN now specifies one hour from the time seen by the decision-making clinician, rather than our previous measure of one hour from arrival. This allows us more accurate comparison with other providers who have already been using the clinician-to-antibiotic timing for some time. This does not affect our aspiration to give antibiotics as soon as is appropriate in the patient journey, and the ED nursing staff are empowered to seek immediate review of patients if they are concerned about red flag sepsis.

Figure 2: Percentage compliance with screening and administration of antibiotics



Data source: *Performance Team – national CQUIN submission.*

3. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

To reduce both total and inappropriate antibiotic usage in hospitals, a competent healthcare professional is required to review the antibiotic prescription within three days of commencement to determine if it is still needed, and if so, if the appropriate antibiotic is being used. This is important as antimicrobial resistance continues to increase and is a major healthcare risk. Based on a quarterly review of 30 patients, the average compliance for the fiscal year is 65.5per cent [combined results] with an observed quarter on quarter improvement in performance.

The Intensive Care National Audit Research Centre (ICNARC) provides useful measures and insight. In 2017/18 the number of high risk sepsis admissions to the Unit is below the national average. Risk adjusted mortality is within the expected range.

Initiatives in 2018/19 to achieve progress

The priority in the last year has been part 2b of the CQUIN: administration of antibiotics within one hour. A number of initiatives to help achieve this are in development, including Sepsis Trolleys in key areas and an education and training programme in intravenous administration and the fostering of a culture of responsibility within the prescriber of the antibiotics.

Emergency scenarios – for example, recognising sepsis – are regularly enacted in the clinical environment, utilising a high fidelity manikin and actual clinical teams to ensure the experience is as realistic as possible. The primary objective is the identification of latent risks –staff knowledge – which can then be addressed.

Electronic triage (e-triage) is now used within SystmOne for the ED as part of a phased electronic patient record. Sepsis screening has been built into this (similar to the AAU model). We hope that this will prompt earlier summoning of a clinician to assess the need for IV antibiotics.

A National Early Warning Score (NEWS), developed by the Royal College of Physicians to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients, was updated in December 2017. The chronic hypoxia sub chart helps to better tailor escalation to baseline oxygen levels in those with respiratory disease. It includes the addition of delirium to the consciousness sub chart, and the reinforcement of the value of aggregate scores versus single parameter extreme recordings. The NEWS2 chart was launched across the acute setting in July 2018.

Other work includes:

- Extending the use of SystmOne screening to other acute units for example, Surgery;
- Embedding the use of SystmOne when a patient becomes septic on the ward;
- Provision of training for nursing staff across the Trust;
- Review of adverse events with reference to the categories to understand where the deficiencies are –
  - Delay in recognition of sepsis;
  - Delay in delivery of intravenous antibiotics;
  - Delay in the delivery of the Sepsis Six (others); and,
  - Delay in senior review/ongoing management.
- Expansion of the Sepsis Champion role across the Trust.

Review of patient case notes by clinical leads is ongoing with the objective of improving screening and the administration of antibiotics. The first sepsis themed mortality case note review took place in December 2018.

Up to April 2017 it has been recognised at national level that coding for sepsis and systemic inflammatory response syndrome (SIRS) is challenging with a lack of consistency for clinical coding practice for sepsis between providers. Recent national changes to coding for sepsis are designed to improve data quality. The Coding Department continues to work closely with clinical leads to improve the accuracy of coding.

Next steps

- Scoping the potential for Patient Group Direction to enable the Outreach Team to administer an immediate dose of antibiotics;
- An electronic Observation System is being developed and soon to go live across the Trust. Automatic flag for Sepsis Review will eventually be part of this system for those patients with NEWS2 greater than five;
- Further themed mortality case note review;

- Embedding of Sepsis Champions across Trust; and,
- Ongoing development of the ED e-triage system, with continuous developments from TPP supporting progress.

In addition to the above, the CQC has tasked the Trust with ensuring the paediatric sepsis pathway documentation – introduced in 2017 – is initiated and completed.

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 2018/19 Airedale NHS Foundation Trust provided and/or sub-contracted 77 relevant health services [as per NHS Improvement's Provider License].

The Airedale NHS Foundation Trust has reviewed all the data available to them on the quality of care in 77 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 90.0 per cent of the total income generated from the provision of relevant health services by the Airedale NHS Foundation Trust for 2018/19.

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 2018/19, 48 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 98 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 2018/19 are as follows: see tables 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in during 2018/19 are as follows: see table 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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 enq

2.1.1 Priority 1 patient experience: improving the quality of wound care for patients both in hospital and the community

The challenge and our aim

The care we provide to patients who have or develop wounds can fundamentally improve the quality of their lives. According to the National Institute for Health Research, there are approximately 79,500 people in England who have a complex wound at any one time; healing can take months, years or never happen at all. Research evidence demonstrates that over 30 per cent of chronic wounds – identified as wounds that have failed to heal for four weeks or more – do not receive a full wound assessment. This can contribute to ineffective treatment and further delay wound healing for patients. Through the provision of standardised care based on research and best practice, patients have the greatest opportunity for healing.

Working collaboratively between primary care, community and the hospital setting the Trust, alongside commissioners and partner organisations, aims to ensure there is an integrated and individualised programme of treatment to support wound healing and garner the associated benefits. Selection of this priority builds on patient feedback on quality improvement initiatives across the local health and social care system to prevent and effectively manage pressure area care.

How we monitor progress

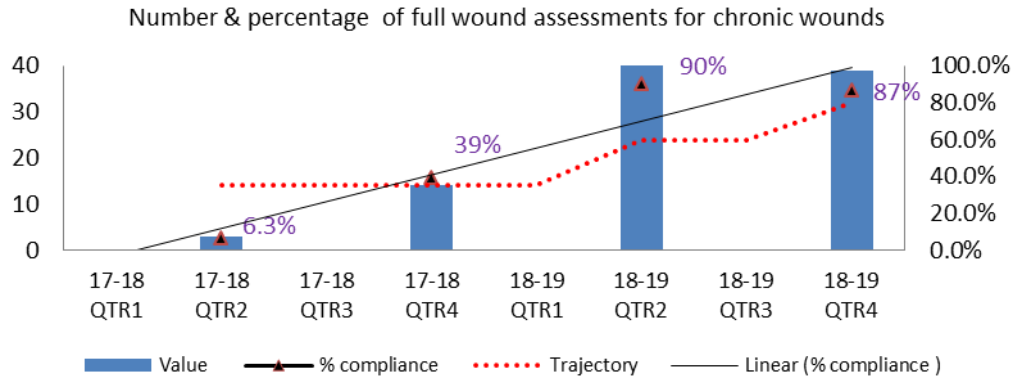
Key actions and milestones are monitored via the Community Services' Quality and Safety meeting and reported through the Integrated Performance Review meeting. Progress is measured through the 2017-19 national CQUIN - Improving the assessment of wounds – with the objective being to increase the number of patients who have a full assessment of chronic wounds.

Current status

Over the last two years Community Services in collaboration with Bradford District Care Foundation NHS Trust has undertaken an audit of the number of wounds that have failed to heal within four weeks and the number of wound assessments completed. This initial review conducted in 2017 found 6.3 per cent of the Trust's district nursing applicable patient group had a full wound assessment. An incremental trajectory for improvement has been agreed: namely, that by March 2019, 80 per cent of wounds that have failed to heal within four weeks will have a comprehensive wound assessment. Progress is illustrated in the following chart and indicates the target was met six months ahead of schedule with latest results showing 87 per cent of the Craven patient group receiving a full wound assessment.

The number of full wound assessments undertaken is denoted by the blue bar for each audit of a district nursing caseload of patients meeting the chronic wound criteria. The black triangle indicates the percentage compliance achieved. The red broken line designates the threshold target of 35 per cent in 2017/18, stretching to 60 percent at by the end of September 2018 and 80 per cent by March 2019. The service gained and has maintained compliance from March 2018.

Figure 1: Number and percentage of full wound assessments for chronic wounds



Data source: *Performance Team – national CQUIN submission.*

In tandem with above, review of patient case notes registered within the Airedale, Wharfedale and Craven locality to evaluate the quality of care and treatment has highlighted areas requiring greater consideration: the effect of medication on wound healing, the impact on quality of life, including social isolation, and, greater attention to potential systemic infection.

Initiatives and progress in 2018/19

Baseline review and ongoing audit inform the local strategies adopted across providers and the Airedale, Wharfedale and Craven locality to reduce this burden of harm, and include the following key actions:

- Delivery of holistic wound assessment training across all relevant Community Service teams.
- Evaluation of the SystmOne configuration to improve the quality of data capture. A SystmOne wound assessment template has been developed based on best practice. Following an initial delay in access experienced by Community Services, this is now available across the district. Limitations of the system have been identified e.g. inclusion of those patients with more than one wound. To support compliance, it is not possible to proceed through the assessment without completing all relevant stages.
- Review of wound associated templates in use across district providers to address completion of each component of the comprehensive wound assessment.
- Uniform and consistent approach to using photography to monitor progress.
- Systematic dissemination of findings at various meetings and forums.

To improve the delivery of holistic skin and wound assessment within the acute setting, the following work has been undertaken:

- A Skin Assessment and Wound Care Plan is now embedded on the ward areas.
- Establishment of a joint wound care Formulary aligned with Community Services and Bradford District Care Foundation NHS Trust.
- Implementation of a Skin Tear Pathway to support accurate assessment and appropriate treatment.
- The acute wound care Formulary is currently under review.

The overall objective is to ensure continuity in the use of creams and dressings, a more accurate assessment of a wound and ultimately increased healing time. In support of this, quarterly wound care study days are available to all staff as is bespoke training for specific departments.

Next steps

- Configuration of SystmOne to ensure a seamless transfer of care at the point of admission and/or discharge.
- Link the findings and recommendations with other quality improvement work streams, such as the management of sepsis and the completion of the Malnutrition Universal Screening Tool (MUST) score.
- Continue to work to achieve nationally set absolute levels of performance based on the assessment of national data returns and review of the latest evidence.
- Planning is underway to develop a Tissue Viability Nurse cupboard which will stock specialist dressings to ensure patients have appropriate and timely care to prevent dressing wastage and improve overall patient experience.

2.1.2 Priority 2 patient safety: improve the prevention, early identification and management of Acute Kidney Injury

The challenge and our aim

Acute kidney injury (AKI) is a sudden episode of kidney failure or kidney damage that happens within a few hours or days, usually as a complication of another serious illness. AKI causes a build-up of waste products in the blood making it difficult for the kidneys to correct the balance of fluid in the body. It usually occurs without symptoms making it difficult to identify. It is estimated that one in five emergency admissions into hospital are associated with AKI and that up to 40,000 excess deaths per year in hospital are due to AKI.[13] Up to 30 per cent of these deaths may be potentially avoidable.[14] Whilst there has not been any local patient engagement as such in the local prioritisation of this work, patients have fed into the national initiatives with our staff participating in in the National Confidential Enquiry.

In recognition that early detection and management has a profound effect upon patient outcomes we seek in collaboration with our "*Right Care*" partners to raise awareness with the aim of reducing the number of patients who develop AKI across the locality. More specifically within the hospital the aim is a reduction in preventable hospital acquired acute kidney injury.

How we monitor progress

[13] Wang H, E, Muntner P, Chertow G, M, Warnock D, G, Acute Kidney Injury and Mortality in Hospitalized Patients. Am J Nephrol 2012;35:349-355

[14] National Confidential Enquiry into Patient Outcome and Death (NCEPOD) [2009] Adding Insult to Injury

A multi-disciplinary AKI Task and Finish Group has been established, chaired by a Consultant in Acute Medicine, to measure the quality improvement, co-ordinate the work streams and consider where additional work is required. Progress is monitored by the clinical groups and reported across the Trust's Integrated Performance Review meeting.

Current status

The primary aim of NHS England's acute kidney programme "*Think Kidneys"* is to reduce the risk of acute kidney injury. To do so, establishing local and national data collection and audit is paramount.

- A standardised data flow via the implementation of a nationally agreed algorithm for laboratory information management systems for the early detection of AKI has been established. Our Pathology Service is one of the 72 per cent of laboratories across England reporting AKI warning stage test results to the UK Renal Registry.
- A patient outcome baseline review for the period February to April 2017 was undertaken by the clinical lead. Of the total number of acute admissions, eight per cent of admitted patients (sample 522) had a diagnosis of AKI. Differentiating patients with a hospital acquired AKI from patients that had an AKI on arrival to hospital is more complex than first appreciated, in part as the hospital code *"hospital acquired"* is seldom used. As a result we have not been able to identify a robust informatics solution to quickly and reliably assess progress. Currently it is necessary to access individual patient records via the pathology reporting system.
- A mortality case note review undertaken over the last year by the Mortality Review Group highlighted the challenge of identifying patients with a hospital acquired AKI from patients with AKI on arrival, making assessment of care and treatment difficult. Of the five AKI deaths reviewed, it was noted that the AKI 8 tool was appropriately completed. Themes identified related to the End of Life pathway and communication with relatives and between specialists.

Initiatives and progress in 2018/19

Following the introduction of a care bundle – AKI 8 – in September 2017 (planned to align with the junior doctor changeover), and an underpinning education programme, a pilot commenced on the Acute Medical Unit in October 2017. In response to clinician feedback the AKI8 tool was re-designed this year and re-formatted as the AKIR3. It was re-launched on the Acute Assessment Unit with support from consultants. Although a snap audit showed reasonable uptake with completing the form to some degree, compliance with action points was poor and informal feedback remains that clinicians see the form as cumbersome and unhelpful. It has not been rolled out further.

Detailed review of AKI within the trust showed no evidence of benefit following introduction of either the AKI8 or AKI R3. The evidence base for AKI care bundles leading to a measurable improvement in either AKI incidence or clinical outcome remains weak.

The setting up of "sick day rules" on SystmOne i.e. guidance on temporary cessation of medicines to patients deemed at high risk of AKI based on an individual risk assessment.

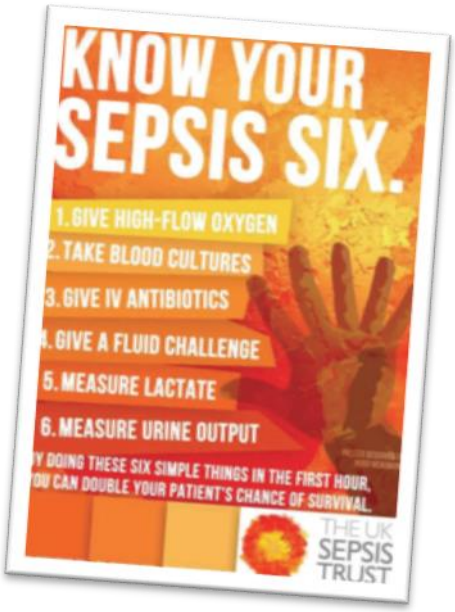
.

Next steps

It is thought that two of every three cases of AKI are already present before hospital admission. In those cases that develop in hospital there may be factors that link to primary care such as a delayed admission with acute illness or inappropriate prescribing. The GP Clinical Director has taken on the AKI clinical lead to progress initiatives in the coming year. Through working with community partners it is hoped a preventative approach can be fostered to improve clinical practice and patient outcomes.

2.1.3 Priority 3 clinical effectiveness: management of sepsis

The challenge and our aim



Sepsis is a common and potentially life-threatening condition where the body's immune system overacts to an infection. Affecting all age groups, sepsis is recognised as a significant cause of mortality and morbidity in the NHS, with around 35,000 deaths attributed to sepsis annually.[15] Reports by the Parliamentary and Health Service Ombudsman have highlighted problems in the detection and treatment of sepsis. [16] Sepsis is a key national priority for NHS England and local commissioning groups. Whilst there has not been any local patient engagement as such, patients have fed into the national toolkit and staff have participated in the Healthcare Quality Improvement Partnership as part of the Clinical Outcome Review Programme's *Sepsis Study*.

The Trust seeks to embed identification and treatment of sepsis in line with national guidance for the Commissioning for Quality and Innovation (CQUIN).

How we monitor progress

Progress is measured and reported through the joint CQUIN *Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)* indicator. NHS England and NHS Improvement believe that the issues of sepsis and antimicrobial resistance are complementary and that developing and implementing a joint CQUIN supports a coherent approach within provider organisations towards reducing the impact of serious infections whilst at the same time reducing the likelihood of the development of strains of bacteria that are resistant to antibiotics. Key actions and milestones are monitored by the Clinical Groups and reported at the Integrated Performance Review meeting.

Current Status

A range of actions are recommended for rapid implementation when a patient presents with sepsis known as the Sepsis Six Bundle. The UK Sepsis Trust and others have developed the concept of the 'Sepsis Six' – a set of six tasks including oxygen, cultures, antibiotics, fluids, lactate measurement and urine output monitoring – to be instituted within one hour by non-specialist practitioners at the front line.[17] It is the prompt administration of antibiotics which is regarded as the most crucial action in the prevention of morbidity and mortality. The Trust has adopted tools for the screening and initial management of sepsis. The national CQUIN has four components. (The fourth arm concerns the reduction in use of antibiotics and is discussed in section *3.2.1 Infection Prevention and Control*.) The first three components are:

---

[15] Royal College of Physicians (2014) Acute Care Toolkit 9: Sepsis https://www.rcplondon.ac.uk/sites/default/files/acute_care_toolkit_9_sepsis.pdf. [Accessed 23/10/18]

[16] Parliamentary and Health Service Ombudsman, *Time to Act. Severe sepsis: rapid diagnosis and treatment saves lives sepsis.* Available at: https://www.ombudsman.org.uk/publications/time-act-severe-sepsis-rapid-diagnosis-and-treatment-saves-lives-0 [Accessed 23/10/18]

[17] http://www.survivingsepsis.org/bundles/Pages/default.aspx [Accessed 23/10/18]

4. Screening for sepsis (Emergency Department and hospital inpatients)

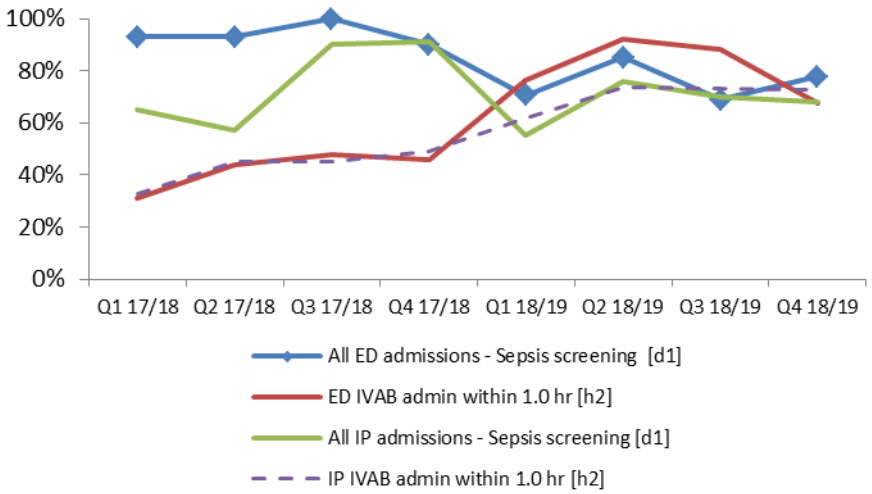
Each month a random sample of ED patients – adult and children – and inpatients who present with symptoms associated with sepsis are reviewed to assess the proportion that are screened.

5. Administration of antibiotics (Emergency Department and hospital inpatients)

Retrospective case note review of a random sample of ED and acute adult inpatients where clinical codes indicate sepsis are reviewed each month. One of its purposes is to understand the level of compliance with the one hour local protocol for the administration of intravenous antibiotics.

The chart below shows ED and hospital inpatient performance against these measures. It must be noted that t the CQUIN now specifies one hour from the time seen by the decision-making clinician, rather than our previous measure of one hour from arrival. This allows us more accurate comparison with other providers who have already been using the clinician-to-antibiotic timing for some time. This does not affect our aspiration to give antibiotics as soon as is appropriate in the patient journey, and the ED nursing staff are empowered to seek immediate review of patients if they are concerned about red flag sepsis.

Figure 2: Percentage compliance with screening and administration of antibiotics



Data source: *Performance Team – national CQUIN submission.*

6. Assessment of clinical antibiotic review between 24-72 hours of patients with sepsis who are still inpatients at 72 hours.

To reduce both total and inappropriate antibiotic usage in hospitals, a competent healthcare professional is required to review the antibiotic prescription within three days of commencement to determine if it is still needed, and if so, if the appropriate antibiotic is being used. This is important as antimicrobial resistance continues to increase and is a major healthcare risk. Based on a quarterly review of 30 patients, the average compliance for the fiscal year is 65.5per cent [combined results] with an observed quarter on quarter improvement in performance.

The Intensive Care National Audit Research Centre (ICNARC) provides useful measures and insight. In 2017/18 the number of high risk sepsis admissions to the Unit is below the national average. Risk adjusted mortality is within the expected range.

Initiatives in 2018/19 to achieve progress

The priority in the last year has been part 2b of the CQUIN: administration of antibiotics within one hour. A number of initiatives to help achieve this are in development, including Sepsis Trolleys in key areas and an education and training programme in intravenous administration and the fostering of a culture of responsibility within the prescriber of the antibiotics.

Emergency scenarios – for example, recognising sepsis – are regularly enacted in the clinical environment, utilising a high fidelity manikin and actual clinical teams to ensure the experience is as realistic as possible. The primary objective is the identification of latent risks –staff knowledge – which can then be addressed.

Electronic triage (e-triage) is now used within SystmOne for the ED as part of a phased electronic patient record. Sepsis screening has been built into this (similar to the AAU model). We hope that this will prompt earlier summoning of a clinician to assess the need for IV antibiotics.

A National Early Warning Score (NEWS), developed by the Royal College of Physicians to standardise the process of recording, scoring and responding to changes in routinely measured physiological parameters in acutely ill patients, was updated in December 2017. The chronic hypoxia sub chart helps to better tailor escalation to baseline oxygen levels in those with respiratory disease. It includes the addition of delirium to the consciousness sub chart, and the reinforcement of the value of aggregate scores versus single parameter extreme recordings. The NEWS2 chart was launched across the acute setting in July 2018.

Other work includes:

- Extending the use of SystmOne screening to other acute units for example, Surgery;
- Embedding the use of SystmOne when a patient becomes septic on the ward;
- Provision of training for nursing staff across the Trust;
- Review of adverse events with reference to the categories to understand where the deficiencies are –
  - Delay in recognition of sepsis;
  - Delay in delivery of intravenous antibiotics;
  - Delay in the delivery of the Sepsis Six (others); and,
  - Delay in senior review/ongoing management.
- Expansion of the Sepsis Champion role across the Trust.

Review of patient case notes by clinical leads is ongoing with the objective of improving screening and the administration of antibiotics. The first sepsis themed mortality case note review took place in December 2018.

Up to April 2017 it has been recognised at national level that coding for sepsis and systemic inflammatory response syndrome (SIRS) is challenging with a lack of consistency for clinical coding practice for sepsis between providers. Recent national changes to coding for sepsis are designed to improve data quality. The Coding Department continues to work closely with clinical leads to improve the accuracy of coding.

Next steps

- Scoping the potential for Patient Group Direction to enable the Outreach Team to administer an immediate dose of antibiotics;
- An electronic Observation System is being developed and soon to go live across the Trust. Automatic flag for Sepsis Review will eventually be part of this system for those patients with NEWS2 greater than five;
- Further themed mortality case note review;

- Embedding of Sepsis Champions across Trust; and,
- Ongoing development of the ED e-triage system, with continuous developments from TPP supporting progress.

In addition to the above, the CQC has tasked the Trust with ensuring the paediatric sepsis pathway documentation – introduced in 2017 – is initiated and completed.

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 2018/19 Airedale NHS Foundation Trust provided and/or sub-contracted 77 relevant health services [as per NHS Improvement's Provider License].

The Airedale NHS Foundation Trust has reviewed all the data available to them on the quality of care in 77 of these relevant health services.

The income generated by the relevant health services reviewed in 2018/19 represents 90.0 per cent of the total income generated from the provision of relevant health services by the Airedale NHS Foundation Trust for 2018/19.

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 2018/19, 48 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 98 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 2018/19 are as follows: see tables 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in during 2018/19 are as follows: see table 3 and 4.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in, and for which data collection was completed during 2018/19, 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 1: National clinical audits undertaken by Airedale NHS Foundation Trust

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
1	Adult Cardiac Surgery	×	N/A	N/A
2	Adult Community Acquired Pneumonia	✓	✓	100
3	BAUS Urology Audits: Cystectomy	×	N/A	N/A
4	BAUS Urology Audits: Female Stress Urinary Incontinence	✓	✓	100
5	BAUS Urology Audits: Nephrectomy	✓	✓	100
6	BAUS Urology Audits: Percutaneous Nephrolithotomy	✓	✓	100
7	BAUS Urology Audits: Radical Prostatectomy	×	N/A	N/A
8	Cardiac Rhythm Management (CRM)	✓	✓	100
9	Case Mix Programme (CMP)	✓	✓	100
10	Elective Surgery (National PROMs Programme) - Hip Replacement	✓	✓	86.8
11	Elective Surgery (National PROMs Programme)- Knee Replacement	✓	✓	93.40
12	Falls and Fragility Fractures Audit Programme (FFFAP) - National Hip Fracture Database	✓	✓	100
13	Falls and Fragility Fractures Audit Programme (FFFAP) - Fracture Liaison Service Database	×	N/A	N/A
14	Feverish Children (care in emergency departments)	✓	✓	100
15	Inflammatory Bowel Disease (IBD)	✓	No	0
16	Major Trauma Audit (TARN)	✓	✓	100
17	Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	✓	✓	100
18	Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	✓	✓	100
19	National Asthma and COPD Audit Programme	✓	✓	100
20	National Audit of Anxiety and Depression	×	N/A	N/A
21	National Audit of Breast Cancer in Older Patients	✓	✓	100
22	National Audit of Cardiac Rehabilitation	✓	✓	100
23	National End of Life Care Audit	✓	✓	100
24	National Audit of Dementia	✓	✓	100
25	National Audit of Intermediate Care	✓	✓	100
26	Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	×	N/A	N/A
27	National Audit of Pulmonary Hypertension National Outcomes and Tertiary Care (specialist centres)	×	N/A	N/A
28	National Audit of Seizures and Epilepsies in Children and Young People	✓	✓	100

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
29	National Bariatric Surgery Registry (NBSR)	×	N/A	N/A
30	Bowel Cancer (NBOCAP)	✓	✓	100
31	National Cardiac Arrest Audit (NCAA)	✓	✓	100
32	National Audit of Rheumatoid and Early Inflammatory Arthritis	✓	✓	100
33	National Audit of Psychosis	×	N/A	N/A
34	National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	×	N/A	N/A
35	National Comparative Audit of Blood Transfusion - Audit of FFP and cryoprecipitate in children and neonates	×	N/A	N/A
36	National Comparative Audit of Blood Transfusion - Massive Haemorrhage	✓	✓	100
37	National Comparative Audit of Blood Transfusion - O Negative	✓	✓	100
38	Congenital Heart Disease (CHD) Adult	×	N/A	N/A
39	National Diabetes Audit - Adults National Core	✓	✓	100
40	National Diabetes Audit - Adults National Footcare Audit	✓	✓	100
41	National Diabetes Audit - Adults National Inpatient Audit	✓	✓	100
42	National Diabetes Audit - Adults National Pregnancy in Diabetes Audit	✓	✓	100
43	National Emergency Laparotomy Audit (NELA)	✓	✓	100
44	National Heart Failure Audit	✓	✓	100
45	National Joint Registry (NJR) Knee Replacement & Hip Replacement	✓	✓	100
46	National Lung Cancer Audit (NLCA) Lung Cancer Consultant Outcomes Publication	✓	✓	100
47	National Maternity and Perinatal Audit	✓	✓	100
48	National Neonatal Audit Programme (NNAP)	✓	✓	100
49	Oesophago-gastric Cancer (NAOGC)	✓	✓	100
50	National Ophthalmology Audit Adult Cataract Surgery	✓	✓	100
51	Diabetes (Paediatric) (NPDA)	✓	✓	100
52	National Prostate Cancer Audit	✓	✓	100
53	National Vascular Registry	×	N/A	N/A
54	Neurosurgical National Audit Programme	×	N/A	N/A
55	Non-invasive Ventilation	✓	✓	100
56	Paediatric Intensive Care (PICANet)	×	N/A	N/A

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
57	Prescribing Observatory for Mental Health (POMH-UK)	×	N/A	N/A
58	Reducing the impact of serious infections (Antimicrobial Resistance and Sepsis)	✓	✓	100
59	Sentinel Stroke National Audit Programme (SSNAP)	✓	✓	100
60	Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	✓	✓	100
61	Seven Day Hospital Services	✓	✓	100
62	Surgical Site Infection Surveillance Service	✓	✓	100
63	UK Cystic Fibrosis Registry	×	N/A	N/A
64	Vital Signs in Adults (care in emergency departments)	✓	✓	100
65	VTE Risk in Lower Limb Immobilisation (care in emergency departments)	✓	✓	100

Exceptions/Comments:

10: Responses received from patients. All patients are offered the opportunity to participate, but not everyone chooses to do so.
11: Responses received from patients. All patients are offered the opportunity to participate, but not everyone chooses to do so.
25: 100 per cent of data for the cases where the Trust opted to submit i.e. home based intermediate care.
31: 100 per cent data submitted from Quarter 3 2018/19 when this audit commenced.
36: Signed up to participate but did not have any massive haemorrhages in the audit period so were unable to submit data.

Where final submission deadlines have not yet passed, the Trust can confirm that data submissions are up to date and a robust system is in place to ensure that all relevant cases are submitted.

Table 2: National Confidential Enquiries (NCEPOD) undertaken by Airedale NHS Foundation Trust

Ref	Title	Eligible	Participation	Per cent eligible patients submitted
1	Cancer in Children, Teens and Young Adults (Child Health Clinical Outcome Review Programme [NCEPOD])	×	N/A	N/A
2	Learning Disability Mortality Review Programme	✓	✓	100
3	Maternal, Newborn and Infant Clinical Outcome Review Programme	✓	✓	100
4	Pulmonary Embolism (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	✓	✓	100
5	Peri-Operative Diabetes (Medical & Surgical Clinical Outcome Review Programme [NCEPOD])	✓	✓	100
6	Mental Health Clinical Outcome Review Programme	×	N/A	N/A
7	National Mortality Case Record Review Programme	✓	✓	100

Data source: Airedale NHS Foundation Trust Clinical Audit Department.

The reports of 34 national clinical audits were reviewed by the provider in 2018/19 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The following is a sample selected on the basis of the 2018 CQC inspection report and its *Insight Report* findings:

Sentinel Stroke National Audit Programme (SSNAP)

Aim: The overall aim of SSNAP is to provide timely information on how well stroke care is being delivered so it can be used as a tool to improve the quality of care that is provided to patients. SSNAP measures both the processes of care (clinical audit) provided to stroke patients, as well as the structure of stroke services (organisational audit) against evidence based standards, including the 2016 National Clinical Guideline for Stroke.

Key successes:
- Joint working with Bradford Teaching Hospital NHS Foundation Trust and commissioners.
- The Community Stroke Team is providing occupational therapy support, including psychological access.
- Early detection of atrial fibrillation via inpatient heart monitoring is in place to support initiating of anticoagulation.
- The latest SSNAP results published in February 2019 show an improvement in the Trust's banding score for both the patient centred and team centred results.

Key issues:
- Therapy staffing levels means there is an inability to provide the required level of rehabilitation. A staffing recruitment process has commenced
- There is no Stroke Early Supported Discharge Team.

National Neonatal Audit Programme (NNAP)

Aim: The NNAP assesses whether babies admitted to neonatal units in the United Kingdom (UK) receive high quality care and identifies areas for quality improvement in relation to the delivery and outcomes of care.

Key successes:
- Generally the unit is average or above against standards. Whilst audit numbers are small so unlikely to be statistically significant, improvement is noted in: the percentage of babies with an admission temperature within the target range; the percentage of mothers that receive antenatal steroids; and, the two year neonatal follow-up rate.

Key issues:
- Previous data suggested that not all eligible mothers were given magnesium sulphate. Review indicated this was a recording issue; latest results show compliance in line with the national average.
- Consultant paediatricians have reviewed how information systems can ensure all patients receive follow up.

National Emergency Laparotomy Audit (NELA)

Aim: Through the provision of high quality comparative data from all providers of emergency laparotomy, NELA aims to enable the improvement of the quality of care for patients undergoing emergency laparotomy.

Key successes:
- Improved proportion of pre-operative documentation of the risk of death for patients undergoing emergency laparotomy; performance is better than the national average.
- The proportion of high risk cases with a consultant surgeon and anaesthetist present in theatre has increased and is above the national average.

Key issues:
- Whilst the majority of highest risk patients are admitted to the Critical Care Unit following emergency laparotomy, results are worse when compared to the national average. This has been highlighted to the service and the wider delivery group.
- Computerized tomography (CT) which has been the subject of local clinical audit (see next section for outcomes).

Severe Sepsis and Septic Shock

Aim: Based on the Sepsis Six, the national audit aims to assess compliance with the Royal College of Emergency Medicine (RCEM) clinical standards for severe sepsis and septic shock to support improved recognition and treatment.

Key successes:
- By the end of 2016 quality focus indicated improved screening levels of 95 per cent using the then measure of a full set of observations and calculation of the National Early Warning Score for ED patients.

Key issues:
- Published in the previous year, 2016/17 data submitted to the national Royal College of Emergency Medicine on the management of sepsis yielded poor results. Subsequent review highlighted data quality input issues which affected ED patient outcomes against fundamental standards. Actions have been taken to ensure validation of data for all RCEM audits.

Intensive Care and National Audit Research Centre (ICNARC)

Aim: Through ongoing participation in the national clinical audit of care for critically ill patients, information is provided that can help improve the standard of our care.

Key successes:
- The Trust continues to submit data to the West Yorkshire Adult Critical Care Operational Delivery Network and reviews this on a monthly basis.
- The 2018 CQC inspection report notes that hospital mortality and non-clinical transfers are within the expected range.

Key issues:
The proportion of non-delayed, out-of-hours discharges to a ward is worse than expected; the Trust is implementing actions to address this.

National Lung Cancer Audit (NCLA)

Aim: The NLCA was developed in response to the finding in the late 1990s that outcomes for lung cancer patients in the UK lagged behind those in other westernised countries and varied between providers.

Key successes:
- Data quality is robust comparing well across the Yorkshire region.
- Availability of stereotactic body radiation therapy (SBRT) has increased overall radiotherapy rates; 15 per cent of patients are now receiving SBRT.
- The proportion of patients with confirmed histology going on to have curative surgery has increased year on year.

Key issues:
- There are no concerns raised by the national audit.

National Bowel Cancer Audit (NBOCA)

Aim: The aim of the National Bowel Cancer Audit (NBOCA) is to measure the quality of care and outcomes of patients with bowel cancer in England and Wales.

Key successes:
- The majority of data is captured although work to enhance data quality is ongoing.
- A high number of laparoscopic surgery cases compared to the national average. Complications and mortality is low.

Key issues:
- Variation in risk assessment grades for patients compared to the national data. The issue has been raised and discussed with anaesthetic colleagues.
- Length of stay post-surgery; it is hoped that a new discharge team strategy will expedite the process.

The reports of 130 local clinical audits were reviewed by the provider in 2018/19 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided.

The following is a sample selected to reflect the range of Trust services, including pathways of care and healthcare professions.

Further actions planned and undertaken in response to audit findings are detailed in the Trust's annual *Clinical Audit Report*.

Doctor's Knowledge of Anaphylaxis Treatment

Aim: To ascertain ongoing knowledge of doctors about anaphylaxis.

Key successes:
- Of the sample of 40 doctors/ advanced nurse practitioners, 85 per cent were aware of the correct treatment.
- Anaphylaxis training is now included in induction for all medical staff and advanced nurse practitioners. Treatment reminders are routinely communicated.

Key issues:
- The need for ongoing training.

Craven Virtual Ward Last Days of Life Follow-up Re-Audit

Aim: To establish whether recommendations for care during the last days of life are being adhered to and documented by health professionals following the implementation of actions identified in a baseline audit conducted in April 2017.

Key successes:
- There is evidence of improvement in the documentation around end of life including full utilisation of the end of life template.
- The proportion of patients with a documented preferred place of death, a Do Not Attempt Cardiopulmonary Resuscitation in place and, a *Comfort and Dignity Plan,* has increased since the last audit with evidence that reversible causes have been considered.

Key issues:
- Nine per cent fewer patients with a documented preferred place of death actually died in that location compared to the 2017 audit.
- There has been a decrease in conversations being documented regarding spiritual beliefs and personal values.

Prescription and Administration of Parkinson's Medications

Aim: To evaluate prescription and administration of medications for those patients with Parkinson's disease.

Key successes:
- The majority of patients had the correct medication doses prescribed on admission.

Key issues:
- Nearly a third of dosages were administered over half an hour early or late. Immediate actions have been taken to ensure that low dose Parkinson's medications in soluble and patch form are available on key wards; a critical timed medication flag has been added on SystmOne; and an education programme for junior doctors and healthcare professionals about Parkinson's disease is available.

Bone Protection Recommendations at Transfer of Care after Hip Fracture in Elderly Patients – Does Orthogeriatic Advice Reach Primary Care?

Aim: To ensure that all elderly patients with fractured neck of femurs have orthogeriatric assessment and that bone protection recommendations are communicated from acute to primary care.

Key successes:
- Results indicate 98 per cent of patients were assessed and reviewed by the Orthogeriatric Team

Key issues:
- 45 of the 100 patients were started on secondary bone protection; 18 were communicated to the GP and three continued on treatment. Identified actions include consideration of SystmOne tasks for notifying GPs about specific patients on discharge; work with Pharmacy to understand how best to ensure medications continue in community; and, establish a Fracture Liaison Service.

Trauma Computerized Tomography (CT) Re-Audit

Aim: A national trauma peer review programme (TARN) raised serious concerns regarding CT scanning performance for trauma patients at Airedale NHS Foundation Trust. It was considered that results did not accurately reflect local performance and an audit was undertaken to understand compliance levels.

Key successes:

- Between 8am and 10 pm, 91 per cent of CT scans for trauma are reported within an hour of request.

Key issues:

- Between 10pm and 8am CT scan reporting guidance levels are not being met; 48 per cent of scans met the 60 minute threshold. This is a decrease on the 2016 result of 93 per cent compliance. Following a recruitment and training programme in April 2018, there has been a 24/7 on-site CT radiographer cover to improve time to CT results out of hours.

Cardiac Rehabilitation Exercise Class Outcome Audit

Aim: To audit the outcomes of Phase 3 cardiac rehabilitation exercise class against national standards.

Key successes:

- The completion rate for cardiac rehabilitation is above nationally reported figures, including in the percentage of patients who have a clinically significant improvement in the shuttle walk test and in the Hospital Anxiety and Depression Scale (HADS) score.

Key issues:

- The HADS is not always completed at initial and final assessment for all patients. Actions have been identified to address this shortfall, including individualised programmes for those patients an increased risk of non-completion.
- Real time input of data has commenced to support more timely analysis.

Audit of Conversions from Day-case Surgery to Inpatient Stay

Aim: To understand why our day case admission rate is high and the extent to which these are potentially avoidable.

Key successes:

- Potential options for reducing the admission rate have been identified including revised Theatre scheduling, new opening times for Ward 20 and nurse-led discharge.
- New fasting guidelines and post-operative urine guidelines have been developed.

Key issues:

- Outstanding actions around the use of fentanyl (rather than morphine for rescue analgesia) and multi-model analgesia anaesthetic techniques.

Bowel Cancer Screening Programme Pathology

Aim: To audit compliance with the operational requirements for departments reporting cases from the NHS Bowel Cancer Screening Programme in particular: the typing of polyps, particularly adenomas; the grading of dysplasia; and, the measurement of polyp size and the avoidance of digit bias.

Key successes:

- The audit demonstrated excellent compliance with national standards and a high quality of diagnostic reporting with due attention to grading, categorisation and measurement.
- All cases are reported within five working days with an average turnaround of 1.8 days.
- Dysplasia grading is consistent with previous audits and within suggested thresholds.

Key issues:

- None identified. Standards are met and no actions required.

2.2.3 Participation in clinical research

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

The number of patients receiving relevant health services provided or sub-contracted by Airedale NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee was 1000.

Airedale NHS Foundation Trust was involved in conducting 71 clinical research studies across all specialties during 2018/19 of which 51 were on the National Portfolio. During 2018/19 Airedale has been commended by the Clinical Research Network for achieving national benchmarks for performance in initiating and delivering research and for exceeding patient recruitment targets.

There were 47 senior clinical staff actively participating in research approved by a research ethics committee at Airedale NHS Foundation Trust during 2018/19, participating in research across 19 clinical specialties. The Trust has been committed to expanding research into new specialties to improve the quality of care and outcomes 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. We aim to offer every patient the opportunity to take part in a clinical trial. This is reflected in the number of research studies undertaken during 2018/19.

In the last three years, Airedale has been formally acknowledged as a contributor to studies reported in 40 publications due to our involvement in National Institute for Health Research portfolio studies. This demonstrates our commitment and desire to improve patient outcomes and experience across the NHS. In addition to this, a further 35 papers arising from academic and own account research have been published in peer reviewed journals since April 2016.

Our engagement in clinical research demonstrates the commitment of Airedale NHS Foundation Trust to improving the quality of care offered to our patients and to making our contribution to wider health improvement leading to better outcomes for patients.

An Airedale Research Education Event was held in November 2018 showcasing some of the research generated.

The following local research project received financial support from the Health Foundation (an independent charity) in 2010. The grant covered clinician and nursing time to set up and administer the programme during its first year. Outcomes of the research were published in 2016.

Impact of a blood management protocol on transfusion rates and outcomes following total hip and knee arthroplasty [18]

N. Frew, D. Alexander, J. Hood, and A. Acornley

Introduction

Preoperative anaemia remains undertreated in the UK despite advice from national agencies to implement blood conservation measures. A local retrospective audit of 717 primary hip/knee replacements in 2008–2009 revealed 25 per cent of patients were anaemic preoperatively. These patients experienced significantly increased transfusion requirements and length of stay. We report the results of a simple and pragmatic blood management protocol in a district general hospital.

Methods

Since 2010 patients at our institution who are found to be anaemic when listed for hip/knee replacement have been offered iron supplementation and/or erythropoietin depending on haemoglobin and ferritin levels. In this study, postoperative blood transfusions,

[18] Ann R Coll Surg Engl. 2016 Jul; 98(6): 380–386. Published online 2016 Jul. doi: 10.1308/rcsann.2016.0139 [accessed 19/07/18]

length of stay and readmissions were assessed retrospectively for all patients undergoing elective primary hip/knee replacement in 2014 and compared with the baseline findings.

Results

During the 12-month study period, 406 patients were eligible for inclusion and none were excluded. Eighty-nine patients (22 per cent) were anaemic preoperatively and sixty-five received treatment. The transfusion rate fell from the baseline levels of 23.0 per cent and 6.7 per cent to 4.3 per cent and 0.5 per cent for hip and knee replacements respectively (p<0.001). The median length of stay reduced from 6 to 3 days (p<0.001) for both hip and knee replacements. The rate for readmissions within 90 days fell from 13.5 per cent to 8.9 per cent (p<0.05).

Conclusions

Preoperative anaemia is common in patients listed for hip/knee replacement and it is associated strongly with increased blood transfusion. The introduction of a blood management protocol has led to significant reductions in transfusion and length of stay, sustained over a four-year period. This suggests that improved patient outcomes, conservation of blood stocks and cost savings can be achieved.

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 2018/19 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 2018/19 and for the following 12 month period are available electronically at: https://www.england.nhs.uk/nhs-standard-contract/cquin/

As part of the drive to improve quality, an amount of funding to be paid to the Trust during 2018/19 for the delivery of services to our patients was dependent upon achieving a range of quality markers. This scheme (CQUIN) linked £3,043,947 of our funding to the delivery of the agreed quality indicators. (This is based on the indicative outturn value for 2018/19.)

During 2018/19 Airedale NHS Foundation Trust delivered CQUINs to the value of £3,002,168 to the satisfaction of our commissioners (to be confirmed).

The monetary total of funding conditional to the delivery of agreed quality indicators in 2017/18 was £2,909,753.

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 2018/19.

Airedale NHS Foundation Trust has participated in special reviews or

investigations by the Care Quality Commission relating to the following areas during 2018/19:

In February 2018 the Care Quality Commission carried out a local systems review in Bradford, where they looked at the flow of over 65-year-olds through the health and social care system. The type of review does not result in a rating, but is designed to understand where improvements can be made. Published in June 2018, the report [2] is generally positive, highlighting how different agencies work collaboratively to keep people safe at home, how we all have a shared purpose, vision and strategy and how well information-sharing is working. There are areas for improvement: access to GPs, better signposting and medicines management after leaving hospital, and quality of domiciliary care. The Bradford and Airedale Health and Wellbeing Board is leading on the identified actions to address areas of shortfall.

The Care Quality Commission undertook its annual inspection a Well-led and Core Service Inspection in November and December 2018. The final report was published in March 2019 with the ratings below. The rating for the safety and well-led domain is "*Requires improvement*" as is the overall Quality summary rating for the Trust.

Ratings for a combined trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Acute	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Community	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016
Overall trust	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019

Ratings for Airedale General Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Medical care (including older people's care)	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Surgery	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Requires improvement Mar 2019	Requires improvement Mar 2019
Critical care	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Maternity	Good Sept 2017	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Sept 2017	Good Sept 2017
Services for children and young people	Good Sept 2017	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Sept 2017	Good Sept 2017
End of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Diagnostic imaging	Requires improvement Mar 2019	N/A	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
Outpatients & diagnostic imaging	Good Aug 2016	N/A	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016
Community health inpatient services	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Community end of life care	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016
Overall*	Good Aug 2016	Good Aug 2016	Good Aug 2016	Good Aug 2016	Outstanding Aug 2016	Good Aug 2016

In February 2019 the Care Quality Commission performed a Review of Services for looked after children in Bradford. The Trust was involved and was subjected to a 2-day on-site visit by the inspection team; at the time of reporting there has been no outcome published.

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

Airedale NHS Foundation Trust intends to take the following action to address the conclusions or requirements reported by the CQC:

In response to the final report the Trust developed a *Quality Improvement Plan* that clearly details the responsible persons along with robust accountability review for sustained compliance with the improvements required. The plan centres not only of the *"must and should do"* recommendations but also on issues identified within the dialogue of the report.

Airedale NHS Foundation Trust has made the following progress by 31st March 2019 in taking such action:

The *Quality Improvement Plan* was developed in response to the CQC *Quality Report* of March 2019 and will be monitored during 2019/20 with added rigor in relation to embedding for consistent and sustained improvements. In addition the Trust has taken the opportunity to review previous CQC reports to identify any outstanding aspects that will be included within the current improvement plan.

The Trust will maintain active communication with the CQC during a programme of relationship meetings and continue to extend invitations to the CQC to attend events and visit clinical areas.

2.2.6 Information on the quality of data

Good data quality underpins the effective delivery of improvements to the quality of patient care. 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 2018/19 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:
99.9 per cent for admitted patient care;
99.4 per cent for outpatient care; and
99.5 per cent for accident and emergency care.
– which included the patient's valid General Practitioner Registration Code was:
95.7 per cent for admitted patient care;
97.5 per cent for outpatient care; and
95.6 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 was formerly used as a system which allowed NHS organisations and partners to assess themselves against national information governance policies and standards. From April 2018 the new Data Security and Protection Toolkit (DSP Toolkit) replaces the Information Governance Toolkit (IG Toolkit). It forms part of a new framework for assuring that organisations are implementing ten data security standards and meeting statutory obligations on both data protection and data security.

As such, it is no longer possible to provide the prescribed regulatory statement and overall score for the Information Governance Assessment Report.
However, the Airedale Foundation Trust Data Security and Protection Toolkit for 2018/19 is published as "Standards Met". Findings are substantiated by a significant assurance rating from third party review.

Clinical Coding error rate

Airedale NHS Foundation Trust was not subject to the Payment by Results clinical coding audit during 2018/19 by the Audit Commission.[19]

However, the Trust was subject in this period to an external Clinical Coding Audit as part of *Data Security and Protection Toolkit* (DSPT) national requirements. The error rate reported for diagnoses and treatment clinical coding was as follows:

- Primary Diagnosis: 5.5 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Diagnosis: 4.8 per cent (DSPT – mandatory required level <20 per cent)
- Primary Procedure: 6.3 per cent (DSPT – mandatory required level <10 per cent)
- Secondary Procedure: 9.1 per cent (DSPT – mandatory required level <20 per cent)

The audit covered a cross-section of all inpatient specialties and across all members of the Clinical Coding Team. The audit reviewed the clinical coding accuracy of 200 finished consultant episodes (FCEs).

[19] NHS Improvement comment: References to the Audit Commission are now out of date because it has closed. From 2014 responsibility for coding and costing assurance transferred to Monitor and then NHS Improvement. From 2016/17 this programme has applied a new methodology and there is no longer a standalone 'coding audit' with errors rates as envisaged by this line in the regulations. It is therefore likely that providers will be stating that they were not subject to "the Payment by Results clinical coding audit" referred to above during 2018/19.

It should be noted that results from clinical coding audits should not be extrapolated further than the actual sample audited.

Airedale NHS Foundation Trust will be taking the following actions to improve data quality as recommended in the audit report:

- All errors found in the audit were fed back to the Coding Team. Any individual training issues have been identified.
- Staffing levels in light of the high FCE to coder ratios remain in view although the low error rates suggest that this is not a major issue despite high FCE per coder ratio.
- The impact of late documentation and non-definitive diagnosis continues to be relayed at monthly speciality clinical governance meetings and to individual consultants.

2.2.7 Learning from Deaths

The Trust has acted on guidance published by NHS Improvement in relation to the *Learning from Deaths Framework*; monitoring and learning from mortality is published each quarter.

During 2018/19; 652 of Airedale NHS Foundation Trust inpatients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:
158 in the first quarter;
148 in the second quarter;
154 in the third quarter;
192 in the fourth quarter.

By 31/03/19, 247 case record reviews and zero investigations have been carried out in relation to the deaths included above.

In zero cases a death was subjected to both a case record review and an investigation.
The number of deaths in each quarter for which a case record review or an investigation was carried out was:
58 in the first quarter;
72 in the second quarter;
58 in the third quarter;
59 in the fourth quarter.

Zero per cent of the patient deaths during the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

In relation to each quarter, this consisted of:
Zero per cent in the first quarter;
Zero per cent in the second quarter;
Zero per cent in the third quarter;
Zero per cent in the fourth quarter.

These numbers have been estimated using *the* Trust Mortality Review Tool; whereby a random 20 sets of medical records are chosen and reviewed by trained reviewers using an on-line tool. Any issues both where learning can be achieved along with excellent care provided are shared within the Mortality Review Group and Speciality Governance for improved care.

The following is a summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the overall inpatient deaths:

There have been a number of themes identified during the process in 2018/19 and these include

- Communication with relatives; this has shown to be excellent during some cases and less good in others; however there are more examples of excellence during 2018/19.
- Variation in the use of the *End of Life Pathway*; there are examples of excellence in a greater number of clinical areas than during 2017/18.
- Clear evidence of good leadership and multi-professional team working resulting in an improved patient and family experience.
- Variation in the recognition and treatment of sepsis, such as time to administer first dose of antibiotics.

As a consequence of what that the Trust has learnt during the reporting period, the following actions have been taken:

- Sharing of monthly learning outcomes with relevant specialty governance leads for discussion and action planning.

- Bespoke discussion following thematic reviews with the specialty for onward cascading of the findings and learning.
- Sharing of excellence in the use of the *End of Life Pathway* and other areas of patient care.
- Sharing of excellence in care by individuals and teams in various trust settings.
- Multi-disciplinary reviewers recruited and trained that has built resilience into the system.
- Bereavement leaflet updated for carers and families with clear guidance regarding raising concerns via PALS in the first instance.

The following actions are proposed following the reporting period:

- Training will continue to be delivered in relation to the challenging conversations for staff in caring for dying patients and their families.
- Additional multi-disciplinary reviewers will be recruited and trained to enable further resilience and support for the review process.

An assessment of the impact of the actions taken by the provider during the reporting period is as follows:

- Improved communication/relationship between governance leads and mortality chair.
- Improved communication/relationship between mortality review group and consultant body.
- Recognition of right care behaviours with examples of excellence flagged to individuals and teams.
- Increased recognition of patients who are dying and with increased use of end of life pathway for dying patients.

Zero case record reviews and zero investigations completed after 01/04/18 related to deaths which took place before the start of the reporting period.

Zero per cent of the patient deaths before the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient.

Zero per cent of the patient deaths during 2017/18 are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2.8 Seven Day Hospital Services

The seven day services programme is designed to ensure patients that are admitted as an emergency receive high quality and consistent care, regardless of whether they are admitted to hospital on a weekday or weekend. Through the provision of a seven day consultant-led acute service there is an opportunity to improve clinical outcomes and deliver a more patient focussed and efficient service; diagnostic equipment, pathology laboratories and operating theatres can be more effectively utilised.

To move toward routine services being available seven days a week, ten clinical standards have been developed, four of which have been identified as priorities on the basis of their potential to positively affect patient outcomes. These are:

- Standard 2 – Specified time to first consultant review
- Standard 5 – Access to diagnostic tests
- Standard 6 – Access to consultant-directed interventions
- Standard 8 – Ongoing specified consultant review by consultant twice daily if high dependency patients, daily for others

Providers have been tasked with implementing these four standards by 2020.

To support quality improvement and measure progress, the Trust is required to submit audit data on a biannual basis to NHS England using an online survey tool. The organisation self-assesses against a compliance threshold of 90 per cent. Results in February 2019 for the period Autumn/ Winter are as follows:

Seven day overall results			
Standard 2	Standard 5	Standard 6	Standard 8
Met	Met	Met	Met
Weekday results			
Standard 2	Standard 5	Standard 6	Standard 8
Met	Met	Met	Met
Weekend results			
Standard 2	Standard 5	Standard 6	Standard 8
Met	Partially met *	Met	Met

Source: *NHS England.*

*Echocardiography is not available; Magnetic Resonance Imaging (MRI) by informal arrangement. Although we meet the standard overall, partial compliance for standard 5 weekend results are in line with national benchmarking.

2.2.9 Sign up to Safety

The patient safety campaign, *Sign up to Safety*, is a national initiative to improve safety and reduce avoidable harm by half. The Trust signed up in 2014 and is committed to creating the right conditions for safer care. We have used the campaign as an opportunity to learn from others. The following are examples of initiatives developed elsewhere that we have implemented locally in the last year:

- A special staff event focusing on our approach to improvement and facilitating learning opportunities. Led by the Organisational Learning and Improvement Team, the key message is that anyone can make improvements.
- Rapid Improvement Events or team-based problem solving designed to focus on process/system problems. Events in the last year have looked at:
  - Complex discharges and how GP referrals for admission are handled to manage patient flow; and.
  - Ways of working and patient pathways within the Acute Assessment Unit.
- A series of Quality Summits focussing on delivering a safe healthcare environment for patients, visitors and colleagues. Key messages were shared via a "Report Learn Share Week", which highlighted aspects of quality and safety from around the Trust.
- The establishment of an Innovation Forum to showcase quality improvement projects – for example implementing medical handovers – and provide an opportunity to discuss with the Organisational Learning and Improvement Team how to start a project and what tools and training is available.

2.2.10 Duty of Candour

In 2014, in response to the inquiry into Mid Staffordshire NHS Foundation Trust, the CQC introduced the statutory duty of candour. The 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. There is an organisational and professional requirement for healthcare providers and registered practitioners to be open with patients and apologise when things go wrong as detailed in the Trust's *Being Open Policy*. The 201Care Quality Commission inspection found that when something went wrong, staff were open and honest and had a good awareness of the Duty of Candour.

Mandatory training is delivered to all clinical and non-clinical staff. Incident monitoring systems are aligned to ensure any incident resulting in moderate harm and above follows the necessary Duty of Candour steps. Annual audit is undertaken to provide assurance of ongoing scrutiny. Over the last year there is one exception: a serious incident where the Trust is unable to complete its obligations in relation to the Duty of Candour owing to this being an ongoing police investigation.

2.2.11 Staff who speak up

In response to the *Gosport Independent Panel Repor*t Airedale NHS Foundation Trust publishes an annual *Freedom to Speak up Guardian Report* on staff who speak up (including whistleblowers).[20]

[20] [20] Detailed analysis and learning from concerns raised can be found in annual *Freedom to Speak up Guardian Annual Report* - latest edition 2017/18: : http://www.airedale-trust.nhs.uk/wp/wp-content/uploads/2018/10/item-12i-FTSU-Annual-report-2017-18-v2.pdf [Accessed 22.01.19]

It is important to cultivate an open and honest culture where reporting concerns is seen as an opportunity to learn. To encourage staff to speak up if they have concerns over quality of care, patient safety or bullying and harassment, the Freedom to Speak up Guardian has focused on collaborative working with employees and their professional representatives, Human Resources as well as Employee Health and Wellbeing. Key actions include:

- Improving visibility through marketing of the role via payslips, posters, screensavers, the Respect and Dignity Campaign, and inclusion in corporate induction, junior doctor training and nursing preceptorship.
- Appointment of a non-executive director with responsibility for speaking up to augment leadership on this issue.
- Supporting employees to raise concerns by improving the skills, knowledge and capability of staff, including managers through a structured mandatory training programme and development of associated resources.

Feedback received from those who have raised concerns has highlighted the need for further work to ensure learning is effectively disseminated and where actions are taken those raising the concern are aware of the outcome and improvements made. This is a key area of ongoing focus.

National data indicates that raising a concern is stressful for individuals; for this reason the Trust approach is part of a wider programme of work to improve the workplace culture and the health and wellbeing of employees through the *People Plan.* Whilst comparatively few concerns are raised anonymously, suggestive of a degree of confidence in the speaking up process, around half of all concerns raised are done so in confidence with the most common reasons being fear of reprisals, a perception that a line manager is complicit and/or a lack of trust in the process. To support employees the following actions have been taken:

- Ensuring that employees suspended from work or leaving the Trust are aware of the work of the Freedom to Speak up Guardian;
- Collection and analysis of data relating to protected characteristics; and,
- Promotion of a zero tolerance approach to anyone suffering disadvantage as a result of raising a concern.

Protect (formerly Public Concern at Work) are experts in whistleblowing and have identified that people from vulnerable groups are the least likely to raise concerns, yet the most likely to report experiencing detriment as a result of raising concerns. Whilst quantitative analysis does not indicate this is an issue for the Trust, this intelligence informs both established inclusion focus group work and initiatives to encourage junior doctors and students to speak up.

2.2.12 Workforce Race Equality Standard

The following measures are included as part of the Workforce Race Equality Standard and are sourced from the *2018 NHS Staff Survey* (published 2018):

- *Indicator 6: The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months.*

For BAME staff 24.8 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to an average of 28.6 per cent across acute providers in England. For white staff, 20 per cent reported experiencing harassment, bullying or abuse from staff in the last 12 months compared to 26.4 per cent across the benchmark group. Results for both groups are about the same as the 2017 survey.

- *Indicator 7: The percentage of staff believing that the Trust provides equal opportunities for career progression or promotion.*

Whilst there is no significant change from 2017 for white staff, with around 90 per cent reporting equal opportunities for career progression, 82.4 per cent of BAME staff reported equal opportunities, an improvement on the 69.5 per cent 2017 return. For both

groups scores compare favourably with the national average for acute providers in England.

The *NHS Constitution* recognises that staff have a right to an environment free from harassment, bullying, aggression and violence. The Trust actively promotes a culture where staff – for example our European and international nurses and doctors – are treated with respect at work and have the tools, training and support to deliver care and the opportunities to develop and progress. BAME, Lesbian, Gay, Bisexual and Transgender (LGBT), Disability and gender inclusion focus groups have been established to support the Trust to become a more inclusive employer, giving voice to the experiences of under-represented groups. We are one of the NHS Employers' Diversity and Inclusion Partners Programme, an initiative to further strengthen this work. This year's Staff Open Day celebrated difference and Equality, Diversity and Human Rights Week hosted two workshops on the theme of exclusion.

The *Workforce Race Equality Action Plan* progresses key issues with specific and measurable actions identified to deliver improvement. The Trust has an *Inclusion Strategy* to help us to become a more encompassing employer. An action plan and annual report overseen by the Board of Directors details the progress made and areas of shortfall such as data collection and analysis, recruitment and development as well as setting out targets for representation and recruitment by 2020. One such initiative is Stepping Up, a leadership development programme for BAME colleagues who work within healthcare. Aimed at BAME leaders and aspiring leaders, the programme is designed for those individuals who want to be involved in creating a transformational change in equality and diversity across the healthcare sector. In a further initiative BAME staff are sharing their insight and lived experience with Board members in support of more inclusive leadership. The reciprocal mentoring scheme facilitates conversations about unconscious bias and the difficulties and barriers faced by BAME colleagues. The aim is to develop a leadership approach across the trust that values the diversity of our workforce.

2.2.13 2018/19 Annual Report on Safe Working Hours: Doctors and Dentists in Training

All doctors in training posts within our Trust are employed under the *2016 Terms of Conditions of Service for NHS Doctors and Dentists in Training (England).* As part of this contract, a Guardian of Safe Working has been appointed to act as champion of safe working hours for doctors in approved training programmes within the Trust and to provide assurance to doctors and employers that doctors are safely rostered and enabled to work in accordance with the revised terms of conditions of service.

As part of these requirements a Guardian of Safe Working Report is presented on a quarterly basis to the (public) Board of Directors. This report includes details of all rota gaps on all shifts and is provided to the local negotiating committee and a newly formed Junior Doctors Forum. In addition it is planned to produce a consolidated annual report – anticipated September 2019 – which will include details of rota gaps and the planned actions for improvement to reduce occurrence. Whilst not timely enough for inclusion in this publication, outcome findings will be reported in the ensuing *Quality Report*. Review of quantitative and qualitative intelligence year to date indicates that trainee doctors are working safely. Where issues have arisen – rostering and induction – the Guardian of Safe Working is working with trainees and departmental leads to identify and implement workable solutions.

2.3 Reporting against core national indicators

To provide a better understanding of comparative performance, the *Quality Report* includes a core set of mandatory national quality indicators selected from the *NHS Outcomes Framework* and categorised within national quality improvement domains. The measures reflect data that providers report on nationally and conform to specified data quality standards and prescribed standard national definitions which are subject to appropriate standardised scrutiny and review.[21]

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 NHS Digital. In line with national guidance, information for (at least) the last two reporting periods is provided.*[22]

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)

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.

Table 3: SHMI

	Jan17 – Dec 17 Pub: Jul 18	**Apr 17 – Mar 18 Pub: Sep 18**	**Jul 17 – Jun 18 Pub: Dec 18**	**Oct 17- Sep 18 Pub: Feb 19**
Airedale NHS Foundation Trust SHMI value	0.99	0.94	0.94	0.90
National average	1.00	1.00	1.00	1.00
The highest value for any acute trust	1.22	1.23	1.26	1.27
The lowest value for any acute trust	0.72	0.70	0.70	0.69
Airedale NHS Foundation Trust SHMI banding	2	2	2	2

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.

[21] Definitions are based on national guidance, including the *NHS Outcomes Framework 2017/18 Technical Appendix.*

[22] Data source: http://content.digital.nhs.uk/qualityaccounts

	Jan17 – Dec 17	Apr 17 – Mar 18	Jul 17 – Jun 18	Oct 17- Sep 18
	Pub: Jul 18	Pub: Sep 18	Pub: Dec 18	Pub: Feb 19
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level for Airedale NHS Foundation Trust	28.1	28.7	28.0	28.5
Percentage of patient deaths with palliative care coded at either diagnosis or speciality level average for England	32.2	32.5	33.1	33.6
The highest value for any acute trust	60.3	59.0	58.7	59.5
The lowest value for any acute trust	11.7	12.6	13.4	14.3

The 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 and data quality definitions.
- To date, the SHMI for the Trust has remained consistent and not subject to significant variation. The Trust continues to view this in line with internal scrutiny of data quality.
- SHMI data is provided through NHS Indicators and is formally signed off by the Medical Director.

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

- Preliminary screening of all inpatient deaths ensures any deaths deemed avoidable or associated with an adverse event are highlighted. All such cases and an additional random sample are routinely reviewed by a Consultant-led Trust Mortality Group each month using a standardised and structured case note review process. This is essentially a more in-depth and validated process; fewer sets of notes are reviewed, but the time spent by the reviewer is considerably longer. Where potentially avoidable mortality is identified, action plans are formulated and learning disseminated.
- A maternal death, death of a child or a death in the ED are not included in this work, but instead are subject to a specialist independent process.
- Highlighted themes and learning, including good practice, is disseminated to the appropriate specialty governance teams and confirmation sought of how this is cascaded.
- Appraisal of mortality, morbidity and other correlative data at the Quality and Safety Committee and specialty clinical governance meetings further supports this work.
- Areas identified for development: continued recruitment and training of in-house multi-disciplinary reviewers to improve process resilience; inclusion of learning into the schedule of Quality Summits planned for 2019/20.

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

2.3.2 Patient Reported Outcome Measures (PROMs)

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 95 per cent control limits. An average adjusted health gain allows fair comparison as the characteristics 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.

As in previous years, the 2018/19 dataset is not included as there is limited response data at this stage: post-operative questionnaires are not sent to Orthopaedic patients until six months after the procedure is carried out. The standardised EQ-5D measure is presented 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. The following information relates to all procedures (primary and revisions).

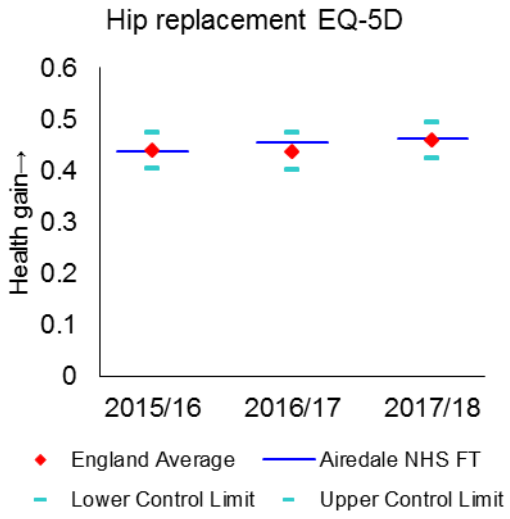


Figure 3

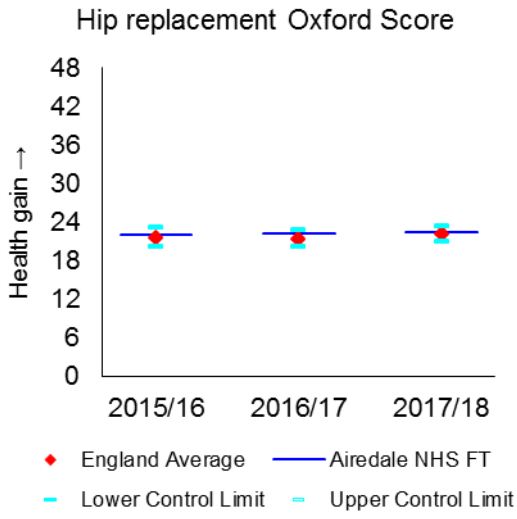


Figure 4

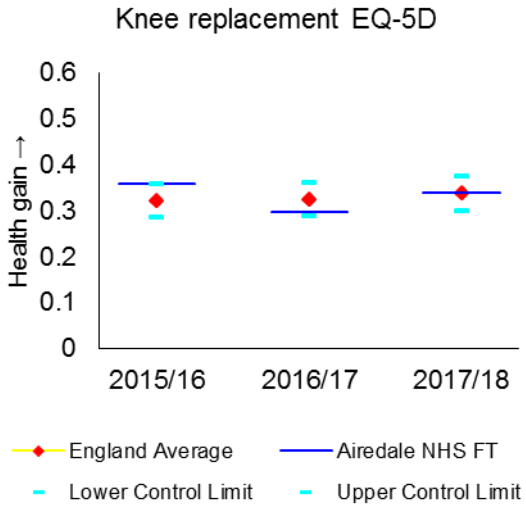


Figure 5

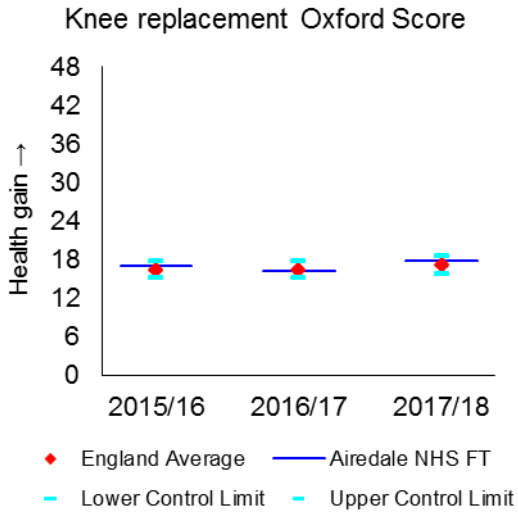


Figure 6

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

- Performance for these measures is within the expected range or better.
- Participation and response rates compare favourably with the national average for England for all procedures.
- The Trust is above the upper 95 per cent control limit for the 2015/16 EQ5D average adjusted health measure for knee replacement; outcomes are better than expected for this patient group.

The 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 rates of participation for each procedure and, although we have less direct influence, response rates are similarly reviewed. The Trust emphasises the importance of returning the questionnaires at pre-operative assessment and in the ward environment at discharge.
- A quarterly monitoring report is circulated to clinical operational leads for dissemination.

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

The data for this section has not been published by Digital Health since December 2013. The section below and comments are historical, but are required to be included. Also provided is our own data on re-admissions to offer more recent information on performance.

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.

Table 4: Emergency re-admissions	**2010/11**	**2011/12 Pub: Dec 13**	**2012/13**
Airedale NHS Foundation Trust percentage 0 to 15 years	11.70	11.32	
National percentage average [England] 0 to 15 years	10.01	10.01	***NHS Digital Health has not updated this metric since 2013 and is pending methodology review***.
The *highest** percentage return by small acute trust 0 to 15 years	12.61	14.87	
The *lowest** 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 *highest** percentage return by small acute trust 16 years or over	12.69	12.69	
The *lowest** 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.

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

The figures presented are from the NHS Digital portal 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. Datasets have not been updated since December 2013. No attempt is made by NHS Digital to assess whether the readmission is linked to the discharge in terms of diagnosis or procedure; nor does the return identify whether the emergency admission is avoidable.

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 and then offer families 24 hour open access for review on the unit. This allows the patient to be readmitted directly to the ward if the parent or carer feels there is any deterioration 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 available year as above. 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 are 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 an admitted spell within 28 days. Data collection changed in March 2015.

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

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.

For the period April 2018 to March 2019 and using the methodology developed by the Health and Social Care Information Centre (now NHS Digital), the Trust's Information Service has calculated the percentage of emergency re-admissions occurring within 28 days of the last and previous discharge from the Trust for all ages as 12.75 per cent.[23]

[23] *Indicator construction:*
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.

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

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 part of the *NHS Outcomes Framework* (indicator 4b: Ensuring that people have a positive experience of care).

Based on the annual CQC's annual *Adult Inpatient Survey*, the measure is 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 a clean, comfortable, friendly place to be. The scores are presented out of 100 with a high score indicating good performance.

Table 5: Responsiveness to patient needs	**2015** 524 replies; 1250 surveyed	**2016** 485 replies; 1250 surveyed	**2017** 474 replies; 1250 surveyed
Airedale NHS Foundation Trust overall percentage score	69.9	67.7	69.8
National percentage score	69.6	68.1	68.6
Highest percentage for any acute trust	86.2	85.2	86.2
Lowest percentage for any acute trust	54.4	60.0	54.4

The *2018 Adult Inpatient Survey* is due in June 2019.

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

The 2017 response rate is 39 per cent compared to a national rate of 41 per cent. The Trust sample varies from year to year and a difference in outcomes is to be expected unlike the national score which is, by definition, adjusted data. This should be factored in when making comparison between years. Demographic analysis shows that a high proportion of patients are aged 60 and above.

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. The 2018 *NHS Staff Survey* places the Trust above average amongst 89 acute providers for the number of staff reporting the effective use of patient/service user feedback.

The 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 Steering Group.
- Implementation of the *Patient and Public Engagement and Experience Strategy* for 2016-2020. The implementation plan follows a phased approach each year and aligns closely to the *Inclusion Strategy* and *"Right Care*" principles and the Trust's *Quality Improvement Strategy.*
- Listening and learning from patient experiences via the Friends and Family Test (FFT) and the Real-time (inpatient) Survey as well as social media and taking action where necessary. Friends and Family reports on the public facing website have been streamlined for simpler access and a link embedded for patients to complete the FFT after discharge.

- We continue to work with partner organisations to ensure a holistic approach to patient engagement.

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

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 21d).

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

Table 6: Staff recommendation	**2016** 1061 replies; 2699 surveyed ***Pub: Mar 2017***	**2017** 1254 replies; 2753 surveyed ***Pub: Mar 2018***	**2018** 1192 replies; 2591 surveyed ***Pub: Feb 2019***
Airedale NHS Foundation Trust percentage	71	73	74
National average percentage acute trusts [England]	70	70	71
Highest percentage for any acute trust	85	86	87
Lowest percentage for any acute trust	69	47	40

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

The response rate is 46 per cent which is above average for acute trusts and consistent with the 2017 rate.

Overall staff engagement has improved to 7.2 compared with 7.0 in 2017 and is above average when compared with other trusts of a similar type. Possible scores range from one to ten, with a higher score indicating high levels of engagement.

Overall the Trust's 2018 *NHS Staff Survey* results compare favourably with trusts of a similar type (acute trusts). The Trust was better than average in eight out of ten of the key themes.

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

- The Trust will be launching a leadership and management enrichment programme to supplement the current leadership development offer and will be developing a leadership community across the Trust.
- Quality of appraisals: to link appraisals to improvements in the way jobs are done and to strengthen objective setting. The next round of appraisals commencing April 2019 will be the focus of guidance and training.
- Inappropriate behaviours: whilst the Trust scores in relation to people experiencing discrimination, harassment, bullying and abuse are better than most other trusts, 15 per cent of staff reported experiencing

inappropriate behaviours from colleagues and nine per cent from managers. This appears to be within particular pockets in the Trust. Future focus will be on reinforcing behavioural expectations and targeted support to hotspot areas.
- Targeted support to teams and departments where colleague experience is below the Trust average.
- Employee involvement in work to address national and local workforce supply issues and to further improve the Trust's approach to governance in relation to quality and safety.

Building a positive safety culture through the following mechanisms:

- Monitoring of staffing levels within the Trust and development of new workforce models;
- Reviewing incidents reported through risk management processes to ensure that these are investigated and appropriate action is taken where necessary;
- Provision of training to all staff in the assessment of risk so these can be appropriately identified and escalated; and,
- Further promotion of the Freedom to Speak up Guardian role to enable staff to feel confident about raising concerns.

2.3.6 Friends and Family Test (FFT) – Patient

The NHS Friends and Family Test (FFT) is a quick and anonymous way for those using services to give their views after receiving care or treatment. It was created to help service providers and commissioners understand satisfaction levels with a service and where improvements can be made.

The percentage of the patient group who are either "*likely*" or "*extremely likely*" to recommend services is presented from a single question posed to patients, *"If a friend or relative needed treatment, I would be happy with the standard of care provided by the Trust."* The higher the percentage score the better. Although there is no statutory requirement to report on the patient element of the Friends and Family Test, we have included this information to support an open picture. No national benchmarks are provided below as, according to NHS England, results are not statistically comparable against other organisations because of the various data collection methods employed. [24]

Table 7: Friends and Family Test Airedale NHS Foundation Trust - percentage recommendation score	**2016/17**	**2017/18**	**2018/19**
Emergency Department Average	94.0%	96.7%	94.8%
Inpatient Average	97.4%	96.3%	97.1%
Community Services	98.0%	98.8%	99.0%
Maternity Services	99.3%	97.3%	98.0%

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

- The Trust monitors response rates against the national average for the Emergency Department, Inpatients and Maternity Services to ensure a sufficient and reliable sample size.
- Minimum response targets have been set of 15 per cent for the Emergency Department; and 25 per cent for Maternity Services (births) and Inpatients (which includes Day Cases). Performance is consistently above the target for most inpatient wards

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

- The FFT card for the Emergency department was redesigned to include a triage information card on the reverse side. This keeps patients better informed about their care and their waiting time in the department, as well as impacting on response rates for FFT because staff are required to hand out these cards as part of the triage process.
- NHS England is conducting a review of the Friends and Family Test with the purpose of giving greater emphasis to qualitative feedback in quality improvement. The new guidance is expected to be released in April 2019 and key actions will focus on its implementation.

[24] NHS England Friends and Family Test data: https://www.england.nhs.uk/ourwork/pe/fft/ [Accessed 01/02/18].

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

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

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.

Table 8: Risk assessment for VTE	**Jan –Mar 2018**	**Apr-Jun 2018**	**Jul-Sep 2018**	**Oct-Dec 2018**
	Pub: Jun 18	Pub: Sep 18	Pub: Dec 18	Pub: Mar 2019
Airedale NHS Foundation Trust percentage	95.68	95.20	95.34	93.76
National percentage average [England]	95.21	95.63	95.49	95.65
The highest percentage return for any acute trust	100.0	100.0	100.0	100.0
The lowest percentage return for any acute trust	67.04	75.84	68.67	54.86

Data Source: *NHS Improvement.*

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

- The national threshold was maintained through 2018 until October. Remedial action has been identified to address the shortfall and provisional figures indicate the target has been achieved between January and March 2019.
- Data is provided weekly to all managers and lead clinicians. Broken down by clinical group, this allows those areas 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.

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

- Continuing to benchmark Airedale's performance against other providers in England and report on a monthly basis through the Trust's Patient Safety Scorecards.
- Regular discussion of VTE assessment data with clinical directors to educate and improve rates across groups.
- Promoting processes of root cause investigation for reported VTE with the dissemination of results to improve overall VTE care.
- A new clinical lead has been appointed with particular focus on the consistent application of VTE prophylaxis.

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

Hospital associated C. *difficile* can be preventable. Since 2012 revised guidance on the clinical testing protocol has resulted in more consistent testing and reporting of cases of C. *difficile* infection across the country.

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

Table 9: Rate of C. difficile	**2015/16**	**2016/17**	**2017/18**
Airedale NHS Foundation Trust rate per 100,000 bed days	14.6	11.2	5.2
National average rate [England] rate per 100,000 bed days	14.9	13.2	13.7
The highest rate for any acute trust rate per 100,000 bed days	67.2	82.7	91.0
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.

Data Source: *Public Health England.*

The 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, NHS Improvement 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.
- Post infection review of 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 avoidable.
- Receipt of the C.*difficile* risk assessment and action plan via an assurance route governed by the Quality and Safety Board Committee.

The 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;
- Ensuring the environment is fit for purpose and supports good infection prevention practices;
- SystmOne antibiotic prescribing flag for those patients with a history of C.*difficile* infection/colonisation;
- Monitoring of the use of antibiotics in comparison with neighbouring and similar sized acute trusts;
- Discussion of anti-microbial prescribing in community at the District Wide Infection Prevention Team Meeting; and,
- Sustaining staff engagement and motivation in the prevention of HCAI.

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

2.3.9 Reported number and rate of patient safety incidents per 1000 bed days reported within the Airedale NHS Foundation Trust and the number and percentage that resulted in severe harm or death

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 signifies when a patient has been permanently harmed as a result of an incident.)

Table 10: Patient safety incidents

Apr – Sep 2018 [Issue: Mar 2019]

	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 1000 bed days]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	3,127	60.8	2	0.1	2	0.1
National position [acute non-specialist n=131]	731,348	42.4	1,771	0.2	706	0.1
The highest value [acute non-specialist n=131]	9,467	107.4	13	0.1	1	0.0
The lowest value [6 complete months] [acute non-specialist n=131]	374	13.1	3	0.5	0.0	0.0

Oct 2017 – Mar 2018 [Issue: Sept 2018]

	All reported patient safety incidents		Severe harm		Death	
	Number	Rate [per 1000 bed days]	Number	Percentage	Number	Percentage
Airedale NHS Foundation Trust	2,829	47.7	5	0.2	1	0.0
National position [acute non-specialist n=134]	730,151	40.87	1,810	0.2	712	0.1
The highest value [acute non-specialist n=134]	19,897	124.0	78	1.2	24	0.2
The lowest value [acute non-specialist n=134]	1,311	24.2	0	0.0	0.0	0.0

Data source: NHS Improvement – National Reporting and Learning System.

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

- Consistent reporting of all patient safety incidents to the National Reporting and Learning System (NRLS) against each of the required six month periods.
- The Trust is characteristically in the upper quartile of reporters. According to the NRLS, organisations that report more incidents usually have a better and more effective safety culture. In order to improve, an understanding of the problems is essential.
- An open and engaged culture to learn from incidents and improve the quality and safety of services as illustrated in the latest 2018 *NHS Staff Survey.*
- Clear and accessible policy and guidelines that ensure incidents are effectively identified managed and investigated and that appropriate measures are taken to prevent recurrence.

The 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 adverse events and near misses. For example it is important that staff report safety risk promptly so that action can be taken to prevent harm to others. The time taken in closing incident investigations has been prioritised with the median time comparing favourably with the provider cohort over recent reporting periods.
- Streamlining of incident categories to support classification and allow more effective evaluation of trends and themes.
- Appointment of a Freedom to Speak up Guardian to provide confidential, independent advice and support to staff in relation to concerns about patient safety, care and treatment.
- Additionally, a quarterly Learning from Serious Incidents Report provides oversight of contributory factors and augments wider organisational learning whilst,
- Key quality and safety messages are shared in a monthly *Quality and Safety Matters* bulletin. Learning has been further augmented via a “Report, Learn, Share Week” in December 2018, which highlighted key aspects of quality and safety –
    - the incident reporting culture,
    - learning from documentation,
    - insulin prescribing and administration medication errors

  – by drawing from analysis of incident reporting, serious incident investigations, clinical audit and, litigation.

Part 3: Other quality improvement information

As well as the improvement projects detailed in section two, the *Quality Report* takes the opportunity to outline other local priority work in the three areas of quality: patient experience, safety and clinical effectiveness. A series of metrics or indicators are included to understand performance 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 seldom heard groups have equal opportunity to be fully involved in all aspects of their care. Where practicable, the principles of experience based co-design are integrated into work streams to ensure patient experience is central.

3.1.1 Improving care for patients living with dementia

The challenge and our aim

"An estimated 25 per cent of hospital beds are occupied by people with dementia. People with dementia … stay in hospital for longer, are more likely to be re-admitted and more likely to die than patients admitted for the same reason." [25] If patients living with dementia are diagnosed in a timely way, this patient group can receive treatment, care and support to improve their experience of the condition.

Through focusing on developing the skills and expertise of our workforce in the recognition and the care of patients living with dementia, the Trust seeks to improve the prompt and appropriate referral to specialist services. This initiative is part of priorities within the *Patient and Public Engagement and Experience Strategy* for 2016-2020.

How we monitor progress

Up to 2018 a multi-disciplinary and agency *Here to Care* Group co-ordinated the key dementia priorities: training, enhancing the environment (wayfinding), patient flow and elective pathway. Membership included Dementia Friends Keighley representatives who together provide independent insight on how we can improve care for this patient group. The Trust is currently in the process of developing a *Dementia Strategy* which will set out revised governance arrangements for all work streams.

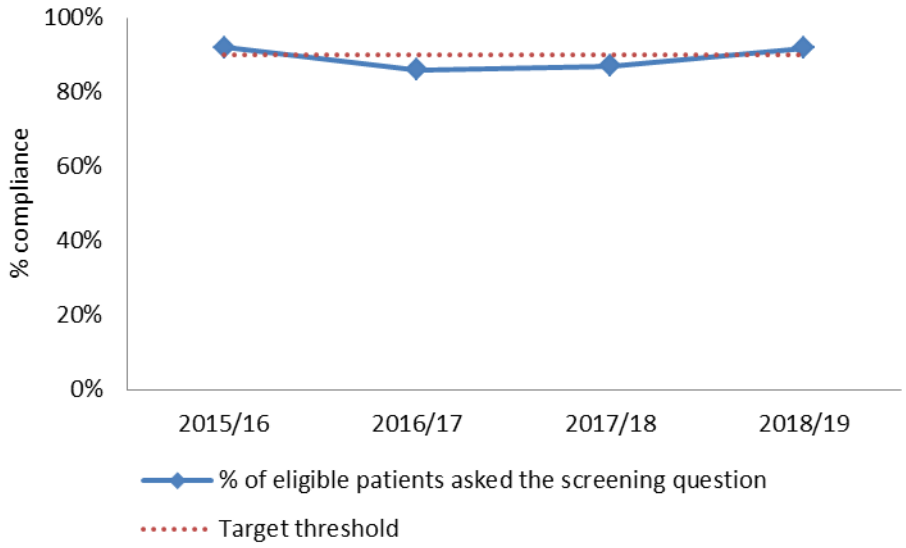
Current status

It is estimated that less than half of people with dementia in England have a formal diagnosis or have contact with specialist services.[25] If diagnosed in a timely way, this patient group can receive the treatment, care and support – social and psychological, as well as pharmacological – to improve their experience of this condition. To ensure prompt and appropriate referral to specialist services,

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

all patients aged 75 and over admitted as an emergency are screened for dementia or delirium. A 90 per cent target of achievement was met in 2018/19.

Figure 7: Time series showing the percentage of eligible patients asked the screening question against the target threshold



Data source: *Information Services Airedale NHS Foundation Trust*

Complaints provide valuable qualitative information which may not be identified by more traditional indicators. From a total of 56 formal complaints over the year, four complaints have been received concerning patients living with dementia**.** Review indicates that in three cases the complaints were directly related to the patients' specific needs; feedback has been shared with teams. In the 2018 Care Quality Commission inspection of Medical Care (including older people's care), it found the service worked hard to provide for the needs of vulnerable groups, such as those with dementia whilst within the Surgical Service there were good examples of innovative practice which improved patient experience for those living with dementia.

Initiatives and progress in 2018/19

In 2016 the Trust participated in the *National Audit of Dementia* to assess the delivery of care for people with dementia admitted to hospital. Whilst results indicated progress is being made, the audit indicated some areas of shortfall, particularly in respect of patient experience: carer communication was ranked below average and the carer rating of patient care was in the lower quartile of participating sites. In 2018 the Trust was selected as a national pilot site for the Enhanced Care Project; this is work that aims to improve the patient experience by ensuring that for those patients who require more frequent observation, interactions are engaging and meaningful. Staff from Ward 6 and Ward 9 and other key colleagues attended project training to set project aims, establish monitoring as well as understand the principles of enhanced supervision and associated assessment tools. Weekly meetings oversaw progress and identified key actions. A roll out of the Enhanced Care Project to other wards is planned with pilot wards offering support.

In parallel with the above project, progress has continued across four established work streams:

1) Improving care initiatives:

- Dementia memory trolleys across wards, Theatres and the ED in addition to a digital and reminiscence therapy unit stocked with games, quizzes, conversation prompts, tactile products, arts/drawing equipment and cognitive activities for use by patients with dementia. Linking with young people's volunteering we aim to deliver more reminiscence and therapeutic activities for patients to participate in.

- Accessible information such as an ED leaflet and placemats for patients with key ward information. A communication support toolkit has also been created and will be rolled out to all wards and other clinical areas in 2019. This is to help staff communicate with patients who have communication difficulties.
- Adoption of the "*End PJ Paralysis*" campaign to promote the importance of mobility in avoiding the risk of reduced bone mass and muscle strength, increased dependence, confusion and demotivation.
- The planning and design of spaces to reflect the requirements of patients living with dementia in regards to their surroundings and the environment (a core element of the Trust's Estate Strategy). Thus the Butterfly Tea Room on the elderly ward provides a social space for patients to use and take part in activities such as bingo and crafts.
- Collaboration with dementia-related charities in Dementia Action Week July 2018 through a marketplace event hosted on our Airedale site for healthcare professionals, patients and carers. Outreach sessions in Keighley town centre commenced in 2018 to garner feedback from patients and carers.

2) Staff education and practice development: mandatory training for clinical and non-clinical staff – including volunteers and bank – ensures all staff have knowledge and skills in caring for people with dementia. During Dementia Action Week a staff session on the acute dementia pathway was held.

   Patient stories are a potent and reflective tool in reinforcing caring behaviours and can be a valuable learning tool for staff. Such stories both celebrate excellent care and highlight where improvements can be made. The following recounts the experience of a patient and carer on an Orthopaedic ward as part of the Enhance Care Project.

The Board heard about a patient on Ward 9. Mr A. has Parkinson's and dementia, and was admitted with fractured neck of femur, following a fall. He stayed in total for two months. During this time his wife visited daily, for several hours, and helped with his care.

The ward asked Mrs A. for specific feedback around enhanced care supervision and, as a result of her feedback and that of others, it has:

•Introduced tabards for staff giving enhanced supervision
•Provided placemats with daily updated information
•Created 'Why am I on enhanced care?' posters
•Introduced more activities
•Given all relatives verbal and written information about enhanced supervision

•Organised special events such as Eid and Royal Wedding parties

Source: Board of Directors' meeting June 2018

By the end of March 2019, 94.1% per cent of the Trust's workforce had achieved competency in dementia awareness training (this incorporates privacy and dignity training). [26]

3) Patient management and assessment: over the last two years the safety huddle methodology at staff handover has been introduced across clinical areas.

4) The development of guidelines for practice: the *Cognitive Impairment/ Dementia Pathway* has been developed within the hospital to complement the Community Collaborative Care Team's dedicated pathway as part of a collaborative and holistic approach to care. More recently guidance for the assessment of delirium, dementia and depression – the 3Ds – has been developed and implemented.

This work is underpinned by our work as an Ambassador Trust for the Butterfly Scheme, an initiative which seeks to highlight the unique needs of those patients affected by dementia by displaying a butterfly icon on the bed management system to make staff aware of a Butterfly Care Plan (individualised care plans detailing personal preferences). A relaunch of this initiative commenced in 2017 spearheaded by Ward Butterfly Champions. To reinforce the effectiveness of this initiative, around 80 Butterfly Champions were recruited from staff.

Hospital stays are generally damaging to people with dementia who can find the acute setting a difficult and disorientating environment. It is not uncommon for a person living with dementia to experience a loss of functioning level and independence following an acute admission. The Trust has adopted John's Campaign, a national drive to promote flexible hospital visiting hours for those caring for people living with dementia. John's Campaign focuses on an open visiting culture, supporting carer access outside of normal visiting hours to minimise the stress and anxiety. This may include staying overnight. Over the last year a *Visitor's Charter* has been introduced explaining what patients can expect from us during a hospital stay, including enhanced visiting times. The objective is to ensure an approach that is inclusive of visitors and patients whilst being mindful of the need for rest and recovery.

Next steps

- The Trust is participating in the 2018 *National Audit of Dementia (Care in General Hospitals)*. As part of the audit, hospital staff who work on an inpatient ward and care for people living with dementia are asked what support and training they have received to help them provide the best care possible. Those caring for someone living with dementia are also encouraged to participate as an invaluable means of understanding the quality of care being provided. Results are anticipated later in 2019. In the meantime the Trust continues to address areas of shortfall identified in the 2016 national audit.
- A *Dementia Strategy* is planned for the organisation with an implementation plan to monitor progress against work streams.

[26] Data source: *Human Resources NHS Foundation Trust [consolidated figure].*

3.1.2 Privacy and dignity

The challenge and our aim

In recent years, high profile reports and inquiries have shown a failure at an individual and organisational level to deliver care with compassion, privacy and dignity. It is important to continually reflect on and challenge the way in which we treat and care for patients, relatives, friends, carers and staff. We know there is a link between the well-being of staff and that of patients. Our priorities are to:

1) Embed our *Fundamental Standards of Caring for People with Dignity and Respect*.
2) Develop a patient-led care environment that is clean, safe, accessible and equipped to underpin privacy and dignity.

How we monitor progress

Privacy and dignity are key principles within the Trust's *Patient and Public Engagement and Experience Strategy 2016-2020* as agreed by the Board of Directors in consultation with stakeholders. Implementation is monitored via the Patient Experience and Engagement Steering Group, established to ensure the experiences of those who use our services and carers are captured and acted upon to improve future care and treatment. Representation includes Estates, the Patient and Carer Panel, local Healthwatch organisations and voluntary groups as well as commissioners.

3.1.2.1 Creating a Customer Service Culture

Current status

The following metrics have been selected to measure improvement in our patients' experience. Each year, as part of the annual CQC *Adult Inpatient Survey*, people are asked by the CQC about different aspects of their care and treatment. Based on these responses, health providers receive scores out of ten. A higher score is better. Results show the Trust is performing *"about the same"* as most other providers. Sustained performance for patients feeling they are treated with respect and dignity whilst in hospital is noted (Q68).

Table 11: Results of the Care Quality Commission Adult Inpatient Survey for last available three years – performance against selected metrics for Airedale NHS Foundation Trust

	2015/16	2016/17	2017/18
[Q34] Were you involved as much as you wanted to be in decisions about your care and treatment?	7.6	7.5	7.5
[Q35] Did you have confidence in the decisions made about your condition or treatment?	8.3	8.3	8.3
[Q36] How much information about your condition or treatment was given to you?	8.0	8.2	8.8
[Q48] Did you feel you were involved in decisions about your discharge from hospital?	7.0	7.2	7.0
[Q63] Did the doctors or nurses give your family or someone close to you all the information they needed to care for you?	5.5	5.7	6.2
[Q67] Overall, did you feel you were treated with respect and dignity while you were in hospital?	8.9	9.0	9.0
[Q73] During your time in hospital did you feel well looked after by hospital staff?	8.8	8.7	See note
[Q68] Overall, how would you rate the care you received?	8.0	8.0	8.2

Data source: Care Quality Commission *National NHS Adult Inpatient Survey 2017 (published June 2018).*
Q73 was removed from the 2017 survey and therefore will not be included in the 2019/20 *Quality Report*.

Benchmarks:

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.

The *CQC Adult Inpatient Survey 2017* score for privacy when being examined or treated within the Emergency Department shows significant deterioration on the preceding period.

In addition to the annual *CQC Adult Inpatient Survey*, NHS England's *National Cancer Patient Experience Survey* 2017 of 413 patients – a response rate of 64 per cent and in line with the national rate – was published in September 2018 with the following case-mix adjusted findings for privacy, dignity and compassionate care:

- For the overall care rating where zero is poor and ten is very good, patients gave an average rating for Airedale of 8.7; the national average score was 8.8.
- Of the 152 respondents to the question, "*Were you always treated with dignity and respect by staff?"* 84 per cent agreed. This result is below the national average, albeit not significantly.
- Of the 152 respondents to the question, "*Were you always given enough privacy when discussing your condition or treatment?"* patients gave an average score of 75 per cent. The score is significantly below the expected range.

Other patient survey results published in the last year:

CQC Maternity Survey 2018 of 123 women – response rate 42 per cent compared to a national rate of 37%– was published January 2019. The survey reports on the experience of women in February 2018. The following results have been compared against other participating providers with the following results:

  - Of the 121 respondents to the question, "*Thinking about your care during labour and birth, were you treated with respect and dignity?*" Airedale scored 9.5 out of a possible score of ten. The higher the score the better. Results were broadly in line with the 2017 return and about the same as other providers.
- The Trust was one of the better performing providers – there were 129 participating sites – in the following questions:
  - *"During your pregnancy, if you contacted a midwife, were you given the help you needed?*
  - *"Thinking about your antenatal care, were you spoken to in a way you could understand?*
  - *"At the very start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?*
  - *"Did the staff treating and examining you introduce themselves?"*
  - *"Looking back, do you feel the length of your stay in hospital after the birth was about right?"*
  - *"Were your decisions about how you wanted to feed your baby respected by midwives?"*
  - *"Did you feel that midwives and other health professionals gave you consistent advice about feeding your baby?"*
  - *"When you were at home after the birth, did you have a telephone number for a midwife or midwifery team that you could contact?"*
- Performance was worse amongst other providers for:
  - *"Did a midwife tell you that you would need to arrange a postnatal check-up of your own health with your GP?"*

There were three mixed sex accommodation breaches notified in April 2018, a time of peak demand. To date there have been no further re-occurrences.

Initiatives and progress in 2018/19

Areas of improvement have been identified from the results of the CQC *Adult Inpatient Survey 2017* notably in the areas of:

- Care and treatment: emotional support to address worries and fears of patients.

It is hoped new uniforms and badges will assist patients and visitors in identifying staff. A Ward Directory Project is ongoing with information available on how to access appropriate support. New volunteer roles to develop activities and to befriend are being implemented. Piloting of the Patient Reporting and Action for a Safe Environment (PRASE) iPad survey continues. Its purpose is to allow inpatients to provide feedback on safety, for example, staff communication, equipment availability and care planning. The pilot began on Ward 9 and in the Emergency Department in January 2018.

- Leaving hospital

To ensure patients are involved in discharge decisions and that home situations are part of the discussion, the qualitative findings are disseminated to the Multi-Agency Integrated Discharge Team and the Discharge Facilitators. To address a perceived shortfall in support from professionals to manage conditions and a lack of written and printed information about medication, nursing and therapy leads have been tasked with ensuring that selected formats for communication are effective.

A series of training initiatives, including *Customer care training* – "*Right Care*", encourage staff to reflect on how compassionate care can be embedded into practice. To instil core values and challenge opposing attitudes and complacency, 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*.[27] Drawing on the real experiences of patients of good and inadequate customer care, its objective is 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."*

Staff and volunteers come to work to do their best for patients and their families, and they deserve a happy, supportive working environment. The Trust aims to promote an environment where staff are treated with respect at work and have the tools, training and support to deliver care and the opportunities to develop and progress. Following on from the launch of core staff values and leadership behaviours, the *People Plan* has been developed offering practical guidance to managers through a leadership and coaching programme. The "Right *Care"* Leaders Programme is aimed at new medical consultants, clinical, support service and corporate leaders; the objective being to provide more formalised developmental training. A Health and Well-being Programme aims to help staff eat well, exercise and take care of mental health; resilience training is available to aid staff to deal with stress.

A Respect and Dignity Campaign was launched in October 2017, to look at how we treat our colleagues. It is important that each of us has an understanding and appreciation of one another's

[27] Department of Health (2013), *The NHS Constitution.* Available from: - https://www.gov.uk/government/publications/the-nhs-constitution-for-england [Accessed 02/02/18].

roles and responsibilities. Disrespectful behaviours can be perceived as bullying or harassment, whereas small gestures can make staff feel valued and part of a team. Developmental inclusion work spearheaded by the inclusion groups – BAME, gender, disability and LGBT – is progressing. The Trust is currently piloting a new approach to staff exit surveys to garner feedback that can be used to support retention.

Next steps

The 2018 CQC inspection highlighted that the Trust is not fully compliant with the accessible information standard in relation to those people with communication needs relating to disability, impairment and sensory loss. The criteria have been reviewed; an action plan developed which will be implemented over the coming year.

Other planned actions:

- Promotion of the work across the organisation of our "*Right care*" Champions.
- Continued commitment to engagement events with both patients and staff, particularly for the more vulnerable groups with the aim of understanding how substantive improvement in their experience can be made.
- Introduction of Schwartz Rounds, a forum for colleagues from all backgrounds, grades and disciplines across both hospital and community areas of the Trust to come together to talk about the emotional, personal and social challenges of working within healthcare. The aim is to provide a safe environment to allow people the time and space to reflect on their roles, share their stories and offer support to one another.
- Implementation of the workforce and inclusion strategies via the *People's Plan* and the *Patient and Public Engagement and Experience Strategy 2016-2020*.

3.1.2.2 A patient-led care environment

The challenge and our aim

There are a range of non-clinical factors which can have an impact on the patient experience of care: cleanliness – the condition, appearance and maintenance of healthcare premises – and the quality and availability of food and drink. The extent to which our environment supports the delivery of care with privacy and dignity is a key area of focus within the *"Right Care"* portfolio.

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. We aspire to an environment that is pleasant, comfortable, calming, clean and safe in clinical and non-clinical areas. We want to make all our open spaces accessible, including outside spaces such as courtyards.

Current status

The annual Patient-Led Assessment of the Care Environment (PLACE) provides a snapshot of how an organisation is performing against a range of areas which impact on the patient experience of care. A fundamental aspect of the assessment is the inclusion of lay assessors who make up to half of the inspection team. Assessment includes: cleanliness, food and drinks, the quality of buildings, including criteria on how well healthcare providers' premises are equipped to meet the needs of caring for patients with dementia and disability.

Our most recent PLACE assessment was carried out between May and June 2018 over seven days and included ten wards and four outpatient departments. Results were published in September 2018. Assessments were undertaken across 270 organisations, of which 218 were NHS providers.

The assessment tool, the composition of the inspection team and the wards selected vary each year invalidating comparison with previous years. The following table provides the site level scores and, to support appraisal, the national average.

Table 12: Airedale General Hospital 2018 PLACE results

	AGH % site score	National % average site level score
Cleanliness	97.20	98.47
Food and hydration	90.57	90.17
Organisation food (catering service)	82.33	90.00
Ward food	93.11	90.50
Privacy, dignity and well-being	80.53	84.16
Condition, appearance and maintenance	89.03	94.33
Dementia	72.50	78.89
Disability	83.35	84.19

Data source: *NHS Digital 2018*

Key findings:

- At national level the largest increases in scores are seen for the dementia and disability domains. Airedale General Hospital site performance is about the same as the national average for disability; performance for dementia is in the lower quartile of providers.
- Overall, the highest national average domain score is for cleanliness, at 98.5 per cent; the Airedale General Hospital site score is 97.2 per cent.

Where issues are identified, these are included in the ongoing PLACE Improvement Plan, which is monitored and progressed through the Patient Environment Action Group meetings. Mini-PLACE audits are carried out on a quarterly basis and include a comprehensive inspection of waste, linen, cleanliness, environment and, food safety at ward level. The Infection Prevention Team and Airedale General Hospital (AGH) Solutions Limited undertake these audits alongside Matrons. In addition, environmental audits are conducted to identify where improvements in the aesthetic elements of the patient environment can be made; individual actions to upgrade are being progressively addressed.

Initiatives and progress 2018/19

The new Acute Assessment Unit opened in the spring of 2018 and includes ensuite facilities and larger bed space than current wards with more privacy for patients; single bedroom facilities for people to stay over; and provision for speciality care (dementia and end of life patients). Accessible toilets and wheelchair access are incorporated into plans. A waiting area, reception and ambulatory lounge are also part of the design. Research indicates that for those living with dementia, changes in the physical surroundings – eye-catching colour contrasting schemes and signage – can encourage greater independence, help patients find their way around and reduce distress. Dementia principles are embedded in the Estate's *Capital Development Strategy* reflected in the wards programme.

Other developments in the last year:

- Ward refurbishment continues on a rolling programme. Following concerns expressed by a patient's family, the cleanliness, condition and appearance of the Ward 5 care environment has been the subject of investigation. Immediate action to relocate the ward was taken with significant work subsequently undertaken to address areas of shortcomings.
- Following on from remedial actions to improve the Dales Unit environment, a business case to incorporate the Dales Unit activity into a wider vision of Theatres has advanced. Subject to capital approval, the new facility should open in 2020; plans include a barn theatre incorporating two theatres and a procedure room.
- A previous CQC inspection tasked the Trust with ensuring that the clinical environment in the Haematology Oncology Day Unit (HODU) meets patient needs and national guidance. Agreed actions include revised pathways to reduce waiting times and clarification of the need for HODU attendance. Through the development of the mobile cancer service – as previously described in this report – we aim to release further clinic time.
- A dedicated space on Ward 7 to provide cystoscopies (bladder investigations) and bronchoscopies (lung investigations, otherwise known as EBUS). These procedures enable early detection of bladder/prostate and lung diseases and having more capacity supports our urology and lung cancer pathways, meaning a swifter diagnosis for patients.
- The opening in August 2018 of a new pathology blood sciences laboratory as part of a complete renovation of Pathology to meet increasing demand for services and create a state of the art facility.
- A reflective non-denominational space is now available within the Chaplaincy complex. This has been further augmented by a wild garden. Friends and relative spaces are incorporated in the ED and within the new Acute Assessment Unit.
- The opening in October 2018 of the Sunbeam Baby Remembrance Garden and the Tree of Tranquillity, an important community resource for those experiencing the loss of a baby.
- The Trust had hoped to work with Transdev to establish a regular bus service that runs between Skipton and Keighley. Regrettably regular delays leaving the hospital site have hindered progress in advancing this initiative. Recent changes to traffic streams on the public road have improved traffic flow and if sustained, discussion with Transdev will be resumed.

Next steps

- Planning permission to construct additional on-site parking has been agreed. The objective is to offer additional patient spaces closer to services and alleviate the pressures on staff parking.
- Building on significant capital developments over the previous years, through the Health and Social Care Partnerships we have submitted bids to further develop our wards and operating theatres.
- The catering contract will be run by AGH Solutions Limited from June 2019 and consultation with wards and departments on how to enhance current provision are underway.
- Castleberg Hospital was closed in April 2017 because of safety concerns following issues with its power supply, heating and drainage. Following extensive consultation with the local Craven community, commissioners have decided to provide inpatient care and restore the hospital. The future model of care will aim to integrate services closer to patients' homes and will include Castleberg Hospital acting as a community-based facility, with the option to provide a broader range of support services, both physical and mental well-being. Castleberg will be subject to a significant refurbishment with two additional single rooms.

3.2 Patient safety

Through targeted quality improvement work, the Trust seeks to reduce patient harm traditionally associated with healthcare, particularly amongst the frail elderly where there is a heightened risk of healthcare associated infections and falls.

3.2.1 Infection prevention and control

The challenge and our aim

Healthcare associated infections (HCAI) are infections that are acquired as a result of healthcare interventions. According to the National Institute for Health and Clinical Excellence, HCAI are a serious risk to patients, causing significant morbidity to those infected. Whilst there are a number of factors that can increase a patient's risk of acquiring an infection, high standards of infection control practice minimise the risk of occurrence. The Trust aims for sustained reduction in the incidence of avoidable harm from C. *difficile* and MRSA bacteraemia infection.

How we monitor progress

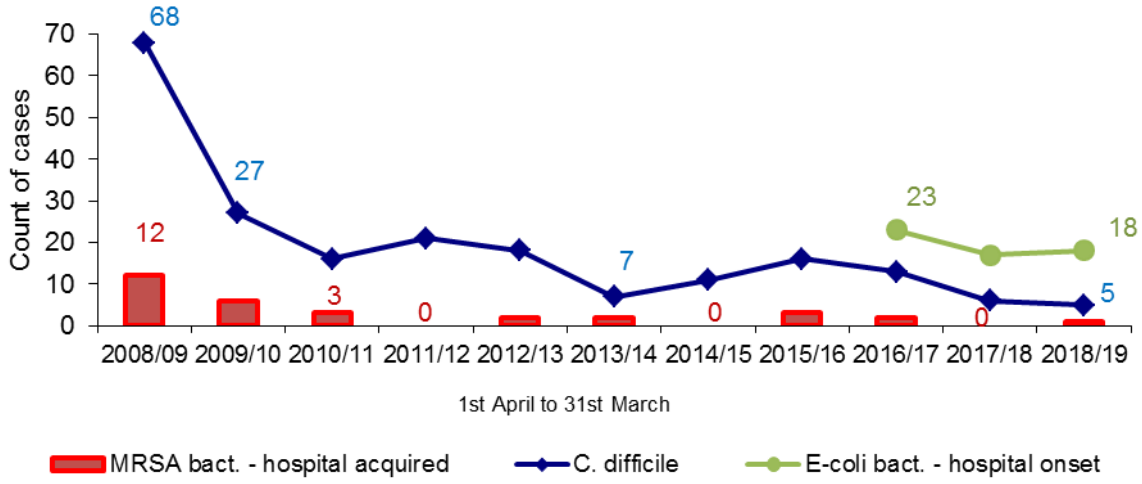
The Infection Control Committee monitors compliance with the standards of *The Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance* (Public Health England, 2015). The District Wide Infection Prevention Team continues to support an integrated approach to infection prevention and control work streams. To engage with local groups and minimise harm from HCAI, a lay member sits on the Infection Control Committee.

Current status

This fiscal year the Trust reported one hospital acquired MRSA bacteraemia; the last case prior to this was in June 2016. Five C. *difficile* cases developed in hospital. Root cause analysis showed that all cases were unavoidable. This year 18 cases of hospital-acquired E.coli bacteraemia were reported. (All data is governed by standard national definitions.)

In response to the following *2017 NHS Adult Inpatient Survey* question, *"In your opinion, how clean was the hospital room or ward that you were in?"* the Trust scored 8.8 out of a possible score of ten. A higher score indicates better performance. The score is *"about the same*" as other providers.

Figure 8: HCAI cases at Airedale General Hospital



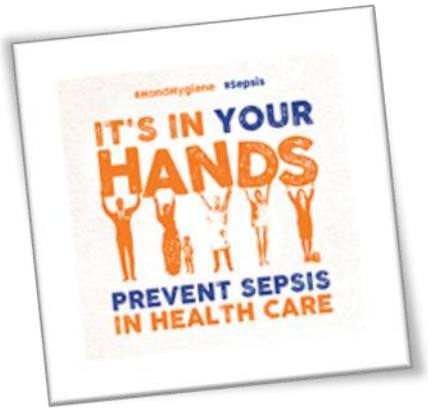
Data source: *Airedale NHS Foundation Trust Infection Prevention.*

Initiatives and progress in 2018/19

To prevent HCAI, we continue to monitor closely the rates of infection, strengthen infection prevention and control measures and learn from best practice. Key measures include the following (please read in conjunction with section *2.3.8: Rate of C.difficile infection* which outlines additional initiatives and processes):

Monitoring of infection prevention and control practices:

- Infection Prevention updates and assurance on measures implemented to reduce HCAI are tabled through the nursing and medical governance groups and via the Infection Control Committee.
- All hospital acquired MRSA bacteraemia and C. *difficile* infections are subject to Post Infection Reviews with learning points cascaded immediately to clinical teams. Methicillin-sensitive Staphylococcus aureus, or MSSA and E.coli cases are investigated if the Consultant Microbiologist requests a review.
- Infection alerts are in place on SystmOne to ensure staff are aware of patients with a history of MRSA, C.*difficile* and multi-resistant organisms. GPs using SystmOne can now access messages entered by the Infection Prevention Team regarding the infection status of patients.



Sustained engagement of staff to maintain motivation in preventing HCAI:

- The monthly hand hygiene audit reports a Trust aggregated compliance average of 98 per cent since April 2018.[28] This is part of a robust and ongoing infection prevention clinical audit programme to evaluate standards for example, of cannula and urinary catheter care.
- Flu vaccination uptake was above the target threshold of 75% for clinical staff in the latest available period.
- Screensavers alerting staff to key infection control and

[28] Airedale NHS Foundation Trust Infection Prevention.

prevention messages have been adopted, for example, Norovirus and CPE (Carbapenemase-producing Enterobacteriaceae).
- Mandatory training and link worker programmes are ongoing with uptake monitored via the Mandatory Training Group. A clinical workbook has been development and external events such as Bradford and Airedale Infection Prevention Study Day promote infection prevention and control principles to a wider audience.

Ensure the environment is fit for purpose and supports infection control practice:

- As described earlier in this report, the cleanliness, condition and appearance of the Ward has been upgraded in response to concerns.
- Domestic Services, Matrons and the Infection Prevention Team have worked closely to monitor standards of cleanliness, including inspections of the care environment, spot audits and routine cleanliness audits in line with national NHS specifications.
- Changes to ward domestic allocation, for example out of hours, enables a higher level of cleaning as staff are not working around the service.
- Routine cleanliness audits are undertaken in line with the NHS framework of audit; a work programme is maintained by the Enhanced Cleanliness Team, including a programmed curtain change.
- Biannual hygiene audit of catering is ongoing. The Department of Health awarded five stars to the main hospital site. Ward kitchens need attention due to wear and tear and receive focus when allocating capital funds.
- Legionella has been effectively targeted through a programme of work to remove little used water outlets with enhanced surveillance in place to ensure progress is maintained.

Antimicrobial stewardship is crucial to minimising resistance. Antibiotic prescribing for inpatients is reviewed by the Consultant Microbiologist and Antibiotic Pharmacist on a weekly basis to optimise the appropriate treatment of patients with infections and minimise the risks associated with inappropriate antibiotic treatment i.e. antimicrobial resistance and healthcare acquired infections. Antibiotic audit indicates a high compliance with Trust guidance.

During 2018-2019, work was completed in moving the prescribing of gentamicin paper based system to an electronic prescribing system, and launch of an electronic vancomycin prescribing system is imminent. These two antibiotics are safer from other options from a clostridium difficile infection and MRSA treatment perspective, but carry risks in terms of complex dosing and acute kidney injury.

Next steps

- In support of the above we continue to develop new and existing policies, guidelines and information leaflets for patients.
- Monitor and risk assess the potential impact of any new or emerging infections and new developments or innovations.
- Following the CQC 2018 inspection recommendation that the Surgical Service ensures all applicable equipment is included within cleaning schedules and fit for use, this action is being worked through.

3.2.2 Reduction of slips, trips and falls sustained by patients admitted to our hospital wards

The challenge and our aim

Falls are a cause of injury, pain, distress, delay in discharge and loss of independent living. Evidence suggests that the effect is particularly compounded for people over the age of 65.[29] The effective management to reduce the number of falls sustained by our inpatients is therefore a high priority.

Current research indicates that multi-component interventions are effective in reducing falls, and that continuous improvement should be built on small incremental changes using a systematic approach to test the impact and feasibility - Plan-Do-Study-Act. Working with the Improvement Academy and using core safety improvement principles, the Trust continues to focus on an incremental decrease in the number of falls and the level of harm these engender. [30]

How we monitor progress

The multi-disciplinary Trust's Falls Steering Group oversees this initiative with the following key areas of focus: multi-factorial falls risk assessment, care and management of patients following a fall, discharge, patient and family information, equipment, and training and education. The Trust is an active member of the district-wide Falls Pathway Development Group.

Current status

Table 13: Airedale NHS Foundation Trust rate of inpatient falls per 1000 bed days [31]

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
2018/19	117214	730	**6.228**	21	**0.179**
2017/18	125885	853	**6.776**	18	**0.143**
2016/17	120771	921	**7.626**	19	**0.157**

[29] Department of Health (2009) Falls and Fractures: effective interventions in health and social care. Crown copyright: COI for DH.

[30] Centre for Reviews and Dissemination (2014), *Preventing Falls in the community*, Effectiveness Matters October 2014. University of York.

[31] ×*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).

Methodology:
Bed occupancy and inpatient falls are calculated from data from Wards: 1/AAU [2]/4/5/6/7/9/10/13/14/16/17/18/19/21 includes Wards 6 Annex when open as temporary ward.

Bed days supplied by the Trust's Information Services Department. Falls comparable with National Reporting and Learning System [NRLS] calculation as follows:

- *X= the total number of all patient falls reported in hospital/unit in the most recent year for which data are available.*
- *Y= the total number of occupied bed days in your hospital/unit in the most recent year for which data are available, multiplied 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).

Ⓐ Data quality subject to third party review in 2015/16

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

Falls are the most commonly reported patient safety incident across acute providers. The table shows all reported inpatient falls across the Trust for the last three years and those which resulted in a fracture. The overall performance shows a decrease year on year in the reported falls rate per 1000 occupied bed days. A sign of a strong safety culture is a reduction in the number of incidents resulting in harm such as fracture. Whilst underlying fracture numbers are at similar levels, those resulting in fracture neck of femur (inpatient wards) have halved in the last year from ten to five cases.

The Royal College of Physician's *National Hip Fracture Database 2018* annual report describes the variation in care for the frail older patient who typically suffers this injury. Ward environments and staffing can contribute to the risk of a hospital fall. In the 2017 report, 5.3 per cent of Airedale inpatients sustained a hip fracture; Airedale reported a value 3.5 per cent in the 2018 report with performance showing an improvement. Across England in 2017, 3.7 of inpatients sustained a hip fracture.

Initiatives and progress in 2018/19

A key component in this quality work has been the introduction of a fall safety briefing (known as a safety huddle) on Wards 4, 5, 6, 9 and the Acute Assessment Unit. Led by a senior clinician, the objective is to identify those patients at high risk of falling and thereby determine how to prevent such a fall. Support from the Improvement Academy is provided in the team's own clinical environment, an approach which recognises the clinical expertise of front line health professionals. Work in the last year has focused on re-invigorating this initiative to ensure staff understand its purpose and continue to prioritise the bundle particularly in times of heightened activity where the temptation can be to focus on the immediate tasks and needs of patients. Monitoring of daily falls data indicates that there are fewer falls on those days where such a huddle is undertaken. Work to sustain progress is being further supported by an initiative to measure the days between falls. From July 2018, work to promote safety huddles has been prioritised with additional support and mentoring provided from the Yorkshire and Humber Improvement Academy. Work to sustain progress is being further supported by an ongoing initiative measuring the days between falls. From April 2018 to March 2019, Ward 5 recorded a stretch of 116 days between falls whilst the AAU, Wards 4 and 9 reported a period of more than 23 days between falls. This is a cultural shift away from accepting inpatient falls as "*normal*" and forms part of a proactive approach to prevention. All wards are in possession of bed and chair alarms; other specific medical equipment is also available, such as low beds, in support of patients assessed as at risk of falling.

Other constituent interventions which have demonstrated success in reducing falls include the *"End PJ Paralysis"* initiative goal is to get inpatients up, dressed and moving and avoid muscle atrophy from inactivity. The recommendation of the Royal College of Physicians *2017 National Falls Audit England and Wales* that providers ensure that all patients who need walking aids have access to the most appropriate type from the time of admission is being prioritised. The Frail Elderly Pathway Team is working with the ED and AAU to ensure staff have the competency to measure patients for walking aides. Further areas where developmental actions have been taken are around continence care planning and the management and assessment of delirium. An assessment tool for delirium, dementia and depression – the 3Ds – has been rolled out in conjunction with a *Continence Care Plan*.

Focussed work continues regarding patients who fall more than once. A key objective is to identify those patients at high risk of falling and determine how to prevent such a fall. Research indicates that an emphasis on reducing multiple falls (by the same patient) can reduce falls by between 20 and 30 per cent with a concomitant reduction in the overall level of harm. Key interventions include intentional rounding – a structured process whereby regular checks are carried out with individual

patients at set intervals – and enhanced supervision to improve the care and safety of those patients at a high risk of falling. In addition, the Enhanced Care Collaborative initiative has been adopted by Wards 4, 6 and 9. Other ward areas are actively using the core principles of enhanced care to provide person centred care promoting safety and optimising wellbeing. This is an NHS Improvement-led programme which focuses on improving the experience of patients who need enhanced supervision, as well as the experience of their carers, and staff providing care. For example, increasing the number of activities for patients needing enhanced supervision helps staff engagement and supports individualised care and patient experience.

Training is fundamental in raising awareness of the role that staff can play in fall prevention. Training is provided at a multi-disciplinary level via monthly induction organised by Practice Development with bespoke sessions available by request.

Other initiatives:

- Review of the process for reporting falls resulting in significant harm. Senior corporate nursing leads provide support to clinical teams by attending those clinical areas where a patient has fallen and sustained significant harm. The Rapid Response Visit identifies any immediate learning prior to a more formal investigative process.
- To evaluate compliance with NICE guidance, a clinical audit has been undertaken of those patients identified from incident data as having sustained a head injury. Resultant actions: the standard operating procedure has been reviewed with roles and responsibilities updated to reflect the changing clinical profile of the workforce.

Next steps

Continue to focus on:

- Best practice and new approaches to patient-centred care. This includes participation in the 2018 Royal College of Physician's *National Falls Audit* with a particular focus on inpatient falls resulting in fracture neck of femur.
- Quality improvement work through collaboration with Yorkshire and Humber Improvement Academy, the Enhanced Care Improvement Collaborative and district wide colleagues. In the last year a series of active ageing events hosted by the Airedale, Wharfedale and Craven clinical commissioning group have been aimed at older people with information about fall prevention.
- Ongoing review of fall risk assessments – the 2018 CQC inspection highlighted that these are not consistently considered.

3.2.3 Frail Elderly Pathway Team initiative

According to NHS England there has been a 65 per cent increase in the episodes of care in hospitals for those aged 75 and over. As we age and body systems decline, we can become more vulnerable to sudden events such as an infection or a fall. Whilst there are times when a frail older

person requires hospital admission, evidence suggests that if frail older people are supported to retain and/or recover independence after illness or injury they are less likely to reach crisis and require urgent care.[32]

The Trust's Patient Co-ordination and Flow Programme is part of transformational work to integrate and co-ordinate the contributions of nursing, medical, allied healthcare professionals, social workers, mental health professionals, GPs, care homes and voluntary organisations into a cohesive system. One such initiative developed over the last four years is the Frail Elderly Pathway Team which aims to instigate proactive care models such as personalised care and support planning and the targeting of geriatric resources.

Composed of Physiotherapists, Occupational Therapists, a Dietician and Senior Nurse, and with some social work input, the team is based on the Acute Medical Unit with Emergency Department in reach. The Frail Elderly Pathway Team's key objectives are to:

- Reduce hospital admissions by early specialist integrated assessment and intervention;
- Facilitate early discharge by commencing rehabilitation at the earliest stage to optimise recovery;
- Reduce length of hospital stay by rapid signposting to Intermediate care and Community Services;
- Act as an interface with Community Advanced Nurse Practitioners from the Collaborative Care Teams and work alongside voluntary and charitable services to avoid unnecessary admission through timely onward referrals; and,
- Provide integrated holistic care and treatment.

How we monitor progress

Meeting monthly, the multi-disciplinary Frail Elderly Pathway Joint Management Team aims to improve the active management of care for older people through review of outcome data – for example length of stay and patient and staff feedback. The group also looks at service improvements and training opportunities to improve the care and assessment of frail elderly patients including: updates on lying and standing blood pressure; medications with an influence on falls; and, use of the Rockford Frailty screening tool. The Patient Co-ordination and Flow Programme forms part of the "*Right Care" portfolio* and is monitored by the Board of Directors with progress reviewed on a quarterly basis.

Current status

A key performance indicator is length of stay, with the Frail Elderly Pathway Team aiming to reduce hospital stays for individual patients during each admission. The data below compares a baseline period (August 2014 to February 2016) when data collection commenced, with performance following the merger of the Ambulatory Care Unit with the Acute Medical Unit and the extension of the Team (March 2016 to September 2016). More recently (October 2016 to September 2017) seven day working was fully established which allows assessment of whether the Team has been able to improve outcomes from the point at which it was able to work most effectively. More recent figures allow evaluation of longer-term performance.

Patients seen by the Frail Elderly Pathway Team and discharged directly from the Acute Assessment Unit:

I. *August 2014 - February 2016: 3.80 days average*
II. *March 2016 – September 2016: 3.37 days average*

[32] NHS England (2014), *Safe, compassionate care for frail older people using an integrated care pathway.* https://www.england.nhs.uk/wp-content/uploads/2014/02/safe-comp-care.pdf [Accessed: 8/12/17]

III. *October 2016 – September 2017: 1.84 days average*
IV. *September 2017 to September 2018: 1.74 days average*

Overall and since the establishment of the team there has been a 2.06 day reduction in average length of stay per patient.

Patients seen by the Frail Elderly Pathway Team on the Acute Assessment Unit before being transferred to base wards for input from other specialties prior to discharge:

I. *August 2014 - February 2016: 17.3 days average*
II. *March 2016 – September 2016: 14.6 days average*
III. *October 2016 – September 2017: 12.05 days average*
IV. *September 2017 to September 2018: 14 days average*

Data source: *Airedale NHS Foundation Trust Information Services.*

Overall and since the establishment of the Team there has been a 3.3 day reduction in average length of stay per patient who after Frail Elderly Pathway assessment are admitted to a base ward. An average of 26 patients are seen each month in ED with 45 per cent of these being discharged to the community and not admitted to an acute ward. Of the patients seen by the Frail Elderly Pathway Team in the Acute Assessment Unit over the last 13 months, 49 per cent were discharged to the community and not admitted to an acute ward.

Qualitative feedback regarding the Frail Elderly Pathway Team commenced collection in August 2018. Assessment indicates the Team is making a tangible difference to the patient experience. An appraisal of the Dietician's community intervention will be undertaken in March 2019 and reported in the next update of this report. The perceptible transformation made by the establishment of a Frail Elderly Pathway Team has been recognised at local and national level through a series of awards and nominations. These accolades highlight the unique role that allied health professionals can play within the wider social, health and care sectors. The CQC 2017 inspection report and local system report for Bradford of how older people move between health and social care commends the team for its proactive approach to ensure patients received the *"Right Care"* as quickly as possible whilst highlighting the effectiveness of relationships-building amongst team members from the health and social care sectors.

Initiatives and progress in 2018/19

The Frail Elderly Pathway Team has been involved from the planning stages of the new Acute Assessment Unit – the integrated ED, Acute Medical, Surgical Assessment, and Ambulatory Care Unit. Seeking to avoid admissions, the Team has offered advice on the Unit's pathways of care and contributed to the rapid improvement events. More recently the Team invited Social Services to attend daily meetings in support of effective discharge planning. This has developed into the *"Get Me Home"* meetings and includes patients from across the hospital.

Other progress:

- In 2017 a quality improvement project looked at the use of the Rockford Frailty score to screen for frailty among patients on the Acute Medical Unit; results indicated the tool supported both identification and appropriate referrals. As a consequence, it has been added to the SystmOne assessment templates.
- To optimise efficiency and avoid the involvement of too many people in one person's care, team members have developed competencies beyond their own core areas.
- Knowledge and ideas to improve the process are shared across disciplines and locations. For example, the evaluation of walking and aid training for ward staff.

- Airedale is one of ten participating sites across Yorkshire and South West England in the HERO (Home-based Extended Rehabilitation of Older people) study, involving older people with frailty admitted to hospital following acute illness or injury. The overall aim is to investigate whether an extended rehabilitation programme using a home-based exercise intervention developed for older people with frailty improves health-related quality of life. The Community Therapists are providing this intervention in the community above usual care for a randomly assigned group over a 24 week period. The aim of the study is to inform community rehabilitation needs for this group of patients.

Next steps

- The Frail Elderly Pathway Team is supporting the new streaming of patients by attending the Ambulatory Care Unit (ACU) where GPs have requested a patient assessment.
- Continue to develop the daily "*Get Me Home"* meeting to improve flow within the AAU and hospital bed base.
- Identifying suitable patients for the existing Home First Service for East Lancashire patients and the new Airedale, Wharfedale and Craven Home First Service.
- Staffing-wise, consideration of the possible introduction of Assistant Practitioners into the existing team is planned. A Geriatrician attached to Frail Elderly Pathway Team commenced in January 2019.

3.3 Clinical effectiveness

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

3.3.1 Quality of healthcare for people with long-term conditions – Airedale Digital Care Hub

The challenge and our 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.[33] 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. Airedale's Digital Care 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.[34]

How we monitor progress

The multi-disciplinary Digital Care Hub Business and Governance Group is responsible for the delivery of this priority. Qualitative and quantitative monitoring is ongoing both internally and externally to support assessment of the impact of the innovation and inform future initiatives and strategy.

[33] 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 [Accessed 02/02/18].

[34] Dr Foster Intelligence (2013), *Dr Foster Hospital Guide 2013*. Dr Foster Limited. p.10.

Current status

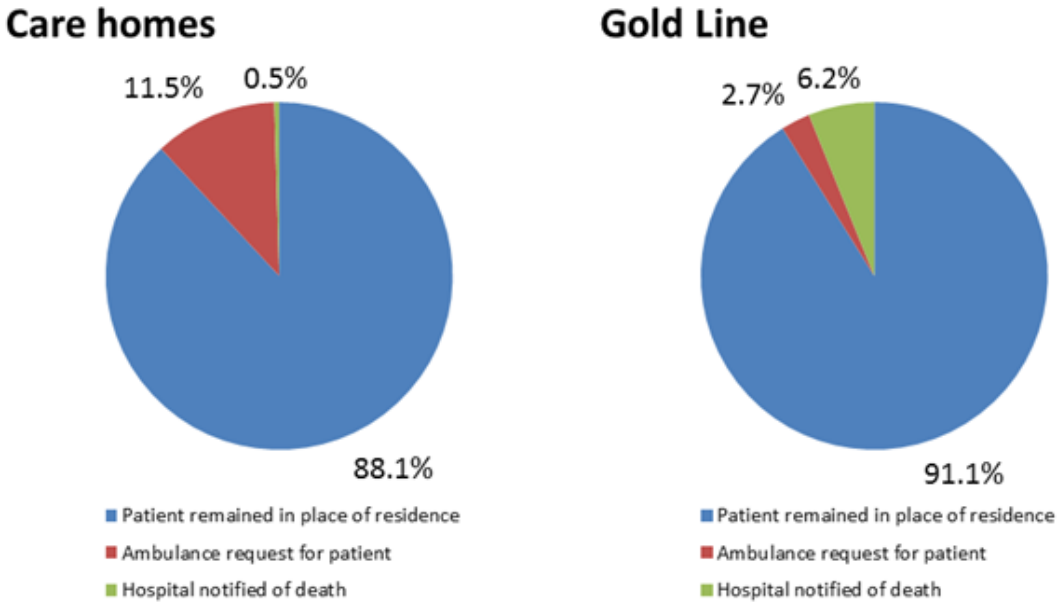
The Airedale Digital Care Hub offers teleconsultation by secure video link with nursing and residential homes. Staffed 24/7 by highly skilled registered healthcare practitioners, the team has developed to include Acute Care, Urgent Care and District Nurses, Fall Practitioners and Occupational Therapists. Areas of additional expertise include specialisms in dementia and palliative care. If required, escalation to a Consultant is available. Via the Hub, the team can review ongoing 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 that a patient's GP is kept informed of consultations. If a patient needs to come to hospital, staff are able to communicate with the Ambulance Service to ensure a direct admission.

Country-wide over 400 nursing and residential care homes are connected to the Hub via the Immedicare Service. Some of the primary reasons for Care homes contacting the Hub include: falls, suspected urinary tract infections, skin complaints, chest infections, pain management and medication issues. The Immedicare Service across Airedale, Wharfedale and Craven district has been decommissioned in the last year.

The Gold Line Service is another example of an innovative approach available via the Digital Hub. Created in partnership with patients, carers, GPs, commissioners and Manorlands Hospice, and made possible through a grant from the Health Foundation. The Gold Line service provides a single point of contact for patients in the last year of life and their carers to be able to access seven day, around the clock help and advice via the Hub. The initial pilot commenced in 2013 across Airedale, Wharfedale and Craven and was extended to the remainder of the Bradford district and its metropolitan populations in 2014.

The following figure illustrates patient outcomes for those registered with and accessing these assistive technologies from the Hub.

Figure 9: Patient outcomes April to December 2018



Data source: *Airedale NHS Foundation Trust Information Services.*

- ✓ The Hub regularly receives in excess of 2500 video calls each month from nursing and residential home patients across England and received calls from over seven thousand individual patients between April and December 2018.
- ✓ Each month the Gold Line Service handles around 1500 telephone calls and received almost two thousand individual patient calls between April and December 2018.
- ✓ Patients from over 600 GPs and 50 plus commissioning groups have been triaged across both the Care Home and Gold Line services. [35]

Other services and progress in 2018/19

Services delivered from the Digital Care Hub which support safe and clinically effective standards of care for those patients with long-term conditions include:

- The Intermediate Care Hub (IC_HUB)

This is a joint health and social care approach, and the result of organisational and district-wide integration work. The IC Hub acts as a health and social care referral point 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 and provide a supported and speedier discharge from hospital.

- The Multi-agency Integrated Discharge Team (MAID Service - known more latterly as Multi-agency Referral Hub)

The Multi-agency Integrated Discharge Team (MAID Service) launched in November 2017. This is collaboration between the IC_Hub team, Case Management Team and social care. The MAID Team aims to practice person centred care planning and support for eligible adults with complex needs, with a clear commitment to ensure patients are discharged safely into the most appropriate setting. The key areas of focus for this service are to maximise well-being, choice, control, independence and function; ensure people get the right care the first time; and, enable safe discharge from hospital.

- Specialist Speech Therapy Service

Following a successful pilot project to deliver an on-screen stammering therapy service from April 2017 to April 2018, the results have been evaluated by Leeds Beckett University and show positive patient outcomes. The project offers a specialist speech therapy service to adults across the UK via video link to patients' laptops, tablets and mobile phones. For patients this approach has many advantages over traditional clinic-based therapy: no travel or parking costs and no need to take time off work. Having won a *Guardian* Public Service award in 2017, the team were finalists at the 2018 *Health Service Journal* awards. The service is now continuing without external funding. The team are successfully supporting people to access the service through Individual Funding Requests submitted via their GP, and referrals have also been received from other providers who do not offer a specialist service.

Next steps

A project group has been established to explore the feasibility of providing a Care Co-ordination Centre across Airedale Wharfedale and Craven. Basic elements of this service exist within the Digital Care Hub – the Immedicare Care Home Service, Gold Line and IC-Hub and MAID Service. The project aims to harmonise services and deliver a holistic and responsive care model that provides the support to manage long-term conditions within the best setting for the individual.

[35] Data source: *Airedale NHS Foundation Trust Information Services.*

3.3.2 The monitoring of Caesarean section rates through the safe promotion of physiological birth

The challenge and our aim

Whilst it is important to point out that a caesarean is in itself, 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, there are a number of risks associated with this procedure for mother and baby. The Maternity Unit aims to optimise opportunities for active physiological birth and to reduce medical intervention where appropriate. Both medical and midwifery staff are fully committed to this philosophy of care.

Following the Royal College of Midwives revised guidance regarding *"normal birth"* we have reviewed our guidelines. We scrutinise what women tell us about our service – most recently in the *2018 CQC Maternity Survey* – and as a service are committed to providing a positive experience for all women under our care.

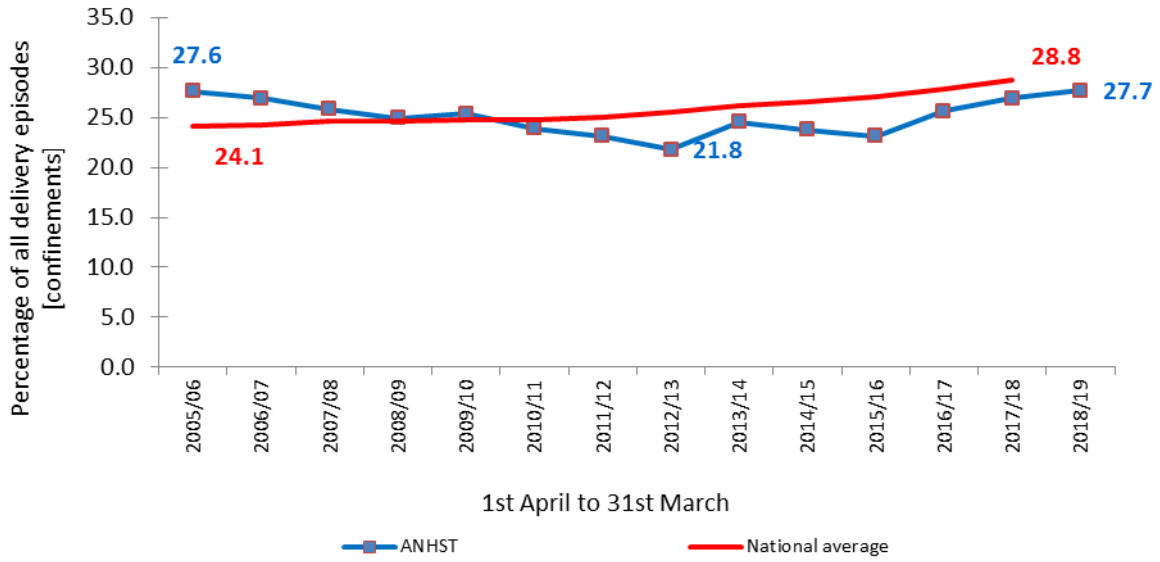
How we monitor progress

To understand performance against this priority, the multi-disciplinary Women's Integrated Governance Group receives monthly aggregated and disaggregated caesarean section rates. Case note review by senior staff against guidance and recommendations for best practice in respect of elective and non-elective caesarean section is regularly undertaken and informs the group discussion. Maternity Voices Partnership Groups have been set up to support the voices of service users to be heard and shape future services. Alongside Family and Friends and Real Time Survey findings, this feedback informs discussion around service provision.

Current status

The latest available England percentage of caesarean hospital deliveries is 28.8 per cent for 2017/18, reflecting a continuing national incremental trend in caesarean birth. The Trust's overall 2018/19 caesarean section rate of 27.7 per cent compares favourably although also shows an increasing trend. Finer grained analysis indicates that the rate for electives is 13.1 percent compared to the England 2017/18 average of 12.6 per cent.

Figure 10: Caesarean section rate for Airedale NHS Foundation Trust long-term trend



Data Source: *Information Services and NHS Digital .*

Initiatives and progress in 2018/19

- The service is part of the National Maternity and Neonatal Health Safety Collaborative, a three year programme launched in 2017 to promote a safety culture and national and neonatal systems and thereby reduce rates of maternal and neonatal deaths, stillbirths and injuries that occur during or soon after birth. Nominated improvement leads from our service continue to build on their knowledge of improvement theory by attending learning sessions and developing improvement goals.
- Maternity Safety Champions within the service promote safer maternity care focusing on human dimensions, systems and processes, clinical excellence and patient experience.
- The bespoke Midwifery Led Unit provides a homely environment. With access to a private outdoor space and a less clinical labour room, it offers a relaxing place to give birth. Resources include a birthing pool. Figures for 2018 indicate almost seven per cent of women labouring in the pool and around six per cent giving birth in water.
- 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 (VBAC). The service's goal is to reduce the number of second caesarean sections through the implementation of the following:

    - The Patient Decision Aid (PDA), introduced in 2014, aims to ensure that all women eligible for VBAC receive and have the opportunity to discuss essential information upon which to base their decision about method of delivery.
    - The Midwife led VBAC clinic, allowing 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.
    - Wireless cardiotocography – CTG – monitors allow women who have had a previous caesarean section to be monitored while remaining active in labour and even to labour in water.

- High risk antenatal care, low risk intrapartum (HALO) care system permits 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 possibility of obstetric intervention and offering the best opportunity for a vaginal birth in a low risk setting.

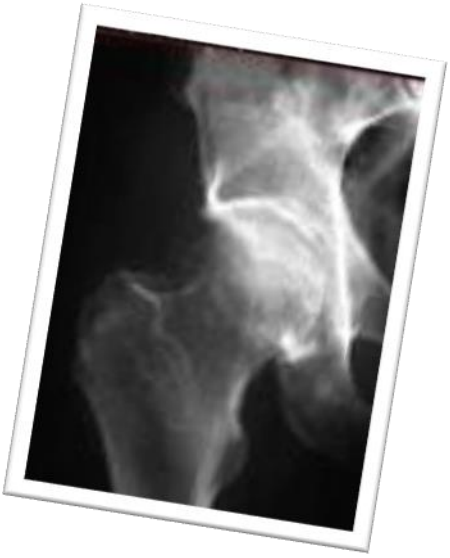
- External Cephalic Version – ECV – is offered to women with a baby in the breech position and for whom it is safe. This may remove the need for caesarean section in those women for whom this manoeuvre is successful.
- A Positive Birth Group has been established by the Labour Ward Manager. Comprised of midwives, the group aims to increase positive birth messages. For example, a Ward Birth Lead has been identified and discussions around increasing training to boost staff facilitation has commenced.
- A pilot has been ongoing for over a year to develop partnership working between Airedale Maternity Unit and local independent midwives and offers the opportunity to support women's birthing choices, continuity of care and enhance safety through, for example, information sharing and training. This approach is proving successful with independent midwives participating in the obstetric emergency training.

Next steps

Planned and ongoing work includes:

- A Rapid Improvement Event supported by the Quality Improvement Team to focus on induction of labour with emphasis on a multi-disciplinary approach.
- Work with women, midwives, clinicians, leaders, managers, researchers and commissioners to implement national *Better Births (*Maternity Review *2016)* recommendations to reduce stillbirths and mother and child deaths through the implementation of a team continuity of care model. Team continuity, is defined as each woman having an individual midwife, who is responsible for co-ordinating care, and who works in a team of up to eight midwives. The woman may meet all members of the team but a "*buddy system*" is in place to reduce the number of midwives seeing women. The initial trajectory is that 20 per cent of women booked for maternity care at Airedale NHS Foundation Trust will receive team continuity of carer by March 2019. Our pilot consists of two teams of hospital and community based midwives. In the initial phase the midwives will work predominantly within their current area of practice, but gradually will work across both hospital and community to increase intrapartum continuity for women. In addition to this we have several fully independent midwives attached to Airedale. We look forward to updating you on progress in the coming year.

3.3.3 Fractured neck of femur improvement project



The challenge and our aim

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.[36] For those who recover, there is a possibility of a loss in mobility and independence.

Research suggests that organisational factors in a patient's treatment can affect outcomes. Our aim is to improve recovery from fractured neck of femur by focussing on such factors in a patient's treatment.

How we monitor progress

Orthopaedic multi-disciplinary audit governance meetings are held monthly to identify areas of improvement and understand outcomes for this group of patients.

Current status

Measurement over time is essential to understand progress and the group monitors best practice targets and participates in the Royal College of Physicians' Falls and Fragility Fracture Audit Programme. According to the *National Hip Fracture Database Annual Report* (NHFD) *2018*, of the 264 cases submitted in 2017, performance is within the top quartile of the 175 eligible providers for the following standards for the management of hip fracture:

- Mobilised out of bed by the day after surgery;
- Nutritional risk assessment;
- Surgery on day of, or day after, admission;
- Spinal anaesthetic and nerve block
- Proportion of arthroplasties which are cemented; and,
- Intertrochanteric fractures (excl. reverse oblique) treated with sliding hip screw

Performance was within the lower quartile for the following:

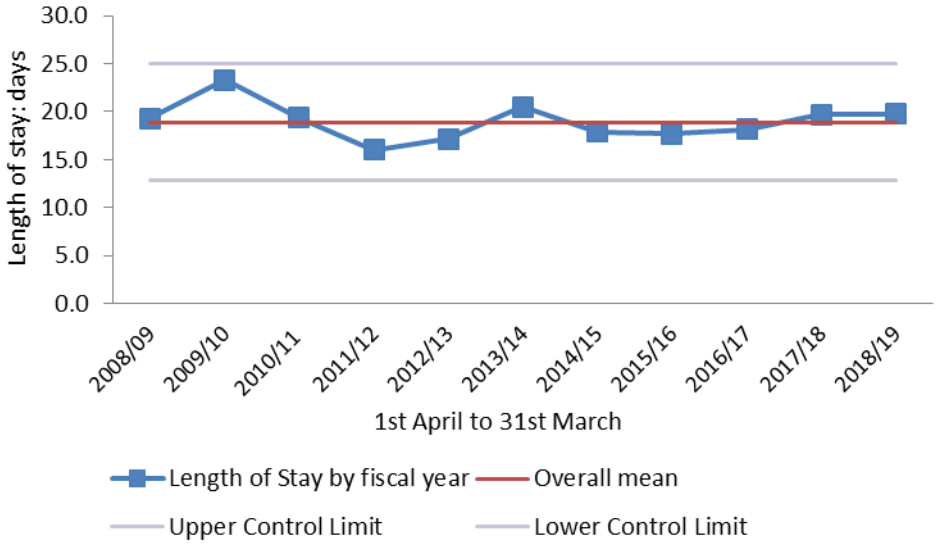
- Mental test score recorded on admission;
- Documented final discharge destination;
- Discharge to original residence within 120 days; and,
- 120 day follow up – not currently undertaken.

In 2018 the best practice tariff was met in 69.8 per cent of Airedale patients compared to 63.2 per cent across England. We aim to continually improve our overall performance for achieving the NHFD best practice tariff. Where standards are not met, the reasons are investigated to understand if clinical care can be more effectively delivered.

[36] NICE (2011), Hip Fracture. *The management of hip fracture in adults. NICE clinical guideline 124.* NICE: Manchester.

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.

Figure 11: Fractured neck of femur mean length of stay [days] for Airedale General Hospital patients



Data source: *Airedale NHS Foundation Trust Information Services.*

The figure describes our performance in the last ten years in the reporting period 1st April to 31st March: mean length of stay is 18.9 days with upper and lower confidence interval (three standard deviations) ranging from 12.8 to 25.0 days. These intervals help to identify variation which falls outside the expected limits and supports understanding of whether length of stay is longer or shorter than expected. Over the last six years performance has been consistently around the average. Between 1st January and 31st December 2017, the overall hospital mean length of stay for eligible England was 18.6 days; performance for Airedale General Hospital was 21.7 days.[37] No adjustment for case mix is made.

Initiatives and progress in 2018/19

To support the delivery of the best practice pathway and improve outcomes for this patient group, the following actions have been taken to address either areas identified in 2017 as requiring improvement or to advance current provision:

- Commencing April 2018 all hip fracture patients are only admitted to the Orthopaedic ward (Ward 9). The provision of a Hip Fracture Receiving Bed on Ward 9 supports the fast track transfer of a patient with a hip fracture from the Emergency Department. The patient can then be moved into another Ward 9 bed rather than being nursed in beds not overseen by specifically trained orthopaedic nurses. This minimises unnecessary pre-operative starving of hip fracture patients awaiting surgery and improves provision of pre-operative carbohydrate loading drinks.
- An Advanced Nurse Practitioner (ANP) works alongside an Orthopaedic Nurse Specialist (ONS) on Wards 9 and 18 to improve continuity of care for Orthopaedic patients.
- The introduction of a blood management protocol for fracture neck of femur patients.

[37] Royal College of Physicians' (2018), *Falls and Fragility Fracture Audit Programme. The National Hip Fracture Database Extended Report 2018.* Health Quality Improvement Partnership. Available at: http://www.nhfd.co.uk/20/nhfdcharts.nsf/fmbenchmarks?readform&report=outcomes&year=2016&region=Yorkshire%20and%20The%20Humber [Accessed 14/01/19].

- Post-operative nutrition has been addressed through offering protein supplements as there is evidence of benefits for this patient with a fragility fracture.
- The 4AT is a rapid clinical instrument for delirium detection. Championed by the ONS, the short test is designed to be used by any healthcare professional when delirium is suspected.
- As of April 2018 post-operative physiotherapy is being provided seven days a week (prior to this it was only available weekdays). The idea is to ensure that all patients who are fit enough are mobilised from bed the day following surgery to reduce complications.
- All junior ward doctors are trained at the start of their rotation by the orthopaedic ANP and ONS to carry out fascia iliac blocks. Our aim is to offer and maintain nerve block in the perioperative period. An audit of its use is planned.
- The aspiration is for all patients with a fractured neck of femur to be admitted under Orthogeriatrics and to be cared for by this team. Due to long-term staffing pressures, including a national shortage of consultant Orthogeritricians, this remains a challenge. In order to support junior doctors and the Care of the Elderly Medical Team a medical post in Care of Elderly Orthopaedics has been funded and staffed by a series of able, competent and motivated Foundation Year 3 doctors. This acts to fill the shortfall between desired Consultant Orthogeriatric Care and available Consultant Orthogeriatric Care.

Next steps

- In line with Public Health England's system based approach, Airedale's Orthopaedic Team is seeking to set up a Fracture Liaison Service (FLS) within the Trust to minimise future fragility fractures. A multi-disciplinary service would identify, investigate, initiate treatment and integrate care for all eligible patients aged 50 and over with a fragility fracture with the aim of reducing the risk of further fractures via education, exercise and risk assessment. Such a service would also address areas of shortfall against the NICE guidelines for fragility fractures as identified in local clinical audit of standards.

Other local trusts, including Bradford Teaching Hospital NHS Foundation Trust, have successful FLS in place. Meetings have been held with commissioners, the Board of Directors and the National Osteoporosis Society to develop a robust patient pathway with staff keen to implement. Unfortunately funding from the commissioners is yet to be obtained and discussions as to provision of a FLS in the near future remain ongoing. In the interim a risk assessment to address this deficiency is in place.

- As a small acute trust, there can be wide variations in activity. It is planned that there will be additional theatre capacity in Orthopaedics within the next 12 to 18 months. This will allow flexibility to absorb these fluctuations in demand for acute theatre time.

3.4 Performance against key national priorities

The following indicators support the national priorities and form part of the appendices 1 and 3 of the current *Single Oversight Framework*. Returns conform to specified data quality standards and prescribed standard national definitions[21] and are subject to third party scrutiny and review.

Indicator	Threshold	2016/17	2017/18	2018/19
All cancers: 62-day wait for first treatment, comprising either:				
▪ from urgent GP referral to treatment	85%	92.3%	89.1%	Ⓐ 86.05%
▪ from NHS Cancer screening service referral	90%	93.8%	91.2%	90.7%
Maximum 18 week waits from referral to treatment in aggregate – patients on an incomplete pathway	92%	Ⓐ 91.5%	Ⓐ 92.3%	92.7%
A&E maximum waiting time of four hours from arrival to admission/ transfer/ discharge	95%	Ⓐ 90.6%	Ⓐ 93.3%	Ⓐ 89.22%
Clostridium difficile: variance from plan	6	4	5	6*
Maximum 6 week wait for diagnostic procedures	99%	-	97.8%	96.3%

* One case awaiting review.

Ⓐ = subject to third party audit on behalf of NHS Improvement. See section 4.5 for detail of data testing in 2018/19.

Data source: *Airedale NHS Foundation Trust Information Services.*

Part 4: Annex

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

The draft *Quality Report* 2018/19 was circulated to NHS Airedale, Wharfedale and Craven CCG, Bradford City CCG and Bradford Districts CCG with the following feedback received:

Scorex House
1 Bolton Road
Bradford
BD1 4AS

Tel: 01274 237290

Airedale NHS Foundation Trust Quality Report 2018/19

On behalf of NHS Bradford District and Craven CCGs, I welcome the opportunity to feedback to Airedale NHS Foundation Trust (ANHSFT) on its Quality Report for 2018/19.

The NHS recently marked its 70th Anniversary; this is a key time to reflect upon achievements across partnerships and look forward to new ways of working, which crucially harnesses the power of people and communities. The Trust has been a key partner in delivering ongoing care and improvements to the population of Bradford District and Craven and has demonstrated a continued commitment to place quality improvement at the very heart of the organisation, from floor to board.

I would like to start by offering my congratulations to the Trust on their key achievements during 2018/19 which include:

- Being named as one of the top five hospitals for patient safety in the CHKS Top Hospitals programme 2018.
- The implementation of the Trauma and Resuscitation Team Skills (TaRTS) course in other hospitals and identified as outstanding practice by the Care Quality Commission (CQC)
- Successful achievement of Joint Advisory Gastrointestinal Endoscopy Accreditation.
- Extended funding for the ACE2 cancer pilot site to establish a ‘one stop shop’.
- Provision of a mobile cancer unit, the first of its kind in the North of England.
- Successful in a joint bid to become a Local Health and Care Record Exemplar (LHCRE) site.

I am also encouraged by the initiatives that contribute to the strengthening of the wider system, which include:

- Joint working with Bradford Teaching Hospitals NHS Foundation Trust and commissioners on the Acute Provider Collaboration programme and in particular the improvement in the stroke services that are delivered across the District. The most recent Sentinel Stroke National Audit Programme (SSNAP) reports an improvement for ANHSFT’s score for both patient and team centred.
- The opening of the new pathology blood science laboratory as part of a whole system pathology renovation.
- As a national pilot site, the successful registration of the first cohort of Nursing Associates with the Nursing and Midwifery Council in January 2019.

- The launch of and inclusion in the Red Bag Hospital Transfer pathway to improve the experience for older people in care homes.

Following the Care Quality Commission (CQC) annual well-led and core service inspection during November and December 2018, I note the Trust received an overall rating of 'Requires Improvement' and also received a combined rating from NHS Improvement (NHSI) and the CQC of 'Good' for 'Use of Resources'. I note that the Trust were rated as 'Good' for the 'Responsive', 'Caring' and 'Effective' domains, and 'Requires Improvement' for 'Safe' and 'Well-Led'. I acknowledge that the inspectors recognised that progress had been made since your last inspection, but identified areas requiring further and more rapid improvement. These include nurse and medical staffing levels and skill mix, and how well leaders improve the quality of services and safeguard high standards of care. In response to the CQC 'Quality Report' of March 2019, I am pleased to note you have developed a Quality Improvement Plan that you will be monitoring with added rigor to embed consistent and sustained improvements.

In response to the recognised national and local workforce shortages and through the Trust's 'People Plan', I note that you are making every effort to recruit, retain and mitigate against medical and nursing staff vacancies. I also note your focus on governance and leadership, including your goal to develop leaders with the required skills at every level of the organisation.

It is disappointing that the Trust have reported three Never Events during 2018/2019. I welcome that the quality report makes reference to working collaboratively with NHS Improvement and details how learning is being implemented into practice.
The priority areas identified by ANHSFT for 2019/20 include a continuation from the previous year in recognition that there are further improvements required. These are:

Patient experience:
- Improving the quality of wound care for patients both in hospital and the community
- Improving care for patients living with dementia
- Privacy and dignity: promotion of a customer services culture

Patient safety:
- Infection prevention and control
- Reduction of slips, trips and falls sustained by patients admitted to our hospital wards
- Improve the prevention, early identification and management of Acute Kidney Injury
- Frail Elderly Care Pathway Team initiative (to identify frailty and enhance care planning between health and social care)

Clinical effectiveness:
- Management of sepsis;
- Airedale Digital Care Hub and the overall quality of healthcare for people with long-term conditions;
- The monitoring of Caesarean section rates through the optimisation of opportunities for physiological birth; and,
- Fractured neck of femur improvement project.

A new priority area for 2019/20 is:
- Improving the care and support for people with mental health needs.

The report includes a review of last years' priorities and I note the improvements the Trust has achieved against these, which includes:

- Collaborative working to successfully achieve the 80% target for wounds that have failed to heal within four weeks to have a comprehensive wound assessment.
- Identification and management of acute kidney injury; working to the recently introduced care bundle alongside an educational programme and raising awareness of the “Think Kidneys initiative”.
- Management of sepsis; working to the recently introduced care bundle, the adoption of screening tools and the introduction of sepsis trolleys in key areas.

Other initiatives include:

- Screening of patients aged 75 and over admitted as an emergency for dementia or delirium, with a 90% target being achieved in 2018-19.
- Adoption of the ‘End PJ Paralysis’ campaign.
- Developing the skills and expertise of the workforce to improve care for patients with dementia.
- The introduction of a fall safety briefing (safety huddle) across a number of wards.

ANHSFT continues in its aspirations to provide high quality safe and effective services and I welcome the Trust’s commitment to further build and improve on these priorities.

ANHSFT has committed to working as one system to integrate care and actively supports local community partnerships. Demonstrable progress has been made towards utilising the opportunities a shared system will bring involving other partners which includes working as part of the West Yorkshire Association of Acute Trusts and the West Yorkshire and Harrogate Health and Care Partnership.

I can confirm that the Trust’s statements of assurance have been completed demonstrating achievements against essential standards.

I recognise that the workforce remains hugely committed to meeting the needs of the local population in a year of both progress and pressures. I commend the Trust’s ongoing commitment to improve the quality and safety of the care that our communities receive. I look forward to continuing to work with you and other partners across the health and social system to ensure that local people will be healthier, happier, and have access to high quality care that is clinically, operationally and financially stable.

Finally I confirm that I believe this report to be a fair and accurate representation of ANHSFT’s achievements and commitments to improve the safety and quality of care of their services.

Helen Hirst
Chief Officer
NHS Airedale, Wharfedale & Craven,
Bradford City & Bradford Districts CCGs

CCGs working together

NHS Airedale, Wharfedale and Craven CCG
Bradford City CCG
Bradford Districts CCG

4.2 Overview and Scrutiny Committee

The draft *Quality Report* 2018/19 was circulated to Bradford Metropolitan District Council Health Overview and Scrutiny Committee and North Yorkshire County Council Overview and Scrutiny Committee for comment. Receipt was acknowledged by both group and the following feedback was received.

Statement from the Chairman of the Scrutiny of Health Committee:

Over the past 12 months, the North Yorkshire Scrutiny of Health Committee has continued to work with the Airedale NHS Foundation Trust to better understand the financial, workforce and clinical pressures within the local health system and the measures that have been put in place to respond to them. This has involved engagement in the West Yorkshire and Harrogate Joint Health Overview and Scrutiny Committee, which is looking at area wide changes to health services including Craven.

The NHS nationally, regionally and locally is undergoing a sustained period of change both planned and reactive. The Scrutiny of Health Committee is committed to maintaining a system-wide view of services that helps to ensure that individual responses to individual problems do not lead to variations in health care provision which mean that people are disadvantaged by where they live in the county.

In 2018/19, the support that has been provided by lead members of the Trust has been appreciated. Over the next year, the Scrutiny of Health Committee looks forward to working with commissioners and providers on the development of integrated and sustainable systems of care in rural areas that use the assets that are currently available in new ways.

County Councillor Jim Clark
Chairman, North Yorkshire Scrutiny of Health Committee
1 May 2019

4.3 Healthwatch

The draft *Quality Report* 2018/19 was circulated to Healthwatch Bradford and District and Healthwatch North Yorkshire and Healthwatch Lancashire for comment. No feedback was received.

How to provide feedback on the Quality Report

Hopefully the Quality Report has been informative. We welcome your feedback and suggestions you may have for next year's publication.

The Annual report and *Quality Report* will be available on our website at:
www.airedale-trust.nhs.uk

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

4.4 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.

NHS Improvement 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 the 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 2018/19 and supporting guidance
- the content of the Quality Report is not inconsistent with internal and external sources of information including:

  o board minutes and papers for the period April 2018 to the date of this statement.

  o papers relating to quality reported to the board over the period April 2018 to [the date of this statement]

  o feedback from commissioners dated 20/05/19

  o feedback from governors dated 14/03/19

  o feedback from local Healthwatch organisations - none received.

  o feedback from Overview and Scrutiny Committee dated 01/05/2019.

  o the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated May 2019

  o the [latest] national patient survey 13/06/2018

  o the [latest] national staff survey 26/02/2019

  o the Head of Internal Audit's annual opinion of the trust's control environment dated 24/05/2019

  o CQC inspection report dated 14/03/2018

- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered
- the performance information reported 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 reported 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 NHS Improvement's annual reporting manual and supporting 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

Chair

Date: 28 May 2019

Chief Executive

Date: 28 May 2019

4.5 NHS Improvement guidance for data quality assurance on Quality Reports

NHS Improvement requires foundation trusts to obtain external assurance on its *Quality Reports*. Set out below is the detailed 2018/19 guidance for auditors to enable review and testing of data quality. To the best of our knowledge and belief the information used to calculate indicators is complete, accurate and relates to the reporting period.

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

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 (Annex B: NHS Constitution measures).

4.5.2 Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

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

Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https: https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

This indicator is as required to be reported by the *Risk Assessment Framework:*
A&E four-hour wait: waiting time is assessed on a provider basis, aggregated across all sites: no activity from off-site partner organisations should be included. The four-hour waiting time indicator applies to minor injury units/walk-in centres.

Numerator
The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as: (Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator
The total number of unplanned A&E attendances

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 (see Annex B: NHS Constitution Measures).

Indicator format
Reported as a percentage

4.6 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) The local NHS organisation responsible for making sure that appropriate health services are in place to meet local people's needs.

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 trust 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.

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 organisations, it ensures that the voices of consumers reach the ears of the decision makers.

NHS Digital The national provider of information, data and information technology systems for health and social care.

NHS 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).

NHS Improvement is responsible for overseeing foundation trusts and NHS trusts, as well as independent providers of NHS funded care. It aims to support the delivery of high quality, compassionate care within local health systems that are financially sustainable.

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 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.

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

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

SAFER patient flow bundle
SAFER is a practical tool to reduce delays for patients in adult inpatient wards. It stands for: S - Senior Review; A – All patients will have an expected discharge date and clinical criteria for discharge; F - Flow of patients to commence at the earliest opportunity from assessment units to inpatient wards; E – Early discharge; R – Review. A systematic multi-disciplinary team review of patients with extended lengths of stay.

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.

Independent Practitioner's Limited Assurance Report to the Council of Governors of Airedale NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Airedale NHS Foundation Trust to perform an independent limited assurance engagement in respect of Airedale NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the "Quality Report") and certain performance indicators contained therein against the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and additional supporting guidance in the 'Detailed requirements for quality reports 2018/19' (the 'Criteria').

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to the limited assurance engagement consist of the national priority indicators as mandated by NHS Improvement:

- Percentage of patients with a maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

We refer to these national priority indicators collectively as "the indicators".

Respective responsibilities of the directors and Practitioner

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the 'NHS foundation trust annual reporting manual 2018-19' and supporting guidance issued by NHS Improvement.

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 is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance and the six dimensions of data quality set out in the ''Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance 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:

- Board minutes for the period 1 April 2018 to the date of this report;
- papers relating to quality reported to the Board over the period 1 April 2018 to the date of this report;
- feedback from commissioners dated 20/05/2019;
- feedback from governors dated 14/05/2019;
- feedback from the Overview and Scrutiny Committee dated 01/05/2019;
- the Trust's complaints report published under regulation 18 of the Local Authority, Social Services and National Health Service Complaints (England) Regulations 2009, dated May 2019;

- the national patient survey dated 13/06/2018;
- the national staff survey dated 26/02/2019;
- the Head of Internal Audit's annual opinion over the Trust's control environment dated 24/05/2019; and
- the Care Quality Commission's inspection report dated 14/03/2019.

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

The firm applies International Standard on Quality Control 1 (Revised) and accordingly maintains a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

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 NHS Foundation Trust as a body, to assist the Council of Governors in reporting Airedale 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 2019, 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 NHS Foundation Trust for our work or this report, except 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 (Revised) '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:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- making enquiries of management;
- limited testing, on a selective basis, of the data used to calculate the indicators tested against supporting documentation;
- comparing the content requirements of the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is narrower 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 that can result in materially different measurements and can affect 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 of these criteria, may change over time. It is important to read the Quality Report in the context of the criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance.

The scope of our limited assurance work has not included governance over quality or non-mandated indicators, which have been determined locally by Airedale NHS Foundation Trust.

Our audit work on the financial statements of Airedale NHS Foundation Trust is carried out in accordance with our statutory obligations and is subject to separate terms and conditions. This engagement will not be treated as having any effect on our separate duties and responsibilities as Airedale NHS Foundation Trust's external auditors. Our audit reports on the financial statements are made solely to Airedale NHS Foundation Trust's members, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work is undertaken so that we might state to Airedale NHS Foundation Trust's members those matters we are required to state to them in an auditor's report and for no other purpose. Our audits of Airedale NHS Foundation Trust's financial statements are not planned or conducted to address or reflect matters in which anyone other than such members as a body may be interested for such purpose. In these circumstances, to the fullest extent permitted by law, we do not accept or assume any responsibility to anyone other than Airedale NHS Foundation Trust and Airedale NHS Foundation Trust's members as a body, for our audit work, for our audit reports, or for the opinions we have formed in respect of those audits.

Conclusion

Based on the results of our procedures, as described in this report, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the Criteria set out in the 'NHS foundation trust annual reporting manual 2018/19' and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in NHS Improvement's 'Detailed requirements for external assurance for quality reports 2018/19'; and
- the indicators in the Report identified as having been subject to limited assurance have not been reasonably stated in all material respects in accordance with the 'NHS foundation trust annual
- reporting manual 2018/19' and supporting guidance.

Grant Thornton UK LLP
Chartered Accountants
Leeds

29 May 2019

CHAPTER 4
ANNUAL ACCOUNTS 2018/19

Independent auditor's report to the Council of Governors of Airedale NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion

Our opinion on the financial statements is unmodified

We have audited the financial statements of Airedale NHS Foundation Trust (the 'Trust') and its subsidiaries (the 'group') for the year ended 31 March 2019 which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers Equity, the Consolidated Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Accounts Directions issued under the National Service Act 2006, the NHS foundation trust annual reporting manual 2018/19 and the Department of Health and Social Care group accounting manual 2018/19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the group and of the Trust as at 31 March 2019 and of the group's expenditure and income and the Trust's expenditure and income for the year then ended;
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care group accounting manual 2018-19; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

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

Conclusions relating to going concern

We have nothing to report in respect of the following matters in relation to which the ISAs (UK) require us to report to you where:

- the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is not appropriate; or
- the Accounting Officer has not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the group's or the Trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue.

Overview of our audit approach

Financial statements audit

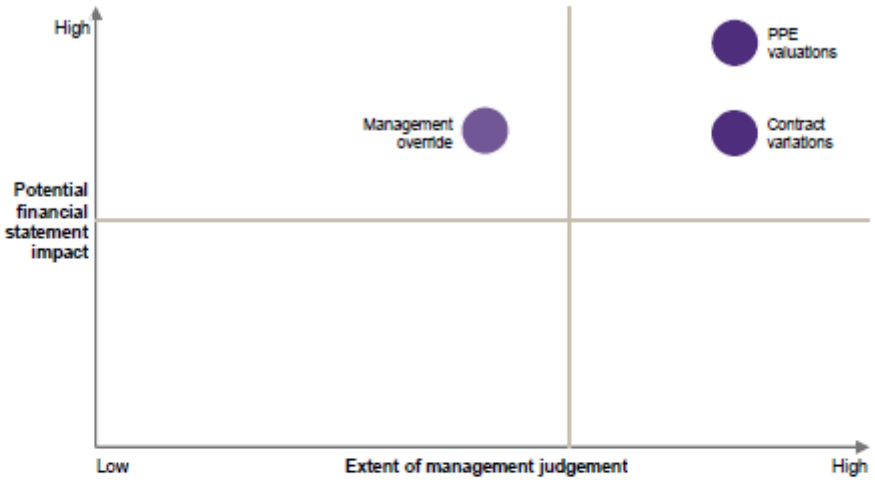
- Overall materiality: £3,031,000, which represents 1.8% of the group's gross operating costs (consisting of operating expenses and finance expenses)
- Key audit matters were identified as:
  - Revenue recognition: contract variations and other operating income
  - Valuation of land and buildings.
- We performed a full scope audit of Airedale NHS Foundation Trust, targeted audit procedures on the subsidiary AGH Solutions Ltd and analytical procedures on the non-significant component Airedale NHS Foundation Trust Charitable Funds.

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

- We identified three significant risks in respect of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (see Report on other legal and regulatory requirements section).

Key audit matters

The graph below depicts the financial statement audit risks identified and their relative significance based on the extent of the financial statement impact and the extent of management judgement.



Key audit matters are those matters that, in our professional judgment, were of most significance in our audit of the financial statements of the current year and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those that had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

Key Audit Matter – Group	How the matter was addressed in the audit – Group
Risk 1: Revenue recognition - occurrence and accuracy of contract variations income and other operating income and existence of associated receivable balances The Trust's significant income streams are operating income from patient care activities and other operating income. Over 91% of the Group's income from activities is from contracts with NHS commissioners. These contracts include the rates for and level of patient care activity to be undertaken by the Trust. The Trust recognises patient care activity income during the year based on the completion of these activities. This includes the block contract, which is agreed in advance at a fixed price, and patient care income from contract variations. Any patient care activities provided that are additional to those incorporated in these block contracts with NHS commissioners (contract variations) are subject to verification and agreement by the commissioners. As such, there is the risk that income is recognised in the financial statements for these additional services that is not subsequently agreed to by the commissioners. Due to the nature of block contracts we have not identified a significant risk of material misstatement in relation to block contracts. 9% of the Group's income is recorded as other operating income (excluding Education and Training income). Due to other operating revenue other than Education and Training income being characterised by estimation and judgements in their recognition we have identified a significant risk of material misstatement in relation to these elements of other operating revenue. We therefore identified the occurrence and accuracy of contract variations income and other operating income, and the existence of associated receivable balances as a significant risk, which was one of the most significant assessed risks of material misstatement.	Our audit work included, but was not restricted to: • Evaluating the Group's accounting policies for recognition of income from patient care activities and other operating income for appropriateness and compliance with the Department of Health and Social Care (DHSC) Group Accounting Manual (GAM) 2018/19; • Updating our understanding of the Trust's system for accounting for income from patient care activities and other operating income and evaluating the design of the associated controls; <u>In respect of patient care income:</u> • Obtaining an exception report from the DHSC that details differences in reported income and expenditure and receivables and payables between NHS bodies, agreeing the figures in the exception report to the Trust's financial records and obtaining supporting information for all differences over £300,000, to corroborate the amount recorded in the financial statements by the Trust; • Corroborating a sample of income from contract variations and year-end receivables to supporting evidence; • Assessing and challenging management's estimates and judgements taken in order to arrive at the income from contract variations recorded in the financial statements; and <u>In respect of other operating income:</u> • Agreeing Provider Sustainability Fund income to NHS Improvement (NHSI) notifications for quarters 1, 2 and 3 and obtaining evidence that NHSI requirements for recognising quarter 4 income have been met. The Group's accounting policies for recognition of revenue from contracts with customers and from NHS contracts and from other operating income is shown in note 1.4 to the financial statements and related disclosures are included in notes 3 and 9. **Key observations:** We obtained sufficient audit evidence to conclude that: • the Group's accounting policies for recognition of contract income and other operating income comply with the DHSC Group Accounting Manual 2018-19 and have been applied appropriately; and • Contract variations income and other operating income and the associated receivable balances are not materially misstated.
Risk 2: Valuation of land and buildings The Trust re-values its land and buildings on a regular basis to ensure that the carrying value is not materially different from fair value This represents a significant estimate by management in the financial statements. In valuing the Trust's estate, management have made the assumption that the main hospital site, if needed to be replaced, would be rebuilt to modern conditions on an alternative site nearby. The Trust commissioned a valuer to value the Trust's newly completed Acute Admissions Unit as at 31 March 2019 the remainder of the estate has not been revalued during the financial year. The impact of the valuation was an impairment of £3.9m for the Acute Admissions Unit charged to the statement of comprehensive income.	Our audit work included, but was not restricted to: • evaluating management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts and the scope of their work • evaluating the competence, capabilities and objectivity of the Trust's valuation expert • discussing with the Trust's valuer the basis on which the valuations were carried out and challenging the key assumptions applied • testing the information used by the valuer to ensure it is complete and consistent with our understanding • testing, revaluations made during the year to ensure they have been input correctly into the Trust's asset register

Key Audit Matter – Group	How the matter was addressed in the audit – Group
We therefore identified valuation of land and buildings as a significant risk, which was one of the most significant assessed risks of material misstatement.	• evaluating the assumptions made by management for any assets not revalued during the year and how management has satisfied themselves that these are not materially different to fair value The group's accounting policy on valuation of land and buildings is shown in note 1.7 to the financial statements and related disclosures are included in note 6. **Key observations** We obtained sufficient audit evidence to conclude that: • the group's accounting policy for valuation of land and buildings complies with the DHSC Group Accounting Manual 2018-19 and has been properly applied • land and buildings are not materially misstated.

Our application of materiality

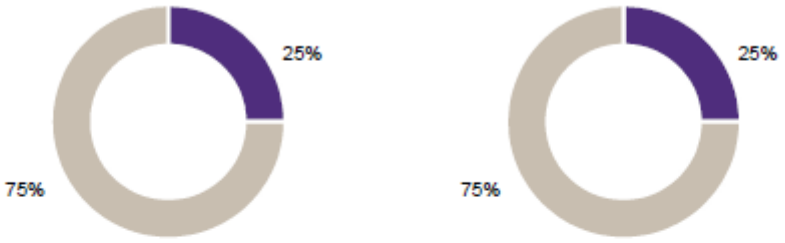
We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality in determining the nature, timing and extent of our audit work and in evaluating the results of that work.

Materiality was determined as follows:

Materiality Measure	Group	Trust
Financial statements as a whole	£3,031,000 which is 1.8% of the group's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the group has expended its revenue and other funding. Materiality for the current year is set at a slightly higher percentage level of gross operating expenses than for the year ended 31 March 2018 (1.75%). This reflects our view that the establishment of the wholly owned subsidiary AGH Solutions Ltd in 2017-18 introduced additional risks to the audit of the group's financial statements in the prior year which are not reflected to the same extent in 2018-19.	£3,000,000 which is 1.8% of the Trust's gross operating costs. This benchmark is considered the most appropriate because we consider users of the financial statements to be most interested in how the Trust has expended its revenue and other funding. Materiality for the current year is set at a slightly higher percentage level of gross operating expenses than for the year ended 31 March 2018 (1.75%). This reflects our view that the establishment of the wholly owned subsidiary AGH Solutions Ltd in 2017-18 introduced additional risks to the audit of the Trust's financial statements in the prior year which are not reflected to the same extent in 2018-19.
Performance materiality used to drive the extent of our testing	75% of financial statement materiality	75% of financial statement materiality
Specific materiality		The senior officer remuneration disclosure in the Remuneration Report has been identified as an area requiring specific materiality of £5,000 based on the disclosure bandings, due to its sensitive nature.
Communication of misstatements to the Audit and Risk Committee	£152,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.	£152,000 and misstatements below that threshold that, in our view, warrant reporting on qualitative grounds.

The graph below illustrates how performance materiality interacts with our overall materiality and the tolerance for potential uncorrected misstatements.

Overall materiality – Group	Overall materiality – Trust



An overview of the scope of our audit

Our audit approach was a risk-based approach founded on a thorough understanding of the group's business, its environment and risk profile and in particular included:

- Evaluation of identified components to assess the significance of each component and to determine the planned audit response based on a measure of materiality and the significance of the component as a percentage of the group's total income, assets and liabilities
- Full scope audit procedures on the Airedale NHS Foundation Trust, which represents over 98% of the total income and expenditure of the group, and over 96% of its total assets employed
- Performing targeted audit procedures on AGH Solutions Limited, focusing on the balances linked to the Trust and any material transactions and balances outside of the group, which represents approximately 1% of the group's income and expenditure, and approximately 2% of its total assets employed
- Performing analytical audit procedures on the non-significant component, Airedale NHS Foundation Trust Charitable Funds, which represents less than 1% of the group's income and expenditure, and less than 1% of its total net assets
- Gaining an understanding of and evaluating the group's internal control environment including its IT systems and controls over key financial systems

Other information

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

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

We have nothing to report in this regard.

In this context, we also have nothing to report in regard to our responsibility to specifically address the following items in the other information and to report as uncorrected material misstatements of the other information where we conclude that those items meet the following conditions:

- Fair, balanced and understandable in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance – the statement given by the directors that they consider the Annual Report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the group and Trust's performance, business model and strategy, is materially inconsistent with our knowledge of the Trust obtained in the audit; or

- Audit and Risk Committee reporting in accordance with provision C.3.9 of the NHS Foundation Trust Code of Governance – the section describing the work of the Audit and Risk Committee does not appropriately address matters communicated by us to the Audit and Risk Committee.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not meet the disclosure requirements set out in the NHS foundation trust annual reporting manual 2018-19 or is misleading or inconsistent with the information of which we are aware from our audit.. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Our opinion on other matters required by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the NHS foundation trust annual reporting manual 2018/19 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure that was unlawful, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS foundation trust annual reporting manual 2018/19, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the group's and the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust and the group without the transfer of the Trust's services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

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

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception - Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion 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 for the year ended 31 March 2019.

We have nothing to report in respect of the above matter.

Significant risks

Under the Code of Audit Practice, we are required to report on how our work addressed the significant risks we identified in forming our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Significant risks are those risks that in our view had the potential to cause us to reach an inappropriate conclusion on the audited body's arrangements. The table below sets out the significant risks we have identified. These significant risks were addressed in the context of our conclusion on the Trust's arrangements as a whole, and in forming our conclusion thereon, and we do not provide a separate opinion on these risks.

Significant risks	How the matter was addressed in the audit
Risk 1: Financial position and Sustainability The Trust continues to operate under increasing financial pressures. Increased activity and the challenging financial position of the Trust's commissioners increased the financial pressures on the Trust in 2018-19.	Our audit work included, but was not restricted to: • reviewing the Trust's 2018/19 outturn position, including the delivery of Cost Improvement Programme schemes • reviewing the Trust's medium term financial strategy, including the reasonableness of the assumptions in the 2019-20 Annual Financial Plan. **Key findings:** • In 2018-19, the Trust achieved its control total, and received an additional £3.4m of Provider Sustainability Funding by delivering an underlying surplus of £543k which was above its control total target by £198k. The Trust also achieved £7.2m of its CIP target of £8.2m (88% achievement). • Whilst the Trust has successfully achieved its financial performance targets for 2018-19, the Board of Directors recognise the underlying financial pressures that continue to face the Trust. • The Trust's 2019-20 Annual Plan has been submitted on the basis of delivering a deficit of £1.8m prior to Marginal Rate Emergency Tariff (MRET). The Trust expects to receive the MRET funding, resulting in a breakeven position. However, this plan is not in line with the expected underlying surplus of £1.4m required by NHSI (prior to MRET). • The Trust anticipates the partnership arrangements across the West Yorkshire and Harrogate Health and Social Care

Significant risks	How the matter was addressed in the audit
	Partnership to provide the financial cover for this variance of £3.2m. • The Trust recognises that it has an underlying deficit of £3m that is has been previously addressing through non recurrent means enabling the Trust to continue to operate at a Use of Resources level 1 (the lowest risk and 'best' rating that a Trust can achieve). • The CIP target 2019-20 is £6.3m to get to a balanced plan after MRET. In our consideration of the Trust's 2019-20 £6.3m CIP plan, at the time of producing this report, the Trust had plans to deliver £4.1m of the CIP. This leaves a gap of £2.2m (35%) to be identified. • The new financial framework does provide a number of risks to the Trust and the wider West Yorkshire health economy. The Trust will need to continue work proactively with commissioners to ensure demand risks are addressed and collaboratively with other West Yorkshire providers to enable the allocation of resources to cover the £3.2m variation between the Trust's Plan and NHSI expected position.
Risk 2: Inspection and oversight by regulators The Care Quality Commission (CQC) follow up inspection report published in September 2017 confirmed the Trust's ratings in the areas of 'Safe' and 'Well Led' services remained as "requires improvement". The report included an action plan and recommendations which the Trust is taking action against and monitoring. We were also aware of the 2018-19 CQC use of resources review which was expected to report by May 2019.	Our audit work included, but was not restricted to: • reviewing the Trust's arrangements for implementing the actions and recommendations arising from the CQC review • identifying any evidence of deterioration in performance • reviewing any further reporting from the CQC or NHSI **Key findings** • In March 2019, the CQC published its latest inspection report carried out during a visit to the Trust in November to December 2018. The report confirmed that ratings for the individual areas had remained the same ie good or adequate with an overall rating of 'Requires Improvement' • The report did not identify any areas where the Trust had deteriorated from the previous review. The report did highlight where services had improved, including the 'use of resources rating of 'good'. It did highlight some continued challenges with 'well-led' and 'safe services' themes. It also identified areas where previous recommendations had not been implemented, for example, implementing the WHO checklist and challenges on staffing levels in some areas. • In response to the report, the Trust has implemented changes to the way in which it monitors and confirms actions are being delivered. A CQC Response Group has been established and additional executive resources have been focused into the Response Group and to also lead 'Audit Quality and Safety' actions at an Associate Director Level.
Risk 3: Performance monitoring of services by AGH Solution Limited to the Trust A number of key services supporting the operation of Airedale General Hospital are now carried out by the Trust's subsidiary company, AGH Solutions Ltd, which became operational on 1 March 2018. The Trust's influence on the quality of these services is now through the contractually agreed performance measures and KPIs with AGHS.	Our audit work included, but was not restricted to: • reviewing the arrangement in place for monitoring the performance of services provided by AGHS **Key findings** • The Operated Healthcare Facilities agreement provides a comprehensive framework setting out the responsibilities of AGHS and standards of service required, together with measures to be taken in the event of substandard performance or service failure. • Over 140 KPIs have been established across all SLA service areas and these are being reported and monitored by the Trust. • Throughout 2018-19, monthly contract management meetings are held between the Trust and AGHS to review the KPIs (as described in the SLA). At the meeting both the Trust and AGHS submit a KPI report. Any 'amber' or 'red' rated KPIs are discussed and mitigation and/or corrective actions are agreed. • Where possible, the member of staff reporting on the KPI uses an automated system to provide the data. Where this

Significant risks	How the matter was addressed in the audit
	is not possible there are local audits or reporting is on an exception basis.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements - Certificate

We certify that we have completed the audit of the financial statements of Airedale NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors, as a body, for our audit work, for this report, or for the opinions we have formed.

Gareth D Mills

Gareth Mills, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

Leeds

29 May 2019

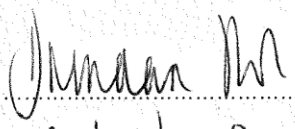
Annual Accounts for the period 1 April 2018 to 31 March 2019

FOREWORD TO THE ACCOUNTS

AIREDALE NHS FOUNDATION TRUST

The accounts for the year ended 31 March 2019 are set out on the following pages and comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers' Equity, the Consolidated Statement of Cash Flows and the Notes to the Accounts.

These accounts for the year ended 31 March 2019 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.

Signed:  .....Brendan Brown - Chief Executive

Date: 28/05/2019

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 NHSI.

Under the NHS Act 2006, NHSI 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 NHSI, 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 him 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 NHSI's NHS Foundation Trust Accounting Officer Memorandum.

Signed: ..... Brendan Brown - Chief Executive

Date: 28/05/2019

NATIONAL HEALTH SERVICES ACT 2006

DIRECTIONS BY NHSI IN RESPECT OF NATIONAL HEALTH SERVICES FOUNDATION TRUSTS' ANNUAL ACCOUNTS

NHSI, 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 NHSI, the independent Regulator of NHS Foundation Trusts

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR TO 31 March 2019

	Note	2018/19 Group	2018/19 Foundation Trust	2017/18 Group	2017/18 Foundation Trust
		£000	£000	£000	£000
Operating income from continuing operations	3	185,716	183,543	168,955	169,060
Operating expenses of continuing operations:	4				
- Operating expenses		(181,116)	(179,310)	(166,768)	(166,723)
Operating Surplus/(Deficit) before Finance costs		4,600	4,233	2,187	2,337
FINANCE COSTS					
Finance income		103	786	113	90
Finance expense - financial liabilities		(49)	(1,001)	(79)	(138)
Finance expense - unwinding of discount on provisions	16.2	(2)	(2)	(2)	(2)
Public Dividend Capital - dividends payable		(1,448)	(1,448)	(1,559)	(1,559)
NET FINANCE COSTS		(1,396)	(1,665)	(1,527)	(1,609)
Gains/(losses) of disposal of assets		(4)	1	615	632
Share of profit/ (loss) of associates/ joint ventures		380	380	350	350
Movement in fair value of investment property and other investments		-	-	-	-
Corporation Tax Expense	1.16	(218)			
SURPLUS/(DEFICIT) FOR THE YEAR		3,362	2,949	1,625	1,710

Movement in Reserves

	Group	Foundation Trust	Group	Foundation Trust

(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 NHSI, the independent Regulator of NHS Foundation Trusts

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR TO 31 March 2019

	Note	2018/19 Group £000	2018/19 Foundation Trust £000	2017/18 Group £000	2017/18 Foundation Trust £000
Operating income from continuing operations	3	**185,716**	**183,543**	**168,955**	**169,060**
Operating expenses of continuing operations:	4				
- Operating expenses		**(181,116)**	**(179,310)**	**(166,768)**	**(166,723)**
Operating Surplus/(Deficit) before Finance costs		**4,600**	**4,233**	**2,187**	**2,337**
FINANCE COSTS					
Finance income		**103**	**786**	**113**	**90**
Finance expense - financial liabilities		**(49)**	**(1,001)**	**(79)**	**(138)**
Finance expense - unwinding of discount on provisions	16.2	**(2)**	**(2)**	**(2)**	**(2)**
Public Dividend Capital - dividends payable		**(1,448)**	**(1,448)**	**(1,559)**	**(1,559)**
NET FINANCE COSTS		**(1,396)**	**(1,665)**	**(1,527)**	**(1,609)**
Gains/(losses) of disposal of assets		**(4)**	**1**	**615**	**632**
Share of profit/ (loss) of associates/ joint ventures		**380**	**380**	**350**	**350**
Movement in fair value of investment property and other investments		**-**	**-**	**-**	**-**
Corporation Tax Expense	1.16	**(218)**			
SURPLUS/(DEFICIT) FOR THE YEAR		**3,362**	**2,949**	**1,625**	**1,710**

Movement in Reserves

	Note	Group 2018/19 £000	Foundation Trust 2018/19 £000	Group 2017/18 £000	Foundation Trust 2017/18 £000
SURPLUS/(DEFICIT) FOR THE YEAR		**3,362**	**2,949**	**1,625**	**1,710**
Share of result of associates/ joint arrangements		**-**	**-**	**-**	**-**
Impairments	6	**-**	**-**	**(6,117)**	**(6,117)**
Revaluations	6	**-**	**-**	**377**	**377**
Other reserve movements		**-**	**(1)**		
TOTAL COMPREHENSIVE INCOME FOR THE YEAR		**3,362**	**2,948**	**(4,115)**	**(4,030)**
Allocation for the year					
(a)Surplus/(Deficit) for the year attributable to					
- Minority interest		**-**	**-**	**-**	**-**
- Owners of parent		**3,362**	**2,949**	**1,625**	**1,710**
Total		**3,362**	**2,949**	**1,625**	**1,710**
(b) Total comprehensive expense for the year attributable to					
- Minority interest		**-**	**-**	**-**	**-**
- Owners of parent		**3,362**	**2,948**	**(4,115)**	**(4,030)**
Total		**3,362**	**2,948**	**(4,115)**	**(4,030)**

All operations are continuing.

The notes on pages 8 to 38 form part of these accounts.

The operating surplus for 2018/2019 in respect of the Foundation Trust includes a net expense on revaluation of the Trusts Property, plant and equipment of £3,818k

Provider Sustainability Funding (PSF) income has been received to the value of £3,353k for achieving the require in year target and an additional £3,437k for achieving the required year end financial targets.

Excluding the 2 items above the Group made an underlying operating surplus of £391k and the Foundation Trust an operating deficit of (£22k).

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2019

		31 March 2019		31 March 2018	
		Group	Foundation Trust	Group	Foundation Trust
	Note	£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	6	**55,206**	**55,206**	**57,204**	**57,204**
Investments in subsidiary	19.4	**-**	**8,891**	**-**	**8,891**
Other Investments	19.5	**578**	**-**	**583**	**-**
Loans to subsidiary	19.4	**-**	**19,615**	**-**	**20,168**
Receivables	9.1	**945**	**945**	**815**	**815**
Total non-current assets		**56,729**	**84,657**	**58,602**	**87,078**
Current assets					
Inventories	8	**2,097**	**763**	**2,184**	**711**
Receivables	9.1	**17,341**	**16,420**	**21,050**	**22,489**
Loans to subsidiary	19.4	**-**	**553**	**-**	**534**
Cash and cash equivalents	10	**15,311**	**11,152**	**9,357**	**7,156**
Total current assets		**34,749**	**28,888**	**32,591**	**30,890**
Current liabilities					
Trade and other payables	11	**(21,919)**	**(17,295)**	**(24,526)**	**(23,062)**
Borrowings	13	**(531)**	**(531)**	**(707)**	**(707)**
Provisions	16	**(775)**	**(775)**	**(773)**	**(773)**
Lease liability	13.2	**-**	**(1,416)**	**-**	**(2,021)**
Other liabilities	12	**(468)**	**(468)**	**(466)**	**(459)**
Total current liabilities		**(23,693)**	**(20,485)**	**(26,472)**	**(27,022)**
Total assets less current liabilities		**67,785**	**93,060**	**64,721**	**90,946**
Non-current liabilities					
Borrowings	13	**(508)**	**(508)**	**(1,013)**	**(1,013)**
Provisions	16	**(924)**	**(924)**	**(971)**	**(943)**
Lease liability	13.2	**-**	**(26,740)**	**-**	**(27,302)**
Other liabilities	12	**(3,627)**	**(3,627)**	**(3,766)**	**(3,766)**
Total non-current liabilities		**(5,059)**	**(31,799)**	**(5,750)**	**(33,024)**
Total assets employed		**62,726**	**61,261**	**58,971**	**57,922**
Financed by (taxpayers' equity)					
Public Dividend Capital		**49,941**	**49,941**	**49,548**	**49,548**
Revaluation reserve		**8,131**	**8,131**	**8,422**	**8,422**
Income and expenditure reserve		**3,696**	**3,189**	**(120)**	**(48)**
Charitable fund reserves	19.6	**958**	**-**	**1,121**	**-**
Total taxpayers' equity		**62,726**	**61,261**	**58,971**	**57,922**

The notes on pages 8 to 38 form part of these accounts.

The financial accounts on pages 1 to 38 were approved by the Board of Directors on

Signed on its behalf by

Andrew Copley - Director of Finance

28-May-19

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2019

GROUP	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Charitable Funds Reserve	Total Tax Payers Equity
	£000	£000	£000	£000	£000
Balance as at 1 April 2018	49,548	(120)	8,422	1,121	58,971
Public Dividend Capital received	393	-	-	-	393
Surplus for the financial year	-	3,525	-	(163)	3,362
Other reserve movements	-	291	(291)	-	-
Impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Balance at 31 March 2019	49,941	3,696	8,131	958	62,726

	£000	£000	£000	£000	£000
Balance as at 1 April 2017	49,548	(1,798)	14,202	1,134	63,086
Public Dividend Capital received	-	-	-	-	-
Surplus for the financial year	-	1,638	-	(13)	1,625
Transfer to I\E reserve for impairments arising from consumption of Economic benefit	-	40	(40)	-	-
Impairments	-	-	(6,117)	-	(6,117)
Revaluations	-	-	377	-	377
Balance at 31 March 2018	49,548	(120)	8,422	1,121	58,971

Foundation Trust Statement of changes in Taxpayers Equity	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Charitable Funds Reserve	Total Tax Payers Equity
	£000	£000	£000	£000	£000
Balance as at 1 April 2018	49,548	(50)	8,422	-	57,920
Surplus for the financial year	-	2,948	-	-	2,948
Public Dividend Capital received	394	-	-	-	394
Other reserve movements	-	291	(291)	-	-
Impairments	-	-	-	-	-
Revaluations	-	-	-	-	-
Balance at 31 March 2019	49,942	3,189	8,131	-	61,262

	£000	£000	£000	£000	£000
Balance as at 1 April 2017	49,548	(1,798)	14,202		61,952
Surplus for the financial year	-	1,710	-	-	1,710
Public Dividend Capital received	-	-	-		-
Other reserve movements	-	40	(40)		-
Impairments	-	-	(6,117)		(6,117)
Revaluations	-	-	377		377
Balance at 31 March 2018	49,548	(48)	8,422	-	57,922

The Statement of Changes in Taxpayers' Equity analyses the movements in reserves and public dividend capital since the previous year.

Information on reserves

Public dividend capital

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

Income and Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficits of the trust.

Revaluation Reserve

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

The notes on pages 8 to 38 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.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED
31 March 2019

	Note	2018/19 Group £000	2018/19 Foundation Trust £000	2017/18 Group £000	2017/18 Foundation Trust £000
Cash flows from operating activities					
Operating (deficit)/surplus from continuing operations		**4,600**	**4,233**	**2,187**	**2,337**
		4,600	**4,233**	**2,187**	**2,337**
Non-cash income and expense					
Depreciation and amortisation	4/6	**2,786**	**2,786**	**2,717**	**2,717**
Impairments and reversals	4/6.1	**3,818**	**3,818**	**6,151**	**6,151**
Non-cash donations/grants credited to income		**(135)**	**(135)**	**(321)**	**(321)**
Decrease in receivables		**3,807**	**6,386**	**(9,562)**	**(31,706)**
(Increase)/Decrease in inventories		**87**	**(52)**	**7**	**1,480**
Decrease in trade and other payables		**(4,702)**	**(7,273)**	**8,775**	**7,343**
Decrease in other liabilities		**(137)**	**(139)**	**(144)**	**(151)**
Decrease in provisions		**(48)**	**(21)**	**(2,604)**	**(2,632)**
Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		**397**	**-**	**(5)**	**-**
NET CASH GENERATED FROM OPERATIONS		**10,473**	**9,603**	**7,201**	**(14,782)**
Cash flows from investing activities					
Interest received		**82**	**786**	**113**	**90**
Purchase of financial assets / investments		**-**	**-**	**-**	**(8,891)**
Proceeds from sales / settlements of financial assets / investments (incl repayments issued on loans to subsidiaries)		**-**	**534**	**-**	**-**
Purchase of Property, Plant and Equipment		**(3,068)**	**(3,068)**	**(6,828)**	**(7,149)**
Sales of Property, Plant and Equipment		**-**	**-**	**50**	**50**
Receipt of cash donations to purchase capital assets		**135**	**135**	**321**	**321**
Charitable funds - net cash flows(used in)/from investing activities	19.6	**-**	**-**	**-**	**-**
Cash movement from acquisitions of business units and subsidiaries (not absorption transfers)		**-**	**-**	**-**	**29,637**
Net cash used in investing activities		**(2,851)**	**(1,613)**	**(6,344)**	**14,058**
Cash flows from financing activities					
Public dividend capital received		**393**	**393**	**-**	**-**
Loans repaid		**(506)**	**(506)**	**(504)**	**(505)**
Capital element of finance lease rental payments		**(177)**	**(1,546)**	**(136)**	**(128)**
Interest Paid		**(47)**	**(37)**	**(37)**	**(37)**
Interest element on Finance lease		**-**	**(966)**	**(42)**	**(101)**
PDC dividend paid		**(1,331)**	**(1,331)**	**(1,849)**	**(1,849)**
Net cash generated from financing activities		**(1,668)**	**(3,993)**	**(2,568)**	**(2,620)**
Net decrease in cash and cash equivalents	10	5,954	3,997	(1,711)	(3,344)
Cash and cash equivalents at 1 April	10	**9,357**	**7,156**	**11,068**	**10,500**
Cash and cash equivalents at 31 March	10	**15,311**	**11,153**	**9,357**	**7,156**

The notes on pages 8 to 38 form part of these accounts.

Note 1.1.1 Accounting Convention

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

Note 1.2 Going Concern Basis

These accounts have been prepared on a going concern basis.

IAS1 requires management to assess as part of the accounts preparation process the Foundation Trust's ability to continue as a going concern.

The Directors have a reasonable expectation that the services provided by the Trust will continue for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the financial statements.

Note 1.3 Consolidation

The Consolidated Accounts of Airedale NHS Foundation Trust show both the NHS Foundation Trust and the Group balances. The Group balances comprise Airedale NHS Foundation Trust, Airedale NHS Foundation Trust Charitable Funds and the subsidiary AGH Solutions Limited.
Subsidiary entities are those over which the trust is exposed to, or has rights to, variable returns from its involvement with the entity and has the ability to affect those returns through its power over the entity. The income, expenses, assets, liabilities, equity and reserves of subsidiaries are consolidated in full into the appropriate financial statement lines.

The Trust has three Joint Ventures in the group accounts these are Immedicare LLP, Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP. These are accounted for using the equity method.

Where subsidiaries' accounting policies are not aligned with those of the Trust (including where they report under UK Financial Reporting Standard (FRS) 102) then amounts are adjusted during consolidation where the differences are material. Inter- entity balances, transactions and gains/losses are eliminated in full on consolidation.

NHS Charitable Funds

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

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- recognise and measure them in accordance with the Trust's accounting policies and
- eliminate intra-group transactions, balances, gains and losses.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

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

Revenue from NHS contracts

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

Revenue from research contracts

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

NHS injury cost recovery scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.5 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 financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

1.5.1 NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

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

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 1.5 Expenditure on Employee Benefits (continued)

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
The NHS Pension Scheme provides 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 1995 and 2008 schemes are 'final salary' schemes. 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'.

With effect from 1 April 2015 the 2015 Pension scheme was introduced for all employees currently in the NHS pension Scheme. Except for employees who at the 1st April 2012 were already over their normal pension age or 10 years or less from their normal pension age and in active membership on both 1 April 2012 and 31 March 2015, who received full protection in their previous scheme. For employees who were more than 10 years but less than 13 years and 5 months from their normal pension age at the 1st April 2012 and in active membership on both 1 April 2012 and 31 March 2015, tapering relief was applied. The Scheme is based on a 1/54th of the annual salary indexed linked to the employees State retirement age.

Pensions Indexation
Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971.

Lump Sum Allowance
A lump sum is payable will depend on the scheme or schemes the employees is a member of a the date of retirement.

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 for death in service, will be paid dependent on the scheme or schemes of the employee at date of death.

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 based on the terms of their scheme or schemes.

Note 1.5 Expenditure on Employee Benefits (continued)

1.5.2 Alternative Pension Scheme - National Employment Savings Trust (NEST) Pension Scheme

Following the Pensions Act 2008 the NHS Foundation Trust had a duty in the financial year ended 31 March 2017 to provide a pension scheme for employees who are ineligible to join the NHS Pension Scheme at the Trust. This includes employees who are members of the NHS Pension Scheme through another role outside of the Trust and those that are not eligible to join the NHS Pension Scheme.

The NHS Foundation Trust has selected NEST as its 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. Employee and employer contribution rates are a combined minimum of 5% (with a minimum 2% being contributed by the Trust) and from October 2018 the combined contribution rate will be 8% (with a minimum 3% being contributed by the Trust).

Note 1.6 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when and to the extent that they have been received, and is measured at current 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 1.7 Property, Plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:-

- it is held for use in delivering services or for administrative purposes
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- 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 lives.

Note 1.7.2 Measurement

Valuation

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

All assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Note 1.7.2 Property, Plant and equipment- Measurement (Continued)

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 current 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 full asset valuations were undertaken by Cushman and Wakefield with a prospective valuation date of 31 March 2018.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and current value for non-specialised operational property, using the alternative site method.

Valuation using the modern equivalent asset basis, with an alternative site means that the valuer has taken into consideration the modern needs of the Trust, in relation to the size and layout of a possible replacement hospital. The valuation also uses the alternative site methodology which means the Hospital could be built in an area where land costs are less than in the current location.

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 valuer when they are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Subsequent Expenditure

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

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 - 16 years - Plant and Machinery
b) Vehicles:- 7 years - Transport Equipment
c) office equipment, furniture and soft furnishings:- 5 - 12 years - Furniture and Fittings
d) Medical and other equipment:- 5 - 16 years - Plant and Machinery
e) IT equipment:- 5 - 10 years - Information Technology
f) Buildings, installations and fittings:- 29 - 90 years - Buildings

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

Note 1.7.2 Property, Plant and equipment - Measurement (Continued)

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

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

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Note 1.7.3 De-recognition

Assets intended for disposal are classified as 'Held for Sale' once all the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable 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’ and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'current value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'current 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.

Note 1.7.4	**Donated and grant funded assets**
	Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
	The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
Note 1.7.5	**Private Finance Initiative (PFI) Transaction**
	PFI transactions which meet the IFRIC 12 definition of a service concession, as per FReM - are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment.
Note 1.7.6	**Intangible Assets**
	Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.
	Software
	Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset.
	The Trust currently has no intangible assets as all software is integral to the hardware.
Note 1.8	**Cash and cash equivalents**
	Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.
	Cash, bank and overdraft balances are recorded at current values.
	There are no significant cash and cash equivalent balances held by the entity that are not available for use by the group.
Note 1.9	**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.
	Pharmacy inventories are valued at weighted average historical cost, as they are held on a computerised inventory system, which calculates the values in this way. The valuation method is deemed a reasonable approximation to current value.

Note 1.10	**Financial Instruments and Financial Liabilities**
Note 1.10.1	**Recognition**
	Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.
	This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.
Note 1.10.2	**Classification and Measurement**
	Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.
	Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.
	Financial assets are classified as subsequently measured at amortised cost, or fair value through income and expenditure.
	Financial liabilities classified as subsequently measured at amortised cost.
	Financial assets and financial liabilities at amortised cost
	Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.
	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 contract receivables, and other contract receivables.
	After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.
	Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Note 1.10	**Financial Instruments and Financial Liabilities (Continued)**
Note 1.10.2	**Classification and Measurement (continued)**
	Impairment of Financial Assets
	For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.
	The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).
	There is no expected credit losses for inter-NHS debtors. The Trust and AGH Solutions split other debtors into categories i.e. overseas visitors, private patients, medical records, staff and general. These classes are assessed for expected credit losses based on the last 12 month's data, and the percentages are then applied to the current debts.
	For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.
	Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.
Note 1.10.3	**Derecognition**
	Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.
	Financial liabilities are derecognised when the obligation is discharged, cancelled or expires.
Note 1.11	**Leases**
Note 1.11.1	**The Trust as lessee**
	Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.
	Finance Leases
	Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.
	The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property, plant and equipment. The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.
	Operating Leases
	Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.
	Contingent rentals are recognised as an expense in the period in which they are incurred.
	Leases of land and buildings
	Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11 Leases (continued)

Note 1.11.2 The Trust as lessor

Finance leases

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

Operating leases

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

Note 1.12 Provisions

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

Clinical Negligence Costs

The NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which in return settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 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 NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.13 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 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:-

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

Note 1.14	**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.
	At any time, the Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.
	A charge reflecting the cost of capital utilised by the Trust is payable as 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 (i) donated assets, (ii) 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, and (iii) any PDC dividend balance receivable or payable. The calculation also excluded the bonus element of the Provider Sustainability Funding. 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 1.15	**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.
	AGH Solutions Limited is a wholly owned subsidiary and is registered for VAT.
Note 1.16	**Corporation Tax**
	Airedale NHS Foundation Trust
	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 2017 this power has not been exercised. Accordingly the Trust is not within scope of Corporation Tax.
	AGH Solutions Limited
	AGH Solutions Limited is a wholly owned subsidiary and is subject to Corporation Tax.
	The tax charge for the year for AGH Solutions is not materially different from the profit multiplied by the prevailing tax rate in the UK of 19%.
	Deferred Taxation
	Tax on the profit or loss for the year comprises current and deferred tax. Tax is recognised in the Statement of Comprehensive Income except to the extent that it relates to items recognised directly in equity or other comprehensive income, in which case it is recognised directly in equity or ither comprehensive income. Current tax is the expected tax payable or receivable on the taxable income or loss for the year, using tax rates enacted or substantively enacted at the reporting date, and any adjustment to tax payable in respect of previous years. Deferred tax is provided on temporary differences between the carrying amounts of assets and liabilities, for reporting purposes and the amounts used for taxation purposes. The amount of deferred tax provided is based on the expected manner of realisation or settlement of the carrying amount of assets and liabilities, using tax rates enacted or substantially enacted on the reporting date. A deferred tax asset is recognised only to the extent that it is probable that future taxable profits will be available against which the temporary difference can be utilised. Deferred taxation - 2018/19 there is no deferred taxation (2017/18 - nil)

Note 1.17	**Foreign Exchange**
	The functional and presentational currency of the Trust is sterling.
	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 1.18	**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 1.19	**Dispensation from the Application of Accounting Standards**
	No dispensations were given in 2018/2019.
Note 1.20	**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 1.20.1	**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 financial statements:-
	HM Treasury requires Trusts to value their land and buildings on a Modern Equivalent Asset (MEA) basis. IAS 16 requires Trusts to ensure that fixed assets are shown in their accounts at a fair value. To ensure compliance a full review of land and buildings values was undertaken. The Trust commissioned Cushman and Wakefield to conduct this piece of work and the Trust has recorded the revised valuation figures in the accounts. The Trust has revalued the assets as at 31 March 2018,net of VAT, in line with the valuation supplied by Cushman and Wakefield. Cushman and Wakefield have carried out the valuation in accordance with RICS valuation standards .The valuation is net of VAT, due to the limited options to re-provide a new hospital build, the most probable option would be to build using a PFI or special purpose vehicle, in which circumstances VAT would be recoverable. The Trust set up a wholly owned subsidiary which is a limited company registered for VAT, which will be responsible for providing a fully managed hospital, This supports the option to value net of VAT. The substance of the transaction between the Trust and AGH Solutions Limited, for the Property,plant and Equipment has resulted in a finance lease. The Trust revalued the work-in-progress AAU build, which was brought into use in 2018/2019. The Trust has chosen not to revalue the reminder of the estate at the 31 March 2019.

Note 1.20.2	**Key Sources of Estimation Uncertainty**
	The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:
	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 1.7 .The carrying value of property, plant and equipment is detailed in Note 6. As stated above Cushman and Wakefield 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 Employment related issues. The valuation of the provision is based on figures supplied by the Trusts legal advisors.
Note 1.21	**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).
	However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.
Note 1.22	**Early adoption of standards, amendments and interpretations**
	No new accounting standards or revisions to existing standards have been early adopted in 2018/19.
Note 1.23	**Accounting Standards and amendments issued but not yet adopted**
	IFRS 14 Regulatory Deferral Accounts -
	Applies to first time adopters of IFRS after 1 January 2016. Therefore not applicable to DHSC group bodies.
	IFRS 16 Leases -
	Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.
	IFRS 17 Insurance Contracts -
	Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted.
	IFRIC 23 Uncertainty over Income Tax Treatments -
	Application required for accounting periods beginning on or after 1 January 2019.

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, as one group.

The Trust has applied the 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 this 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 surplus reported to the Trust Board under the Clinical Group reporting structure was £2,949k excluding the NHS Foundation Charitable Funds and AGH Solutions Limited, which is the same as the position reported in the Statement of Comprehensive Income.

There have been no changes from prior periods in the measurement methods used to determine reported segment profit or loss.

The composition of the entity's reportable segments has not changed since the previous reporting period.

AGH Solutions Limited is a wholly owned subsidiary of the Trust reporting to the Trust's Board but is managed as an independent limited company

AGH Solutions Limited's activities are **primarily those of the Operator of a Fully Managed Healthcare Facility**.

2.1 Operating Segments-Statement of Cash Flow

AGH Solutions Limited and Airedale NHS Foundation Trust Charitable fund's activities are included in this account for consolidation.

3 Operating Income from continuing operations

3.1 Analysis operating income

	Note	2018/2019 Group	2018/2019 Foundation Trust	2017/2018 Group	2017/2018 Foundation Trust	
		£000	£000	£000	£000	
Income from patient care activities (by nature):						
Elective income		24,819	24,820	23,621	23,621	
Non elective income		44,068	44,068	38,769	38,769	
Outpatient income		17,540	17,539	15,564	15,564	
Accident and Emergency income		8,080	8,080	7,443	7,443	
Community Services		4,447	4,447	4,660	4,660	
Other NHS clinical income		46,441	46,441	46,902	46,902	
Private patient income		201	201	166	166	
AfC pay award central funding		1,851	1,851			
Other non-protected Clinical income		15,973	15,802	11,558	11,558	X X
Total income from activities		**163,420**	**163,249**	**148,683**	**148,683**	
Income from patient care activities (by source):						
NHS Foundation Trust		2,405	2,233	2,213	2,213	
NHS Trusts		544	544	-	-	
CCGs and NHS England		149,577	149,578	145,096	145,096	
Department of Health & Social Care - other		1,851	1,851	-	-	
NHS Other		-	-	2	2	
Non NHS: Private Patients		201	201	166	166	
Non NHS: Overseas visitors		33	33	41	41	
NHS injury scheme (see below*)		584	584	490	490	
Non NHS: Other		8,225	8,225	675	675	
Total income from activities		**163,420**	**163,249**	**148,683**	**148,683**	
Other operating income from contracts with customers (in accordance with IFRS 15):						
Research and development (contract)		1,161	1,161	1,222	1,222	
Education and training (excluding notional apprenticeship levy income)		5,229	5,229	4,134	4,134	
Non-patient care services to other bodies		3,134	1,147	1,167	1,167	
Provider sustainability / sustainability and transformation fund income (PSF / STF)**		6,789	6,789	6,692	6,692	
Income in respect of employee benefits accounted on a gross basis		588	580	436	436	
Other contract income (see note 3.2)		4,902	5,253	6,045	6,395	
Other non-contract operating income (non-IFRS 15):						
Rental revenue from operating leases		10	-	10	10	
Charitable and other contributions to expenditure		135	135	321	321	
Charitable Funds: Incoming Resources excluding investment income	19.6	348	-	245	-	
Total other operating income		**22,296**	**20,294**	**20,272**	**20,377**	
Total operating income		**185,716**	**183,543**	**168,955**	**169,060**	

X In 2018/19, Pathology JV income was included within the Trust and Group income position under the category 'Other non-protected Clinical income', which was not the case in 2017/18. For comparative purposes, the income figure for Pathology JV not included in 2017/18 income was £6.45m.

***** NHS injury scheme income is subject to a provision for doubtful debts of 21.89% (2017/18 - 22.84%) to reflect expected rates of collection.
****** Sustainability and transformation fund (STF) refers to 2017/18 only for prior year comparison, the funding was re-named to Provider sustainability fund income (PSF) for the financial year 2018/19

3.2 Analysis of Other Contract Income: Other

	2018/2019 Group	2018/2019 Foundation Trust	2017/2018 Group	2017/2018 Foundation Trust
	£000	£000	£000	£000
Car Parking	1,426	1,397	1,222	1,222
Catering	16	2		
Estates maintenance	177	(2)	22	22
Pharmacy Sales	30	30	39	39
Staff Accommodation rental	27	44	63	63
Crèche services	890	890	701	701
Clinical Tests	1,320	1,320	1,188	1,188
Clinical Excellence	-	-	-	-
Other income	1,016	1,572	2,810	3,160
	4,902	**5,253**	**6,045**	**6,395**

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 .

3.3 Analysis of income from activities

(mandatory and non-mandatory services replaced with commissioner requested services)

	2018/2019 Group	2018/2019 Foundation Trust	2017/2018 Group	2017/2018 Foundation Trust
	£000	£000	£000	£000
Commissioner requested services	140,345	140,345	130,639	130,639
Non-commissioner requested services	23,075	22,904	18,044 **X**	18,044 **X**
Total	**163,420**	**163,249**	**148,683**	**148,683**

X In 2018/19, Pathology JV income was included within the Trust and Group income position under the category 'Other non-protected Clinical income', which was not the case in 2017/18. For comparative purposes, the income figure for Pathology JV not included in 2017/18 income was £6.45m.

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 Trust's principal 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 2018/2019 the Trust has not increased the percentage beyond the 5% threshold.

3.5 Overseas visitors (relating to patients charged directly by the Trust)

	2018/19 Group	2018/19 Foundation Trust	2017/18 Group	2017/18 Foundation Trust
	£000	£000	£000	£000
Income recognised this year	**33**	**33**	**41**	**41**
Cash payments received in year	**40**	**40**	**20**	**20**
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**18**	**18**	**26**	**26**
Amounts written off in-year (relating to invoices raised in current and previous years)	**0**	**0**	**9**	**9**

4. Operating Expenses from continuing operations

4.1 Operating expenses comprise:

	Note	2018/2019 Group	2018/2019 Foundation Trust	2017/2018 Group		2017/2018 Foundation Trust	
		£000	£000	£000		£000	
Services from NHS Foundation Trusts		1,152	1,152	781		781	
Services from NHS Trusts		21	21	902		902	
Services from other NHS bodies		-	-	-		-	
Purchase of healthcare from non NHS bodies		442	413	247		247	
Remuneration of non-executive directors		122	122	123		123	
Employee expenses - staff		124,539	116,377	111,019	X	110,405	X
NHS charitable funds - employee expenses		-	-	-		-	
Supplies and services - clinical (excluding drug costs)		15,714	9,852	13,140	X	12,391	X
Supplies and services - general		3,071	135	2,679		2,679	
Establishment		850	346	317		263	
Transport (business travel only)		510	500	443		443	
Transport (other)		146	72	190		190	
Premises - business rates payable to local authorities		640	640	480		480	
Premises - other		7,294	25,497	7,985		9,782	
Movement in credit loss allowance: contract receivables / contract assets	9.3	10	10	17		17	
Movement in credit loss allowance: all other receivables and investments	9.3	131	117	17		17	
Change in provisions discount rate(s)		-	-	-		-	
Inventories written down (net, including inventory drugs)		42	-	33		33	
Drugs Inventories consumed		11,592	11,634	11,726		11,726	
Rentals under operating leases - minimum lease payments		1,416	-	1,400		1,400	
Depreciation on property, plant and equipment	6.1	2,786	2,786	2,717		2,717	
Impairments of property, plant and equipment	6.1	3,818	3,818	6,151		6,151	
Audit services- statutory audit*		51	51	53		53	
Audit services- non-statutory audit - quality		6	6	6		6	
Other auditor remuneration (external auditor only)**		20	-	15		-	
Audit fees payable to external auditor of charitable fund accounts		4	-	4		-	
Clinical negligence - amounts payable to NHS Resolution (premiums)		4,136	4,136	3,776		3,776	
Loss on disposal of other property, plant and equipment		-	-	-		-	
Legal fees		82	81	(3)		(3)	
Consultancy costs		228	157	1,027		883	
Internal audit costs - (not included in employee expenses)		52	33	164		164	
Training, courses and conferences		459	432	398		398	
Patient travel		-	-	-		-	
Redundancy - (included in employee expenses)		-	-	-		-	
Hospitality		-	-	16		16	
Insurance		116	13	50		50	
Losses, ex gratia & special payments- (not included in employee expenses)		24	23	65		65	
Research and development - non-staff		29	29	7		7	
Other		1,088	857	603		578	
NHS charitable funds: Other resources expended	19.6	525	-	237		-	
Operating expenses		**181,116**	**179,310**	**166,785**		**166,740**	

X In 2018/19, Pathology JV expenditure was included within the Trust and Group expenditure position, which was not the case in 2017/18. For comparative purposes, the expenditure figure for Pathology JV not included in 2017/18 pay expenditure was £4.3m and non-pay expenditure was £1.5m, the majority of which related to 'Supplies and services - clinical (excluding drug costs)'.

* Statutory Audit fees include VAT
** The auditing of accounts of any associate of the Trust - AGH Solutions Ltd

The external audit liability is limited to a maximum of £2 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 2018/19 was 1.247k . This lease arrangement commenced on 22 October 2001 and was scheduled to run for 15 years, this was subsequently extended for 4 years with a possible additional extension of a further 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:

	2018/19 Group	2018/19 Foundation Trust	2017/18 Group	2017/18 Foundation Trust
	£000	£000	£000	£000
Other minimum operating lease rentals	1,416	1,276	1,400	1,400
	1,416	1,276	1,400	1,400

4.2.2 Total future minimum operating lease payments due:

	2018/19 Group	2018/19 Foundation Trust	2017/18 Group	2017/18 Foundation Trust
	£000	£000	£000	£000
Within 1 year	1,392	1,271	1,389	1,389
Between 1 and 5 years	808	647	2,049	2,049
After 5 years	-	-	-	-
	2,200	1,918	3,438	3,438

4.3 Operating leases as lessor

AGH Solutions Ltd has operating leases in place with Local Care Direct limited relating to the use of accommodation on the Airedale General hospital site. The value of the lease payments from Local Care Direct in 2018/19 was £10k.

	2018/19 Group	2018/19 Foundation Trust	2017/18 Group	2017/18 Foundation Trust
	£000	£000	£000	£000
Rents recognised in year	10	-	10	10
Total future minimum operating lease income due:	£000	£000	£000	£000
Within 1 year	10	-	10	-
	10	-	10	-

5. Employee expenses and numbers

5.1 Employee expenses

	Group					
	2018/19			2017/18		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	97,508	97,163	345	87,910	86,809	1,101
Social Security Costs	8,651	8,651	-	8,447	8,447	-
Apprenticeship levy	447	447	-	462	462	-
Employer contributions to NHS Pensions Agency	11,603	11,603	-	10,873	10,873	-
Other Pensions	37	37				
Termination benefits	-	-	-	-	-	-
Agency/Bank staff	6,571		6,571	3,327	-	3,327
NHS Charitable funds staff	-	-	-	-	-	-
	124,817	117,901	6,916	111,019	106,591	4,428

	Foundation Trust					
	2018/19			2017/18		
	Total	Permanently Employed	Other	Total	Permanently Employed	Other
	£000	£000	£000	£000	£000	£000
Salaries and wages	90,916	90,571	345	87,472	86,371	1,101
Social Security Costs	8,140	8,140	-	8,412	8,412	-
Apprenticeship levy	430	430		462	462	
Employer contributions to NHS Pensions Agency	10,812	10,812	-	10,873	10,873	-
Other Pensions	27	27		-		
Termination benefits	-	-	-	-	-	-
Agency/Bank staff	6,052	-	6,052	3,327	-	3,327
NHS Charitable funds staff	-	-	-	-	-	-
	116,377	109,980	6,397	110,546	106,118	4,428

	Group					
	Total 2018/19 Number	Permanently Employed Number	Other Number	Total 2017/18 Number	Permanently Employed Number	Other Number
Medical and dental	295	263	32	276	251	25
Administration and estates	609	584	25	537	537	-
Healthcare assistants and other support staff	682	608	74	624	587	37
Nursing, midwifery and health visiting staff	705	675	30	751	680	71
Scientific, therapeutic and technical staff	442	442	-	412	412	-
Other	-	-	-	-	-	-
Total	2,733	2,572	161	2,600	2,467	133

	Foundation Trust					
	Total 2018/19 Number	Permanently Employed Number	Other Number	Total 2017/18 Number	Permanently Employed Number	Other Number
Medical and dental	295	263	32	276	251	25
Administration and estates	490	478	12	536	536	-
Healthcare assistants and other support staff	506	432	74	604	567	37
Nursing, midwifery and health visiting staff	706	676	30	751	680	71
Scientific, therapeutic and technical staff	437	437	-	412	412	-
Other	-	-	-	-	-	-
Total	2,434	2,286	148	2,579	2,446	133

WTE = Whole time equivalents

5.3 Retirement due to ill health

During 2018/19 from the 1 April 2018 to the 31 March 2019 there were 4 early retirements from the NHS agreed on the grounds of ill health (2017/18 - 5). The estimated additional pension liabilities of these ill-health retirements will be £330k (2017/18 : £336k) .The cost of these ill-health retirements will be borne by the NHS Business Authority - Pensions Division.

5.4 Exit packages

The following is the breakdown of the 2018/19 Exit packages

	Group	Foundation Trust	Group	Foundation Trust
Exit Packages Cost Band	Number of agreed departures	Number of agreed departures	Cost of departures £000	Cost of departures £000
<£10,000	-	-	-	-
£10,001-£25,000	-	-	-	-
£25,001-£50,000	-	-	-	-
£50,001-£100,000	-	-	-	-
£100,001-£150,000	1	1	107	107
TOTAL	1	1	107	107
Addition Analysis				
MARS	0	0	0	0
Early retirements	1	1	107	107
In lieu of notice	0	0	0	0
TOTAL	**1**	**1**	**107**	**107**

There were no compulsory Redundancies

5.5 Directors Remuneration

	Year ended 31 March 2019	Year ended 31 March 2019	Year ended 31 March 2018	Year ended 31 March 2018
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Aggregate emoluments to Executive Directors	966	966	1,202	1,202
Remuneration to Non-Executive Directors	122	122	123	123
Pension Costs	95	95	74	74
	1,183	**1,183**	**1,399**	**1,399**

There has been no compensation or exit packages paid for directors resigning in the year

6. Property, plant and equipment (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 2018	2,956	35,579	5,453	6,145	11,201	112	12,608	249	74,303
Additions - purchased	-	2,269	-	314	615	-	1,250	23	4,471
Additions - leased	-	-	-	-	-	-	-	-	-
Additions - assets purchased from cash donations/grants	-	74	-	-	-	31	-	30	135
Impairments charged to the revaluation reserve	-	-	-	-	-	-	-	-	-
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	-
Revaluations	-	(3,873)	-	-	-	-	-	-	(3,873)
Reclassifications	-	6,145	-	(6,145)	-	-	-	-	-
Disposals	-	-	-	-	(73)	(33)	(259)	-	(365)
Cost or valuation At 31 March 2019	**2,956**	**40,194**	**5,453**	**314**	**11,743**	**110**	**13,599**	**302**	**74,671**
Depreciation at 1 April 2018	-	-	-	-	7,639	70	9,270	120	17,099
Provided during the year	-	742	81	-	880	24	1,034	25	2,786
Impairments charged to operating expenses	-	3,818	-	-	-	-	-	-	3,818
Reversal of impairments credited to operating Expenditure	-	-	-	-	-	-	-	-	-
Revaluations	-	(3,873)	-	-	-	-	-	-	(3,873)
Disposals	-	-	-	-	(73)	(33)	(259)	-	(365)
Depreciation at 31 March 2019	**-**	**687**	**81**	**-**	**8,446**	**61**	**10,045**	**145**	**19,465**
Net book value									
- Owned - Purchased at 31 March 2019	1,543	18,135	821	314	1,080	-	3,426	32	25,351
- Finance Lease as at 31 March 2019	1,413	20,619	4,551	-	2,217	23	128	96	29,047
- Donated at 31 March 2019	-	754	-	-	-	26	-	29	809
Total at 31 March 2019	**2,956**	**39,508**	**5,372**	**314**	**3,297**	**49**	**3,554**	**157**	**55,207**
Asset Financing									
Owned - Purchased	1,543	18,135	821	314	1,080	-	3,426	32	25,351
Finance lease	1,413	20,619	4,551	-	2,217	23	128	96	29,047
Donated	-	754	-	-	-	26	-	29	809
Total at 31 March 2019	**2,956**	**39,508**	**5,372**	**314**	**3,297**	**49**	**3,554**	**157**	**55,207**

6.2 Current year analysis of property, plant and equipment:

In 2018/19, 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

Under IFRS 9 Fair value hierarchy, the Trust's assessment is that all assets fall under Level 2.

At 31 March 2018 the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by Cushman and Wakefield 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. At the 31st March 2019 the Acute Assessment Unit was revalued as it was the only asset transferred from work in progress during the financial year.

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 2017	2,530	45,602	7,338	1,625	11,065	136	12,348	237	80,881
Additions - purchased	-	862	-	4,187	571	-	377	11	6,008
Additions - leased	-	-	-	-	-	-	-	-	-
Additions - assets purchased from cash donations/grants	-	321	-	-	-	-	-	-	321
Impairments charged to the revaluation reserve	-	(5,839)	(1,295)	-	-	-	-	-	(7,134)
Reversal of impairments credited to the revaluation reserve	412	605	-	-	-	-	-	-	1,017
Revaluations	14	(5,972)	(590)	-	-	-	-	-	(6,548)
Disposals	-	-	-	333	(435)	(24)	(117)	1	(242)
Cost or valuation At 31 March 2018	**2,956**	**35,579**	**5,453**	**6,145**	**11,201**	**112**	**12,608**	**249**	**74,303**
Depreciation at 1 April 2017	-	-	-	-	7,475	80	8,327	98	15,980
Provided during the year	-	692	82	-	841	15	1,065	22	2,717
Impairments charged to operating expenses	170	5,719	852	-	-	-	-	-	6,741
Reversal of impairments credited to operating Expenditure	(179)	(411)	-	-	-	-	-	-	(590)
Revaluations	9	(6,000)	(934)	-	-	-	-	-	(6,925)
Disposals	-	-	-	-	(677)	(25)	(122)	-	(824)
Depreciation at 31 March 2018	**-**	**-**	**-**	**-**	**7,639**	**70**	**9,270**	**120**	**17,099**
Net book value									
- Owned - Purchased at 31 March 2018	2,956	35,579	121	-	3,047	14	3,333	101	45,151
- Finance Lease as at 31 March 2018	-	-	4,620	6,145	388	2	5	1	11,161
- Donated at 31 March 2018	-	-	712	-	127	26	-	27	892
Total at 31 March 2018	**2,956**	**35,579**	**5,453**	**6,145**	**3,562**	**42**	**3,338**	**129**	**57,204**
Asset Financing									
Owned - Purchased	1,544	16,478	832	-	526	-	3,174	12	22,566
Finance lease	1,412	18,389	4,621	6,145	3,036	42	164	117	33,926
Donated	-	712		-	-	-	-	-	712
Total at 31 March 2018	**2,956**	**35,579**	**5,453**	**6,145**	**3,562**	**42**	**3,338**	**129**	**57,204**

6.4 Prior year analysis of property, plant and equipment:

At 31 March 2018 the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by Cushman and Wakefield 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.

6.5 Revaluation of Property, Plant 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 2018/2019 the net book value of the Property has been revalued net of VAT.

6.6 Donors of property, plant and equipment:

	2018/19	2017/18
	£000	£000
Friends of Airedale	**91**	**-**
Airedale NHS FT Charitable Fund	**44**	**115**
	135	**115**

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 Public Dividend Received

Public Dividend Capital (PDC) of £394k has been received in 2018/19, £381k regarding IHR and £11.5k for Pharmacy software upgrades.
No Public Dividend Capital (PDC) was received in 2017/2018.

7. Current year intangible fixed assets (Group and Foundation Trust)

The Trust had no intangible fixed assets at the 31 March 2019 (31 March 2018 - none).

8. Inventories

8.1 Analysis of inventories

	31 March 2019 £000	31 March 2019 £000	31 March 2018 £000	31 March 2018 £000
	Group	Foundation Trust	Group	Foundation Trust
Drugs	**679**	**678**	**685**	**685**
Other	**1,391**	**85**	**1,461**	**26**
Energy	**27**	**-**	**38**	**-**
Total	**2,097**	**763**	**2,184**	**711**

8.2 Inventories recognised in expenses

	2018/19	2018/19	2017/18	2017/18
	£000	£000	£000	£000
	Group	Foundation Trust	Group	Foundation Trust
Inventories recognised as an expense in the year	24,259	17,600	24,666	24,145
Write-down of inventories (including losses)	42	42	33	33
Total	24,301	17,642	24,699	24,178

9. Trade and other receivables

9.1 Trade and other receivables are made up of:

Current		31 March 2019 £000	31 March 2019 £000	31 March 2018 £000	31 March 2018 £000
	Note	Group	Foundation Trust	Group	Foundation Trust
Contract receivables* - NHS		9,825	9,742	-	-
Contract receivables* - with other related parties		5,959	5,105	-	-
Trade Receivables* - NHS		-	-	8,990	8,990
Trade Receivables* - with other related parties		-	-	2,993	10,083
Capital receivables (including accrued capital related income)		-	-	1,058	1,058
Allowance for impaired contract receivables / assets		(281)	(281)	(271)	(271)
Allowance for impaired other receivables		(230)	(215)	(99)	(99)
Prepayments		-	-	974	912
VAT Receivables		1,928	1,928	6,035	706
Accrued Income*		-	-	829	824
PDC Dividend receivable		140	140	257	257
Other receivables		-	554	281	29
Charitable Funds Trade and other receivables	19.4	-	-	3	-
		-			
Total		17,341	16,973	21,050	22,489
Non-Current					
Contract receivables* - with other related parties		945	945	-	-
Accrued income*		-	-	815	815
Other receivables		-	19,615	-	20,702
Total		945	20,560	815	21,517

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.

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

9. Trade and other receivables (continued)

9.2 Impact of implementing IFRS 9 & IFRS 15

9.2.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018. IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting. Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £1k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in no decrease in the carrying value of receivables. The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost.

9.2.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018. IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount
that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services. As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

9.3 Allowances for credit losses

Allowances for credit losses - 2018/19

	31 March 2019 £000	31 March 2019 £000
	Group	Foundation Trust
Balance at 1 April 2018	370	370
New allowances arising	141	126
Changes in existing allowances	-	-
Reversals of allowances	-	-
Utilisation of allowances (write offs)	-	-
Changes arising following modification of cotractual cash flows	-	-
Balance at 31 March 2019	511	496

The lifetime expected credit loss provision has been calculated under IFRS 9 principals. The total debt (excluding NHS debt) has been split into a number of debtor classes, and then each type risk assessed for potential write-off. The basis for the lifetime expected credit loss has been calculated using the historical probability of write-off for that class, as a percentage of the annual debt. Using this methodology the category of general debtors has increased by £117k in 2018/19.

NHS Injury Benefit Scheme income is subject to a provision for impairment of 21.89% to reflect expected rates of collection. Other debts are split into classes and assessed for impairment under IFRS 9 by using the simplified method to calculate the expected credit loss over the lifetime of the debt. This assessment is based on the historic probability of collection adjusted for any forward-looking information available .

Allowances for credit losses - 2017/18

	31 March 2018 £000	31 March 2018 £000
	Group	Foundation Trust
Balance at 1 April 2018	362	362
Increase in allowance recognised in income statement	66	66
Amounts utilised	(9)	(9)
Unused amounts reversed	(49)	(49)
Balance at 31 March 2018	370	370

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

10. Cash and cash equivalents

	31 March 2019		31 March 2018	
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Balance at 1 April 2018	9,357	7,156	11,068	10,500
Net change in year	5,954	3,996	(1,711)	(3,344)
Balance at 31 March 2019	15,311	11,152	9,357	7,156
Made up of:				
Cash with Government Banking Service	11,868	11,148	7,152	7,152
Cash at commercial banks and in hand	3,443	4	11	4
Other current investments	-	-	2,194	-
Cash and cash equivalents	15,311	11,152	9,357	7,156

11. Trade and other payables

		31 March 2019	31 March 2019	31 March 2018	31 March 2018
	Note	Group	Foundation Trust	Group	Foundation Trust
Current		£000	£000	£000	£000
Trade payables - NHS		3,398	3,398	2,744	2,744
Trade payables - Non-NHS		1,310	1,730	1,160	181
Capital payables (including capital accruals)		2,282	2,282	775	775
Accruals		8,363	5,916	3,741	3,364
VAT payable		356	204	5,530	5,530
Social Security Costs		1,300	1,228	1,289	1,220
Other taxes payable		1,062	1,018	962	931
Accrued interest on other loans *		-	-	1	1
Other Payables		3,445	1,519	8,292	8,316
PDC dividend payable		-	-	-	-
Charitable Funds - Trade and other payables	19.4	403	-	32	-
TOTAL		21,919	17,295	24,526	23,062

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

12. Other liabilities

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
	Group	Foundation Trust	Group	Foundation Trust
Current	£000	£000	£000	£000
Deferred income	468	468	466	459
Non-Current				
Deferred income	3,627	3,627	3,766	3,766
	4,095	4,095	4,232	4,225

The figures in this Non-current section and £139k of the Current 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).
Additionally there is £44k of deferred income from Overseas visitors agreed with Airedale, Wharfedale and Craven CCG, the balance is deferred income from organisation outside the NHS, income will be released in line withy service delivery.

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

	Revenue recognised from NHS providers	Revenue recognised from other DHSC group bodies	Revenue recognised from non DHSC group bodies
	2018/19 £000	2018/19 £000	2018/19 £000
Revenue recognised in the reporting period that was previously included in the contract liability balance (i.e. release of deferred IFRS 15 income)	-	-	424
Revenue recognised in the reporting period from performance obligations satisfied (or partially satisfied) in previous periods (e.g. changes in transaction price)	-	-	-
	-	-	424

The Trust have assessed Deferred income contract liabilities under IFRS 15 with regards to changes to contractual terms such as timing of right to consideration or performance obligations and changes in estimates and judgements and found them to be minimal

13. Borrowings (Group and Foundation Trust)

13. 1 Foundation Trust Financing Facility Loan

	31 March 2019 £000	31 March 2019 £000	31 March 2018 £000	31 March 2018 £000
	Group	Foundation Trust	Group	Foundation Trust
Current				
Obligations under Loan	**506**	**506**	**505**	**505**
Non-Current				
Obligations under Loan	**508**	**508**	**1,013**	**1,013**
	1,014	**1,014**	**1,518**	**1,518**

The Trust obtained a loan from the Foundation Trust Financing Facility on the 12 July 2011 repayable over 10 years, in the sum of £4.8 millions to support capital developments. The Trust repaid £506k of the loan in 2 instalments in 2018/2019

13. 2 Finance lease obligations by type

	31 March 2019	31 March 2019	31 March 2018	31 March 2018
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Current				
Buildings	**-**	**702**	**-**	**1,356**
Equipment	**25**	**739**	**177**	**867**
Non-Current				
Buildings	**-**	**24,510**	**-**	**24,308**
Equipment	**-**	**2,230**	**25**	**2,994**
	25	**28,181**	**202**	**29,525**

The Trust has a £29.6m finance lease with its wholly owned subsidiary, AGH Solutions Limited, which is eliminated on consolidation. The lease has a 25 years life starting on the 1 March 2018 Additionally the Trust has a lease in place 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.

Amounts payable under finance leases:	**Minimum lease payments**				**Present value of minimum lease payments**			
	March 2019 £000	March 2019 £000	March 2018 £000	March 2018 £000	March 2019 £000	March 2019 £000	March 2018 £000	March 2018 £000
	Group	Foundation Trust	Group	Foundation Trust	Group	Foundation Trust	Group	Foundation Trust
Within one year	**25**	**1,441**	**177**	**3,189**	**25**	**1,441**	**177**	**2,223**
Between one and five years	**0**	**6,716**	**25**	**10,435**	**0**	**6,716**	**25**	**8,892**
After five years	**0**	**20,024**	**0**	**28,469**	**0**	**20,024**	**0**	**18,410**
Less future finance charges	**0**	**0**	**0**	**(12,568)**	**0**	**0**	**0**	**0**
Present value of minimum lease payments	**25**	**28,181**	**202**	**29,525**	**25**	**28,181**	**202**	**29,525**

14. Contingencies (Group and Foundation Trust)

At 31 March 2019 the NHS Foundation Trust has £34k contingent liability for legal expenses, which is based upon information provided by NHS Resolution.

15. Third Party Assets (Group and Foundation Trust)

Airedale NHS Foundation Trust held £1k of monies on behalf of patients at the 31st March 2019 (No monies for 31st March 2018).

16. Provisions

16.1 Provisions current and non-current

	Current		Non-current	
	31 March 2019 Group and Foundation Trust £000	31 March 2018 Group and Foundation Trust £000	31 March 2019 Group and Foundation Trust £000	31 March 2018 Group and Foundation Trust £000
Pensions relating to the early retirement of staff pre 1995	125	122	924	943
Legal claims	65	42	-	-
Redundancy	-	-	-	-
Other	585	609	-	28
	775	773	924	971

16.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995 £000	Legal claims £000	Redundancy £000	Other £000	Total £000
At 1 April 2018	1,065	42	-	637	1,744
Arising during the year	106	36	-	469	611
Changes in discount rate	-	-		-	-
Utilised during the year	(125)	(13)	-	(132)	(270)
Reclassification	-	-	-	-	-
No longer required	-	-	-	(389)	(389)
Unwinding of discount	3	-	-	-	3
At 31 March 2019	1,049	65	-	585	1,699
Expected timing of cash flows:					
Within one year	125	65	-	585	775
Between one and five years	502	-	-	-	502
After five years	422	-	-	-	422
	1,049	65	-	585	1,699

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 relate to a small number of employment cases which were outstanding at the end of the financial year. All the provisions relate to Airedale NHS Foundation Trust.

16.3 Contingent liability

Clinical Negligence Liabilities
£106,251,915 is included in the provisions of the NHS Resolution at 31 March 2019 in respect of clinical negligence liabilities of the Trust (31 March 2018 - £66,032,808).

17. Losses and special payments (Group and Foundation Trust)

	31 March 2019				31 March 2018			
	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
			£	£			£	£
Losses								
Loss of Cash	-	-	-	-	-	-	-	-
Bad Debts	13	-	1,000	-	46	-	10,000	-
Stores losses	22	-	40,000	-	0	-	-	-
Damages to Premise	6	-	4,000	-	13	-	33,000	-
		41		**45,000**		**59**	-	**43,000**
Special payments							-	
Compensation under legal obligation	11	-	63,000	-	1	-	10,000	-
Loss of personal effects	10	-	3,000	-	21	-	7,000	-
Other	1		-		0		-	
		22		**66,000**		**22**		**17,000**
Total losses and special payments	63	**63**	111,000	**111,000**	81	**81**	**60,000**	**60,000**

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 2019 were £763k (£169k for 2017/2018).

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		£000
2018/19	1,183	2017/2018	1399

The expenditure above, is key management personnel compensation which is analysed as follows

	2018/2019	2017/2018
	£000	£000
Short term employment benefits	1,088	1,325
Post-employment benefits	95	74
Termination benefits	0	0
	1,183	1,399

Short term benefits employer benefits include salaries, employer's social security contributions and benefit in kind.

Post-employment benefits include employer's contribution to the 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 2019.

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 and Social Care is the parent department and as such 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:

The Department of Health and Social Care regards £2m to be the balance at which formal agreement between parties is required, the parties which meet this criteria are included below

NHS Airedale, Wharfedale & Craven CCG
NHS East Lancashire CCG
NHS Bradford Districts CCG
Health Education England
NHS England,CSU,LAT
NHS Litigation Authority

HMRC
NHS Pension Scheme
Bradford Metropolitan Council

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 LLP, with Involve Ltd. An expected distribution of £380k has been reflected as an accrual in the accounts of the Trust for 2018/2019. The profit is shown on page 4 of the accounts as share of profit/(loss) of associates / joint ventures.

The Trust also has a 50% equity in Integrated Laboratory Solutions LLP and Integrated Pathology Solution LLP with Bradford Teaching Hospitals Foundations Trust, for which it has accounted no profit or losses in the Trusts accounts for 2018/2019, the Trust is limited to a loss of £1 with the Joint ventures. In applying the Equity method the Group will not disclose any unrecognised share of losses of a joint venture or associate, until such time as profits outweigh losses.

19.4 Summary statement of Financial activities with Airedale NHS Foundation Trust AGH Solutions Ltd

AGH solutions LimitedStatement of Financial Position(Balance sheet)	**2018/19 £000**	**2017/18 £000**
Non current assets		
Lease	**26,740**	**27,301**
Current Assets		
Debtors: amounts falling due within one year		
Inventories	**1,333**	**1,473**
Trade and Other Receivables	**5,182**	**5,870**
Debtors: amounts falling due after more than one year		
Cash and Cash Equivalents	**3,376**	**1,634**
Creditors: amounts falling due within one year		
Loan	**(553)**	**(707)**
Other Creditors	**(7,069)**	**(6,584)**
Net current Assets	**2,269**	**1,686**
Creditors: amounts falling due after more than one year		
Loan	**(19,615)**	**(20,168)**
Net Assets	**9,394**	**8,819**
Capital and reserves		
Called-up share capital	**8,891**	**8,891**
Profit and loss account	**503**	**(72)**
Shareholders' funds	**9,394**	**8,819**

Investment in Subsidiary Undertakings

The shares in the subsidiary company AGH Solutions Ltd comprises a 100% holding in the share capital consisting of 8,891,000 ordinary £1 shares.

Income and Expenditure Account

Income		**23,775**		**1,908**
Expenditure				
Pay	**(8,162)**		**(658)**	
Non Pay	**(15,080)**		**(1,343)**	
		(23,242)		**(2,001)**
Operating deficit		**533**		**(93)**
		983		**82**
Interest receivable		**(722)**		**(61)**
Interest payable		**(218)**		**0**
Corporation tax				
		43		**21**
Surplus / (Deficit)		**576**		**(72)**

The year-end for the AGH Solutions is 31st March 2019

Statement of Financial Position (Balance Sheet)	2018/19 12 Months £000	2017/18 12 Months £000
Investments	578	583
Current Assets		
Trade and other receivables	0	3
Cash and Cash Equivalents	783	567
	783	570
Current Liabilities		
Trade and other payables	(403)	(32)
Net Assets	**958**	**1,121**
Funds of Charity		
Restricted Funds	4	4
Unrestricted Funds	954	1,117
	958	**1,121**

Movements on Reserves

	Total	Restricted	Unrestricted
Balance At 1 April 2018	1121	4	1117
Net incoming	(163)	0	(163)
Balance at 31 March 2019	**958**	**4**	**954**

The year-end for the Charitable Funds is 31st March each year.

20. Financial instruments.

	31 March 2019 Group	31 March 2019 Foundation Trust	31 March 2018 Group	31 March 2018 Foundation Trust
	£000	£000	£000	£000
Financial assets				
Receivables (excluding non financial assets) - with DHSC group bodies	9,813	9,733	5,690	5,412
Receivables (excluding non financial assets) - with other bodies	6,393	25,723	11,563	32,069
Cash and cash equivalents at bank and in hand	14,528	11,152	8,790	7,156
NHS Charitable funds: financial assets	1,361	0	1,153	0
Total	32,095	46,608	27,196	44,637

The NHS Foundation Trust's financial assets all fall under the category 'loans and receivables'.

Financial liabilities				
Borrowings excluding Finance leases and PFI liabilities	1,014	1,014	1,518	1,518
Obligations under Finance leases	25	28,181	202	29,525
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	3,388	3,388	10,436	2,725
Trade and other payables (excluding non financial liabilities) - with other bodies	15,410	11,457	9,037	8,934
NHS Charitable funds: financial liabilities	0	0	0	0
Total	19,837	44,040	21,193	42,702

The NHS Foundation Trust's financial liabilities all fall under the category 'other financial liabilities'.

Maturity of financial liabilities				
In one year or less	19,329	16,791	20,155	13,349
In more than one year but less than two years	508	1,973	530	1,690
In more than two year but less than five years	0	3,816	508	4,063
in more than five years	0	21,459	0	23,600
Total	19,837	44,039	21,193	42,702

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.

20. Financial instruments (continued)

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

20.1 Carrying value and fair value of financial assets 31 March 2019

	Financial assets at amortised cost	Financial assets at fair value through I&E - mandated	Financial assets at fair value through I&E - designated	Financial assets at fair value through OCI - mandated	Investments in equity instruments designated at fair value through OCI	Total
	31 March 2019	**31 March 2019**	**31 March 2019**	**31 March 2019**	**31 March 2019**	**31 March 2019**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Receivables (excluding non financial assets) - with DHSC group bodies	9,813					9,813
Receivables (excluding non financial assets) - with other bodies	6,393					6,393
Other investments / financial assets	0					0
Cash and cash equivalents	14,528					14,528
Consolidated NHS Charitable fund financial assets	0		1,361			1,361
Total	**30,734**	**0**	**1,361**	**0**	**0**	**32,095**

20.2 Carrying value and fair value of financial liabilities 31 March 2019

	Financial assets at amortised cost	Financial assets at fair value through I&E - mandated	Financial assets at fair value through I&E - designated	Financial assets at fair value through OCI - mandated	Total
	31 March 2019	**31 March 2019**	**31 March 2019**	**31 March 2019**	**31 March 2019**
	£000	**£000**	**£000**	**£000**	**£000**
DHSC loans	1,014				1,014
Other borrowings excluding finance lease and PFI liabilities	0				0
Obligations under finance leases	25				25
Obligations under PFI, LIFT and other service concession contracts	0				0
Trade and other payables (excluding non financial liabilities) - with DHSC group bodies	3,388				3,388
Trade and other payables (excluding non financial liabilities) - with other bodies	15,410				15,410
Other financial liabilities	0				0
IAS 37 provisions which are financial liabilities	0				0
Consolidated NHS charitable fund financial liabilities	0				0
Total	**19,837**	**0**	**0**	**0**	**19,837**

20.3 Carrying value of financial assets under IAS 39 as at 31 March 2018

	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	31 March 2018	**31 March 2018**	**31 March 2018**	**31 March 2018**
	£000	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	18,440			18,440
Other investments / financial assets	0			0
Cash and cash equivalents	8,790			8,790
Consolidated NHS Charitable fund financial assets	0	1,153		1,153
Total	**27,230**	**1,153**	**0**	**28,383**

20.4 Carrying value of financial liabilities under IAS 39 as at 31 March 2018

	Held at amortised cost	Held at fair value through I&E	Total book value
	31 March 2018	**31 March 2018**	**31 March 2018**
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	1,518		1,518
Obligations under finance leases	202		202
Obligations under PFI, LIFT and other service concession contracts	0		0
Other borrowings	0		0
Trade and other payables excluding non financial liabilities	19,473		19,473
Other financial liabilities	0		0
Provisions under contract	0		0
Consolidated NHS charitable fund financial liabilities	0		0
Total	**21,193**	**0**	**21,193**

20. Financial instruments (continued)

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 being 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 PRA (Prudential Regulation Authority)

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.

Price Risk

The Foundation Trust is not 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 DHSC 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. Intra-Government Balances (Group and Foundation Trust)

	Receivables amounts falling due within one year	Receivables amounts falling due after more than one year	Payables amounts falling due within one year	Payables amounts falling due after more than one year
	£000	£000	£000	£000
English NHS Foundation Trusts	**974**	**-**	**863**	**-**
English NHS Trusts	**369**	**-**	**388**	**-**
Department of Health and Social Care	**-**	**-**	**-**	**-**
Public Health England	**-**	**-**	**9**	**-**
Health Education England	**365**	**-**	**6**	**-**
NHS England & CCGs	**8,094**	**-**	**1,223**	**-**
RAB Special Health Authorities	**9**	**-**	**45**	**-**
NHS Whole Government Accounting bodies	**1**	**-**	**898**	**-**
Other Whole Government Accounting bodies	**1,940**	**-**	**4,247**	**-**
As at 31 March 2018	**11,752**	**-**	**7,679**	**-**

23. Events after the Reporting year

There are no adjusting or non-adjusting events of a financial nature after the reporting year requiring disclosure.

Annual accounts of -

Airedale NHS Foundation Trust
Airedale General Hospital
Skipton Road
Keighley
Yorkshire
England
BD20 6TD

http://airedale-trust.nhs.uk

Airedale NHS Foundation Trust is an NHS provider of Healthcare.

CONTACT INFORMATION

Airedale NHS Foundation Trust
Airedale General Hospital
Skipton Road
Steeton
Keighley
West Yorkshire
Bd20 6td

Tel: 01535 652511
www.airedale-trust.nhs.uk

This annual report and accounts is available on our website at 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

Governors

Governors can be contacted via the Company Secretary at the above address Tel: 01535 284815 Email: 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

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 Helen Roberts, Patient Information Officer. Tel: 01535 294413. Email: 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.

Follow us on Twitter @AiredaleNHSFT