Airedale
NHS Foundation Trust

AIREDALE NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS
2020/21

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Welcome from the Chair

During what has been an unprecedented year, it has continued to be my privilege to chair this Trust and observe how it is responded to coronavirus, both demonstrating resilience and continually adapting in light of the different phases of that pandemic the nation faced. The Trust acknowledges the sadness for many in the loss of loved ones and the continued uncertainty that we all still face.

None of us could have imagined last March what our Trust's fiftieth year would bring each of us, both personally and professionally. Having stated previously how proud I am to be the chair of this Trust which is at the heart of the community where I live, throughout this pandemic never have I been prouder of the resilience and achievements of every colleague. Similarly the Trust has been inspired and overwhelmed by the levels of generosity and support from our communities. It has been incredible and the report from our Airedale Hospital & Community Charity on p17 highlights the wide-ranging and generous support.

When the lockdown was first announced, we quickly deployed home working wherever possible, shielded those with medical conditions and followed Covid-secure guidelines in line with the latest advice towards our key aim to keep all colleagues and patients safe.

In line with prevailing national guidance, my Non-Executive Director colleagues and I have, like so many others, adapted to working from home while staying connected with the Trust. Although we have missed our face to face interactions with teams, wards and departments, all of us working from home have been well informed through different mediums about key developments in what has been an incredibly fast-moving situation. Formal meetings along with more regular informal briefings, including the Trust-wide virtual staff briefing sessions, have all been extremely valuable for Board members to stay connected.

On behalf of the Board, thanks go to everyone involved in providing the Trust's services in such challenging circumstances. This ask of colleagues is of course not unique to the Trust and applies to all healthcare providers, be that primary care; social care and relevant parts of the voluntary sector, such as hospices. Partnership arrangements provide access to utilise skills available elsewhere as part of a shared vision to optimise healthcare provision across the community the Trust serves. The Trust's Board members acknowledge the support of everyone involved with the Trust as well as the commitment and enthusiasm all colleagues bring in fulfilling their duties across all of its sites together with the services provided in the community.

Executive members of the Trust's Board have gone above and beyond to respond to the pandemic, having to apply the multitude of national guidance and make rapid decisions after having assumed a command and control decision-making structure last March. Non-Executive Director colleagues have supported executive colleagues by offering insights and independent counsel. Throughout the year the Trust's Board has consistently demonstrated true leadership and provided stability during the turbulence this pandemic has brought.

I would also like to thank the Council of Governors who have continued to engage in the work of the Trust, albeit in very different ways to previous years. Their insight, support and

contribution has been really valuable to the Board. Staff governors have provided an insight into the frontline experience and to the impact of both local and national decision-making on colleagues. The Council of Governors have also been helpful conduits of relevant information to the Trust's members, helping to combat misinformation, and sharing the true picture of the Trust's activity both at the hospital and out in the community.

Sustainably remains a key ambition for the Trust and I am pleased that we continue to be mindful of the environment as part of our look to the future. For example, we have been looking to further offset our carbon footprint via tree planting in our grounds and gardens. Planting a tree is a gift for future generations, and it seems fitting that we have done this in our fiftieth year, for the benefit of our future workforce and patients.

Brendan's chief executive's report highlights the further maturity of system working across the Bradford district and Craven place, as well as the wider region. This coming year will see further changes as a result of the government's white paper in Integrated Care Systems, and Airedale's voice will continue to be represented as part of the West Yorkshire & Harrogate Health & Care Partnership's development in line with that white paper. The Trust will embrace those changes as part of its continued development and commitment to continuous improvement. The constant throughout all this is the Trust's continued focus on meeting all of the wider healthcare requirements of the Airedale, Wharfedale and Craven population, working collaboratively with all system partners to achieve that. Working together will enable achievement of the best possible outcomes for everyone.

As we enter the Trust's new financial year uncertainty remains regarding future phases of this pandemic. We are seeing green shoots of hope, thanks to the pace of the vaccination programme and a reducing prevalence of Covid-19 in communities compared to when it peaked. The true impact of the pandemic will however continue to emerge, when some of the longer term effects such as long covid and wellbeing will inevitably have greater focus compared to when the pandemic first broke. As part of the transitioning of this pandemic becoming an epidemic, the Trust will continue to adapt and build on what's been learned over the previous year. After such an eventful year which truly cemented the Trust's role as a cornerstone within its community, we anticipate that the coming year will see further progression for the Trust and its partnerships; population; patients as well as all our people.

Andrew Gold
Chair, Airedale NHS Foundation Trust

24 June 2021

CHAPTER 1
PERFORMANCE REPORT

SECTION 1: Overview of Performance

The purpose of this overview of performance is to provide information about the Trust, its purpose, the key risks to the achievement of our objectives and how we have performed during the year.

Chief Executive's Statement

I have never been prouder to be part of Airedale.

Over the last year the courage and determination of our teams has humbled and inspired me. Together, and with the wider NHS, we have been at the heart of this pandemic, bringing all our skills and experience to bear to care for members of our communities impacted by this indiscriminate virus. Individuals have been shattered, families have been devastated. Life, as we all know it, has changed irrevocably. Throughout this incredibly difficult year our teams have worked tirelessly to care for people in a rapidly changing and challenging environment.

And yet despite – or perhaps because of – the pandemic, we have also managed to achieve real, transformational change in the way we work over the last year. The challenge and the need for rapid decision-making has broken down traditional barriers and destroyed silos, enabling us to work in new ways, both within the Trust and in our wider system. It has also cemented our Trust at the heart of our community, highlighting the work of the NHS to the wider world like never before. You can read some of highlights from a year that has been both extraordinarily difficult and incredibly uplifting on p14

Our performance this year

We started the year in an unusual position. We had followed national guidance in relation to pausing services as we received our first Covid-19 patients. We paused all elective activity to free up capacity in our bed base, continuing only with urgent, emergency and cancer surgery, with the support of the independent sector. Our Emergency Department attendances reduced significantly, and remained lower than usual for much of the year. We reconfigured our bed base to manage the flow of Covid-19 patients vs non-covid patients. We introduced restrictions on visiting and set up virtual visiting along with wraparound services - but it has been hard for patients and their families, and we recognise that. Our community teams supported the increased critical care workforce required and adapted swiftly to the new requirements for covid safety in people's homes. This was in addition to their own caseloads increasing, which the teams continue to respond to as the impacts of the pandemic continue to be felt by our patients. Our infection prevention team worked across our four hospital sites – Airedale, Castleberg, Skipton and Ilkley Coronation - to ensure that all services operated safely.

You can read more about this in our Performance Report on p24, which includes our key performance metrics for the year. The Board has remained focused on these metrics through the year, whilst recognising the atypical situation in which we found ourselves. I would like to thank my executive and non-executive colleagues, and our governors, for their support, insight and challenge that has, as ever, been invaluable, particularly as we navigated new and uncharted waters.

In the north of England we had a different experience of the pandemic compared to other parts of the country. We saw three distinct peaks – April, November 2020 and February 2021. Local residents also spent the majority of the year following the first lockdown living under some level of enhanced restrictions, which has had a significant impact on people's livelihoods and mental health. Our duty as an employer has been the care of our staff, and the wellbeing of our workforce has been a primary focus over the last year. Via the generosity of our communities and funding from NHS Charities Together, we have been able to put a number of resources in place for our workforce. At the onset of the pandemic we implemented wellbeing rooms on wards and in departments, where people could take time out, and developed our wellbeing garden as a space for reflection. Mental health support was expanded and extended, and a wealth of resources shared with our people. We have installed water coolers, bought picnic benches, provided cooling hoods for wearing with PPE and so much more, which you can read about on p17.

We have continued to develop and grow our workforce, and you can read more about this in our Staff Report in Chapter 2. As part of our nurse staffing strategy, we have welcomed over 90 nurses from India, a recruitment drive which began in 2019/20. Coming so far from home and starting work in a global pandemic is not how any of us would wish to start in a new role, but they took it in their stride and have become indispensable members of our workforce. In last year's Annual Report I referenced the provision of IT solutions to support agile working, and I am pleased to say that these solutions continue to work exceptionally well, enabling many of our staff to work from home.

We have been grateful this year for the support of local media in celebrating our people, and their work during the pandemic. Our regional broadcast media have shone a light on a variety of roles and services, including our domestic teams, anaesthetics, dietietics, theatres, allied health professionals, nursing teams, emergency department, gardening team, our acute respiratory care unit and our mobile cancer care unit. This has reflected on the NHS as a whole, and I am extremely grateful both to the media outlets and to our people who took part.

One benefit of the pandemic has been the increase in collaborative working. Across our local system of Bradford district and Craven we are working closer and more effectively than ever. This builds on a solid bedrock of mutual respect, shared history and a desire to provide seamless services across health, care and our voluntary sector for our communities. As we move into the new financial year, we have declared our priorities and formalised our focus to become the Act as One programme, encompassing health and care

in our district. You can read more about our ambitions for the programme in the Partnership section.

As part of our 50th anniversary celebrations, we were honoured to receive a video message from His Royal Highness Prince Charles, the Prince of Wales. Our celebrations were inevitably somewhat muted, given the circumstances, but receiving a message from His Royal Highness was a fitting tribute to our staff and volunteers, and they were touched and moved by it.

In his message, HRH the Prince of Wales referenced his visit in 1970 to open the then state-of-the-art hospital. We are now planning a new hospital that will reflect our ambition for the provision of modern, innovative healthcare for our communities, well beyond the next 50 years.

We have learned much from the pandemic, and there is much to build on and look forward to as we move into the new financial year. To quote a local legend, Captain Sir Tom Moore, tomorrow will be a good day.

Brendan Brown
Chief Executive, Airedale NHS Foundation Trust

24 June 2021

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

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 **3000** permanent staff between the Trust and its subsidiaries and have over **350** volunteers. During 2020/21 over **29,000** patients spent at least one night in our hospital; over **2,000** babies were born at the hospital last year; more than **55,000** people attended our A&E department; and we saw over **130,000** outpatients. Our community teams made over **93,000** visits and our Hub made more than **44,000** telemedicine contacts. We have an annual budget operating income of over **£200 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 Bradford District and Craven, and East Lancashire Clinical Commissioning Groups (CCGs), as well as regional specialist commissioners and NHS England.

Highlights of our year 2020/21

While the pandemic brought with it some significant clinical and service challenges, it did also result in huge amounts of support and good will for our colleagues and patients from our local communities. It also drove innovation and transformation of our services at a rate we have not seen before.

In April we opened our wellbeing rooms for staff as a quiet space to take a breath and recharge. The rooms are available 24/7 and are stocked with items that have been donated by the community including mugs, drinks, snacks and hand cream. The wellbeing rooms were introduced to provide staff with a place they can go to take a pause and ground themselves if they are feeling overwhelmed, a space to do some calming techniques such as mindful breathing, somewhere to have a drink, snack or a short rest and a space to talk and to get support if needed.

In May we created special memory cards, to recognise early pregnancies that are sadly lost. Prompted by a conversation with a patient who had miscarried, the team from the Early Pregnancy Assessment Unit decided to develop a card to recognise first trimester pregnancies that unfortunately miscarry, an idea supported by the miscarriage association website, to offer an element of comfort and lasting recognition of the loss. The cards were created by Collisons, a local personalised card company who actively help local charity projects, in collaboration with the Airedale Hospital & Community Charity.

In July we celebrated our 50th anniversary, in the same week that the NHS had its 72nd birthday. Airedale Hospital opened its doors to the first patients on Sunday 5 July 1970 when 60 patients were transferred from Victoria Hospital. In December 1970 the hospital was then officially opened by HRH Prince Charles, the Prince of Wales. We received a personal video for our staff from Prince Charles in October, thanking our 'remarkable' staff for their dedication and expressing how "humbled and deeply grateful" he and his family were for their work during the pandemic.

In August we created our first one stop clinic for children with cerebral palsy. Children with the condition would usually have to attend the hospital multiple times to see different professionals so the team created a one stop service with the children seeing a consultant paediatrician, physiotherapist, occupational therapist, orthotist, nurse and radiographers, all at one appointment. Children and their families can come now for an appointment with a very clear outcome where they are able to discuss their issues and have a plan of action after it. It also means parents don't have to repeat themselves as having multiple

professionals there at the same time means queries can be answered at the appointment by the specialist teams.

In September we became the **first hospital in Yorkshire and one of the first trusts in the country** using the latest pioneering technology for patients having cataract surgery. The opening of Airedale Hospital's brand new £100,000 SurgiCube operation unit means patients can have microsurgeries, like cataract surgery, quickly, easily and safely as day patients in the Dales Suite. For patients it also means they don't have to prepare for surgery in the same way. The patient can be placed under the ultra-clean air flow of the SurgiCube in various ways allowing for a 'small surface surgery' to be performed on various parts of the body. They don't need to dress for surgery and the fact that they can sit down themselves on the treatment chair and the surgery is completed quickly creates a much more relaxing experience.

In October our orthopaedic Surgeons launched the first NHS 'one-stop' upper limb clinic to include a consultant radiologist, significantly reducing waiting and treatment times for patients with shoulder pain. The new clinic means patients with shoulder or elbow problems including bursitis, impingement or rotator cuff injuries and tennis or golfer's elbow, will be able to see a consultant surgeon and consultant radiologist , get a diagnosis and treatment plan and start treatment such as injections and physiotherapy, all at the same appointment. It reduces patient appointments at the hospital from four to one and reduces waiting times to around four weeks, making a significant difference for those patients in pain and discomfort.

In November a group of staff from our Emergency Department were shortlisted for an NHS Parliamentary Award after being nominated by local MP Robbie Moore. 'Hearts in Little Hands' are a team from the hospital's Emergency Department who teach children, parents and carers CPR and basic lifesaving skills. The team, who before the pandemic visited primary schools across the area in their own time to share their expertise via demonstrations and songs, were shortlisted for the Excellence in Urgent and Emergency Care Award Category.

In January we became one of the first trusts in the North of England to revolutionise our biopsy service for men with suspected prostate cancer by offering patients a transperineal prostate biopsy under local anaesthetic to investigate for prostate cancer. The ground-breaking new service means that prostate biopsies are performed in the safest way possible, significantly reducing the risk of infection. It also allows for more extensive and accurate biopsies of the prostate gland which helps to reduce the number of biopsies required in the future. By offering this procedure, Airedale Hospital meets and surpasses NICE guidelines and offers Gold Standard care, placing the Trust on a par with other leading centres such as Guys and St Thomas's Hospital in London.

Pandemic highlights

The challenge of fighting Covid-19 has led to significant change in our ways of working. From receiving our first Covid-19 patients, to managing our third peak in demand in January/February this year, we have learned rapidly and adjusted working practices to care for and treat patients with the virus.

Our first Covid-19 patient arrived in the Trust on 19 March 2020. Ahead of that, the Trust had moved to a formal command and control structure, with Bronze, Silver and Gold command levels. These continue to function well and have enabled a rapid response at all stages of the pandemic.

At the same time, and in response to the tidal wave of clinical guidance around how to treat Covid-19 patients, protect staff and manage the clinical environment, the Clinical Reference Group (CRG) was set up. The Group's remit is to review national guidance, consider ethical challenges and identify and recommend wellbeing support for clinical staff. This is done by multi-professional clinicians making clinical recommendations to Gold to support decision making around the Trust's Covid-19 response. CRG has proved an invaluable space for review and debate throughout the pandemic, and is now part of the organisation's formal governance structures.

Personal protective equipment (PPE) quickly became a primary concern, nationally. Our AGH Solutions procurement team worked ceaselessly to ensure that we had a sufficient supply of the appropriate PPE, adapting efficiently to new guidance and requirements for different stock. Neither our hospital nor community services have run short of PPE over the course of the year, which is a testament to their commitment and dedication to ensuring staff were protected.

Technology was key in enabling meetings and decision-making forums to continue. Deployment early on of Cisco Webex and subsequently MS Teams has allowed the Trust to work safely and efficiently, and individuals to be able to work more flexibly. Similarly, the use of Attend Anywhere for outpatient appointments has increased exponentially, with good feedback from patients and families. Our telemedicine service has also expanded into all care homes in Bradford district and Craven, giving our clinicians the ability to do remote assessments and giving care home staff and residents peace of mind.

In April our Acute Respiratory Care Unit (ARCU) was set up, on ward 13. This enabled patients who were very ill but did not require intensive care support to be treated in an environment where they could be closely monitored and stepped up or down, as required. ARCU has cared for some of our sickest patients, and have seen many make a good recovery.

Long covid is an increasing issue. Members of our community, therapy and medical teams have worked with trusts across our region to develop a screening tool to identify the rehabilitation needs of patients, post-Covid. This was an early development in spring 2020, which has helped countless patients to access the rehabilitation that they need.

Our hospital Vaccine Centre went live on 11 January and as at 31 March 2021 had given first vaccinations to over 8000 people in cohorts 1 – 9 as per the Joint Committee of Vaccinations and Immunisations, as well as beginning the second vaccinations programme. Staff members from our clinical and corporate teams also supported the setting up and delivery of vaccines at other vaccination hubs across the district.

Airedale Hospital & Community Charity

Throughout this extraordinary year, the support of our communities has been incredible. It has allowed a greater focus than ever on staff and patient wellbeing, something that has been sorely needed in these most challenging of times.

The Airedale Hospital & Community Charity was official rebranded in March 2020, having previously been known as Airedale NHS Foundation Trust Charitable Fund. The aims and objectives of the Charity are clearly set out in the annual strategy and are closely aligned with the Trust's objectives. These objectives allow us to support our people and their wellbeing, improve patient experience, progress services and innovation, support services delivered in partnership and support population need.

The Charity in this period saw some incredible growth in the public profile and income. A key aim for future years is to continue this growth and to aid public understanding of the purpose of the Charity.

Fundraising highlights

Covid-19

The Covid-19 pandemic had a huge impact on the Charity. A specific appeal, Care for Airedale, was launched soon after the official rebranding in April 2020, in response to the immense support from the local community. The appeal raised almost £20k for the wellbeing of staff and patients. The Charity, along with the support of the Trust, was able to pay this kindness forward by coordinating collections and donations to the local foodbank. The Charity also received gifts from both local and national businesses which were distributed across the Trust.

NHS Charities Together & Captain Tom

As a proud member of NHS Charities Together, the Charity was delighted to play an active part in the hugely successful national NHSCT Covid-19 appeal. The appeal presented a number of opportunities to be involved in media interviews both on screen and in print which were undertaken by members of the Charity team and ANHSFT staff. Through NHS Charities Together, Airedale Hospital & Community Charity has so far been in receipt of nearly £160k from Captain Sir Tom Moore and the thousands of other fundraisers that supported the appeal. With Captain Tom's strong links to Keighley the Charity was proud to be part of his story and the legacy he left behind.

Young fundraisers
Throughout the year the Charity team has been proud to work with a large number of young fundraisers within the local community. Notable examples are:

- Inspired by Captain Tom a young girl, aged 6, raised over £800 litter picking in her local community
- An inner town school cycled over 1,000 km during health week and raised over £2.5k

How funds have been spent
Funds continue to be spent in line with the Charity's objectives and primarily on items over and above core NHS provision. A main focus has been and continues to be on the general wellbeing of employees.

Other areas of support include:

- 50 air flow hoods for the ARCU/ICU teams
- 15 additional water coolers in clinical areas
- 25 patient activity boxes
- 11 picnic benches
- A portable wheelchair scale

Above all, the highlight of this year has been the support of our local community. We are humbled by their generosity which has helped to give our staff much-needed support and comfort during this difficult year.

Our Subsidiaries

AGH Solutions Ltd
AGH Solutions Ltd is the Trust's wholly-owned subsidiary, providing estates and facilities management, procurement, and transport and security services to the Trust. Established in 2018, the company has over 400 staff, a third of whom have been brought in house from previously outsourced contracts.

Highlights from 2020/21

- Significant work across Airedale NHS FT's hospital and subsidiary sites to make them covid-safe, including maintaining consistent stocks of the full range of PPE, enhanced cleaning regimes, estates works to upgrade facilities and the installation of social distancing signage.
- Providing the soft facilities management for the NHS Nightingale Hospital Yorkshire and the Humber 500-bed hospital.
- Estates and procurement support for the establishment of the hospital's vaccination centre, and to a local primary care network using Skipton Hospital as a vaccination hub.
- Ongoing management of reinforced autoclaved aerated concrete (RAAC) plank issues.

Plans for 2021/22

- Establishing a modular ward and ICU, and undertaking a programme of decant of wards to facilitate RAAC safety works in wards.
- Delivery of theatres new build and hospital perimeter road enhancements, plus planning application and subsequent build (pending the planning permission outcome) of helipad.
- Enhance sustainability and continue the strategy to be carbon zero by 2040.
- Continue to improve our community impact through local sourcing and local employment opportunities, such as the Kickstart campaign.

Immedicare

The Immedicare Joint Venture has been in place since April 2013, a partnership between Airedale and Involve – a provider of visual collaboration solutions. Immedicare services support care homes 24/7 365 days a year providing video-enabled clinical healthcare services delivered into care homes across the UK from via our digitally enabled care hub. We offer clinical expertise, in-depth knowledge of healthcare challenges, and the best technical design, delivery and support available.

Highlights from 2020

In 2020/21 Immedicare was ideally placed to support care homes during the pandemic in keeping patients in their place of residence without onward referral to hospital. As a result there was a rapid increase during the first half of 2020/21 in the number of care homes using Immedicare services. A pharmacy service was also introduced as a pilot and will be taken forward into 2021.

Pre-pandemic, in total, there were over 24,000 consultations conducted in the year

- 89% of patients remained in their place of residence
- 65% of consultations did not end with an onward referral
- 60% of consultations where the care home would have contacted a GP were not referred to a GP
- 23% of all consultations were for a falls-related concern (i.e. (suspected) fracture or head injury)
- 4,653 (84%) of falls-related consultations did not result in an ambulance request

Plans for 2021/22

The changing landscape of commissioning in the NHS means that the priority for Immedicare is ensuring there are good relationship management arrangements in place to support the market and client requirements going forward. The team are also developing a new package of services which will be tested and shared later in the year.

Integrated Pathology Solutions

Pathology services are provided by Integrated Pathology Solutions LLP (IPS), a joint venture between the pathology departments of Airedale, Bradford and Harrogate hospital trusts, covering 400 staff. IPS provides a high quality diagnostic and consultative service to

clinical users of all three trusts, and to primary and secondary care providers. Their services have been vital during the pandemic; in particular in testing for Covid-19.

Highlights from 2020/21

- Rapid introduction and installation of PCR equipment carried out to enable on-site testing for SARS-CoV-2. Currently averaging over 20, 000 tests per months with an average turnaround time of 6 hours.
- IPS's recent user survey across Airedale and Bradford overall showed that the service is meeting user requirements with high user satisfaction.
- The service continues to meet regulatory requirements and, following recent inspections, has been recommended for UKAS accreditation to ISO 15189.

Plans for 2021/22

- Consolidate the position of the joint venture within West Yorkshire & Harrogate Pathology network.
- Implement the new regional Pathology Laboratory Information Management System across all sites.
- Further develop the molecular testing service and expand the repertoire of tests offered on-site.

Key issues, opportunities and risks

Key issues, opportunities and risks for the Trust during 2020/21 were:

- **Availability of workforce**
  While the Trust has had significant success in international recruitment, the global pandemic impacted on the ability to bring these staff into the country and the position in relation to nurse staffing. The Trust has an ongoing recruitment challenge in both nursing and medical posts. This will continue to be a challenge in 2021/22 and there is an increased focus on local recruitment wherever possible. Medical staffing has been challenging in particular services, including paediatrics, critical care and some specialties which have relied on locum cover.

- **Demand for services**
  Transformation of the way in which services are delivered has been accelerated as part of the response to the Covid-19 pandemic. This is resulting in different ways of working including telephone triage with primary care; increased use of the Trust's Mycare24 and Digital Care Hub services; virtual outpatients; and the implementation of new technologies including SurgiCube. Locally we experienced three waves of increased numbers of patients coming into the hospital with Covid 19, in March 2020, November 2020 and January 2021. This also impacted on our community services who were managing an increased number of patients with covid and long covid in the community as well as those patients who were not accessing inpatient care. During the early part of 2020/21 the Trust saw a significant drop in the demand for both urgent and planned non-covid care. However towards the end of 2020/21 demand has increased significantly with consistently high numbers of patients coming in to our emergency department.

- **Financial position**
  The Group financial position was a deficit of £21.1m for 2020/21, including an impairment of £24.3m, which arose out of the Trust's annual revaluation of its estate. The position included a favourable stock movement on nationally procured PPE of £0.78m and donated asset income of £0.44m. The underlying position excluding these items, which operational performance is measured against, was a surplus of £2m.

  Total income from continuing activities for 2020/21 was £228.3 million. The Trust had a cash balance of £26.2 million at the close of the financial year. An analysis of this is shown in the Consolidated Statement of Cash flows.

  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 positive movement of £230k in the year 2020/21.

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 Trust's capital programme invested £12.0 million in 2020/21 to improve its buildings and equipment. Examples of the higher value capital expenditure schemes included construction works on the new barn theatre, backlog maintenance of the hospital site, investment in replacement medical equipment, replacement Information Technology plus development of Scan for Safety and the Integrated Health Record. The Trust's estate was revalued in 2020/21 due to national guidance issued on the use of Reinforced Autoclaved Aerated Concrete (RAAC) panels. A comprehensive assessment of the condition of the RAAC roof panels used throughout the hospital took place in 2020/21 and a programme of works to reinforce any areas requiring support is underway.

The Trust has developed a balanced annual plan for 2021/22. The financial planning regime remains fluid due to the ongoing impact of COVID-19, resulting in national planning submissions covering only the first half of 2020/21. In line with the finance regime for the second half of 2020/21, the Trust will receive block income from CCGs and NHSE/I. In addition, funding to offset COVID expenditure and a reduction in non NHS income will be received from the ICS. Any costs related to the COVID Vaccination Programme and COVID testing will be reimbursed separately to this. Further detail on funding for the second half of 2021/22 is yet to be released.

The 2021/22 plan includes a challenging waste reduction target, increased investment in nursing staff and support to improve pathways. The Board remains determined to ensure robust financial governance to ensure the long term sustainability of the Trust.

- **Estate**

  The hospital opened in 1970 and had an expected 30 year lifespan. There have been ongoing issues relating to the age of the building, its construction and the 30,000 sq. feet of flat roof. During the year, the Trust received a safety alert in relation to the failure of reinforced autoclaved aerated concrete (RAAC) planks, which make up the roof of the hospital. This resulted in the need to undertake investigations as to the level of deterioration of these planks and a risk assessment of the Trust building. This is in addition to backlog maintenance issues which need to be addressed. During 2020 the Board approved a Strategic Outline Case for a new build and this is being taken forward with NHS England.

- **Performance**

  The Trust maintained good performance against the access standards for cancer diagnosis and urgent surgery. The pandemic significantly impacted our ability to deliver other key performance indicators such as diagnostics and referral to treatment times, as set out in the single oversight framework – see performance section on p24

Going concern disclosure

After making enquiries, the directors have a reasonable expectation that the Airedale NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future due to:

- Strong financial position with some risk around high levels of nursing vacancies currently covered by bank and agency workers. The Trust has recently recruited approximately 88 international nurses to mitigate this risk. The trajectory for temporary staffing is that bank and agency will reduce during the year ahead.

- The Trust has structural issues with its old estate, aligned to the aerated concrete risk which will require a new build in future years. NHSI have supported emergency funding of £10m for 2021/22 and are considering the remainder of the full bid of £24m to support maintenance work over the next 3 years. £24m is the current estimate of costs that are required to ensure the buildings remain stable until 2030, which is when national teams have committed to replace all RAAC buildings.

- There remains risk around Covid and the future implication of increased costs; however the current financial regime remains in place in the first half of the next financial year and conversations remain ongoing around the second half of the financial year, which will be largely dependent on success with the national vaccination programme. This reduces this financial risk considerably for 2021/22.

- Nationally it has been agreed to fund all organisations through block contracts until the end of September 2021, with an elective recovery fund for any additional activity achieved above the baseline calculation, therefore costs associated with additional activity should be covered.

- Based on a series on scenarios, the Trust is expecting to be able to manage a balanced financial position for 2021/22.

For these reasons they continue to adopt the going concern basis in preparing the accounts.

Consideration of risks to the financial sustainability of the organisation is a separate matter to the application of the going concern concept. Determining the financial sustainability of the organisation requires an assessment of its anticipated resources in the medium term. Any identified significant risk to financial sustainability is likely to form part of the risks disclosures included in the wider performance report, but is a separate matter from the going concern assessment.

Summary of performance

Performance in the financial year was significantly impacted as a result of the coronavirus pandemic.

During 2020/2021, Command, Control and Coordination arrangements were rapidly implemented and these continued to be in place across the full year.

This responded to all aspects of managing services in the face of an international pandemic, such as hospital configuration of the estate, clinical requirements (e.g. critical care capacity, Acute Respiratory Care Unit), community services provision, interpretation and implementation of national guidance, workforce planning, providing a safe environment (e.g. infection prevention and control) and equipment management (e.g. PPE, Oxygen supply).

Some service provision was maintained during the Level 4 national emergency, for urgent, emergency and cancer care.

Nationally, whilst performance standards continued to be reported, the management of NHS provider performance against national standards externally was postponed, recognising the effect of the pandemic on large proportion of our planed care work. This is reflected in the table below.

Key performance indicators

Indicator	Target	Q1	Q2	Q3	Q4
Total time in ED under 4hrs	**95%**	92.7%	90.1%	84.5%	86.1%
Referral to Treatment Time, 18 wks.	**92%**	65.8%	58.6%	72.4%	69.3%
Diagnostics 6 Week Wait	**99%**	38.4%	58.9%	74.4%	88.4%
Cancer 2 week wait	**93%**	90%	94.5%	90.5%	93.4%
Cancer 2 week wait (breast symptomatic)	**93%**	94.9%	96%	67.6%	85.3%
Cancer 31 days from diagnosis to first treatment	**96%**	100%	99.5%	99.5%	97.4%
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%**	82.4%	87.5%	76.4%	85.7%

Cancer 62 day wait for first treatment (NHS Cancer Screening Referral Service)	**90%**	100%	25%	80%	47.1%

It should be noted that:

- Our Urgent and Emergency Care performance has seen five of the 12 months running at 90% or above for 4 hour wait standard and only one individual month being below 84%
- At all times the Trust has remained open for cancer work (although there was some impact for Endoscopy and Radiology through the period April to July). Our approach to cancer planning was to ring-fence capacity where possible within the planned care environment, to ensure priority access for patients as and when required. This has resulted in reasonably high levels of cancer performance across the year for most national standards, although we remain cautious about future impact as all health and care services restart.
- There was a significant impact on elective access times, with a considerable amount of work outside of the top two clinical priority categories stood down for the majority of the year. This has resulted in both a large backlog of work that will need to be completed in 2021/2022, including lengthening waits.
- However, during this period we have worked with partners across our system and approximately 2,000 patients have been seen through support from independent sector providers, mainly for Orthopaedics, Ophthalmology Endoscopy and Diagnostics (MRI, CT, Gastroscopy and Cystoscopy).
- Diagnostic performance continues to show a sustained improvement month on month since the first wave of the pandemic started to reduce in May. Performance against the 6 week performance standard was 88.16% at the end of February, very close to meeting the 90% national standard.

Quality of Care

The Trust is registered with the Care Quality Commission (CQC) without conditions.

In the autumn of 2020, the CQC carried out a series of provider collaboration reviews. The aim of these reviews was to support providers of health and social care services by sharing learning and helping to drive improvements for those accessing care. One of these reviews covered West Yorkshire and Harrogate. The findings highlighted a number of areas of good practice, including:

- Staff moving between providers to reduce gaps in staffing and improve patient care;
- Increased crisis phone line support in anticipation of the impact of the COVID-19 pandemic and the effect the lockdowns may have on people's mental health;
- Implementation of a primary care urgent service for people with COVID-19 symptoms between four primary care networks and a GP federation, which had a total of 27 GP practices;

- Examples of providers working together to tackle inequalities, using technology to provide healthcare and supporting children and young people.

The Report was published in January 2021 and can be accessed via www.cqc.org.uk. The CQC "highlighted the fact they heard inspiring stories of how the pandemic served as a catalyst for change. Providers worked together to ensure urgent and emergency care services and pathways adapted quickly and safely, and that people received the right care, in the right place, at the right time".

The Care Quality Commission's inspection timetable has been paused as a result of coronavirus arrangements.

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 full report can be accessed from the CQC's website at www.cqc.org.uk

A Quality Improvement Plan was developed in response to the CQC Quality Report of March 2019 and the majority of the actions have now been implemented. This has been monitored through the Quality and Safety Committee and Board.

The Trust has maintained active communication with the CQC during the year via quarterly virtual engagement meetings and monthly virtual meetings which were put in place to keep the CQC informed during the coronavirus pandemic. It is intended to resume a programme of engagement visits once the coronavirus arrangements allow.

A system-wide approach to the Equality Delivery System and to agreeing equality objectives

Under the Public Sector Equality Duty Airedale NHS FT is required to publish a set of Equality Objectives every four years (2012-2016, 2016-2020 and 2020-2024) and review progress with local stakeholders. As part of this, Bradford District and Craven, the local NHS commissioning organisations, provider trusts and communities of interest (representatives from the local community and voluntary sector) have been working jointly on EDS2 assessment and action planning since 2012, and are now preparing for EDS3.

Equality & Diversity leads from Bradford Teaching Hospitals FT, Airedale NHS Foundation Trust, Bradford District Care Foundation Trust and the CCG met with colleagues from community partnership organisations for a final review of our progress against those Equality Objectives (and subsequently EDS2) that specifically relate to patient experience, and to receive feedback from them for our next steps. These panels discussed our performance in meeting our current equality objectives using the EDS framework and helped us to amend and agree the equality objectives for 2020 to 2024.

All of the Trust's Equality Objectives align to the strategic aims in the Inclusion Strategy:

- Inclusive leadership at all levels
- Empowered, engaged and well-supported staff
- Improved patient access and experience

Airedale's Equality Objectives 2020-2024

- To implement the Accessible Information Standard (AIS).
- To improve BAME service users' access and experience of services.
- To increase awareness of mental health issues and to improve access and experience of mental health service users across the health economy.
- To implement the recommendations in the Unhealthy Attitudes Stonewall Study and Equity partnership LGB&T Local Health Needs Assessment.
- Carry out a Gender Pay Gap Audit using a recognised audit framework.
- To implement the Workforce Race Equality Standard (WRES).
- Prepare for the implementation of the Workforce Disability Equality Standard (WDES) by preparing data and developing and delivering plans to tackle the issues identified.

The Board receives data and updates from the Director of People and HR relating to the EDS3 outcomes relating to workforce (including the Gender Pay Gap, WRES and WDES) and you can read more about our progress in the Staff Report on p63.

The Board also receives an annual Equality and Diversity report which reports on progress relating to equality objectives involving staff and patients.

Equality objectives relating directly to patients are reviewed in line with the strategic aims and implementation plan for the Patient Experience Steering Group.

Progress over the last year has been limited due to the pandemic. Despite this, we have continued to work with local communities and groups to promote services, in particular on public health messaging around Covid-19 and ensuring equity of access to vaccinations.

Social, community and human rights issues

We support our staff to play a full part in the community in a voluntary capacity, for example, by acting as governors for schools or trustees for local charities.

Activities have been curtailed this year because of the pandemic, but links continue to be made with many community groups, with the support of voluntary and community sector colleagues across our district. This has enabled us to share important Covid-19 and vaccine information, and correct misinformation.

The community response to the Trust and the wider NHS has been unprecedented this year. Their generosity has been far-reaching, and is described in the charity highlights on p17. The Trust continues to be grateful for the support of the Airedale Hospital and Community Charity (previously Airedale NHS Charitable Funds) and Friends of Airedale.

We continued to support Sue Ryder Care, who runs our local hospice Manorlands, as the charity that our staff can choose to support through the Pennies from Heaven salary deduction scheme.

Modern Slavery Act 2015

The Trust has zero tolerance of slavery and human trafficking and is committed to maintaining and improving systems, processes and policies to avoid complicity in human rights violation and to prevent slavery and human trafficking in our supply chain.

As per the requirements of the Modern Slavery Act 2015 we publish a statement about the actions we are taking in respect of modern slavery on the Trust website. This statement is reviewed and updated annually. Our current statement can be seen on the Trust website here: www.airedale-trust.nhs.uk/about-us/equality-diversity-inclusion/modern-slavery-statement/

Overseas Operations

The Trust does not operate outside of the UK.

Important events since the end of the financial year 31 March 2021

Details of any post balance sheet events are provided in note 26 of the accounts.

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

Rob Aitchison	Chief Operating Officer
David Crampsey	Medical Director
Joanne Harrison	Director of People and OD
Amanda Stanford	Chief Nurse
Amy Whitaker	Director of Finance

Non-Executive Directors

Rhys Davies	Chair of the Charitable Funds Committee
Andrew Dumbleton	Chair of the Finance, Performance and Digital Committee
Melanie Hudson	Chair of the People Committee
Nadira Mirza	Deputy Chair, Senior Independent Director, and Chair of the Board Nominations and Remuneration Committee
David Wharfe	Chair of the Audit and Risk Committee
Andy Withers	Chair of the Quality and Safety Committee

The gender balance of the Board as at 31 March 2021:

	Female	Male
Non-Executive Directors	2	5
Executive Directors	3	3

The age profile of the Board as at 31 March 2021:

Age range	Number of Directors
18 – 39	1
40 – 49	3
50 – 59	4
60 - 69	5
70 +	0

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.

As at 31 March 2021 no member of the Board had declared an interest which may conflict with their management responsibilities as per the requirements of the NHS Improvement Code of Governance. The Chair who held office during the year ended 31 March 2021, 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 Director of Corporate Affairs and Group Company Secretary and is available for public inspection on the Trust's website at www.anhst.nhs.uk .

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;
- Shape a positive culture for the Board and the Trust;
- 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;
- Monitor 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 work plan which ensures it focuses on its responsibilities and the long-term strategic direction of the Trust. It meets six times a year in public to conduct its business and has five meetings which focus on strategic development. The Board also meets on other occasions to discuss matters requiring Board consideration. Board members 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, that of its committees and of its individual directors. An independent review of the Board's performance, against NHS Improvement's well-led framework, was undertaken in 2020 and the results and action plan were shared at the Public Board meeting in September 2020. In March 2021, the Board self-assessed its performance through the completion of a questionnaire. The results of the self-assessment and a final update regarding implementation of the well-led review recommendations will be considered by the Board during the 2021/22 financial year.
At the year end, the Board consisted of the Chief Executive plus five Executive Directors, three non-voting Directors and seven Non-Executive Directors, including a non-executive Chair. This split 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 to constructively challenge, influence and help the executive team develop proposals on such strategies.

The Board of Directors works as a unitary Board and directors have been selected to ensure the success of the organisation as a Foundation Trust, with an appropriate balance of clinical, financial, business and management background and skills. Should it be necessary to remove either the 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 non-voting directors (one of which is also the company secretary).

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 ARC; 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 and other key management leads 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 Nominations and Remuneration Committee (NRC) 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 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 NRC and ARC.

Disclosures of the remuneration paid to the Chair, Non-Executive Directors and Directors are given in the Remuneration Report on p49.

Biographies of the Board of Directors

The Board of Directors who served during the year comprised the following executive and non-executive directors:

Current 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 which is based in Silsden and is 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. As well as being Chair of the Board, Andrew also chairs the Council of Governors and the Appointments and Remuneration Committee.

Rhys Davies
Appointment: July 2019
Rhys has extensive executive experience in technology and change across the commercial, higher education, research, leisure and health sectors. Rhys' previous roles include Chief Information Officer (CIO) at Queen Mary University, Interim CIO at St Mary's University, Non-Executive Chairman at YHMAN Ltd, Director of Information Technology at University of Leeds, Group Director of Information Services at William Hill and IT Director at Wm Morrison Supermarkets. Prior to these leadership roles he gained extensive supermarket and supply chain experience at Asda and Tesco. Rhys is a member of the Finance, Performance and Digital Committee; the Quality and Safety Committee; and the People Committee and is Chair of the Charitable Funds Committee

Andrew Dumbleton
Appointment: July 2019
Andrew is a Chartered Accountant with expertise in project, corporate and property finance, and audit acquired in multiple sectors. He is currently a Director of ASD Associates Ltd. Andrew is skilled in providing advice on major change and project finance infrastructure projects. His previous roles include Partner at BDO LLP, Director at RSM Robson Rhodes, Associate Director at KPMG and Manager at NM Rothschild and Sons Ltd.
Andrew is a member of the Audit and Risk Committee, the Charitable Funds Committee and Chairs the Finance, Performance and Digital Committee.

Melanie Hudson, Non-Executive Director
Appointment: May 2019

Melanie has spent the majority of her career working within the Further Education sector mainly in a strategic role reporting into and regularly advising and supporting the Board and its associated committees. More recently Melanie was the Deputy Principal for Kirklees College and Dewsbury Centre Principal. Melanie has over 20 years' experience leading and managing the Human Resources and Organisational Development divisions, as well as having responsibility for the Estates and Capital Strategy, marketing and communications, ICT, Risk Management and Health and Safety. She has held numerous senior roles including Vice Principal Corporate Services, Kirklees College, Director of Corporate Services, Kirklees College, Assistant Principal for Human Resources and Equality, Huddersfield Technical College and Director of Corporate Services and Clerk to the Corporation, The Community College Hackney. Melanie chairs the Trust's People Committee; is a member of the Audit and Risk Committee; and holds the position as non-executive chair of the Trust's wholly owned subsidiary, AGH Solutions Limited. She is also the NED Champion for Freedom to Speak Up, the Guardian of Safe Working Board lead, the NED Champion for Whistleblowing and the NED Champion for Wellbeing.

Nadira Mirza, Non-Executive Director

Appointment: May 2019

Nadira has a successful track record of strategic leadership, transformational change and people management within large complex organisations. She has significant experience of working at Board level within the education and voluntary sectors and in the NHS – she was a NED on the unitary Board of the Bradford District Care Trust (BDCT) for six and a half years where she was also the Senior Independent Director (SID) for a term chairing a number of business critical committees such as Quality and Safety, Human Resources, Charities and Mental Health Legislation and was Deputy Chair of Audit, Finance Investment and Business and Remuneration. Nadira is the Trust's Senior Independent Director; Chairs the Board Nominations and Remuneration Committee; and is a member of the People Committee. Nadira also attends Black, Asian and Minority Ethnic (BAME) network meetings and is the NED Champion for Maternity where she ensures the voice of women is head.

David Wharfe

Appointment: March 2020

David is a Chartered Management Accountant. He worked in the NHS for 35 years. During that period he held a number of Director of Finance posts in various NHS organisations, including Sefton Health Authority and Ashton, Leigh and Primary Care Trust. His most recent role prior to retirement was as the Executive Director of Finance for NHS Lancashire.

David was previously a non-executive director at East Lancashire Hospitals NHS Trust, where he Chaired the Finance & Performance Committee. David is Chair of the Audit and Risk Committee and a member of the Finance, Performance and Digital and Charitable Funds committees. He also attends Lesbian, Gay, Bisexual and Transgender (LGBT) network meetings and is the NED Champion for Procurement.

Andy Withers
Appointment: April 2020
Andy was a General Practitioner in Bradford from 1986 and has held various roles in the local health economy including Chair of Bradford Districts Clinical Commissioning Group until end of March 2020. He has extensive medical leadership experience including establishing and chairing the Clinical Group in the West Yorkshire & Harrogate Health & Care Partnership. He has served on several national NHS groups and was a member of the Oversight Group of the Integrated Care System (ICS). He was a member of many of the Bradford & Craven Health and Care system boards. Previously he was Chair of the Local Medical Committee. He retired from Practice in 2019.

Andy is Chair of the Quality and Safety Committee and is a member of the Council of Governor's Appointments and Remuneration Committee. He is also a member of the Audit and Risk and Nominations and Remuneration committees. Andy is the NED Champion for End of Life Care and for Learning from Deaths.

Non-Executive Directors who also held positions during the year

Maggie Helliwell, Non-Executive Director
July 2016 – May 2020
Maggie started her career at Airedale hospital as a Junior Doctor in the 1990s before becoming a GP at Ling House in Keighley, a role she held for 35 years. Maggie became Chair of the Worth Valley Health Consortium in the 1990s whilst working part-time as a GP. She was later appointed Medical Director of Airedale Primary Care Trust (PCT) and Clinical Governance lead when four PCTs across the district merged. Maggie returned to Airedale hospital in 2007 prior to retirement.

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 directors' judgement.

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 and 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. He has a proven track record for health and care leadership, and

consistent improvements in the delivery of healthcare across hospital and community settings.

He is the Senior Responsible Officer for workforce across the Bradford and Airedale place, and for the West Yorkshire and Harrogate Health and Care Partnership Board. Brendan was also selected to participate in first cohort of The National Leadership Centre programme, a cabinet supported programme developed to enhance the social and economic well-being of the country by supporting the leaders of public services to work together across the public sector system.

Rob Aitchison, Chief Operating Officer
Appointed: April 2019
Rob was appointed Chief Operating Officer on 1st April 2019. He previously worked at Calderdale and Huddersfield NHS Foundation Trust where he was most recently Director of Operations for four years. Prior to this he has held strategy and operational management roles working across primary and secondary care. Rob joined the NHS Management Training Scheme in 2007 and maintains a keen interest in supporting the development of others.

David Crampsey, Medical Director
Appointed: July 2020
David was appointed Medical Director in July 2020; after previously holding the position of Deputy Medical Director and Divisional Director for Surgery and Diagnostics at the Trust from Feb 2018. He is actively involved in system leadership at Place, and across West Yorkshire and Harrogate, and has been Co-Chair of the Bradford District and Craven System Planned Care Oversight Board.

David trained as an ENT Surgeon in Glasgow, London and Christchurch, New Zealand. He was appointed as a Consultant Otolaryngologist in 2011, with a specialist interest in Rhinology and Vertigo. He was Lead Clinician for ENT within NHS Greater Glasgow and Clyde from 2012 to 2017. He has an interest in teaching and education, with a teaching award from the University of Otago. He was also Honorary Clinical Senior Lecturer and Undergraduate Lead for ENT at the University of Glasgow.

David has had an active interest in leadership and management for many years, and participated in Cohort 10 of the NHS Scotland Delivering the Future leadership development programme. He is a member of the Faculty of Medical Leadership and Management, and a member of the BMA Medical Managers' Committee.

Joanne Harrison, Director of People and OD
Appointed: September 2019
Joanne has almost 20 years' experience of working in Human Resources and Organisational Development, in both the commercial and public sectors. Joanne's previous roles include: Deputy Director of Workforce and Organisational Development; Interim

Executive Director of Workforce and Organisational Development; HR Business Partner; HR Manager; Interim General Manager at Harrogate & District NHS Foundation Trust (HDFT) and HR and Development Manager at Habitat UK.

Amanda Stanford, Chief Nurse
Appointed: 1 January 2021
Amanda initially joined the Trust as a non-voting member of the Board and prior to that worked at the Care Quality Commission (CQC) as Head of Inspection, North East, Yorkshire & Humber before being appointed as Interim Deputy Chief Inspector for London & South in 2017 and then Central England in 2018. Prior to joining the CQC she worked at York Teaching Hospital NHS FT as Directorate Manager, General Surgery and Urology covering York and Scarborough. Amanda's early career was as Clinical Nurse Specialist in Respiratory Medicine before moving into operational management at Hull & East Yorkshire NHS Trust as a Nurse Manager.

Amy Whitaker, Director of Finance
Appointed: November 2020
Amy has 18 years' experience of working in NHS finance, having joined the NHS Graduate Training Scheme in 2002. Amy joined the Trust in 2013 as Deputy Director of Finance, and in 2018 supported the establishment of AGH Solutions, a wholly owned subsidiary of the Trust, for which she was appointed Director of Finance. Amy became the Interim Director of Finance in May 2020 until her substantive appointment in November 2020. Throughout her career she has mainly worked across Acute and Specialist trusts in a variety of financial management roles. Amy remains a keen supporter of the graduate training scheme, being passionate about the development of finance teams, and with a particular interest in diversity and inclusion across NHS finance.

Executive Directors who also held positions at the Trust

Jill Asbury, Director of Nursing
July 2017 – December 2020
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 spent most of her working career at Leeds Teaching Hospitals NHS Trust where she was Head of Nursing for Education and Workforce before Joining Airedale.

Andrew Copley, Director of Finance
January 2013 – May 2020
Andrew is a Fellow of the Associate of Chartered Certified Accountants with nearly 20 years financial management experience. He joined the Trust 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 in Bradford.

Karl Mainprize, Medical Director
June 2014 – May 2020
Prior to joining the Trust, Karl had been Deputy Medical Director at York Hospitals NHS Foundation Trust. Before 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 has six committees. Two are required as set out in the Trust's Standing Orders:
• Nominations and Remuneration committees –see Remuneration Report p49.
• Audit and Risk Committee

In addition, the Board has established four committees to carry out detailed scrutiny and provide assurance on key areas of the Trust business:
- Quality and Safety Committee
- Finance, Performance and Digital Committee
- People Committee
- Charitable Funds Committee

Each committee is chaired by a Non-Executive Director and is supported by Executive Directors and managers from across the Trust.

Audit and Risk Committee
The role of the Audit and Risk Committee is to critically review the governance and assurance processes on which the Board places reliance, to ensure the long term viability of the organisation. The Committee is charged with ensuring the adequacy and effective operation of the overall control systems of the organisation, with specific focus on the framework of risks, controls and related assurances that underpin the delivery of the organisation's objectives.

The Audit and Risk Committee has approved terms of reference which are reviewed annually and are available on request.

The Non-Executive Director membership of the Audit and Risk Committee during 2020/21 was:
Andrew Dumbleton - member of the Committee
David Wharfe – Chair of the Committee
Andy Withers – member of the Committee
Maggie Helliwell until 31.5.20

Additionally, the Director of Finance and other senior managers including the Director of Corporate Affairs and the Assistant Director, Healthcare Governance, attend Audit Committee meetings. One member of the Council of Governors is also invited to attend and observe each meeting.

The Trust and the Committee are supported by the Internal Audit and Counter-fraud Service provided by Audit Yorkshire and its external auditors Grant Thornton. If necessary, the Committee may also seek independent legal or other professional advice.

The Committee met six times during 2020/21. The meeting in June specifically looked at the Annual Report and Accounts. The attendance at the Committee for the financial year 2020/21 is provided on p40.

The Committee has an annual work plan which shows how it plans to discharge its responsibilities under its terms of reference. The Committee Chair provides a report to the Board which sets out key items of discussion and anything for escalation. A self-assessment of the Committee's performance was completed at the end of 2020/21.

The principal activities of the Committee over the year were:

Financial reporting

The primary role of the Committee in relation to financial reporting is to review, with both management and the external auditor, the appropriateness of the annual financial statements concentrating on:

- the quality and acceptability of accounting policies and practices;
- the clarity of the disclosures, compliance with financial accounting standards and the relevant financial reporting requirements;
- material areas in which significant judgements have been applied or there has been discussion with the external auditor.

To aid the review, the Committee received reports from the Director of Finance and also reports from the external auditor on the outcomes of their interim and year-end audit process. The key significant risk highlighted by the external auditor in their 2020/21 plan related to the valuation of land and buildings particularly in respect of the impact of the Reinforced Autoclaved Aerated Concrete issue.

The external auditor's audit report following the completion of the audit provided the Committee with assurance over the Trust's accounts showing they are free from material misstatement and give a true and fair view of the Trust's financial performance. In discussing the financial statements as part of its review of the Annual Report and Accounts the Committee considered the valuation of the estate and the resulting impairment of £30m. The Committee received a paper from the Director of Finance detailing the evidence to support the Trust's going concern status. The Committee reviewed this paper and

confirmed their support for recommending to the Trust Board that the financial statements should be prepared on a going concern basis.

Governance and Risk Management

During the course of the year the Committee has continued to ensure the Trust's governance arrangements are reviewed in line with the Code of Governance for Foundation Trusts published by NHS Improvement. Any changes are reflected within the relevant Trust policies and procedures and reported to the Committee for approval.

The Committee has continued to pay particular attention to the Trust's risk management arrangements and reviewed the Risk Management annual report. The Committee also received a report on a review of the risk management arrangements of the Trust which provided an overview of activity to be undertaken to strengthen risk management processes within the Trust from ward to Board during 2020. It was agreed that the Committee would consider this after six months. In addition the Committee approved a standard operating procedure for the Board Assurance Framework.

The Committee reviews, on a regular basis, the risks that are described within the Trust's Board Assurance Framework and Trust Risk Register. The Committee has oversight of, and relies on the work of the Risk and Compliance Group to scrutinise risk registers and performance against national risk and safety standards.

Of particular importance is the review of the disclosure statements that flow from the Trust's assurance processes with internal control weaknesses described within the Annual Governance Statement. The Committee discussed and agreed upon the disclosed areas of internal control gaps as described within the 2020/21 Annual Governance Statement.

The Committee undertook a self-assessment and identified a number of actions to improve its effectiveness. These included:

- Further development of the BAF and sources of assurance
- Undertaking deep dives on BAF risks
- An understanding of the relationship between the Committee and the Trust subsidiaries
- Ensuring private conversations are held with the external auditors

Additional activities of the Committee during the year included:

- Review and approval of the internal audit plan, and more detailed programme of work, ensuring that this was consistent with the audit needs of the Trust
- Consideration of the major findings of internal audit work, the appropriateness of management responses, and the timeliness of completion of agreed actions
- Review of all external audit reports and the annual audit letter
- Statement and changes in, and compliance with, accounting policies and practices
- Review of all work related to security, fraud and corruption as set out in the Secretary of State Directions

The Audit and Risk Committee also received regular or specific reports on:

- Losses and compensation payments
- Waiver of tendering process and competitive quotations
- Write off of debts
- Any allegation of suspected fraud notified to the Trust.

The duty to appoint the External Auditors lies with the Council of Governors. A panel of Governors supported by trust officers and the Chair of the Audit and Risk Committee is established to oversee the procurement of external audit services regarding the appointment and retention of the external auditor. The external audit function is provided by Grant Thornton who were re-appointed in 2020 for a three-year period.

The Group 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 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 and Safety Committee is chaired by Dr Andy Withers, Non-Executive Director. Membership also includes Rhys Davies, Non-Executive Director, Melanie Hudson, Non-Executive Director, Amanda Stanford, Executive Chief Nurse and David Crampsey Medical Director.

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 Committee

Rhys Davies, Non-Executive Director became chair of the Committee from 1 April 2021. Membership also includes, Andrew Dumbleton, Non-Executive Director; Andrew Gold, Chair of the Trust and Non-Executive Director; David Crampsey, Medical Director; Joanne Harrison, Director of People and OD; and Christine Highley, Public Governor. The Director of Corporate Affairs, Charity Manager and Senior Finance Manager also attend. The Committee acts on behalf of the Board of Directors in its capacity as Corporate Trustee of the Airedale Hospital and Community Charity (charity number 1050730).

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 Director of Corporate Affairs or via the Charity Commission website.

Finance, Performance and Digital Committee

The Finance, Performance and Digital 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 Andrew Dumbleton, Non-Executive Director and also comprises non-executive directors David Wharfe and Rhys Davies. The Finance Director and the Chief Operating Officer are also members.

The Committee 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. The Committee monitors progress against the Digital Strategy and receives assurance on the implementation of key digital projects and programmes.

People Committee

The People 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 is chaired by Melanie Hudson and includes Rhys Davies and Nadira Mirza as its Non-Executive Director members. The Director of People and OD; Executive Chief Nurse; and Medical Director are also members.

Director attendance at Board and Committee meetings 2020/21

Directors	Board of Directors	Audit & Risk Committee	NRC*	Charitable Funds Committee	Quality and Safety Committee	Finance Committee	People Committee
Non-Executive Directors							
Andrew Gold	6/6	-	10/10	-	-	-	-
Andrew Dumbleton	6/6	6/6	--	3/3	-	9/9	-
Rhys Davies	6/6	-	-	-	7/10	7/9	4/6
Maggie Helliwell	1/1	1/1	-	-	2/2	-	-
Melanie Hudson	6/6	-	-	-	10/10	-	6/6
Nadira Mirza	6/6	-	10/10	-	-	-	6/6
David Wharfe	6/6	6/6	-	3/3	-	8/9	-
Andy Withers	6/6	5/5		-	10/10	-	-
Executive Directors							

Brendan Brown	6/6	-	10/10	-	-	-	-
Rob Aitchison	6/6	-	-	1/3	5/10	8/9	
Jill Asbury	4/5	-	-	-	7/8	-	3/4
Andrew Copley						1/1	
David Crampsey	5/5	-	-	-	8/8	-	6/6
Joanne Harrison	6/6	-	10/10	2/3	-	-	6/6
Karl Mainprize	1/1	-	-	-	2/2	-	1/1
Amanda Stanford	1/1	-		-	2/2	-	
Amy Whitaker	6/6	6/6		-	-	8/8	-

*NRC – Nominations and Remuneration Committee

NHS Improvement's well–led framework

During 2019/20, the Board of Directors commissioned an independent review of its leadership and governance by the Good Governance Institute based on NHS Improvement's well-led framework and the Care Quality Commission's well-led key lines of enquiry, using a well-established review technique that has as its basis the triangulation of evidence. The review activities included interviews with key individuals within Airedale and external stakeholders; a documentation review; and meeting observations. The recommendations from the review and resultant action plan were considered at the September 2020 Public Board meeting and are available on the Trust website http://www.airedale-trust.nhs.uk/wp/wp-content/uploads/2020/08/item-11-Company-Secretarys-Report-1.pdf

As an external independent review was conducted in 2019/20, the Trust is not required to commission a further independent review until 2022/23. Consequently, Board members self-assessed the Board's performance during 2020/21 through the completion of a questionnaire. The results of the questionnaire were considered by the Board in April 2021, along with an update regarding the implementation of outstanding actions arising from the Well-Led review.

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 2020/21		
Year to 31 March 2021	**Numbers**	**Year to 31 March 2020**
49,660	Number of bills paid to date	52,547
36,936	Number of bills paid in 30 days	14,105
74.38%	Percentage of bills paid in 30 days	26.84%

Year to 31 March 2021	**Values**	**Year to 31 March 2020**
£167,072k	£k Value of bills paid to date	£152,182k
£142,399k	£k Value of bills paid in 30 days	£98,316k
85.23%	Percentage of bills paid in 30 days	64.60%

NHS Trade Creditors Summary of Position 2020/21		
Year to 31 March 2021	**Numbers**	**Year to 31 March 2020**
1,757	Number of bills paid to date	1,634
604	Number of bills paid in 30 days	157
34.38%	Percentage of bills paid in 30 days	9.61%

Year to 31 March 2021	**Values**	**Year to 31 March 2020**
£7,957k	£k Value of bills paid to date	£6,589k
£3,365k	£k Value of bills paid in 30 days	£1,230k
42.29%	Percentage of bills paid in 30 days	18.67%

The Trust's review of processes and the subsequent improvement plan has resulted in a significant increase in performance, as demonstrated in the table above. This increased performance provides the platform for further development in 2021/22, as the Trust works towards the target of 95% of invoices paid within 30 days.

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 principal 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 Trust is required to seek approval from the Council of Governors. Due to covid, during 2020/21 private patient income significantly reduced and was well below the 5% threshold. The private patient income for 2020/21 was £38k (2019/20 £148k).

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.

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 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).

Quality of Care

To provide a better understanding of comparative performance, the 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 Trust reports nationally. Information of performance against the core indicators and

performance thresholds is given in the Quality Report 2020/21. Due to the arrangements under Coronavirus, the Quality Report is not required to be included in this Annual Report. Limited information is provided in the Director's Report. The Quality Report will be published on the Trust's website after 30 June 2021.

Quality Governance

The Trust has implemented new Quality Governance arrangements and the Quality Assurance Framework reflects the refreshed and strengthened arrangements. During the year the Trust Board also approved a Quality Strategy which will be implemented during 2020/21.

Further details about the Foundation Trust's quality governance arrangements are included within the Annual Governance Statement in Section 7 of the Annual Report. Further information about patient care activities and stakeholder relations will be found in the Quality Report.

SECTION 2 - REMUNERATION REPORT

Annual Statement on Remuneration

The Trust has established two committees responsible for the remuneration, appointments and nomination of Board Directors: the Appointment and Remuneration Committee and the Board Nominations and Remuneration 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. During 2020/21 the Committee met twice. Attendance at the Committee is included in this report.

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.

The Committee uses the guidance set out by NHS Improvement on a remuneration structure for NHS provider chairs and non-executive directors. The guidance provides a benchmark for levels of remuneration in the foundation trust sector. For non-executive directors there is a single uniform annual rate of £13,000 with supplementary payments made to the chair of Audit and Risk Committee and to the Senior Independent Director.

For chairs, a remuneration range was applied according to the size of a Trust based on its annual turnover and complexity. For Airedale, this means the Trust falls into group 1 with a remuneration range of between £40,000 and £45,100. There has been no uplift in pay in 2020/21.

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.

Board Nominations and Remuneration 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 non-voting Directors. During 2020/21 the Committee met ten times. Attendance at the Committee is included in this report.

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 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, is 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 2020/21.

The Committee led the appointment of three executive posts: Medical Director, Director of Finance and Chief Nurse. The NRC considered recommendations from the appointment panel and agreed the preferred candidates for each role. As a result David Crampsey was appointed Medical Director, with effect from July 2020, Amy Whitaker was appointed as Director of Finance in November 2020 and Amanda Stanford became the Chief Nurse in January 2021.

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

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 NRC 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 NRC 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 NRC 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. 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 in line with the guidance from NHS Improvement. https://improvement.nhs.uk/documents/6110/Chair_and_NED_Remuneration_Structure_1nov.pdf Members of the Committee conflicted by the Committees' recommendations are excluded from the decision making process. The Chair and Non-Executive Directors receive annual remuneration in line with guidance on Chair and Non-Executive remuneration published by NHS Improvement and additional payments are currently paid to: ➢ Senior Independent Director; ➢ Chair of the Audit and Risk Committee;
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 57 and 59 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 2021 or who served as a Director of the Trust at any time during the year ended 31 March 2021, the commencement date and term of the service agreement or contract for services, and details of the notice periods.

Director	Contract start date	Contract term (years)	Unexpired term at the date of publication (months)	Notice period by the Trust (months)	Notice period by the director (months)
Non-Executive Directors					
Andrew Gold	1 June 2019	6 years**	14 months	3 months	3 months
Rhys Davies	1 July 2019	3 years	15 months	3 months	3 months
Andrew Dumbleton	1 July 2019	3 years	15 months	3 months	3 months
Maggie Helliwell*	1 June 2016	4 years	-	-	-
Melanie Hudson	7 May 2019	3 years	13 month	3 months	3 months
Nadira Mirza	7 May 2019	3 years	13 month	3 months	3 months
David Wharfe	1 March 2020	3 years	23 months	3 months	3 months
Andy Withers	1 April 2020	3 years	24 months	3 months	3 months
Executive Directors					
Rob Aitchison	1 April 2019	Indefinite term	Not applicable	3 months	3 months
Jill Asbury	11 January 2016	Indefinite term	Not applicable Retired December 2020		
Brendan Brown	4 June 2018	Indefinite term	Not applicable	3 months	3 months
Andrew Copley	1 January 2013	Indefinite term	Not applicable Moved to a system role May 2020		
David Crampsey	1 September 2020	Indefinite term	Not applicable	3 months	3 months
Joanne Harrison	4 September 2019	Indefinite term	Not applicable	3 months	3 months
Karl Mainprize	3 June 2014	Indefinite term	Not applicable Retired May 2020		
Amanda Stanford	1 January 2021	Indefinite term	Not applicable	3 months	3 months
Amy Whitaker	1 November 2020	Indefinite term	Not applicable	3 months	3 months

*Maggie Helliwell's term of office was extended for one year from 1 June 2019
** Serving a second term of office

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.

Expenses paid to Governors 2020/21

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.

	2020/21	2019/20
Number of Governors in office	20	20
Number of Governors receiving expenses	0	3
Total expenses paid to Governors	£0	£137.76

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 2019/20 to determine Executive Director pay. For the Trust, this Framework applies to Executive Directors and non-voting Directors, collectively referred to as Very Senior Managers (VSM).

The Trust remains committed to the principle of fair pay and is mindful of the need to determine 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 Trust confirms that, via the Board Nominations and Remuneration Committee ('NRC),' the policy

on executive remuneration (the Framework) is, and will continue to be, reviewed on an annual basis. NRC reviewed executive director remuneration levels in 2020 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 Nominations and Remuneration Committee;
- Pay and reward reflects pay developments and awards in the wider public sector and takes into 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 note 5 of the accounts.

Salaries and Allowances (for the period 1 April 2020 to 31 March 2021)

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.

	2020-21 (12 months)					
Name and Title	**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**
Mr Rob Aitchison - Chief Operating Officer	120-125	0	0	0	27.5-30	145-150
Ms Jill Asbury - Director of Nursing	80-85	0	0	0	0	80-85
Mr Brendan Brown- Chief Executive	180-185	0	0	0	42.5-45	220-225
Mr Andrew Copley - Director of Finance	10-15	0	0	0	0	10-15
Mr David Crampsey - Medical Director	150-155	0	0	0	37.5-40	185-190
Mrs Joanne Harrison - Director of People and OD	95-100	0	0	0	50-52.5	150-155
Dr Karl Mainprize - Medical Director	30-35	0	0	0	0	30-35
Mrs Amanda Stanford – Chief Nurse	25-30	0	0	0	12.5-15	35-40
Mrs Amy Whitaker - Director of Finance	95-100	0	0	0	70-72.5	170-175
Mr S R Davies - Non Executive Director	10-15	0	0	0	0	10-15
Mr A M Dumbleton - Non-Executive Director	10-15	0	0	0	0	10-15
Mr Andrew Gold - Chair	40-45	0	0	0	0	40-45
Dr Maggie Helliwell - Non-Executive Director	0-5	0	0	0	0	0-5
Mrs M T Hudson - Non Executive Director	10-15	0	0	0	0	10-15
DR N S Mirza - Non Executive Director	15-20	0	0	0	0	15-20
Mr D Wharfe - Non Executive Director	10-15	0	0	0	0	10-15
Dr A Withers - Non Executive Director	10-15	0	0	0	0	10-15

Mr Rob Aitchison – Chief Operating Officer started April 2019
Ms Jill Asbury- Director of Nursing - retired December 2020
Mr Andrew Copley - Director of Finance – left April 2020
Mr David Crampsey – Acting Medical Director June 2020, Medical Director from September 2020
Dr Maggie Helliwell - Non-Executive Director left May 2020
Mrs M T Hudson – Non-Executive Director started May 2019
Dr N S Mirza – Non-Executive Director started May 2019

Mr D Wharfe – Non-Executive Director started May 2020

Dr A Withers - Non Executive Director started May 2020

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 they became entitled to it at the end of the financial year
PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year
LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year
LSB is the amount of lump sum ,adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year

Salaries and Allowances (for the period 1 April 2019 to 31 March 2020)

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.

	2019-20 (12 months					
Name and Title	**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**
Mr Rob Aitchison-Director of Operations	115-120	0	0	0	75-77.5	195-200
Ms Jill Asbury- Director of Nursing	110-115	100	0	0	-7.5--5	105-110
Mr Brendan Brown- Chief Executive	170-175	100	0	0	40-42.5	215-220
Mr Andrew Copley - Director of Finance	140-145	100	0	0	47.5-50	190-195
Miss Bridget Fletcher - Chief Executive	0	0	0	0	0	0
Mrs Joanne Harrison- Director of People and OD	50-51	0	0	0	37.5-40	90-95
Ms Stacey Hunter - Director of Operations	0	0	0	0	45-50	0
Dr Karl Mainprize - Medical Director	170-175	100	0	0	-35--32.5	135-137
Mr Nicolas Parker - Director of People and OD	25-30	0	0	0	-7.5--10	15-20
Mr Jeremy Cross - Non-Executive Director	10-15	0	0	0	0	10-15
Mr S R Davies - Non Executive Director	10-15	0	0	0	0	10-15
Mr A M Dumbleton Non-Executive Director	10-15	0	0	0	0	10-15
Mr Andrew Gold - Chair	40-45	0	0	0	0	40-45
Prof Anne Gregory-Non -Executive Director	0-5	0	0	0	0	0-5
Dr Maggie Helliwell - Non-Executive Director	10-15	0	0	0	0	10-15
Mrs M T Hudson- Non Executive Director	10-15	100	0	0	0	10-15
Mr Mark Lam- Non-Executive Director	0-5	0	0	0	0	0-5
Mrs Lynn McCracken-Non-Executive Director	5-10	0	0	0	0	5-10
Dr N S Mirza- Non Executive Director	10-15	0	0	0	0	10-15
Mr D Wharfe - Non Executive Director	0-5	0	0	0	0	0-5

Pension Benefits as at 31 March 2021

Name and title	Real Increase in Pension at retirement age	Real Increase in Pension Lump Sum at Pension age	Total accrued pension at Pension age at 31 March 2020	Lump Sum at pension Age Related to Accrued Pension at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
Mr Rob Aitchison - Chief Operating Officer	0-2.5	0	20-25	30-35	277	247	9	0
Ms Jill Asbury - Director of Nursing	0	0	40-45	130-135	0	974	0	0
Mr Brendan Brown - Chief Executive	2.5-5	0	15-20	0	204	155	21	0
Mr Andrew Copley - Director of Finance	0	0	50-55	120-125	1122	1122	0	0
Mr David Crampsey - Medical Director	7.5-10	0	5-10	0	82	50	7	0
Mrs Joanne Harrison - Director of People and Organisational Development	2.5-5	2.5-5	15-20	20-25	202	156	29	0
Dr Karl Mainprize - Medical Director	0	0	65-70	100-105	1077	1077	0	0
Mrs Amanda Stanford – Chief Nurse	0-2.5	0	40-45	100-105	875	828	20	0
Mrs Amy Whitaker - Director of Finance	2.5-5	5-7.5	35-40	70-75	534	463	52	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.

Due to a change in indexation methodology for public sector pension schemes, from August 2019 the method used by NHS Pensions to calculate CETV values was updated. The CETV values at 31 March 2019 and 31 March 2020 may have been calculated using different methodologies, and this change may have impacted the real increase in CETV figure. The benefits and related CETVs do not allow for any potential adjustment arising from the McCloud judgement

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. 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

SECTION 3 - STAFF REPORT

Analysis of Staff Costs

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 Trust. This information includes employees in the Group, on short term contracts of employment, agency/temporary staff, locally engaged staff overseas, and inward secondments from other entities.

	2020/21			**2019/20 12 months**		
Employee expenses	**Total**	**Permanently employed**	**Other**	**Total**	**Permanently employed**	**Other**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**
Salaries and wages	**121,530**	121,530	0	106,389	105,936	453
Social security costs	**11,669**	11,669	0	10,425	10,425	0
Employers contributions to NHS Pensions Agency	**19,697**	19,697	0	17,472	17,472	0
Apprenticeship levy	**550**	550	0	490	490	0
Other pensions	**104**	104	0	74	74	0
Agency/contract staff	**7,545**		7,545	8,868	0	8,868
NHS Charitable Funds staff	0	0	0	0	0	0
TOTAL	**161,095**	**153,550**	**7,545**	**143,718**	**134,397**	**9,321**

Analysis of Staff Numbers

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

	2020/21			2019/20		
Average number of employees*	Total Number	Permanently employed Number	Other Number	Total Number	Permanently employed Number	Other Number
Medical and Dental	356	312	44	332	284	48
Administration and Estates	716	680	36	647	630	17
Healthcare assistants and other support staff	906	843	63	798	702	96
Nursing, midwifery and health visiting staff	771	728	43	733	685	48
Scientific, therapeutic and technical staff	434	431	3	454	454	-
TOTAL	3,183	2,994	189	2,964	2,755	209

*WTE = whole time equivalent

Trust and AGHS Combined:
The Trust and its wholly owned subsidiary employed 3,591 (primary assignment only, permanent and fixed term contracts) staff comprising 2,886 female staff and 705 male staff.

Trust only:
The Trust employed 3,183 (primary assignment only, permanent and fixed term contracts) staff comprising 2,646 female staff and 534 male staff.

Sickness Absence data
The Trust continues to support employees' health and wellbeing and attendance. The sickness absence rate for 2020/21 is shown below. Data on sickness absence is published by NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Staff Turnover data
The rolling 12 month staff turnover figure for April 2020 to March 2021 was 10.24%. Data on staff turnover is also published by NHS Digital: https://digital.nhs.uk/data-and-information/publications/statistical

Employee Policies and Actions
Supporting the health and wellbeing of colleagues across the Foundation Trust remains of key important 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. During 2020/21 the importance of health and wellbeing has continued and been highlighted as part of the response to the Covid-19 pandemic.

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, mental health support and immunization programmes for both flu and Covid-19.

The Foundation Trust actively promotes an employee assistance programme (EAP) that offers a multichannel service including 24 hour 7 days a week telephone helpline. The service is supported by a dedicated website and direct email access to 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.

As part of the response to the Covid-19 pandemic the Foundation Trust introduced a number of supporting services and programmes to complement the existing offer. These included:

- Psychological well-being materials and resources at both a local and national level;
- Wellness Recovery Action Plans;
- Fortnightly sessions for Clinically Extremely Vulnerable colleagues
- Recruitment of an in-house Psychologist;
- Well-being/wobble rooms to pause, recharge and reflect which have been filled with generous donations from the public;
- Providing opportunities for reflection through tools such as virtual Schwartz rounds;
- Annual wellbeing conversations;
- Agile working arrangements;
- Staff Connect – a mobile application to enable wide reaching communication of key messages across the Trust

Recognising the need to identify those who were at a greater risk of infection or adverse outcome from Covid-19, the Foundation Trust developed a risk assessment approach in line with the Faculty of Occupational Medicine as part of an overall Risk Reduction Framework. The approach was developed in partnership with the HR team and BAME staff network with oversight from the Workforce Bronze Group established in March 2020. From this approach 100% of colleagues identified as at greater risk have had the opportunity for an individual risk assessment.

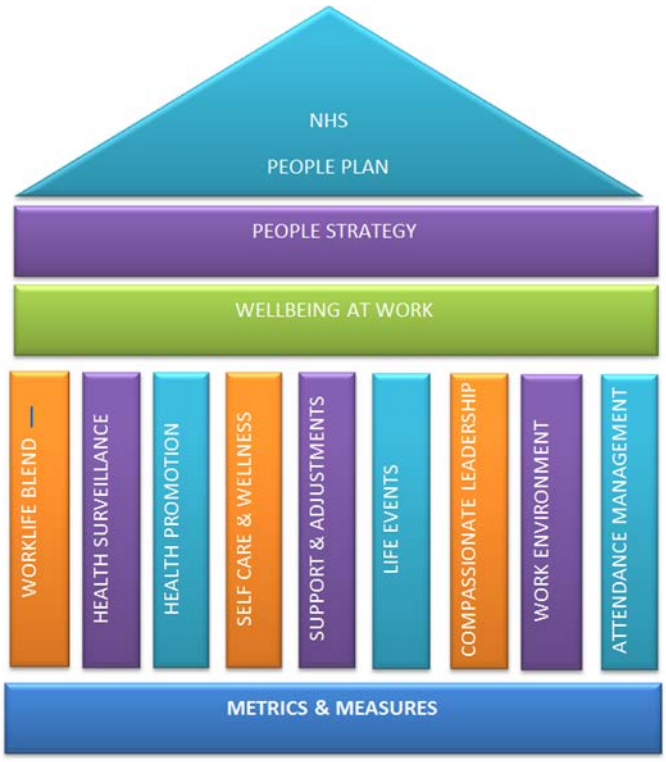
As part of the Foundation Trust's command and control approach for the Covid-19 pandemic, the Workforce Bronze group informed a robust Redeployment approach for those colleagues who were required to move at short notice across teams working in a flexible and agile way, sometimes outside of professional groups. The redeployment

approach included a period of readiness, arrangements for the redeployment period itself and arrangements for a supported return to the original work area.

Alongside Covid-19 pandemic response the Foundation Trust launched a People Strategy to cover the period 2020-2025 with an overall ambition of supporting people to thrive and flourish in all that we do. This is underpinned by four strategic ambitions:

- value our people by promoting a positive culture and working environment that allows everyone to thrive and flourish
- work towards having enough people to provide great services and care and endeavor to address any material gaps through recruitment
- have people who want to work for us because of our positive reputation and who are reflective of our population
- make sure our people have the right skills and resources to develop and be able to succeed

In pursuit of improving people practices the Foundation Trust is seeking to review a number of key people policies. A key development in 2020 was the new Wellbeing at Work policy with a clear foundation of people centered practices. The policy sets out the approach the Trust will take to support a culture of workplace wellbeing. The policy incorporates the following pillars of wellbeing:



In addition to this the Foundation Trust launched a reviewed Disciplinary policy during 2020 to ensure a people centered approach to support conduct matters affecting our colleagues in the workplace focused around a fair and just culture. The refreshed approach was informed by a national independent review of people practices following a case at another

NHS organisation which led to seven national recommendations. The Trust has a clear action plan that is regularly reviewed to ensure that ongoing learning is taken in this area.

Equality and Diversity

Policy in Relation to Disabled Employees

The Foundation Trust has a number of policies and practices to support colleagues living with disabilities and colleague who develop a disability during employment. These include the Recruitment and Selection Policy, Wellbeing at Work Policy and Flexible Working policy. All policies are subject to an Equality Impact Assessment to ensure that appropriate mitigations can be put in place to counter any adverse impact.

The Staff with Disabilities network has recently recruited a co-chair to the group, this is a key achievement for the group and will help drive the actions associated with the Workforce Disability Equality Standard (WDES) with a view to ensuring the ongoing development of polices relating to disabled employees.

The individual risk assessment process encourages conversations to support those individuals with underlying health conditions and enable managers to talk through the risk reduction framework which is an individual agreement to support employees with a disability. During Covid the Foundation Trust also introduced the sunflower lanyard which identifies anyone with a hidden disability and this is available for those staff who have been identified through the support of the Employee Health and Wellbeing Service.

With the Wellbeing at Work policy, an associated toolkit is available for line managers to support colleagues in the workplace, this toolkit will include guidance on reasonable adjustments and the reasonable adjustments passport to support colleagues with disabilities.

Equality Delivery System

The Foundation Trust serves a diverse population and is committed to ensuring that services are accessible to all. This is supported through an inclusive approach to people practices, including; leadership, policy development, recruitment, engagement, training and developing colleagues.

The Foundation Trust is fully committed to meet its core requirements under the Equality Act 2010 and Public Sector Equality Duty. During 2020 the Foundation Trust published refreshed Equality Objectives to enhance and focus the work undertaken in support of the inclusion agenda for both patient experience and as an employer. The Foundation Trust regularly seeks assurance and commits to actions as part of the NHS Equality Delivery System.

The ongoing support and development of inclusion Staff Networks to promote has enabled colleagues to share their experiences and has resulted in the development of key

workstreams relating to the Workforce Race Equality Standard and Workforce Disability Equality Standard. The Staff Networks are each sponsored by an Executive and Non-Executive Director and have the aim to provide a voice to underrepresented groups and to seek to understand the people experience to inform overall decision making. During 2020 the Staff Network formed an important part of the Foundation Trust's Covid-19 response, in particular engagement with the BAME Staff Network to understand experiences and impact as part of the colleague risk assessment process. The Staff Networks have the opportunity to provide feedback as part of the formal governance structure through the Inclusion Group, chaired by the Director of People and Organisational Development. This group has responsibility for oversight and delivery of key workstreams relating to the inclusion agenda focused around colleague experience.

Staff engagement

The Trust recognises that a high level of employee engagement is crucial to improving, the satisfaction of our people, improvements in patient care and their experience at the Trust. The Trust has a formal partnership agreement in place with Trade Unions and staff organisations representing employees. The Trust currently has three staff governor seats, which represent the views of staff on the Council of Governors and Trust working groups. There are also consultation mechanisms through the Joint Local Negotiating Committee for medical staff and the Airedale Partnership Group for all employees, these have been supported by the involvement of Trade Union colleagues in the key decisions relating to Covid -19 through the Workforce Bronze meetings.

The opportunities posed by technology over the last 12 months has driven innovative approach to engagement, this has included regular executive briefings for colleagues where colleagues can ask questions and fortnightly virtual meetings with shielding colleagues. The regular shielding meetings were hosted by the Wellbeing at Work lead and key individuals joined the calls from the Infection Prevention and Employee Health and Wellbeing Service where required. The meetings gave a forum for shielding colleagues to meet, support one another and discuss key issues and implications resulting from changing government advice. Feedback was received which confirmed individuals attending the groups felt supported and listened to.

During the pandemic the Trusts Chief Executive Officer and Director of People and Organisational Development held a number of feedback sessions with BAME colleagues from across the Trust to give a safe space for colleagues to share their experiences and support they might need in response to the Covid-19 pandemic. This provided an additional route of escalation and feedback during the course of the pandemic and were used to inform the approach going forwards.

The Foundation Trust has also undertaken extensive engagement relating to the ongoing development of health and wellbeing initiatives as part of the overall offer, this has given colleagues multiple opportunities and methods for providing feedback and has enabled a well informed and detailed health and wellbeing offer to be developed for 2021.

Local employee surveys are undertaken on at least a quarterly basis through the year to measure employee satisfaction and monitor specific issues. The results are compiled along with the annual NHS Staff Survey inform local team action plans, which are monitored at divisional level and overseen by the People Committee.

The Foundation Trust has introduced a new staff communication and engagement tool during 2020 called Staff Connect which enables clearer and more targeted communication with different groups of colleagues. It also provides a mechanism for engaging and gaining feedback from colleagues on a range of different topics and priorities.

NHS Staff Survey

The NHS staff survey is conducted annually. The results from questions are grouped to give scores across ten indicators. The 2020 annual survey of NHS staff was conducted from October to December 2020 and the results published in March 2020.

The response rate to the 2020 survey was 44%, this shows a decline to the previous year but is in line with the national average response rate of 45% for acute and community Trusts.

Scores for each indicator together with that of the survey benchmarking group of acute trusts are presented below:

Theme	2020 Score	Benchmarking Group	2019 score	Benchmarking Group	2018 score	Benchmarking Group
Equality, diversity & inclusion	**9.3**	**9.1**	**9.4**	9.0	**9.4**	9.1
Health & wellbeing	**6.4**	**6.1**	**6.3**	5.9	**6.3**	5.9
Immediate managers	**7.0**	**6.8**	**7.1**	6.8	**7.0**	6.7
Morale	**6.5**	**6.2**	**6.4**	6.1	**6.3**	6.1
Quality of care	**7.5**	**7.5**	**7.3**	7.5	**7.3**	7.4
Safe environment – Bullying & harassment	**8.4**	**8.1**	**8.3**	7.9	**8.4**	7.9
Safe environment – Violence	**9.6**	**9.5**	**9.6**	9.4	**9.6**	9.4
Safety culture	**7.0**	**6.8**	**7.0**	6.7	**7.0**	6.6
Staff engagement	**7.3**	**7.0**	**7.2**	7.0	**7.2**	7.0
Team working	**6.6**	**6.5**	**6.7**	6.6		

The Foundation Trust scored above average when compared to the acute and community peer in 9 out of the 10 key themes. Four of the key themes have seen an improvement since the previous year, with three key themes declining and three key themes remaining the same as the previous year's staff survey.

An in depth analysis is undertaken of results at a departmental, divisional and Trust level. A report is provided to the People Committee, as a sub committee of the Trust Board, to

highlight the key areas of focus. This work is supported by an overall Trustwide action plan. The action plan will be monitored by the People Experience Group with exceptions reported to the People Committee.

For divisional reporting, the reports indicate areas of exemplar practice and areas that require development. Each division is required to identify key actions that will be monitored through Integrated Performance Reviews.

Trade Union Facility Time

There is a requirement to report trade union facility time in accordance with the Trade Union (Facility Time Publication Requirements) Regulations 2017 in the annual report and on the website by the 31 July each year. The up to date information will be available on the Trust's website at http://www.airedale-trust.nhs.uk/work-with-us/trade-unions/

Fair Pay Information

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

The banded remuneration of the highest paid director in Airedale NHS Foundation Trust for 2020/2021 was £187,500 (2019/20, £173,250) which was 7.26 times (2019/20, 7 times) the median remuneration of the workforce, which was £25,817 (2019/20, £24,214).

In 2020/2021 5 (2019/20, 8) employees received remuneration in excess of the highest paid director. Remuneration ranged from £0 to £247,000 (2019/20, £0 to £320,000). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

Expenditure on consultancy

During 2020/21 the Trust spent £264,000 on consultancy.

Off-payroll engagements

Table 1: For all off-payroll engagements as of 31 March 2021, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2021	0
Of which….	
Number that have existed for less than one year at time of reporting	0
Number that have existed for less between one and two years at time of reporting	0
Number that have existed for between two and three years at time of reporting	0

Number that have existed for between three and four years at time of reporting	0
Number that have existed for four or more years at time of reporting	0

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2020 and 31 March 2021, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020	0
Of which….	
Number assessed as within scope of IR35	0
Number assessed as not within scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on trust's payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members, and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements	0

Exit packages

There were no exit packages agreed or paid during 2020/21.

Gender pay gap

The Trust publishes its information on the gender pay gap position for the Trust on the Cabinet Office website: https://gender-pay-gap.service.gov.uk/employer/VmGn22sN and on the Trust website: http://www.airedale-trust.nhs.uk/about-us/equality-diversity-inclusion/wres-information/

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 and/or procedures 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;
- Non-Executive Director attendance at Council of Governor and Governor Involvement Group meetings in order to develop an understanding of the views of Governors and members regarding the Trust; 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;
- 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;
- Council of Governors' agenda setting process;
- Collective performance evaluation mechanism for the Council of Governors;
- Board Nominations and Remuneration Committee for Executive Directors;
- Appointments, Remuneration and Terms of Service Committee for Non-Executive Directors;
- Provision of high quality reports to the Board of Directors and Council of Governors;
- Well-led Board evaluation (undertaken by the Good Governance Institute in 2019/20) 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 and Risk Committee arrangements;

- Annual Members Meeting and Annual General Meeting, where information regarding the representativeness of the Trust's membership and action taken to engage the Trust's membership is presented;
- Meetings between the Board and Council of Governors regarding the Trust's annual plan;
- 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 Trust has two membership constituencies:
- A public member constituency; and
- A staff member constituency

The number of members in each constituency at 31 March 2021 is shown below.

Member Constituency	Number of Members
Bingley	734
Bingley Rural	408
Craven	852
Ilkley / Wharfedale	837
Keighley East / Central	1721
Keighley West / Worth Valley	1290
Skipton	980
Settle and Mid-Craven	555

South Craven	634
West Craven	627
Pendle East and Colne	428
Rest of England	1772
Staff	
Total number of Foundation Trust members	

Public Member Constituency

The Foundation Trust has 12 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 work undertaken by the Trust 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 2021 the Foundation Trust had 10,807 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 2020, the Foundation Trust had over 3182 staff members.

Constitution Changes
A review of the Constitution took place in February 2020. The Council of Governors and Trust Board agreed the following changes:

- Removal of references to appointments on the formation of the Foundation Trust;
- Correction of a small number of inaccuracies in the Public constituency table appended to the document;
- The merging of sections regarding the practice and procedures of the Council of Governors with relevant sections within the Trust's Standing Orders/Standing Financial Instructions/Scheme of Delegation; and
- The inclusion of the procedure for appointing the Senior Independent Director.

Membership Engagement 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.

In 2019/20, the Council of Governors developed an engagement plan to describe how they would continue the work of engaging with members and the public and collect feedback from the public, and members, including staff and to present that feedback to the Board of Directors. This will form part of a wider Public and Patient Engagement Strategy due to be finalised during 2021.

The engagement plan 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.

Governor Involvement Group (formerly the Membership Development Group)
This Group is responsible for developing the membership by recruitment, retention, communication and engagement and meets monthly. During 2020/21, the Covid-19 pandemic curtailed any engagement events in public settings. Consequently, all engagement was undertaken through email, the website or post (in the case of the elections). Governors:-

- contributed to the involvement of members and the public in the annual plan;
- obtained feedback from members and the public, shared this with the Board and provided a response back to the members and public.

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. However, whilst new members joined the Trust during 2020/21, it was not possible for Governors to utilise traditional methods (such as face to face discussions) to recruit new members.

Membership Engagement

During 2020/21, members were engaged in the work of the Trust primarily through email communication or the website. They were also invited to attend the Annual Members Meeting which was held on 18 September 2020.

Once Covid-19 restrictions are relaxed, Governors will consider the best ways to recruit new members from under-represented groups. .

Membership Involvement

In December 2020, Governors represented the views of members and the public during Foundation Trust annual plan discussions. These views were collated and presented to the Board by the Governors to ensure their consideration as part of the annual planning process.

Our Council of Governors

The Council of Governors currently comprises 20 governor seats – the majority, elected – who play a vital role in the governance of the Trust, working closely with the Board of Directors. They represent the interests of the 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 Chair 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 Trust's auditors;
- Holding the Non-Executive Directors to account, individually and collectively, for the performance of the Board of Directors as a whole;
- 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.

In June 2021, one Governor was elected by our members to represent the Bingley constituency.

Despite the efforts of the Trust and Governors, we did not receive a nomination for the Settle and Mid-Craven constituency (for the second year running), the Rest of England constituency or the Doctors and Dentist constituency and these seats will remain vacant until the 2022 elections.

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. However, following guidance issued by NHS Improvement and a decision made by both Governors and the Board, a decision was taken to postpone the 2021 elections and to hold these in 2022. It was recognised the engagement of members and the public regarding the vacant seats would be limited due to Covid-19 restrictions. 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 2020/21 is shown on p80.

The annual ballot of governors for the appointment of a lead governor and deputy lead governor was held during the year. Karen Ellison, Governor for Ilkley and Wharfedale, was duly confirmed as Lead Governor, and Mr Paul Maskell, Governor for West Craven was confirmed 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 2020. At the time, the Trust was awaiting information regarding the 2020/21 annual planning round.

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. The Trust has provided opportunities for its governors to attend the national Governwell training programme organised by NHS Providers.

Governors are invited to observe all of the Board committees. 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 as a whole; 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 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.

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.

During 2020/21, the Chair held monthly briefing sessions with the Council of Governors to keep them appraised of the Trust's response to the Covid-19 pandemic and its impact on the usual performance of the Trust.

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.

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 further training will continue to be provided as appropriate.

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 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 2020/21

Member	Tenure	Constituency	Meetings attended
Public Elected Governors			
Peter Home	Elected 1 June 2020	Bingley	3/4
Ros Seton	Elected 1 June 2019	Bingley Rural	2/4
Nick Cole	Elected 1 June 2019	Craven	4/4
Margaret Berry	Elected 1 June 2016	South Craven	1/4
John Bootland	Re-elected 1 June 2017	Keighley Central	0/4
Olukauyode Dada	Elected 1 June 2019	Skipton	4/4
Karen Ellison	Elected 1 June 2019	Ilkley & Wharfedale	3/4
Vacant seat	-	Rest of England	-
Vacant seat	-	Settle and Mid Craven	-
Paul Maskell	Re-elected 1 June 2018	West Craven	2/4
Christine Highley	Elected 1 June 2018	Keighley West	4/4
Jerry Stanford	Re-elected 1 June 2018	Pendle East and Colne	4/4
Appointed Governors			
Mehnaz Khan	Appointed 6 October 2020	Voluntary Sector	0/1
Cllr Caroline Firth	Appointed 1 June 2018	Bradford Metropolitan District Council	4/4
Cllr Gillian Quinn	Appointed 3 June 2019	North Yorkshire County Council	2/4
Tom Whipp	Appointed 6 June 2019	Pendle Borough Council	3/4
Staff Governors			
Annette Ferrier	Elected 1 November 2017	Allied health professionals and scientists	3/4
David Haston	Elected 1 June 2019	Nursing and Midwives	2/4
Michael Smith	Elected 1 June 2018	All other Staff	2/4
In addition the Chair's attendance is recorded as follows:			
Andrew Gold	Chair		4/4

Contacting the Foundation Trust Office

The Trust office continues to be a central point of contact for all members to make contact with the Trust and the Council of Governors. It can be contacted during office hours, Monday to Friday on 01535 294540 (24 hour answerphone also available) or by email to members@anhst.nhs.uk

A list of Governor contact email addresses is published on the 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 Trust's position as at 25 May 2020 and further reporting was paused for the remainder of the year as a result of the pandemic.

Current segmentation information for NHS Trusts and Foundation Trusts is published on the NHS Improvement website. The Trust has not been subject to any enforcement action by NHS Improvement (Monitor).

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, other items of comprehensive income total and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the accounting officer is required to comply with the requirements of the *Department of Health and Social Care 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 and Social Care 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;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy; and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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 them 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.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum.*

Brendan Brown
Chief Executive
24 June 2021

SECTION 7 - ANNUAL GOVERNANCE STATEMENT

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 2021 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

As Accountable 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, Performance and Digital Committee
- People Committee

Independent assurance on the effectiveness of the system of internal control and overall governance arrangements is provided by the Audit and 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 a report from the Chair of the Committee which highlights the

key areas of discussion and any items escalated for the attention of the Board. The Board receive these alongside the Board Assurance Framework and the high level risk register.

The Trust has a Risk and Compliance Group which 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 Chief Nurse and is attended by other executive colleagues. Divisional 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 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 Chief Nurse are jointly responsible for clinical governance. Whilst each has been allocated specific duties and responsibilities there are clear lines of accountability to each individual.

- The Chief Nurse is also 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. She is also the director of infection prevention and control, and the lead director for 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 Chief Digital Officer is Senior Information Risk Owner and has responsibility for information governance;

- The Director of People and OD 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 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 the 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 division has a 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 patient safety and risk management process; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Trust recognises the importance of supporting staff through appropriate training, development and access to systems. The quality and safety team support 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 2020/21 we achieved 90% compliance against this programme despite the restrictions of the pandemic. 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 and Safety Committee.

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 managed 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 2020/21.

I have ensured that all risks of which I have been made aware are reported to the Board of Directors. All new significant risks are escalated to me as Chief Executive and the executive team. They are reviewed and assessed 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 annually and endorsed by the Board of Directors. The Strategy provides a framework for managing risks across the organisation. 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.

As part of a programme of regular reviews, in 2020 the Strategy was assessed against good practice and revised following feedback and learning from the Trust's well-led governance review.

The Strategy sets out the role of the Board and its committees together with individual responsibilities of the chief executive, executive directors, other senior managers and all staff in managing risk. It 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. 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 (strategic objectives);
- Factors which could prevent those objectives being achieved (strategic 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 target rating.

The Board Assurance Framework provides assurance to the Board, that these risks are being adequately controlled and informs the preparation of the Annual Governance Statement. The Board Assurance Framework was reviewed quarterly during the year by the Board and its committees and did not identify any significant gaps in control/assurance.

The Board of Directors undertook specific training in relation to the identification of risk and the use of the Board Assurance Framework in August 2020.

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. The Board committees provide assurance to the Board that the areas within their terms of reference and any risks are being managed appropriately. This enables the Board to focus on matters of strategic importance or those risks requiring escalation.

In November 2019, the Board of Directors commissioned an independent review of its leadership and governance by the Good Governance Institute based on NHS Improvement's well-led framework and the Care Quality Commission's well-led key lines of enquiry. The review focused on the following points:

- The current and potential role of the Board
- The appropriateness and effectiveness of information flows between the Committees and the Board
- How assurance is provided between the Committees and the Board
- How the Board ensures that the Trust's strategy is implemented
- The risk appetite at Board level and how risk is assessed and reviewed

Due to the start of the pandemic in March 2020, the report back of the results was delayed to July 2020. The report identified areas of good practice and those for further development. Of particular note for the Annual Governance Statement are:

- The Trust has high-quality, approachable and visible leadership
- Business flow and processes are sound and most governance support systems are seen as generally effective and comprehensive
- Significant evidence, at Committees and Board level, of the flow of evidence up through the organisation
- Evidence of good use of information by the Board and Committees
- The production of Committee assurance reports by the Chairs

Areas for further development included:

- A need to develop more robust Board to ward assurance
- Strengthening of the Board Assurance Framework and risk management arrangements including risk appetite
- Ongoing development of performance management arrangements

An action plan has been developed to address the areas of improvement alongside those identified in the 2019 Care Quality Commission inspection report, the recommendations from the Internal Audit annual review of the board assurance framework and the risk management action plan. While some of these development areas have been delayed due to the impact of the pandemic, a number have been addressed including:

- Risk management training for the Board including the use of the Board Assurance Framework throughout the governance structure
- Inclusion of the high level risk paper and board assurance framework in the public board papers
- A review of the risk management policy
- Revised risk management training programme for leadership teams
- A detailed review of divisional risk registers and strengthened risk reporting arrangements to the Risk and Compliance Group
- Introduction of deep dive reviews of board assurance framework risks at Audit and Risk Committee

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 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 the Trust has put in place specific governance arrangements 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. The CQC Response Group, which has executive membership, was responsible for the delivery of the plan and reported to 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 has a clear line of sight of the improvement changes in the organisation.

In September 2020, the Board of Directors received a report showing that all but 5 must do actions had been completed, and that each of the remaining 5 required a more sustained period of performance before being able to demonstrate that they were fully embedded. It was therefore agreed to stand down the CQC Response Group and build these five areas for a deep dive in the Quality and Safety Committee work plan over the next two years. These areas were:

- Nurse staffing and the impact on patient care
- Mortality review process and governance
- Sepsis and septic shock performance and completion of audits
- Accessible information standard compliance
- Mental health strategy

There has been significant work on all of these areas over the last two years and it is expected that the majority of these will move to completed during 2021.

Performance information

The Board reviews performance data each month against NHS Improvement and CQC standards and outcomes via its Integrated Performance Report focusing on key performance indicators; quality, safety, patient experience and clinical outcomes; people and organisational development; and finance.

The Trust adopts a bottom-up approach to performance management which includes monthly integrated performance review meetings with each division. During the review meetings members of the divisional leadership present their performance and risk positions for scrutiny by the executive team, chaired by the Chief Operating Officer. This was further reinforced in 2020/21 with the introduction of an Accountability Framework which describes the levels of responsibility and accountability from Board to ward.

The Board requires exception reports to be presented should any nationally mandated performance standards not be met. Examples of exception reports presented to the Board in 2020/21 include the 4 hour emergency care standard, 6 week diagnostic standard, and the referral to treatment times.

Data security

The Trust takes a robust approach to ensuring data security is managed and any risks are assessed in a timely manner. Risks to data security are continuously assessed and added to the IM&T risk register. The Data Security and Protection Toolkit (DSPT) allows organisations to measure their performance against the National Data Guardian's 10 data security standards. At the time of completing this report, assessment against the standards was still underway, due to a change in the deadline for reporting. A sample of the evidence to support some of the mandatory items has been subject to internal audit review by Audit Yorkshire and a final assurance opinion will be given at the end of June 2021. For 2019/20 all standards were met and the baseline for 2020/21 was published in February 2021.

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. The Trust has an electronic incident reporting system, accessible to all colleagues. Incident reporting is promoted through induction and training programmes, regular communications, patient safety walk rounds, peer review and inspections. 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 – A director-led 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 via the Quality and Safety Committee.
- Never events - The Trust had zero never events during 2020/21 (two in 2019/20 and three in 2018/19). Any never event 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. A summary of any settled claim is disseminated where appropriate to:
    - involved clinician(s)
    - Relevant Clinical Director
    - Directors
    - Quality and Safety Team

The annual claims report goes to the Quality and Safety Committee for review and assurance.

As at 31 March 2021 Airedale NHS Foundation Trust had identified a number of risks, which are being managed and mitigated, scoring 15 or above on the high level risk register which could impact on the achievement of corporate objectives, compliance with its licence or Care Quality Commission rating in the following areas:

- Estates issues and the impact of Reinforced Aerated Autoclaved Concrete (RAAC)
- Shortfall in the number of acute Consultant Paediatricians
- Nurse staffing levels and recruitment
- A number of areas relating to IT infrastructure and stability
- Ligature risks

The impact of the building being largely constructed of RAAC has the highest score of 25 on the Trust High Level risk register and is also a BAF strategic risk. RAAC was the subject of a Structural Safety Alert in May 2019 following the collapse of a school constructed of the material. Airedale is 85% constructed of RAAC. This has also resulted in an impairment of £24m, which arose out of the Trust's annual revaluation of its estate. To manage the risk, the Trust has carried out detailed structural surveys and put in short term remedial works to address any areas of concern. The key risk is the lack of a clear process to secure capital funding to rebuild the affected parts of the hospital building and a long term plan for the

hospital. There has been significant engagement of national, regional and local bodies to try to address the risk in the medium term. This is part of an ongoing programme of work. The Trust has had £10m of the national RAAC emergency capital allocation ring fenced to support remedial works, roof repairs, and decant space which will reduce the safety risk but will not reduce the long term strategic risk to the Trust and its ability to deliver safe, effective services. A bid for a further £5m has been submitted to NHS England/Improvement.

Nurse staffing levels have continued to be a risk throughout 2020/21. The Trust had significant levels of international nursing recruitment which resulted in an improvement; however there were delays in the ability to bring these staff into the country as a result of the pandemic. The Trust Board has an approved People Strategy which sets the ambition for how we will recruit, retain and develop the workforce. The implementation of this Strategy is monitored through the People Committee. The People Committee has also received updates throughout the year on each specific staff group. There has also been an increased focus on the health and wellbeing of our people through both the People Committee and the Board and a number of actions taken to provide support to colleagues across the Trust.

The Board receives the an update on nursing and midwifery staffing at each meeting and a six monthly 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. During 2021/22 there will be an increased focus on domestic recruitment as well as retention of the workforce.

There are challenges in medical staffing in specific specialties. During 2020/21 paediatric consultant staffing remained an area of focus. There has been significant recruitment into this area over the last year and it is expected that this risk will reduce during 2021/22.

IT and digital risks relate to both the use of systems and the stability of systems. A Chief Digital Officer was appointed in December 2020 jointly with Bradford Teaching Hospitals NHS Foundation Trust and has been leading work to strengthen the Trust's Digital Strategy and identify funding and support to address the digital risks. The impact of these risks relates to the quality of services and so are monitored through the Quality and Safety Committee as well as Finance, Performance and Digital Committee.

Mental health arrangements and ligature risks were an area highlighted by the CQC. A review of all clinical areas has identified remaining ligature risk points which are being addressed. The Trust has also had 3 serious incidents relating to mental health. A quality summit has been held with Bradford District Care NHS Foundation Trust to identify areas of learning and improvement. This work is ongoing and is being reported to the Care Quality Commission and monitored through the Quality and Safety Committee.

During 2020/21 the Trust's financial position was not identified as a risk due to the national financial arrangements relating to covid funding. The Trust's year-end financial position

showed an underlying surplus of £2M, £3M better than plan. The Trust delivered a cost improvement plan of £3.4M, £71k better than plan.

Financial and activity planning guidance from NHS England for 2021/22 was delayed and there remains uncertainty about the financial funding arrangements in the second half of the year once the national financial arrangements post covid are confirmed. The Trust is continuing to support investment in increased nursing staff, aligned to activity and acuity increases, investment in IT and support to improve pathways. The Board remains determined to ensure robust financial governance is maintained to ensure the long term sustainability of the Trust.

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 has a Patient and Public Engagement and Experience Steering Group which reports to the Quality and Safety Committee and which agrees the arrangements by which stakeholders are involved in those risks which directly affect them. The Steering Group was paused during 2020/21 in line with NHS England's 'Reducing the Burden' guidance on governance arrangements during the pandemic. However ongoing stakeholder engagement took place in some of the key risk mitigation including the RAAC arrangements, the ligature risk reviews and patient experience of personalised services during the pandemic.

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

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with referent to the guidance) within the past 12 months, as required by the '*Managing Conflicts of Interest in the NHS'* guidance.

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. During 2021/22 the Trust will establish a

Sustainability Committee to provide assurance to the Board of Directors on progress and achievement relating to sustainability objectives and targets.

Covid-19

Throughout 2020/21, the Trust has had in place command and control arrangements to manage the operational planning, response and mitigation of the impact of the pandemic on services, patients and its people. For the first six months of 2020/21, the capacity of the executive team was structured in order to get the best possible outcomes for the population.

The executive team was separated in response to the situation:

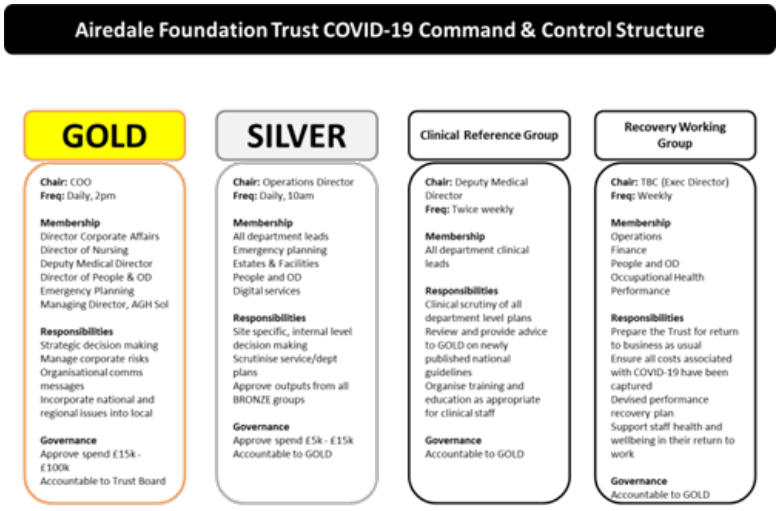
- Gold Command: Chief Operating Officer; Chief Nurse; Medical Director; Director of Corporate Affairs
- Business as usual and recovery: Director of People and OD; Director of Quality and Safety; Director of Finance; Director of Strategy and Planning

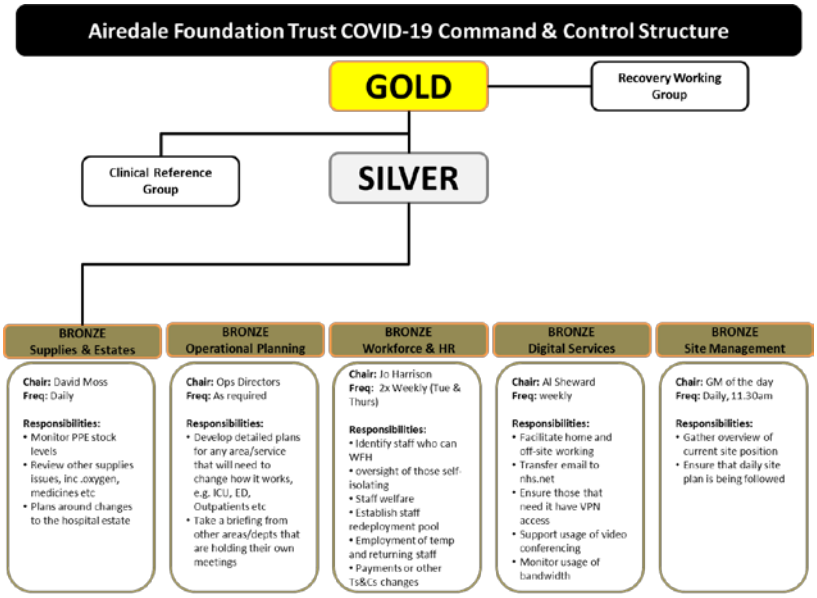
Following the first wave, the team came back together and Gold command was made up of the executive team with input from the operational directors.

Gold command meetings were held daily in the first instance, moving to twice a week. Silver was held daily also moving to twice a week. At the time of writing this report, both Gold and Silver command meet weekly as we reset services and manage the range of information, guidance and instruction issued to manage the pandemic and vaccine programme.

The Trust also set up a Clinical Reference Group (CRG), made up of senior clinicians representing divisions, specialties and professional groups across the organisation. The CRG reviewed guidance and emerging information and made recommendation to Gold. The CRG remains in place and continues to provide advice and recommendations to Gold and the Executive Team on managing clinical risk and clinical practice.

The Command and Control arrangements are:





Financial and operational decisions taken at Gold Command are reported through the weekly executive team to ensure that there is broader oversight and executive challenge where required. These are reported in summary to the relevant board committees.

During the first 12 months of the pandemic, a risk log was maintained, reviewed and managed by Gold Command with the overarching risks reported to Audit and Risk Committee. Towards the end of 2020/21 the risks were reviewed and incorporated within the corporate risk register as part of the move to reset and business as usual.

Throughout the pandemic, the Trust's Board and committee governance structure was maintained. The agendas of committees were streamlined with papers being prioritised on a risk basis. All carried forward items were noted and incorporated into future meetings. There were no remaining items of carry over at the end of the financial year.

During 2020/21 the Trust carried out a review of its governance arrangements and response to the pandemic. This was also the subject of an Internal Audit which included a

review of the financial governance of covid funding. This gave an opinion of significant and high assurance respectively. As the Trust moves to reset, these governance arrangements will be reviewed.

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

The Trust has set its strategic and annual objectives through the approval of its Five Year Strategy. 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 and the Finance, Performance and Digital Committee.

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 Finance, Performance and Digital Committee terms of reference also include scrutiny of the Trust's cost improvement plans ('CIP') and the Committee 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 Chief Digital Officer – 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). During 2020/21 the Board appointed a Chief Digital and Information Officer to join the Board of Directors as a shared post with Bradford Teaching Hospitals NHS Foundation

Trust. He provides strategic oversight and accountability for the robustness of the Trusts clinical and non-clinical IT systems.

The Trust has a Chief Clinical Information Officer, who is also the Trust's Caldicott Guardian. Freedom of Information compliance is managed by the Head of Information Governance and Data Protection Officer, (also a shared appointment with Bradford Teaching Hospitals Foundation Trust) 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, Chief Clinical Information Officer, Information Governance Manager, Head of IT and other senior representatives from across the Trust. The IGG is accountable to the Finance, Performance and Digital Committee. The IGG regularly reports and informs on progress and compliance against the standards and the SIRO signs off the annual submission. During 2020/21, the Trust had no serious information governance reportable incidents that required noting as breaches in the Data Security and Protection Toolkit.

Data Quality and Governance

The Trust has arrangements in place to ensure it processes data that is accurate, reliable, timely, complete and sufficient, facilitating translation into meaningful information whenever and wherever required. The Chief Executive has Board level responsibility for ensuring an effective policy for data quality is in place within the Foundation Trust. The Head of Information takes responsibility for data governance across the organisation. There is a Data Quality Assurance Group, jointly chaired by the Assistant Director of Healthcare Governance with attendance from the Chief Clinical Information Officer, Head of Performance Information, IT lead, Information Governance lead, and representatives from across all divisions. The group receives reports relating to standards of data quality; reviews new legislation and best practice relevant to data quality; reviews adverse event forms relating to data quality; and assess data quality risks and issues. The Trust has achieved all Assertions in the Data Security and Protection Toolkit related to data quality.

There are robust validation processes in place for all of the key performance indicators, including the referral to treatment time standards. The tracking team validate and track all patients on a pathway. The Trust has a reporting system which flags any anomalies, which are followed up and addressed at the weekly Patient Access meeting which is chaired by the Operations Director for Surgical Services.

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 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 our external auditors, Grant Thornton; Audit Yorkshire; Care Quality Commission; NHS Providers, who provided risk management training and development for the Board; the Good Governance Institute, who carried out our well-led governance review; and NHS Resolution.

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 committees report to the Board at the first available Board meeting after each Committee meeting with urgent matters being 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 independent assurance to the Board. The Committee is made up of three non-executive directors, one of whom is chair. 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 counter fraud 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 the quality metrics. The Quality and Safety Committee is chaired by a Non- Executive Director and reports to the Board of Directors.

People Committee
The People Committee 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, Performance and Digital Committee
The Finance, Performance and Digital Committee scrutinises 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 Committee also monitors progress against implementation of the digital strategy and risks to the achievement of this. 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. During the year, a health and safety manager was appointed to review the arrangements in place and ensure that there are robust mechanisms for the governance and implementation of health and safety across the Trust.

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 28 completed internal audit reports in 2020/21. There were 12 reports with significant or high assurance and 13 where an opinion was not required. Three internal audits received limited assurance: two for the Trust – risk management framework; and learning to improve; and one for AGH Solutions – waste management. The one on risk management reflects the improvement work, described earlier in this statement, to date to improve the risk management arrangements across the Trust, while identifying that this needs to be fully embedded. Action plans and progress on all of the recommendations made by Internal Audit 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 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 during the year.

External Audit
External audit provides independent assurance on the accounts, annual report, and Annual Governance Statement. 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 24 June 2021 with the inclusion of an 'emphasis of matter' to draw attention to the significance of the RAAC impairment.

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 2021 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 ended 31 March 2021.

Brendan Brown
Chief Executive
24 June 2021

ANNUAL ACCOUNTS
2020/21

Independent auditor's report to the Council of Governors of Airedale NHS Foundation Trust

Report on the Audit of the Financial Statements

Opinion on financial statements

We have audited the financial statements of Airedale NHS Foundation Trust (the 'Trust') and its subsidiaries and joint ventures (the 'group') for the year ended 31 March 2021, which comprise the Consolidated Statement of Comprehensive Income, the Consolidated Statement of Financial Position, the Consolidated Statement of Changes in Taxpayers' Equity, the Foundation Trust 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 accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

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 2021 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 accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; 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, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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.

Emphasis of matter – Exceptional item - impairment

In forming our opinion on the financial statements, which is not modified, we draw attention to the exceptional item – Impairment of £24.3 million reported in the Consolidated Statement of Comprehensive Income and note 1.27 to the financial statements. As disclosed in note 1.27 the Statement of Comprehensive Income reports an exceptional impairment of the Trust's buildings of £24.3 million due to a fault in Reinforced Autoclaved Aerated Concrete panel construction of the hospital This impairment has resulted in a 60 percent reduction in the value of the Trust's hospital buildings.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the group and the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the group or the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the group and Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the group and Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the group and Trust and the group and Trust's disclosures over the going concern period.

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

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

The responsibilities of the Accounting Officer with respect to going concern are described in the 'Responsibilities of the Accounting Officer and Those Charged with Governance for the financial statements' section of this report.

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.

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 in April 2020 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 comply with the disclosure requirements set out in the NHS foundation trust annual reporting manual 2020/21 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.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 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, 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 an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

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 of the Airedale NHS Foundation Trust, 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 2020/21, 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 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 group and 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

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

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the group and Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).

- We enquired of management and the Audit and Risk Committee, concerning the group and Trust's policies stand procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the Audit and Risk Committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the group and Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls. We determined that the principal risks were in relation to:
  - Closing journals posted during the preparation of the financial statements.
  - Material journals which fall outside of the auditor's expectations.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on unusual material journals and closing journals posting during the preparation of the financial statements
  - challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations specifically related to note 1.27 that has been emphasised above
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue and/or expenditure recognition, and the significant accounting estimates related to land and buildings valuations.
- Assessment of the appropriateness of the collective competence and capabilities of the group and Trust's engagement team included consideration of the engagement team's
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the group and Trust operates
  - understanding of the legal and regulatory requirements specific to the group and Trust including:
    - the provisions of the applicable legislation
    - NHS Improvement's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The group and Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, financial statement consolidation processes, expected financial statement disclosures and business risks that may result in risks of material misstatement.

– the group and Trust's control environment, including the policies and procedures implemented by the group and Trust to ensure compliance with the requirements of the financial reporting framework.

Report on other legal and regulatory requirements – 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 – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, 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 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accounting Officer

The Chief Executive, as 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. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Airedale NHS Foundation Trust for the year ended 31 March 2021 in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

28 June 2021

Independent auditor's report to the Council of Governors of Airedale NHS Foundation Trust

In our auditor's report issued on 28 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice, until we had:

 Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 28 June 2021 we reported that, in our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

Report on other legal and regulatory requirements - 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 – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, 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 2021.
We have nothing to report in respect of the above matter.

Responsibilities of the Accounting Officer

The Chief Executive, as 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. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;

- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Airedale NHS Foundation Trust for the year ended 31 March 2021 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

17 September 2021

FOREWORD TO THE ACCOUNTS

AIREDALE NHS FOUNDATION TRUST

The accounts for the year ended 31 March 2021 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 2021 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: 24th June 2021

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 NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require 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, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care 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 judgements 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 and Social Care 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;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and;
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

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.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in NHSI's NHS Foundation Trust Accounting Officer Memorandum.

Signed: ……Brendan Brown - Chief Executive

Date: 24th June 2021

NATIONAL HEALTH SERVICES ACT 2006

DIRECTIONS BY NHS IMPROVEMENT IN RESPECT OF NATIONAL HEALTH SERVICES FOUNDATION TRUSTS' ANNUAL ACCOUNTS

NHS Improvement, 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:

(a) references to "the accounts" and to "the annual accounts" refer to:

for an NHS foundation trust in its first operating period since being authorised as an NHS foundation trust, the accounts of an NHS foundation trust for the period from point of licence until 31 March

for an NHS foundation trust in its second or subsequent operating period following initial authorisation, the accounts of an NHS foundation trust for the period from 1 April until 31 March

for an NHS foundation trust in its final period of operation and which ceased to exist as an entity during the year, the accounts of an NHS foundation trust for the period from 1 April until the end of the reporting period

(b) "the NHS Foundation Trust" means the NHS Foundation Trust in question.

2. Form and content of accounts

(1) The accounts of an NHS foundation trust kept pursuant to paragraph 24(1) of Schedule 7 to the 2006 Act must comply with the requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) in force for the relevant financial year.

3. Annual accounts

(1) The annual accounts submitted under paragraph 25 of Schedule 7 to the 2006 Act shall show, and give a true and fair view of, the NHS foundation trust's income and expenditure, cash flows and financial state at the end of the financial period.

(2) The annual accounts shall follow the requirements as to form and content set out in chapter 1 of the NHS Foundation Trust Annual Reporting Manual (FT ARM) in force for the relevant financial year.

(3) The annual accounts shall comply with the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM) as in force for the relevant financial year.

(4) The Statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation trust.

4. Annual accounts: 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.

5. Annual accounts: Foreword to accounts

(1) The foreword to the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

Signed by the authority of NHSI, the independent Regulator of NHS Foundation Trusts

CONSOLIDATED STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR TO 31 March 2021

		2020/21		2019/20	
		Group	Foundation Trust	Group	Foundation Trust
	Note	£000	£000	£000	£000
Operating income from continuing operations	3	**228,250**	**226,192**	**201,097**	**198,287**
Operating expenses of continuing operations:	4				
- Operating expenses		**(224,190)**	**(223,320)**	**(200,548)**	**(198,955)**
- Exceptional item - Impairment*	1.27	**(24,313)**	**(24,313)**	**-**	**-**
Operating Surplus/(Deficit) before Finance costs		**(20,253)**	**(21,441)**	**549**	**(668)**
FINANCE COSTS					
Finance income	6.1	**16**	**666**	**144**	**808**
Finance expense - financial liabilities	6.2	**(7)**	**(877)**	**(14)**	**(940)**
Finance expense - unwinding of discount on provisions	6.2 / 17.2	**8**	**8**	**(3)**	**(3)**
Public Dividend Capital - dividends payable		**(761)**	**(761)**	**(1,386)**	**(1,386)**
NET FINANCE COSTS		**(744)**	**(964)**	**(1,259)**	**(1,521)**
Gains/(losses) of disposal of assets	6.4	**10**	**10**	**-**	**-**
Share of profit/ (loss) of associates/ joint ventures		**465**	**465**	**180**	**180**
Movement in fair value of other investments	6.4	**81**	**-**	**(69)**	**-**
Corporation Tax Expense	1.18	**(428)**	**-**	**1,338**	**-**
SURPLUS/(DEFICIT) FOR THE YEAR		**(20,869)**	**(21,930)**	**739**	**(2,009)**

OTHER COMPREHENSIVE INCOME **Will not be reclassified to income and expenditure**		Group	Foundation Trust	Group	Foundation Trust
	Note	2020/21 £000	2020/21 £000	2019/20 £000	2019/20 £000
Impairments/Reversals	7	**(5,849)**	**(5,849)**	**(238)**	**(238)**
Revaluations	7	**149**	**149**	**-**	**-**
Other reserve movements		**216**	**-**	**-**	**-**
TOTAL COMPREHENSIVE INCOME/(LOSS) FOR THE YEAR		**(26,353)**	**(27,630)**	**501**	**(2,247)**
Surplus/ (deficit) for the period attributable to:					
Airedale NHS Foundation Trust		**(20,869)**	**(21,930)**	**739**	**(2,009)**
Total		**(20,869)**	**(21,930)**	**739**	**(2,009)**
Total comprehensive income/ (expense) for the period attributable to:					
Airedale NHS Foundation Trust		**(26,353)**	**(27,630)**	**501**	**(2,247)**
Total		**(26,353)**	**(27,630)**	**501**	**(2,247)**

All operations are continuing.

* Impairment of £24,313k charged to operating expenses as an exceptional item due to reduced life expectancy of Airedale General Hospital based on its construction method of Reinforced Autoclaved Aerated Concrete (RAAC) panels. See sections 1.8.2, 1.22.2 and 1.27 for further details.

The notes on pages 9 to 48 form part of these accounts.

CONSOLIDATED STATEMENT OF FINANCIAL POSITION
as at 31 March 2021

		31 March 2021		31 March 2020	
		Group	Foundation Trust	Group	Foundation Trust
	Note	£000	£000	£000	£000
Non-current assets					
Property, plant and equipment	7	**36,703**	**36,703**	**57,436**	**57,436**
Investments in subsidiary / joint ventures	20.3/20.4	**515**	**9,406**	**180**	**9,071**
Other Investments	20.5	**580**	**-**	**505**	**-**
Loans to subsidiary	20.4	**-**	**18,451**	**-**	**19,043**
Receivables	10.1	**3,183**	**1,594**	**2,804**	**1,109**
Total non-current assets		**40,981**	**66,154**	**60,925**	**86,659**
Current assets					
Inventories	9	**2,896**	**1,421**	**2,001**	**719**
Receivables	10.1	**8,017**	**8,732**	**21,673**	**20,464**
Loans to subsidiary	20.4	**-**	**592**	**-**	**572**
Cash and cash equivalents	11	**26,182**	**21,864**	**16,515**	**12,350**
Total current assets		**37,095**	**32,610**	**40,189**	**34,105**
Current liabilities					
Trade and other payables	12	**(27,424)**	**(28,569)**	**(30,474)**	**(27,663)**
Borrowings	14	**-**	**-**	**(508)**	**(508)**
Provisions	17	**(1,071)**	**(825)**	**(741)**	**(741)**
Lease liability	14.2	**-**	**(1,515)**	**-**	**(1,465)**
Other liabilities	13	**(2,095)**	**(2,095)**	**(455)**	**(455)**
Total current liabilities		**(30,590)**	**(33,004)**	**(32,178)**	**(30,832)**
Total assets less current liabilities		**47,486**	**65,759**	**68,936**	**89,932**
Non-current liabilities					
Borrowings	14	**-**	**-**	**-**	**-**
Provisions	17	**(1,318)**	**(1,318)**	**(958)**	**(891)**
Lease liability	14.2	**-**	**(23,761)**	**-**	**(25,276)**
Other liabilities	13	**(3,348)**	**(3,348)**	**(3,487)**	**(3,487)**
Total non-current liabilities		**(4,666)**	**(28,427)**	**(4,445)**	**(29,654)**
Total assets employed		**42,820**	**37,332**	**64,491**	**60,278**
Financed by (taxpayers' equity)					
Public Dividend Capital		**55,887**	**55,887**	**51,205**	**51,205**
Revaluation reserve		**1,454**	**1,454**	**7,883**	**7,883**
Income and expenditure reserve		**(15,829)**	**(20,010)**	**4,325**	**1,190**
Charitable fund reserves	20.5	**1,308**	**-**	**1,078**	**-**
Total taxpayers' equity		**42,820**	**37,332**	**64,491**	**60,278**

The notes on pages 9 to 48 form part of these accounts.

The financial accounts on pages 1 to 48 were approved by the Board of Directors on

Signed on its behalf by: ……Amy Whitaker - Executive Director of Finance

Date: 24th June 2021

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2021

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 2020	51,205	4,325	7,883	1,078	64,491
Public Dividend Capital received	4,682	-	-	-	4,682
Surplus/(Deficit) for the financial year	-	(21,099)	-	230	(20,869)
Transfer to retained earnings on disposal of assets	-	729	(729)	-	-
Other reserve movements	-	216	-	-	216
Net impairments	-	-	(5,849)	-	(5,849)
Revaluations - property, plant and equipment	-	-	149	-	149
Balance at 31 March 2021	55,887	(15,829)	1,454	1,308	42,820

CONSOLIDATED STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2020

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 2019	49,941	3,696	8,131	958	62,726
Public Dividend Capital received	1,264	-	-	-	1,264
Surplus for the financial year	-	619	-	120	739
Transfer to retained earnings on disposal of assets	-	10	(10)	-	-
Net impairments	-	-	(238)	-	(238)
Revaluations - property, plant and equipment					-
Balance at 31 March 2020	51,205	4,325	7,883	1,078	64,491

The statement of changes in taxpayers' equity is for the Group, the consolidated Charitable fund balances are identified separately in the table.

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.

Charitable funds reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted; a breakdown is provided in note 20.5

The notes on pages 9 to 48 form part of these accounts.

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2021

Foundation Trust	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total Tax Payers Equity
	£000	£000	£000	£000
Balance as at 1 April 2020	51,205	1,190	7,883	60,278
Public Dividend Capital received	4,682	-	-	4,682
Deficit for the financial year	-	(21,930)	-	(21,930)
Transfer to retained earnings on disposal of assets	-	729	(729)	-
Net impairments	-	-	(5,849)	(5,849)
Revaluations - property, plant and equipment	-	-	149	149
Balance at 31 March 2021	55,887	(20,010)	1,454	37,332

FOUNDATION TRUST STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 March 2020

Foundation Trust	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Total Tax Payers Equity
	£000	£000	£000	£000
Balance as at 1 April 2019	49,941	3,189	8,131	61,261
Public Dividend Capital received	1,264	-	-	1,264
Deficit for the financial year	-	(2,009)	-	(2,009)
Transfer to retained earnings on disposal of assets	-	10	(10)	-
Net impairments	-	-	(238)	(238)
Revaluations - property, plant and equipment	-	-	-	-
Balance at 31 March 2020	51,205	1,190	7,883	60,278

The Statement of Changes in Taxpayers' Equity analyses the movements in reserves and public dividend capital since the previous year.

The notes on pages 9 to 48 form part of these accounts.

CONSOLIDATED STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2021

	Note	2020/21 Group £000	2020/21 Foundation Trust £000	2019/20 Group £000	2019/20 Foundation Trust £000
Cash flows from operating activities					
Operating (deficit)/surplus from continuing operations		(20,253)	(21,441)	549	(668)
		(20,253)	(21,441)	549	(668)
Non-cash income and expense					
Depreciation and amortisation	4/7	3,192	3,192	2,963	2,963
Impairments and reversals	4/7.1	24,313	24,313	1,047	1,047
Non-cash donations/grants credited to income	7.8	(442)	(442)	(43)	(43)
(Increase)/Decrease in receivables		13,658	11,648	(6,068)	(4,120)
(Increase)/Decrease in other Assets		146	-	1,631	-
(Increase)/Decrease in inventories		(895)	(702)	96	44
Increase/(Decrease) in trade and other payables		(1,007)	(1,409)	8,033	9,516
Increase/(Decrease) in other liabilities		1,501	1,501	(153)	(153)
Increase/(Decrease) in provisions		698	519	3	(64)
Corporation Tax Paid		(361)	-	(293)	-
Charitable Funds - net adjustments for working capital movements, non-cash transactions and non-operating cash flows		89	-	(333)	-
Other movements in cash flow		3	1	-	-
NET CASH GENERATED FROM OPERATIONS		20,642	17,179	7,432	8,522
Cash flows from investing activities					
Interest received		1	666	121	808
Proceeds from sales / settlements of financial assets / investments (incl repayments issued on loans to subsidiaries)		-	572	-	553
Distributions received from joint ventures		130	130	-	-
Purchase of Property, Plant and Equipment		(14,121)	(9,714)	(5,594)	(5,594)
Sales of Property, Plant and Equipment		10	10	-	-
Receipt of cash donations to purchase capital assets		-	-	10	10
Net cash used in investing activities		(13,980)	(8,336)	(5,463)	(4,223)
Cash flows from financing activities					
Public dividend capital received		4,682	4,682	1,264	1,264
Loans repaid		(508)	(508)	(506)	(506)
Capital element of finance lease rental payments		-	(1,465)	(25)	(1,441)
Interest Paid		(7)	(7)	(20)	(20)
Interest element on Finance lease		-	(871)	-	(920)
PDC dividend paid		(1,162)	(1,162)	(1,478)	(1,478)
Net cash generated from/(used in) financing activities		3,005	669	(765)	(3,101)
Net increase in cash and cash equivalents	11	9,667	9,513	1,204	1,198
Cash and cash equivalents at 1 April	11	16,515	12,351	15,311	11,153
Cash and cash equivalents at 31 March	11	26,182	21,864	16,515	12,351

The notes on pages 9 to 48 form part of these accounts.

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 or 101) 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 Hospital & Community Charity. 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 1.3 Consolidation (continued)

Joint Ventures

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

Note 1.4 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).
Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts
The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 due to the COVID-19 pandemic, affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21

The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners with a top-up from NHSi/E to ensure financial balance was maintained. For the second half of the year, block contract arrangements were agreed at Integrated Care System level with agreements in place around the management of any financial risk. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

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

Note 1.4 Revenue from contracts with customers (continued)

Comparative period (2019/20)

In the comparative period (2019/20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

Revenue from research contracts

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

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

Provider sustainability fund (PSF) and Financial recovery fund (FRF)

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

The Trust received £1,107k PSF related to quarter 4 2019/20 in June 2020. PSF and FRF are not applicable for 2020/21 and onwards.

Education

The Trust receives income training from Health Education England (HEE). A performance obligation relating to delivery of training which is satisfied over the financial year. The obligation is met in line with the payments made in year. Training is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is HEE, but the benefits received are indirect as services are provided to the trainee.

Note 1.5 Other forms of income

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

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

Note 1.6 Expenditure on Employee Benefits

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

Pension costs

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

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs are 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 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

Note 1.6 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 allowance will depend on the scheme or schemes the employees is a member of at 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 1.8 Property, Plant and equipment

Note 1.8.1 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.

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 1.8.2 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.

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 1.8.2 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 most recent full asset valuation was undertaken by Cushman and Wakefield with a valuation date of 31 March 2021.

This valuation has taken into account the current market valuation and the deterioration of the Reinforced Autoclaved Aerated Concrete (RAAC) panel construction of large areas of Airedale General Hospital, leading to an overall reduction in value of circa £30m. This valuation and RAAC issue will be covered in more detail in section 1.22.1 (page 22), 1.22.2 (page 23) and 1.27 (page 24).

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 lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	2	56
Dwellings	25	44
Plant & machinery	5	10
Transport equipment	7	7
Information technology	5	10
Furniture & fittings	5	12

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 1.8.2 Property, Plant and equipment - Measurement (Continued)

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 expenditure.

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

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of

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 1.8.3 De-recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Note 1.8.4 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.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Note 1.8.5 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.

The Trust currently has no PFI transactions.

Note 1.8.6 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, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

The Trust currently has no intangible assets as all software is integral to the hardware.

Note 1.9 Cash and cash equivalents

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

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

There are no significant cash and cash equivalent balances held by the entity that are not available for use by the group.

Note 1.10 Inventories

Pharmacy inventories are valued at weighted average historical cost. All other inventories are valued at the lower of cost and net realisable value using the first in, first out (FIFO) method.

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

Note 1.11 Financial Assets and Financial Liabilities

Note 1.11.1 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 the Office of National Statistics (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements 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 1.11.2 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, 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 1.11	**Financial Instruments and Financial Liabilities (Continued)**
Note 1.11.2	**Classification and Measurement (continued)**
	Financial assets and financial liabilities at fair value through income and expenditure
	Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive income.
	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 are 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 months' 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 1.11.3	**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 de-recognised when the obligation is discharged, cancelled or expires.
Note 1.12	**Leases**
Note 1.12.1	**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.

Note 1.12.2 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 1.13	**Provisions**
	The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.
	Clinical Negligence Costs
	NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 17.3
	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 1.14	**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 15 where an inflow of economic benefits is probable. Contingent liabilities are not recognised, but are disclosed in Note 15, 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 1.15	**Public Dividend Capital**
	Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received. A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.
	This policy is available at:
	https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts
	In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.
Note 1.16	**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 1.17	**Climate change levy**
	Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.
Note 1.18	**Corporation Tax**
	At Budget 2020, the government announced that the Corporation Tax main rate (for all profits except ring fence profits) for the years starting 1 April 2020 and 2021 would remain at 19%. At Budget 2021, it was announced that the rate will remain at 19% for the financial year starting 1 April 2022, and will then rise to 25% for the financial year starting 1 April 2023.
	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 Limited is not materially different from the profit multiplied by the prevailing tax rate in the UK of 19%. See Note 23.
	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 other 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 - 2020/21 £1.777m (2019/20 - restated at £1.855m). See Note 24.

Note 1.19	**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 1.20	**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 1.21	**Dispensation from the Application of Accounting Standards**
	IFRS 16 Lease - 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. However, application for the NHS is now deferred until 2022/23 Accounting year. The deferral does not apply to the Trust's wholly owned subsidiary (AGH Solutions Ltd), who will report under IFRS 16 in its 2020/21 accounts. When consolidating the subsidiary into the Trust's group accounts, the Trust group accounting policies will continue to be on an IAS 17 basis in 2020/21, so consolidation adjustments will be required.
Note 1.22	**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 1.22.1	**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 i.e. the "replacement cost" is based on the cost of a modern replacement asset that has the same productive capacity as the property being valued. 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 with the remit that the MEA valuation should be based on an alternative site basis, but in the current location. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at current (i.e. MEA site area 6.8 hectares, compared to existing site 20.93 hectares, a reduction of 2/3).
	As stated in note 1.8.2, the Trust has had a full revaluation of its estate as at 31 March 2021. As the Trust has not had a full revaluation since 2018, it elected as a first stage to have a revised valuation to bring its values held and the lives of its buildings up-to-date with RICS valuation standards prior to adjusting for the impact of Reinforced Autoclaved Aerated Concrete (RAAC) panels. This is a temporary adjustment, which was taken to revaluation reserve, where there were available balances to take, the remainder being charged to operating expenses, in line with accounting policy.
	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.

Note 1.22.2 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) Property Plant and Equipment
The Trust's accounting policy for property, plant and equipment is detailed in Note 1.8. The carrying value of property, plant and equipment is detailed in Note 7. As stated above Cushman and Wakefield (C&W) 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. This judgement has been used in determining the asset lives of different areas of the site, on the basis of their condition.

(a1) Reinforced Autoclaved Aerated Concrete (RAAC) panels

In late 2018, the flat roof of a school collapsed, caused by the failure of RAAC panels. In May 2019, the Standard Committee on Structural Safety (SCOSS) issued an alert and guidance to NHS England as a small number of hospitals in the UK use RAAC construction, Airedale General Hospital being one of those affected. In September 2020, the Trust received guidance that RAAC panels are to be removed from all buildings by 2030, if not earlier. This information has triggered an impairment review of the Trust building values. The Trust Management evaluated a number of options on how to proceed in the most appropriate way given this unusual and uncertain situation, and have appointed structural engineers to advise upon this matter.

A full revaluation exercise was carried out in February 2021 to inform a valuation dated 31 March 2021, with the valuer taking into account the issue above.

As noted in 1.22.1, the first stage of this process was a revised valuation to update the value of Trust land and buildings, and their associated lives. This led to an net impairment of circa £5m.

The second stage, was to reflect the permanent diminution of value generated by the reduction in lives of the affected blocks to nine years to meet the 2030 deadline. This led to an impairment of circa £20m.

The third stage of the process, was to account for the temporary impairment of areas of the hospital, where significant and urgent remedial works are required to the RAAC construction elements in order to extend the safe useful life of the affected buildings until 2030. C&W advised the Trust that the associated liability would be taken into account by a potential Purchaser of the asset as at 31 March 2021, and should therefore be accounted for in the valuation. As at 31 March 2021, the Trust are however not in a position where they are able to reliably measure/quantify the extent and cost of the remedial works required and therefore not able to reliably take the liability into account in the valuation.

To mitigate the above uncertainty, the Trust has reviewed the condition of the RAAC panels and classified the blocks into 3 groups, Red – 2 year life, Amber – 4 year life and Green – full residual life (9 years). The asset lives in the valuation have been calculated in accordance with the advised residual lives.

The Trust believe that the Red/Amber/Green (RAG) rating is the most appropriate approach for the following reasons:
• It is the most evidence based approach which takes account of the varying condition of the panels around the hospital site, using knowledge gained from the ongoing site surveys;
• It will be reviewed annually and the effect of the planned remedial works will be adjusted for.

Stage three led to a further impairment of £5m.

Impairments related to stage one and three of the process described above were taken to revaluation reserve, where there were available balances to take, the remainder being charged to operating expenses. Impairments related to stage 2, due to their permanent nature, were charged directly to operating expenses. Overall, this led to an impairment of building value of £30m in total (£24m charged to operating expenses and £6m charged against the revaluation reserve).

(a2) COVID-19

In last year's accounts, the valuer declared a 'material valuation uncertainty' in the valuation report on the basis of uncertainties in markets caused by COVID-19. The Royal Institute of Chartered Surveyors (RICS) have revised their guidance as they determined that COVID-19 was not affecting the value of healthcare assets, and so the 'material uncertainty' has been removed.

(a3) Sensitivity analysis

Due to the assumption in the valuation methodology, generating a degree of uncertainty, this will increase any sensitivities around changes in the values of buildings.

A 1% change in the valuation would have £367k impact on the Trust statement of financial position with a £7k impact on the PDC dividend due to be paid next year and accrued in these financial statements.

A variation of 1 year on asset lives would impact on the Trust statement of financial position by £1.49m (2019/20 - £877k).

Note 1.23 Losses and Special Payments

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

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

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

Note 1.26 **Accounting Standards and amendments issued but not yet adopted**

IFRS 16 Leases

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

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will 'grandfather' its assessments made under the old standards of whether existing contracts contain a lease. The concept of 'Grandfathering' is where an entity has previously assessed whether a contract contains a lease (or not), and as a practical expedient, when applying the new standard can re-use that work, rather than having make a new assessment.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability, adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The implementation date for IFRS 16 in the NHS was revised in November 2020, to 1 April 2022. Due to the need to re-assess lease calculations, together with uncertainty on expected leasing activity in from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the work the Trust did in preparation for the transition for 1st April 2020 (which was deferred due to COVID), showed minimal impact. Nothing has fundamentally changed in the Trust's leasing arrangements since that time, so there is no expectation that this standard to have a material impact on non-current assets, liabilities and depreciation.

Note 1.27 **Exceptional Item - Impairment to Statement of Comprehensive Income £24.3m**

Reinforced Autoclaved Aerated Concrete (RAAC) panels

As previously noted in sections 1.8.2 and 1.22.2, the Trust's accounts have reported an exceptional impairment of Trust buildings due to a fault in Reinforced Autoclaved Aerated Concrete panel construction of the hospital.

This event is exceptional, mainly on two fronts;

1) the magnitude of this issue, covering 85% of the hospital site has resulted in a reduction of 60% of the value of the hospital buildings, and a reduction in the remaining useful lives of the affected blocks from an average of circa forty years to nine years to meet the national guidance for removal, and

2) the unique nature of the issue, impacting Airedale and only six other hospitals in England.

We consider this as a significant material change to the Consolidated Statement of Comprehensive Income and also due to its unique nature, we have reported this as an additional line item in this primary statement.

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. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners with a top-up from NHSi/E to ensure financial balance was maintained. For the second half of the year, block contract arrangements were agreed at Integrated Care System level with agreements in place around the management of any financial risk.

Our main commissioners for the year are listed in the related party disclosure (see Note 20.2).

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 (21,930k) 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	2020/21 Group	2020/21 Foundation Trust	2019/2020 Group	2019/2020 Foundation Trust
Income from patient care activities (by nature):		**£000**	**£000**	**£000**	**£000**
Block contract / System Envelope income		77,073	77,073	99,911	99,911
High cost drugs from Commissioners		10,028	10,028	8,646	8,646
Other NHS Clinical Income		30,944	30,944	44,378	44,378
Community Services		5,180	5,180	5,049	5,049
Private patient income		38	38	148	148
** Central funding		5,974	5,650	5,340	5,009
Other non-protected Clinical income		67,534	67,709	15,747	15,544
Total income from activities		**196,771**	**196,622**	**179,219**	**178,685**
Income from patient care activities (by source):					
NHS Foundation Trust		2,654	2,505	2,200	2,000
NHS Trusts		36	36	155	155
CCGs and NHS England		185,429	185,350	166,425	166,094
Department of Health & Social Care - other		69	69	-	-
NHS Other		-	145	42	42
Non NHS: Private Patients		38	38	148	148
Non NHS: Overseas visitors		7	7	41	41
* NHS injury scheme (see below)		298	298	853	853
Non NHS: Other		8,174	8,174	9,355	9,352
Total income from activities		**196,705**	**196,622**	**179,219**	**178,685**
Other operating income from contracts with customers (in accordance with IFRS 15):					
Research and development (contract)		972	972	1,065	1,065
Education and training (excluding notional apprenticeship levy income)		6,629	6,629	6,041	6,041
Non-patient care services to other bodies		2,232	822	2,955	1,098
Provider sustainability / sustainability and transformation fund income (PSF / STF)		-	-	5,177	5,177
*** Reimbursement and top up funding		13,542	13,542	-	-
Income in respect of employee benefits accounted on a gross basis		820	818	570	570
Other contract income (see note 3.2)		2,405	2,373	5,296	5,263
Other non-contract operating income (non-IFRS 15):					
Rental revenue from operating leases		-	-	-	-
Notional income from Apprenticeship Fund		455	455	344	344
**** Donated equipment from DHSC for COVID response (non-cash)		357	357	-	-
**** Contributions to expenditure - receipt of equipment donated from DHSC for COVID response below capitalisation threshold		3	3	-	-
**** Contribution to expenditure - consumables (inventory) donated from DHSC group bodies for COVID response		3,514	3,514	-	-
Charitable and other contributions to expenditure		85	85	43	43
Charitable Funds: Incoming Resources excluding investment income		465	-	387	-
Total other operating income		**31,479**	**29,570**	**21,878**	**19,601**
Total operating income		**228,184**	**226,192**	**201,097**	**198,287**

***** NHS injury scheme income is subject to a provision for doubtful debts of 22.43% (2019/20 - 21.79%) to reflect expected rates of collection.
** 6.3% Pension contribution from Department of Health.
******* This relates to income received to reimburse for additional costs incurred during the COVID response and top ups for lost income.
********These relate to equipment or consumables given to the Trust to aid in the COVID-19 response.

3.2 Analysis of Other Contract Income: Other

	2020/2021 Group	2020/2021 Foundation Trust	2019/2020 Group	2019/2020 Foundation Trust
	£000	£000	£000	£000
Car Parking	187	184	1,452	1,412
Catering	296	-	354	-
Estates maintenance	-	-	21	-
Pharmacy Sales	2	2	60	60
Staff Accommodation rental	5	5	33	16
Crèche services	605	605	775	775
Clinical Tests	18	18	992	992
Clinical Excellence	-	-	-	-
Other income	1,292	1,559	1,609	2,008
	2,405	**2,373**	**5,296**	**5,263**

The "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 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure.

Please note - Due to the COVID-19 pandemic the funding from Commissioners was split into 2 separate funding regimes through the financial year - months 1-6 (April 2020 to September 2020) which encompassed all services but not separately identified and months 7-12 (October 2020 to March 2021) which were. As a practical expedient all commissioner block income has been included as commissioner requested, as due to the limitations imposed by the pandemic, there was minimal activity that was not essential/mandatory. Therefore, the values are not directly comparable with previous

This information is provided in the table below:

	2020/2021 Group	2020/2021 Foundation Trust	2019/2020 Group	2019/2020 Foundation Trust
	£000	£000	£000	£000
Commissioner requested services	187,465	187,465	141,259	141,259
Non-commissioner requested services	9,306	9,157	37,960	37,426
Total	**196,771**	**196,622**	**179,219**	**178,685**

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 Trust's 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 2020/2021 the Trust has not increased the percentage beyond the 5% threshold.

3.5 Overseas visitors (relating to patients charged directly by the Trust)

	2020/2021 Group	2020/2021 Foundation Trust	2019/2020 Group	2019/2020 Foundation Trust
	£000	£000	£000	£000
Income recognised this year	**7**	**7**	**41**	**41**
Cash payments received in year	**7**	**7**	**32**	**32**
Amounts added to provision for impairment of receivables (relating to invoices raised in current and prior years)	**0**	**0**	**0**	**0**
Amounts written off in-year (relating to invoices raised in current and previous years)	**17**	**17**	**0**	**0**

4. Operating Expenses from continuing operations

4.1 Operating expenses comprise:

	Note	2020/2021 Group	2020/2021 Foundation Trust	2019/2020 Group	2019/2020 Foundation Trust
		£000	£000	£000	£000
Purchase of healthcare from NHS and DHSC bodies		1,729	1,742	1,876	1,876
Purchase of healthcare from non NHS bodies		1,295	1,320	991	913
Employee expenses - staff		160,759	148,983	143,058	132,759
Remuneration of non-executive directors		146	140	142	142
Supplies and services - clinical (excluding drug costs)		16,781	12,025	16,532	10,445
Supplies and services - clinical utilisation of consumables from DHSC group bodies for COVID response		2,732	2,732	-	-
Supplies and services - general		2,870	111	2,322	25
Supplies and services - general: notional cost of equipment donated from DHSC for COVID response below capitalisation threshold		3	3	-	-
Drugs Inventories consumed		12,473	12,473	12,182	12,182
Inventories written down (net, including inventory drugs)		41	41	98	98
Consultancy costs		264	219	218	194
Establishment		1,247	865	716	473
Premises - business rates payable to local authorities		614	614	594	594
Premises - other		9,132	28,547	8,086	26,185
Transport (business travel only)		343	335	439	320
Transport (other)		341	310	503	484
Depreciation on property, plant and equipment	7.1	3,192	3,192	2,963	2,963
Impairments of property, plant and equipment	7.1	24,313	24,313	1,047	1,047
Movement in credit loss allowance: contract receivables / contract assets		(48)	(48)	60	60
Movement in credit loss allowance: all other receivables and investments		201	213	(73)	(80)
Change in provisions discount rate(s)		-	-	7	7
Audit services- statutory audit*		102	102	54	54
Other auditor remuneration**		18	-	20	-
Audit fees payable to external auditor of charitable fund accounts		2	-	2	-
Clinical negligence - amounts payable to NHS Resolution (premiums)		5,410	5,410	4,106	4,106
Legal fees		115	115	34	23
Insurance		123	27	100	12
Internal audit costs - (not included in employee expenses)		47	37	77	68
Training, courses and conferences		1,177	1,156	888	888
Notional apprenticeship expenditure		455	455	344	344
Rentals under operating leases - minimum lease payments		1,948	1,896	1,917	1,805
Losses, ex gratia & special payments- (not included in employee expenses)		-	-	29	29
NHS charitable funds: Other resources expended	20.5	329	-	219	-
Other		349	304	997	939
Operating expenses		**248,503**	**247,633**	**200,548**	**198,955**

Amounts payable to Grant Thornton (UK) LLP totalled £104K, which is for the statutory group audit fee (£102K) and fees payable for charitable funds accounts Independent Examination (£2K)

* Statutory Audit fees include VAT

** The auditing of accounts of any associate of the Trust - AGH Solutions Limited. This audit is performed by Cowgill Holloway LLP (trading as Cowgills). The external audit liability is limited to a maximum of £2 million.

Employee expenses includes £5.974 which equates to 6.3% of the employer pension contribution which the department of health is funding and has a corresponding revenue entry in note 3.1

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 2020/21 was £1,289k . 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. An extension until October 2022 has been agreed. 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 photocopiers, cars, leased property and other equipment . 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:

	2020/21	2020/21	2019/20	2019/20
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Other minimum operating lease rentals	1,948	1,896	1,917	1,805
	1,948	1,896	1,917	1,805

4.2.2 Total future minimum operating lease payments due:

	2020/21	2020/21	2019/20	2019/20
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Within 1 year	1,859	1,849	1,911	1,791
Between 1 and 5 years	1,497	1,496	2,040	2,008
	3,356	3,345	3,951	3,799

5.3 Retirement due to ill health

During 2020/21 from the 1 April 2020 to the 31 March 2021 there was 1 early retirement from the NHS agreed on the grounds of ill health (2019/20 - 4). The estimated additional pension liability of this ill-health retirement was £91k (2019/20 : £231k). The cost of these ill-health retirements will be borne by the NHS Business Authority - Pensions Division.

5.4 Exit packages

There are no exit packages in 2020/21 (2019/20 1 at £30k).

5.5 Directors Remuneration

	Year ended 31 March 2021 Group £000	Year ended 31 March 2021 Foundation Trust £000	Year ended 31 March 2020 Group £000	Year ended 31 March 2020 Foundation Trust £000
Aggregate emoluments to Executive Directors	789	789	763	763
Remuneration to Non-Executive Directors	136	136	142	142
Pension Costs	104	104	115	115
	1,029	**1,029**	**1,020**	**1,020**

There has been no compensation or exit packages paid for directors resigning in the year

6 Finance and Other

6.1 Finance Income (Group)

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

	2020/21	2019/20
	£000	£000
Interest on bank accounts	1	121
NHS charitable fund investment income	15	23
Total finance income	16	144

6.2 Finance Expenditure (Group)

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

	2020/21	2019/20
	£000	£000
Interest expense:	7	17
Interest on late payment of commercial debt	-	3
Total interest expense	7	20
Unwinding of discount on provisions	(8)	(3)
Other finance costs	-	-
Total finance costs	(1)	17

6.3 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulation 2015 (Group)

	2020/21	2019/20
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	3
	-	3

6.4 Other gains / (losses) Group

	2020/21	2019/20
	£000	£000
Gains on disposal of assets	10	-
Total gains / (losses) on disposal of assets	10	-
Fair value gains / (losses) on charitable fund investments & investment properties	81	(69)
Total other gains / (losses)	91	(69)

7. Property, plant and equipment (Group and Foundation Trust)

7.1 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
Valuation/gross cost at 1 April 2020 - brought forward	2,956	41,215	5,447	1,047	8,342	102	15,385	274	74,767
Additions - purchased	-	2,942	-	2,904	1,681	-	4,503	-	12,030
Additions - equipment donated from DHSC for COVID response (non-cash)	-	-	-	-	357	-	-	-	357
Additions - donations of physical assets (non-cash)	-	-	-	13	72	-	-	-	85
Impairments charged to the revaluation reserve	-	(5,628)	(358)	-	-	-	-	-	(5,986)
Reversal of impairments credited to the revaluation reserve	135	2	-	-	-	-	-	-	137
Revaluations	168	(25,114)	(1,521)	-	-	-	-	-	(26,467)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals/derecognition	-	-	-	-	(435)	-	(7,777)	-	(8,212)
Cost or valuation At 31 March 2021	**3,259**	**13,417**	**3,568**	**3,964**	**10,017**	**102**	**12,111**	**274**	**46,711**
Accumulated depreciation at 1 April 2020 - brought forward	-	1,248	161	-	4,557	54	11,167	144	17,331
Provided during the year	-	812	82	-	769	21	1,482	26	3,192
Impairments charged to operating expenses	-	24,120	1,278	-	-	-	-	-	25,398
Reversal of impairments credited to operating expenses	(19)	(1,066)	-	-	-	-	-	-	(1,085)
Revaluations	19	(25,114)	(1,521)	-	-	-	-	-	(26,616)
Disposals	-	-	-	-	(435)	-	(7,777)	-	(8,212)
Depreciation at 31 March 2021	**-**	**-**	**-**	**-**	**4,891**	**75**	**4,872**	**170**	**10,008**
7.2 Property, plant and equipment financing - 2020/21									
Net book value as at 31 March 2021									
Owned - Purchased	3,259	13,289	3,568	3,951	4,696	2	7,239	80	36,084
Finance Leased	-	-	-	-	-	-	-	-	-
Owned - Donated/Granted	-	128	-	13	73	25	-	23	262
Owned - Equipment donated from DHSC and NHSE for COVID response	-		-	-	357	-	-	-	357
NBV total at 31 March 2021	**3,259**	**13,417**	**3,568**	**3,964**	**5,126**	**27**	**7,239**	**103**	**36,703**

7.3 Current year analysis of property, plant and equipment:

In 2020/21, equipment previously used in the provision of services were disposed of and replaced as necessary in order to continue to meet the Foundation Trust's obligations to provide Commissioner Related Services.

Under IFRS 9 Fair value hierarchy, the Trust's assessment is that all assets fall under Level 2.

At 31 March 2021 the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work 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.

7. Property, plant and equipment (Group and Foundation Trust)

7.4 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 2019	2,956	40,194	5,453	314	8,311	100	13,486	274	71,087
Additions - purchased	-	2,526	-	733	1,277	-	1,899	-	6,435
Additions - leased	-	-	-	-	-	-	-	-	-
Additions - assets purchased from cash donations/grants	-	10	-	-	-	33	-	-	43
Impairments charged to the revaluation reserve	-	(235)	(3)	-	-	-	-	-	(238)
Reversal of impairments credited to the revaluation reserve	-	-	-	-	-	-	-	-	-
Revaluations	-	(1,280)	(3)	-	-	-	-	-	(1,283)
Reclassifications	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(1,246)	(31)	-	-	(1,277)
Cost or valuation At 31 March 2020	**2,956**	**41,215**	**5,447**	**1,047**	**8,342**	**102**	**15,385**	**274**	**74,767**
Depreciation at 1 April 2019	-	687	81	-	5,015	51	9,931	116	15,881
Provided during the year	-	796	81	-	788	34	1,236	28	2,963
Impairments charged to operating expenses	-	1,045	2	-	-	-	-	-	1,047
Reversal of impairments credited to operating Expenditure	-	-	-	-	-	-	-	-	-
Revaluations	-	(1,280)	(3)	-	-	-	-	-	(1,283)
Disposals	-	-	-	-	(1,246)	(31)	-	-	(1,277)
Depreciation at 31 March 2020	**-**	**1,248**	**161**	**-**	**4,557**	**54**	**11,167**	**144**	**17,331**
7.5 Property, plant and equipment financing - 2019/20									
Net book value as at 31 March 2020									
Owned - Purchased	2,956	39,217	5,286	1,047	3,786	3	4,217	103	56,615
Finance Leased	-	-	-	-	-	-	-	-	-
Owned - Donated/Granted	-	750	-	-	-	45	-	26	821
Total at 31 March 2020	**2,956**	**39,967**	**5,286**	**1,047**	**3,786**	**48**	**4,217**	**129**	**57,436**

7.6 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 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 2020 the New Beach Car Park was revalued as it was the only asset transferred from work in progress during the financial year.

7.7 Revaluation of Property, Plant and Equipment (Group and Foundation Trust)

Note 1.8 of the accounting policies defines the accounting treatment required by the Trust following a revaluation. In 2020/2021 the net book value of the Property continues to be valued net of VAT.

7.8 Donors of property, plant and equipment:

	2020/21 £000	2019/20 £000
Friends of Airedale	-	34
Airedale NHS FT Charitable Fund	73	10
HELP (Helicopter Emergency Landing Pads)	12	-
Covid assets from DHSC	357	-
	442	44

No restrictions or conditions were placed on the donated assets by the donor, with the exception of the donation from HELP which can only be used for the provision of a helicopter landing pad. Donated assets are valued at the cost paid by the donor which reflects their fair value.

7.9 Public Dividend Received

Public Dividend Capital (PDC) of £4,682k has been received in 2020/21.
Public Dividend Capital (PDC) of £1,264k was received in 2019/2020.

8. Current year intangible fixed assets (Group and Foundation Trust)

The Trust had no intangible fixed assets at the 31 March 2021 (31 March 2020 - none).

9. Inventories

9.1 Analysis of inventories

	31 March 2021 £000 Group	31 March 2021 £000 Foundation Trust	31 March 2020 £000 Group	31 March 2020 £000 Foundation Trust
Drugs	550	550	662	662
Other	1,530	89	1,296	57
Energy	34	-	43	-
Consumable donated from DHSC group (Personal Protective Equipment)	782	782	-	-
Total	2,896	1,421	2,001	719

9.2 Inventories recognised in expenses

	2020/21 £000 Group	2020/21 £000 Foundation Trust	2019/20 £000 Group	2019/20 £000 Foundation Trust
Inventories recognised as an expense in the year	26,322	15,430	21,769	12,475
Write-down of inventories (including losses)	41	41	98	98
Total	26,363	15,471	21,867	12,573

10. Trade and other receivables

10.1 Trade and other receivables are made up of:

Current	Note	31 March 2021 £000 Group	31 March 2021 £000 Foundation Trust	31 March 2020 £000 Group (restated)	31 March 2020 £000 Foundation Trust (restated)
Contract receivables		6,378	6,258	18,801 *	17,720
Allowance for impaired contract receivables / assets		(293)	(293)	(341)	(341)
Allowance for impaired other receivables		(358)	(349)	(157)	(136)
Prepayments		1,043	904	768	675
VAT Receivables		253	1,252	933	933
PDC Dividend receivable		633	633	232	232
Other receivables		350	326	1,008 **	983
Charitable Funds Trade and other receivables	20.5	11	-	31	-
Total		8,017	8,732	21,275	20,066

* 2019/20 contract receivables included an accrual for the 6.3% NHS Pension contribution from the centre (Group £5,340k, Trust £5,009k). This was ultimately unnecessary and therefore there is no corresponding entry in the 2020/21 accounts.

** 2019/20 other receivables included an accrual for clinicians pensions of £398k as 'current' i.e. less than one year, based on the best information available at the time. However, it has now become apparent that it should be classified as 'non-current' i.e. greater than one year. To aid comparability with the 2020/21 accounts, the 2019/20 has been restated as 'non-current'.

Non-Current

Contract receivables - with other related parties	2,716	1,127	2,804	1,109
Clinician pension	467	467	398 **	398
Total	3,183	1,594	3,202	1,507

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.

10. Trade and other receivables (continued)

10.2 Allowances for credit losses
Allowances for credit losses - 2020/21

	31 March 2021 £000	31 March 2021 £000
	Group	Foundation Trust
Balance at 1 April 2020	498	476
New allowances arising	213	213
Reversals of allowances	(60)	(48)
Balance at 31 March 2021	651	641

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 of 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.

NHS Injury Benefit Scheme income is subject to a provision for impairment of 22.43% (2019/20 21.79%) 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 - 2019/20

	31 March 2020 £000	31 March 2020 £000
	Group	Foundation Trust
Balance at 1 April 2019	511	496
New allowances arising	67	60
Reversals of allowances	(80)	(80)
Balance at 31 March 2020	498	476

11. Cash and cash equivalents

	31 March 2021		31 March 2020	
	Group	Foundation Trust	Group	Foundation Trust
	£000	£000	£000	£000
Opening balance at 1 April	16,515	12,351	15,311	11,153
Net change in year	9,667	9,513	1,204	1,198
Closing balance at 31 March	26,182	21,864	16,515	12,351
Made up of:				
Cash with Government Banking Service	21,860	21,860	12,926	12,346
Cash at commercial banks and in hand	4,322	4	3,589	4
Cash and cash equivalents	26,182	21,864	16,515	12,351

12. Trade and other payables

	Note	31 March 2021 Group	31 March 2021 Foundation Trust	31 March 2020 Group	31 March 2020 Foundation Trust
Current		£000	£000	£000	£000
Trade payables		4,056	4,011	6,329	9,459
Capital payables		1,042	5,449	3,133	3,133
Accruals		11,507	9,568	9,246	8,655
Annual Leave Accrual*		2,125	2,125	141	141
VAT payable		83	-	1,267	-
Social Security Costs		1,687	1,597	1,511	1,423
Other taxes payable		1,315	1,255	1,137	1,149
Other Payables		5,487	4,564	7,636	3,702
PDC dividend payable		-	-	-	-
Charitable Funds - Trade and other payables	20.5	122	-	74	-
TOTAL		27,424	28,569	30,474	27,663

*Annual Leave Accrual

Due to the material nature of the value, the annual leave accrual is shown separately from other accruals in the 2020/21 accounts. To aid comparability between the current year and the prior year, the 2019/20 figure has also been separated from other accruals.

13. Other liabilities

	31 March 2021 Group	31 March 2021 Foundation Trust	31 March 2020 Group	31 March 2020 Foundation Trust
Current	£000	£000	£000	£000
Deferred income : Contract Liability (IFRS 15)	2,095	2,095	455	455
Non-Current				
Deferred income : Contract Liability (IFRS 15)	3,348	3,348	3,487	3,487
	5,443	5,443	3,942	3,942

The figures in this non-current section and £139k of the Current section relate to the deferred income/contract liability (IFRS 15) balance resulting from bringing the arrangements with FRONTIS onto the Statement of Financial Position as required by Department of Health and Social Care guidance. 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 22).

Additionally there is £49k of deferred income from Overseas visitors agreed with Bradford, District and Craven CCG, the balance being deferred income/ contract liability (IFRS 15) from organisations that have a contract that could allow the amounts to be recovered, for which income will be released in line with service delivery.

14. Borrowings (Group and Foundation Trust)

14.1 Foundation Trust Financing Facility Loan

	31 March 2021 £000 Group	31 March 2021 £000 Foundation Trust	31 March 2020 £000 Group	31 March 2020 £000 Foundation Trust
Current				
Obligations under Loan	-	-	508	508
Non-Current				
Obligations under Loan	-	-	-	-
	-	-	508	508

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 million to support capital developments. The Trust repaid £508k of the loan in 2 instalments in 2020/2021.The loan has now been paid in full.

14.2 Finance lease obligations by type

	31 March 2021 Group	31 March 2021 Foundation Trust	31 March 2020 Group	31 March 2020 Foundation Trust
	£000	£000	£000	£000
Current				
Buildings	-	749	-	725
Equipment	-	765	-	739
Non-Current				
Buildings	-	23,036	-	23,786
Equipment	-	725	-	1,490
	-	25,276	-	26,741

The Trust has a 25 year finance lease with its wholly owned subsidiary, AGH Solutions Limited, which commenced on 1 March 2018. For the Group this is classed as an inter-company transaction and is eliminated on consolidation.

Amounts payable under finance leases:	Minimum lease payments				Present value of minimum lease payments			
	March 2021 £000 Group	March 2021 £000 Foundation Trust	March 2020 £000 Group	March 2020 £000 Foundation Trust	March 2021 £000 Group	March 2021 £000 Foundation Trust	March 2020 £000 Group	March 2020 £000 Foundation Trust
Within one year	-	1,515	-	1,465	-	1,515	-	1,465
Between one and five years	-	3,130	-	4,645	-	3,130	-	4,645
After five years	-	20,631	-	20,631	-	20,631	-	20,631
Present value of minimum lease payments	-	25,276	-	26,741	-	25,276	-	26,741

15. Contingencies (Group and Foundation Trust)

At 31 March 2021 the NHS Foundation Trust has £2.6k contingent liability for legal expenses, which is based upon information provided by NHS Resolution.

16. Third Party Assets (Group and Foundation Trust)

Airedale NHS Foundation Trust held £1k of monies on behalf of patients at the 31st March 2021 (£1k for 31st March 2020).

17. Provisions

17.1a Provisions current and non-current (Group)

	Current		Non-current	
	31 March 2021 Group	31 March 2020 Group (restated)	31 March 2021 Group	31 March 2020 Group (restated)
	£000	£000	£000	£000
Pensions relating to the early retirement of staff pre 1995	128	128	851	891
Legal claims	3	30	-	-
Clinical Pensions	-	- *	467	398
Other	940 **	185	-	67
	1,071	343	1,318	1,356

* 2019/20 current provisions included £398k for clinicians pensions, which was based on the best information available at the time. However, it has now become apparent that it should be classified as 'non-current' i.e. greater than one year. To aid comparability with the 2020/21 accounts, the 2019/20 has been restated as 'non-current'.

** Other provisions (current) have increased 2020/21, mainly due to two items;
1) COVID clawback £506k,
2) Annual leave provision for AGH Solutions Limited £226k, which could not be included within the Trust accrual as it fell outside of the NHS arrangement.

17.1b Provisions current and non-current (Trust)

	Current		Non-current	
	31 March 2021 Foundation Trust	31 March 2020 Foundation Trust (restated)	31 March 2021 Foundation Trust	31 March 2020 Foundation Trust (restated)
	£000	£000	£000	£000
Pensions relating to the early retirement of staff pre 1995	128	128	851	891
Legal claims	3	30	-	-
Clinical Pensions	-	- *	467	398
Other	694	185	-	-
	825	343	1,318	1,289

* 2019/20 current provisions included £398k for clinicians pensions, which was based on the best information available at the time. However, it has now become apparent that it should be classified as 'non-current' i.e. greater than one year. To aid comparability with the 2020/21 accounts, the 2019/20 has been restated as 'non-current'.

17.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995	Legal claims	Clinical Pensions	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2020	1,019	30	398	252	1,699
Arising during the year	112	-	69	1,033	1,214
Utilised during the year	(129)	(10)	-	(87)	(226)
No longer required	(15)	(17)	-	(258)	(290)
Unwinding of discount	(8)	-	-	-	(8)
At 31 March 2021	979	3	467	940	2,389
Expected timing of cash flows:					
Within one year	128	3	-	940	1,071
Between one and five years	514	-	-	-	514
After five years	337	-	467	-	804
	979	3	467	940	2,389

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. A provision has been made for Clinical Pensions based on an estimate provided by the Department of Health, for which it will reimbursement from the department when the claims are made. This agreement covers 2019/2020 additional tax contributions.

17.3 Contingent liability

Clinical Negligence Liabilities
£128,728,410 is included in the provisions of the NHS Resolution at 31 March 2021 in respect of clinical negligence liabilities of the Trust (31 March 2020 - £108,125,992).

20. Related Party Transactions

20.1 Transactions with Key Management Personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel are 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.

	2020/21	2019/20
	£000	£000
The transactions with board members are as follows	1,029	1,020

The expenditure above, is key management personnel compensation which is analysed as follows

	2020/21	2019/20
	£000	£000
Short term employment benefits	925	905
Post-employment benefits	104	115
	1,029	1,020

Short term employment 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 are disclosed within the Trust's annual report. There were no outstanding balances with directors as at 31 March 2021.

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.

20.2 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 £5m to be the level at which formal agreement between parties is required, the parties which meet this criteria are included below

NHS Bradford, District & Craven CCG
NHS East Lancashire CCG
NHS Wakefield CCG
Health Education England
NHS England (Core and Regional Office)
NHS Resolution
HM Revenue and Customs (HMRC)
NHS Pension Scheme

In addition, the NHS Foundation Trust has had a number of transactions with other Government Departments and other central and local Government bodies.

20.3 Transactions with Joint Venture

The Foundation Trust has a 50% equity share in Immedicare LLP, with Involve Ltd. The profit is shown on page 4 of the accounts as share of profit of associates / joint ventures.

The Trust also has a 33% equity in Integrated Laboratory Solutions LLP (ILS) and Integrated Pathology Solution LLP (IPS) with Bradford Teaching Hospitals NHS Foundation Trust and Harrogate & District NHS Foundation Trust, for which it has accounted no profit or losses in the Trust's accounts for 2020/21, 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.

The Trust provides summarised financial information for the Joint Ventures, as both ILS and IPS are currently cumulatively loss making, making the values immaterial to the Trust and Group. Immedicare has a cumulative profit of £1,030k which is reflected in the group accounts.

20.4 Summary Financial Activities Wholly Owned Subsidiary - AGH Solutions Limited (Unaudited)

The year-end for the AGH Solutions Limited is 31st March 2021.

Investment in Subsidiary Undertakings

The shares in the subsidiary company AGH Solutions Limited comprises a 100% holding in the share capital consisting of 8,891,000 ordinary £1 shares.

Loan to subsidiary

At its inception, AGH Solutions Limited was financed by a loan from Airedale NHS Foundation Trust of £20,746k, to be repaid over 25 years. As at 31st March 2021 the amount outstanding on the loan is £19,043k.

Financial Performance

The unaudited financial statements of AGH Solutions Limited show a profit of £831k for 2020/21 (£1,163k restated 2019/20). The restatement was largely due to a change in the deferred tax asset improving the financial position by £162k and £54k of other items. See note 24 for more details on the reason for the deferred tax change.

20.5 Analysis of Airedale Hospital & Community Charity Charitable Funds reserve

Airedale Hospital & Community Charity

Statement of Financial Activities

	2020/21		2019/20
Funds of Charity	**£000**		**£000**
Restricted Funds	92	*	4
Unrestricted Funds	1,216		1,074
	1,308		**1,078**

Movements on Reserves

	Total	Restricted	Unrestricted
Balance At 1 April 2020	1,078	4	1,074
Net incoming	230	88	142
Balance at 31 March 2021	**1,308**	**92**	**1,216**

The year-end for the Charitable Funds is 31st March each year.

NHS charitable funds are consolidated by NHS foundation trusts where the trust determines they have control as outlined in accounting policy. Other foundation trusts may also have charities meeting the definition of local control that are not locally consolidated on the grounds of materiality.

Restricted funds are funds that are to be used in accordance with specific restrictions imposed by the donor, for example where the donor has specified that their donation should be spent on a specified ward, patients, nurses or project fund. Endowment funds are funds which the trustees are required to invest or to keep and use for the charity's purposes.

Unrestricted income funds comprise those funds that the trustees are free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include general funds, where the donor has not specified or restricted the use the charity may make of their donation. General funds additionally generate income from Gift Aid, investment income, interest and donations given specifically to cover running costs.

*NHS Charities Together Grants
As part of the COVID response, the Trust was awarded £162k grant funding from NHS Charities together. This funding is to be treated as restricted. The closing fund balance as at 31st March 2021 for NHS Charities Together is £88k.

21. Financial instruments.

Management considers 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 limited 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.

In accordance with IFRS 7 Financial Instruments: Disclosures, the NHS Foundation Trust should disclose information that enables users of the accounts to evaluate the nature and extent of risks arising from financial instruments to which the entity is exposed at the end of the reporting period. These risks typically include, but are not limited to the following four categories:

i) Credit Risk

The risk that one party will cause a financial loss for the other party by failing to discharge an obligation.

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.

ii) Liquidity Risk

The risk that an entity will encounter difficulty in meeting obligations associated with its financial liabilities

The Foundation Trust's net operating costs are incurred under the current financial regime of block contracts which remain in place in the first half of the next financial year. Conversations remain ongoing around the second half of the financial year, which will be largely dependent on success with the national vaccination programme.

• Nationally it has been agreed to fund all organisations through block contracts until the end of September 2021, with an elective recovery fund for any additional activity achieved above the baseline calculation, therefore costs associated with additional activity should be covered.

• Based on a series on scenarios, the Trust is expecting to be able to manage a balanced financial position for 2021/22.

The Trust also finances its Capital expenditure from retained depreciation, and any accumulated surpluses.

iii) Market Risk

The risk that the fair value or future cash flows of a financial instrument will fluctuate due to changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price 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.

The Foundation Trust is not materially exposed to any price risks through contractual arrangements.

iv) Foreign Currency Risk

Foreign currency risk is the financial risk arising from fluctuations in the value of a base currency (£) against a foreign currency in which an organisation has assets or obligations.

The Foundation Trust has negligible foreign currency income, expenditure assets or liabilities.

21 Financial instruments (continued)

21.1 Carrying value of financial assets (Group)

Carrying value and fair value of financial assets as at 31 March 2021

	Held at amortised cost	Held at fair value through I&E	Total book value
	31 March 2021	**31 March 2021**	**31 March 2021**
	£000	**£000**	**£000**
Trade and other receivables excluding non financial assets	9,260	-	9,260
Cash and cash equivalents	25,343	-	25,343
Consolidated NHS Charitable fund financial assets	-	1,430	1,430
Total at 31 March 2021	**34,603**	**1,430**	**36,033**

Carrying value and fair value of financial assets 31 March 2020

	Held at amortised cost	Held at fair value through I&E	Total book value
	31 March 2020	**31 March 2020**	**31 March 2020**
	£000	**£000**	**£000**
Trade and other receivables excluding non financial assets	22,513	-	22,513
Cash and cash equivalents	15,899	-	15,899
Consolidated NHS Charitable fund financial assets	-	1,152	1,152
Total at 31 March 2020	**38,412**	**1,152**	**39,564**

21.2 Carrying value of financial assets (Trust)

Carrying value and fair value of financial assets as at 31 March 2021

	Held at amortised cost	Total book value
	31 March 2021	**31 March 2021**
	£000	**£000**
Trade and other receivables excluding non financial assets	7,537	7,537
Other investments / financial assets (AGHS Loan)	19,043	19,043
Cash and cash equivalents	21,864	21,864
Total at 31 March 2021	**48,443**	**48,443**

Carrying value and fair value of financial assets 31 March 2020

	Held at amortised cost	Total book value
	31 March 2020	**31 March 2020**
	£000	**£000**
Trade and other receivables excluding non financial assets	19,733	19,733
Other investments / financial assets (AGHS Loan)	19,615	19,615
Cash and cash equivalents	12,350	12,350
Total at 31 March 2020	**51,698**	**51,698**

21 Financial instruments (continued)

21.3 Carrying value of financial liabilities (Group)

Carrying value of financial liabilities 31 March 2021

	Held at amortised cost	Total book value
	31 March 2021	**31 March 2021**
	£000	**£000**
Loans from the Department of Health and Social Care	-	-
Trade and other payables (excluding non financial liabilities)	24,217	24,217
Total at 31 March 2021	**24,217**	**24,217**

Carrying value and fair value of financial liabilities 31 March 2020

	Held at amortised cost	Total book value
	31 March 2020	**31 March 2020**
	£000	**£000**
Loans from the Department of Health and Social Care	508	508
Trade and other payables (excluding non financial liabilities)	26,485	26,485
Total	**26,993**	**26,993**

21.4 Carrying value of financial liabilities (Trust)

Carrying value of financial liabilities 31 March 2021

	Held at amortised cost	Total book value
	31 March 2021	**31 March 2021**
	£000	**£000**
Loans from the Department of Health and Social Care	-	-
Obligations under finance leases	25,276	25,276
Trade and other payables (excluding non financial liabilities)	25,717	25,717
Total at 31 March 2021	**50,993**	**50,993**

Carrying value and fair value of financial liabilities 31 March 2020

	Held at amortised cost	Total book value
	31 March 2020	**31 March 2020**
	£000	**£000**
Loans from the Department of Health and Social Care	508	508
Obligations under finance leases	26,741	26,741
Trade and other payables (excluding non financial liabilities)	25,091	25,091
Total	**52,339**	**52,339**

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, due to the nature of financial instruments held.

21.5 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		**Trust**	
	31 March 2021	**31 March 2020 restated***	**31 March 2021**	**31 March 2020 restated***
	£000	**£000**	**£000**	**£000**
In one year or less	24,217	27,010	27,232	27,080
In more than one year but not more than five years	-	-	3,130	4,645
In more than five years	-	-	20,631	20,631
Total	**24,217**	**27,010**	**50,993**	**52,356**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis (a difference of £17k).

22. Private Finance Initiative contracts

22.1 PFI schemes off-Statement of Financial Position

The Trust has no off-statement of Financial Position PFI schemes.

22.2 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 (although not technically a PFI) 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.

23. Corporation Tax

	2020/21 £000	2019/20 £000
UK corporation tax expenses	**350**	271
Adjustment from prior year	-	4
current tax expenses	**350**	**275**
Origination and reversal of temporary differences	-	(32)
Deferred tax charge / (credit)	78	(1,581)
Total income tax (income)/expense in statement of comprehensive Income	**428**	**(1,338)**
Reconciliation of Effective tax rate		
Surplus for the year	**1,259**	**954**
Tax using the UK corporation tax rate of 19%	239	181
Deferred tax - additions in year	-	(1,694)
Deferred tax - amortised during the year	78	81
Expenses not deductible to tax	12	12
Short-term timing differences - accounting write-down in excess of capital allowances	48	40
Other - Short-term timing differences	51	42
Total tax (income) expense	**428**	**(1,338)**

24. Deferred Tax

	2020/21 £000	2019/20 £000
Deferred Tax brought forward	1,855	1,694
Movement in year	(78)	(81)
Change in tax rate	-	242
Deferred Tax carried forward	**1,777**	**1,855**

* A reduction in the UK Corporation tax rate from 19% to 17% (effective from 1 April 2020) was substantively enacted on 6 September 2016. In the 11 March 2020 Budget it was announced that the UK tax rate will remain at 19% and not reduce to 17% from 1 April 2020. As the new rate was not substantively enacted as at 31 December 2019, the tax rate and deferred tax liability as at the balance sheet date were measured at the enacted rate of 17%. In the Group accounts this has been enacted as a Reserve adjustment.

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Airedale NHS Foundation Trust
Skipton Road
Steeton
Keighley
West Yorkshire
BD20 6TD

The main hospital telephone number (switchboard) is: 01535 652511

www.anhst.nhs.uk