Airedale NHS
NHS Foundation Trust

AIREDALE NHS FOUNDATION TRUST
ANNUAL REPORT AND ACCOUNTS
2011/12

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2011/12

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CHAIRMAN'S STATEMENT

There were three predominant strands to the Foundation Trust's work in 2011/12 - modernising the way care is delivered to our patients, preparing for the new commissioning environment and improving the efficiency of our organisation. Great strides were made in all three areas.

You will read in the pages of this Annual Report about the way our delivery of care is changing, with increased emphasis on care closer to home supported, to a growing extent, by tools such a telemedicine.

You will also read about how the Foundation Trust is working to establish relationships with the emerging new commissioners and, reflecting their higher profile in healthcare, the local authorities. Our commissioning environment is undergoing enormous change. The partners we have worked with for the past six years (the Strategic Health Authority and Primary Care Trusts) are being abolished and the shape of our new commissioner is emerging only slowly. We see the changes taking place as offering a great opportunity to improve the service the Foundation Trust delivers to the population it serves and we are enthusiastic about the future.

Lastly, during the course of 2011/12 we cut our costs by more than 8%. We did this without reducing the number of doctors or diluting the nurse/bed ratio. This was one of the most successful efficiency programmes of any Trust in the country. The staff throughout the Foundation Trust who delivered the efficiency savings are to be congratulated. Cutting costs has the potential to have an adverse impact on clinical quality but we are alert to this and we are monitoring quality closely.

There were changes to the Board's membership during the year. Rob Dearden joined the Board as Interim Director of Nursing from Calderdale and Huddersfield NHS Foundation Trust and has made a positive impression already. Christine Miles joined as Associate Director of Operations and has established a firm grasp of the Foundation Trust's operational performance. Towards the end of the year, following a successful career in the private sector, Justine Steele joined as Associate Director of Organisation Development and Workforce.

There were also changes to the Council of Governors. We have elections every year and a small number of Governors retire. 2011/12 was no exception. In particular, Pam Essler retired as the representative of NHS Bradford and Airedale and therefore stepped down as Deputy Lead Governor. John Roberts was elected to take her place. The Foundation Trust has a very able Council of Governors, all of them volunteers, and I should like to thank them for the very considerable effort they put into the work of the Foundation Trust.

Airedale is a well-run Foundation Trust. Operational performance is excellent, we pursue the highest standards of clinical safety and effectiveness and we are committed to delivering a patient experience that is second to none. The Foundation Trust faces a further challenging year in 2012/13 but the Board believes the Foundation Trust has the leadership and commitment throughout the organisation to deliver the results that are required.

On behalf of the Board, I should like to thank every member of staff for their contribution during the year. I should like to thank the volunteers without whom the hospital would not have the character it has. And I should like to thank our commissioners and the GPs who refer patients to us for their continued support.

This year the Staff Open Event is on Wednesday 22 August and the Annual General Meeting and Public Open Event are on Thursday 23 August. I encourage everyone with an interest in Airedale Hospital to attend these events to see at first hand how we run your hospital on your behalf.

Colin Millar
Chairman

CHIEF EXECUTIVE'S OVERVIEW

2011/12 was a significant year for Airedale NHS Foundation Trust given this was our first full year as a Foundation Trust.

It began with the transfer of some of the community services from NHS North Yorkshire and York and NHS Bradford and Airedale (now NHS Airedale, Bradford and Leeds) on 1 April 2011. This meant that the Foundation Trust became responsible for adult community services in the Craven area and some specialist nursing services in Bradford and Airedale.

During 2011/12, this has helped us progress our vision to transform the way we provide services for our local community by bringing care closer to patients and enabling them to spend less time in hospital.

For our staff, the year also saw a significant change as we implemented a workforce reduction programme to help us achieve the financial savings we needed to make. Whilst we sadly said goodbye to close colleagues, their legacy has given us a firm foundation to move forward and face the challenges of a new health and social care system.

In light of this, I am very pleased to report that Airedale achieved a 'green' governance rating from Monitor, the independent regulator, for NHS Foundation Trusts, throughout the whole of 2011/12 – the highest rating possible. Airedale also achieved a Monitor financial risk rating of three and finished the year with a rating of four – using the rating where one is significant and five is no financial risk – a major achievement, particularly given the significant savings we have also achieved this year.

I am also immensely proud of our infection prevention successes this year as the Foundation Trust recorded no hospital acquired MRSA bacteraemia cases for the entire period of 2011/12 – in fact none since October 2010. This achievement is unprecedented and is recognition again of the commitment and expertise of our staff.

In 2011/12, Airedale continued to build on its already significant technological innovation in the development of telemedicine – a system whereby patients can receive medical consultations in their home via a TV link - when a regional Telehealth Hub, funded by the Yorkshire and Humber Strategic Health Authority, was opened in September 2011. Benefits are already being seen by our patients with long term conditions as well as those in nursing homes, and a number of hospital admissions have been avoided by the online intervention of clinical staff working round the clock in the Hub.

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

I would particularly like to thank all our staff and our volunteers for their continued commitment and support as well as all our patients for choosing Airedale.

Bridget Fletcher
Chief Executive

WHO WE ARE AND WHAT WE DO

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

We employ over 2,900 staff and have around 400 committed volunteers. Last year, we cared for over 26,000 elective inpatients and day cases, more than 27,000 non-elective patients and over 142,000 outpatients. Our Accident and Emergency department saw more than 54,000 patients and over 2,400 babies were born at the hospital last year. We have an annual budget of £138 million.

We provide services from our main hospital site and from community hospitals – such as Skipton Hospital and Castleberg Hospital, near Settle – as well as health centres owned by our Primary Care Trusts (PCTs). The PCTs commission health services from us for the patients within their GP practices and the three main PCT's referring patients to us are – NHS Airedale, Bradford and Leeds (formerly NHS Bradford and Airedale), NHS North Yorkshire and York and NHS East Lancashire.

At Airedale we have a vision -

"To be the hospital chosen by the community for putting patients first, providing excellent, innovative and diverse services, delivering safe standards of care, all underpinned by the constant pursuit of efficiency."

We are serious about safety and believe there is a clear link between providing safe healthcare and delivering strong finances.

In support of this, during 2011/12, we worked to a series of key principles supporting the delivery of the vision for the years ahead.

These have been further updated to reflect the progress already made by the Foundation Trust against its key milestones and to respond to the key priorities outlined both nationally and locally.

- ***Safety, quality and the patient experience remain at the centre of everything the organisation does***

- ***The need to be serious about efficiency and business control in order to be viable in the future***

- ***In response to the changing landscape, continuing to develop our existing services whilst also designing and delivering new ways of working, using diversified models of care both in and out of a hospital setting***

- ***Partnership working forms a significant part of the design and delivery of our services***

- ***Ensuring the value of the Airedale brand is retained within the community and beyond***

- ***Adapting the size and shape of the workforce in response to the updated service strategy***

Overall, our vision is about an approach centred on increasing the pace of quality improvement whilst delivering significant savings.

In this annual report and accounts we summarise our progress against these strategic objectives as we record another successful year in pursuit of our vision.

OPERATING AND FINANCIAL REVIEW

OUR FINANCES

The Foundation Trust once more delivered an operating surplus and ended 2011/12 with an underlying surplus of £471k although impairments of (£1,823k) caused by the change to Modern Equivalent Assets valuation techniques, restructuring expenditure of (£4,267k) and Transformation of Services Income of £3,639k resulted in a technical deficit of (£1,979k.)

These results arise from continuing to implement cost improvement plans and new ways of working during the year, and will continue next year.

The tables on pages 101 to 106 provide a high level comparison of the Foundation Trust's summary financial position.

INCOME AND EXPENDITURE

Total income from continuing activities for 2011/12 was £138 million. An analysis of this is shown on the following pages.

CASH

The Foundation Trust had a cash balance of £11.2 million at the close of the financial year.

BORROWING LIMIT

At 31 March 2012, the Foundation Trust has a total borrowing limit, set by Monitor, of £23.6 million. This is the amount of money the Foundation Trust can borrow based upon a detailed financial risk assessment. Included within this is a working capital facility of £10 million.

During 2011/12, the Foundation Trust borrowed £4.8 million to support capital investments.

MONITOR RISK RATING

Monitor, the independent regulator for NHS Foundation Trusts, assesses the financial risk of Foundation Trusts using a rating whereby 1 is significant and 5 is no financial risk.

The Foundation Trust achieved a financial risk rating of 4 at the end of 2011/12. The tables below summarise the rating performance throughout the year and provide a comparison to the previous year.

	Annual Plan 2010/11	Q1 2010/ 2011	Q2 2010/ 2011	Q3 2010/ 2011	Q4 2010/ 2011
Financial risk rating	**3**	**3**	**3**	**3**	**3**
Governance risk rating	**Amber/ Green**	**Green**	**Green**	**Green**	**Green**

	Annual Plan 2011/12	Q1 2011/ 2012	Q2 2011/ 2012	Q3 2011/ 2012	Q4 2011/ 2012
Financial risk rating	**3**	**3**	**3**	**3**	**4**
Governance risk rating	**Green**	**Green**	**Green**	**Green**	**Green**

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

FINANCIAL OUTLOOK

In our long term financial planning we have considered a range of severe financial possibilities given the current economic climate, and we believe the Foundation Trust can withstand the impact of these possibilities.

The Foundation Trust will however be expected to improve overall efficiency by 6% in 2012/13 and 5% in the following year, which is in line with our strategic three year plan, set out last year.

The Foundation Trust has now managed to achieve financial balance for six successive years, and the Board remains determined to deliver efficiency improvements to ensure the long term sustainability of the Foundation Trust.

CAPITAL INVESTMENT ACTIVITY

The Foundation Trust's capital programme has invested over £5.8 million in 2011/12 to improve its buildings and equipment.

The largest single significant investment has been to completely replace the electrical infrastructure systems across the entire hospital site. Over the life of the project, expenditure will be in the region of £8 million.

The work began in September 2010 and is due to be completed in May 2012 and ensures that the hospital has a sufficient and secure supply both for its current needs and also for any developments planned for the future.

We have also focused effort on enhancing medical and surgical equipment at a cost of over £194,000.

ACCOUNTING POLICY

There has been a change in accounting policy in respect of Donated Assets, in so far as donated assets are charged to the Income, in the year in which they are received and not as previously to the donated asset reserve. The implementation of this change has been back dated to 1/4/10, and has therefore affected the opening balance on the Income and Expenditure reserve.

INVESTMENTS

The Foundation Trust made no investments in 2011/12.

PRIVATE PATIENTS

Under the terms of authorisation, the Foundation Trust's proportion of income from private patients should not exceed the proportion of total income achieved in 2002/03. The allowable proportion for the Foundation Trust is 1.9%. The private patient income for 2011/12 was £507,000, representing 0.37% of the Foundation Trust's total patient related income. The Foundation Trust is therefore compliant with this statutory obligation.

COST IMPROVEMENT PROGRAMME (CIP)

A formal cost improvement programme (CIP) was approved for 2011/12, which set targets and actions plans aimed at improving efficiency. The CIP was monitored monthly and achieved £8.5 million recurring in 2011/12 against the full year effect target of £11.5 million. Examples of higher value schemes are:

- Workforce reduction programme £1.9 million;
- Departmental skills mix review £2.7 million;
- Reduction in bed base £989k; and
- Savings from procurement cost reductions £761k.

COUNTERING FRAUD AND CORRUPTION

The Foundation Trust complies with the Secretary of State's directions on counter fraud measures issued in 2004. The Foundation Trust has a Reporting Concerns and Whistleblowing Policy which incorporates counter fraud measures. A specific Counter Fraud and Corruption Policy was also established in 2010/11.

The Foundation Trust has a dedicated section on counter fraud on the staff intranet. Presentations were given to staff during the year about tackling fraud in the NHS and who to contact if they suspect fraud has been committed. Articles are also published in our weekly staff briefing. To support ongoing awareness among staff, the Local Counter Fraud Specialist also attends staff events to promote awareness.

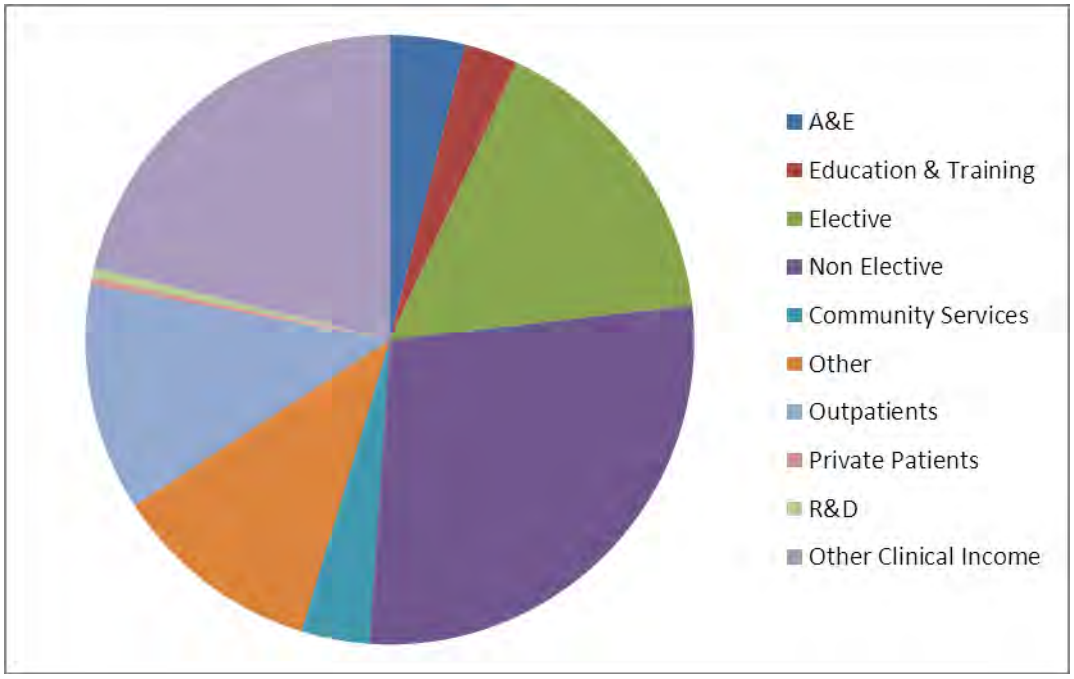
CHARITABLE FUNDS

The Trust, which is directed by the Board, acts as Corporate Trustee of the Airedale NHS Foundation Trust Charitable Funds. The Foundation Trust's charitable funds are operated for the benefit of the staff and patients in accordance with the objects of the charity. The funds are used for the purchase of equipment and the provision of amenities for both patients and staff, in accordance with the objects of the charity.

The Foundation Trust received a number of very generous donations throughout the year, from many parts of the community for which it is very grateful. The Friends of Airedale and Airedale New Venture were again very supportive in their fundraising efforts. During the year the Charitable Funds purchased a large number of items of equipment and enhancements to fixtures and fittings for the wards and departments within the Foundation Trust.

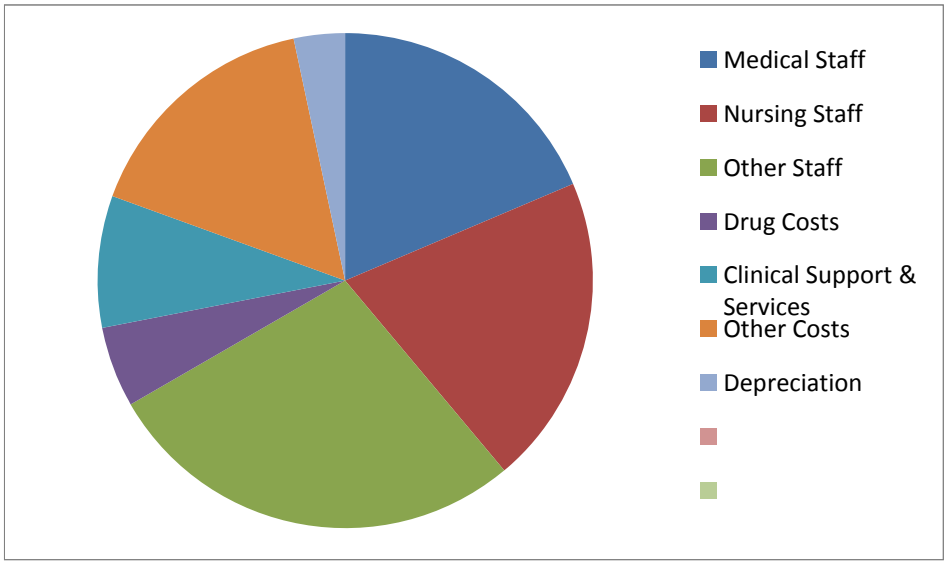
A full set of accounts relating to charitable funds is available from the Director of Finance at the address shown on the final page of this report.

INCOME



	2011/12	
	£000	%
Income		
A&E	5,334	3.9
Education & Training	3,966	2.9
Elective	22,611	16.4
Non Elective	38,557	27.9
Community Services	5,022	3.6
Other	15,427	11.2
Outpatients	16,681	12.1
Private Patients	507	0.4
R&D	744	0.5
Other Clinical Income	29,330	21.1
Total	**138,179**	

EXPENDITURE



	2011/12	
	£000	%
Expenditure		
Medical Staff	25,665	18.5
Nursing Staff	28,279	20.4
Other Staff	38,534	27.8
Drug Costs	7,208	5.2
Clinical Support & Services	12,050	8.7
Other Costs	22,346	16.1
Depreciation	4,606	3.3
Total	**138,688**	

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE AUDITORS

To the best of each Director's knowledge and belief, there is no information relevant to the preparation of their report of which the Company's Auditors are unaware.

Each of the Directors has taken all steps that a Director might reasonably be expected to have taken to be aware of all relevant audit information and to establish that the Foundation Trust's Auditors are aware of that information.

AUDITORS AND AUDIT FEE

The Foundation Trust's external auditor is the Audit Commission. Disclosure of the cost of work performed by the auditor in respect of the reporting period is shown right/below.

Audit Area	**Fee 2011/12 (£)**
Statutory Audit	**£46,000***
Quality Report	**£5,000***
Whole of government accounting	**£2,500***

* All the above figures exclude VAT

The fee for audit services included work relating to Use of Resources, Value for Money Conclusion, and risk-based audit work. The Audit Commission also undertook external assurance audit work on the 2011/12 Quality Report. Ensuring conflicts of interest are avoided is a fundamental criterion in the selection of any third party auditor for assignments with which the Foundation Trust is involved.

ANNUAL REPORT AND ACCOUNTS

This annual report and accounts is available on our website at www.airedale-trust.nhs.uk

If you need a copy in a different format, such as large print, braille or in another language, then please contact our Interpreting Services on Tel: 01535 292811 or email interpreting.services@anhst.nhs.uk

BUSINESS REVIEW

SERVICE DELIVERY

Focus on access times has seen us deliver on a number of high profile requirements.

Almost all of our patients – around 90/95% – are being treated within 18 weeks of their referral to us and over 95% of our patients are being admitted, treated or discharged within four hours of arriving in our Accident and Emergency Department. The Foundation Trust's performance on the national cancer standards has also achieved the required levels. In addition, following significant work by our maternity team, the numbers of breastfeeding mothers has increased significantly and has achieved the locally agreed rate for 2011/12.

Through contracts with our PCT Commissioners, the Foundation Trust has delivered an increased level of activity in 2011/12 across non-elective, elective and outpatient work. This work reflects dealing with both an increased level of demand whilst also delivering on key access waiting time targets**.**

Key requirements around performance and information have been met and the Foundation Trust has also delivered on the local clinical quality schedule and received the full incentive allocation associated with it.

Progress against all the business objectives set out in the Foundation Trust's Business Plan, are reported to the Board on a quarterly basis. The year end position showed the majority of the objectives had been delivered and for the areas not yet completed, work is ongoing that will be carried forward for completion in 2012/13.

DEVELOPING SERVICES

Investment in and development of a number of clinical services took place during 2011/12.

In orthopaedics, foot and ankle surgery was reintroduced as a service for the first time in several years. In addition the othopaedics team discussed the potential for GPs to book patients direct for shoulder arthroscopy.

During 2011/12, work was completed across the region resulting in Airedale achieving trauma unit status in April 2012.

For stroke care, we have introduced a seven day service to assess and treat patients who have had Transient Ischaemic Attack (TIA). This was a key priority for our local GPs and so we have responded to key local commissioning priorities.

In gynaecology, we have introduced an assessment and treatment unit – for women in the early stages of pregnancy for example – designed to offer an alternative pathway of care for that avoids admissions, where appropriate.

The Foundation Trust also opened the Telehealth Hub in September 2011 as part of its key strategic approach to digital healthcare. The Hub offers a range of Telehealth care across a range of specialties including:

- Remote consultant opinion to the HM Prison Service in England;
- Supporting elderly patients with long term conditions in their own homes, nursing and residential care homes;
- Supporting children with diabetes to manage their condition at home;
- Supporting rural communities with community based remote outpatient consultations; and
- Enhancing recovery for stroke patients through our telemedicine service.

Community Services were successfully transferred during the year. The teams, which cover Craven, Airedale and Wharfedale, are:

- Craven Virtual Ward (district nurses, community matrons, case manager)
- Craven Fast Response Team and Out of Hours nursing service
- Castleberg Hospital, Skipton Hospital and Settle Health Centre
- Site support services
- Airedale Collaborative Care Team (ACCT)
- Specialist nursing team (specialist neurological rehabilitation, heart failure, diabetes, cardiac rehabilitation, haemoglobinopathies counsellor)

Reablement funding was also secured for the next two years to support transformation of care, which is central to the Foundation Trust's strategy.

This enabled the Foundation Trust to make additional beds available in the community, at Castleberg Hospital, near Settle and at local nursing and residential care homes.

PERFORMANCE

PUTTING PATIENTS FIRST

The past year has seen the Foundation Trust build on the previous year's performance. Not only did we finish the year having achieved national targets we also met our PCTs local quality standards.

In August 2011, Airedale Hospital was named as one of 40 top hospitals by CHKS - an independent provider of healthcare intelligence and quality improvement services. The top hospitals programme, which is now in its eleventh year, aims to celebrate excellence in the NHS and the award is made based on an evaluation of 20 indicators of clinical effectiveness, health outcomes, efficiency, patient experience and quality of care. Since the year end, Airedale also achieved the national CHKS Patient Safety Award for 2012 and was the only hospital to be nominated in both the patient safety and quality of care categories.

Of particular note, in October 2011, a Care Quality Commission report was published, following an unannounced inspection of the hospital in April 2011, which recognised it as being fully compliant with regard to both dignity and nutrition for older people. The report on Airedale Hospital says, "The staff we spoke to had an understanding of the importance of respecting and involving people who use the Trust's services."

And in November 2011, the Foundation Trust was named as the most recommended hospital in the Yorkshire region in the 2011 Dr Foster Hospital Guide. The accolade, which is a new category in the annual publication, asks patients what they think about individual hospitals. It lists Airedale Hospital as being recommended by 82% of

patients. The hospital was also recognised for its low mortality rates.

During 2011/12, the Foundation Trust was also a finalist and highly commended by the Health Service Journal in the Acute Healthcare organisation of the Year awards.

Continuing to put patients first and developing improvements to quality and safety have been the top priority in 2011/12. This is also evidenced by the fact that the Foundation Trust has not had a hospital acquired MRSA case since October 2010.

HOW THE FOUNDATION TRUST IS MONITORED

Monitor requires each Foundation Trust board to submit an annual plan, quarterly and ad hoc reports. Performance is monitored against these plans to identify where potential and actual problems might arise. Monitor publishes quarterly and annual reports on these submissions and assigns each Foundation Trust with an annual and quarterly risk rating, which are designed to indicate the risk of a failure to comply with the terms of authorisation. Three risk ratings are published for each NHS Foundation Trust on:

- Governance (rated red, red/amber, amber/green or green);
- Finance (rated 1-5 where one represents the highest risk and five the lowest); and
- Mandatory services risk rating (services the Foundation Trust is contracted to supply to its commissioners).

Based on these risk ratings, the intensity of monitoring and the potential need for regulatory action is considered on a case-by-case basis. This also applies where a Foundation Trust is performing well, for example moving from the usual quarterly monitoring to six-monthly monitoring. Monitor's analysis of our submissions and the Foundation Trust's current ratings are:

REGULATORY RATINGS

Performance against the 2011/12 Monitor Compliance Framework for Quarter 4 is rated green. The Foundation Trust achieved a green rating for governance and a financial risk rating of 3, for the first three quarters in 2011/12 and a rating of 4 for the final quarter of 2011/12.

NATIONAL SURVEYS

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

The results of the 2011 outpatient survey were published in February 2012. The survey involved 163 acute and specialist NHS trusts and received more than 72,000 responses.

The independent survey asked the views of adults who had visited Airedale Hospital's outpatients department in May 2011. The outpatients were asked what they thought about different aspects of the care and treatment they received

The survey highlighted a number of positive findings, with Airedale NHS Foundation Trust achieving mostly average or better than average performance in comparison with other hospitals in the majority of the categories looked at by the survey.

The results of the ninth survey of adult inpatients, which was conducted between June and August 2011, were published by the Care Quality Commission in April 2012.

It involved 161 acute and specialist NHS trusts and looked at the experiences of over 70,000 people who were admitted to hospital with at least one overnight stay.

The Foundation Trust scored well for privacy and dignity and infection prevention practices. Around nine out of ten respondents had confidence and trust in the nurses treating them and nearly eight out of ten rated the care they received highly.

A programme of work to address the areas identified for improvement in both the outpatient and inpatient survey reports will be addressed during 2012/13.

REAL TIME INPATIENT SURVEY

The Foundation Trust continued to implement its own real time inpatient survey in 2011/12 as a means of helping staff make improvements to the care and services that are provided to patients. The survey is undertaken on a daily basis, Monday to Saturday, supported by the Foundation Trust's volunteers who assist patients being discharged that day to complete the survey.

The project is overseen by a Sub-Group, whose members continually monitor progress and include volunteer representatives. There have also been three volunteer events, which have proved a useful way of sharing experiences, refining the way the survey is conducted and also feeding back to the volunteers on how their work helps the teams on the wards to improve their care of patients.

During 2011/12, the survey was expanded into other areas and now also covers maternity services, endoscopy and physiotherapy. Further areas for consideration include the children's unit.

PATIENT ENVIRONMENT AND ACTION TEAM (PEAT)

Hospital cleanliness and reducing the risk of healthcare associated infections both continue to be a high priority for the Foundation Trust.

Our Patient Environment Action Team (PEAT) assessments undertaken in 2011/12 continue to demonstrate that Airedale provides a clean environment for patient care.

Our PEAT score was rated as 'good' for the environment and 'good' for providing care linked to issues related to privacy and dignity.

Site Name	Environment Score	Food Score	Privacy & Dignity Score
Airedale Hospital	Good	Excellent	Good

Diet and nutrition is a vital part of a patient's health and is an aid to recovery from ill health.

The Foundation Trust continues to provide a high standard of catering for our patients and staff, with food being rated as 'excellent' by our PEAT assessment in 2011/12.

During 2011/12, the catering team redesigned the hospital's patient menus. The menu review was a collaborative process between the Foundation Trust and Sodexo, its catering partner, and included feedback from both patients and staff on the existing menus. The format of the menus was changed to give greater flexibility for preparation and alterations to menus, if these were required. The new menus were introduced in April 2012.

CLEANER AND SAFER

The Foundation Trust has continued to make improvements in reducing healthcare acquired infections.

During 2011/12, the Foundation Trust did not have any hospital acquired MRSA bacteraemia - a significant achievement for the hospital and its staff. This compares to 12 MRSA cases in 2008/09 and 21 in 2003/04. For Clostridium difficile, the number of people affected has risen slightly with 21 hospital acquired cases in 2011/12 compared to 16 in the previous year.

Our Matron for Infection Prevention works closely with all staff, the Interim Director of Nursing and the Director of Infection Prevention and Control in order to ensure that we provide best practice in infection prevention and control. Important patient safety initiatives aimed at achieving even further reductions in the number of healthcare acquired infections have been introduced. These include enhancing staff training to improve hand hygiene; developing up to date information for both patients and staff; and training and assessing our staff in asepsis practice and techniques.

STATEMENT IN RESPECT OF INFORMATION GOVERNANCE SERIOUS INCIDENTS REQUIRING INVESTIGATION

The Trust manages the reporting of personal data related incidents through the Incident Reporting System. All incidents are classified in terms of severity on a scale of 0-5 in terms of either/both risk to reputation and risk to individuals in accordance with the Department of Health Gateway Reference 13177 dated January 2010. The Foundation Trust had no incidents classified at a severity rating of 3-5 that met the criteria for inclusion in the annual governance statement. The Foundation Trust recorded 4 classified at a severity rating of 1-2 which have been

aggregated and listed below. All are investigated and actions plans put in place to mitigate risks.

Category	Nature	Total
I	Loss/theft of inadequately protected electronic equipment, devices or paper documents from secured NHS premises	
II	Loss/theft of inadequately protected electronic equipment, devices or paper documents from outside secured NHS premises	2
III	Insecure disposal of inadequately protected electronic equipment, devices or paper documents	
IV	Unauthorised disclosure	2
V	Other	

During 2011/12 the role of Senior Information Risk Owner (SIRO) was the responsibility of the Medical Director.

SUPPORTING SAFE, QUALITY CARE

The following departments continue to work with the Interim Director of Nursing, the Medical Director and their teams to help support the delivery of high quality, safe care.

- Quality and Safety
- Complaints management and PALS
- Nursing Practice Development Team
- Patient and Public Engagement and Experience
- Infection Prevention
- Safeguarding

SAFER PATIENT INITIATIVE

Following completion of The Safer Patient Initiative 2 (SPI2), we have continued using the methodology learnt in SPI2. As agreed with the Institute of Health Improvement and Health Foundation we are continuing to report our safety and quality data on a monthly basis. The organisation continues to be an active member of the Safer Patients Network run by the Health Foundation, ensuring greater learning and understanding is applied around safe patient care.

EMERGENCY PLANNING

The Foundation Trust has continued to develop its plans to deal with emergencies in line with national regulations and guidance. The Foundation Trust put its emergency plans to the test during the industrial action of November 2011. The day highlighted many areas of good practice and forward planning as well as some lessons for the future, which are being incorporated into our emergency plans.

PRIVACY AND DIGNITY

The Foundation Trust's Dignity Room, an initiative set up by a group of staff at the hospital in 2009, continues to go from strength to strength. Their passion for dignity, together with the help of the Friends of Airedale and Airedale New Venture charities, has ensured that the initiative not only continues but grows each year.

In 2011/12, the Dignity Room was a finalist and highly commended in the Nursing Times annual awards, in the category 'Enhancing Patient Dignity'.

The Dignity Room has been successful because of its potential to touch every patient within the hospital and to treat patients with compassion, kindness, dignity and respect, thereby enhancing the patient experience.

The Dignity Room, located on Ward 4 in the hospital, stocks a range of essential items which are all provided free of charge, including slippers, warm clothing, underwear and toiletries such as soap, shaving foam, razors, toothpaste, toothbrushes, shampoo and combs. It enables patients who have been admitted to hospital in their nightwear and without toiletries to access day to day essential items. This allows them to go home or be transferred to other places of care wearing day clothes.

During 2011/12 the Dignity Room has expanded its range of clothing to include skirts as an option instead of trousers and extra large sizes as well as additional toiletries such as lip balm and dry shampoo. It is also working with other areas of the

hospital, such as the children's unit, to see what support it may be able to offer to younger patients.

A patient's relative, who was helped by the Dignity Room, says: "On his discharge, he was sent home with these articles which belong to the Dignity Room. It gave him pleasure to wear them whilst on the ward as they were so much more suitable than his own clothes."

SAME-SEX ACCOMMODATION

The hospital provides same-sex accommodation by having separate male and female wings on all wards and doors which have been added to all of the four-bedded bays on all our inpatient wards. Toilet and shower facilities in some wards/departments have also been upgraded. This means the Foundation Trust continues to be compliant with the Department of Health's requirements to provide same-sex accommodation.

LEARNING FROM COMPLAINTS

The Foundation Trust continues to deal with complaints in accordance with the legislation for complaints handling, which came into effect in April 2009. The Patient Liaison Service (PALS) and complaints team have done a great deal of work to respond to individual concerns at the point of care and as a result, the Foundation Trust has seen a 15 per cent reduction in the number of formal complaints during the year, from 85 in 2010/11 to 72 in 2011/12. We have worked hard to learn from formal complaints. Examples are:

"*Your concern* *… I suffered an injury to my face caused by the tape used whilst under anaesthetic.*

Our response *… as a result of the complaint a new type of intubation tie was purchased and is now in use."*

"Your concern *… waiting for the supply of a chemotherapy drug was distressing.*

Our response *… stock levels have now been revised and increased; this continues to be monitored."*

CLINICAL GOVERNANCE

Clinical governance is the framework through which NHS organisations deliver and continually improve the quality of their services and safeguard high standards of care, by creating an environment in which excellence in clinical care will flourish.

This means being able to produce and maintain effective change so that high quality care is delivered.

The Foundation Trust has a committee structure designed to monitor and take forward the improvements to the clinical quality and safety of the services it offers patients. The Board of Directors is the accountable committee for quality. It is supported by a Board sub-committee and a number of other specialist groups and committees.

The Board of Directors receives a regular detailed report documenting progress and assurances from these various groups and committees that quality is improving. We have a corporate risk register that sets out potential risks to us meeting our targets and objectives. Our committee structure incorporates regular reviews of the corporate risk register and the Board Assurance Framework.

QUALITY REPORT

1 Statement on quality from the Chief Executive

I am pleased to present Airedale's Quality Account for 2011/12. We strive to be the hospital chosen by the community for putting patient's first, whilst providing excellent, innovative services and delivering safe standards of care. Recent high profile reports and inspections serve as a clear reminder of the consequences of failure to focus on the quality of care and to listen to the concerns of patients and relatives. In April 2011 the Care Quality Commission, the independent regulator of health care in England, made an unannounced inspection of nutrition and dignity in the elderly, as part of a wider targeted programme. We were found to be delivering care with compassion, dignity and respect and were praised for trying out a new scheme to help patients who have memory loss due to dementia.

The aim of this year's Quality Account is to report on progress made against our priorities for 2011/12. It provides an overview of the quality of care we provide and how we plan to improve on this over the coming year. This year's Account also includes progress with the integration of hospital and community services as we develop new pathways which respond to the changing needs of our local population. As the work our Airedale Community Collaborative Team illustrates, integrated care, through its focus on a range of services delivered at the most appropriate point for patients, has the potential to improve quality and places the focus firmly on benefiting our service users. This team's collaborative work has been recognised through the receipt of a national award.

As I reported last year, in the current economic climate, the NHS has some major challenges ahead if it is to deliver the changes set out in the new Health and Social Care Bill. With approximately 250,000 patients using our services each year, we must continue to make efficient use of resources in order to provide the most effective care. Our pioneering telemedicine work offers the potential to allow us to capitalise on its flexibilities and meet the healthcare needs of the local community and beyond.

I would like to take this opportunity to express my thanks to our staff, volunteers, governors and foundation Trust members for their continued support and dedication in delivering high quality care for our patients and to their families in these difficult times. We can only provide a great patient experience if we value and cherish our most valuable resource – our staff. Their commitment and loyalty gives me confidence that we will continue to deliver our vision of being at the centre of our community as we endeavour to meet the challenges ahead.

All the information used and published in the Quality Account to the best of my knowledge, is accurate and complete.

Bridget Fletcher

Bridget Fletcher
Chief Executive
28 May 2012

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

Introduction: The Foundation Trust's vision is to be the hospital chosen by the community for putting patients first. It has at heart "*No decision about me, without me."* This involves creating a culture whereby services are patient centred with staff continually looking at ways of improving care and treatment at every stage of a patient's journey. Our quality improvement programme focuses on three domains: patient experience, patient safety and the clinical effectiveness of care and treatment. This Account seeks to provide accurate, timely, meaningful and comparable measures to allow our stakeholders to assess our success in delivering this vision.

Our stakeholders: We continue to consult with our stakeholders – patients and carers, staff, volunteers, Council of Governors, commissioners, the local authority and voluntary groups - in the development of our quality plans. A review of our quality indicators has taken place over the last year, underpinned by the Foundation Trust's *Forward Annual Plan Strategy 2012-14* and a revision of our *Quality and Safety Strategy.* In the process, a wide range of staff were consulted and the Foundation Trust's performance against national, regional and local quality and safety priorities was reviewed.

We have engaged much earlier this year with the local community and patient representatives in the production of the Quality Account, asking about priorities from their perspective. A public event was held in September 2011 to seek feedback on our Quality Account, with invitations extended to the Local Involvement Networks (LINks), the Local Authority, the Foundation Trust's Patient and Carer Panel and the Council of Governors. This initiative was further consolidated by a community event in October 2011, specifically designed to engage with socially excluded groups. Joint working has also taken place with Bradford LINk to reach people in rural areas. Foundation Trust members were also canvassed for their opinions on our quality improvement plans via an online survey. In addition, over the last year, the Foundation Trust has invited local Overview and Scrutiny Committees (OSCs) and other special interest groups to see our work. Public health events have been held at a number of locations throughout this period. The collective intelligence generated, combined with the Foundation Trust's overarching vision, has guided and informed the Quality Account Steering Group in its consideration of future priorities for 2012/13 and beyond.

We intend to expand our engagement next year and, amongst others, involve our newly developing Youth Panel. The Youth Panel encompasses several groups of young people from surrounding districts and aims to provide us with a younger person's perspective on the quality of our care, treatment and services and the way we do things. We are hopeful that these enthusiastic groups of young people will enable us to think differently about certain quality issues, which will be reflected in next year's Quality Account.

1. The patient experience

During the last twelve months we have been drawing together a ***Patient and Public Engagement and Experience Strategy.*** We have talked to community groups and individuals to find out what is important to them. The strategy sets out our approach over the next three years and will be delivered through a detailed annual implementation plan, overseen by the Board of Directors. The strategy builds upon current good practice, while setting an ambitious framework for changing the way that we do things. Most importantly, this means putting patients at the centre of everything we do.

Recent regulatory reports have highlighted how some parts of the NHS are failing to provide the elderly and those at risk with dignified and compassionate care. The purpose of the health services is to support people "at times of basic need, when care and compassion are what matter most."[1]. In April 2011, the Care Quality Commission (CQC) conducted an unannounced visit to Airedale Hospital to assess how well older people are treated during their stay. In particular, the CQC focused on whether patients are treated with dignity and respect and whether their nutritional needs are met. The inspection team found the Foundation Trust was meeting privacy, dignity and nutrition standards. The hospital was praised for its use of the Butterfly Scheme, which helps patients who have memory loss due to dementia, by giving staff practical advice to make sure they are meeting individual needs.

"Staff treat patients respectfully and ensure that they are involved in decisions about their care where this is possible. Patients told us that all of the staff were pleasant and respectful; they felt staff listened and responded to their needs in a timely manner. During our visit we saw positive evidence of this and the staff we spoke to had an understanding of the importance of respecting and involving people who use the Foundation Trust's services."

Dignity and Nutrition for Older People Review of Compliance Airedale NHS Foundation Trust June 2011.

We strive to provide a dignified death for patients at the end of their life and appropriate support to their relatives and carers. *The National Care of the Dying Audit* is one of the Department of Health's 2011/12 Quality Accounts recommended audits. In 2011 the Foundation Trust took part in this audit for the first time, together with 178 other hospitals. An individual report was received in December 2011 detailing our performance. In seven of the eight key performance indicators we were benchmarked in the middle 50 per cent of hospitals; for the remaining indicator we were in the top 25 per cent of performing hospitals. We are currently working to improve aspects of care. We are aware that there is only one opportunity to get this right and create a positive lasting memory for families.

Adults and children with learning disabilities are some of the most vulnerable members of our society with significantly worse health outcomes.[2] Our matrons have collaborated with the Bradford and Craven Health Task Groups to improve the quality of healthcare for people with learning disabilities. Using a proven nursing standard methodology, a learning disability benchmark has been developed to provide a process to share and compare practice.

The Foundation Trust continues to engage with black minority ethnic groups (BME). In 2010/11 a focus group looked at our maternity service provision and the needs of BME women: 28 women and 12 men were consulted during a 12 week period in eight different locations. Although feedback on the quality of our services was reassuring, there are aspects of our service that we need to improve upon and we are actively looking at the best way of doing this.

We are excited by the possibilities offered by telemedicine technologies and how innovation can transform patient outcomes, particularly for those with long-term conditions. Presently, patients living with diabetes have to come for regular hospital appointments with nurses and doctors to review and monitor their condition. Having a set top box system in their home means that many of these visits can be delivered remotely and ensures that people have timely access to services and information that help them to make their own decisions.

"Following my amputation I found it hard to get to hospital. The set top box helps me a great deal

[1] Department of Health (2011) *The Operating Framework 2012/13* – p.2
[2] Michael Jonathon (July 2008) *Independent Inquiry into access to healthcare for people with learning disabilities* - p.7

and has reduced the number of hospital visits and allowed me to receive my care remotely. It's excellent." John 2011

Volunteers: Our volunteers continue to play a significant and valuable role in supporting quality improvement. Staffed by volunteers and supported by the Foundation Trust's charities, our *"Dignity Room"* is one such activity. Its aim is to support patients who had no day clothes when they arrived in hospital, or where none were brought in during their stay. This work was "Highly Commended" in the *2011 Nursing Times Awards* in the category, *Enhancing Patient Dignity,* but more important to us is what patients tell us:

"I only have a niece who helps me but she forgot to bring my outdoor clothing. I am grateful to have these clothes –I am a proud lady and would have hated to have gone [home] in my nightwear."

Learning how we can improve: The Trust receives a significant amount of feedback about its care and services via Complaints and the Patient Advice and Liaison Service (PALS). In 2011/12 there were 1975 contacts with PALS. We received and investigated 72 formal complaints during this period compared to 85 in the preceding period[3]. The Trust takes complaints extremely seriously and is committed to identifying where lessons can be learnt:

"Your concern *… I suffered an injury to my face caused by the tape used whilst under anaesthetic.*

Our response *…as a result of the complaint a new type of intubation tie was purchased and is now in use".*

"Your concern*…waiting for the supply of a chemotherapy drug was distressing.*

Our response *…stock levels have now been revised and increased; this continues to be monitored."*

Source: Airedale NHS Foundation Trust Complaints Team 2011

Intelligence generated by surveys, including our real time inpatient review and external patient websites is invaluable in understanding the experiences and needs of our patients. In the latter case, patients are asked to leave a comment about their care and to say whether or not they recommend the hospital. According to Dr Foster's Good Hospital Guide (2011), Airedale is one of those hospitals most often recommended with an 82 per cent rating. We were the only hospital in Yorkshire to be in the top ten. The results of our 2011 CQC Outpatient Survey show that the majority of patients attending appointments at Airedale Hospital have said they are happy with the service they receive. It is heartening to know that a vast number of our patients are confident with the service we deliver.

2. Patient safety

nds: These continue on a weekly basis with both executive and non-executive directors in attendance to ensure safety and the experience of patients and carers remains a strategic priority. This programme has been extended in 2011 to encompass our newly integrated

[3] The annual Airedale NHS Foundation Trust Complaints and Concerns Report 2011/12 will be available in June 2012 at: http://www.airedale-trust.nhs.uk/About/corporateinfo/complaints.html
[4] National Patient Safety Agency (NPSA) National Reporting and Learning System [1/10/10-31/03/11]
[5] Department of Health (2011) *Whole System Demonstrator Programme*

hours visits. There were 29 walk-rounds in 2011 with 30 planned for 2012.

Minimising the number of **healthcare associated infections** remains a high priority for patients and the Foundation Trust. The last hospital MRSA bacteraemia was on 29th September 2010: the last from the community was 22nd November 2011. A similar highlight is the work of our ICU team with the last ventilator associated pneumonia (VAP) case confirmed in January 2008.

Learning from incidents: The first step towards improving patient safety is to understand where problems are occurring. We have reviewed our adverse event process, increasing our focus on support, education and training. This has had a positive impact on our reporting rates which have risen from 3.8 per 100 admissions in the period October to March 2010, to 6.9 per 100 admissions in the same six-month period in 2011 (median for small acute trusts 6.2).[4] Our latest available rate (April to September 2011) is 6.3 with a median of 6.5. Emphasis has been given on where incidents occurred, particularly in the case of pressure ulcers. We can distinguish between those that developed in hospital care and those that were present when a patient was admitted. This gives us a clearer picture of the hospital and the wider care sector and helps us address problems and improve care.

The National Patient Safety Agency (NPSA) publishes regular patient safety alerts, warning hospitals about practices that are potentially unsafe. The warnings recommend a date by which changes to practice should be implemented. We were compliant with all relevant NPSA safety alerts issued in 2011/12.

3. Clinical effectiveness

In 2011 we established a Teleheath Hub on the Airedale General Hospital site. Two core services are now being offered for patients with long- term conditions:

- Telemedicine: this allows two-way video consultations between healthcare professionals and patients and carers to support the delivery of acute and out-patient clinical care outside the hospital.

- Telemonitoring: remote monitoring tools capture physiological measurements e.g. blood pressure and relay them to the Hub for review, and where necessary, an assessed response.

Does the use of technology as a remote intervention make a difference? The Department of Health undertook a comprehensive study to show the potential capabilities of telehealth and telecare. The first set of findings show that, "if delivered effectively, teleheath can substantially reduce mortality; reduce the need for admissions to hospital and lower the time spent in hospital and/or mortality; and reduce the need for admissions to hospitals and lower the time spent in hospital and/or A&E." [5]

We are seeking to integrate these new technologies into the care and services we deliver and are at the forefront of this national initiative. This gives us confidence that we can effectively transform the way services are delivered to ensure that we use innovation to put people at the centre. We are jointly working to provide a 24/7 365 days a year stroke thrombolysis service, covering 18 hospital sites and 50 stroke consultants across the whole of the Yorkshire and Humber region. This will ensure patients requiring this treatment receive faster access to specialists, supporting clinical care and treatment for patients who have had a stroke.

4. A balanced view: Our aim is to continue to develop a culture of openness, accountability,

responsibility and challenge. It is important to us that our Quality Account is accurate and presents an unbiased view of the quality delivered by Airedale NHS Foundation Trust.

The NHS needs to deliver efficiency savings without compromising quality, but at the same time we must change and redesign our clinical services. Plans for annual efficiency savings, including the workforce reduction programme, have been scrutinised by Monitor and the Foundation Trust was subject to a second stage review in 2011 in which the financial regulator sought assurance that quality and safety will not be compromised.

Staff survey: The health and wellbeing of our staff is an important factor in providing safe and effective care for patients. The 2011 National NHS Staff Survey revealed issues around work pressure and staff motivation at work Nationally, the percentage of staff feeling there are good opportunities to develop their potential at work was disappointing. A review of our current practice has been undertaken and an action plan prioritising great line management, encouraging an engaged workforce and ensuring effective resourcing is being implemented.

Integrated care: Following the Department of Health's initiative to transform community services, Airedale is now the provider of these services within the locality. We realise that we need to do more to integrate service delivery not only across primary and secondary care, but also between mental and physical health and social care organisations. These services are central to our vision to put people at the centre and in control. Through our Transform Programme, we are currently looking at how we can work better with partners, including voluntary organisations, so that services are organised around the interests of patients and service users rather than institutions. Delays in establishing community based alternatives to support patients in their own homes have meant we have not yet been able to deliver fully the model of care to which we aspire. However, we continue to make good progress and have expanded the Airedale Community Collaborative Team (ACCT) and telemedicine installations into nursing homes within the area which will enable us to continue with our transformation.

Summary: We continue to monitor and review our services and work closely with our stakeholders to ensure that all our patients receive high quality personalised care with dignity and respect at the forefront.

In November 2011, Airedale NHS Foundation Trust was one of only six finalists in the Acute Healthcare Organisation of the Year category and the only one to be awarded "Highly Commended".

The judges visited the hospital to see for themselves how we are working to involve patients and the local community in developing services as well as how improvement programmes are benefitting patients and staff.

Andrew Catto
Medical Director

Rob Dearden
Interim Director of Nursing

28 May 2012

2 Priorities for improvement: current and future

Table 1 sets out local quality improvement indicators identified in the Quality Account since its inception in 2009/10. Within the domains of patient experience, patient safety and clinical effectiveness, a quality priority has been selected (denoted as **bold** type).

Table 1: Our Quality Account local quality indicators priorities:

Domain/Year	2009/10	2010/11	2011/12	2012/13
Patient experience	**Real time inpatient feedback**	**Real time inpatient feedback**	**Real time inpatient feedback**	**Improving nutritional care for patients with dementia**
	Privacy and dignity	Privacy and dignity	Privacy and dignity	Privacy and dignity
	Same sex accommodation	Same sex accommodation	Improving nutritional care for patients with dementia	Real time patient feedback
Patient safety	**Inpatient falls**	**Inpatient falls**	**Inpatient falls**	**Inpatient falls**
	Infection prevention	Infection prevention	Infection Prevention	Infection prevention
	Pressure ulcers	Pressure ulcers	Pressure Ulcers	Pressure ulcers
Clinical effectiveness of care and treatment	**A & E**	**A & E**	**Telemedicine**	**Telemedicine**
	Caesarean section rate	Caesarean section rate	Caesarean section rate	Caesarean section rate
	Fractured neck of femur	Fractured neck of femur	Fractured neck of femur	Fractured neck of femur
	Children's RI project	Children's RI project	Enhanced recovery	Enhanced recovery

For 2011/12 our top three priorities are as follows:

1. ***Patient experience:*** *Real time inpatient feedback;*
2. ***Patient safety****: Reduction of slips, trips and falls sustained by patients admitted to our hospital wards; and*
3. ***Clinical effectiveness:*** *The use of telemedicine to improve the overall quality of healthcare for people with long-term conditions.*

We report on our progress against these in 2011/12 in Section 2 of this report. Our other local quality indicators, including community services, are updated in Section 3.

For 2012/13 our top three future priorities will be as follows:

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

2.1 Priority 1 patient experience*: real-time inpatient feedback survey*

Rationale and aim

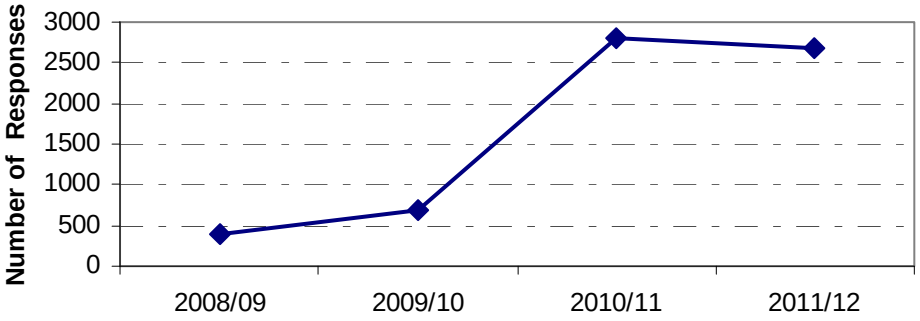
The real time inpatient feedback survey has been the main patient experience priority in our Quality Account for the past two years. This is in line with views about priorities expressed by patient representatives attending the public events. The results from the real time survey complement the information received from the national annual CQC Inpatient Survey about patient satisfaction with care and treatment. This provides an early warning of any problem areas. This means immediate attention can be given and action taken where necessary.

The survey is carried out by volunteers in order to remove as much bias as possible. They visit every medical and surgical ward on a daily basis (except Sunday) and assist patients who are ready for discharge to complete a questionnaire, using a portable computer. The information from the completed questionnaires is uploaded onto the Foundation Trust's central internal data system and the findings are then instantly available to Foundation Trust staff.

Current status

The survey has been running now for four years. A steering group made up of staff and volunteers meets regularly to continuously assess and analyse progress and to give advice on possible improvements. The progress in participation rate achieved between 2009/10 and 2010/11 has been maintained with 15 per cent of all patients discharged from participating wards completing a questionnaire.

The number of Airedale patients who have completed the real-time inpatient survey



Progress reports are presented to the Foundation Trust's quarterly Patient and Public Engagement and Experience (PPEE) Steering Group and within the Director of Nursing's monthly report to the Board of Directors.

As well as covering all the medical and surgical inpatient beds, a pilot survey has been taking place to include physiotherapy, maternity and endoscopy. We are also looking to extend it further into the Children's Unit.

Some of the improvements made as a result of the real time survey have included:

- Using the ward's 'whiteboard' to alert staff to explain discharge medication to patients;
- Installing dimmer function on night lights;
- The display of *'You said…we did'* statements on wards on a monthly basis; and
- Reviewing the ward information booklet.

Initiatives and progress in 2011/12

The following gives details of progress made for each of the initiatives set out in the 2010/11 Quality Account:

- ***Consideration to be given to other initiatives that will increase the number of questionnaires completed by patients who are due for discharge***

One difficulty in achieving this aim has been a changing situation of ward re-configurations due to demand and pressure for beds. However, due to much better communication with and between the volunteers, ways of increasing the numbers of completed questionnaires has been discussed. There are some enthusiastic youngsters amongst the volunteers who find it easier due to college commitments, to undertake the survey on a weekend. This means we are now covering six days instead of five.

It is difficult to decide upon a right time to capture as many patients as possible who are ready for discharge. Consideration must also be given to protected meal times. Initially surveys were undertaken in the afternoon, but many patients had already been discharged. This was changed to take place in the morning, but there are still, occasionally, problems in identifying patients ready for discharge as ward rounds have not been completed. In view of this, we are now trialling a combination of both, with some volunteers visiting the wards during the morning and some during the afternoon.

- ***Undertake further volunteer recruitment to cater for the expected extension of the survey, to cover other services***

We are proud of what our volunteers have achieved in enabling us to seek feedback from our patients. To build on their excellent work, we continue to recruit volunteers and six have been recruited to assist with the endoscopy clinic and physiotherapy surveys. During the trial for the maternity survey, some of our regular inpatient survey volunteers are also covering the post-natal ward and we will encourage members of the Maternity Services Liaison Committee to also become involved.

- ***Continue to improve communication with the volunteers to encourage continuity of support***

We have worked closely with our volunteers and held a number of events to continue to develop the inpatient survey and to analyse progress. This has resulted in a number of practical measures including setting up a centralised resource room and improving the technology to assist data uploading and analysis.

"It was delightful to undertake the survey and the staff have been extremely welcoming and helpful."

Comment made by one of the volunteers at the volunteer event held in November 2011.

Our volunteers have also helped us to refine the questions based on their feedback from patients and we now also include a comments box to include their individual comments.

"The comments inputted in the text box are most revealing in many instances and help provide the story."

Comment taken from volunteer event held in November 2011.

- ***Regular progress reports in the weekly "Staff Brief" to keep Foundation Trust staff fully updated on the learning***

Following discussion at the Real Time Survey Steering Group, the survey's results are now discussed at every joint ward sisters' operational meetings. This is to promote continuous improvement and to ensure that any remedial actions are undertaken.

- ***Continue to reflect on the findings and integrate these with other patient feedback in order to demonstrate tangible improvement to care and services***

During the year a Patient a Public Engagement and Experience (PPEE) Operational Group has been formed, which is responsible for overseeing the Foundation Trust's engagement/patient experience activities and to ensure that actions are undertaken and evaluated. Reports are submitted - on a quarterly basis - to the PPEE Steering Group for assurance that improvement to patient care and services is taking place.

Initiatives in 2012/13 to achieve progress:

- Consolidate all newly introduced specialty surveys and the inpatient survey to ensure systems are running as smoothly and effectively as possible;
- Develop a new system of reporting that will provide the Board of Directors with more detailed benchmarked information; and
- Consider the practicalities of extending the real time inpatient survey to include the Children's Unit.

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

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

Rationale and aim

Falls are a common cause of injury to patients and may result in pain, distress, delay in discharge and loss of independent living. Patient falls are consistently in our top three reported patient safety incidents. The effective management of risk to reduce the number of inpatient falls was selected as an important priority in 2009/10. The Foundation Trust has aimed to demonstrate a year on year reduction in the number of falls sustained by patients while they are in hospital.

Although hospital inpatients are particularly at risk of falling due to medical conditions and factors such as poor memory, eyesight, continence problems, research estimates that up to 30 per cent of falls can be prevented[6]. A Falls Management Steering Group has been in place since June 2010 and is responsible for implementing robust systems and processes to reduce the risk of falls and resultant harm and injury.

Current status

Fiscal Year	Falls	Bed Days	Falls Per Thousand Bed Days
2009/10	1089	127983	8.5
2010/11	1197	123529	9.7
2011/12	1100	101078	10.9

Despite our continued focus on reducing the number of falls, disappointingly, the falls rate has shown a steady increase. Airedale, however, continues to encourage, and has, high levels of falls reporting and it is worthy of note that *all* slips, trips and falls (including those that might be deemed a minor incident) are included in the data. The number of falls and occupied bed days has actually decreased over the course of last year and might be an indication that our prevalence measures are beginning to embed in practice. We remain committed to further reducing falls incidence within the coming fiscal year.

Initiatives in 2011/12

- The Foundation Trust's *Falls Policy* was revised and approved by the Foundation Trust's Quality and Safety Operational Group in January 2012 in line with NHSLA Level 2 standards and is to be further aligned with our community services.
- A new falls assessment form has been implemented alongside an individualised care plan.
- A patient information leaflet on falls has been produced for patients, carers and visitors (presently in draft). This explains what can be done to reduce the risk of a patient falling whilst in hospital.
- Eleven floor-level beds for patients at high risk of falling out of bed have been purchased.
- All wards have been supplied with bed and chair alarms for high risk patients.
- A process for reporting falls which result in significant harm has been developed.
- In November 2011, the Foundation Trust participated in a national falls clinical audit organised by the Royal College of Physicians; we await recommendations.
- The Foundation Trust continues to contribute to the district-wide Bradford and Airedale Integrated Falls and Bone Health Strategy Group.
- A pathway for staff to follow when a patient falls has been developed in line with the National Patient Safety Agency alert *Essential Care after an Inpatient Fall* (2011).

[6] Institute for Innovation and Improvement (2009) *High Impact Actions for Nursing and Midwifery*

- Footwear can be obtained for patients from the *"Dignity Room"* to help reduce the likelihood of an inpatient fall and support patient safety.

Initiatives in 2012/13 to achieve progress

- The falls leaflet will be reviewed by the Foundation Trust's Readers Panel, prior to implementation.
- Monitoring mechanisms continue to be reviewed and strengthened. We are in the process of developing a live database for those falls which result in significant harm in order to support learning and prevention.
- We will pursue our interest in the benefits of cushioned flooring in wards where patients who are at a high risk of falls are cared for.
- Our annual bed rails audit will be repeated and recommendations acted upon.
- We will continue to raise awareness that safeguarding patients from falling is everyone's business.

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

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

Rationale

The Strategic Health Authority (SHA) has commissioned primary care trusts to carry out the *Quality, Innovation, Productivity and Prevention (QIPP) Strategy*. [7] This has been developed with the intention of supporting trusts at the time of a challenging external environment with the aim of improving the quality of care whilst delivering efficiency savings. Long-term conditions have been adopted by NHS Bradford, Airedale and Leeds, initially chronic obstructive pulmonary disease (COPD), with the focus on using telemedicine technology to improve the quality of healthcare for this group.

COPD is a term used for a number of conditions, including bronchitis and emphysema. COPD leads to damaged airways in the lungs, causing them to become narrower and making it harder for air to get in and out of the lungs. In more severe cases, normal activities can become more difficult and anxiety levels may increase. "Chronic" means that the problem is long-term. We know that people with long-term conditions do not want to spend time in hospital unnecessarily, they want more control over decisions about their care and they want to live a normal life. [8]

Aim

We will achieve the following outcomes as part of the QIPP agenda:

- Use technology in the home, including care homes, to improve the quality of patient care;
- Design care around patients to reduce their time in hospital and support their early discharge;
- Improve the response and access to care and provide better out of hours support to our patients;
- Actively encourage patients to learn more about their disease and promote self-care; and
- Actively engage with patients about their own care and learn from their experience.

Methodology and current position

Patients with long term conditions are provided with a set top box which enables patients to receive and make video conferencing calls between their home and the Telehealth Hub situated at the Airedale General Hospital site. The Hub is a regional service supporting the use and deployment of telehealth. It operates on a 24/7 basis and allows both acute and planned consultations for a range of medical specialties, including patients with chronic obstructive pulmonary disease (COPD), heart failure and diabetes.

Funding was identified for a group of 40 patients with COPD and they were selected based on strict criteria on who would benefit from this approach. Since the opening of the telehealth hub in September 2011, the telemedicine team has performed telemedicine consultations providing clinical support to patients with COPD. It is estimated that this work has prevented ten unnecessary admissions and 23 visits from GPs thereby allowing clinical resources to be used in more effective ways.

A survey of patient satisfaction and clinicians' responses to this approach has been conducted.

"I'm now much more comfortable at home and generally less anxious. I now have peace of mind. If I get ill I will get a fast response from Airedale."

Pauline, 2011.

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[7] NHS Yorkshire and Humber (2009) *Quality, Innovation, Productivity and Prevention (QIPP) Strategy*
[8] Department of Health (2011) *Whole System Demonstrator Programme*

"The set top box helps my patients fit their appointments into their lifestyle. The care is arranged around them, no need for lots of travel, finding parking spaces or waiting in outpatients. We just call the patient and they receive care in their own living room at home."

Caroline Williams, Senior Sister, 2011

Initiatives and progress up to 2011/12

- Airedale NHS Foundation Trust is one of three regional partners from Yorkshire and Humber who provide both telehealth and telemedicine clinical response services to other trusts via the regional Telehealth Hub.
- Building work to create the Telehealth Hub commenced in 2011. Work was completed ahead of schedule and under budget in September 2011.
- We were awarded £1.5 million by the Technology Strategy Board to develop an affordable two way video technology for use in the home. Working with Red Embedded Systems, a technology partner based locally, patients are now able to have a remote video call over a simple broadband connection. This collaboration has led to a solution that patients find easy to use and enables the Hub to provide health information in the form of a video consultation.

- In 2010 Airedale NHS Foundation Trust successfully secured funding from the European Commission to participate in a three year project spanning four European countries. The RICHARD project - Research ICT based Clusters for Healthcare Applications Research and Development Integration – is currently undertaking research in telemedicine as a model for managing chronic disease. Working with the Advanced Digital Institute and the Collaboration for Leadership in Applied Health Research and Care, the focus is on the management of care for diabetes patients.

Initiatives in 2012/13 to achieve progress

- The Foundation Trust is working with a number of local nursing and residential homes to provide 24-hour access to specialist medical teams and remote treatment. Via the Telehealth Hub, residents or patients are offered immediate access to secondary care consultants, allowing them to receive routine or acute consultations. This also means that before any patient is transferred to hospital, the care staff can seek medical opinion. We are able to change and prescribe medication if required and we can review ongoing clinical observations. If patients need to come to hospital, we will communicate with the ambulance service to ensure they are admitted directly to the medical assessment unit. .

- Develop a locally determined measure of quality to ensure systems are accurate and the collection of information is consistent.
- Explore the qualitative aspects of this initiative to ensure that the issues that patients and carers have indicated matter most to them are captured.
- To continue our collaboration with industry, NHS colleagues, social care and professional partners as part of the Department of Health's *"Three Million Lives"* campaign.

"No more draughty trips in an ambulance to hospital anymore, I can stay at home and be looked after by the staff I know who get the specialist advice from the hospital."

Mary, 2011

Lead Executive Director
Bridget Fletcher, Chief Executive
Clinical and Implementation Leads
Dr. Richard Pope, Director Innovation, Research and Development
Caroline Williams, Telemedicine Manager

2.4 Quality of services provided

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

2.4.1 Review of services

During 2011/12 Airedale NHS Foundation Trust provided and sub-contracted 65 NHS services [as per Schedule 2 in Monitor's Terms of Authorisation].

Airedale NHS Foundation Trust has reviewed all the data available to them on the quality of care in 65 of these NHS services.

The income generated by the NHS services reviewed in 2011/12 represents 90.5 per cent of the total income generated from the provision of NHS services by Airedale NHS Foundation Trust for 2011/12.

2.4.2 Participation in clinical audits

Clinical audit measures the quality of care and services against agreed standards and recommends improvements where necessary.

During 2011/12, 42 national clinical audits and 3 national confidential enquiries covered NHS services that Airedale NHS Foundation Trust provides.

During 2011/12 Airedale NHS Foundation Trust participated in 79 per cent of national clinical audits and 100 per cent of national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Airedale NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

Table 2: National Clinical Audits

	Audit Title	*Applicable to ANHSFT*	*ANHSFT Participation*	*Per cent eligible patients submitted*
1	Elective surgery – hernia (National patient related outcome Measures [PROMS])	✓	✓	118
2	Elective surgery – knee replacement [PROMS]	✓	✓	115
3	Elective surgery – hip replacement [PROMS])	✓	✓	111
4	Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	105.4
5	Risk factors (National Health Promotion in Hospitals Audit)	✓	✓	100
6	Hip fracture (National Hip Fracture Database)	✓	✓	100
7	Ulcerative colitis and Crohn's disease (UK IBD Audit)	✓	✓	100
8	Pain management (College of Emergency Medicine)	✓	✓	100
9	Adult critical care (ICNARC CMPD)	✓	✓	100
10	Bedside transfusion (National Comparative Audit of Blood Transfusion)	✓	✓	100
11	Medical use of blood (National Comparative Audit of Blood Transfusion)	✓	✓	100
12	Adult asthma (British Thoracic Society)	✓	✓	100
13	Emergency use of oxygen (British Thoracic Society)	✓	✓	100

14	Perinatal mortality (MBRRACE-UK)	✓	✓	100
15	Care of dying in hospital (NCDAH)	✓	✓	100
16	Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	100
17	Seizure management (National Audit of Seizure Management)	✓	✓	100
18	Neonatal intensive and special care (NNAP)	✓	✓	100
19	Cardiac arrhythmia (Cardiac Rhythm Management Audit)	✓	✓	100
20	Parkinson's disease (National Parkinson's Audit)	✓	✓	100
21	Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓	✓	100
22	Potential donor audit (NHS Blood & Transplant)	✓	✓	100
23	Hip, knee and ankle replacements (National Joint Registry)	✓	✓	100
24	Acute stroke (SINAP)	✓	✓	100
25	Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	100
26	Diminished Conscious Level in Children (DeCon)	✓	✓	100
27	Nutrition Screening (BAPEN)	✓	✓	100
28	National Diabetes Inpatient Audit	✓	✓	100
29	Lung cancer (National Lung Cancer Audit)	✓	✓	94
30	Elective surgery – varicose veins [PROMS])	✓	✓	92
31	Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	✓	48
32	Severe trauma (Trauma Audit & Research Network)	✓	✓	35
33	Diabetes (National Adult Diabetes Audit)	✓	×	0
34	Heart failure (Heart Failure Audit)	✓	×	0
35	Intermediate Care	✓	✓	Underway
36	Pleural procedures (British Thoracic Society)	✓	*	
37	Non invasive ventilation -adults (British Thoracic Society)	✓	*	
38	Adult community acquired pneumonia (British Thoracic Society)	✓	*	
39	Paediatric asthma (British Thoracic Society)	✓	**	
40	Paediatric pneumonia (British Thoracic Society)	✓	*	
41	Cardiac arrest (National Cardiac Arrest Audit)	✓	*	
42	Severe sepsis and septic shock (College of Emergency Medicine)	✓	*	
43	Bronchiectasis (British Thoracic Society)	×	N/A	
44	CABG and valvular surgery (Adult cardiac surgery audit)	×	N/A	
45	Carotid interventions (Carotid Intervention Audit)	×	N/A	
46	Chronic pain (National Pain Audit)	×	N/A	
47	Coronary angioplasty (NICOR Adult cardiac interventions audit)	×	N/A	
48	Head and neck cancer (DAHNO)	×	N/A	
49	Intra-thoracic transplantation (NHSBT UK Transplant Registry)	×	N/A	
50	Liver transplantation (NHSBT UK Transplant Registry)	×	N/A	
51	Oesophago-gastric cancer (National O-G Cancer Audit)	×	N/A	
52	Paediatric cardiac surgery (NICOR Congenital Heart Disease Audit)	×	N/A	
53	Paediatric intensive care (PICANet)	×	N/A	
54	Peripheral vascular surgery (VSGBI Vascular Surgery Database)	×	N/A	
55	Prescribing in mental health services (POMH)	×	N/A	
56	Renal replacement therapy (Renal Registry)	×	N/A	
57	Renal transplantation (NHSBT UK Transplant Registry)	×	N/A	

58	Schizophrenia (National Schizophrenia Audit)	×	N/A

* Not adopted by the Foundation Trust during 2011/12
** Signed up to participate for 2012/13
To the best of our knowledge the participation rates given above are accurate [30th April 2012].

Explanation for variation from 100 per cent submission rate:
Nos 1, 2, 3, 4, 29, 30, and 31: published data is based on the "anticipated" number of patients.
No. 32: the Foundation Trust commenced participation from July 2011. Published data is from Jan-Dec 2011 and is based on the "anticipated" number of patients.
No. 33: ongoing difficulties with data extraction.
No. 34: the Foundation Trust commenced participation on 1st April 2012.

Table 3: National Confidential Enquiries

	NCEPOD Enquiries	*Applicable to ANHSFT*	*ANHSFT Participation*	*Per cent requested information submitted*
1	Cardiac arrest procedures	✓	✓	100
2	Peri-operative Care	✓	✓	100
3	Asthma deaths (NRAD)	✓	✓	Underway

The reports of 34 national clinical audits were reviewed by Airedale NHS Foundation Trust in 2011/12 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Dementia Care in General Hospitals
An action plan is underway. This includes the hospital-wide roll out of the "Butterfly Scheme" (*see section 3.1.1*), hospital-wide staff training in dementia and modifications to six inpatient wards to improve the therapeutic environment for these patients. Dementia care is an ongoing Foundation Trust priority.

National Care of the Dying
An end of life care plan has been developed and progress is being monitored by the End of Life Strategy Group. Actions include the production of mouth care guidelines and to seek the views of bereaved relatives regarding their experience of their loved-one's care on the Liverpool Care Pathway (end of life care).

Inpatient Diabetes
A "Think Glucose" action list has been produced. This includes the management of hypoglycaemia being targeted as a priority.

Nutrition Screening
Aspects of nutritional care training are already provided to nurses and include the use of the Malnutrition Universal Screening Tool (MUST). Nursing documentation is being amended to make recording nutritional risk clearer, based on food intake.

The National Hip Fracture Database
The patient pathway has been improved with the introduction of an ortho-geriatric service and multidisciplinary team meetings. A fractured neck of femur patient information booklet has been developed.

The reports of 176 local clinical audits were reviewed by Airedale NHS Foundation Trust in 2011/12 and Airedale NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Audit ID 2099: Stroke - Time of Admission to CT Scan and Aspirin Administration (Re-audit)
Conclusions: An overall improvement in service provision has been demonstrated compared with the results of the original audit.
The number of patients receiving a computerised tomography (CT) scan within 24 hours has improved from 88 to 94 per cent. The number of patients receiving aspirin within 24 hours has improved from 55 to 81 per cent. Stroke patients are now admitted directly to the Stroke Unit from A&E.
Actions: (1) To achieve 100 per cent CT scan and aspirin administration within 24 hours for all stroke patients. (2) To continue direct admissions to the Stroke Unit from A&E. (3) To re-audit in 12 months' time.

Audit ID 2071: Lymphoedema Service Patient Satisfaction Survey
Conclusions: Most patients are happy with the level of service received. However some concerns have been raised and these are addressed in the action plan.
Actions: (1) The appointment letter has been changed to include additional information. (2) Clinic waiting times will be audited to ensure that patients do not have to wait too long for their first appointment. (3) Discharge will be discussed at the earliest opportunity with patients and their relatives and will be included in the care plan.

Audit ID 1984: Annual Patient Consent Audit
Conclusions: The patient survey shows that 100 per cent of patients were “satisfied”; of those 93 per cent were “very satisfied” and 7 per cent “satisfied” with the support they received to enable them to make their decision to give consent. The same numbers felt very satisfied or satisfied with the overall consent process. The high satisfaction level of patients is reassuring. However, there is still work to be done especially with regard to consent training and the process for delegated consent assurance.
Actions: (1) Remind all staff of the importance of completing consent forms fully and of advising all patients regarding the risks and intended benefits. (2) Continue to provide supporting patient information for procedures. (3) Implement and monitor the uptake of consent training. (4) Implement and monitor the training of those to whom consent taking is delegated to ensure that all who take consent are appropriately trained to do so competently. (5) Re-audit in 12 month’s time.

2.4.3 Participation in clinical research

Clinical research and clinical trials are an everyday part of the NHS. The people who do research are mostly the same doctors and other health professionals who treat people. A clinical trial is a particular type of research that tests one treatment against another. Airedale NHS Foundation Trust is committed to research as a driver for improving the quality of care and patient experience. Research is a core part of the NHS, enabling it to improve the current and future health of the people it serves.

The number of patients receiving NHS services provided or sub-contracted by Airedale NHS Foundation Trust in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 1213.

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

Airedale NHS Foundation Trust was involved in conducting 136 clinical research studies across all specialties during 2011/12.

There were 59 clinical staff participating in research approved by a research ethics committee at Airedale NHS Foundation Trust during 2011/12. These staff participated in research across 14 different medical specialties. The Foundation Trust is committed to expanding research into new specialties to improve the quality of care for our patients.

As well, in the last three years, 19 publications have resulted from our involvement in National Institute for Health Research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

2.4.4 Goals agreed with commissioners

Commissioners are responsible for ensuring that adequate services are available for their local population by assessing needs and purchasing services. *High Quality Care for All (2008)* included a commitment to make a proportion of providers' income conditional on quality and innovation, through the Commissioning for Quality and Innovation (CQUIN) payment framework.

Use of Commissioning for Quality and Innovation (CQUINS) payment framework

A proportion of Airedale NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between Airedale NHS Foundation Trust, and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/12 and for the following 12 month period are available electronically at:
http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html

As part of the drive to improve quality, an amount of funding to be paid to the Foundation Trust during 2011/12 for the delivery of services to our patients was dependent upon achieving a range of quality markers. This scheme (CQUIN) linked £1,739,190 of our funding to the delivery of the agreed quality indicators. This is based on the indicative outturn value for 2011/12*

During 2011/12 Airedale NHS Foundation Trust delivered CQUINs to the value of £1,434,083 to the satisfaction of our commissioners.

*Final values are currently being agreed ahead of year end invoices being issued

2.4.5 What others say about the provider

The Care Quality Commission (CQC) is the independent regulator of health and social care in England. We are pleased to report that we have declared full compliance with all the regulations and that, presently, there are no conditions on our registration.

Statements from the Care Quality Commission

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

The Care Quality Commission has not taken enforcement action against Airedale NHS Foundation Trust during 2011/12.

Airedale NHS Foundation Trust is not subject to periodic reviews by the CQC.

Airedale NHS Foundation Trust has participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 1st April 2011 – March 31st 2012: responsive review into termination of pregnancy (TOP) services. The Trust was fully compliant. [All providers known to provide TOP services were subject to a responsive review in March 2012].

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

In October 2010 Airedale NHS Foundation Trust participated in a special review of support for families with disabled children. The review, published by the CQC on 22nd March 2012, presents the views and experiences of disabled children and their families. It includes survey data from commissioners and acute hospitals about services provided from September 2009 to September 2010. The report has been formally received into the organisation with recommendations currently under consideration.

In March 2012, a report was submitted to the CQC about the Safe and Secure Handling of Medicines at Airedale NHS Foundation Trust. The report was submitted as part of an initiative driven by the Department of Health to seek assurance from all hospitals regarding their compliance with national standards. It concluded there are overall sound systems in place for medicines management and it included a summary of the findings from recent audits as well as associated action plans.

2.4.6 Data quality

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

NHS Number and General Medical Practice Code Validity

Airedale NHS Foundation Trust submitted records during 2011/12 to the Secondary Uses service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data
– which included the patient's valid NHS number was:

99.79 per cent for admitted patient care
99.36 per cent for out patient care
99.08 per cent for accident and emergency care

– which included the patient's valid General Medical Practice Code was:

100 per cent for admitted patient care
100 per cent for out patient care
100 per cent for accident and emergency care

Information governance toolkit attainment levels

Airedale Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 76 per cent and was graded "satisfactory," demonstrating full Level 2 compliance.

The attainment levels assessed within the toolkit provides an overall measure of the quality data systems, standards and processes within an organisation.

Clinical Coding error rate

Airedale NHS Foundation Trust was subject to the Payment by Results clinical coding audit

during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding clinical coding were:

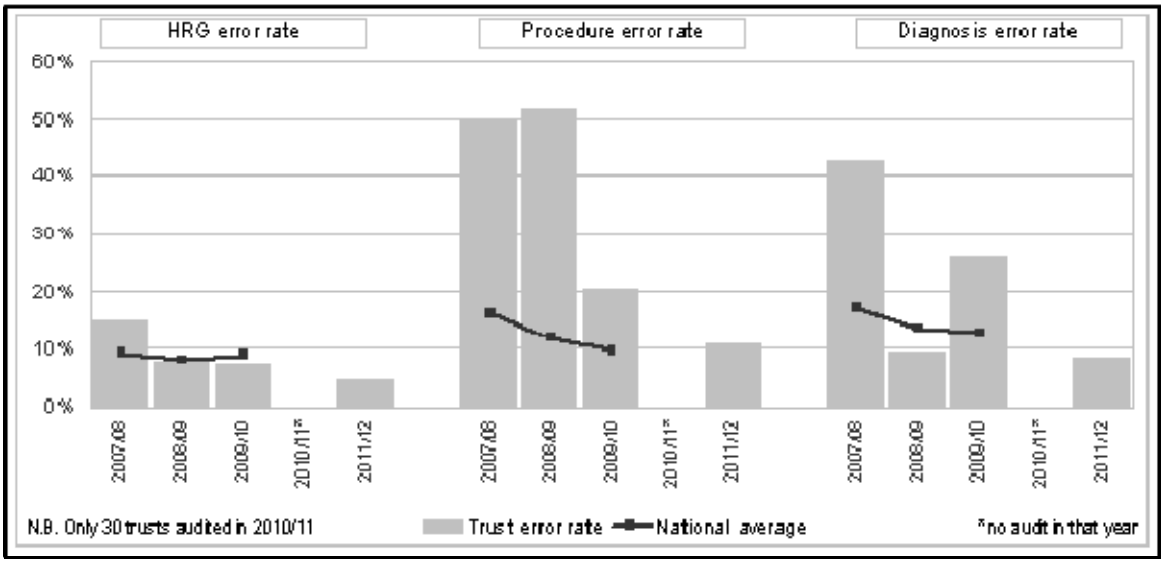
Primary Diagnoses Incorrect 11.0 per cent
Secondary Diagnoses Incorrect 5.7 per cent
Primary Procedures Incorrect 14.2 per cent
Secondary Procedures Incorrect 7.8 per cent

Statement on relevance of data quality and actions to improve data quality

Airedale NHS Foundation Trust will be taking a number of actions to improve data quality:

The graph below demonstrates the improvements in the clinical coding error rates since the last Payment by Results (PbR) clinical coding audit in 2009/10. (Airedale NHS Foundation Trust was not required to have a Payment by Results clinical coding audit in 2010/11 since the Trust was not amongst the 20 per cent worst performing trusts nationally). However, the Foundation Trust seeks to improve the quality of clinical coding year on year; during 2012/13 the Trust will specifically address the following recommendations from the PbR audit:

- Ensure that cardiac angiography reports are available at the time of coding and the contents are reflected in the clinical coding
- Ensure oesophagogastroduodenoscopy procedures with CLO tests are coded appropriately
- Ensure the presence of coronary stents or coronary angioplasty status are coded appropriately
- Ensure snare excision of lesion of colon in colonoscopy or sigmoidoscopy are coded appropriately



HRG stands for Healthcare Resources Group. This is a grouping system for describing similar types of patient diagnosis/procedures and is used for claiming payment from commissioners.

Other actions

Additionally, the Foundation Trust will seek to build on the actions from a clinical coding data quality review as part of a Safer Patient Pathway programme by:

- Increasing the identification and coding of mandatory co-morbidities;
- Increasing the clinical liaison and awareness of the national clinical coding best practice guidelines;
- Ensuring that all relevant data is available to the clinical coding team in a timely way; and
- Increasing the number of clinical coders who hold the recognised clinical coding qualification.

3 Review of quality performance

As well as the selected improvement projects detailed in Section 2, this report takes the opportunity to outline our other priority work in the three areas of patient experience, safety and clinical effectiveness. Metrics or measures are included with a selection of service specific and organisational indicators. Where possible, historical and benchmarking data is provided to enable greater understanding.

3.1 Patient experience

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

3.1.1 Improving nutritional care for patients with dementia

Lead Executive Director
Rob Dearden, Director of Nursing
Clinical Lead and Implementation Lead
Debra Fairley, Deputy Director of Nursing
Fiona Throp, Senior Nurse Older People
Jane McSharry, Senior Nurse Practice Development

Nearly 70,000 people in the UK suffer from dementia and the Alzheimer's Society predicts this figure will increase to 940,000 by 2021 due to the aging population[9]. Dementia can have serious affects on nutrition, malnutrition being a common factor in people with dementia (Watts et al 2007).[10] The refusal to eat, loss of appetite, forgetting to chew and swallow and being distracted are all frequently observed in patients with dementia. Through focusing on the quality of care for patients with dementia, the Foundation Trust seeks to ensure that nutritional needs are met.

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

- Highlight the special needs of patients whose memory is permanently affected by dementia by displaying (with appropriate consent) a butterfly symbol.
- Provide staff with simple, practical guidance towards meeting the needs of these patients - the REACH response: Remind, Explain, Arrange, Check, History.
- Alert staff to the use of carer information via the *All about* Me form which offers helpful information, enabling staff to better engage and creating a more positive experience for the patient. In completing the form, input from relatives and carers is encouraged to ensure a patient's care plan reflects preferences and dislikes, including food and drink. For example, if people prefer or find finger foods easier to eat, these can be provided from the catering department via the dietetic assistants. Finger foods can be helpful for people who do not want to sit down and eat.

The *All about Me* document can provide information that indirectly improves nutrition, hydration and the mealtime experience. One of our patients, who was at times distressed, enjoyed music. Her family were involved in her plan of care and music was put in her room which relaxed her enough to eat her meals.

Over the last year the Butterfly Scheme has been introduced and is currently operational on four wards with plans to implement further in the coming year. Training has been delivered locally with nurses and health care support workers (HCSW) seen as pivotal in ensuring other staff groups (phlebotomists, physiotherapists, doctors) understand the significance of the butterfly symbol and utilise the *All about Me* information. Guidance focuses on how to approach patients

[9] NHS Choices *(2011) A Behind the Headlines Special Report* p.4

[10] Watts, V.et al., (2007) *Feeding Problems in dementia* Geriatric Medicine 37:8 –pp.15-19

and carers to ascertain whether they wish to participate. Training has now been included within the Foundation Trust's privacy and dignity programme for both clinical and non-clinical staff.

To ensure this good practice is supported and built upon, the following have taken place over the last year:

- Action plans have been developed and implemented to improve the provision of nutrition for our older people in hospital with dementia based on the recommendations from the Health Service Ombudsman's *"Care and Compassion"* report, the National Dementia Strategy (2009), the Foundation Trust's ongoing annual Essence of Care benchmarking process on nutrition and feedback from the Patient Advice and Liaison Service, complaints, patients and carers.
- Participation in the *National Enhanced Dementia Audit* between May 2010 and March 2011 with key findings captured within a Dementia Strategy action plan.
- The establishment of an Operational Group for Vulnerable Adults with a work stream dedicated to enhancing standards of care for patients with dementia.
- A monthly audit of patients with dementia was undertaken to explore their care in detail and seek feedback from the next of kin.
- A Nutrition and Hydration multidisciplinary group has evolved from a Fluid Balance Working Group to govern clinical practice in all aspects of nutrition and hydration.
- Review of the Foundation Trust's patient mealtime policy.
- Daily reports to matrons of the number of patients who require assistance to eat via the green knife and fork symbol. This monitoring allows support staff, including "feeding buddies", to be assigned to those wards requiring greater support to help patients to eat and drink.

- Expansion of the "feeding buddy" system. In addition to an increased number of volunteers who are trained and assessed as competent to feed patients, non-nursing staff offer their time to help feed vulnerable patients in ward areas. We now have 18 volunteers and seven staff members who have undergone training and competency assessment to assist patients to eat and drink. This compares to nine volunteers and three staff members in 2010/11.

"I really enjoy helping on Ward 6 with the feeding at breakfast time, it's become part of my morning routine now. Its great to have found such a rewarding way of volunteering to do something – with a full time job its difficult to go and do voluntary work abroad (as my daughter is about to do at the end of the month), so this is a great and convenient alternative.
All the staff on Ward 6 are very helpful and pleasant, especially the hostesses, so it gives me a totally different start to the day."

Airedale Manager 2012

- In recognition that carers are key partners in the delivery of care, the Foundation Trust has worked with the voluntary organisation, carersresouce.org to provide information, advice and support to staff and carers on two of our four Butterfly Scheme Wards.
- In January 2011 the Foundation Trust supported the Patient Safety First's Nutrition and Hydration Week. Displays were organised to explain initiatives and members of the senior management team visited wards at lunchtime to observe practice.

It is important that we are able to monitor the effectiveness of these measures. In 2011/12, the Foundation Trust received five formal complaints raising concerns to do with nutrition. One of these concerned a patient with dementia. Actions arising from these were dealt with in accordance with our complaints processes in order to seek early resolution and ensure that lessons are learned.

As referenced earlier, the Foundation Trust was one of 100 hospitals inspected in 2011 by the CQC against the outcomes of respecting and involving people who use services and meeting nutritional needs. The Foundation Trust was amongst just 45 hospitals that were found to be fully compliant with both standards. The Butterfly Scheme and the monthly dementia audit were

highlighted as good practice in the inspection report.

I had an enquiry about the scheme from a hospital in New Zealand. So how did they hear about it? Because a member of [the New Zealand] staff's mother, who has dementia, was an inpatient at your hospital and the relatives were all really impressed with the way the scheme worked there!

I think you should pass this on to the team; it really does speak volumes for the care they provide. Fabulous!

Congratulations,

Barbara

Barbara Hodkinson, Founder and Coordinator of The Butterfly Scheme

3.1.2 Privacy and dignity

Lead Executive Director
Rob Dearden, Interim Director of Nursing
Clinical Lead and Implementation Lead
Debra Fairley, Deputy Director of Nursing
Noel McEvoy, Senior Nurse Safeguarding Adults,
Fiona Throp, Senior Nurse Older People

The Foundation Trust's Privacy and Dignity Policy, launched in June 2009, sets out clear standards to ensure that all patients are treated with privacy, dignity, fairness and respect. Implementation of this policy is well underway and led by the Foundation Trust's Senior Nurse for Older People. Privacy and dignity training commenced in 2010 and is included as part of the Foundation Trust's mandatory updates. The links between privacy and dignity and safeguarding continue to be developed with training including the assessment and planning of care for vulnerable adults. Staff evaluation of the training in 2011 has been largely positive:

"Very powerful video at the end – a good reminder to all."

"Promotes extra thought."

As previously described, our *Dignity Room* has been nationally recognised, but more importantly, it continues to support our most vulnerable patients, ensuring they are clothed and warm whilst in hospital and in readiness for discharge. The room contains a replenished stock of clothes, including footwear, and toiletries for patients. Some of the reasons for its use by staff include: house fires, soiled clothes, lost clothes, only night wear brought in, no family or family not close by and patients feeling cold on the ward. The supply of footwear supports patient safety, reducing the risk of a slip, trip or fall.

"I was recently a patient in Airedale Hospital. My admission was sudden and unexpected and as I am 84 years old and live alone, I was totally unprepared. Two weeks later I was transferred to [intermediate care] and was without suitable clothes. One of the nurses … recognised my problem and brought some clothes from your shop.
I would like to say thank you so much and ask that you accept this donation."

The use of technologies also enhances a patient's privacy and dignity during their care as well as improving access to services, addressing inequalities and delivering a better patient experience. Through the use of video-conferencing equipment we provide immediate access and support to prisons throughout England from our Accident and Emergency service. This work dovetails with national initiatives around preserving dignity and patient privacy; prisoners no longer have to

travel to local healthcare providers to receive care. Where consultations take place at local providers the prisoners are handcuffed and escorted by a guard at all times. Our service allows only themselves and a nurse to be present for the consultation and therefore preserves a prisoner's privacy and dignity.

"My first visit to hospital was in a high visibility boiler suit handcuffed to two guards. Everyone stared at me when I arrived and there was no privacy talking to the doctor. For the follow-up I was with the nurse in the Prison hospital and was able to talk directly to the doctor. It was much more private and I didn't have anyone staring at me.
Previously I have had to wait for care but the care received was great and fast."

Privacy and dignity standards are also evaluated using the *Essence of Care* benchmarks and the inpatient survey (see Table 4).

The metrics below have been selected in order to measure improvement in our patients' experience. We know that there is some work for us to do with regard to improving the quality of information that we provide for patients and their relatives, particularly around discharge planning. The metrics have been selected with this in mind.

Table 4: Patient experience performance against selected metrics	**2011/ 12**	**2010/ 11**	**2009/ 10**	**2008/ 09**
Did you feel you were treated with respect and dignity while you were in hospital?	**8.8**	**8.9**	**8.9**	**9.0**
Did you feel you were involved in decisions about your discharge from hospital?	**7.2**	**7.2**	**7.2**	**7.4**
Did hospital staff give your family or someone close to you all the information they needed?	**6.2**	**5.7**	**5.8**	**5.7**
Overall, how would you rate the care you received?	**7.9**	**7.9**	**8.0**	**8.2**

Data source: *Care Quality Commission (Quality Health), National NHS Inpatient Survey 2011. People are asked by the CQC about different aspects of their care and treatment. Based on these responses, trusts receive scores out of ten. A higher score is better.*
GREEN = best performing trusts
AMBER = trusts about the same
RED = worst performing trusts

The quality of the environment in which care is delivered links to the experience of the patient but also to safety, particularly in relation to healthcare acquired infections. In the annual NPSA's Patient Environment Action Team (PEAT) inspections in the non-clinical aspects of patient care, the Foundation Trust achieved the following:

Table 5: Patient environment action team inspections (PEAT)	**2012**	**2011**	**2010**	**2009**	**2008**
Environment	Good	Good	Good	Good	Good
Food (and Hydration)	Excellent	Excellent	Excellent	Excellent	Excellent
Privacy and Dignity	Good	Excellent	Good	Good	Good

The 2012 scores are unconfirmed; the validated data will be published by the **NPSA** in June/July 2012.
Figure parameters: *PEAT 2012 Scoring and Weighting System*

3.2 Patient safety

Together with the reduction of inpatient falls, infection prevention and the reduction in unavoidable pressure ulcers have been chosen as specific areas of focus for the Foundation Trust for 2011/12.

3.1.1 Infection prevention

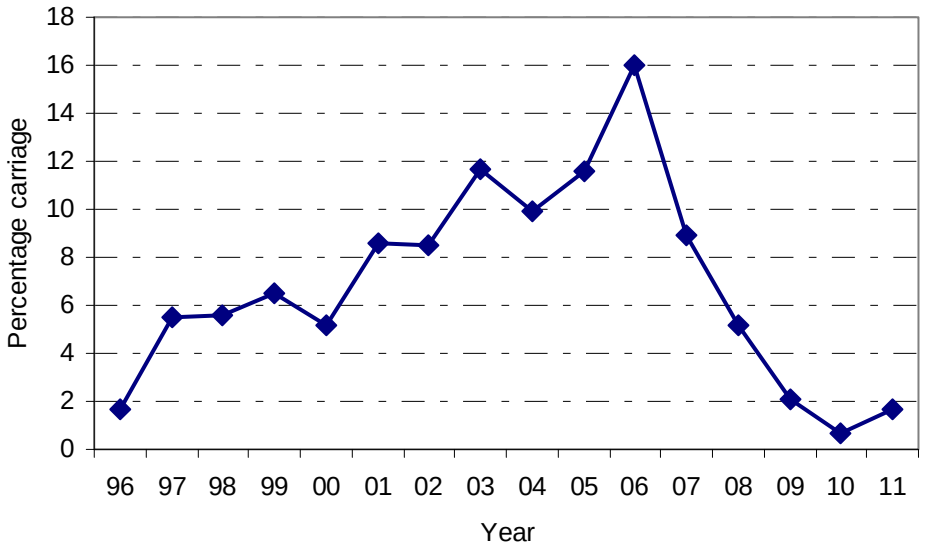
Lead Executive Director
Rob Dearden, Interim Director of Nursing
Clinical Lead and Implementation Lead
Debra Fairley, Deputy Director of Nursing
Allison Charlesworth, Matron Infection Prevention

Healthcare associated infections (HCAI) are a significant cause of poor patient experience; increased length of stay; and associated with increased use of antibiotics and analgesia. The risk of acquiring an infection whilst in our hospital remains low. In 2010/11 the Foundation Trust had its lowest levels of MRSA bacteraemia cases since 1996 whilst *Clostridium difficile* levels were the best since records began. Over the last year we have continued to build on this achievement with zero MRSA bacteraemia cases (see **Table 6).**

This year has seen both the introduction and strengthening of a series of measures designed to combat HCAI:

- The Interim Director of Nursing meets with the Matron for Infection Prevention and senior sisters/charge nurses twice a month to review individual ward plans with regard to the prevention of HCAIs.
- A root cause analysis was undertaken for all hospital acquired MRSA, MSSA and Ecoli bacteraemias and *Clostridium difficile* infections with learning points cascaded immediately to clinical teams.
- The MRSA prevalence survey carried out in December 2011 revealed that carriage rates remained at low levels.

Percentage of inpatients carrying MRSA



- Weekly executive hand hygiene walk rounds led by the Matron for Infection Prevention and the Clinical Director for Diagnostics continue to support the “bare below the elbows” and Hand Hygiene Guidelines.
- The monthly hand hygiene audit continues to report compliance at 90 per cent and above.
- Domestic Services undertake routine cleanliness audits; the enhanced cleanliness team maintain their excellent work.
- In accordance with Department of Health guidance, we now report diagnosed cases of Ecoli

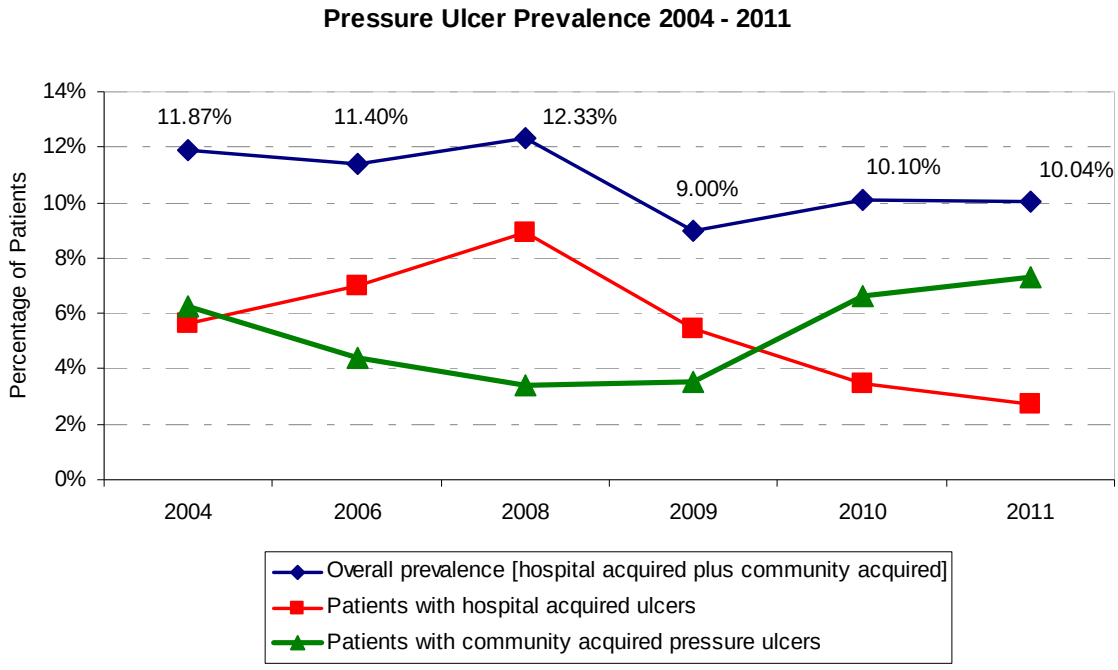
bloodstream infections to the Health Protection Agency.

- Our Consultant Microbiologist monitors hospital acquired pneumonia cases.
- In 2011/12 we participated in the *National One Week MRSA Prevalence Survey* and the *European Point Prevalence Survey on Health Care Associated Infections and Antimicrobial Use*.
- The infection prevention team has established links with community teams over the year.
- Infection prevention and control practice is closely monitored through 'spot' audits with immediate feedback to senior sisters/charge nurses followed by summary reports to be shared with teams.

3.1.2 Management of pressure area care

Lead Executive Director
Rob Dearden, Interim Director of Nursing
Clinical Lead and Implementation Lead
Debra Fairley, Deputy Director of Nursing
Janine Ashton, Tissue Viability Nurse

We understand that the prevention of hospital acquired pressure ulcers and improved treatment and management of acquired ulcers (both community and hospital) will help improve our patients' quality of life, reduce length of hospital stay as well as reduce the risk of associated complications such as infection, pain and disability. Improved nursing care and management of pressure ulcers have resulted in a reduction in the prevalence of hospital acquired pressure ulcers from 8.9 per cent reported in 2008 to 2.70 per cent in 2011.



Annual prevalence study was not undertaken in 2005 and 2007

At a national level, methodological differences in studies and differing patient populations restrict meaningful comparisons between healthcare providers. ArjoHuntleigh assist with annual prevalence audits across many hospitals in the UK, allowing it to compile the ArjoHuntleigh National Audit Database with a patient population of 26,083 nationally. It is unpublished data and does not provide a case mix adjustment and so cannot provide a true benchmark. However, due to the absence of any other available measure and the fact that our prevalence audit follows the same format, our results can be compared with ArjoHuntleigh's national prevalence.

ArjoHuntleigh's hospital acquired prevalence for 2008/09 (combined population of 52, 366) was reported as 6.18 per cent compared to Airedale's 4 per cent; please note both figures exclude category 1 pressure ulcers as this is excluded in ArjoHuntleigh's published data. Despite no new data being released from ArjoHuntleigh, the Foundation Trust's 2011 prevalence, excluding category 1 pressure ulcers, was 1.9 per cent; this is significantly less than the ArjoHuntleigh national figure.

The Foundation Trust's prevalence audit examines the provision of appropriate pressure area care equipment to prevent and manage pressure ulcers. In 2011, 98 per cent of the Foundation Trust's patients had their clinical needs met. Over the last year, the Foundation Trust has invested in a range of pressure relieving equipment, including mattresses, cushions and chairs. Further funding has been secured for foam mattress covers to replace damaged covers and extend the lifespan of the mattress.

Good nutrition is a key factor in the prevention of pressure ulcers. NICE guidance states that nutritional screening should take place within 24 hours of hospital admission. In January 2012, a range of activities to raise awareness were promoted during our Patient Safety First's Nutrition and Hydration Week, including displays publicising initiatives and improvements and the presence of our senior management team on the wards during meal times.

The ArjoHuntleigh eTRACE system is set up to send automatic email alerts to the Deputy Director of Nursing, the Assistant Director of Patient Safety, senior matrons, the Senior Nurse for Safeguarding Adults and the Tissue Viability Nurse following entry of a category pressure ulcer of a category 2 pressure ulcer or above. Since November 2010, all category 3 and 4 hospital acquired pressure ulcers have been reported as serious incidents, resulting in a root cause analysis with findings reported to the Board of Directors.

The following is a range of patient safety metrics previously reported in our Quality Account:

***Table 6:** Patient safety - performance against selected metrics*	2011/12	2010/11	2009/10	2008/09
# MRSA Bloodstream infection (number)	**0**	**3∗**	**6**	**12**
# Patients with C-Diff infection (number)	21	**16∗**	**27**	**67**
# Per cent of surgical cases with WHO checklist[11]	**100**	**100**	68	N/A
Central Venous Catheter line bacteraemia infections	**0.00**	**0.06**	**0.09**	**0.38**
Ventilator Associated Pneumonia (VAP) rate	0	0	0	0

Green	= year on year improvement
#	Denotes a CQUIN or commissioner interest.
∗	Hospital acquired as per amendments to national reporting.
N/A	Not applicable

[11] The World Health Organisation checklist is a tool for clinical teams to improve the safety of surgery by reducing deaths and complications.

Mortality rates 2010/11: source *Dr Foster Hospital Guide 2011*

There are many ways to measure mortality rates; the Dr Foster *2010-11 Hospital Guide* features four measures of mortality:

1. ***Hospital Standardised Mortality Ratio (HSMR)***: a measure of deaths while in hospital care based on 56 conditions which represent 80 per cent of deaths. Deaths only take place in hospital. The HSMR is a relative ratio comparing the organisation to an England average of 100. The green traffic light indicates that the HSMR is significantly better than the national average.
2. ***Summary Hospital-level Mortality Indicator (SHMI)*:** deaths following hospital treatment. Based on all conditions, deaths are measured which take place in or out of hospital for 30 days following discharge.
3. ***Deaths after surgery***: surgical patients who have died from a possible complication.
4. ***Deaths in low-risk conditions***: deaths from conditions where patients would normally survive.

The Foundation Trust's mortality rate in the context of wider organisational quality is assuring:

Airedale NHS Foundation Trust 2010/11

SHMI	HSMR	Deaths in low risk conditions*	Deaths after surgery
93	**84**	**0.64**	**68**

*Per 1,000 deaths
GREEN = lower than expected
BLUE = within expected

3.3 Clinical effectiveness

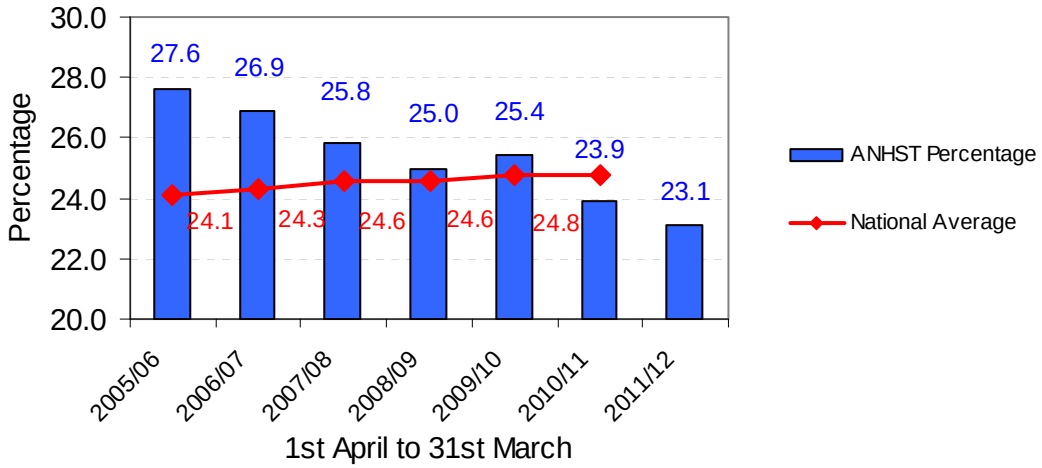
The following projects concentrate on clinical outcomes and the delivery of clinical excellence in care and treatment.

3.3.1 Management of the number of caesarean sections

Lead Executive Director
Dr. Andrew Catto, Medical Director
Clinical Lead and Implementation Lead
Mr Naren Samtaney, Clinical Director Obstetrics and Gynaecology

There are a number of risks associated with caesarean section, both for the mother and the baby and over the long- term. Work has continued within Maternity Services aimed at reducing the number of caesarean sections during 2011/12.

Caesarean section rate for Airedale NHS Foundation Trust against the national average



Data Source: Evolution Maternity System. National average data source: Health Episode Statistics (not available as yet for 2011/12).

Key performance indicators launched in 2010 continue to audit the quality of care provided throughout Maternity Services. Together with the normality guideline, escalation policy and communication framework, these initiatives actively involve staff in clinical decision making. The *Safety Briefing* continues to be used to ensure a safe and accountable transfer of information at staff changeover. Collectively these measures, alongside the maternity dashboard (described in the 2010/11 *Quality Account*) and the NPSA intrapartum scorecard, have allowed the service's key risks to be identified to aid and support decision making in the interests of patient safety.

All emergency caesarean operations are audited weekly by a multi-disciplinary team led by consultant obstetricians with feedback passed directly to clinicians. Audit results are displayed within clinical areas. The Innovation and Improvement Group, facilitated by a lead midwife for normality, is encouraging normal[12], active birth and raising awareness amongst all staff. This links with the recent collaboration with the Yorkshire and Humber Health Innovation and Education Cluster with focus on the use of admission cardiotocography for low risk women which, if used, may increase the risk of caesarean section by 20 per cent. [13]

[12] The World Health Organisation (1997) defines normal birth as spontaneous in onset, low risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 weeks of pregnancy. After birth, mother and infant are in good condition.

[13] National Collaborating Centre for Women's and Children's Health (2007) *Intrapartum Care of Healthy Women and their Babies During Childbirth*. London. RCOG Press

The philosophy of all our consultant led clinics is to promote Vaginal Birth After Caesarean Section (VBAC) whilst taking into consideration the new NICE guidelines. It is important that we understand which women are having caesarean sections. The Robson Criterion, a framework which allows us to divide women who gave birth into ten groups based on specific characteristics, is now being used to monitor the section rate on a monthly basis with information reported to the PCT and SHA. This allows us to analyse each of the ten groups to determine which group has a higher rate of caesarean section and allows us to focus our strategy.

3.3.2 Enhanced Recovery Programme

Lead Executive Director
Dr.Andrew Catto, Medical Director
Implementation Leads
Mr Alex Acornley, Consultant
Mr Basit Khan, Consultant
Mr Naren Samtaney, Clinical Director Obstetrics and Gynaecology
Denise Todd, Matron Surgical Services
Julie Livesey, General Manager, Surgical Services

Enhanced recovery is a new way of improving the experience and wellbeing of patients who need major surgery. Funded by the Department of Health and endorsed by the National Cancer Action Team, the principles of the Foundation Trust's Enhanced *Recovery* programme are to ensure that the patient is in the best possible condition prior to surgery, has the best management during the operation and the best post-operative rehabilitation. The Foundation Trust identified orthopaedics and colorectal as the first clinical specialties to implement the programme and has recently extended it to include gynaecology.

The pathway and rationale:

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

Over the last year in orthopaedics:

- An integrated pathway has been developed.
- Patient information booklets have been approved and are in use.
- A referral flowchart has been devised to facilitate discussion and agreement with local GP commissioners.

A Joint Replacement School is now operational two to three times monthly. This is multi-disciplinary in focus with patients receiving information required from the various disciplines.

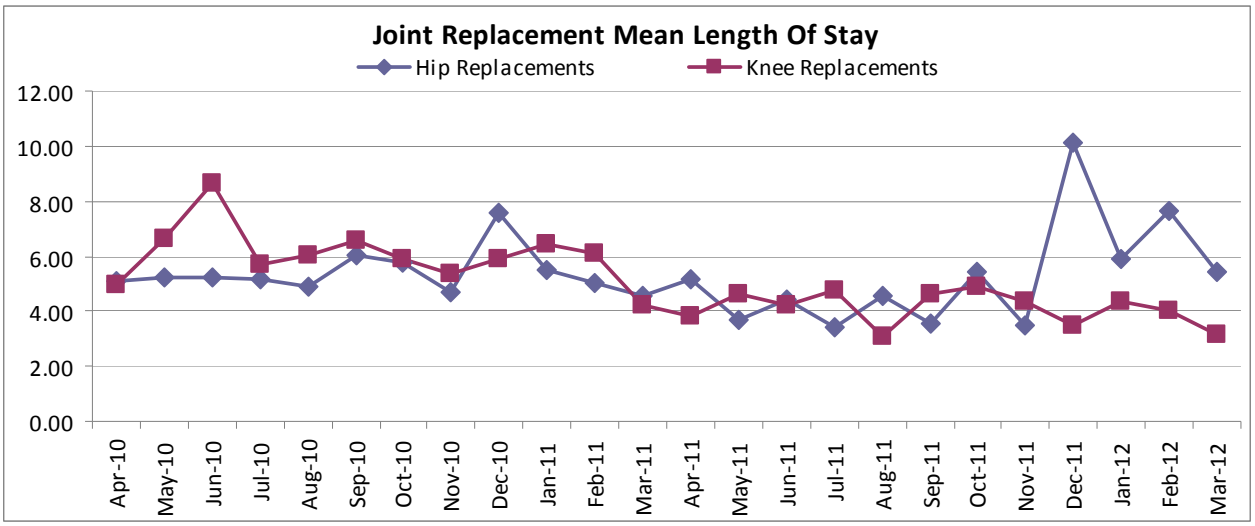
In the colorectal specialty, all patients are now entered onto the Enhanced Recovery Pathway. Initial problems with social service referrals have been resolved. Nutricia carbohydrate drinks are

made available as these are essential to the pre-operative preparation stages.

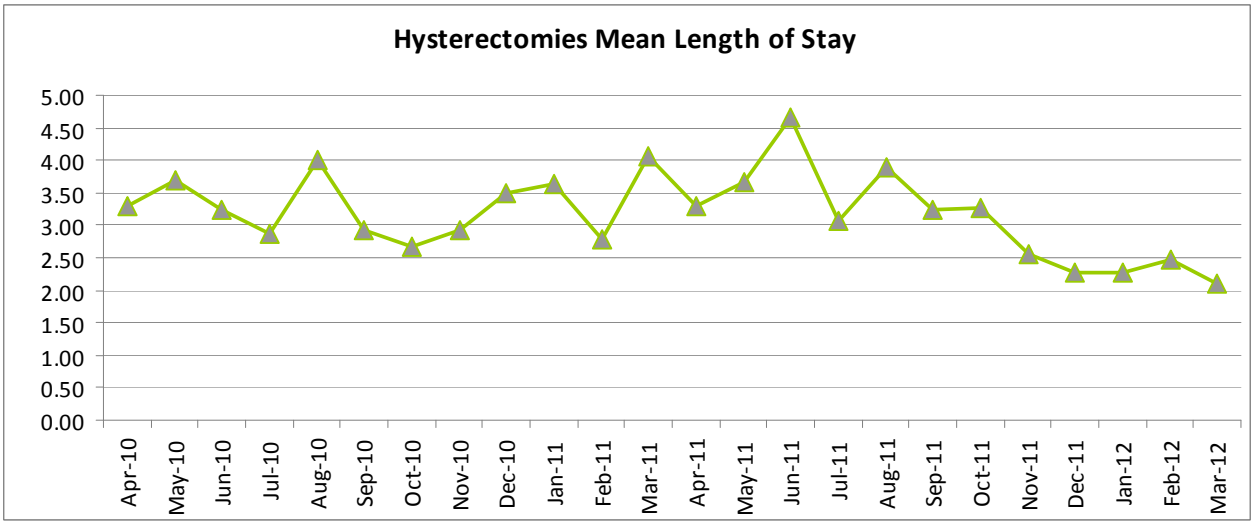
In gynaecology, patients are seen by a clinical nurse specialist to enable pre-admission education and provide information. More recently, the principles of this programme have been introduced within our urology services.

The programme continues to have an enthusiastic multi-disciplinary team approach and the Foundation Trust is working with the SHA and the Yorkshire Cancer Network to identify other specialties where it would be appropriate. When such a pathway is implemented, the reduced post-operative convalescence period and early achievement of functional milestones, leads to a shorter length of stay (LOS) in hospital patients.

Enhanced Recovery Programme mean length of stay for Airedale NHS Foundation Trust Patients since April 2010:



Please note that the spike in December 2011in the mean length of stay for hip replacement relates to one patient who had a protracted length of stay due to complications.



Please note that not all of March 2012 episodes are fully coded as yet.

3.3.3 Fractured neck of femur improvement project

Lead Executive Director
Dr.Andrew Catto, Medical Director
Implementation Lead
Ian Segovia, Orthopaedic Nurse Practitioner
Denise Todd, Matron Surgery
David Butterfield, Patient Service Manager
Julie Livesey, General Manager, Surgical Services

A broken hip, also known as a fractured neck of femur, is the most serious consequence of falls primarily affecting the elderly. The average age of a patient (in England in 2010/11) sustaining a hip fracture was 81 years old[14] and mortality is high. For those who recover, there is a possibility of a loss in mobility and independence and significant co-morbidities. Although hip fracture is affected by multiple factors, including age and underlying co-morbidities, studies have shown that organisational factors in a patient's treatment can affect outcomes.

The Foundation Trust's Orthopaedic Rapid Improvement Group continues to meet regularly to identify areas for improvement and positive outcomes for this group of patients. Over the last year this has included:

- The introduction of ortho-geriatric ward rounds - four times a week - to ensure all patients with a fracture neck of femur are reviewed within 72 hours.
- Having 'protected' beds on a dedicated ward.
- Developing a patient information booklet which has been adapted from the *Enhanced Recovery* project booklet.
- Quarterly submissions to the National Hip Fracture Database with a marked improvement in data quality submissions in the final two fiscal quarters.
- The appointment of a new orthopaedic nurse practitioner – which is a new developmental post.
- Agreement of a standard admissions pro forma.

One marker of the quality of care that patients receive is the total length of NHS care following a fractured neck of femur. This varies considerably from trust to trust, with the average length of stay (LOS) ranging from 17 to 40 days. [15] The figures below have been calculated using date of discharge.

	2011/12	2010/11	2009/10	2008/09
Fractured neck of femur mean length of stay	16.00[N]	19.38	23.28	19.31

[N] *Please note that not all of March 2012 episodes are fully coded as yet.*

[14] *NHS Choices*
[15] NHS Institute for Innovation Improvement *Delivery of Quality and Value: Fractured Neck of Femur*, p.4
[N] Please note that not all of March 2012 episodes are fully coded as yet.

Table 7: Clinical effectiveness - performance against selected metrics	2011/12	2010/11	2009/10	2008/09
28 Day Emergency Readmission Rate	5.7	6.1	6.0	6.5
# **Liverpool Care Pathway – end of life care**[16]	89.9%	N/A	N/A	N/A

# Denotes a CQUIN or commissioner interest. Please note metric measures may change year to year.
N/A Not applicable

3.4 Community services

This year has seen the implementation of the *Productive Community Services Programme* from the Institute for Innovation and Improvement. As with TCS, the ambition of this project is to use evidence based practice and put front line staff at the centre of the design and delivery of services. By increasing community staff understanding of how they are performing and giving them access to improvement tools and meaningful real-time information, the programme allows them to re-design working practices, reduce inefficiencies, and free up more time to spend with patients.

The 15-18 month programme has been designed so that front-line teams can implement the modules themselves. Modules, which are currently being worked through include: planning our workload, working better with key care partners, patient status at a glance and well organised working environment. Initial monitoring of the programme demonstrates the following outcomes:

- Driving distances reduced by 15 per cent;
- Number of visits a team is capable of, increased by 10 per cent;
- Time spent managing referrals down by 5 per cent;
- Stock reduced by 20 per cent [well organised environment];
- Time spent looking for stock items reduced by 50 per cent; and
- Handover time reduced by 50 per cent.

Monitoring of team morale has also commenced. This work is ongoing and the new ways of working that are created will need to be regularly revisited to ensure systems and measures are being maintained and the benefits realised.

3.5 Quality management systems

The Foundation Trust believes it is important that patients understand our commitment to quality improvement. We make every effort as an organisation to maintain and improve the quality of services we provide. These processes compliment patient experience, safety, and the effectiveness of care and treatment.

3.5.1 Workforce factors

A high quality workforce where staff and volunteers are engaged, trained and supported is key to the delivery of safe effective care and a positive patient experience. As part of the work to realise efficiencies, the Foundation Trust implemented a workforce reduction programme in 2011. At all times, our aim was to avoid compulsory redundancies and reductions in staff delivering face-to-face patient care. We understand that in the current climate staff are concerned about job security and this has the potential to affect staff morale and engagement. Over the last year, executive directors have worked with Human Resources and our staff side representatives to develop an engagement plan:

- *A **Skills for Great Line Management Programme*** commenced in November 2010 and involves supporting managers to gain the skills they need to manage effectively. This year has seen the programme re-invigorated with the opportunity of accreditation. A series of discussions on what consistently good line management looks like have taken place. This will help develop a standard of good people management and support the review of the

[16] The Liverpool Care Pathway (LCP) for the Dying Patient provides an evidence based framework for the delivery of appropriate care for dying patients and their relatives. The figure above is the rate of eligible adults who died on the LCP.

Foundation Trust's Appraisal Policy.

- The *2011 National NHS Staff Survey* reveals an increase in the percentage of staff reporting good communication between senior management and staff with a score from 19 per cent in 2010 to 27 per cent in 2011. (The national average for acute trusts is 26 per cent).
- We reported in last year's account on our progress in **Assessing the Quality of Medical Appraisal for Revalidation** (AQMAR). The AQMAR process has now been replaced by the Organisational Readiness Self Assessment (ORSA). The Foundation Trust has completed the ORSA submission; issues for development are in hand and an action plan has been developed.
- A **Medical Education Bulletin**, published quarterly, was introduced in 2011 to keep staff informed of the latest developments and highlight opportunities for continuing professional development.
- The *2011 National NHS Staff Survey* highlights issues around work pressure felt by staff. Key actions have been identified to deliver effective resourcing, including reviewing the appointment processes for consultants and locums. Quality management systems addressing productivity and efficiency (and including the "Time to Care" initiative highlighted by David Cameron) continue to be championed by the Airedale Service Improvement Team. These are described in sections 3.4 and 3.5.3.

- The *NHS Staff Survey 2011* revealed that some of our staff reported suffering from work related stress. The Foundation Trust is currently embedding a ***Staff Health and Wellbeing Strategy*****.** This work was commended following a report from the NHS Yorkshire and Humber Strategic Health Authority which showed Airedale was one of only three trusts in the region to receive all green ratings in relation to strategy measures. Wards and departments identified as stress 'hotspots' have been identified and work is ongoing to address issues with pleasing feedback. Some of the hotspot areas are now self-managing and have initiated their own processes for identifying and tackling any new pressures. The results of the *2011 NHS Staff Survey* will be used to identify new hotspots areas and to review the health and wellbeing action plan for the next year.

***Table 8:** Staff experience performance against selected metrics*	2011/12	2010/11	2009/10	2008/09	National Average 2011
Percentage of staff appraised in the last 12 months	**92**	89	89	84	81
Percentage of staff appraised with personal development plans in last 12 months	**76**	72	74	70	68
Percentage of staff suffering work related stress	**32**	31	29	32	29

Data Source: Care Quality Commission *National NHS Staff Survey 2011*
Key: **GREEN** – positive finding, better than average
RED – negative finding, worse than average

3.5.2 Information systems

We are committed to providing information to support patient choice, integrate care and the sharing of information between organisations, and to allow better use of aggregated information. These are some of the developments over the last year:

- Research shows that 80 per cent of patients actively seek information about their condition but often find the process of finding high quality information frustrating and time consuming. The Medical Education Team has recently launched a ***Health Information Service*** for patients, friends and family. We hope the service will support patients in being better informed and encourage active engagement in managing their condition. A dedicated 'pod' within the Information Centre provides users with a quiet area to view multi-media material, browse information online and read leaflets and books specific to their condition. Tailored information can also be sourced for the user and sent out by post or email.

- The ***Maternity Services Website*** was officially launched in November 2011. The website has been developed over 18 months in response to service users' comments and input. Our aim is for women that are booked to have their baby at Airedale, or those individuals who wish to find out more about our services, have access to up-to-date information relevant to their individual needs. As Airedale covers a large geographical area, local information for North Yorkshire, East Lancashire and West Yorkshire has also been incorporated.
- As we described in previous Accounts, a monthly audit of ***Nursing Key Performance Indicators*** across wards in the Foundation Trust has been ongoing since August 2007. This has demonstrated considerable improvements in the standard of nursing care and record keeping. This year has seen our community hospital at Castleberg implement the programme alongside maternity midwifery services both within hospital and in community. The Medical Directorate continues to implement its own version – ***Medical Key Performance Indicators*** – with obstetrics and gynaecology being the latest recruits.
- In 2009/10 we reported that a ***Nurse e- Handover*** system was being piloted. We can report that implementation is now complete. It is a secure, centralised system for nursing records that automatically transfers information as patients move between wards, avoiding the need for data re-entry.
- Building on the success of the maternity dashboard, ***quality and safety dashboards*** have been developed for medical and surgical services. A visual display of information allows performance to be tracked and identifies key risks to safeguard patient safety at a local level that can be communicated between clinical teams and the Board.

3.5.3 Aligning quality and business strategy: productivity and efficiency

As a Foundation Trust we are aware of the need to identify and prioritise activities which improve both quality and harness productivity. The LEAN philosophy of best practice, continuous improvement and the elimination of waste is promoted and led by our Airedale Service Improvement Team and is an effective means of delivering our QIPP strategy.

An extensive training programme means that we have the ability and capability to train our own staff in a continuous cycle of productivity and efficiency. We continue to champion the NHS Institute for Improvement and Innovation *Productive Series* - better care through focusing on efficiency - including: *The Productive Ward – Releasing Time to Care Programme*; *The Productive Theatre; The Productive Leader*; and *The Productive Community Services*.

The Productive Maternity Programme

Following the positive outcomes of *The Productive Ward*, this year has seen Maternity Services implement the *Productive Maternity Programme*. With its focus on re-design and streamlining the service, this is an opportunity to revitalise the workforce and increase our capacity to care for patients. Both hospital and community based services are participating in and working on structured methods designed to improve the environment and systems and processes. Our aim is to achieve significant and lasting improvements, predominately in the extra time that we can give to patients, as well as improving the quality and safety of care and seeking to eliminate inefficient work practices. Current areas of focus include: improving 'handover'; the management of blood results; reducing the time women wait for doctors; and computer discharging. The achievements have been recognised nationally with our Maternity Services being the only maternity unit to be shortlisted as a finalist in *"The Productive Series 2012 Awards".*

Health Service Journal Efficiency Awards 2011

An efficiency strategy from the therapy and dietetics teams was shortlisted in the first *Health Service Journal* Efficiency Awards, in September 2011. The project initially started out as part of the hospital's cost improvement programme with therapy and dietetics services looking at ways to reduce their costs without affecting their services to patients.

The project team needed a way to identify where services were being delivered inefficiently and where more capacity was required to cope with patients' needs so a "capacity calculator" was created. This allowed the services to gain an overview of which staff worked when and where and also what effect changes such as sickness or maternity leave would have for the remaining staff and patients. In addition, the team wanted to look at the balance of time staff spent between working with patients and undertaking administrative tasks.

"The final strategy helped to make sure there was a fair allocation of workloads across therapy and dietetics services as well as creating better planning and booking of patient appointments. We also now have a model which can be adopted by other teams at the hospital to ensure their services are efficient, workloads are fair and patients get the time they need for quality care."

Enid Feather, Head of Therapies, Airedale NHS Foundation Trust

Text messaging to remind patients of hospital appointments

We have introduced text messaging to remind patients of their appointments. More than 13,500 patients did not attend their hospital appointments last year – this is one in ten people who missed their consultation. This is costly, particularly as appointments could be offered to other patients. If a patient cannot attend an appointment and has forgotten to tell us, the text includes a phone number to call so that we may be able to offer the appointment to someone else.

3.5.4 Aligning quality and business strategy: innovation, learning and cost saving

We continue to develop innovative approaches which are efficient and sustainable whilst being supportive of the needs of our patients, particularly in the development and use of healthcare technologies. Dr Richard Pope, Director of Innovation, Research and Development and the lead consultant for Telemedicine, plays a vital role. Working closely with industry, education and health partners, he provides the clinical expertise to deliver these technologies effectively:

"By sharing my clinical experience with management and technical colleagues, I am able to influence the direction and scope of new products and services. These will improve the quality and efficiency of clinical care delivery, whilst also delivering important health and wellbeing support to all."

In 2010, we were among 18 teams across the health service to be awarded an annual Health Foundation Shine Award. The project - Blood Conservation for Primary Joint Replacement - focused on reducing the transfusion rate by half in at-risk patients through initiating earlier tests and, if necessary, treatment for anaemia. The overall aim was to demonstrate that quality can be improved at the same time as costs are reduced. Airedale featured in the final report published by the Health Foundation in December 2011. Our project was one of three considered the most successful. The report acknowledged that the experiences of the teams showed how difficult it is to accurately demonstrate savings. Quality improvements were considered less difficult to identify. This is a reflection of the challenge facing the NHS to demonstrate improvements in quality and transformation of care can equate to real savings. This is why accurate work on the benefits of telemedicine in quality and cost of provision is of such interest both locally and nationally.

3.6 National targets and regulatory requirements

The following indicators support the national priorities as set out in the Department of Health's Operating Framework 2011/12 and includes performance against relevant indicators and performance thresholds set out in Appendix B of Monitor's Compliance Framework.

	Target	2011/12	Target	2010/11	Target	2009/10
Clostridium difficile year on year reduction	18 [Standard national contract de minimis of 50 for the year]	21	83 [Standard national contract de minimis of 50 for the year]	**16**∗	108	**27**
MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	2 [Monitor de minimis of 6 for the year]	**0**	3 [Monitor de minimis of 6 for the year]	**3**∗	10	**6**
Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	93%Referral 93% Breast Symptomatic	**98.1%** Referral **98.9%** Breast Symptomatic	93%Referral 93% Breast Symptomatic	**95.9%** Referral **95.9%** Breast Symptomatic	93% Referral 93% Breast Symptomatic	**95.6%** Referral **97.0%** Breast Symptomatic
Maximum waiting time of 31 days from diagnosis to treatment for all cancers (first treatment – diagnosis treatment time to treatment).	96%	**100%**	96%	**99.2%**	96%	**98.1%**
Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments (subsequent treatments)	94% Surgery 98% Drug	**100%** Surgery **100%** Drug	94% Surgery 98% Drug	**98.5%** Surgery **100%** Drug	94% Surgery 98% Drug	**100%** Surgery **100%** Drug
Maximum waiting time of 62 days from all referrals to treatment for all cancers	85% Referrals 90% Screening	**91.3%** Referrals **95.9%** Screening	85% Referrals 90% Screening	**92.7%** Referrals **96.9%** Screening	85% Referrals 90% Screening	**92.0%** Referrals **90.1%** Screening
18-week maximum wait from point of referral to treatment (admitted patients)	90%	**93.4%**	90%	**91.9%**	90%	**92.9%**
18-week maximum wait from point of referral to treatment (non-admitted patients)	95%	**97.9%**	95%	**97.2%**	95%	**97.1%**
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	**97.7%**	98%	**98.4%**	98%	**98.3%**

∗ Hospital acquired as per amendment to national reporting.
GREEN = achievement against the target.

3.7 Local Involvement Networks (LINks)

The draft Quality Account was circulated to Bradford, North Yorkshire and Lancashire LINks and the following feedback was received in May 2012:

Statement by Bradford District LINk Care Quality Working Group (CQWG)

Bradford LINk thanks the Airedale NHS Foundation Trust **(**ANHSFT) staff for their helpfulness and readiness to discuss the management of quality. We would like to congratulate the Trust for the clarity of the report (clearly setting out their focus on the three domains of patient experience, patent safety and clinical effectiveness), for their detailed and careful analysis of issues, for their honesty in addressing areas of concerns and for their clear acknowledgement of specific areas for improvement.

We are pleased to see that the Chief Executive of the Trust emphasises the need to continue to provide care with compassion, dignity and respect.

The Trust is to be commended on its work to tackle dementia. We share the Trust's concern to find ways of keeping people comfortable in difficult circumstances and it is particularly important to help people to take their meals.

An example of the honesty of the presentation in this set of Quality Accounts is the manner in which statistics are presented on falls and trips even though these appear to reflect badly on the Trust. If resources permit, it might be useful to set out the age of patients who suffer falls or trips in future. The increase in the falls rate may be partly a result of the increasing age and/or frailty of patients. Even so, continuing efforts to minimise the numbers of falls, slips and trips is welcome – the Trust is to be commended in acknowledging that the increased rates recorded is worrying. Examples of steps taken and detail of the care in dealing with this would be useful in future.

We welcome the focus on providing good end-of-life care and the use of the Liverpool Care Pathway.

We also support the Trust's participation in clinical trials. It is important to learn from up-to-date research.

We urge that the ANHSFT continue their efforts to minimise waiting times and are glad to see that this features as an important issue in clinical trials with lymphoedema patients (page 30) and are concerned to see a small increase in numbers waiting longer that 4 hours in A&E.

As we have said previously we think that the way the Trust involves volunteers in surveying patients is excellent practice which other Trusts can learn from – it is important to ensure a degree of confidentiality and independence when gathering patient feed-back. The Dignity Room initiative is also very important.

We are interested in the trends revealed by some of the data published in this set of Quality Accounts and welcome further reflection in the hope of facilitating opportunities for further learning. For example, why had Airedale until recently exceeded national rates for Caesareans section (page 32) and why was there a recent increase in the length of stay for patients receiving knee replacements? Also, it would be useful if average mortality rates across the country could be quoted to allow comparison (page 31). We cannot be sure what is being conveyed in the data on clinical coding error rate – is this a measure of what turns out to be an error in the initial diagnosis or an error in recording what had been a correct diagnosis (page 22)?

It is good to see the section on page 7 explaining learning from untoward incidents. Similarly, we admire how the Trust sets out how they learn from patient feedback for example in the "your concern – our response" comments set out on page 6 where the way in which issues are going

to be addressed is spelt out. We would welcome consideration of how the response of patients who are too ill, too old or too vulnerable to give feedback by existing methods and have no visitors to speak up for them could be facilitated. Similarly we welcome the initiative to remind patents of appointments by mobile text messaging but would want to give some thought to how best to liaise with patients who are not regular users of the new technologies.

The section dealing with the enhanced recovery programme (Page 33 – 3.3.2) describes significant work. It is important to liaise with community services.

We have long been concerned with changes in nursing practice and we were interested to discuss the information provided on pressure ulcers. We recall that some years ago there was sufficiently nursing capacity available to implement a regime of regularly turning frail patents in order to minimise the development of ulcers. We welcome ANHSFT's efforts to reduce the incidence of pressure ulcers and urge a programme of education and supervision of nursing home practice in a drive to reduce the rate of community acquired pressure ulcers (page 29)

We are pleased to see the results of the Trust's work on reducing infection (page 28,30, 38) and urge continuing vigilance.

Lancashire LINk response to Airedale NHS Foundation Trust Quality Account:

Report presentation

Members commended the Trust on how well the report has been presented and the use of a glossary, making it easy to read and understand and an example for other Trust's to follow.

The use of written, statistical and pictorial information which avoided the need for long wordy paragraphs was also found to be a good way for the public to understand the information being presented as in section 3.1.1.

Including details and a photograph of the Chief Executive together with key members of staff leading on each priority was commented on as being positive information to include, demonstrating responsibilities clearly.

Report Content

Overall members thought the content provided a good picture of where improvements have been made in priority areas, where improvements can still be made and how the Trust intends to implement them. Good use has been made of external data and information to confirm findings for example in section 1.1 where the success of the 'Dignity Room' was highly commended in the 2011 Nursing Times Awards and section 2.4.3 highlighting that 19 publications have resulted from the Trusts involvement in National Institute for Health Research.

Examples of where members thought improvements could be made included information presented in graph form comparing information year on year. Some information given is in descending year order and other in ascending year order; it was felt that this should be provided in a consistent order to avoid confusion.

In section 3.1.1, table 4 provides information regarding patient experience performance against selected metrics but there is no explanation as to what the Essence of Care Benchmarks are and how the Trust is performing against these benchmarks. It would also have been useful to have an explanation as to why performance of 2 of the 4 metrics has reduced.

Members commended the introduction of the Telemedicine service which is seen as an invaluable service for patients who might otherwise find it difficult or distressing to visit the hospital and avoid unnecessary admission/readmissions.

Members also found the information given in 3.1.1 regarding care for patients with dementia particularly interesting and provides reassurance that the Trust is working hard to ensure that the

needs of patients with dementia are met.

Walter D Park MBE BA (Hons) PhD
Chair of Lancashire LINk

3.8 Overview and Scrutiny Committee (OSCs)

The draft Quality Account was circulated to the Health Overview and Scrutiny Committee (OSC) for Bradford Metropolitan District Council and the North Yorkshire Scrutiny of Health Committee; no feedback was received.

3.9 NHS Bradford, Airedale and Leeds (Primary Care Trust)

NHS Bradford and Airedale (part of the NHS Airedale, Bradford and Leeds cluster PCT) welcomes the opportunity to comment on Airedale NHS Foundation Trust's Quality Account for 2011/12, the third quality account since the national introduction of Quality Accounts.

As a commissioner of care services on behalf of the local population, we believe this Quality Account demonstrates a commitment to quality improvement and high quality services. The Operating Framework for the NHS in England describes quality as spanning three areas: safety, effectiveness and patient experience. This Quality Account provides an overview of these areas and overall is a fair reflection of the provider's achievement of quality of service delivery against the backdrop of a changing NHS.

Delivering care and treatment in an organisation with a wide range of complex services requires strong commitment to continuously monitoring and delivering high quality patient care. NHS Bradford and Airedale (NHSBA) is pleased to note early engagement with community, local Involvement networks and patient representatives in the development of this Quality Account. The inclusion of the youth panel will bring a different set of reflections and priorities for future accounts.

The Trust has continued to make significant progress over the past 12 months to improve the quality of patient care and services. These improvements have been particularly challenging for the Trust, whilst undergoing significant reorganisation of structures, capacity and services, particularly following the transfer of some community services into the organisation. In light of these challenges, we are especially pleased to note the following achievements:

- Airedale NHS Foundation Trust is registered with the Care Quality Commission and their registration status is fully compliant and no enforcement action has been taken by the CQC.
- It is particularly pleasing to note improvements to eliminate mixed sex accommodation to deliver increased privacy and dignity for patients.
- It is pleasing to note that the '*patient experience – seeking excellence in services'* survey uses quotes from patients to good effect within the report.
- The reporting of incidents is considered positive by NHSBA in that it is indication of an organisation's safety culture and this is actively encouraged.

- The potential improvements in patient experience and care following the development and implementation of the pioneering telemedicine service, being one of three regional partners delivering such a service in Yorkshire and Humber
- The Trust's work on improving dignity, respect and nutrition standards and CQC's recognition of the implementation of the 'butterfly' scheme.
- Work undertaken to enhance patient recovery following surgery.
- The Trust was shortlisted for their therapy and dietetics efficiency strategy in 2011.
- Work undertaken to reduce non attendance for hospital appointments.

The Trust has implemented the second year of Commissioning for Quality and Innovation (CQUIN) scheme with greater success in 2011/12. Achievement of venous thromboembolism (VTE) risk assessments is above national average, End of life care assessment and care provision has improved. However, it is disappointing to note that, despite additional funding, the Trust has not achieved full implementation and achievement across all of the 2011/12 CQUIN indicators.

In reviewing this Quality Account, NHSBA would recommend that further opportunities to enhance the quality of patient care and services should be considered within the Trust priorities:

- The Trust has demonstrated participation in national clinical audits and confidential enquiries. The commissioner understands that the Trust has participated in all but two of the eligible National Clinical Audit and Patient Outcomes Programme (NCAPOP). At the time of writing this statement, ANHSFT had not confirmed to the commissioner which of the audits relevant for inclusion in the Quality Account had been completed.
- The Trust acknowledges national patient and staff survey data however, not all data was available to the Trust at the time of developing the Quality Account. Acting on the findings of survey results to improve patient and staff experience is essential for continued delivery of quality. NHSBA would welcome inclusion of such in the 2012/13 Quality Account.
- Training, capability, deployment and skill mix of the workforce to deliver against the priorities outlined within the Quality Account could be incorporated and strengthened in future accounts and NHSBA anticipate such reporting to be realised throughout 2012/13 through the contract mechanisms.
- This Quality Account covers a broad number of areas with a lack of explicit information and improvement relating to complaints. However we are aware of work being undertaken by the Trust around themes and trends and work in progress on addressing these by specialities. Inclusion in future accounts would be welcomed. We understand that a web link will be provided in the final Quality Account that directs readers to a full and detailed report including learning from complaints. However, explicit reference providing some examples of learning within the body of the Quality Account would have been valued.
- Future quality accounts should reflect the Trust's on-going work and future aspirations in relation to Healthcare Associated Infections (HCAI), especially as the Trust has challenging targets for 2012/13. NHSBA would welcome more explicit reference as to how such challenges will be addressed in future Quality Accounts.
- Future accounts should reflect latest CQUIN position and provide links to the new scheme.

NHSBA acknowledge the continued prioritisation of investment that the Trust has made in its services over the last year and its continued intentions for quality improvements in 2012/13. It is clear that the Trust has many committed and enthusiastic staff members

who contribute to a positive experience for patients.

NHS Bradford and Airedale commends Airedale NHS Foundation Trust for its proactive approach towards providing high quality services for its patients.

Dr. Damian Riley
Medical Director, NHS Airedale, Bradford and Leeds
On behalf of NHS Airedale and Bradford

3.10 How to provide feedback on the Account

We welcome your views on our Quality Account, specifically:

- Where you think the biggest improvements on our quality priorities can be made?
- How to engage our stakeholders in our work to improve the quality of services?
- Do you have any comments or suggestions on the format of our Quality Account?
- Your suggestions for quality priorities in 2012/13?

The Annual report and Quality Account will be available on our website at:
www.airedale-trust.nhs.uk

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

Acknowledgements to: *Caroline Booton, Clinical Governance Facilitator and Analyst, Alison Fuller, Assistant Director Healthcare Governance, Debra Fairley, Deputy Director of Nursing, Karen Dunwoodie, Patient Experience Lead, Hannah Crossley, Planning Performance and Contracting Manager and Ben Jackson, Information Lead.*

3.11 Statement of directors' responsibilities in respect of the Quality Report

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

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

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

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011-12;
- the content of the Quality Report is not inconsistent with internal and external sources of information including;
  - Board minutes and papers for the period April 2011 to May 2012;
  - Papers relating to quality reported to the Board over the period April 2011 to May 2012;
  - Feedback from NHS Bradford and Airedale, as lead commissioner, dated 24/05/12;
  - Feedback from Governors, dated 10/04/12;
  - Feedback from Lancashire LINk, dated 18/05/12;
  - Feedback from Bradford and District LINk Care Quality Working Group, dated 21/05/12;
  - The Trusts draft 2011/12 complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 21/05/12;
  - The 2011 national patient survey, dated 24/04/12;
  - The 2011 national staff survey, dated 20/03/12;
  - The Head of Internal Audits annual opinion over the trust's control environment, dated 31/03/12; and
  - Care Quality Commission quality and risk profiles, April 2012**.**
- the Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information reported in the Quality Report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report and these controls are subject to review to confirm that they are working effectively in practice; and
- the data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) (published at www.monitornhsft.gov.uk/annualreportingmanual as well as the standards to support data quality for the preparation of the Quality Report (available at www.monitornhsft.gov.uk/annualreportingmanual)).

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

By order of the Board.

Colin Millar
Chairman
28 May 2012

Bridget Fletcher
Chief Executive
28 May 2012

Independent Auditor's Report to the Council of Governors of Airedale NHS Foundation Trust on the Annual Quality Report

I have been engaged by the Council of Governors of Airedale NHS Foundation Trust to perform an independent assurance engagement in respect of Airedale NHS Foundation Trust's Quality Report for the year ended 31 March 2012 (the "Quality Report") and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2012 subject to limited assurance consist of the national priority indicators as mandated by Monitor:

- MRSA; and
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

I refer to these national priority indicators collectively as the "indicators".

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

My responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to my attention that causes me to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Detailed Guidance for External Assurance on Quality Reports.

I read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and considered the implications for my report if I became aware of any material omissions.

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

- Board minutes for the period April 2011 to May 2012;
- Papers relating to quality reported to the Board over the period April 2011 to May 2012;
- Feedback from NHS Bradford and Airedale, as lead commissioner dated 24/5/12 May 2012;
- Feedback from Governors dated 10/4/12;
- Feedback from Lancashire LINk dated 18/5/12;
- Feedback from Bradford and District LINk Care Quality Working Group dated 21/5/12;

- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 – May 2012 (draft version);
- The 2011 national patient survey;
- The 2011 national staff survey;
- Care Quality Commission quality and risk profiles April 2012; and
- The Head of Internal Audit's annual opinion over the trust's control environment for the year ended 31 March 2012.

I consider the implications for my report if I become aware of any apparent misstatements or material inconsistencies with those documents (collectively the "documents"). My responsibilities do not extend to any other information.

I am in compliance with the applicable independence and competency requirements of the Chartered Institute of Public Finance and Accountancy (CIPFA) Standard of Professional Practice and Ethics. My team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Airedale NHS Foundation Trust as a body, to assist the Council of Governors in reporting Airedale NHS Foundation Trust's quality agenda, performance and activities. I permit the disclosure of this report within the Annual Report for the year ended 31 March 2012, to enable the Council of Governors to demonstrate that it has discharged its governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Council of Governors as a body and Airedale NHS Foundation Trust for my work or this report save where terms are expressly agreed and with my prior consent in writing.

Assurance work performed

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

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- Testing key management controls;
- Analytical procedures;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the *NHS Foundation Trust Annual Reporting Manual* to the categories reported in the Quality Report; and
- Reading the documents listed under respective responsibilities of the Directors and auditors.

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

Limitations

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

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

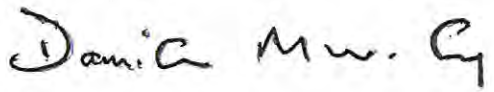
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

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

Conclusion

Based on the results of my procedures, nothing has come to my attention that causes me to believe that, for the year ended 31 March 2012:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual*;
- the Quality Report is not consistent in all material respects with the sources specified in section 2.1 of Monitor's Detailed Guidance for External Assurance on Quality Reports 2011-12; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the *NHS Foundation Trust Annual Reporting Manual* and the six dimensions of data quality set out in the *Detailed Guidance for External Assurance on Quality Reports*.



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30 May 2012

Damian Murray

Engagement Lead (Officer of the Audit Commission)

3 Leeds City Office Park, Holbeck, Leeds, West Yorkshire, LS11 5BD

DIRECTORS' REPORT

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;
- Note advice from, and consider the views of, the Council of Governors;
- Set the strategic direction and leadership of the Foundation Trust;
- Ensure the Terms of Authorisation are complied with;
- Set organisational and operational targets;
- Assess, manage and minimise risk;
- Assess achievement against the above objectives;
- Ensure that action is taken to eliminate or minimise, as appropriate, adverse deviations from objectives; and
- Ensure that the highest standards of corporate governance are applied throughout the organisation.

The full Board of Directors has met formally with the Council of Governors during the year, to seek and consider the views of the Governors in considering the Foundation Trust's Annual Plan for the coming year. As this was Airedale's first full year as a Foundation Trust, the emphasis was placed on ensuring Governors engaged fully in planning for the 2012/13 Annual Plan. Regular meetings are held with Governors, attended by Directors, in which specific topics chosen by Governors are discussed. The single Chairman of both the Board of Directors and the Council of Governors ensures synergy between the two Boards through regular meetings and updates.

In addition, Governors and Directors, including the Chairman attend members' events that are held regularly at the hospital on subjects requested by members. Past topics have focused on diabetes, cancer and organ donation and transplantation.

The Chairman has also held a series of 'Meet the Chairman' events throughout the year. These give Governors and Directors the opportunity to network with both public and staff members of the Foundation Trust. Topics covered have included hospital food, CT and MRI scanning and the Foundation Trust's plans for the future.

The Directors (both Executive and Non Executive) meet regularly with Governors during their day to day working through meetings, network sessions, Chairman's briefings, consultations and information sessions. Examples include participation in Foundation Trust working groups, and consultations about the Annual Plan and Quality Account. The Foundation Trust has also established a buddying system in which each of the Executive and Non Executive Directors meet informally with a number of Governors to provide briefings and up to date information about the Foundation Trust.

The Board is made up of five Executive Directors and six Non Executive Directors including the Chairman. It also has two Associate Directors – the Director of Organisational Development and Workforce and the Director of Operations.

Responsibility for the appointment of the Chairman and Non Executive Directors resides with the Council of Governors. The Appointments and Remuneration Committee, which comprises four members of the Council and two Non Executive Directors plus the Chairman, is responsible for bringing recommendations to the Council. The Committee may have an independent assessor in attendance if appropriate.

Executive Directors are appointed by the Non Executive Directors and the Board Appointments Committee has delegated responsibility for bringing recommendations to the Board. The composition of the Board for the year of the report is set out on the following pages, which also includes details of background, committee membership and attendance at meetings. The Board may delegate any of its powers to a Committee of Directors or to an Executive Director and these matters are set out in the Scheme of Decisions reserved to the Board and the Scheme of Delegation. Decision making for the operational running of the Foundation Trust is delegated to the Executive Directors Group, which comprises all of the Executive

Directors, Associate Directors and the Company Secretary.

The Board has an annual schedule of business which ensures it focuses on its responsibilities and the long-term strategic direction of the Foundation Trust. It meets monthly to conduct its business and Board members also attend seminars and training events throughout the year.

As the hospital reached the end of its first year as a Foundation Trust, the Board held a rigorous evaluation of its own performance and individual Directors, which is key to ensuring the Foundation Trust's sustainable success. The evaluation was undertaken by an external company in partnership with the Audit Commission and presented to the Board. The outcome of the evaluation exercise was incorporated into a programme of reforms implemented during the year. Individual Directors have also had detailed appraisals of their roles and an annual appraisal process is in place with regular reviews of objectives set by the Chief Executive. A baseline assessment of skills, experience and competencies of all Board members was also carried out to help inform an on-going development programme.

The Chairman appraises the performance of the Non Executives and makes recommendations to the Council of Governors, while the Senior Independent Director leads the Chairman's appraisal and makes a recommendation to the Council of Governors. An annual appraisal process is in place and Non Executive Directors are involved in regular development activities including Board workshops, and attendance at seminars and conferences. We consider we have the appropriate balance and completeness in the Board's membership to meet the ongoing requirements of an NHS Foundation Trust.

The Board of Directors who served during the year comprised the following Executive and Non Executive Directors:

NON EXECUTIVE DIRECTORS

The Council of Governors is responsible for appointing the Chairman and Non Executive Directors of the Foundation Trust.

Disclosures of the remuneration paid to the Chairman, Non Executive Directors and senior managers are given in the Remuneration Report on page 77.

Colin Millar, Chairman
Colin was appointed Chairman in December 2005 and is currently serving a second term of four years, which will expire in November 2013. His early career was in marketing with an international consumer goods company, principally in the UK but also in Japan and East Africa. Subsequently he held senior marketing appointments in the financial services sector. Latterly, he owned and ran a market research company supplying information to companies and trade organisations throughout the world. He is Non Executive Director of a regional building society and a Trustee of a hospice in Leeds. He has held a number of voluntary appointments in education and social housing.

Alan Sutton, Non Executive Director and Deputy Chairman
Alan was appointed a Non Executive Director in September 2002. Alan is currently a part-time University Examiner and Lay Chairman for Leeds University Medical Deanery. Alan was previously employed as Assistant Principal of Bradford College and has experience of strategic planning and capital investment. Alan is currently serving his last term of office as Non Executive Director, and will retire from the Foundation Trust on 31 May 2012.

David Adam, Non Executive Director
David was appointed a Non Executive Director in February 2007. His current term of office is due to end in January 2014. David is a chartered accountant with almost 40 years financial management experience, including 13 years as a PLC Finance Director with two publicly listed companies. He previously worked as Finance Director in a number of large UK plc subsidiaries and has also held the post of Chief Executive of a large educational supply company. He has also held Non Executive Director roles in three UK companies as well as being a Pension Fund Trustee for over 20 years.

Ronald Drake, Non Executive Director
Ronald was appointed a Non Executive Director in February 2007 and is serving his

second term of office, which is due to end in January 2014. Ronald has many years of qualified experience since being admitted to the Roll in 1978 and is a Partner of a national legal practice. He has also been a part-time employment tribunal Judge since 1977.

Sally Houghton, Non Executive Director
Sally was appointed a Non Executive Director in February 2006 and is currently serving a third term, which is due to end in 2013. Sally is a qualified accountant and has over twenty years experience in multi-national manufacturing and engineering companies, some of which was at Finance Director level.

Jeff Colclough, Non Executive Director
Jeff was appointed a Non Executive Director in February 2006 and is currently serving a third term, which is due to end in 2013. Jeff has over 25 years DTI experience both in the UK and overseas and was Chief Executive of Business Link for seven years. He operates his own business and management consultancy firm and is previous Chair of Yorkshire Forward Regional ICT Business Group for Digital 20/20

The Board considers that all the Non Executive Directors are independent.

EXECUTIVE DIRECTORS

Bridget Fletcher, Chief Executive
Bridget was appointed Chief Executive in November 2010, having previously been Chief Operating Officer/Chief Nurse. She joined the Trust as Director of Nursing in 2005. Prior to this she held various senior management roles in other NHS Trusts and was responsible for acute health services and professional nursing services

Rob Dearden, Interim Director of Nursing
Rob joined Airedale NHS Foundation Trust on secondment in August 2011. Prior to this, he was Deputy Director of Nursing at Calderdale and Huddersfield NHS Foundation Trust (CHFT). He qualified as a Registered General Nurse in 1987 at Manchester Royal Infirmary and then as a Registered Mental Nurse at Wigan Infirmary in 1990. He later specialised in Care of Older People and Rehabilitation Medicine in Manchester, Wirral and Halifax. Rob has a significant background in Practice Development and is an Associate of The University of Leeds.

Sheenagh Powell, Director of Finance
Sheenagh joined Airedale as Director of Finance in February 2010 from NHS Doncaster where she recently held the post of Director of Finance. Her portfolio includes planning, performance and IT as well as estates and procurement. Prior to 2006, Sheenagh held the role of Director of Finance to four PCT Boards including NHS Doncaster, Craven, Harrogate and Rural District PCT. She was also a member of the Department of Health Contractor Stakeholders Performance Group.

Dr Andrew Catto, Medical Director
Andrew was appointed Medical Director on 1 August 2009, having previously been Assistant Medical Director and Commissioning Director with the Trust. Between 2005 and 2009 he was Head of the Bachelor of Medicine and Surgery degrees at the University of Leeds. He joined Airedale in 2005 having been involved in clinical research since 1993 and a Senior Lecturer in Medicine between 2000 and 2005.

Ann Wagner, Director of Strategy and Business Development
Ann joined Airedale in September 2006 as Director of Corporate Development, since when her portfolio has developed and now encompasses business development including responsibility for the Telehealth Hub. Her previous experience includes holding a number of Executive Director roles at the Strategic Health Authority where she was responsible for service improvement and performance development. Ann was the Executive Director Lead with responsibility for Airedale achieving Foundation Trust status in June 2010.

REGISTER OF INTERESTS

A register of interests for all members of the Board of Directors is held within the Trust and is continually updated. There are no company Directorships or other significant interests held by Directors that are considered to conflict with their management responsibilities. The Register of Interests is available on request from the Company Secretary.

STATEMENT ON GOING CONCERN

After making enquiries, the Directors have a reasonable expectation that the Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Bridget Fletcher
Chief Executive

28 May 2012

BOARD OF DIRECTORS - MEETINGS

Attendance at meetings 2011/12

Members	Board of Directors	Finance Committee	Audit Committee	Remuneration Committee	QSAC
Colin Millar	11/11	4/4		2/2	5/6
David Adam	11/11	4/4	5/5	1/1	
Jeff Colclough	11/11	4/4	5/5	2/2	
Ron Drake	10/11	2/4		2/2	6/6
Sally Houghton	11/11	4/4	5/5		
Alan Sutton	9/11	2/4		1/1	4/6
Bridget Fletcher	10/11	4/4			
Andrew Catto	10/11	3/4			3/6
Rob Dearden (from September 2011)	6/6	1/2			3/4
Debra Fairley (up to May 2011)	2/2	1/1			1/1
Sheenagh Powell	11/11	4/4	4/5		
Ann Wagner	10/11	2/4			

COUNCIL OF GOVERNORS

The Council of Governors consists of 36 Governors – the majority, elected – who play a vital role in the governance of the Foundation Trust, working closely with the Board of Directors. They represent the interests of the Foundation Trust's public and staff constituencies as well as its members and partner organisations in the local community including healthcare, universities, voluntary organisations and local authorities under the terms of the Foundation Trust's Constitution. The Council has a number of statutory duties as defined in the Constitution which include:

- The appointment (or removal) of the Chairman and Non Executive Directors of the Foundation Trust and approval of the appointment of the Chief Executive;
- Deciding on the pay and allowances, and other terms and conditions of office, of the Chairman and Non Executive Directors;
- Appointing the Foundation Trust's auditors;
- 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.

The Council also holds to account the Board of Directors for its management of the organisation and we value the contribution our Governors make and the different perspectives they bring to the development of services. We have 26 Governors elected by our members (including staff members) through a secret ballot who represent the following constituencies (groups):

- **Bradford Metropolitan District Council (five Governors)**
- **Craven District Council (five Governors)**
- **Pendle Borough Council (five Governors)**
- **Leeds City Council (one Governor)**
- **Rest of England (one Governor)**
- **Staff and Volunteers (six Governors)**

Of the remaining 10 nominated Governors, these represent the interests of partner organisations in the local community including healthcare, universities, voluntary organisations and local authorities. Two of the Governor seats, allocated for NHS East Lancashire and a business representative, are currently vacant.

A ballot was held during 2011 for the appointment of a Lead Governor. Mr Adrian Mornin, one of the Governors for Keighley Central, was duly elected as Lead Governor. Mr John Roberts, Governor for Worth Valley was subsequently elected as Deputy Lead Governor following a separate election process.

A joint meeting with the Board of Directors is held twice yearly to review progress on the Foundation Trust's Annual Plan and to consider priorities for the forthcoming year. During our first full year as a Foundation Trust, our Governors have become fully engaged in different activities and working groups and familiarised themselves with the complexities of such a large organisation.

In consultation with the Council of Governors, the Board re-appointed Non Executive Director, Mr David Adam, as the Senior Independent Director. Mr Adam is available to Governors if they have concerns, which contact through the normal channels of Chairman, Chief Executive or Director of Finance have failed to resolve or for which contact is inappropriate.

Governors from the public and staff constituencies were elected to office for one, two or three years (determined by numbers of votes polled in the inaugural 2010 election, with the three-year tenure going to individuals receiving the most votes until all three-year tenure seats are filled) and 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 2011/12 is shown below.

COUNCIL OF GOVERNORS MEETINGS

Attendance at Council of Governors meetings 2011/12

Governors	Tenure	Constituency	Meetings attended
Elected Governors			
Janet Ackroyd	3 years from June 2011	South Craven	1/3
Peter Allen	3 years from June 2010	Skipton	4/4
Peter Beaumont	3 years from June 2010	Wharfedale	3/4
Neil Boyle	Not re-elected in May 2011	South Craven	1/1
Andrew Brocklehurst	3 years from June 2011	Settle and Mid Craven	3/3
David Child[1]	1 year from June 2011	Bingley	3/3
Terry Gudgeon	Resigned May 2011	Lower Wharfe Valley	0/1
Mark Haw-Wells	Resigned May 2011	Bingley	0/0
Jean Hepworth	3 years from June 2011	Keighley East	3/3
Valerie Kimberley	3 years from June 2011	West Craven	3/3
Anne Medley	3 years from June 2011	Keighley West	4/4
Adrian Mornin	2 years from June 2010	Keighley Central	3/4
Mohammed Nazam	3 years from June 2011	Keighley Central	2/4
Chris Nolan	2 years from June 2010	West Craven	3/4
John Osborn	3 years from June 2010	Rest of England	2/4
Sheila Paget	3 years from June 2010	Ilkley	3/4
Barbara Pavilionis	2 years from June 2010	Skipton	3/4
Alan Pick	2 years from June 2010	South Craven	4/4
John Roberts	3 years from June 2010	Worth Valley	3/4
Shirley Shields	Resigned May 2011	Keighley East	0/1
Alan Sturgess	Resigned May 2011	Settle and Mid Craven	1/1
Pat Thorpe	3 years from June 2010	Bingley Rural	3/4
Ray Tremlett	Resigned October 2011	Pendle East and Colne	2/3
John Wickham	Resigned April 2011	West Craven	1/1
Valerie Winterburn	2 years from June 2010	Craven	4/4
Stakeholder Governors	**Tenure**	**Constituency**	**Meetings attended**
Appointed Governors			
Pam Essler	Resigned December 2011	NHS Bradford & Airedale	3/3
Anne Forster	Appointed from June 2010	University of Leeds	3/4

Neil Franklin	Appointed from January 2012	NHS Bradford & Airedale	1/1
Robert Heseltine	Appointed from June 2010	North Yorkshire County Council	3/4
Naz Kazmi	Appointed from June 2010	Voluntary Sector	1/4
Ann Kerrigan	Appointed from June 2010	Pendle Borough Council	0/1
Dorothy Lord	Appointed from May 2011	Pendle Borough Council	1/3
Bill Redlin	Appointed from June 2010	NHS North Yorkshire & York	3/4
Pauline Sharp	Appointed from June 2010	Bradford Metropolitan District Council	4/4
Marcia Turner	Appointed from June 2010	Craven District Council	4/4
Staff Governors	**Tenure**	**Constituency**	**Meetings attended**
Elected Governors			
Rachel Binks	2 years from June 2010	Nurses and Midwives	4/4
David Petyt	3 years from June 2010	Registered Volunteers	4/4
Naren Samtaney	2 years from June 2010	Doctors and Dentists	0/4
Karen Swann	2 years from June 2010	Nurses and Midwives	1/4
Alan Walshaw	Resigned May 2011	Allied Health Professionals & Scientists	0/1
Katie Watson	3 years from June 2011	All Other Staff	3/3
In addition the Council of Governors meetings were attended by the following Directors:			
Non Executive Directors	**Job Title**		**Meetings attended**
Colin Millar	Chairman		4/4
David Adam	Senior Independent Director		4/4
Jeff Colclough	Non Executive Director		2/4
Ronald Drake	Non Executive Director		3/4
Sally Houghton	Non Executive Director		3/4
Alan Sutton	Non Executive Director		3/4
Executive Directors			
Bridget Fletcher	Chief Executive		4/4
Andrew Catto	Medical Director		2/4
Robert Dearden (add DF)	Interim Director of Nursing		2/2
Debra Fairley	Interim Director of Nursing		
Sheenagh Powell	Director of Finance		4/4
Ann Wagner	Director of Strategy and Business Development		4/4

NOTES

[1] In line with the Constitution election rules, David Child was offered the seat of Bingley for a one year appointment upon Mark Haw-Wells resignation

MEMBERSHIP

The Foundation Trust has two membership constituencies:

- A public constituency; and
- A staff constituency.

PUBLIC CONSTITUENCY

An individual who lives in one of the following public constituencies may become a member of the Foundation Trust by making an application for membership to the Foundation Trust.

Constituencies within the public constituency	Local Authority electoral areas/or local authority electoral areas falling within the following Electoral Wards
Bingley	Bingley
Bingley Rural	Bingley Rural
Craven	Craven
Ilkley	Ilkley
Keighley East	Keighley East
Keighley Central	Keighley Central
Keighley West	Keighley West
Wharfedale	Wharfedale
Worth Valley	Worth Valley
Skipton	Skipton East, Skipton North, Skipton South, Skipton West, Embsay with Eastby, Grassington, Upper Wharfedale, Barden Fell
Settle and Mid-Craven	Settle and Ribblebanks, Gargrave and Malhamdale, Hellifield and Long Preston, Penyghent, Bentham, Ingleton and Clapham
South Craven	West Craven, Aire Valley with Lothersdale, Cowling, Glusburn, Sutton in Craven
West Craven	Coates, Craven, Earby
Pendle East and Colne	Barrowford, Boulsworth, Foulridge, Horsfield, Vivary Bridge, Waterside
Lower Wharfe Valley	Rawdon and Guiseley, Otley and Yeadon
Rest of England	Rest of England

STAFF CONSTITUENCY

An individual who is employed by the Foundation Trust under a contract of employment (which includes full and part time contracts of employment) may become a member of the Foundation Trust provided:

- He or she is employed by the Foundation Trust under a contract of employment which has no fixed term or has a fixed term of at least 12 months; or
- He or she has been continuously employed by the Foundation Trust under a contract of employment for at least 12 months.

Individuals who exercise functions for the purposes of the Foundation Trust, otherwise than under a contract of employment with the Foundation Trust, may become members of the staff constituency provided such individuals have exercised these functions continuously for a period of at least 12 months.

The staff constituency is divided into the following constituencies:

- Doctors and dentists who are registered with their regulatory body to practice;
- Nurses and midwives who are registered with their regulatory body to practice;
- Allied health professionals and scientists who are registered with their regulatory body to practice;
- All registered volunteers (with a minimum of 12 months service); and
- All other staff.

AUTOMATIC MEMBERSHIP FOR STAFF

All eligible staff are automatically made members in the staff constituency unless they inform the Foundation Trust they do not wish to do so.

This automatic membership of the staff constituency does not apply to the volunteer constituency who are given the option to opt in to membership.

The Foundation Trust achieved a total membership of over 11,000 members at the year end split between:

- Public members: 9,113
- Staff members: 2,653

SUMMARY OF MEMBERSHIP STRATEGY

The Membership Development Strategy covering the period 2011/12 is reviewed by the Membership Development Group, the Council of Governors and the Board of Directors on a regular basis.

The purpose of the Membership Development Strategy is to develop a representative membership and clarify the way in which the Council of Governors, Membership Development Group, Foundation Trust Membership Office and the members themselves will be involved with upholding the Foundation Trust's corporate and business objectives.

The strategy will ensure that the membership is:

- Fully represented at all levels;
- Clearly informed; and
- Used appropriately in decision making around service provision.

The strategy aims to:

- Ensure public membership is representative of the community it serves (in terms of nationality, gender, disability, ethnic origin, age, social background, geographical spread and social deprivation);
- Ensure that all staff groups are given equal opportunity to become involved;
- Identify levels of involvement and participation within the membership according to the wishes and needs of individuals; and
- Ensure a continuous approach to the development of the membership in terms of both numbers and level of engagement.

The target for membership recruitment had previously been set at 1,000 per year. This target proved to be ambitious and whilst the target was not met in 2011/12, a significant number of new members were recruited.

During the past year, to reflect this and in light of the Governors decision that there should be a more concentrated focus on engagement of current members, the Membership Development Strategy has been reviewed by the Governor's Membership Development Group and the Council of Governors agreed:

- That the Strategy should focus on ensuring active engagement with existing members and the local community; and
- The previously approved Strategy to increase total public membership by 1,000 each year be restated to a 5% increase year on year.

THE MEMBERSHIP DEVELOPMENT GROUP

This group is responsible for developing the membership by recruitment, retention, communication and engagement. The group meets monthly and amongst others, delivered the following membership activities in 2011/12:

- Assisting in planning the public open event;
- Contributing ideas to the member newsletters;
- Raising the profile of Governors and membership at hospital open events, shows and other recruitment activities; and
- Promotion of membership and the role of Governors through neighbourhood forums, patient participation groups and other local community groups.

RECRUITMENT ACTIVITY DURING 2011/12

New members have been recruited at a variety of events aimed at specific groups,

such as students, as well as at local shows held within the local area and in town centres members of the general public.

MEMBERSHIP ACTIVITY 2011/12

This year has also seen a number of key developments with regard to membership engagement, development and communications.

OPEN EVENT / ANNUAL GENERAL MEETING

In September 2011, we delivered our annual Open Event and Annual General Meeting which attracted over 250 visitors. The Open Event provided interactive displays, presentations and behind the scenes tours from a wide variety of departments and clinical areas within the Foundation Trust.

We also held a separate staff open event, the day before the public event and this event was very successful with over 250 staff visiting us on the day to get advice and information on staff health initiatives and other employee information and benefits.

'FOCUS ON ...' EVENTS

Our 'Focus on' sessions are presentations/demonstrations in response to the interests expressed by our members. They provide all members with opportunities to gain more of an insight into how our services operate. The programme ran throughout 2011/12 and included sessions focusing on:

- Diabetes
- Cancer
- Organ donation and transplantation

Each member is asked to complete a feedback form and to make suggestions for future events. These are taken into account when determining future event programmes.

We also continue to hold drop in sessions before each 'Focus on' event where members can meet their Governors and find out more about their role and have the opportunity to ask questions or give feedback about our services. We also advertised the Governor email addresses on our website and bi-annually with the newsletter and encourage our members to contact their local Governor with any feedback.

'MEET THE CHAIRMAN' EVENTS

Our 'Meet the Chairman' events are an opportunity for interested members to regularly meet the Chairman and find out about the role of a Governor. We held a number of these events during 2011/12 with featured talks playing an integral part. Talks included:

- Hospital food;
- CT/MRI scanning; and
- Our plans for the future.

In February 2012 we also ran an event for members interested in becoming a governor with information on the role and responsibilities, the role in practice and the election process.

MEMBERSHIP COMMUNICATIONS

This year we have sent our regular communications newsletter to all our membership households. These communications, by hard copy, newsletter or email, are exclusive to our members and they provide updates on new developments at the Foundation Trust, information on membership activities, useful patient information and health advice.

All this information is also available on the Foundation Trust section of our website.

All new members receive a welcome letter which includes a membership card containing membership contact information and details of the Foundation Trust website.

YOUNG PEOPLES' MEMBERSHIP DEVELOPMENT

This year we have continued our recruitment drive of young people via local schools and by holding specific events for young people focusing on health related matters such as:

- Fractures;
- Applying for medical school;
- A day in the life of a surgeon and nurse; and
- NHS careers.

We have continued to produce a Young Members newsletter, specifically aimed at our members aged 16-21 years, which gives our young members health information and invitations to our events.

INCREASING REPRESENTATION

This year we have continued our aim to have an increasingly representative membership by targeted recruitment and by hosting events in specific areas with specific groups in the community.

MEMBERSHIP INTERESTS AND INVOLVEMENT

The 'Welcome' mailing members receive, also includes a form for members to record their areas of special interest. This is returned to the Foundation Trust and allows us to create a database of interests where members are interested in contributing, for example by completing a survey or participating in a focus group. During 2011/12 we asked our members for feedback on our Annual Plan whose comments are then considered by Governors and the Board of Directors as part of the annual planning process for the coming year.

THE FOUNDATION TRUST OFFICE

The Foundation Trust Office continues to be a central point of contact for all members to make contact with the Foundation Trust and the Council of Governors. It can be contacted during office hours, Monday to Friday on 01535 292727 (24 hour answerphone also available) or by email to members@anhst.nhs.uk

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

Members are also sent, by email or post according to their preference, a bi-annual Governor update with their Foundation Trust newsletter, which details the contact email address for their own Governor.

Members are also invited, via their newsletter and the website, to meet Governors at drop in sessions before every member talk, held monthly throughout the year.

Governors also take part in the annual public open day, staff event and theatres open day, giving members an opportunity to meet with them and discuss any issues or questions.

GOVERNANCE

The Foundation Trust Board of Directors and Council of Governors have discharged their functions throughout the year through a number of sub-committees as outlined below.

AUDIT COMMITTEE

The Audit Committee is chaired by a Non Executive Director – Mrs Houghton, and has a further two Non Executive Directors, Mr Adams and Mr Colclough as members. Its terms of reference are approved by the Board of Directors. The Committee has an annual work plan which shows how it plans to discharge its responsibilities under its terms of reference. Minutes of each meeting are reported to the Board along with any recommendations by the Chairman of the Audit Committee. Committee members carry out a self assessment each year. The Committee reports to the Board of Directors through its annual report on its work in support of the Annual Governance Statement, specifically commenting on the fitness for purpose of the Board Assurance Framework, the completeness and embeddedness of risk management in the Foundation Trust, the integration of governance arrangements and the appropriateness of the self-assessment against the Care Quality Commission.

Its main duties throughout the year were:

- **Financial reporting** – The Audit Committee monitors the integrity of the financial statements of the Foundation Trust and any formal announcements relating to the Foundation Trust's financial performance, reviewing significant financial reporting judgements contained in them. The Committee received and approved the Foundation Trust accounts and the Annual Governance Statement for 2011/12.

- **Governance, risk management and internal control** – The Committee reviews the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Foundation Trust's activities (both clinical and non-clinical) that support the achievement of the Foundation Trust's objectives. The Committee received the Foundation Trust's Board Assurance Framework and various audit reports concerning these matters, during this period. The Committee received reports outlining the progress made in planned counter fraud work and general issues concerning the NHS Counter Fraud Service (CFS). The Committee also reviewed as appropriate the findings of other relevant significant assurance functions, both internal and external to the Foundation Trust and considered the implications to the governance of the Foundation Trust.

- **Internal audit** – The Committee ensures that there is an effective internal audit function established by management that meets mandatory internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and the Board of Directors. The Committee received the internal audit plan, internal audit annual report and progress reports in this period and also received the review of the internal audit function by external audit and the Director of Finance.

- **External audit** – The Audit Committee reviews and monitors the external auditor's independence and objectivity and the effectiveness of the audit process. The Committee received and reviewed external audit plans and regular routine reports, along with holding regular private discussions with the external auditors and internal audit. The external auditor attends each Audit Committee meeting.

The Company Secretary was the formal secretary for the Committee and ensured that coordination of papers and minutes were produced in accordance with the Chairman of the Committee. The Foundation Trust has a process agreed by Governors for the agreement of non-audit services provided by external audit; however we did not require any additional non-audit service during the period.

FINANCE COMMITTEE

A separate Finance Committee comprising the full Board of Directors, and chaired by the

Chairman, met quarterly in 2011/12. The focus of the Committee is to ensure the overall financial health of the organisation whilst ensuring that quality, performance and investment is not compromised.

CLINICAL QUALITY, SAFETY AND ASSURANCE COMMITTEE

The Clinical Quality, Safety and Assurance Committee, chaired by Mr Drake, Non Executive Director, provides the Board of Directors with assurances of clinical effectiveness, quality of clinical practice, safety of patients and patient experience. It also provides support to the Board of Directors in developing an integrated approach to governance by ensuring implementation of robust systems which enable the Foundation Trust to achieve its clinical objectives

CHARITABLE FUNDS SUB COMMITTEE

The Charitable Funds Sub Committee, chaired by Mrs Houghton, Non Executive Director, acts on behalf of the Foundation Trust in its capacity as Corporate Trustee.

The purpose of the committee is to give additional assurance to the Board of Directors 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.

REMUNERATION REPORT

APPOINTMENTS AND REMUNERATION COMMITTEE

The Appointments and Remuneration Committee is established for the purpose of overseeing the recruitment and selection processes to secure the appointments of Non Executive Directors (including the Chairman) in accordance with the knowledge, skills and experience approved by the Board of Directors. The Committee also oversees the review of remuneration levels of the Chairman and Non Executive Directors. The Committee makes recommendations to the Council of Governors on the appointment of Non Executive Directors (including the Chairman) of the Foundation Trust and the Chairman and Non Executive Directors remuneration levels.

The standing membership of the Committee comprises:

- Chairman of the Foundation Trust (Mr Colin Millar)
- Deputy Chairman of the Foundation Trust (Mr Alan Sutton)
- Senior Independent Director of the Foundation Trust (Mr David Adam)
- Two elected Governors (*Mr John Osborne and Mr Peter Beaumont)
- One stakeholder Governor (Mrs Pauline Sharpe)
- One staff Governor (Mrs Karen Swann)
- Lead Governor and elected Governor (Mr Adrian Mornin)

* Mr John Osbourne resigned from the Committee during 2011/12 and was replaced by Mr John Roberts.

The Director of Organisational Development and Workforce or the Head of Human Resources also attended in an advisory capacity.

During 2011/12, the Committee met in relation to the re-appointment of two Non Executive Directors – Mr Jeff Colclough and Mrs Sally Houghton, and to consider the process for replacement of Mr Alan Sutton as Non Executive Director. The Committee also considered the Board succession plan for Non Executive Directors. It was concluded by the Committee and recommended to the Council of Governors to re-appoint Mr Colclough and Mrs Houghton for a further 12 month appointment. The decision to re-appoint for a reduced term of office was taken to ensure a more evenly spaced retirement of Non Executive Directors over the next three years.

The Committee also undertook for the first time the appointment of a new Non Executive Director to replace Mr Alan Sutton who retires in 2012. The process involved the establishment of selection panel to recruit and work with an external recruitment consultant to source suitable candidates. The panel undertook a series of long listing and short listing meetings prior to conducting interviews. The preferred candidate was then recommended for approval by the Council of

Governors at its meeting in April 2012 to take up office on 1 June 2012. The Council of Governors at its meeting on 25 April 2012 duly approved the appointment of Professor Anne Gregory as Non Executive Director, with effect from 1 June 2012.

A separate nominations committee, named the Board Appointments Committee, is established for the purpose of overseeing the recruitment and selection process for Executive Directors and the appointment of formal Board positions e.g. Senior Independent Director. The members of the Committee comprise the Chairman, Chief Executive (or another Executive Director when considering the appointment of the Chief Executive) and at least two Non Executive Directors. The Director of Organisational Development and Workforce or their representative is in attendance to provide specialist HR advice.

REMUNERATION AND TERMS OF SERVICE COMMITTEE

The Remuneration and Terms of Service Committee is established to determine the remuneration of Executive Directors and those employees earning more than £50,000 (or pro-rata if part time) covered by Agenda for Change or the Consultant Contract.

The Committee met during the 2011/12 period to consider the latest independent benchmarking information for Director's remuneration and to agree the appropriate level of remuneration. The Committee, which is made up of the Chairman and three Non Executive Directors, met on two occasions, with the Chief Executive attending all meetings, except where her terms and conditions and appraisal were being discussed. The Director of Organisational Development and Workforce (or their representative) also attended all meetings.

The pay policy of the Executive Directors of the Board, was agreed by the Committee in June 2011. This indicated salaries should be positioned against benchmark salaries provided by Income Data Services.

No performance related pay scheme (e.g. pay progression or bonuses) is currently in operation within the Foundation Trust for Executive or Non Executive Directors. All other senior managers are subject to Agenda for Change pay rates, terms and conditions of service, which are determined nationally.

Each year, the Committee considers a report from the Chief Executive which summarises the performance of individual Directors against their agreed objectives. The Committee then makes a decision about each director's salary review, linked to their performance.

For Executive Directors, appointments are not time limited and the period for serving notice, whilst historically has been six months, will in future be three months. Contractual provision for early termination is not appropriate as the contracts are not fixed term. Liability for early termination is therefore not calculated. No significant termination payments have been made since the organisation became a Foundation Trust. The Foundation Trust's remuneration reports are subject to a full external audit.

Details of remuneration and person information are detailed on pages 65, 66 and 79.

MEDIAN REMUNERATION NOTE

The HM Treasury FReM requires the disclosure of the median remuneration of the Trust's staff and the ratio between this and the mid point of the banded remuneration of the highest paid Director. The calculation is based on full-time equivalent staff of the Trust at the end of 2011/2012 on an annualised basis.

Median remuneration of staff	£23,589
Mid point of highest paid Director	£142,500
Ratio	6:1

ASSESSMENT AGAINST THE MONITOR CODE OF GOVERNANCE

Airedale NHS Foundation Trust complies with the Monitor Code of Governance. All of the principles set out in the Code of Governance are reflected in the Foundation Trust's Constitution.

REMUNERATION OF SENIOR MANAGERS

Salary and Allowances (For period 1 April 2011 to 31 March 2012)

Name and Title	2011/12			2010/11		
	Salary (bands of £5000) £000	Other Bonuses (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Bonuses (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
Mr David Adam, Non Executive Director	10-15	0	0	5-10	0	0
Mr Andrew Catto, Medical Director (1)	25-30	0	0	20-25	0	0
Mr Jeff Colclough, Non Executive Director	10-15	0	0	5-10	0	0
Mr Ronald Drake, Non Executive Director	15-20	0	0	5-10	0	0
Mr Rob Dearden, Interim Director of Nursing (2)	65-70	0	0	n/a	n/a	n/a
Mrs Debra Fairley, Interim Chief Nurse (3)	20-25	0	0	75-80	0	0
Miss Bridget Fletcher, Chief Executive (4)	140-145	0	0	125-130	0	0
Mrs Sally Houghton, Non Executive Director	10-15	0	0	5-10	0	0
Mr Colin Millar, Chairman	40-45	0	0	20-25	0	0
Mrs Sheenagh Powell, Director of Finance (5)	105-110	0	3900	105-110	0	0
Mr Alan Sutton, Non Executive Director	10-15	0	0	5-10	0	0
Mrs Ann Wagner, Director of Strategy & Business Development	110-115	0	0	115-120	0	0

Notes:
(1) Dr Andrew Catto – Medical Director pay only included
(2) Mr Rob Dearden – appointed as Interim Director of Nursing with effect from 1 August 2011
(Mr Dearden is currently on secondment from Calderdale and Huddersfield NHS Foundation Trust)
(3) Mrs Debra Fairley – Interim Chief Nurse from 1 April 2011 to 28 June 2011
(4) Miss Bridget Fletcher – Director of Nursing from 29 June 2011 to 31 July 2011
(5) Benefit in kind relates to a car lease benefit

No Executive Directors are Non Executive Directors of any other organisation
No former senior managers received compensation in the period 1 April 2011 to 31 March 2012

PENSION ENTITLEMENTS OF SENIOR MANAGERS

The definition of senior managers is those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments. The Foundation Trust has decided that this refers to just Executive and Non Executive Directors of the organisation.

Pension Benefits

Name and title	Real Increase in Pension at Age 60 (bands of £2500) £000	Real Increase in Pension Lump Sum at Age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5000) £000	Lump Sum at Age 60 Related to Accrued Pension at 31 March 2012 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Miss Bridget Fletcher, Chief Executive	5.0-7.5	20.0-22.5	60-65	185-190	1197	993	204	0
Dr Andrew Catto, Medical Director	2.5-5.0	7.5-10.0	35-40	105-110	608	483	125	0
Mr Rob Dearden, Interim Director of Nursing	2.5-5.0	12.5-15.0	25-30	80-85	427	301	126	0
Mrs Debra Fairley, Interim Chief Nurse	-2.5-0.0	-5.0- -2.5	20-25	65-70	379	330	49	0
Mrs Sheenagh Powell, Director of Finance	0.0-2.5	2.5-5.0	40-45	125-130	852	786	66	0
Mrs Ann Wagner, Director of Strategy & Business Development	0.0-2.5	0.0-2.5	30-35	90-95	540	483	57	0

As Non Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

The factors used to calculate 2012 CETV have changed. The new factors used in the calculation are higher than previous factors used. This means that the value of CETV for some members has increased by more than expected since 31 March 2011.

Bridget Fletcher
Chief Executive

28 May 2012

PUBLIC INTEREST DISCLOSURES

INNOVATION AND DEVELOPMENT

In 2011/12, Airedale continued to build on its already significant technological innovation in the development of telemedicine – a system whereby patients can receive medical consultations in their home via a TV link - when a regional Telehealth Hub, funded by the Yorkshire and Humber Strategic Health Authority, was opened in September 2011.

Benefits are already being seen by our patients' with long term conditions as well as those in nursing homes, where a number of hospital admissions have been avoided by the online intervention of clinical staff working round the clock in the Hub.

RESEARCH AND DEVELOPMENT

The Foundation Trust's research and development team took part in 138 research studies during 2011/12. Patient recruitment also increased, by over 50%, to national portfolio clinical trials, from 314 in 2010/11 to 486 in 2011/12. Research work was also broadened to include three new specialties – orthopaedics, gynaecology and rheumatology.

The Foundation Trust was also the first Trust in the region to implement the Research Support Services (RSS) guidelines for research governance and to have a Research and Development Operational Capability Statement (RDOCS) signed off by its Board.

SERVICE IMPROVEMENT (LEAN)

The LEAN Healthcare Academy (LHA) was founded by the Foundation Trust in partnership with the Ilkley Virtual College in November 2006. (The Virtual College is an experienced provider of LEAN training to industry.)

In April 2010, the challenge for Airedale was to stand alone, without the help of the Virtual College and use the Lean skills learnt as the methodology for changing the future of Airedale. The Lean department changed and became the Airedale Service Improvement Team (ASIT).

In mid 2010, the team was tasked with setting up of four Programme Boards and the Programme Executive Group, to enable the Executive team to monitor what programmes and projects were being undertaken across the organisation and be assured that the work projects would realise benefits for both patients and the Foundation Trust. A fifth programme, Transform, was added in 2011.

The team delivers Lean training, to both in house and external staff. The training provides a toolkit and methodology to eliminate waste and improve the way teams work to make them more efficient. At the same time the ASIT has developed its own training materials.

Current work includes supporting and facilitating on several work steams including the foot pain pathway, cardiology administration processes and referral pathways, improving reporting and booking process in radiology and the implementation of pathology e-requesting

The ASIT also uses 'The Productive Series' to support staff to deliver improvements that are driven by themselves, by empowering them to ask difficult questions about practice and to make positive changes to the way they work. The process promotes a continuous improvement culture leading to real savings in materials, reducing waste and vastly improving staff morale.

In March 2012, Richard Wylde, service improvement manager, and Sue Speak, head of service improvement received a double accolade from the Lean Healthcare Academy. Richard was awarded Lean Champion of the Year for his work with the Foundation Trust's maternity unit and Sue received a special award for her outstanding contribution, over a number of years, to the lean initiative. The hospital's maternity team were also nominated for their work on the productive series

OUR STAFF

The Foundation Trust has an ethos of diversity and using talents to best effect regardless of age, disability, ethnicity, gender, religion and belief or sexual

orientation. We aim to give full and fair consideration to all applicants who apply for jobs at the Foundation Trust.

We have Foundation Trust Guidelines on recruitment and selection, which take into account the need for reasonable adjustment for disabled employees. We also have a policy on managing attendance, which contains specific provision for dealing with employees who have become disabled. The development of all staff has a high priority and is based on a Knowledge and Skills Framework and individual's personal development plans.

During the year, we ensured we communicated with staff on matters that concern them as employees. Staff had access to information through the Foundation Trust's intranet, weekly staff bulletins, and monthly team briefings which are cascaded throughout the organisation within 24 hours after the Board of Directors meeting via email. Individual directorates also have their own management and clinical team meetings where core messages are delivered. These systems have been used throughout the year to communicate the financial and economic factors affecting the performance of the Foundation Trust.

In July 2011, the Foundation Trust implemented a workforce reduction programme, aimed at reducing costs, which contributed towards the significant savings the Foundation Trust needed to make in 2011/12.

In September 2011, we held our second staff Open Event in addition to our annual public Open Event, which staff are also able to attend. We again received a very positive response from staff and will be holding a similar event in 2012. Foundation Trust member events are also open to staff members.

ANNUAL STAFF SURVEY

The 2011 annual survey of NHS staff was conducted in October 2011.

The four key findings for which Airedale NHS Foundation Trust compares most favourably with other acute trusts in England are:

- Percentage of staff appraised in last 12 months;
- Percentage of staff believing the trust provides equal opportunities for career progression or promotion;
- Percentage of staff having equality and diversity training in last 12 months; and
- Fairness and effectiveness of incident reporting procedures.

The one key finding where staff experiences have improved since the 2010 survey is:

- Percentage of staff reporting good communication between senior management.

The four key findings for which Airedale NHS Foundation Trust compares least favourably with other acute trusts in England are:

- Percentage of staff reporting errors, near misses or incidents witnessed in the last month ;
- Work pressure felt by staff;
- Percentage of staff feeling there are good opportunities to develop their potential at work; and
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in last month.

STAFF SURVEY

	2010/11		**2011/12**		**Trust Improvement/Deterioration**
Response rate	Trust	National Average	Trust	National Average	
	50%	54%	52%	54%	Increase in 2 % points

	2010/11		**2011/12**		**Trust Improvement/Deterioration**
Top four ranking scores	Trust	National Average	Trust	National Average	
% of staff appraised in the last 12 months	89%	78%	92%	81%	Increase in 3 % points
% of staff believing the trust provides equal opportunities for career progression or promotion	91%	90%	93%	90%	Increase in 2 % points (This question not in the top four in 2010/11)
% of staff having equality and diversity training in the last 12 months	61%	41%	66%	48%	Increase in 5 % points
Fairness and effectiveness of incident reporting procedures	3.51	3.45	3.55	3.46	Increase of 0.04 (This question not in the top four in 2010/11)

	2010/11		**2011/12**		**Trust Improvement/Deterioration**
Bottom four ranking scores	Trust	National Average	Trust	National Average	
% of staff reporting errors, near misses or incidents witnessed in the last month	95%	95%	93%	96%	Decrease of 2 % points (This question not in the bottom four in 2010/11)
Work pressure felt by staff	3.28	3.11	3.33	3.12	Increase of 0.05
% of staff feeling there are good opportunities to develop their potential at work	34%	41%	34%	40%	No change
% of staff witnessing potentially harmful errors, near misses or incidents in last month	39%	37%	41%	34%	Increase of 2 % points (This question not in the bottom four in 2010/11)

HUMAN RESOURCES MANAGEMENT

Research tells us that effective line management and leadership is critical to effective service delivery.

In October 2011, the Foundation Trust began an organisational wide staff engagement exercise. Teams were encouraged to have conversations about 'What makes a great line manager' and feedback their ideas. At the same time, the Executive Directors attended team meetings in other directorate areas, to facilitate these discussions and hear for themselves what the organisation was doing well and how it could improve staff engagement.

We received dozens of suggestions from staff across the Foundation Trust and these were developed into a framework of 'Standards for Great Line Management'. Details of the new standards, as well as supporting training modules, were distributed to managers and staff in March 2012.

The Human Resource Management service has also been re-designed to ensure the most effective business contribution. For example the Human Resources Team have a led a programme which has reduced the Foundation Trust's sickness absence.

The staff sickness absence for 2011/12 is shown below:

Days lost (long term)	25,102
Days lost (short term)	14,959
Total days lost	**40,061**
Total staff years	**2172.27**
Average working days lost	18.4
Total staff employed in period (headcount)	3,157
Total staff employed in period with no absence (headcount)	1,271
Percentage staff with no sick leave	**40.3%**

WORKING IN PARTNERSHIP

We have continued to develop our strategic and other partnerships from a clinical, business and financial perspective. During 2011/12 we continued to work with our partners to ensure that as an organisation we are outward looking and connected to our local community, enabling and supporting health, independence and the well being of our patients.

LINKS WITH OUR COMMISSIONERS

Our population's healthcare is commissioned in the main by three Primary Care Trusts (PCTs) – NHS Bradford and Airedale, which in 2011/12 accounted for 62.3% of the Foundation Trust's revenue from patient care activity; NHS North Yorkshire and York which last year accounted for 24.1% of the Foundation Trust's revenue from patient care activity and NHS East Lancashire which accounted for 11.5% of the Foundation Trust's revenue from patient care activity. During 2011/12 our main commissioner – NHS Bradford and Airedale – became part of a new cluster organisation, NHS Airedale, Bradford and Leeds.

PCTs continue to develop their longer term commissioning strategies and service development plans as the transition to Clinical Commisioning Groups (CCGs) moves closer. Our annual plan and three year plan have been developed in line with this to enable us to support delivery of our commissioners' intentions.

STRATEGIC AND BUSINESS PARTNERSHIP ARRANGEMENTS

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

- A strategic clinical partnership with its neighbouring Trust, Bradford Teaching Hospitals NHS Foundation Trust, who support us in providing sustainable services in our single handed specialties and hub and spoke arrangements for Ear Nose Throat, ophthalmology, dental specialties and plastic surgery.
- A *strategic clinical partnership* with tertiary centre, Leeds Teaching Hospitals NHS Trust, which provides support in a number paediatric services. Additionally they provide a wide range of diagnostics in Pathology and X-ray which, by and large, is highly specialist and not available at Airedale NHS Foundation Trust.
- A *Private Finance Initiative* (PFI) with SIEMENS Medical Systems for a managed technology service to supply

and maintain diagnostic x-ray equipment to the Foundation Trust.

- A *Public Private Partnership* (PPP) with Frontis Homes for the provision of staff residential accommodation on site.
- *Liaison* with NHS Airedale, Bradford and Leeds (working on behalf of West Yorkshire commissioners) and Local Care Direct – an independent primary care out of hours provider – to provide out of hours services in accommodation adjoining the Foundation Trust's Accident and Emergency department.
- The Foundation Trust worked in partnership with its three main commissioners to develop a proposal to run a *telemedicine pilot* delivering care directly into patient's homes and nursing homes. The pilot focused on providing care to nursing homes residents, patients suffering from an exacerbation of COPD and diabetes patients.
- *Local Improvement Finance Trusts* ('LIFT') developments. The Foundation Trust has played, and continues to play, an active part in building developments and is an active member of the Bradford and Airedale Strategic Partnering Board. In partnership with its commissioners, the Foundation Trust is working on the redevelopment of services in the Bingley locality where a new Health Centre came on stream in February 2010. These new facilities provide opportunities for outreach rehabilitation services and new and consultant follow up outpatient appointments. This move is entirely in keeping with the Foundation Trust's strategic aim to provide local services. Similar opportunities are being pursued for the Keighley and Ilkley localities where LIFT proposals are being worked up in to viable schemes, and, with NHS East Lancashire for their LIFT development in Colne and NHS North Yorkshire and York for their development at Castleberg Hospital in Settle.

In addition to the above partnerships, alliances and developments, during 2011/12 the Foundation Trust also had a number of partnerships with contractors for outsourced services including car parking and security with CPP, transport with Ryder and catering with Sodexo.

TRAINING AND DEVELOPMENT

The Foundation Trust has continued to invest in the development of managers and leaders over the last year, to enable us to achieve business goals. Based on learning and evaluation for 2011/12 these programmes are being updated regularly to meet business needs.

AIREDALE STAFF PARTNERSHIP

We have a strong staff side/management partnership, the Airedale Staff Partnership (APG), which is a joint negotiating and consultation body to promote joint working in the interests of patient care.

Collaboration with them throughout a challenging year for the Foundation Trust, particularly in relation to the workforce reduction programme, brought real benefits for staff and patients.

CHILDCARE SUPPORT

Our onsite 'Nightingales Nursery' continues to provide high quality childcare at competitive rates for the Foundation Trust and other NHS employees. Open from 7.00am until 7.00pm, five days a week, 52 weeks of the year, it caters for babies and children up to the age of five.

This high quality service is regulated and approved by OFSTED and an inspection in May 2011 gave it an overall rating of 'good' and six 'outstanding' ratings. The nursery was praised for its capacity for continuous improvement, effective leadership and management, its ability to evaluate its success, and successful working relationships with parents, carers and other agencies.

Financial support is also offered to Foundation Trust staff, either through a full salary sacrifice scheme for staff who use the onsite nursery, or childcare vouchers for staff choosing alternative childcare. The manager of this service provides a wide range of support and training for parents and parents to be, including maternity workshops for parents to find out about rights and benefits and baby massage and yoga classes.

HEALTH AND WELLBEING

Research shows that looking after the health and well being of the workforce pays significant dividends in relation to attendance, performance, productivity and motivation. Airedale is at the leading edge of the innovative work. It is led by our Employee Health and Wellbeing team, and works to assist management and staff to protect health, promote well being and prevent ill health.

In September 2011, a new service started for staff offering free, confidential help and support with any work, personal or family issue to all employees and their families. The new Employee Assistance Programme (EAP) introduced by Employee Health and Wellbeing services is provided by Workplace Options, an expert provider of employee support services and which is completely independent of Airedale Hospital. It operates 24 hours a day, 365 days a year.

The EAP replaces the previous staff counselling service and provides specialist support including a telephone helpline, information packs, and short-term counselling. Its employee support staff will have access to a wealth of up-to-date practical information and resources.

Airedale staff are able to get help on a wide range of problems including: work-life balance, relationships, child care, health and well-being, debt, disability and illness, careers, bereavement and loss, stress, caring for the elderly, life events, immigration, anxiety and depression, family issues, bullying and harassment, education, consumer rights and workplace pressure.

MANAGING RISK

All wards and departments continue to work with the Quality and Safety team in the identification of risk and analysis of incidents. This work is important to the improvement of patient safety and the delivery of clinical services. Systems are in place whereby all risks and reported incidents are assessed and monitored.

A Committee, whose members include all the Executive Directors, consider the risks carried by the Foundation Trust on a monthly basis, and the Board of Directors receives a regular report about the management of those risks documented in the risk register.

The Foundation Trust has achieved compliance with the NHS Litigation Authority Risk Management standards at Level 2 for Acute Trust services and Level 1 for Maternity Services. These standards recognise the Foundation Trust's commitment to safe practice and effective risk management.

HEALTH AND SAFETY

The key group in the management of health and safety at Airedale NHS Foundation Trust is the Joint Health and Safety Committee. This comprises management, staff side representatives and reports into the Executive Strategic Risk Management Group (ESRMG), and can be escalated to the Board where indicated by magnitude of risk.

The Committee ensures that the Foundation 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 Foundation Trust, and ensuring compliance with the Health and Safety at Work Act 1974 (and related regulations).

The Committee is chaired by the Director of Operations, whose role includes being the designated lead Director for health and safety for both the Foundation Trust's Executive Directors Group and the Board. They are supported in this role by the Health, Safety and Emergency Planning Manager who works in the Quality and Safety Team.

The Foundation Trust was subject to one Health and Safety Executive (HSE) inspection during 2011/12. This was:

- Pathology

The visit to Pathology (in particular Microbiology and the Category 3 Room facilities) was from the HSE Biological Agents Unit on Thursday 26 April 2012. No issues were raised – the team were given a few verbal suggestions to further improve their practice.

POLITICAL AND CHARITABLE DONATIONS

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

PATIENT AND PUBLIC ENGAGEMENT AND EXPERIENCE

Engagement with patients and the public is extremely important to the Foundation Trust as a means of improving patient experience.

Following last year's creation of a Patient and Public Engagement and Experience Steering Group, a Patient and Public Engagement and Experience Operational Group was formed to closely monitor information about engagement and experience activity in a way that will enable the Foundation Trust to ensure it meets the five commissioner requirements.

A patient and public engagement and experience policy aimed at improving the patient experience was developed and a three year strategy prepared in order to ensure that patient involvement activities are embedded into all aspects of the Foundation Trust's business.

The following outlines some of the Foundation Trust's patient and public engagement activities.

VOLUNTEERING

Airedale NHS Foundation Trust is supported by two very active volunteer groups, the Friends of Airedale and Airedale New Venture. There are around 400 active volunteers who undertake vital and diverse activities across the hospital. Whether it's acting as guides for patients attending appointments, assisting our patients to eat and drink during meal times; staffing the volunteer shops, taking the shop or library trolley to patients on the ward; or helping patients to attend our religious services, our volunteers are an invaluable resource for our staff and patients.

The two charities Friends of Airedale and Airedale New Venture contributed around £136,000 last year to the hospital. The funds were raised through the two shops, the car boot sales that are held in the grounds of the hospital during the summer months and through public donations. The money was used to buy a range of new equipment for the hospital, including equipment for a children's play area in the hospital's outpatients department, monitors for the stroke unit, a new electric door for one of the disabled toilets for visitors and specialist wheelchairs for the outpatients department as well as:

- £11,000 on clothing and toiletries for the Dignity Room
- £24,000 on two new estate cars for the volunteer transport section

As highlighted by the CQC report 'Dignity and Nutrition for Older People', published in October 2011, it is important to make sure that people have enough to eat and drink when they are in hospital. A lot of work has been done at Airedale Hospital to ensure that patients do get the right nutritional care and our volunteers provide crucial support to our nurses and ward hostesses to help patients eat and drink.

Following our feeding buddy trial last year to train hospital staff so that they could help ward staff assist patients to eat and drink at meal times, an increased number of volunteers have also become involved in the scheme. These volunteer feeding buddies are an invaluable support to our ward staff in this key area of patient experience.

Another key element of patient experience is the feedback we receive from our real time patient survey, which a number of volunteers help the hospital with six days a week. During 2011/12 a new survey for the Foundation Trust's maternity and endoscopy services was developed, requiring significant support from our volunteers to undertake it. Our volunteers have really risen to this new challenge and have been very supportive of our continued work in the area.

PATIENT AND CARER PANEL

As part of the Foundation Trust's commitment to engage service users in the development of services, and to gain a range of different perspectives and views, a Patient and Carer Panel was set up in 2007 and is now well established. It meets monthly and is

consulted about various aspects of the Foundation Trust's business, including service developments and new initiatives.

During 2011, the Panel's terms of reference were revised in order to have clearer direction. The Panel currently has seven task groups focusing on communication; the appointments system; the Foundation Trust's meals service; services for dementia patients; patient falls; Foundation Trust policies; and actions from past visits.

Our overall aim is to ensure that work undertaken by our task groups influences real and sustained improvement in a range of services from a patient perspective.

YOUTH PANEL

During 2011/12, our patient engagement and experience lead visited local schools and colleges to discuss creating a youth panel for the hospital with pupils and teachers. A number of groups have embraced the idea and in January 2012, a small number visited the hospital as the first stage in the process. Their initial feedback has already been helpful to help us better understand how we can improve the healthcare we provide for young people in our local community.

The Youth Panel aims to help us fully engage with young people in our community and they have been instrumental is setting up how it could work and what it should do.

PATIENT INFORMATION

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

In June 2011, a new information pod was set up in Airedale Hospital's health information centre to help patients and visitors to find out more about their health, condition or medication. People can use video, audio and interactive websites through the computer in the enclosed area to discover more about staying healthy and managing long term conditions. The service is a drop-in service, but patients can also pre-arrange a specific time to use the pod between 9am and 5pm, Monday to Friday. Information is available about:

- conditions and interventions
- self care and management advice
- other patients personal experiences
- advice on benefits and social care
- details of local or national support groups.

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

The Readers' Panel whilst being popular always needs to recruit new members. Contact details for the Readers' Panel are shown on the final page of this Annual Report.

LEARNING FROM THOSE WITH A DISABILITY

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

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

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

PATIENT ADVICE AND LIAISON SERVICES (PALS)

As well as providing information, advice and support to help patients, families and their carers, the emphasis within the Foundation Trust is for PALS to work closely with front-line staff, particularly our matrons, in order to help resolve issues and queries as quickly as possible for patients.

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

In 2011/12, PALS dealt with 1,975 contacts, of which 1,833 were specifically related to Airedale NHS Foundation Trust. Of these, 278 were compliments sent directly to PALS; 364 were requests for information; and 1,191 were categorised as expressions of concern, dissatisfaction and requests for action to be undertaken.

Each caller receives a thoughtful and sympathetic response and people are given advice and support about the treatment that they have received or require. Key themes from calls are identified and our staff aim to respond to needs that have been identified. During 2011/12, of the 1,883 contacts relating to Airedale:

- 58% of requests were resolved on the day they were received;
- 63% of queries were settled within 24 hours; and
- 72% of requests were completed within three working days.

Examples of learning from PALS issues include:

- The carer of a person with learning difficulties has agreed to help the Trust in developing services for LD patients following raising concerns re care on the wards
- Following a concern related to use of patients' own medication in hospital, a new Trust wide policy has been developed and introduced to allow the use of patients own medication when it is presented in a dosset box or similar format.

The PALS office is located at the entrance to Ward 18. Contact with the PALS office can also be made by telephoning 01535 294019 or via email: PALS.Office@anhst.nhs.uk

COMMUNITY ENGAGEMENT

Foundation Trust staff support many health related groups in both a business and voluntary capacity. We also support our staff to play a full part in the community, for example, by acting as Governors for schools.

Our now well established Patient and Carer Panel ensures we involve our community in monitoring standards and in the development of services.

During the year we continued to build on our link with Craven College as well as setting up a new one with Ilkley Grammar School. As a result, we have successfully recruited many young people to join our Foundation Trust membership as well as begun the initial process to develop a Youth Panel – see page 87 - with both groups. We also developed links with local BME groups and improved membership representation from different communities.

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

CORPORATE SOCIAL RESPONSIBILITY

The Foundation Trust works to be environmentally responsible and aware of its social impact on the community it serves. During the year we have worked to ensure that we make purchases not just from big corporations but from a mix of small, medium and large businesses and social enterprises, in order to ensure we invest more in the local economy and community and contribute to regeneration.

The Foundation Trust is committed to reducing its carbon footprint with a Foundation Trust endorsed Carbon Management Strategy. Our staff have continued to work closely with external consultants, such as the Carbon Trust, to monitor energy usage to enable the consumption to be reduced and thereby reduce our carbon footprint as well as reduce costs.

As part of our travel plans we continue to promote the use of public transport to staff for journeys to work. We also take part in the Cycle2Work scheme, which enables staff to buy bicycles for work using a monthly salary sacrifice scheme to encourage staff to reduce car use.

REDUCING OUR CARBON FOOTPRINT

The CRC Energy Efficiency Scheme (formerly known as the Carbon Reduction Commitment) is the UK's mandatory climate change and energy saving scheme. It is central to the UK's strategy for improving energy efficiency and reducing CO_2 emissions as set out in the Climate Change Act 2008.

The scheme is mandatory for all organisations whose electricity consumption is equivalent to an annual electricity bill of approximately £500k, so therefore applies to Airedale NHS Foundation Trust.

The Climate Change Act 2008 requires carbon dioxide and greenhouse gas emission reductions of 34% by 2020 and 80% by 2050 against 1990 performance. The same Act establishes that from 2010 all Government departments, including the NHS, will receive annual carbon budgets which they must adhere to.

The Foundation Trust has developed a Carbon Management Plan (CMP) which commits it to reducing CO_2 by 15% by 2015 from a 2007 baseline figure. Potential savings to the Foundation Trust could be around £1 million by that date. By following the CMP and delivering its objectives, the Foundation Trust will achieve a reduction of 15% on its 2007 carbon footprint (estate only figures) by 2015. This will mean that we will have not only reduced our carbon output but also reduced expenditure on utilities and the maintenance and operation of our estate.

The CMP will mean an improved environment for our local population, patients, visitors and staff.

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF AIREDALE NHS FOUNDATION TRUST

The National Health Service (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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Airedale NHS Foundation Trust to prepare each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Airedale NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS Foundation Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Bridget Fletcher
Chief Executive

28 May 2012

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 2012 and up to the date of approval of the Annual Report and Accounts.

CAPACITY TO HANDLE RISK

As Accounting Officer, I have overall responsibility for ensuring that there are effective risk management and integrated governance systems in place within the Foundation Trust and for meeting all statutory requirements and adhering to guidance issued by Monitor in respect of governance and risk management.

The Foundation Trust has a risk management strategy, which is reviewed and endorsed by the Board of Directors annually; there is a clearly defined structure for the management and ownership of risk through the development of the risk register and assurance framework. The 'high level' risks and assurance framework are monitored in the Board's sub committees and by the Board of Directors.

Some aspects of risk are delegated to the Foundation Trust's Executive Directors:

- The Medical Director is responsible for clinical governance, and has overall lead for risk management and patient safety with support from the Assistant Director of Healthcare Governance and Assistant Director of Patient Safety. The Medical Director is also responsible for information governance risks. The Assistant Director of Healthcare Governance is also responsible for reporting to the Board of Directors on the development and progress of the quality and patient safety strategy and for ensuring that the strategy is implemented and evaluated effectively;

- The Medical Director is also the executive lead (with management support provided from the Assistant Director of Healthcare Governance) to ensure a fully integrated and joined up system of risk and control management is in place on behalf of the Board;

- The Director of Nursing is responsible for infection prevention and control;

- The Director of Operations is responsible for health and safety;

- The Director of Finance provides the strategic lead for financial and performance risk and the effective coordination of financial controls throughout the Foundation Trust.

- The Director of Organisational Development and Workforce is responsible for workforce planning, staffing issues, education and training; and

- All heads of service, Clinical Directors and managers have delegated responsibility for the management of risk

and patient safety in their areas. Risk is integral to their day-to-day management responsibilities. It is also a requirement that each individual division produces a divisional/directorate patient safety and risk register, which is consistent and mirrors the Foundation Trust's patient safety and risk register requirements and is in line with the risk management strategy.

All members of staff have responsibility for participation in the risk/patient safety management system through:

- Awareness of risk assessments which have been carried out in their place of work and to compliance with any control measures introduced by these risk assessments;
- Compliance with all legislation relevant to their role;
- Following all Foundation Trust policies and procedures;
- Reporting all adverse incidents and near-misses via the Foundation Trust incident reporting system;
- Attending regular training as required ensuring safe working practices;
- Awareness of the Foundation Trust patient safety and risk management strategy and their own divisional/directorate patient safety and risk management strategy; and
- Knowing their limitations and seeking advice and assistance in a timely manner when relevant.

The Foundation Trust recognises the importance of supporting staff. The risk management team act as a support and mentors to Foundation Trust staff who are undertaking risk assessments and managing risk as part of their role. Risk assessment training is available to all members of staff and includes:

- Corporate induction training when staff join the Foundation Trust;
- Mandatory update training for all staff every two years; and
- Targeted training on specific areas including risk assessment, incident reporting and incident investigation.

The Foundation Trust seeks to learn from good practice and will investigate any serious incidents, complaints and SIRI's (Serious Incidents Requiring Investigation) via the Root Cause Analysis Group. The findings are reviewed by the Foundation Trust's Assurance Panel to ensure learning points are implemented. Assurance is gained by presenting reports to the Foundation Trust's quality assurance groups and committees and/or the Board of Directors. Any learning points for staff are published via staff briefings.

In addition to the Foundation Trust reviewing all internally driven reports, the Foundation Trust adopts an open approach to the learning derived from third party investigations and audits, and/or external reports. During 2011/12, the Foundation Trust has taken on board recommendations from a number of external reports including the Report by the Parliamentary and Health Service Ombudsman on Complaints about Disability Issues (October 2011); Close to home: an inquiry into older people and human rights in home care (Equality and Human Rights commission, November 2011); and Dignity and Nutrition for Older People: Review of Compliance (June 2011). The Board reviewed the Reports and monitoring of the action plans implemented to address these recommendations was undertaken at Board sub-committee level.

The Foundation Trust actively seeks to share learning points with other health organisations, and pays regard to external guidance issued. Accordingly, the Foundation Trust will undertake gap analyses and adjust systems and processes as appropriate in line with best practice.

THE RISK AND CONTROL FRAMEWORK

The Board approved risk management strategy has defined the Foundation Trust's approach to risk throughout the year. The strategy determines the requirements for the identification and assessments of risks and for control measures to be identified and how

risks should be managed and the responsibilities of key staff in this process. As an organisation seeking to develop its innovative work in the field of telemedicine, the Foundation Trust is risk aware, and adopts a risk management approach.

The risk management strategy assigns responsibility for the ownership and management of risks to all levels and individuals to ensure that risks which cannot be managed locally are escalated through the organisation. The process populates the risk register and board assurance framework, to form a systematic record of all identified risks. All risks are evaluated against a common grading matrix, based on the Australia/New Zealand risk management standard to ensure that all risks are considered alike. The control measures, designed to mitigate and minimise identified risks, are recorded within the risk register and board assurance framework.

The Board Assurance Framework sets out:

- What the organisation aims to deliver (corporate/strategic objectives);
- Factors which could prevent those objectives being achieved (principle risks);
- Processes in place to manage those risks (controls);
- The extent to which the controls will reduce the likelihood of a risk occurring (likelihood); and
- The evidence that appropriate controls are in place and operating effectively (assurance).

The Board Assurance Framework provides assurance, through ongoing review, to the Board that these risks are being adequately controlled and informs the preparation of the Statement on Internal Effectiveness and the Annual Governance Statement. The Board Assurance Framework and risk register have identified no significant gaps in control/assurance.

The Foundation Trust's risk management processes have identified a number of risks. The most significant are outlined below along with how they have been/are being managed and mitigated and how outcomes are being assessed.

The Foundation Trust's financial position is subject to a number of risks. Its position is dependent on delivering productivity and efficiency improvements. This is against a difficult national economic background and changing NHS landscape. The strategy of focusing on partnership working to deliver system change is therefore continuing and will continue in to 2012/13 and beyond.

The Foundation Trust is mitigating these risks through rigorous budgetary control and management of significant productivity and efficiency improvements. Outcomes are being measured by monthly review of financial performance by the Board, in addition to scrutiny of the impact of efficiency savings on patient safety and quality of service.

Maintaining the security of the information that the Foundation Trust holds provides confidence to patients and employees of the Foundation Trust. To ensure that its security is maintained an Executive Director has been identified to undertake the role of Senior Information Risk Owner (SIRO). The SIRO has overseen the implementation of a wide range of measures to protect the data we hold and a review of information flows to underpin the Foundation Trust's information governance assurance statements and its assessment against the information governance toolkit. The review against the information governance toolkit provides me with assurance that these aspects are being managed and identified weaknesses addressed. During 2011/12, the Foundation Trust had no incidents classified at a severity rating of 3-5 that met the criteria for inclusion in the Annual Governance Statement.

Control measures are in place to ensure all organisations' obligations under equality, diversity and human rights legislation are complied with. This is evidenced by the response to the Equality Act 2010 in which Foundation Trust built on the work undertaken the previous year in reviewing the Single Equality Scheme at board level and the inclusion and completion of equality impact assessments on all the Foundation Trust's policies. Accordingly, the Board

approved the proposed approach and action plan for delivering the Equality Delivery System, approved the objectives of the System for publication and nominated a Non Executive Lead.

The Foundation Trust also ensures that the Patient and Carer Panel is consulted and engaged on all matters relating to risk. This is evidenced by the Patient and Carer Panel reviewing all policies relating to patient experience prior to approval by a Foundation Trust management committee.

Discussion has been ongoing throughout the year with colleagues in primary care trusts to ensure all key access targets are being met from within available resource. There have been regular contract management meetings with the Foundation Trust's lead Primary Care Trust – NHS Bradford & Airedale and other reviews with NHS North Yorkshire & York and NHS East Lancashire.

The Foundation Trust successfully registered, without conditions, with the Care Quality Commission in 2010, and continues to be fully compliant with the requirements of registration with the Care Quality Commission. Assurance against the requirements of the CQC registrations is monitored on an ongoing basis throughout the year by the Executive Lead responsible for ensuring compliance for each of the CQC outcomes.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

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

REVIEW OF ECONOMY, EFFICIENCY, AND EFFECTIVENESS OF THE USE OF RESOURCES

The Foundation Trust has a comprehensive system that sets strategic and annual objectives. The Board of Directors sets these objectives with regard to the economic, efficient and effective use of resources.

The objectives set reflect national and local performance targets for standards of patient care and financial targets to deliver this care within available resources. Within these targets, the Foundation Trust includes specific productivity and efficiency improvements. These are identified from a range of sources including internal review such as internal audit and external organisations such as the NHS Litigation Authority, the Audit Commission and other benchmarking agencies.

The Foundation Trust has a robust monitoring system to ensure that it delivers the objectives it identifies. Ultimate responsibility lies with the Board which monitors performance through reports to its monthly meetings. Underpinning this is a system of monthly reports on financial and operational information to the Foundation Trust's executive management group, and clinical management group. Reporting at all levels includes detail on the achievement against productivity and efficiency targets.

The Foundation Trust operates within a governance framework of Standing Orders, Standing Financial Instructions and other processes. This framework includes explicit arrangements for:

- Setting and monitoring financial budgets;
- Delegation of authority;
- Performance management; and
- Achieving value for money in procurement.

The governance framework is subject to scrutiny by the Foundation Trust's Audit Committee and internal and external audit.

ANNUAL QUALITY ACCOUNT

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

2009/2010 was the initial development year of a Quality Account for Airedale NHS Foundation Trust. The Foundation Trust has built on the extensive work undertaken to develop the Quality Account during the previous two years and has drawn on the various guidance published in-year in relation to the Quality Account.

The Foundation Trust developed its vision, values and priorities through wide involvement and in consultation with patients, carers, staff, external stakeholders and Governors. The consultation process for the Quality Account included a number of presentations made to the Board of Directors and Council of Governors on Quality Accounts, a workshop session with representatives from the Council of Governors, LINk's and Patient and Carer Panel as well as members of the public. In addition, Foundation Trust members were canvassed for their opinions on the Foundation Trust's quality improvement plans via an online survey.

Through this engagement the Foundation Trust has been able to ensure the areas chosen provide a balanced view of the organisations priorities for 2011/2012. In the preparation of the Quality Account, the Foundation Trust appointed a Quality Account project lead to develop the Quality Account, reporting direct to the Medical Director, and a Quality Account Steering Group was established, whose membership included Governor representatives. A formal review process was established, involving a presentation of the Foundation Trust's initial draft account to its external stakeholders (Overview and Scrutiny Committee's, Local Involvement Network's and Commissioners). The Quality Account drafts were formally reviewed through the Foundation Trust's governance arrangements (formal management group, Board sub committee and Board of Directors). The Foundation Trust set priorities for 2011/12 were patient safety, patient experience and clinical effectiveness. Priorities were then developed to embed and monitor quality improvement processes, set against the needs of patients in the delivery of the Foundation Trust's services.

The Foundation Trust has utilised divisional performance reports, governance and quality reports, clinical outcome measures, mortality reports, Dr Foster and CHKS benchmarking data and a range of key national targets to govern the work associated with these priorities. The data used to report the Foundation Trust's quality performance in 2011/2012 was taken from national data submissions, CHKS and national patient surveys. The quality and safety metrics were reported regularly to the Board through the performance and governance reports. Assurance was gained by sharing the Quality Account with PCT Commissioners, LINks and OSCs as required by national regulation. The Audit Commission will undertake a review of the arrangements in place at the Foundation Trust to secure the data quality of information included in the Quality Account. The report prepared by the Audit Commission will be submitted to Monitor by the end of June 2012.

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 Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on

the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, and the executive risk management group, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The 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 the Audit Commission, Care Quality Commission, Internal Audit, NHS Litigation Authority and the Health and Safety Executive.

The following groups and committees are involved in maintaining and reviewing the effectiveness of the system of internal control:

- The Board of Directors has overall accountability for delivery of patient care, statutory functions and Department of Health requirements;

- The Audit Committee oversees the maintenance of an effective system of internal control and reviews the statement on internal effectiveness and Annual Governance Statement;

- The Executive Strategic Risk Management Group oversees the risk management process at operational level, ensuring that risks are managed and/or escalated in line with the Risk Management Strategy;

- The Assistant Director of Healthcare Governance through the Executive Strategic Risk Management Group ensures that a fully integrated approach is taken when considering whether the Foundation Trust has in place systems and processes to support individuals, teams and corporate accountability for the delivery of safe patient centered, high quality care;

- The Clinical Quality, Safety and Assurance Committee together with its sub-group provide the Board of Directors with assurances of clinical effectiveness, quality of clinical practice, safety of patients and patient experience. It also supports the Board of Directors in developing an integrated approach to governance by ensuring implementation of robust systems which enable the Foundation Trust to achieve its clinical objectives; and

- Internal audit is provided by the West Yorkshire Audit Consortium (WYAC). WYAC present the internal audit work plan at the Audit Committee for approval which is then monitored by both the Audit Committee and the Executive Strategic Risk Management Group. The Head of Internal Audit presents an annual opinion on the overall adequacy and effectiveness of the Trusts risk management, control and governance processes. This is achieved through a risk based plan of work, agreed with management and approved by the Audit Committee.

Review and assurance mechanisms are in place and the Foundation Trust continues to develop arrangements to ensure that:

- Management, including the Board, regularly reviews the risks and controls for which it is responsible;

- Reviews are monitored and reported to the next level of management;

- Changes to priorities or controls are recorded and appropriately referred or actioned;

- Lessons which can be learned, from both successes and failures, are identified and circulated to those who can gain from them; and

- Appropriate level of independent assurance is provided on the whole process of risk.

We acknowledge that the Foundation Trust is entering a period of significant change and will therefore continue to adapt to the changing NHS landscape through an iterative process of review of governance arrangements.

CONCLUSION

My review confirms no significant internal control issues have been identified for the year ended 31 March 2012.

Bridget Fletcher
Chief Executive

28 May 2012

AUDITOR'S REPORT ON THE SUMMARY FINANCIAL STATEMENTS

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF AIREDALE NHS FOUNDATION TRUST

Opinion on the summary financial statements

I have examined the summary financial statement for the year ended 31 March 2012 which comprises the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and parts of the remuneration report to be audited.

This report is made solely to the Council of Governors of Airedale NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. My audit work has been undertaken so that I might state to the Board of Governors those matters I am required to state to it in an auditor's report and for no other purpose. To the fullest extent permitted by law, I do not accept or assume responsibility to anyone other than the Foundation Trust as a body, for my audit work, for this report or for the opinions I have formed.

Respective responsibilities of directors and auditor

The directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 "The auditor's statement on the summary financial statement in the United Kingdom" issued by the Auditing Practices Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of Airedale NHS Foundation Trust for the year ended 31 March 2012.

Damian Murray

30 May 2012

Officer of the Audit Commission

3, Leeds City Office Park, Holbeck, Leeds, LS11 5BD

FOREWORD TO THE ACCOUNTS

AIREDALE NHS FOUNDATION TRUST

The accounts for the period ended 31 March 2012 are set out on the following pages and comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Tax Payers Equity, the Statement of Cash Flows and the Notes to the Accounts.

These accounts for the period ended 31 March 2012 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: B A Fletcher ..... Bridget Fletcher - Chief Executive

Date: 28/05/2012

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER OF THE AIREDALE NHS FOUNDATION TRUST

The National Health Service Act 2006 states that the Chief Executive is the Accounting Officer of the trust. The relevant responsibilities of the accounting officer, including his 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 accounting officers' memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the National Health Service Act 2006, Monitor has directed Airedale NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Airedale NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

Signed: B A Fletcher ..... Bridget Fletcher - Chief Executive

Date: 28/05/2012

NATIONAL HEALTH SERVICES ACT 2006

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

Monitor , the Independent Regulator of NHS Foundation Trusts , with the approval of HM Treasury , in exercise of powers conferred on it by paragraph 25(1) of Schedule 7 of the National health Services Act 2006, hereby gives the following Directions:

1. Application and interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these Directions "The Accounts" means

for an NHS foundation trust in its first operating period since authorisation, the accounts of an NHS foundation trust for the period from authorisation until 31 March

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

"the NHS foundation trust" means the NHS foundation trust in question

2. Form of Accounts

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

(2) The accounts shall meet the accounting requirements of the 'NHS Foundation Trust Annual Reporting Manual' (FT ARM) as agreed with HM Treasury, in force for the relevant year.

(3) The statement of Financial Position shall be signed and dated by the chief executive of the NHS foundation Trust.

(4) The Annual Governance Statement shall be signed and dated by the chief executive of the NHS foundation Trust.

3. Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

4. Approval on behalf of HM Treasury

(1) These directions have been approved on behalf of HM Treasury

Signed by the authority of monitor, the independent Regulator of NHS foundation trusts

STATEMENT OF COMPREHENSIVE INCOME FOR THE 12 MONTH PERIOD
31 March 2012

	Note	2011/12 £000	2011/12 £000	2010/11 10 months period £000	2010/11 10 months period £000
Operating income from continuing operations	3	**138,179**		106,538	
			138,179		106,538
Operating expenses of continuing operations:	4				
- Operating expenses		**(138,688)**		(105,396)	
		-	**(138,688)**	-	(105,396)
Operating Surplus/(deficit) before Finance costs			**(509)**		1,142
FINANCE COSTS					
Finance income		**37**		18	
Finance expense - financial liabilities		**(156)**		(86)	
Finance expense - unwinding of discount on provisions		**(36)**		(32)	
Public Dividend Capital - dividends payable		**(1,315)**		(1,263)	
NET FINANCE COSTS			**(1,470)**		(1,363)
SURPLUS/(DEFICIT) FOR THE PERIOD			**(1,979)**		(221)

The operating expenses for 2011/2012 and 2010/2011 include exceptional items relating to impairments on property, plant & equipment resulting from Modern equivalent Asset Valuation of £1,823,000 and £392,000 respectively. The operating expenses for 2011/2012 also includes an exceptional cost for restructuring of £4,267,000 and operating income includes an exceptional income item of £3,639,000 to fund the Transformation of Services. Excluding the exceptional items the Foundation trust made a surplus of £471,000 in 2011/2012 .

From the 1st April 2011 Community services contracts with a value of £5,879,000 were transferred to the Foundation Trust and are reflected in operating income and expenditure.
Due to changes in the Accounting treatment of Donated assets , which were retrospectively applied to 1st April 2010, the deficit for 2010/2011 has been restated as £221,000 , (previously accounts deficit £107,000).

	Note	2011/12 £000	2010/11 £000
SURPLUS/(DEFICIT) FOR THE YEAR		**(1,979)**	(221)
Other comprehensive income			
Impairments	6	**(4,255)**	(3,806)
Revaluations	6	**1,892**	147
Other Reserve Movements		**-**	-
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**(4,342)**	(3,880)

The 2010/2011 accounts were prepared for the 10 Month period 1st June 2010 to 31th March 2011

TCS (Transforming Community Services) transferred a contract income value of £5,022k from North Yorkshire and York PCT, and Bradford and Airedale PCT from the 1/4/2011

All operations are continuing.

The notes on pages 7 to 34 form part of these accounts.

STATEMENT OF FINANCIAL POSITION
as at 31 March 2012

	Note	31 March 2012	restated 31 March 2011	restated 1 June 2010
		£000	£000	£000
Non-current assets				
Property, plant and equipment	6	**50,002**	52,896	56,176
Trade and other receivables	9.1	**907**	1,042	495
Total non-current assets		**50,909**	**53,938**	**56,671**
Current assets				
Inventories	8	**2,349**	2,264	2,216
Trade and other receivables	9.1	**4,163**	3,986	3,895
Cash and cash equivalents	10	**11,216**	5,162	7,650
Total current assets		**17,728**	11,412	13,761
Current liabilities				
Trade and other payables	11	**(11,592)**	(9,276)	(9,774)
Borrowings	13	**(599)**	(77)	(77)
Provisions	16	**(1,521)**	(480)	(900)
Other liabilities	12	**(139)**	(139)	(139)
Total current liabilities		**(13,851)**	(9,972)	(10,890)
Total assets less current liabilities		**54,786**	55,378	59,542
Non-current liabilities				
Borrowings	13	**(4,901)**	(960)	(1,024)
Provisions	16	**(1,187)**	(1,238)	(1,342)
Other liabilities	12	**(4,603)**	(4,743)	(4,859)
Total non-current liabilities		**(10,691)**	**(6,941)**	**(7,225)**
Total assets employed		**44,095**	48,437	52,317
Financed by (taxpayers' equity)				
Public Dividend Capital		**44,319**	44,319	44,319
Revaluation reserve		**6,572**	8,961	12,620
Income and expenditure reserve		**(6,796)**	(4,843)	(4,622)
Total taxpayers' equity		**44,095**	48,437	52,317

The notes on pages 7 to 34 form part of these accounts.

The 2010/2011 accounts were prepared for the 10 Month period 1st June 2010 to 31th March 2011

Signed: B A Fletcher ..... Bridget Fletcher - Chief Executive

Date: 29/05/2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE PERIOD ENDED 31 March 2012

	Public Dividend Capital	Income and Expenditure Reserve	Revaluation Reserve	Donated Asset Reserve	Total
	£000	£000	£000	£000	£000
Balance as at 1 April 2011	44,319	(4,843)	8,961	-	48,437
Surplus/ (Deficit) for the financial year	-	(1,979)	-	-	(1,979)
Impairments	-	-	(4,255)	-	(4,255)
Revaluations	-	-	1,892	-	1,892
transfer between reserves on revaluation		26	(26)		-
Balance at 31 March 2012	44,319	(6,796)	6,572	-	44,095

	£000	£000	£000	£000	£000
Balance as at 1 June 2010	44,319	(4,622)	12,620	-	52,317
Surplus/ (Deficit) for the financial year	-	(221)	-	-	(221)
Impairments	-	-	(3,806)	-	(3,806)
Revaluations	-	-	147	-	147
Balance at 31 March 2011	44,319	(4,843)	8,961	-	48,437

The notes on pages 7 to 34 form part of these accounts.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 March 2012

	Note	2011/12 £000	2010/11 £000
Cash flows from operating activities			
Operating surplus from continuing operations		(509)	1,142
		(509)	1,142
Non-cash income and expense			
Depreciation and amortisation	4	4,606	3,770
Impairments		1,823	392
PDC Dividend Accrued		(115)	-
(Increase)/decrease in trade and other receivables		73	(638)
(Increase)/decrease in inventories		(85)	(48)
Increase/(decrease) in trade and other payables		1,286	(569)
Increase/(decrease) in other liabilities		(140)	(116)
Increase/(decrease) in provisions		1,026	(556)
TCS Creditor		8	
NET CASH GENERATED FROM/(USED IN) OPERATIONS		7,973	3,377
Cash flows from investing activities			
Interest received		37	18
Purchase of Property, Plant and Equipment	6	(4,730)	(4,165)
Sales of Property, Plant and Equipment		-	-
Net cash generated from/(used in) investing activities		(4,693)	(4,147)
Cash flows from financing activities			
Loans received		4,800	-
other loans		(85)	(64)
Loans repaid		(253)	-
Other Capital receipts		(121)	(46)
Interest Paid		(62)	-
Interest element on Finance lease		(56)	(86)
PDC dividend paid		(1,449)	(1,522)
Net cash generated from/(used in) financing activities		2,774	(1,718)
Net increase/(decrease) in cash and cash equivalents	10	6,054	(2,488)
Cash and cash equivalents at 1 April 2011	10	5,162	7,650
Cash and cash equivalents at 31 March 2012	10	11,216	5,162

The notes on pages 7 to 34 form part of these accounts.

The 2010/2011 accounts were prepared for the 10 Month period 1st June 2010 to 31th March 2011

Note 1 Accounting Policies and Other Information

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and the HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

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

Note 1.1 Consolidation

These accounts are for Airedale NHS Foundation Trust alone as there are no associates, joint ventures or joint operations. The Trust has no subsidiaries except Charitable funds , for which the Trust acts as Corporate Trustee, as per note 1.17 the Trust has been granted dispensation not to consolidate in 2011/2012.

Note 1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration received or receivable in the normal course of business, net of discounts and, where appropriate, other sales related taxes. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

The figures quoted are based upon income received in respect of actual activity undertaken within each category. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Airedale NHS Foundation Trust contracts with NHS commissioners following the Department of Health's Payment by Results methodology. The income associated with incomplete inpatient spells (spells which begin in one financial year but are incomplete at the year end date) is matched to the appropriate financial year. The value of incomplete spells of care has been calculated using estimation techniques and has been included in NHS receivables for the current year.

Note 1.3 Expenditure on Employee Benefits

Short Term Employee Benefits

Salaries, wages and employment related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension Costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website: www.nhsbsa.uk/pensions.

The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

The scheme is subject to full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:-

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution rates to be paid by employers and scheme members. The last such disclosed valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.The 2008 valuation has been undertaken, the report has yet to be disclosed to individual organisations.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6% with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pensions Scheme taking effect from 1 April 2008, his valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings. On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2012 is based on detailed membership data as at 31 March 2008 (the latest mid-point) updated to 31 March 2012 with summary global member and accounting data.

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

c) Scheme provisions

In 2008-09 the NHS Pension Scheme provided defined benefits, which are illustrated below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the scheme or the specific conditions that must be met before these benefits can be obtained.

Annual Pensions

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th for the 1995 section and on the best of the last three years pensionable service and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in consumer prices in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Members can purchase additional service in the NHS scheme and contribute to money purchase AVCs run by the schemes approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Preserved Benefits
Where a scheme member ceases NHS employment with more than two years service they can preserve their accrued NHS pension for payment when they reach retirement age.

Compensation for Early Retirement
Where a member of the scheme is made redundant they may be entitled to early receipt of their pension plus enhancement, at the employer's cost.

Note 1.4 Expenditure on Other Goods and Services

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

Note 1.5 Property, Plant and equipment

Property, plant and equipment is capitalised where:-
a) It is held for use in delivering services or for administrative purposes;

b) It is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
c) It is expected to be used for more than one financial year; and
d) The cost of the item can be measured reliably.
In addition, property, plant and equipment is capitalised if it:-
a) individually has a cost of at least £5,000; or
b) Forms a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they have broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control, or
c) Forms part of the initial setting up of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. Thereafter they are stated at cost less accumulated depreciation and any recognised impairment loss.

All assets are measured subsequently at fair value.

The carrying values of property, plant and equipment are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Land and buildings are valued at fair value in accordance with the revaluation model set out in IAS 16. Land and buildings are revalued at least every five years. More frequent valuations are carried out if the Foundation Trust believes that there has been a significant change in value.

Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors Valuation standards. The last asset valuations were undertaken by the Valuation Office Agency with a prospective valuation date of 1 April 2012, using the Desktop method of valuation.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and fair value for non-specialised operational property.

For non-operational properties including surplus land, the valuations are carried out at open market value

Assets in the course of construction are valued at cost and are revalued by professional valuers when they are brought into use.

Operational equipment is valued at net historic cost.

Subsequent Expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an of asset is replaced, the cost of the replacements capitalised if it meets the capital recognition criteria as above. Where subsequent expenditure is simply restoring the asset to the specification assumed by its economic useful life then the expenditure is charged to operating expenses.

Depreciation

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

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by professional valuers appointed by the Trust.

Property, plant and equipment is depreciated on a straight line basis over the estimated lives which are:-

a) Engineering plant and equipment:- 5 - 15 years,
b) Vehicles:- 7 years,
c) office equipment, furniture and soft furnishings:- 5 - 10 years,
d) Medical and other equipment:- 5 - 15 years,
e) IT equipment:- 3 - 6 years
f) Buildings, installations and fittings:- 15 - 80 years

The assets residual values and useful lives are reviewed, and adjusted if appropriate, at each statement of financial position date. An assets carrying amount is written down immediately to its recoverable amount if the assets carrying amount is greater than its estimated recoverable amount.

Property, plant and equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the classification. Assets under the course of construction are not depreciated until the asset is brought into use.

Disposals

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sale proceeds and the carrying amount of the asset and is recognised in the Statement of Comprehensive income.

Revaluation gains and losses

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

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

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

Impairments

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (1) the impairment charged to operating expenses and (2)the balance in the revaluation reserve attributable to that asset before the impairment.

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

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Derecognition

Assets intended for disposal are classified as 'Held for Sale' once all the following criteria are met:-

a) The asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

b) The sale must be highly probable i.e.:-

- management are committed to a plan to sell the asset,
- an active programme has begun to find a buyer and complete the sale,
- the asset is being actively marketed at a reasonable price,

- the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'
- the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

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

Property, Plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the assets economic life is adjusted. The asset is derecognised when scrapping or demolition occurs.

Protected Assets

Assets that are required for the provision of mandatory services are protected. Assets which are not required for mandatory services are not protected and may be disposed of by the Trust without the approval of Monitor (the independent Regulator of NHS Foundation Trusts).

Donated Assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to Income, unless the donor has imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case , the donation is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. Donated fixed assets are valued and depreciated as described above for purchased assets.

Note 1.6 Government Grants

Government grants are grants from Government bodies other than income from Primary Care Trusts or NHS Trusts for the provision of services. Grants from the Department of Health are accounted for as Government grants. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure the grant is taken to the statement of comprehensive income ,unless the donor has imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor ,in which case, the grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met. Grant assets are valued and depreciated as described above for purchased assets.

Note 1.7 Inventories

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the first in, first out method.

Note 1.8 Financial Instruments and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services) which are entered into in accordance with the Trusts normal purchase sale or usage requirements, are recognised when, and to the extent which performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets in respect of assets acquired through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

Derecognition

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

Financial liabilities are derecognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Loans and Receivables'

Financial liabilities are classified as 'Other Financial Liabilities'

Loans and Receivables

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

The Trusts loans and receivables comprise; cash and cash equivalents, NHS receivables, accrued income and other receivables.

Loans and receivables are recognised initially at fair value. In all cases the fair value is the transaction value. Any long term receivables that are financial instruments require discounting to reflect fair value.

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

Financial Liabilities

All financial liabilities are recognised initially at fair value. In all cases the fair value is the transaction value.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as long term liabilities.

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

Impairment of Financial Assets

At the Statement of Financial date, the Trust assesses whether any financial assets (loans and receivables) are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of an allowance account for credit losses.

Note 1.9 Leases

Finance Leases

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

The asset and liability are recognised at the inception of the lease, and are derecognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the Statement of Comprehensive Income.

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Note 1.10 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk adjusted cash flows are discounted using HM Treasury's discount rate of 2.8% in real terms for pension liabilities(2.9% 2010/11). All other provisions are discounted at the General discount rate of 2.2% (2.2% 2010/2011).

Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA, which in return settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the trust. The total value of clinical negligence provisions carried out by the NHSLA on behalf of the Trust is disclosed at Note 16

Non-clinical Risk Pooling

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

Note 1.11 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed on Note 14 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 14 , unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:-

a) Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control, or

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

Note 1.12 Public Dividend Capital

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

A charge reflecting the cost of capital utilised by the Trust is payable as PDC Dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, cash held with the Government Banking Service and any PDC dividend balance receivable or payable. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

Note 1.13 Value Added Tax

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

Note 1.14 Corporation Tax

The Trust is a Health Service body within the meaning of s519 ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is power for the Treasury to disapply the exemption in relation to the specified activities of a Foundation Trust (s519 (3) to (8) ICTA 1988), but as at 31 March 2012 this power has not been exercised. Accordingly the Trust is not within scope of Corporation Tax.

Note 1.15 Foreign Exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange rate gains and losses are taken to the Statement of Comprehensive Income.

Note 1.16 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are banked and shown within cash and creditors in the Trust's accounts.

Note 1.17 Dispensation from the Application of Accounting Standards

HM Treasury has granted a dispensation from the application of IAS 27 by NHS Foundation Trusts in relation to the consolidation of NHS charitable Funds for 2011/12.

Note 1.18 Critical Accounting Judgements and Key Sources of Estimation Uncertainty

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

Note 1.18.1 Critical Judgements in Applying Accounting Policies

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

a) HM Treasury requires Trusts to value their land and buildings on a Modern Equivalent Asset (MEA) basis. IAS 16 requires Trusts to ensure that a fixed assets are shown in their accounts at a fair value. To ensure compliance a 'desk top' review of land and buildings values was undertaken. The Trust commissioned the Valuation Office Agency (VOA) to conduct this piece of work and the Trust has recorded the revised valuation figures in these accounts.

Note 1.18.2 Key Sources of Estimation Uncertainty

The following are the key assumptions concerning the future and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year:-

a) In measuring income for the year management has taken account of all available information. Income estimates that have been based on actual information related to the financial year.
Included in the income figure is an estimate for incomplete spells, patients undergoing treatment that is only partially complete at year end. The number of incomplete spells for each specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which relates to the current year.
Injury compensation scheme income is also included to the extent that it is estimated it will be received in future years. It is recorded in the current year as this is the year in which it was earned. However as cash is often not received until future periods, when claims have been settled, an estimate must be made as to the collectability.

b) In estimating expenses that have not yet been charged for, management has made a realistic assessment based on costs actually incurred in the year to date, with a view to ensuring that no material items have been omitted.

c) The Trust's accounting policy for property, plant and equipment is detailed in Note 6 . The carrying value of property, plant and equipment as at 31 March is detailed in Note . As stated above the VOA has provided an MEA valuation of land and buildings, whilst on an annual basis management estimates the useful economic lives of equipment based on management's judgement and experience. When management identifies that actual useful lives differ materially from the estimates used to calculate depreciation, that charge is adjusted prospectively.

d) The Trust has a number of provisions, the largest of which relates to the early retirement costs of former staff. The valuation of the provision in respect of each former member of staff is based on guidance issued by the Department of Health at the point of retirement. As this valuation is based on average life expectancy actual costs are likely to differ from the estimated provision figures.

Note 1.19 Losses and Special Payments

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

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Note 1.20 Transforming Community Services (TCS)

The 2011/12 FReM required that all transfers between public sector bodies be accounted for using merger accounting. Therefore , in the 2011/2012 accounts , the divesting body of community services will report no activity in respect of TCS transferred functions , while the receiving body will report 12 months worth of activity.

The Department of Health has considered the feasibility of the restatement of prior period cpomparison for all local bodies (including NHS Foundation Trusts) and considers it is impracticable to undertake this restatement for all bodies on the basis of cost and availability of information.

To achieve consistency, NHS Foundation trusts should not include prior years comparators for transfers under TCS, and should action the amendments to 2011/2012 opening balances by means of adjustments to 1 April 2011 opening balances.

This limitation only applies to the prior year comparators that are include in the 2011/2012 accounts for TCS and cannot be applied in any other context. The rules under merger accounting continue to apply for all other transfers.

2 Operating segments

The NHS foundation trust's management has reviewed IFRS 8 (Operating Segments) and the aggregation criteria contained therein, they have determined that the trust meets the aggregation criteria and therefore will report as one segment "Healthcare".

3 Operating Income from continuing operations

3.1 Analysis operating income

	2011/2012 12 Months £000	Restated 2010/2011 10 Months £000
Income from activities by classification:		
Elective income	**22,611**	19,499
Non elective income	**38,557**	34,831
Outpatient income	**16,681**	14,155
Accident and Emergency income	**5,334**	4,115
Community Services	**5,022**	-
Other NHS clinical income	**29,330**	23,674
Private patient income	**507**	495
Other non protected Clinical income	**8,967**	1,064
Total income from activities	**127,009**	97,833
Income from activities by source:		
NHS Foundation Trust	**314**	187
NHS Trusts	**1,006**	234
Strategic Health Authorities	**77**	-
Primary Care Trusts	**124,260**	96,274
Department of Health - other	**-**	-
NHS Other	**47**	-
Non NHS: Private Patients	**507**	495
Non NHS: Overseas visitors	**15**	-
NHS injury scheme (see below*)	**562**	425
Non NHS: Other	**221**	218
Total income from activities	**127,009**	97,833
Other operating income:		
Research and development	**744**	457
Education and training	**3,966**	3,412
Charitable and other contributions to expenditure	**406**	238
Non-patient care services to other bodies	**1,666**	1,602
Profit on disposal fixed asset	**1**	1
Rental revenue from operating leases	**-**	15
Staff Recharges	**196**	
Other (see note 3.2)	**4,191**	2,980
Total other operating income before exceptional item	**11,170**	8,705
Transitional investment		
Total other operating income	**11,170**	8,705
Total operating income	**138,179**	106,538

*NHS injury scheme income is subject to a provision for doubtful debts of 9.6% (2011: 9.6%) to reflect expected rates of collection.

2010/2011 Income is based on the 10 month period from the 1 June 2010 to the 31 March 2011 .

The value of NHS Income from TCS (Transforming Community Services) transferred at the 1/4/2011 from Bradford and Airedale PCT and North Yorkshire & York PCT included in the above note 3.1 is Income from activities £5,022k and other income £857k

Other Non Protected Clinical income includes a value of £3,639k for Transformation of Services.

3.2 Analysis of Other Operating Income: Other

	2011/2012 12 Months £000	2010/2011 10 Months £000
Car Parking	**769**	507
Estates maintenance	**370**	541
IT Recharges	**11**	-
Pharmacy Sales	**134**	4
Staff Accommodation rental	**7**	7
Crèche services	**574**	460
Catering	**76**	126
Clinical Tests	**839**	-
Clinical Excellence	**60**	-
Property Rentals	**2**	2
Other income (see below)	**1,349**	1,333
	4,191	2,980

The "Other" other income of £1,349k is made up of a wide variety of items, including items such as course fees income and sales of non patient services to other organisations. Clinical Tests include the provision of Telemedicine services.

3.3 Analysis of income from activities by mandatory and non-mandatory services

	2011/2012 12 Months £000	2010/2011 10 Months £000
Mandatory services	**110,280**	91,390
Non-mandatory services	**16,369**	6,443
Total	**126,649**	97,833

The value of Non mandatory Income from TCS (Transforming Community Services) transferred at the 1/4/2011 from Bradfo Yorkshire & York PCT included in the above note 3.3 is £5,022k

3.4 Private patient income

	2011/2012 12 Months £000	2010/2011 10 Months £000	Base year 2002/03
Private patient income	**507**	495	1,458
Total income from activities	**138,178**	106,543	77,826
Proportion (as percentage)	**0.37%**	0.46%	1.87%

Section 44 of the National Health Service Act 2006 requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion during 2002/03 (base year). The allowable percentage for Airedale NHS Foundation Trust is 1.9%. The Trust is therefore compliant with the requirements of the act .

4. Operating Expenses from continuing operations

4.1 Operating expenses comprise:

	2011/2012 12 Months £000	Restated 2010/2011 10 Months £000
Services from NHS Foundation Trusts	536	200
Services from NHS Trusts	793	500
Services from other NHS bodies	28	3
Purchase of healthcare from non NHS Bodies	162	593
Employee Expenses - Executive directors	527	462
Employee Expenses - Non-executive directors	122	61
Employee Expenses - Staff	91,961	74,244
Drug costs	7,208	5,681
Supplies and services - clinical	12,050	9,699
Supplies and services - general	2,475	2,008
Establishment	1,386	902
Transport	530	328
Premises	5,393	3,705
Increase in provision for irrecoverable debts	27	52
Inventories write down	-	-
Inventories consumed	-	-
Impairment of Plant, Property and Equipment	1,823	392
Depreciation on property, plant and equipment	4,606	3,770
Audit services- statutory audit	82	73
Audit services- internal audit	79	85
NHS Litigation Authority contribution - Clinical Negligence	2,967	2,129
Loss on disposal of property, plant and Equipment	-	1
Legal fees	180	3
Consultancy costs	381	260
Training, courses and conferences	356	36
Patients travel	5	5
Redundancy	4,267	-
Hospitality	26	12
Insurance	91	83
Losses, ex gratia and special payments	40	45
Other	587	64
Operating expenses	**138,688**	105,396

2010/2011 Income is based on the 10 month period from the 1 June 2010 to the 31 March 2011 .

The value of expenditure from TCS (Transforming Community Services) transferred at the 1/4/2011 from Bradford and Ai included in the above note 4.1

Employee Expenses - Staff	3,928
Services from other NHS bodies	148
Drug costs	3
Supplies and services - clinical	103
Supplies and services - general	5
Establishment	240
Premises	309
NHS Litigation Authority contribution - Clinical Negligence	13
Other	483
	5,232

Operating expenses
Other costs transferred as part of the TCS transfer have been absorbed in to general overheads as part of combined efficiencies

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 period 2011-12 was £1,044k (2010-11 £1,049k). This lease arrangement commenced on 22 October 2001 and is scheduled to run for 15 years. A review of the lease arrangements has determined that this should be treated as an operating lease under IFRS. Siemens invested £1.73 million at the start of the contract and it is envisaged that a total of £6.35 million will be spent on new equipment during the period of the contract. At the end of the contract, the Trust has the option to purchases the equipment at its market value or may require the operator to remove it. The annual charge for the service is fixed at £853k including an annual amount of £262k for maintenance.

The balance of lease payments relates to small operating leases in respect of Pathology analysers, Endoscopy equipment, photocopiers and cars. In all these cases the Trust has the option to purchase the equipment at its market value at the end of the lease or can require the operator to remove them.

4.2.1 Operating expenses include:

	2011/2012 12 Months	2010/2011 10 Months
	£000	£000
Other minimum operating lease rentals	**1,547**	1,442
	1,547	1,442

4.2.2 Total future minimum operating lease payments due:

	2011/2012 12 Months	2010/2011 10 Months
	£000	£000
Within 1 year	**1,488**	1,182
Between 1 and 5 years	**4,985**	5,319
After 5 years	**-**	741
	6,473	**7,242**

4.3 Operating leases as lessor

The trust has operating leases in place with Local Care Direct ltd and Davric Construction ltd relating to the use of accommodation on the Airedale General hospital site. The value of the lease payments from Local Care Direct in 2011/2012 was £9k and is expected to run until 31 March 2014.The value of the lease from Davric Construction ltd is £9k and currently being reviewed, as the initial contract has expired.

	2011/2012 12 Months	2010/2011 10 Months
	£000	£000
Rents recognised in period	**18**	15
Total future minimum operating lease income due:	**£000**	£000
Within 1 year	**9**	13
Between 1 and 5 years	**-**	17
After 5 years	**-**	-
	9	30

5. Employee expenses and numbers

5.1 Employee expenses

	2011/2012 12 Months Total	**Permanently Employed**	**Other**	2010/2011 10 Months Total	Permanently Employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**75,676**	**74,697**	**979**	60,802	59,518	1,284
Social Security Costs	**5,530**	**5,420**	**110**	4,471	4,382	89
Employer contributions to NHS Pensions Agen	**8,722**	**8,722**	**-**	7,155	7,155	-
Termination benefits	**4,267**	**4,267**	**-**	-	-	-
Agency/contract staff	**2,560**	**-**	**2,560**	2,278	-	2,278
	96,755	**93,106**	**3,649**	74,706	71,055	3,651

5.2 Average number of employees (WTE basis)

	Total Number	**Permanently Employed Number**	**Other Number**	Total 2011 Number	Permanently Employed Number	Other Number
Medical and dental	**227**	**227**	**-**	240	240	-
Administration and estates	**477**	**477**	**-**	509	509	-
Healthcare assistants and other support staff	**449**	**449**	**-**	432	432	-
Nursing, midwifery and health visiting staff	**683**	**683**	**-**	655	655	-
Scientific, therapeutic and technical staff	**360**	**360**	**-**	365	365	-
Bank and agency staff	**43**	**-**	**43**	29	-	29
Other	**2**	**2**	**-**	2	2	-
Total	**2,241**	**2,198**	**43**	2,232	2,203	29

WTE = Whole time equivalents

At the 31/3/2012 Staff transferring under TCS (Transforming Community Services)	**WTE**
Nursing, midwifery and health visiting	**56**
Healthcare assistants and other support	**40**
Administration and estates	**11**
Scientific, therapeutic and technical staff	**3**
	110

5.3 Retirement due to ill-health

During 2011/2012 from the 1/4/1011 to the 31/3/2012 there were 4 early retirements from the NHS agreed on the grounds of ill health(2010/11 :5). The estimated additional pension liabilities of these ill-health retirements will be £154k (2010/2011 : £396k) .The cost of these ill-health retirements will be borne by the NHS Business Authority - Pensions Division.

5.4 Staff Sickness Absence

	2011/2012	2010/2011
Days Lost (Long term)	25,102	26860
Days Lost (Short term)	14,959	15,175
Total Days lost	**40,061**	**42,035**
Total Staff years	**2,172**	**2,187**
Average working days lost	**18.4**	**19.2**
Total Staff Employed in period (Headcount)	3,157	3,065
Total Staff Employed in period with no Absence (Headcount)	1,271	1,196
Percentage Staff with no sick leave	**40.3%**	**39.0%**

5.5 Exit packages

The following is the breakdown of the 2011/2012 Exit packages

Exit Packages Cost Band	Number of agreed departures	Cost of departures £000
<£10,000	17	98
£10,001-£25,000	31	516
£25,001-£50,000	28	950
£50,001-£100,000	18	1,482
£100,001-£150,000	8	811
£150,001-£200,000	0	0
>£200,000	0	0
TOTAL	**102**	**3,857**
Addition Analysis		
MARS	68	774
Voluntary redundancy	34	3,083
TOTAL	**102**	**3,857**

£770,000 is paid or payable to the Pensions Agency in respect of Early retirement not arising from Ill health
There were no compulsory Redundancies

5.6 Median Remuneration

The HM Treasury FReM requires the disclosure of the median remuneration of the Trust's staff and the ratio between this and the mid point of the banded remuneration of the highest paid Director. The calculation is based on full-time equivalent staff of the Trust at the end of 2011/2012 on an annualised basis.

Median remuneration of staff	£23,589
Mid point of highest paid Director	£142,500
Ratio	**6.1**

6. Property, plant and equipment

6.1 Current year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2011	2,660	36,433	5,318	107	11,903	120	10,592	50	67,183
Additions - purchased	-	4,934	-	142	361	-	340	-	5,777
Additions - donated	-	63	-	-	31	27	-	-	121
Reversal of impairments	-	20	-	-	-	-	-	-	20
Impairments charged to revaluation reserve	-	(4,198)	(77)	-	-	-	-	-	(4,275)
Revaluations	-	(1,940)	(141)	-	-	-	-	-	(2,081)
Disposals	-	-	-	-	(840)	(24)	(696)	-	(1,560)
Cost or valuation At 31 March 2012	**2,660**	**35,312**	**5,100**	**249**	**11,455**	**123**	**10,236**	**50**	**65,185**
Depreciation at 1 April 2011	-	-	-	-	7,537	90	6,644	16	14,287
Provided during the year	-	1,998	152	-	954	10	1,487	5	4,606
Reclassifications	-	-	-	-	-	-	-	-	-
Impairments charged to I&E	-	1,823	-	-	-	-	-	-	1,823
Transfer to revaluation reserve	-	(3,821)	(152)	-	-	-	-	-	(3,973)
Disposals	-	-	-	-	(840)	(24)	(696)	-	(1,560)
Depreciation at 31 March 2012	**-**	**-**	**-**	**-**	**7,651**	**76**	**7,435**	**21**	**15,183**
Net book value									
- Purchased at 31 March 2012	2,660	35,052	535	249	2,793	11	2,801	20	44,121
- Finance Lease as at 31 March 2012	-	-	-	-	851	-	-	-	851
- PFI as at 31 March 2012	-	-	4,565	-	-	-	-	-	4,565
- Donated at 31 March 2012	-	260	-	-	160	36	-	9	465
Total at 31 March 2012	**2,660**	**35,312**	**5,100**	**249**	**3,804**	**47**	**2,801**	**29**	**50,002**
Asset Financing									
Owned	2,660	35,052	535	249	2,793	11	2,801	20	44,121
Finance lease	0	0	0	0	851	0	0	0	851
Private finance initiative	0	0	4,565	0	0	0	0	0	4,565
Donated	0	260	0	0	160	36	0	9	465
Total at 31 March 2012	**2,660**	**35,312**	**5,100**	**249**	**3,804**	**47**	**2,801**	**29**	**50,002**

6.2 Current year analysis of property, plant and equipment:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
Net Book Value	£000	£000	£000	£000	£000	£000	£000	£000	£000
Protected assets at 31 March 2012	1,539	23,138	-	-	-	-	-	-	24,677
Unprotected assets at 31 March 2012	1,121	12,174	5,100	249	3,804	47	2,801	29	25,325
Total at 31 March 2012	**2,660**	**35,312**	**5,100**	**249**	**3,804**	**47**	**2,801**	**29**	**50,002**

At 31 March 2012, the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by Alison Mobbs MRICS, Senior Surveyor DVS, Valuation Office Agency, Leeds Valuation Office, 42 Eastgate, Leeds. The Valuation Office Agency has confirmed that the valuation has been undertaken with regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition. The finance lease in this section relates to the provision of Catering services from Sodexo to the Trust. the arrangement commenced in May 2009 and has a life of 10 years.

6. Property, plant and equipment

6.3 Prior year property, plant and equipment comprises of the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 June 2010	2,660	38,044	5,365	-	11,783	133	10,421	40	68,446
Additions - purchased	-	4,049	-	107	171	-	171	-	4,498
Additions - donated	-	8	-	-	28	-	-	10	46
Reclassifications	-	-	-	-	-	-	-	-	-
Impairments charged to revaluation reserve	-	(3,793)	(13)	-	-	-	-	-	(3,806)
Revaluations	-	56	91	-	-	-	-	-	147
Disposals	-	-	-	-	(79)	(13)	-	-	(92)
Cost or valuation At 31 March 2011	**2,660**	**38,364**	**5,443**	**107**	**11,903**	**120**	**10,592**	**50**	**69,239**
Depreciation at 1 June 2010	-	-	-	-	6,839	90	5,329	14	12,272
Provided during the year	-	1,539	125	-	776	13	1,315	2	3,770
Reclassifications	-	-	-	-	-	-	-	-	-
Impairments charged to I&E	-	392	-	-	-	-	-	-	392
Transfer to revaluation reserve	-	-	-	-	-	-	-	-	-
Disposals	-	-	-	-	(78)	(13)	-	-	(91)
Depreciation at 31 March 2011	**-**	**1,931**	**125**	**-**	**7,537**	**90**	**6,644**	**16**	**16,343**
Net book value									
- Purchased at 31 March 2011	2,660	36,194	560	107	3,229	14	3,948	24	46,736
- Finance Lease as at 31 March 2011	-	-	-	-	969	-	-	-	969
- PFI as at 31 March 2011	-	-	4,758	-	-	-	-	-	4,758
- Donated at 31 March 2011	-	239	-	-	168	16	-	10	433
Total at 31 March 2011	**2,660**	**36,433**	**5,318**	**107**	**4,366**	**30**	**3,948**	**34**	**52,896**
Asset Financing									
Owned	2,660	36,433	560	107	3,397	30	3,948	34	47,169
Finance lease	0	0	0	0	969	0	0	0	969
Private finance initiative	0	0	4,758	0	0	0	0	0	4,758
Donated	0	0	0	0	0	0	0	0	-
Total at 31 March 2011	**2,660**	**36,433**	**5,318**	**107**	**4,366**	**30**	**3,948**	**34**	**52,896**

6.4 Prior year analysis of property, plant and equipment:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
Net Book Value	£000	£000	£000	£000	£000	£000	£000	£000	£000
Protected assets at 31 March 2011	1,539	23,817	-	-	-	-	-	-	25,356
Unprotected assets at 31 March 2011	1,121	12,616	5,318	107	4,366	30	3,948	34	27,540
Total at 31 March 2011	**2,660**	**36,433**	**5,318**	**107**	**4,366**	**30**	**3,948**	**34**	**52,896**

At 31 March 2011, the Trust's land and Buildings were revalued on a modern equivalent asset basis. The valuation work was carried out by Michael Burgess MRICS, Senior Surveyor DVS, Valuation Office Agency, Wycliffe House, Green Lane, Durham. The Valuation Office Agency has confirmed that the valuation has been undertaken with regard to International Financial Reporting Standards (IFRS) as applied to the United Kingdom public sector and in accordance with HM Treasury guidance, International Valuation Standards and requirements of the Royal Institution of Chartered Surveyors (RICS) Valuation Standards 6th Edition. The finance lease in this section relates to the provision of Catering services from Sodexo to the Trust: the arrangement commenced in May 2009 and has a life of 10 years.

6. Property, plant and equipment (continued)

6.5 Donors of property, plant and equipment:

	2011/2012 12 Months £000
HODU refurbishment donated by HODU Trust Fund	63
Zeiss OCT machine donated by General Trust Fund	25
Linear Array Transducer donated by Cardiac Disbursement Trust Fund	6
2 Peugeot Tepee Vehicles donated by Friends of Airedale	27
	121

For the 10 month period in 2010/2011 donated Assets were £46k

7. Current year intangible fixed assets

The trust had no intangible fixed assets at the 31 March 2012

8. Inventories

8.1 Analysis of inventories

	31 March 2012 £000	31 March 2011 £000
Drugs	668	457
Consumables	1,571	1,731
Energy	110	76
Total	2,349	2,264

8. Inventories (continued)

8.1 Inventories recognised in expenses

	2011/2012 12 Months £000	2010/2011 10 Months £000
Inventories recognised as an expense in the year	**17,434**	**13,686**
Write-down of inventories (including losses)	**25**	**23**
Total	**17,459**	**13,709**

9. Trade and other receivables

9.1 Trade and other receivables are made up of:

	31 March 2012 £000	31 March 2011 £000
Current		
NHS receivables	**2,256**	1,750
Provision for the impairment of receivables	**(179)**	(177)
Prepayments	**643**	1,010
VAT Receivables	**160**	362
PDC Dividend receivable (Department of Health)	**115**	-
Other receivables	**1,168**	1,041
Total	**4,163**	3,986
Non-Current		
NHS receivables	**-**	-
Provision for the impairment of receivables	**-**	-
Accrued income	**769**	869
other receivables	**138**	173
Total	**907**	1,042

The majority of the NHS foundation trust's trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by government to buy NHS patient care services, no credit scoring for them is considered necessary.

9.2 Movements in the provision for impairments of receivables

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April 2011	**177**	**125**
Increase in allowance recognised in income statement	**40**	**52**
Amounts utilised	**(25)**	**-**
Unused amounts reversed	**(13)**	**-**
Balance at 31 March 2012	**179**	**177**

NHS Injury Benefit Scheme income is subject to a provision for impairment of 9.6% to reflect expected rates of collection. Other debts are assessed by management considering age of debt and the probability of collection.

9.3 Ageing of non-impaired receivables past their due date

	31 March 2012 £000	31 March 2011 £000
0-30 Days	**59**	**70**
30-60 Days	**42**	**1**
60-90 Days	**138**	**24**
90-180 Days	**21**	**5**
over 180 Days	**-**	**-**
	260	**100**

10. Cash and cash equivalents

	31 March 2012 £000	31 March 2011 £000
Balance at 1 April 2011	5,162	7,650
Net change in year	6,054	(2,488)
Balance at 31 March 2012	11,216	5,162
Made up of:		
Cash with Government Banking Service	11,206	5,155
Cash at commercial banks and in hand	10	7
Cash and cash equivalents	11,216	5,162

11. Trade and other payables

Current	31 March 2012 £000	31 March 2011 £000
Receipts in advance	627	708
NHS payables	1,279	1,130
Amounts due to other related parties revenue	178	
Non-NHS trade payables-capital	1,588	618
Non-NHS trade payables-revenue	890	546
Accruals	371	364
PDC Payable	-	19
Other Payables	4,770	4,019
Sub Total	9,703	7,404
Tax payable	1,889	1,872
TOTAL	11,592	9,276

12. Other liabilities

Current	31 March 2012 £000	31 March 2011 £000
Deferred income	139	139
Non Current		
Deferred income	4,603	4,743
	4,742	4,882

The figures in this section relate to the deferred income balance resulting from bringing the PFI arrangements with FRONTIS onto the Statement of Financial Position as required by Department of Health Guidance on PFI under IFRS. The residences came into use in May 2005 and the deferred income credit balance is set to reduce in equal instalments over a period of 40 years from that date, whereupon ownership will transfer to the Trust. (Note 20)

13. Borrowing

13. 1 Finance Trust Financing Facility Loan

	31 March 2012 £000	31 March 2011 £000
Current		
Obligations under Loan	505	
Non Current		
Obligations under Loan	4,043	
	4,548	-

The Trust obtained a loan from the Foundation Trust Financing Facility on the 12/7/2012 repayable over 10 years , in the sum of £4.8 millions to support capital developments. The first instalment of the loan was repaid on the 15th March in the sum of £252k.

13. 2 Finance lease obligations

	31 March 2012 £000	31 March 2011 £000
Current		
Obligations under finance leases	94	77
Non Current		
Obligations under finance leases	858	960
	952	1,037

The Trust has one finance lease in place at 31 March 2012. This is with Sodexo and relates to the provision of equipment as part of the catering service provided to the Trust, which commenced in May 2009. The lease is set to run for 10 years from that date, when £1.174 million worth of capital expenditure was incurred by Sodexo in establishing the catering facility. At the end of the contract the Trust will have the option to purchase all equipment and fixtures for £1. In the 2011-12 financial year the annual finance charge was £94k and the annual lease liability was £86k.

Amounts payable under finance leases:	Minimum lease payments		Present value of minimum lease	
	March 2012 £000	April 2011 £000	March 2012 £000	April 2011 £000
Within one year	180	180	95	86
Between one and five years	719	719	495	446
After five years	384	564	362	505
Less future finance charges	(331)	(426)		
Present value of minimum lease payments	952	1,037	952	1,037

14. Contingencies

The NHS foundation trust has £20k contingent liability for legal expenses, which is based upon information provided by the NHS Litigation Authority.

15. Third Party Assets

Airedale NHS Foundation Trust did not hold any monies on behalf of patients at the 31st March 2012 or the 31st March 2011.

16. Provisions

16.1 Provisions current and non current

	Current		Non current	
	31 March 2012 £000	31 March 2011 £000	**31 March 2012 £000**	31 March 2011 £000
Pensions relating to the early retirement of staff pre 1995	**122**	**119**	**1,187**	**1,238**
Legal claims	**55**	**33**	**-**	**-**
Other	**1,344**	**328**	**-**	**-**
	1,521	480	**1,187**	1,238

16.2 Provisions by category

	Pensions relating to the early retirement of staff pre 1995 £000	Legal claims £000	Other £000	**Total £000**
At 1 April 2011	**1,357**	**33**	**328**	**1,718**
Arising during the year	**44**	**44**	**1,338**	**1,426**
Utilised during the year	**(121)**	**(6)**	**(97)**	**(224)**
No longer required	**(7)**	**(16)**	**(225)**	**(248)**
Unwinding of discount	**36**	**-**	**-**	**36**
At 31 March 2012	**1,309**	**55**	**1,344**	**2,708**

Expected timing of cash flows:

Within one year	**122**	**55**	**1,344**	**1,521**
Between one and five years	**486**	**-**	**-**	**486**
After five years	**701**	**-**	**-**	**701**
	1,309	55	1,344	**2,708**

The Pensions relating to other staff provision is expected to be fully utilised within the next 11 years. This statement is based on information provided by the NHS business Services Authority - Pensions Division. As the provision was establishment before the existence of 'back to back' arrangements, no reimbursement is expected.

The legal claims have a probability factor of 10%, 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.

£13,759,225 is included in the provisions of the NHS Litigation Authority at 31 March 2012 in respect of clinical negligence liabilities of the Trust (31 March 2011 - £8,250,037).

17. Losses and special payments

	31 March 2012 Total number of cases	**31 March 2012 Total value of cases £**	31 March 2011 Total number of cases	31 March 2011 Total value of cases £
Losses	**185**	**56,473**	**144**	**28,450**
Special payments	**23**	**35,837**	**21**	**53,731**
Total losses and special payments	**208**	**92,310**	165	82,181

The NHS foundation trust's losses and special payments include uncollectable private patient/other debts and ex gratia payments in respect of the loss of personal items. The payments are recorded on a cash basis rather than an accruals basis.

18. Contractual Commitments

Commitments under capital expenditure contracts at 31 March 2012 were £416,000.

Commitments under non cancellable revenue contracts at 31 March 2012 are £3,850,000.

18. Related Party Transactions

18.1 Transactions with Key Management Personnel

IAS 24 requires disclosure of transactions with key management personnel during the year. Key management personnel is defined in IAS as "those persons having authority and responsibility for planning, direction and controlling the activities of the entity. directly or indirectly ,including any director (whether executive or otherwise) of that Entity". The trust has deemed that its key management personnel are the board members (directors and non-executive directors) of the Trust.

The transactions with board members are as follows	£000
2011/2012	683

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

	£000
Short term employment benefits	623
Post employment benefits	60
Termination benefits	0
	683

Short term benefits employer benefits include salaries, employer's social security contributions and benefit in kind
Post employment benefits include employer's contribution to NHS Pension Scheme

The remuneration of individual Board members is disclosed with in the Trust's. annual report. There were no outstanding balances with directors as 31 March 2012

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

18.2 Transactions with other related parties

Airedale NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year the NHS foundation trust had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

	Income £000	**Expenditure £000**
NHS Bradford & Airedale	78,455	458
NHS East Lancashire	12,932	-
NHS North Yorkshire & York	31,251	222
Bradford Teaching Hospitals NHS Foundation Trust	436	1,142
Leeds PCT	1,136	5
Bradford District Care Trust	2,316	191
Yorkshire & The Humber SHA	4,006	3
Leeds Teaching Hospitals NHS Trust	641	1,045
NHS Business Authority	-	1
NHS Blood Transfusion Service	-	723
NHS Litigation Authority	-	3,044
other NHS bodies	2,139	824
	133,312	**7,658**
HMRC		17,733
NHS Pension Scheme		13,112
Bradford Metropolitan Council		489
Audit Commission		82
Other	35	3
	35	**31,419**

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

The NHS foundation trust has also received £320k of revenue from the NHS foundation trust's own Charitable Funds, for which the NHS foundation trust is a corporate Trustee.

19. Financial instruments.

	31 March 2012 £000	31 March 2011 £000
Financial assets		
NHS Trade and other receivables excluding non financial assets	**2,255**	1,758
Non-NHS Trade And other receivables excluding Non-financial assets	**1,564**	1,672
Cash and cash equivalents at bank and in hand	**11,216**	5,162
Total	**15,035**	8,592

The NHS foundation trust's financial assets all fall under the category 'loans and receivables'.

Financial liabilities		
Borrowings excluding Finance leases and PFI liabilities	**4,848**	-
Obligations under Finance leases	**952**	1,037
NHS Trade and other payables excluding non financial assets	**1,745**	1,130
Non-NHS Trade and other payables excluding Financial assets	**6,756**	4,996
Total	**14,301**	**7,163**

The NHS foundation trust's financial liabilities all fall under the category 'other financial liabilities'.

Maturity of financial liabilities		
In one year or less	**9,100**	6,211
In more than one year but less than two years	**726**	199
In more than two year but less than five years	**1948**	390
in more than five years	**2527**	363
Total	**14,301**	**7,163**

Management consider that the carrying amounts of financial assets and financial liabilities recorded at amortised cost in the financial statements approximate to their fair value.

Because of the continuing service provider relationship that the NHS foundation trust has with the Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS foundation trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies. The NHS foundation trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS foundation trust in undertaking its activities.

Liquidity Risk

The Foundation Trust's net operating costs are incurred under 3 year rolling contracts with local Primary Care Trusts, which are financed from resources voted annually by Parliament. The Foundation receives such contract income in accordance with Payment by Result(PBR),which is intended to match the income received in year by reference to the National Tariff procedure cost. The Foundation Trust receives cash each month based on an annually agreed level of contract activity, and there are monthly corrections made to adjust for the actual income due under PBR , to minimise the affects on cash flow.

The foundation Trust Currently finances its capital expenditure from internally generated funds, no use of the Foundations Borrowing limit is currently been made.

Interest Rate Risk

With the exception of cash balances , the Foundation Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Foundation Trust monitors the risk but does not consider it appropriate to purchase protection against it.

Foreign Currency Risk

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

Credit Risk

The Foundation Trust receives the majority of its income from Primary Care Trusts and Statutory bodies and so the credit risk is Negligible. The Foundation Trusts treasury management policy minimises the risk of loss of cash invested by limiting its investments to

- the government banking service and the National Loans Fund
- Banks registered directly regulated by the FSA

The policy limits the amounts that can be invested with any one non-government owned institution and the duration of the investment to £3m and 3 months.

Price Risk

The Foundation Trust is no materially exposed to any price risks through contractual arrangements.

20. Private Finance Initiative contracts

20.1 PFI schemes off-Statement of Financial Position

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

20.2 PFI schemes on-Statement of Financial Position

Since May 2005 residential services have been provided to the Trust by FRONTIS, a registered social landlord. This involved FRONTIS constructing an accommodation block and mews houses. FRONTIS are responsible for the maintenance of the accommodation and management of residential accommodation services, including the collection of rents from tenants. The Trust guarantees an occupancy level of 90%, but FRONTIS remits a share of any rents received for occupancy over 90%.

The accounting treatment of this arrangement was covered in a DH publication called 'Accounting for PFI under IFRS'. In this publication it was recognised that such arrangements involved the operator receiving all or most of its income from individual users rather than the Trust. The arrangement falls within the scope of IFRIC 12 and such is recognised as an item of Property, Plant & Equipment on the Statement of Financial Position at its fair value. The opposite entry at the point at which the asset was recognised was as a deferred income balance.

The arrangement is set to run for a period of 40 years from May 2005, but does not involve any cash flows between the Trust and FRONTIS. As such there is no imputed finance lease and service charges. During this period FRONTIS are responsible for maintaining the property, but at the end of the 40 year period ownership will revert to the Trust.

21. Prudential Borrowing Limit (PBL)

The NHS foundation trust is required to comply with, and remain within, a total prudential borrowing limit. This is made up of two elements:

- the maximum cumulative amount of long term borrowing. This is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code . The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit.

- the amount of any working capital facility approved by Monitor.

Further information on the NHS Foundation Trust's Prudential Borrowing Code and Compliance Framework can be found on the website of Monitor, the independent Regulator of Foundation Trusts.

The NHS foundation trust had a total long term borrowing limit of £23.6 million in 2011/12 .In 2011/2012 the trust obtained a loan, repayable over 10 years in the value of £4.8 millions, to support capital developments.

The NHS foundation trust has a £10 million approved working capital facility. This is in place but has not been used during the year.

The NHS foundation trust does have borrowing which arise out the Finance lease obligations in respect of the Catering lease with Sodexo which a current value of £952k.The contract commenced in May 2009 and has a life of 10 years.

Financial ratio	Actual ratios 2011/12	Approved PBL ratios 2011/12	Actual ratios 2010/11	Approved PBL ratios 2010/11
Minimum dividend cover	7.7x	>1.0 x	4.0 x	>1.0 x
Minimum interest cover	65.4x	>3.0 x	58.6 x	>3.0 x
Minimum debt service cover	20.7x	>2.0 x	33.6 x	>2.0 x
Maximum debt service to revenue	0.40%	<2.5%	0.10%	<2.5%

22. Intra-Government Balances

	amounts falling due within one year £000	Receivables amounts falling due after more than one year £000	amounts falling due within one year £000	amounts falling due after more than one year £000
English NHS Foundation Trusts	**88**		**242**	
English NHS Trusts	**251**		**207**	
Department of Health	**-**		**-**	
English Strategic Health Authorities	**85**		**-**	
English Primary Care Trusts	**1,310**		**416**	
RAB Special Health Authorities			**246**	
NHS Whole Government Accounting bodies	**-**			
Other Whole Government Accounting bodies	**-**			
As at 31 March 2012	**1,734**	**-**	**1,111**	**-**

23. Events after the Reporting period

There are no adjusting or non-adjusting post balance sheet events requiring disclosure.

CONTACT DETAILS

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www.airedale-trust.nhs.uk

PALS
The PALS team at Airedale NHS Foundation Trust offer support, information and advice to patients, relatives and visitors. The PALS office is located at the entrance to Ward 18 and is open weekdays from 8.00 am to 4.00 pm. Tel: 01535 294019. Email: PALS.Office@anhst.nhs.uk

READERS PANEL
The Readers Panel whilst being popular always needs to recruit new members. If you would be interested in joining this group, please contact Karen Dunwoodie, patient experience lead, on Tel: 01535 294027 who will be able to give you more information.

VOLUNTEERS
New volunteers are always welcome and if you are interested in becoming a volunteer at Airedale Hospital, please contact our Voluntary Services Manager on Tel: 01535 295316. Email: voluntary.services@anhst.nhs.uk