Bradford Teaching Hospitals **NHS**
NHS Foundation Trust

# Annual Report and Accounts

2015-2016

**FUTURE**
IMAGINE • INNOVATE • IMPROVE

**Patients First**
Together, putting patients first

**Bradford Teaching Hospitals NHS Foundation Trust**

**Annual Report and Accounts 2015-2016**

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

# Contents

# 1. Introduction

Bradford Teaching Hospitals NHS Foundation Trust is responsible for providing hospital services for the people of Bradford and, in a growing number of specialties, for communities across Yorkshire.
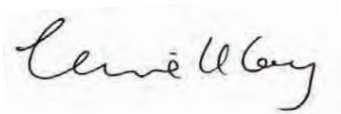
We became a Foundation Trust on 1 April 2004 – among the very first in the NHS to do so - and employ over 5,500 staff, serving a population of approximately 530,000. We also have one of the largest membership bases in the country with over 49,000 members, equating to 11% of the eligible local population.

We currently operate over several sites; the Bradford Royal Infirmary provides the majority of acute inpatient services, and St Luke's Hospital provides inpatient community health services, outpatient and rehabilitation services. We also manage three community hospitals: Westwood Park, Westbourne Green, and Eccleshill.

Bradford Royal Infirmary has over 900 beds and is also home to one of the busiest Accident and Emergency Departments (AED) in the country, with more than 130,000 attendances each year.   The maternity unit is also one of the NHS's busiest, delivering more than 6,000 babies per year.

St Luke's Hospital has approximately 80 beds and provides a variety of outpatient services, including haemodialysis  and provides inpatient community health services and daycase facilities.

As a teaching hospital, the Foundation Trust is at the forefront of research and development in healthcare, and is supported by the Bradford Institute for Health Research This promotes a culture of learning and professional development that ensures that all doctors, nurses and other healthcare professionals practice the highest clinical standards.

**Professor Clive Kay**
**Chief Executive**
**26 May 2016**

# 2. Performance Report

## 2.1 Overview of Performance

### 2.1.1 Statement from Chief Executive on Performance

2015-2016 has been another very busy year for us. We have faced extremely challenging financial constraints and unprecedented demand for services, including high levels of emergency demand sustained throughout the year.

However, despite these challenges our staff have continued to work together to deliver high quality and safe services for all our patients.

The Care Quality Commission (CQC) issued its report on our services in April 2015 and rated us as 'requires improvement'. Our staff responded immediately and rose to the challenge, making rapid and substantial improvements to drive forward the quality, safety, and experience of care that our patients receive.

Extra doctors and nurses, the creation of modern new facilities and an unprecedented focus on quality and safety spearheaded our package of improvements. We received a follow-up visit from the CQC in January 2016 and we are currently awaiting the outcome of that inspection.

At the forefront of our improvement work has been the launch of 'Future' – our biggest and most important improvement programme. Future breaks new ground, involves all staff and its launch signalled the start of a new approach for harnessing the innovation and imagination of our staff.

This year signalled the start of one of the most important eras in our history with two flagship and far-reaching projects.

Construction began on our long-awaited new hospital wing at Bradford Royal Infirmary – part of a £75m investment to improve patient care across our hospitals over the next five years.

The new build will transform our children's services, improve our elderly care provision and provide a long-awaited, state-of-the-art intensive care unit with increased single room provision.

We also procured an internationally-recognised Electronic Patient Record (EPR) system – one of the largest single transformation projects that we have carried out. Our investment will break new ground in the way it promotes standardised care and best practice.

Working in partnership with colleagues from Calderdale and Huddersfield NHS Foundation Trust, our EPR system aims to deliver improvements in quality, safety and efficiency and is a foundation of our transformation programmes.

This year saw phase one of our £2m gastroenterology unit expansion taking shape. The unit will allow more patients to be treated in an endoscopy day-case unit with a dedicated room for capsule endoscopy.

We have also started the £2m refurbishment of the Accident & Emergency Department (AED) at Bradford Royal Infirmary as part of our ambitious vision to create a more efficient acute medicine service for the people of Bradford. It has been designed to provide a slicker and more efficient service, with faster senior clinician involvement at an early stage in the patient pathway.

The scale and number of successes we have achieved in 2015-2016 has been outstanding given the very challenging environment we have been working in. We have demonstrated that we have the capacity and capability to improve safety, break new ground with our approach to transformation and further enhance the experience of our patients.

### 2.1.2 Purpose and activities of the Foundation Trust

The purpose of the Foundation Trust is set out in its Constitution as follows:

The principal purpose of the Foundation Trust is the provision of goods and services for the purposes of the health service in England

The Foundation Trust may provide goods and services for any purposes related to:

- the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and

- the promotion and protection of public health.

### 2.1.3 History of the Foundation Trust and statutory background

Bradford Teaching Hospitals NHS Trust was authorised to become an NHS Foundation Trust by Monitor, the Independent Regulator of NHS Foundation Trusts, under Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. The Authorisation came into force on 1 April 2004.

### 2.1.4 Key issues and risks affecting the Foundation Trust

During the year the Directors identified the following to be the key risks that could affect the Foundation Trust in delivering its objectives:

1. We fail to adequately engage with our patients and local population;

2. Failure to maintain a safe service due to insufficient recruitment and retention of staff;

3. We fail to maintain compliance with CQC regulatory requirements;

4. We are unable to maintain our financial stability and as a result fail to meet our Monitor licensing conditions;

5. We fail to successfully implement our new Electronic Patient Record (EPR) system as scheduled. The EPR project is described on page 201 of the Quality Report;

6. We are unable to develop and maintain positive relationships with our key external partners;

7. We fail to develop vertically and horizontally integrated care pathways.

The controls in place and assurance that the controls are effective are monitored by the Board through its quarterly reviews of the Board Assurance Framework.

### 2.1.5 Going concern disclosure

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.

## 2.2 Performance Analysis

### 2.2.1 Measurement of performance and the key measures used

As a Foundation Trust the main regulatory body responsible for overseeing Foundation Trust performance has been Monitor, an executive non-departmental public body, sponsored by the Department of Health. The Foundation Trust has made quarterly submissions to Monitor throughout the financial year 2015-2016. From 1 April 2016 Monitor became part of NHS Improvement.

The Foundation Trust continually measures its performance against a wide variety of key measures including but not exclusive to:

- Monitor Risk Assessment Framework access targets.

- National contract quality measures.

- Locally quality measures agreed with the local commissioner.

- Internally agreed performance measures.

The Foundation Trust has submitted ten Key Performance Indicators as part of the Monitor annual plan submission for 2016-2017 and will provide monthly information against these indicators as part of its quarterly submissions. These indicators address various areas of hospital performance such as access to services, financial control and efficiency. The indicators submitted were as follows:

- Referral to treatment time, incomplete pathways;

- Emergency care standard - Total time in AED under 4 hours;

- Cancer 2 Week Wait for all urgent referrals (cancer suspected);

- Cancer 62 Day Wait for first treatment (from urgent GP referral for suspected cancer);

- Clostridium difficile - meeting the Clostridium difficile objective;

- Liquidity Days;

- Income & Expenditure Margin (Variance from Plan);

- Agency Staff Expenditure Ceiling;

- Staff satisfaction survey - (As measured by 2016-2017 national CQUIN) Threshold = +5% compared to 2015;

- Outpatient new appointment DNA (did not attend) rates.

For relevant indicators the Foundation Trust uses the nationally mandated definitions as provided by:

- National contract guidance;

- Monitor Risk Assessment Framework guidance;

- NHS Data Dictionary definitions;

- NHS contract technical guidance.

The Foundation Trust has a regular cycle of performance monitoring which incorporates:

- Daily reporting against key indicators incorporating dashboard presentations;

- Weekly performance meeting with Clinical Divisions;

- Monthly Clinical Division performance reviews conducted by Executive Directors;

- Monthly reporting to the Foundation Trust Performance Committee

The Foundation Trust uses a variety of information resources to support analysis of performance using electronic data captured across a number of hospital systems. To support this, the Foundation Trust has invested in a new data warehouse and is developing a business intelligence solution to provide end users with direct access to performance information.

Performance information is presented in a variety of ways incorporating:

- Trend analysis;

- RAG (read amber green) ratings;

- Dashboard presentations;

- Comparative analysis;

- Predictive trend analysis.

### 2.2.2    Analysis of Performance

**Overview of Performance for 2015-2016**

The Foundation Trust has experienced a challenging year to maintain previous high levels of performance principally against the Monitor Risk Assessment Framework access targets.

High levels of emergency demand have continued throughout the year which has affected performance against both the elective and non-elective access standards.

Due to the failure to achieve the emergency care standard in three quarters over a twelve month period, under Monitor Risk Assessment Framework guidance, this automatically triggered a 'Governance concern' and moved the Foundation Trust's overall Governance rating from 'Green' to Under review'. The Foundation Trust remained rated as 'Under review' in quarter 4 2015-2016 and is awaiting further information requests from Monitor as per the agreed process. Under the terms of the framework Monitor will consider the nature and context of the breach before deciding on further action.

The Foundation Trust continued to perform well against Cancer thresholds and infection control standards.

The monthly performance against the Monitor Risk Assessment Framework access targets is provided in the table below with additional information comparing yearly performance provided on page 128 of the Quality Report.

**Monitor Risk Assessment Framework Access 2015-2016 monthly performance**

| Monitor risk assessment framework | | | | Overall Rating: Due to the cumulative failures of the Emergency Care Standard the FT's Monitor rating has been moved from 'Green' to 'Under Review' | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CQC | The CQC inspected the FT in January. The report is awaited. | | | | | | | | | | | | | | | |
| | | Threshold | Change | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
| Access thresholds | 18 weeks incomplete | >=92% | ▼ | 94.6% | 93.8% | 93.9% | 92.6% | 92.1% | 92.2% | 92.0% | 92.3% | 92.0% | 91.6% | 92.3% | 92.1% |
| | Emergency Care Standard | >=95% | ▼ | 96.4% | 94.0% | 92.2% | 95.4% | 95.1% | 95.3% | 93.5% | 94.6% | 91.9% | 91.3% | 91.6% | 90.7% |
| | Cancer 62 day FT urgent GP referral | >=85% | ▼ | 84.7% | 87.9% | 88.6% | 89.6% | 85.1% | 86.9% | 90.6% | 90.4% | 92.9% | 88.7% | 91.7% | 90.8% |
| | Cancer 62 day FT following screening | >=90% | ▲ | 83.9% | 100.0% | 91.9% | 100.0% | 100.0% | 100.0% | 97.9% | 98.0% | 100.0% | 97.4% | 95.5% | 96.3% |
| | Cancer 31 day ST surgery | >=94% | ▲ | 88.0% | 96.7% | 93.3% | 100.0% | 98.1% | 98.0% | 100.0% | 98.1% | 100.0% | 94.4% | 97.4% | 97.6% |
| | Cancer 31 day ST Drugs | >=98% | ◄► | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | Cancer 31 day FT | >=96% | ▲ | 99.2% | 97.5% | 100.0% | 98.8% | 97.9% | 98.7% | 97.8% | 100.0% | 100.0% | 98.3% | 96.1% | 100.0% |
| | Cancer 2WW Urgent Referral | >=93% | ▼ | 95.9% | 95.3% | 94.6% | 94.0% | 95.0% | 95.2% | 95.8% | 95.8% | 95.5% | 94.8% | 95.4% | 90.0% |
| | Cancer 2WW Breast Referral | >=93% | ◄► | 97.2% | 88.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | Clostridium Difficile - Agreed as due to lapse in care | FY <=51 | ▼ | 4 | 2 | 4 | 1 | 3 | 1 | 2 | 0 | 1 | 2 | 0 | 4 |

**Access key performance indicators**

The Foundation Trust has experienced continued pressures against both elective and non- elective access targets with continued demand for emergency beds which peaked in the last quarter of the year.

- The Emergency care standard was not achieved for the full financial year with performance reported as 93.5% against a threshold of 95%. The Foundation Trust did not achieve the threshold in the last six months of the year. For the full financial year attendances were up 1.7% on 2014-2015 mostly due to the increases seen in the final quarter (+11.8%). The AED averaged 365 daily attendances in 2015-2016 compared to 360 in 2014-2015. In Quarter 4, 2015-2016 the daily average attendance was 379 compared to 342 in Quarter 4 2014-2015. March 2016 was the second highest month for attendances in the last six financial years and 9.9% higher than March 2015. This position is reflected nationally where many Trusts have experienced difficulties in achieving the threshold.

- The RTT Incomplete threshold was achieved when calculated for the full financial year (92.6% against a threshold of 92%). The position is measured and reported on a monthly basis with the Foundation Trust reporting achievement of the threshold in all months except January 2016. Under the terms of the Monitor Risk Assessment Framework this constituted a failure of the quarter. The position has deteriorated compared to previous years and reflects the continuing pressures experienced in demand and capacity.

- Monitor Cancer thresholds are measured on a quarterly basis and all thresholds were reported as achieved for each quarter. All cancer thresholds were achieved when calculated for the full financial year 2015-2016. This compares favourably to the position seen nationally.

**Infection control key performance indicators**

The Foundation Trust has reported improved performance in the area of infection control with reductions in reported Clostridium difficile and MRSA (Methicillin-resistant Staphylococcus aureus) cases compared to the previous financial year. The Foundation Trust performed better than the threshold applied to Clostridium difficile (maximum of 51 cases).

- The Foundation Trust reported 5 MRSA cases, attributed to the Trust, for the financial year 2015-2016. This compares to 7 cases reported in financial year 2014-2015.

- The Foundation Trust reported 24 Clostridium difficile cases, attributed to the Trust, for the financial year 2015-2016. This compares to 32 cases reported in financial year 2014-2015.

**CQUIN (Commissioning for Quality and Innovation) 2015-2016 performance**

Final submissions for the national CQUINs on AKI (Acute Kidney Injury), Sepsis and Dementia are due in mid-May 2016. Projected positions are provided below where available. The Foundation Trust has continued to deliver a high level of achievement against the local and NHS England CQUINs requirements.

- The national CQUIN on AKI, introduced this year, is projected to be achieved for all quarters

- The continuing national CQUIN on dementia is projected to be achieved for all quarters.

- The new national CQUIN on sepsis did not meet the trajectory in quarter 3 but is projected to achieve for each other quarter.

- The new national CQUIN on AED diagnosis coding is projected to be partially achieved in quarter 4

- Locally agreed CQUINs requirements have been met for all quarters except the quarter 1 requirement for the long term conditions CQUINs

- NHS England CQUINs have been achieved with the exception of the quarter 1 requirements for the Hepatitis C Network CQUIN.

**Financial Overview**

**Overview of Financial Performance for 2015-2016**

- The Foundation Trust planned for an income and expenditure deficit of £3.5m in 2015-2016, which took into account some non-recurring expenditure during the year relating to out-patient improvement activities, the New Hospital Wing development and implementation of an Electronic Patient Record system (EPRs)

- For 2015-2016, the Foundation Trust has reported an income and expenditure deficit of £6.5m, which is £3m worse than planned.

- The planned deficit position required the Foundation Trust to make £15m of efficiency savings during 2015-2016 which equated to 4.2% of operating expenses. The main reason for the deficit being higher than planned were a shortfall against the efficiency savings requirement and an increase in agency staff cost premiums.

The table below summarises how the position changed between 2014-2015 and 2015-2016:

| | Position at 31.3.15 £m | Position at 31.3.16 | | | % Change on Previous Year |
| --- | --- | --- | --- | --- | --- |
| | | Plan £m | Actual £m | Variance £m | |
| Total Income | 364.6 | 366.1 | 369.9 | 3.8 | 1.5% |
| Operating Expenditure | -348.8 | -355.8 | -363.3 | -7.5 | 4.2% |
| **EBITDA** | **15.8** | **10.3** | **6.6** | **-3.7** | |
| Interest, Depreciation, Impairment & Dividend | -14.0 | -13.8 | -13.1 | 0.7 | |
| **Surplus / (Deficit)** | **1.8** | **-3.5** | **-6.5** | **-3.0** | |

- Despite the deterioration in the income and expenditure position, the Foundation Trust has been able to invest £21.8m in capital expenditure and to maintain a relatively strong liquidity position throughout the year resulting in an end of year cash balance of £66.2m.

**Income**

The total income reported for the 2015-2016 financial year was £369.9m which is split as follows:

- Income from Activities - £332.7m

- Other Operating Income - £37.2m

A more detailed composition of income in 2015-2016 is summarised in the table below:
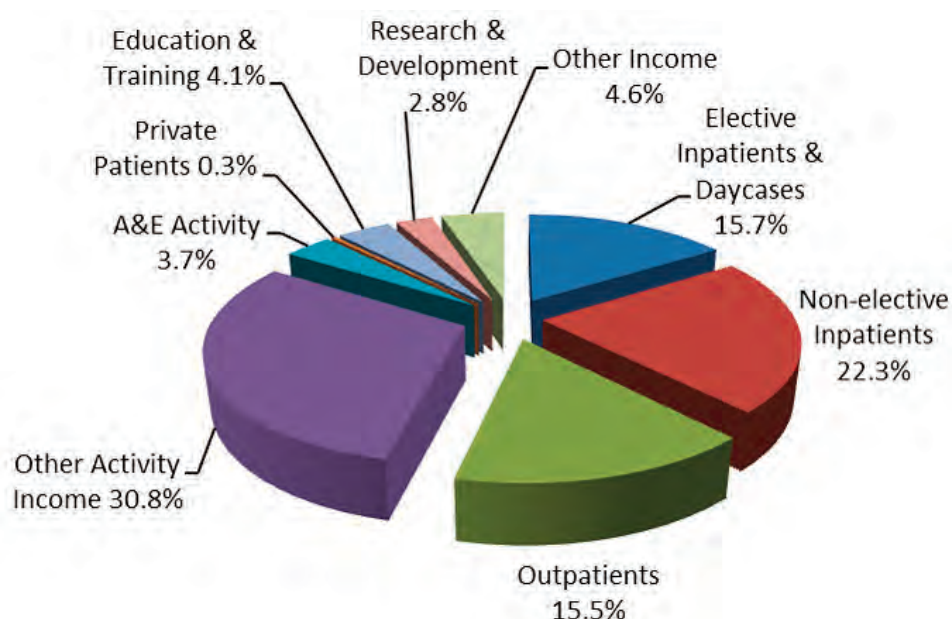


Income from activities is primarily income from Clinical Commissioning Groups (CCGs) and NHS England in relation to the provision of patient treatment services under contractual and commissioning arrangements. Other income is primarily non-patient related income and includes income for education and training, research activities, catering, car parking and other services.

The Foundation Trust has delivered more income than planned mainly through:

- Higher than planned levels of non-elective in-patient activity; and

- Increased high cost items such as drugs and blood products chargeable to the CCGs and NHS England on a usage basis.

**Expenditure**

The total expenditure reported for 2015-2016 was £376.4m which is split as follows:

- Pay bill for staff - £238.3m;

- Non-Pay costs including drug costs - £125.0m;

- Financing costs including depreciation and Public Dividend Capital - £13.1m.

A more detailed composition of expenditure in 2015-2016 is summarised in the table below:
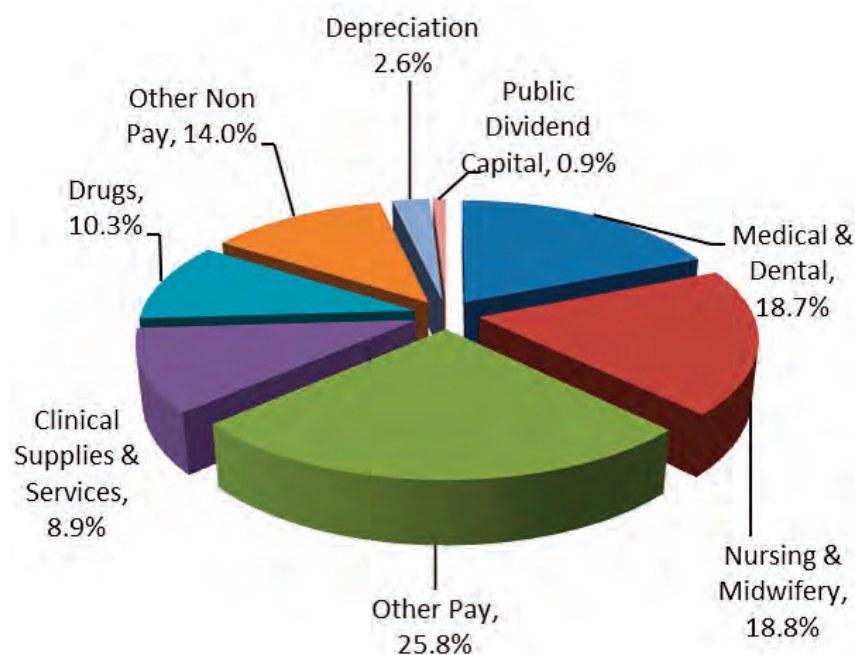


The Foundation Trust has incurred higher expenditure than planned through:

- Pay costs overspends associated with agency staff cost premiums, additional nursing costs for 1:1 patient care and premium rate payments for waiting list initiatives;

- The prescribing of specialist high cost drug and blood products;

- Delivery of efficiency requirements falling short of the planned levels.

**Efficiency Requirements**

The Foundation Trust commenced the year with a plan to deliver a £3.5m deficit which represented 1.0% of turnover.  Delivery of this target required the Foundation Trust to secure efficiencies of £15m mainly through the delivery of cost improvement programmes (CIPs) that deliver real cash releasing savings.

The efficiency plans have been delivered through a cost improvement programme carried out across the clinical divisions and support service departments.  In addition, a number of corporately sponsored schemes have been commissioned to support the delivery of CIPs. By not delivering its CIP target in full, the Foundation Trust's deficit of £6.5m was higher than planned.

**Looking Forward to 2016-2017**

The financial outlook for the forthcoming and future years continues to pose a significant financial challenge which will need to be delivered through an extensive efficiency programme at a time of ever increasing expectations for improving the quality and safety of healthcare and increasing demand.

For the forthcoming years the Foundation Trust will continue to link the delivery of efficiency gains with service improvement and transformation through the Trust Improvement Board. Improving the quality of care by removing waste and inefficient processes will in turn lead to more effective patient experience.

**Key Financial Risks**

The Foundation Trust started 2015-2016 with a number of significant financial risks, which have been partially managed through the delivery of the financial position highlighted above.

The main financial risks for 2016-2017 are as follows:

- Budgetary control targets and the efficiency targets against a backdrop of inflationary cost pressures, service developments, demand increases and quality improvement initiatives;

- Delivery of a cost improvement target of £24.4m required to meet the £8.8m control target surplus set by Monitor;

- Planned activity and income levels and ensuring robust, timely counting and charging processes are in place to facilitate monthly reporting; and

- Delivery of contractual indicators that attract financial penalty clauses for non-delivery.

In addition to maintaining the strong financial management arrangements, the main contingencies identified to mitigate against the above risks should they materialise are to:

- Identify further Divisional and centrally driven productivity and efficiency initiatives;

- Identify non recurrent measures that will release savings in-year;

- Closely monitor progress on access targets using the capacity review provisions within the contract to mitigate the application of financial penalties by the CCGs;

- Implement detailed monitoring and management of performance against contractual indicators with rigorous internal mechanisms for targeting both delivery and improvement;

- Generate additional income/contribution;

- Maintain regular dialogue with Divisions, to ensure internal reporting processes are appropriately identified where contractual changes have been introduced.

**Trust Improvement Programme**

The Foundation Trust has an improvement programme to oversee both quality and value for money improvements in the Foundation Trust. This is overseen by the Trust Improvement Board which has a robust project management approach and individual work streams led by Executive Directors, Clinicians and Transformation Leads. Quality Improvement is integral to many of the workstreams. Each programme has a series of milestones to facilitate timely delivery as well as key metrics against which performance can be demonstrated and judged.

High level governance arrangements surrounding our Improvement Programme are shown in the diagram below:
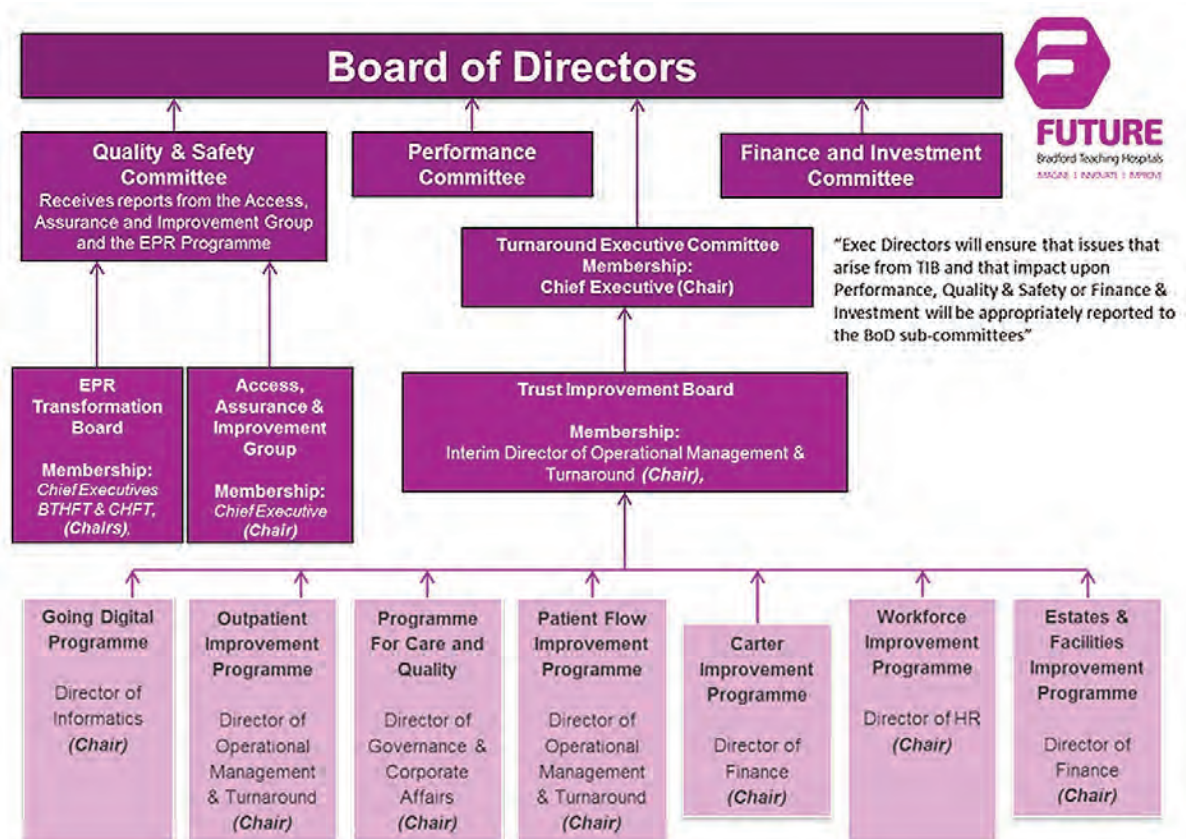


The Trust Improvement Board has identified and is pursuing a number of Trust-wide modernisation and service improvement initiatives as part of the Cost Improvement Programme which will secure improved value for money through recurrent productivity and efficiency benefits. There are seven programmes in total as follows:

- Going Digital Programme;
- Outpatient Improvement;
- Programme for Care and Quality;
- Patient Flow;
- Carter Efficiency Programme;
- Workforce Improvement;
- Estates and Facilities.

The Foundation Trust continues to pursue improvements in value for money for the services it provides, together with the drive for improvements in the qualitative aspects of care. This has been demonstrated through the continued investment in the infrastructure and estate to provide modern, fit for purpose facilities and meet nationally prescribed standards.

This is evidenced by the development of the New Hospital Wing which at the Bradford Royal Infirmary (BRI) site which will house modern paediatric and elderly care ward facilities, a new Intensive Care Unit, together with a new main entrance and concourse.

The Foundation Trust is also investing in an electronic patient record system, which will transform the administration of clinical data which will allow significant improvements in patient care and safety, along with efficiency and productivity opportunities after its implementation.

The Divisional annual plans and the capital programme also identify a number of ambitious schemes and service developments that will:

• enhance service delivery;
• align capacity to ensure services are provided from the optimum location; and
• deliver real qualitative improvements to the services provided.

The Foundation Trust's Programme Management Office, Transformation team and Quality Improvement team are working closely with the Divisions to secure sustainable and tangible change throughout the organisation. The remit of the teams, working in partnership is to:

• facilitate change and innovation;
• maximise efficiency and productivity;
• instil a culture of continuous improvement;
• train staff in improvement tools and techniques; and
• coordinate programmes of improvement work.

Through working with services and teams and challenging behaviours and processes, the significant outcomes will be the redesign of services/processes together with measurable efficiency, productivity and financial gains.

The continued development of service line reporting/management will improve the Foundation Trust's knowledge regarding the relative standing of services in relation to the income it receives through tariff. This will be further facilitated by the roll-out of a patient level costing system, providing detailed costing schedules on a per patient basis. The information produced by these two systems will provide an excellent opportunity to examine in detail those services that both do and do not appear to provide value for money and to identify opportunities for transformation and efficiency savings.

**Cash and Statement of Financial Position**

The cash position has decreased to £66.2m (2014-2015 £67.5m) which is largely due to the increased capital programme in 2015-2016 and the income and expenditure deficit of £6.5m.

**Long Term Borrowing**

The Foundation Trust secured a loan of £10m over 10 years from the Department of Health (DH) (Formerly the Independent Trust Finance Facility [ITFF]). The current amount outstanding is £3m and the final principal repayment is due in January 2019. This loan was used to fund a modular ward block at the BRI site.

Further loans from the ITFF have been taken to finance the capital investment strategy. Firstly, a loan of £20m was secured over 20 years to fund the New Hospital Wing. A total of £18.5m has been drawn down by the end of the financial year and no repayments have yet been made, with the final principal repayment due in February 2035.

Secondly a loan of £16m was secured over 8 years to finance the investment in the electronic patient record. A total of £9.8m has been drawn down and no repayments have been made. The final principal repayment is due in November 2024.

The Foundation Trust has also secured interest free loans from the Salix Energy Efficiency Loan Scheme. The total value of interest free Salix loans which are still to be repaid is £112k. The final principal repayment will be made in September 2017.

**The balances outstanding on each of these loans are shown below:**

|  | 31 Mar 16 £000 | 31 Mar 15 £000 |
|---|---|---|
| **Current** |  |  |
| Loans from ITFF – Ward Block 1 | 1,000 | 1,000 |
| Loans from ITFF – New Hospital Wing | 973 | 0 |
| Loans from ITFF – Electronic Patient Record | 0 | 0 |
| Salix Loans | 75 | 145 |
|  | **2,048** | **1,145** |
|  |  |  |
| **Non Current** |  |  |
| Loans from ITFF – Ward Block 1 | 2,000 | 3,000 |
| Loans from ITFF – New Hospital Wing | 17,527 | 2,300 |
| Loans from ITFF – Electronic Patient Record | 9,800 | 0 |
| Salix Loans | 37 | 113 |
|  | **29,364** | **5,413** |

**Investments**

The Foundation Trust does not have any investments in subsidiaries or joint ventures. The Trust invests any short term cash surpluses in the Government Banking Service and the National Loans Fund Temporary Deposit facility in line with the approved policy.

**Capital Programme**

Capital investment totalling £21.8m was made during the year. The main elements of the capital programme were as follows:

| Scheme | £million |
|---|---|
| Information Technology Schemes | 6.9 |
| Medical Equipment | 1.1 |
| Buildings and Engineering Maintenance and Upgrade | 2.2 |
| New Building Schemes & Other Strategic Investments | 11.6 |
| **Total** | **21.8** |

### 2.2.3 Environmental matters

Bradford Teaching Hospitals NHS Foundation Trust is committed to be a 'sustainable organisation caring for the future; working within financial, social and environmental limits'[1] by ensuring the 'efficient and effective use of resources'[2] so that 'we meet our regulatory targets and obligations'[3].

As part of this compliance the Foundation Trust has to demonstrate its continual environmental performance by presenting in the publically accessed areas a Display Energy Certificate (DEC). A DEC benchmarks the operational rating (zero being the best rating and over 150[4] being the worst rating) using the actual energy used in the building over a 12 month period by assigning an A to G rating[5] to the asset. Therefore this is a good indicator to demonstrate that the Foundation Trust is continually improving its energy and environmental performance and reducing its carbon emissions.

In the last round of Display Energy Certificates in December 2015 the Horton Wing at St Luke's Hospital (SLH) moved into the B rating category from a C rating. The operational ratings of each of the Bradford Royal Infirmary (BRI), Bradford Maternity and St Luke's Hospital sites are provided in the following graphs.

1. *Bradford Teaching Hospitals NHS Foundation Trust – Together, putting patients first strategy.*
2. *Bradford Teaching Hospitals NHS Foundation Trust Values Charter.*
3. *Bradford Teaching Hospitals NHS Foundation Trust – Together, putting patients first strategy.*
4. *An operational rating is a measure of the annual Carbon emission per unit of area of the building caused by its consumption of energy, compared to a value that would be considered typical for the particular type of building. Operational Rating = (Building CO2 emissions/Building area) x (100/Typical CO2 emissions per unit area).*
5. *The Operational Rating is related to a label, which the Government has determined is displayed on an "A to G" scale in a similar manner to many household appliances.*

## Display Energy Certificate - BRI



## Display Energy Certificate - Maternity



## Display Energy Certificate - Horton Wing
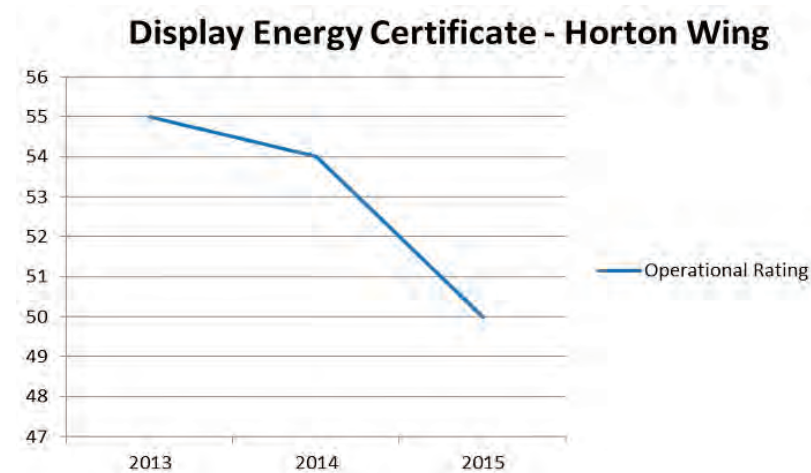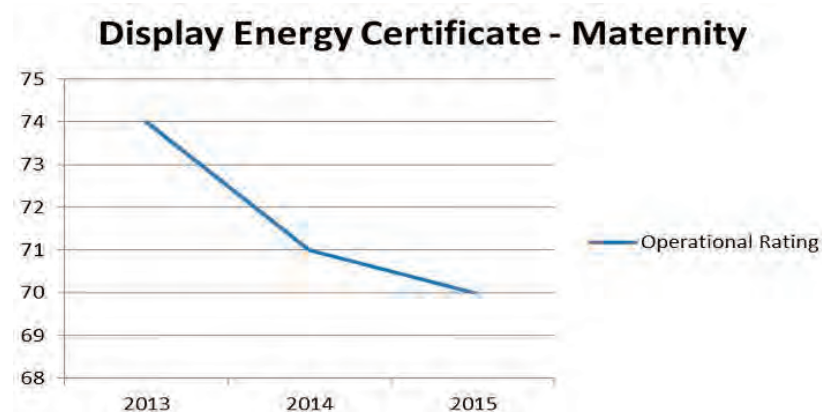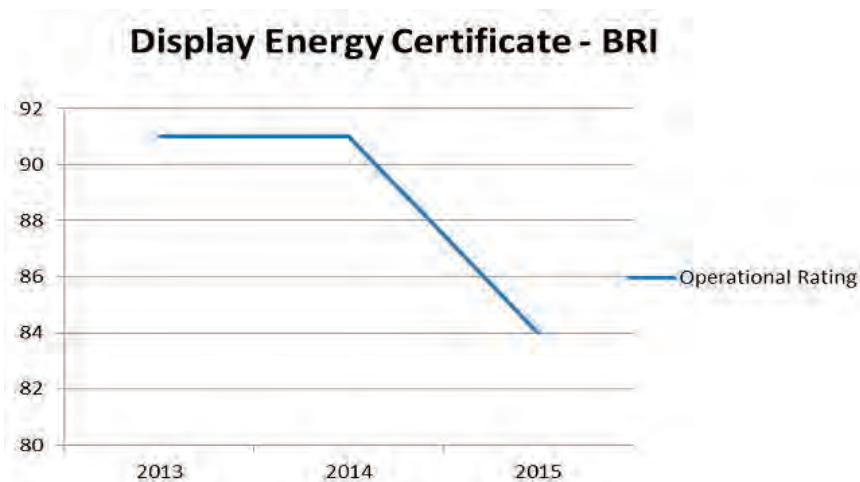


It should be noted that zero is the best rating, and a rating of 100 is a typical hospital building.

These environmental improvements are due to several contributing factors including investing over £800,000 in upgrading the old inefficient combined heat and power (CHP) plants at BRI, the installation of solar photovoltaics arrays at both BRI and SLH, and the installation of energy efficient (LED) lighting throughout the hospital sites. These investments support the recommendations made by Lord Carter in his independent report to the Department of Health to improve operational productivity and performance.

The Foundation Trust is committed to the UK's Climate Change Act 2008 which has legally binding targets of reducing carbon emissions by 34% by 2020 and 80% by 2050, based on 1990 levels. As a healthcare provider, employer and purchaser of goods and services, the Foundation Trust recognises that it has a significant impact on the environment and acknowledges its role in promoting sustainability and improving environmental performance.

This commitment is clearly demonstrated in the Estates & Facilities annual (ERIC) returns to the Department of Health. The Foundation Trust is in the best 25% when benchmarked against similar organisations for carbon emissions.

The forthcoming year is pivotal to ensuring that the Foundation Trust's commitments are firmly laid out to ensure compliance with the Climate Change Act 2008 targets. To take this forward, the Foundation Trust has a dedicated Environment and Sustainability Manager who will lead this, including the development of the relevant strategies, and ensuring policies and procedures are embedded throughout the organisation's activities.

Within the forthcoming year the following documents are due for Board of Directors' approval:

• Sustainability Development Strategy;

• Waste Management Policy;

• Corporate Green Travel Plan.

These documents will form part of a framework which will support the Foundation Trust's carbon reduction commitment and build upon successful previous initiatives such as LED lighting upgrades, CHP installation and energy efficiency campaigns.

### 2.2.4 Important events since year end

#### Resignation of Chairman

The Chairman of the Foundation Trust, Lord Kamlesh Patel of Bradford OBE, will step down on 31 May 2016, in order to move to a role supporting The Rt. Hon Baroness Scotland of Asthal QC, Secretary-General of the Commonwealth of Nations.   The process for appointing his successor has been commenced.

#### Executive Director Appointments

Karen Dawber has been appointed as the Foundation Trust's new Chief Nurse.  She is currently the Director of Nursing at Warrington and Halton Hospitals NHS Foundation Trust.

John Holden has been appointed as the Director of Strategy and Integration.  He is currently Director of Policy, Partnership and Innovation at NHS England.

Karen and John are both due to join the Trust during the summer months.

### 2.2.5 Overseas operations

The Foundation Trust has no overseas operations.

# 3. Accountability Report

## 3.1 Directors' Report

### 3.1.1 The Board of Directors

The Board of Directors is responsible for the day-to-day management of the Foundation Trust and the operational delivery of its services, targets and performance.

The Board reviews the Matters Reserved to the Board and Scheme of Delegation regularly and the last review took place in December 2015. Matters reserved to the Board include:

- The definition of the strategic aims and objectives of the Foundation Trust;

- Approval annually of revenue and capital budgets;

- Ratification of proposals for the acquisition, disposal or change of use of land and/or buildings;

- Approval of organisational structures to facilitate the discharge of business by the Foundation Trust.

The Scheme of Delegation sets out detailed arrangements for the delegation of budgetary control and financial procedures to Executive Directors.

The Board of Directors considers the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

**Composition of the Board of Directors**

During the year the Board of Directors has comprised of the following members:

**Chairman**

Professor Lord Patel of Bradford

**Executive Directors**

Professor Clive Kay – Chief Executive

Ms Bernie Bluhm – Interim Director of Operational Management and Turnaround (from 8 June 2015)

Ms Pat Campbell, Director of Human Resources

Ms Cindy Fedell, Director of Informatics

Dr Bryan Gill – Medical Director (from 5 May 2015)

Mr Matthew Horner – Director of Finance

Mrs Sally Scales – Acting Chief Nurse (from 5 March 2016)

Ms Donna Thompson, Director of Governance and Corporate Affairs

**Former Executive Directors**

(Directors who resigned or whose term of office ended during the year)

Mrs Jackie Ardley – Interim Chief Nurse (from 1 May 2015 to 4 March 2016)

Mrs Helen Barker – Chief Operating Officer (from 3 June 2013 to 10 May 2015)

Ms Juliette Greenwood – Chief Nurse (from 22 July 2013 to 30 April 2015)

Dr Robin Jeffrey – Interim Medical Director (from 1 September 2014 to 4 May 2015)

**Non-Executive Directors**

Professor Grace Alderson

Dr Trevor Higgins

Dr Mohammed Iqbal

Professor Bill McCarthy (from 1 November 2015)

Mr David Munt

Mr Amjad Pervez

Ms Selina Ullah (from 1 September 2015)

Mrs Pauline Vickers

Professor James Walker

The appointment of Selina Ullah and Professor Bill McCarthy during the year was intended to ensure the Board had an appropriate balance of skills, to ensure continuity, and to strengthen important links with the University of Bradford.  In addition it was believed that the current workload justified the additional appointments.

It is the opinion of the Board of Directors that all Non-Executive Directors are independent and that the composition of the Board is appropriate to the requirements of the Foundation Trust.

**Register of Interests**

The Board of Directors and Council of Governors undertake an annual review of its Register of Declared Interests.  At each meeting, there is a standing agenda item that also requires Board members and members of the Council of Governors to make known any interest in relation to the agenda, and any changes to their declared interests.

The Register of Declared Interests for the Board of Directors and Council of Governors is maintained by the Foundation Trust Secretary. The registers are available to the public by request from the Trust Secretary, using the details below:

**Trust Secretary**

Trust Headquarters
Bradford Royal Infirmary
Bradford, BD9 6RJ
Telephone: 01274 36 4946

There are no Company Directorships or other significant interests held by the individual Directors or Governors that may cause a conflict with the responsibilities of their respective roles.

### 3.1.2  Better Payment Practice Code Performance

The Better Payment Practice Code requires organisations to aim to pay all valid undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. As an NHS Foundation Trust, the Foundation Trust is not bound by this code, but seeks to abide by it as it represents best practice.

The Foundation Trust continues to improve transactional processing to pay creditors within this target whilst maintaining a balance on appropriate authorisation and validation of invoices. There were no interest charges paid in 2015-2016 from claims under the Late Payment of Commercial Debts (Interest) Act 1998.

|  | 2015-2016 | |
|---|---|---|
|  | Number | £000 |
| Total Non-NHS trade invoices paid in the year | 71,994 | 152,038 |
| Total Non-NHS trade invoices paid within target | 59,902 | 131,552 |
| Percentage of Non-NHS trade invoices paid within target | 83% | 86% |
| Total NHS trade invoices paid in the year | 2,498 | 20,220 |
| Total NHS trade invoices paid within target | 1,680 | 14,012 |
| Percentage of NHS trade invoices paid within target | 67% | 69% |

|  | 2014-2015 | |
|---|---|---|
|  | Number | £000 |
| Total Non-NHS trade invoices paid in the year | 61,748 | 123,500 |
| Total Non-NHS trade invoices paid within target | 52,339 | 103,834 |
| Percentage of Non-NHS trade invoices paid within target | 84% | 86% |
| Total NHS trade invoices paid in the year | 2,293 | 20,890 |
| Total NHS trade invoices paid within target | 1,677 | 14,324 |
| Percentage of NHS trade invoices paid within target | 72% | 71% |

### 3.1.3 Enhanced Quality Governance Reporting

The Foundation Trust's approach to quality and quality governance is presented in detail in the Quality Report (page 127) and also the Annual Governance Statement (page 73).

**Use of Quality Governance Framework / Well Led Framework**

The Board of Directors carried out a detailed self-assessment against the Well Led Framework in January 2015 with support from the Good Governance Institute. Compliance with the Quality Governance Framework was reviewed by the Integrated Governance and Risk Committee in February 2015. These reviews helped inform the corporate priorities for 2015-2016 and these priorities were reviewed by the Board of Directors on a quarterly basis.

In April 2015 Monitor incorporated the Quality Governance Framework into a revised Well Led Framework. The Board of Directors subsequently reviewed the results of previous self- assessments alongside the revised Framework and agreed that a further self-assessment would be carried out in the first quarter of 2016. In accordance with the requirements of the Framework an external governance review will be carried out by 30 April 2017.

**Use of Foundation Trust status to develop services**

**New Hospital Wing**

Our new £28m hospital wing at Bradford Royal Infirmary is expected to be completed by autumn this year.

Over three levels, it will house two new children's wards, a new orthogeriatric ward with four-bed bays and a £4.75m state-of-the-art intensive care unit with 16 single bedrooms – two of which are full isolation suites. The hi-tech features include switchable glass walls which change from frosted to transparent at the flick of a switch and a daylight-emulating lighting system.

BAM Construction Limited has been appointed to carry out the work, and the project also includes a major revamp at the main entrance of BRI with a new reception area which will house a new Patient Advice and Liaison Service (PALS) and Bereavement Centre, as well as retail outlets such as a shop, coffee bar and restaurant.

There will also be improvements to the hospital's rear entrance with improved access for visitors, staff, and those with disabilities. Extra car parking spaces for visitors will also be created under the scheme.

The New Hospital Wing is the Foundation Trust's single biggest project within an ambitious capital programme which will see £75m spent on improving patient care in our hospitals over the next five years.

## Stakeholder relations

The Foundation Trust has entered into a wide range of significant partnerships and alliances to facilitate the delivery of improved healthcare, some of which are illustrated in the chart below and more detail is provided on three of the more significant arrangements:



The work of Project Search is described in the Equality Report on page 84.

## Well North/Well Bradford

Well Bradford was officially established in January 2016 as a "spoke" of the Well North program based at the University of Manchester. It is a phase 2 site joining 8 others across the North of England on this Public Health England program. The Foundation Trust is leading the program on the behalf of the Bradford Integration and Change Board (ICB) and is the only Acute Trust to be doing so within the programme.

Well Bradford's current working objectives are:

To use Bradford and Airedale's combined community and health assets to improve health outcomes for the poorest, fastest. To do so we will:

- Investigate how acute hospitals may influence the determinants of health within their wider geographic setting;
- Support locally generated ideas and projects to improve health and wellbeing;
- Leave each place we touch with a sustainable health-related Community and Voluntary Service;
- Encourage local socially minded entrepreneurs and improve employment opportunity;
- Foster a wider understanding between acute care and the local community

**West Yorkshire Association of Acute Trusts**

The West Yorkshire Association of Acute Trusts (WYAAT) is an innovative collaborative which brings together NHS trusts delivering acute hospital services from across West Yorkshire and Harrogate to drive forward the best possible care for our patients.

The vision is to create a region-wide efficient and sustainable healthcare system that embraces the latest thinking and best practice so we can consistently deliver the highest quality of care and outcomes for our patients. By bringing together the wide range of skills and expertise across West Yorkshire and Harrogate there is an immense opportunity to work differently, be innovative and drive forward change to support patients. By thinking and working as a system, it is hoped that we can reduce duplication and work more efficiently to deliver the highest quality care for the people of West Yorkshire and Harrogate.

**Stanford Risk Authority**

The Trust has been invited to participate in an international collaborative working with partners in the UK and USA. Stanford Risk Authority, California is leading a pilot study over 2 years to assess whether innovative risk management processes, implemented within Stanford hospitals in the USA are transferable to other healthcare organisations throughout the USA and UK.

### 3.1.4 Income Disclosures

As required under Section 43(2A) of the NHS Act 2006, the Foundation Trust confirms that the income it received from provision of goods and services for the purposes of the health service in England is greater than the income it received from the provision of goods and services for any other purpose. Furthermore, the generation of "non-NHS related income" does not impact adversely on the quality of healthcare services delivered by the Foundation Trust.

### 3.1.5 Audit Disclosures

For each individual who is a Director at the time that this reports was approved:

- So far as the director is aware, there is no relevant audit information of which the NHS Foundation Trust's auditor is unaware; and

- The Director has taken all reasonable steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information, and to establish that the NHS Foundation Trust's auditors are aware of this information.

A Director is regarded as having taken all the steps that they ought to have taken as a Director in order to do the things mentioned above and:

- made such enquiries of his/her fellow Directors and the Foundation Trust's auditors for that purpose; and

- taken such steps (if any) for that purpose, as are required by his/her duty as a director of the NHS Foundation Trust to exercise reasonable care, skill and diligence.

## 3.2    Remuneration Report

### 3.2.1    Annual Statement on Remuneration (from Chair of the Remuneration Committee)

The Chairman chairs the Nominations and Remuneration Committee with all the Non-Executive Directors as members.

The Nominations and Remuneration Committee agrees the appointments process, salaries and terms and conditions for new Executive Director posts.  The Committee is also responsible for the review of appraisal outcomes for Executive Directors where these are linked to pay and the award of any salary increases. Starting salaries for new appointments are personally authorised by the Chairman.

The major decision on senior managers' remuneration was made in respect of the Medical Director.  Following consideration of his previous salary package, the ability to recruit and benchmarked salary information, the Committee agreed to a total salary package of £230,000.  This was inclusive of a silver clinical excellence award which is nationally funded and equates to £46,644.

The Committee had also in year to agree to two Board level Interim positions due to the inability to recruit to the Chief Nurse position and the need to appoint to an Interim Director of Operations whilst the structure of the Executive Director team was determined.  The Committee agreed to both appointments being retained by the Foundation Trust for up to 12 months.

Given the Secretary of State letter of 2 June 2015 where he asked Chairs to ensure that HMT guidance on 'off payroll' appointments was rigorously followed the above plan was discussed with Monitor and a disclosure made to the Department of Health.

The Interim Chief Nurse left with effect from 4 March 2016. The Nominations and Remuneration Committee agreed to a new salary for the Deputy Chief Nurse to act up to the Chief Nurse position until a substantive appointment is made.

The Nominations and Remuneration Committee agreed to a new non-voting Board member of Director of Strategy and Integration during this period.

**Professor Lord Patel of Bradford OBE**
**Chairman**
**26 May 2016**

### 3.2.2    Senior Managers Remuneration Policy

Two Executive Directors are on agenda for change terms and conditions. Two have been appointed to a single point which were based on previous earnings and therefore deemed the maximum of the scale.  All other Executive Directors are appointed on a 3 point salary scale with any incremental increase being on the basis of exceptional performance tied in with the Foundation Trust meeting its regulatory and corporate objectives with the award of any increase being based upon delivery of current year objectives.  Pay progression where it applies is on the basis of a £5000 increment.

The Remuneration Policy was revised in September 2015 following the Department of Health letter, 2 June 2015.

The Policy was made clearer in respect of the rationale for setting salary levels, in particular those higher than £142,500, the current level of the Prime Minister's salary, to be able to document against the following reasons:

- To match pay in the job from which they were recruited;

- To maintain relativities with other Very Senior Manager posts in the organisation;

- To match the market rate;

- Failure to recruit at a lower rate;

- Need to pay recruitment and retention premia;

- Other (which should be quantified).

Other considerations should be:

- The talent market alongside the individual's performance, experience and value to the Foundation Trust;

- Market data and peer group analysis;

- Affordability within the Foundation Trust's budgetary constraints, internal relativities, public perception and pay guidance in force at the time.

The Remuneration Committee will continue to monitor the above factors in order to ensure that remuneration levels are reasonable.

There are no annual bonuses in place for Executive Directors.

Terms and conditions for Executive Directors are aligned to Agenda for Change and any cost of living increase will be aligned to any pay award made to senior staff on Agenda for Change terms and conditions.

There are no other components to the Remuneration Policy.

### 3.2.3    Annual Report on Remuneration

### Service Contracts Obligations

The Foundation Trust has no separate obligations contained in contracts of employment for senior managers which would lead to a compensation commitment if a contract was terminated early.

### Policy on Payment for Loss of Office

Notice periods under Executive Director contracts are 3 months.

Either party can waive their right to notice or accept payment in lieu.

There is no separate policy for loss of office of Executive Directors.  The Foundation Trust works within the principles contained in HM Treasury Guidance on how to manage public funds in respect of 'special payments' and the Code of Governance for NHS Foundation Trusts.

Executive Director contracts contain immediate dismissal provisions for a number of categories.

The Foundation Trust's Redundancy Policy also applies.

**Statement of Consideration**

The Foundation Trust is mindful of the pay of direct reports where this is applicable.

The concept of pay being linked to performance is in line with the Foundation Trust's Appraisal, Development and Performance Management Policy for agenda for change staff which came into effect 1 February 2015.

The Foundation Trust does not consult with employees when preparing the remuneration policy for senior managers.

Attendance at meetings of the Remuneration Committee 2015-2016

| Members | 30.04.15 | 25.06.15 | 10.09.15 | 10.12.15 | 11.02.16 | TOTAL |
|---|---|---|---|---|---|---|
| Kamlesh Patel | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Grace Alderson | ✓ | ✓ | ✗ | ✓ | ✓ | 4 of 5 |
| Trevor Higgins | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Mohammed Iqbal | ✓ | ✓ | ✓ | ✓ | ✗ | 4 of 5 |
| David Munt | ✓ | ✓ | ✓ | ✗ | ✓ | 4 of 5 |
| Amjad Pervez | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Pauline Vickers | ✓ | ✓ | ✓ | ✗ | ✓ | 4 of 5 |
| James Walker | ✗ | ✓ | ✗ | ✗ | ✓ | 2 of 5 |
| Selina Ullah | | | ✓ | ✗ | ✗ | 1 of 3 |
| Bill McCarthy | | | | ✓ | ✓ | 2 of 2 |
| Clive Kay (in attendance) | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Pat Campbell (in attendance) | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| � ■ Denotes period when not a member of the Board | | | | | | |
| ✓ = attended | | X = apologies sent | | | | |

# Directors' Remuneration - Remuneration of senior managers

Note: It is the view of the Board that the authority and responsibility for controlling major activities is retained by the Board and is not exercised below this level.

| 2015-2016 Name and Title | Salary and Fees (Bands of £5,000) £000s | Taxable Benefits (to the nearest £100) £00s | Annual performance related bonuses (Bands of £5,000) £000 | Long term performance related bonuses (Bands of £5,000) £000 | Pension related benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Professor Lord Patel of Bradford (Chairman) | 55 – 60 | - | - | - | - | 55 – 60 |
| Professor Clive Kay (Chief Executive) | 245 – 250 | | | | 35.0 - 37.5 | 280 – 285 |
| Ms Jackie Ardley (Interim Chief Nurse)[1] | 140 -145 | - | - | - | - | 140 -145 |
| Mrs Helen Barker (Chief Operating Officer)[2] | 10 – 15 | | | | 0 – 2.5 | 10 – 15 |
| Ms Bernie Bluhm (Interim Director of Operational Management and Turnaround)[3] | 220 – 225 | - | - | - | - | 220 – 225 |
| Dr Bryan Gill (Medical Director)[4] | 205 – 210 | - | - | - | 25.0 – 27.5 | 235 – 240 |
| Ms Juliette Greenwood (Chief Nurse)[5] | 10 – 15 | - | - | - | 0 – 2.5 | 10 – 15 |
| Mr Matthew Horner (Director of Finance) | 135 – 140 | - | - | - | 17.5 – 20.0 | 155 - 160 |
| Dr Robin Jeffrey (Medical Director)[6] | 15 – 20 | - | - | - | - | 15 – 20 |
| Mrs Sally Scales (Acting Chief Nurse)[7] | 0 – 5 | - | - | - | 0 – 2.5 | 0 – 5 |
| Ms Pat Campbell (Director of Human Resources) | 100 – 105 | - | - | - | 12.5 – 15.0 | 115 – 120 |
| Ms Cindy Fedell (Director of Informatics) | 105 – 110 | - | - | - | 12.5 – 15.0 | 120 – 125 |
| Ms Donna Thompson (Director of Governance and Corporate Affairs) | 100 – 105 | - | - | - | 12.5 – 15.0 | 110 – 115 |
| Professor Grace Alderson (Senior Independent Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Dr Trevor Higgins (Non-Executive Director) | 15 – 20 | - | - | - | - | 15 – 20 |
| Dr Mohammed Iqbal (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Professor Bill McCarthy (Non-Executive Director)[8] | - | - | - | - | - | - |
| Mr David Munt (Non-Executive Director) | 15 – 20 | - | - | - | - | 15 – 20 |
| Mr Amjad Pervez (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Mrs Selina Ullah (Non-Executive Director)[9] | 5 -10 | - | - | - | - | 5 – 10 |
| Mrs Pauline Vickers (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Professor James Walker (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |

[1] Mrs Jackie Ardley, Interim Chief Nurse from 1 May 2015 to 4 March 2016, [2] Mrs Helen Barker, Chief Operating Officer to 10 May 2015, [3] Ms Bernie Bluhm, Interim Director of Operational Management and Turnaround from 8 June 2015, [4] Dr Bryan Gill, Medical Director from 5 May 2015, [5] Ms Juliette Greenwood, Chief Nurse to 30 April 2015, [6] Dr Robin Jeffrey, Medical Director to 4 May 2015, [7] Mrs Sally Scales, Acting Chief Nurse from 5 March 2016, [8] Professor Bill McCarthy, Non-Executive Director from 1 November 2015, [9] Mrs Selina Ullah, Non-Executive Director from 1 September 2015

Note: It is the view of the Board that the authority and responsibility for controlling major activities is retained by the Board and is not exercised below this level.

| 2014-2015 Name and Title | Salary and Fees (Bands of £5,000) £000s | Taxable Benefits (to the nearest £100) £00s | Annual performance related bonuses (Bands of £5,000) £000 | Long term performance related bonuses (Bands of £5,000) £000 | Pension related benefits (Bands of £2,500) £000 | Total (Bands of £5,000) £000 |
|---|---|---|---|---|---|---|
| Mr David Richardson (Chairman)[1] | 10 – 15 | - | - | - | - | 10 – 15 |
| Professor Lord Patel of Bradford (Chairman)[2] | 40 – 45 | - | - | - | - | 40 – 45 |
| Mr Bryan Millar (Chief Executive)[3] | 75 – 80 | - | - | - | - | 75 – 80 |
| Professor Clive Kay (Medical Director/Chief Executive)[4] | 245 – 250 | - | - | - | 30.0 - 32.5 | 280 – 285 |
| Mrs Helen Barker (Chief Operating Officer) | 115 – 120 | - | - | - | 15.0 – 17.5 | 135 – 140 |
| Ms Juliette Greenwood (Chief Nurse) | 115 – 120 | - | - | - | 15.0 – 17.5 | 135 – 140 |
| Mr Matthew Horner (Director of Finance) | 130 – 135 | - | - | - | 17.5 – 20.0 | 150 - 155 |
| Dr Robin Jeffrey (Medical Director)[5] | 115 -120 | - | - | - | - | 115 –120 |
| Ms Pat Campbell (Director of Human Resources) | 90 – 95 | - | - | - | 12.5 – 15.0 | 105 – 110 |
| Ms Cindy Fedell (Director of Informatics)[6] | 100 – 105 | - | - | - | 12.5 – 15.0 | 115 – 120 |
| Ms Donna Thompson (Director of Governance and Corporate Affairs)[7] | 40 – 45 | - | - | - | 5.0 – 7.5 | 45 - 50 |
| Professor Grace Alderson (Senior Independent Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Dr Trevor Higgins (Non-Executive Director) | 15 – 20 | - | - | - | - | 15 – 20 |
| Dr Mohammed Iqbal (Non-Executive Director)[8] | 0 – 5 | - | - | - | - | 0 – 5 |
| Mr David Munt (Non-Executive Director) | 15 – 20 | - | - | - | - | 15 – 20 |
| Mr Amjad Pervez (Non-Executive Director)[9] | 0 – 5 | - | - | - | - | 0 – 5 |
| Mrs Pauline Vickers (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Professor James Walker (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Mr John Waterhouse (Non-Executive Director)[10] | 10 – 15 | - | - | - | - | 10 – 15 |

[1] Mr David Richardson, Chairman to 30 June 2014, [2] Prof Lord Patel of Bradford, Chairman from 1 July 2014, [3] Mr Bryan Millar, Chief Executive to 31 August 2014, [4] Prof Clive Kay, Medical Director to 31 August 2014, Interim Chief Executive from 1 September 2014 to 10 December 2014, Chief Executive from 11 December 2014, [5] Dr Robin Jeffrey, Medical Director from 1 September 2014, [6] Ms Cindy Fedell, Director of Informatics received £8k non-taxable relocation expenses, [7] Ms Donna Thompson, Interim Director of Governance and Corporate Affairs from 10 September 2014 to 31 January 2015, Director of Governance and Corporate Affairs from 1 February 2015, [8] Dr Mohammed Iqbal, Non-Executive Director from 1 February 2015, [9] Mr Amjad Pervez, Non-Executive Director from 1 February 2015, [10] Mr John Waterhouse, Non-Executive Director to 31 January 2015

**Pension entitlement of senior managers**

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

| 2015-2016 Name and Title | Real increase in pension at pension age (Bands of £2,500) £000s | Real increase in pension lump sum at pension age (Bands of £2,500) £000s | Total accrued pension at age 60 at 31st March 2016 (Bands of £5,000) £000s | Lump sum at pension age related to accrued pension at 31st March 2016 at 31 March 2016 (Bands of £5,000) £000s | Cash Equivalent Transfer Value* at 01 April 2016 (Bands of £1,000) £000s | Real increase / (decrease) in Cash Equivalent Transfer Value * at 31st March 2016 (Bands of £1,000) £000s | Cash Equivalent Transfer Value* at 31 March 2015 (Bands of £1,000) £000s |
|---|---|---|---|---|---|---|---|
| Professor Clive Kay (Chief Executive) | 10.0 – 12.5 | 30.0 – 32.5 | 75 – 80 | 235 – 240 | 1,485 – 1,486 | 207 - 208 | 1,263 – 1,264 |
| Mrs Helen Barker (Chief Operating Officer)[1] | 0.0 – 2.5 | (0.0 – 2.5) | 45 – 50.0 | 130 – 135 | 769 - 770 | 1 – 2 | 745 – 746 |
| Dr Bryan Gill (Medical Director)[2] | 20.0 – 22.5 | 60.0 – 62.5 | 90 – 95 | 275 – 280 | 1,830 – 1,831 | 439 – 440 | 1,331 – 1,332 |
| Ms Juliette Greenwood, (Chief Nurse)[3] | 0.0 – 2.5 | 0.0 – 2.5 | 50 – 55.0 | 150 – 155 | 969 – 970 | 2 – 3 | 929 – 930 |
| Mr Matthew Horner (Director of Finance) | 0.0 – 2.5 | 0.0 – 2.5 | 40 – 45.0 | 110 – 115 | 608 - 609 | 26 – 27 | 575 - 576 |
| Mrs Sally Scales (Acting Chief Nurse)[4] | 0.0 – 2.5 | 0.0 – 2.5 | 30 – 35 | 95 – 100 | 577 – 578 | 0 – 1 | 565 – 566 |
| Ms Pat Campbell (Director of Human Resources) | 2.5 – 5.0 | 12.5 – 15.0 | 35 – 40.0 | 110 – 115 | 678 - 679 | 84 – 85 | 586 - 587 |
| Mr Cindy Fedell (Director of Informatics) | 2.5 – 5.0 | 0.0 | 0 – 5 | 0.0 | 48 – 49 | 21 – 22 | 26 - 27 |
| Ms Donna Thompson (Director of Governance and Corporate Affairs) | 10.0 – 12.5 | 35.0 – 37.5 | 45 – 50.0 | 135 – 140 | 912 - 913 | 253 - 254 | 650 - 651 |

* The Cash Equivalent Transfer Value is the actuarially assessed capitalised value of the pension scheme benefits accumulated by a member at a particular point in time. The benefits valued are the member's accumulated benefits and any contingent spouse's pension payable from the scheme. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

[1] Mrs Helen Barker, Chief Operating Officer to 10 May 2015, [2] Dr Bryan Gil, Medical Director from 5 May 2015, [3] Ms Juliette Greenwood, Chief Nurse to 30 April 2015,
[4] Mrs Sally Scales, Acting Chief Nurse from 5 March 2016

# Governor and Director Expenses

### Expenses Claimed by Directors

The total number of Directors holding office during 2015-2016 was 22 (the number in 2014-2015 was 19).

The number of Directors receiving expenses during 2015-2016 was 13 (the number in 2014-2015 was 15). The aggregate sum of expenses paid to Directors was £20,085 (2014-2015 £17,434).

### Expenses Claimed by Governors

The total number of governors holding office during 2015-2016 was 21 (the number in 2014-2015 was 22).

The number of Governors receiving expenses during 2015-2016 was 4 (the number in 2014-2015 was 5). The aggregate sum of expenses paid to governors in 2015-2016 was £214 (2014-2015 £367).

### Director Remuneration Disclosures

### Executive Directors

A salary scale is agreed for each Executive Director post in line with the principles set out earlier. If an individual is not appointed on the maximum of the scale any salary increase will be on the basis of exceptional performance tied in with the Foundation Trust meeting its regulatory and corporate objectives. The awarding of any increase is based upon delivery of current year objectives.

All other terms and conditions relating to Executive Directors were aligned to Agenda for Change and in the case of the Medical Director, medical and dental terms and conditions.

### Non- Executive Directors

Remuneration of Non-Executive Directors is determined by the Council of Governors. Non- Executive Directors receive a single fee and there are no additional fees payable for other duties and no other items that are considered to be remuneration in nature.

### Fair Pay Multiple

The HM Treasury Financial Reporting Manual requires the Foundation Trust to disclose the median remuneration of its staff as at 31 March and the ratio between this and the mid-point of the banded remuneration of the highest paid Director.

The banded remuneration of the highest paid Director in the financial year 2015-2016 was £245k-£250k (2014-2015, £245k- £250k). This was 9.5 times (2014-2015 9.6 times) the median remuneration of the workforce, which was £26,014 (2014-2015 £25,783). In 2015-2016 Nil (2014-2015 Nil) employees received remuneration in excess of the highest paid Director.
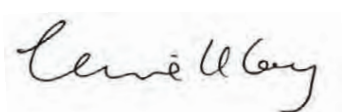
The median salary calculation is based on the spine point of individuals employed by the Foundation Trust on the last day of the financial year, 31 March 2016. Each staff member's spine point was taken and the median calculated from this population. Agency costs were not included as it was considered impracticable to evaluate the individual cost of vacant posts covered by temporary workers and deemed that such calculation would not materially alter the calculation of the median.

**Payment for Loss of Office**

Notice periods under Executive Director Contracts are 3 months.

Either party can waive the right to notice or accept payment in lieu of notice.

There is no separate policy for loss of office of Executive Directors, Trust policy would work within the principles contained in the HM Treasury Guidance on how to manage public funds in respect of 'special payments' and the Code of Governance for NHS Foundation Trusts.

**Professor Clive Kay**
**Chief Executive**
**26 May 2016**

### 3.2.4 Staff Report

**Analysis of Staff Numbers**

| At 31 March 2016 | | | |
|---|---|---|---|
| **Group** | **Female** | **Male** | **Total** |
| Directors | 8 | 10 | 18 |
| Senior Managers | 213 | 157 | 370 |
| Other Employees | 4,188 | 1,115 | 5,303 |
| **Total** | **4,409** | **1,282** | **5,691** |

| At 31 March 2015 | | | |
|---|---|---|---|
| **Group** | **Female** | **Male** | **Total** |
| Directors | 7 | 8 | 15 |
| Senior Managers | 215 | 161 | 376 |
| Other Employees | 4,181 | 1,088 | 5,269 |
| **Total** | **4,403** | **1,257** | **5,660** |

**Staff Sickness Disclosure**

| Staff sickness absence | 2015-2016 Number | 2014-2015 Number |
|---|---|---|
| Total Days Lost | 58,380 | 57,602 |
| Total Staff Years | 4,951 | 4,985 |
| **Average working Days Lost** | **12** | **12** |

*Source: HSCIC - Sickness Absence and Workforce Publications - based on data from the ESR Data Warehouse. Please note these figures are based on the calendar year.*

**Staff survey**

**Statement of approach to staff engagement**

We make every effort to ensure that our staff are engaged and involved.

During the last year we:

- Launched the Chief Executive's weekly 'Let's Talk' e-bulletin to staff;

- Have encouraged staff to respond to provide feedback on key issues they wish to raise directly with the Chief Executive;

- Held Listening Events with the Chief Executive at a range of Trust locations;

- Continued with Executive Director and Senior Manager walkrounds of wards and departments;

- Held combined Non-Executive and Executive formal walkrounds;

- Held informal departmental visits by the Executive team;

- Explored issues raised by staff in the 2014 Staff Survey through surveys and informal feedback sessions;

- Created staff forums and drop in sessions within Divisions;

- Created local staff newsletters;

- Used screensavers to share key messages;

- Produced a quarterly staff news bulletin;

- Held regular senior leaders forum and masterclasses;

- Encouraged staff to put forward ideas to improve quality and efficiency and held Dragons' Den events.

A Staff Engagement and Equality Manager started in June 2015. Their role is to liaise with Departments and Divisions to identify actions and share best practice, designed to improve staff experience.

**National Staff Survey 2015 - Summary of performance**

The Foundation Trust's score for overall staff engagement is 3.77 against a national average for acute Trusts of 3.79. Scores range from 1 to 5 with 1 indicating that staff are poorly engaged and 5 indicating that staff are highly engaged. Although the Foundation Trust's score was slightly below average when compared with a Trust of a similar type, the figures for the last three years show overall engagement levels have remained constant despite the challenges and change experienced by our staff.

We are proud that our staff say they are highly motivated and enthusiastic, and believe their role makes a real difference to patients.

The overall indicator of staff engagement is calculated using the key findings of:

• Perceived ability to contribute to improvements at work;

• Willingness to recommend the Trust as a place to work or receive treatment;

• The extent to which staff are motivated at work.

The 2015 response rate is 10% higher than 2014 and above average compared to Acute Trusts in England.

| Response Rate | 2015 | 2014 | 2013 | 2012 |
|---|---|---|---|---|
| Trust | 46% | 36% | 43% | 37% |
| National Average | 41% | 42% | 49% | 50% |

**The 5 key findings**

| Top 5 Ranking Scores – 2015 | Trust | National Average | Ranking |
|---|---|---|---|
| **KF 27:** Percentage of staff/colleagues reporting most recent experience of harassment, bullying or abuse | 46% | 37% | Highest (best) 20% |
| **KF 23:** Percentage of staff experiencing physical violence from staff in last 12 months | 1% | 2% | Lowest (best) 20% |
| **KF 21:** Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion. This is the Key Finding in which the Trust has improved since 2014. | 91% | 87% | Highest (best) 20% |
| **KF 3:** Percentage agreeing that their role makes a difference to patients/service users | 92% | 90% | Highest (best) 20% |
| **KF 16:** Percentage of staff working extra hours | 68% | 72% | Lowest (best) 20% |

The 5 key findings for which Bradford Teaching Hospitals NHS Foundation Trust compared least favourably with other Acute Trusts in England are:

| Bottom 5 ranking scores – 2014 | Trust | National Average | Ranking |
|---|---|---|---|
| **KF 25:** Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or members of the public | 25% | 28% | Highest (worst) 20% |
| **KF 10:** Support from immediate managers * | 3.57 | 3.69 | Lowest (worst) 20% |
| **KF 20:** Percentage of staff experiencing discrimination at work in last 12 months ** | 14% | 10% | Highest (worst) 20% |
| **KF 18:** Percentage feeling pressure in last 3 months to attend work when feeling unwell | 65% | 59% | Highest (worst) 20% |
| **KF 6:** Percentage reporting good communication between senior management and staff | 26% | 32% | Below (worse than) average |

*\* The score for this Key Finding is based on a scale where 5 is high and 1 is low*

*\*\* This is a combined score based on whether staff say they have experienced discrimination from patients/service users, their relatives or other members of the public and their manager/team leader or other colleagues.*

The largest local change where staff experience has improved is:

**KF 21** Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion – scores increased from 85% in 2014 to 91% in 2015.

**Future Priorities and Targets**

We will be taking a strategic approach to all our people work to address the outcomes of the Survey in a co-ordinated way, in line with our corporate strategy. Our priorities will be:

• Supporting staff who feel they are discriminated, harassed, bullied or abused by patients, relatives and members of the public;

• Management and leadership capability;

• Staff feeling under pressure to attend work when unwell;

• Supporting staff to reduce the number of harmful errors/near misses/incidents;

• Continuing improvements in the way we use patient feedback;

• Evaluating the interventions delivered for staff on harassment and bullying at work;

• Making further improvements to how we engage and communicate with staff.

Divisions will use their results to update their people plans. Their activities will be supported by HR, who will help share ideas and best practice between Divisions where scores have increased and other areas of the Trust, and link Divisional activity to strategic corporate priorities.

We continue to focus on the four indicators measured under the Workforce Race Equality Standard (WRES) which forms part of the NHS Standard Contract. The indicators relate to harassment and bullying, equal opportunities and discrimination. An action plan is being developed in consultation with the BME Network and the Diversity Workstream to address the concerns that our BME staff have raised, and will link to work underway within the Trust on leadership development, Inclusive Talent Management and the review of nurse experience.

**HM Treasury Review of Tax Arrangements of Public Sector Appointees**

The following tables demonstrate the Foundations Trust's compliance with HM Treasury guidelines on "off-payroll engagements".

**For all off-Payroll engagements as of 31 March 2016, for more than £220 per day and that last longer than six months**

| | |
|---|---|
| **No. of existing arrangements as of 31 March 2026 Of which ….** | **32** |
| **No. that have existed for less than one year at the time of reporting** | **19** |
| **No. that have existed for between one and two years at the time of reporting** | **7** |
| **No. that have existed for between two and three years at the time of reporting** | **3** |
| **No. that have existed for between three and four years at the time or reporting** | **1** |
| **No. that have existed for four or more years at the time of reporting** | **2** |

**For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016, for more than £220 per day and that last for longer than 6 months**
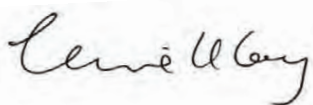
| | |
|---|---|
| No. of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016 | 22 |
| No. of the above which include contractual clauses giving the Trust the right to request assurance in relation to income tax and National Insurance obligations | 22 |
| No. for whom assurance has been requested Of which … | 15 |
| No. for whom assurance has been received | 12 |
| No. for whom assurance has not been received | 3 |
| No. that have been terminated as a result of assurance not being received | 0 |

**For any off-payroll engagements of board members and/or senior officials, and/or, senior officials with significant financial responsibility, between 1 April 2015 and 31 March 2016**

| | |
|---|---|
| No. of off-payroll engagements of board members, and / or, senior officials with significant financial responsibility, during the financial year | 2 |
| No. of individuals that have been deemed board members and/ or senior officials with significant financial responsibility during the financial year. This figure must include both off-payroll and on-payroll engagements | 22 |

The Trust tried to recruit to the Chief Nurse vacancy on 3 occasions without success, but has recently made an external appointment with a start date of August 2016. The vacant Chief Operating Officer role was expanded to cover the turnaround agenda. The longer term strategy for the responsibilities within this role has been subject to an on-going review. It was not possible to cover these roles internally on a temporary basis and therefore it was imperative to fill these important roles with experienced external interims.

In terms of the off-payroll engagements for board members, the Interim Chief Nurse was engaged between 1 May 2015 to 4 March 2016, and the Interim Director of Operational Management and Turnaround was engaged on 8 June 2015 and was still in post at 31 March 2016 (with an actual leaving date of 24 May 2016).

**Professor Clive Kay**
**Chief Executive**
**26 May 2016**

## Health and Safety

Further to the previous review of the Trust's governance arrangements for health and safety, the Foundation Trust has reviewed, rationalised and implemented a new committee structure. The Trust has a Health & Safety Committee, which is chaired by the Director of Governance & Corporate Affairs and whose membership includes Staff Side representatives, managers representing the Divisions and Corporate Departments and a Non-Executive Director. The Health & Safety Committee reports to the Integrated Governance & Risk Committee, which reports to the Board of Directors. The Director of Governance & Corporate Affairs is the nominated Executive Lead for Health & Safety and is a member of the Board.

Awareness of health and safety has been raised through the publication of booklets for all staff members and all Directors, setting out clearly the respective responsibilities and the use of screen savers on all computers to publish important messages for staff relating to health & safety. The Board of Directors has received training on health & safety.

2066 health and safety risk incidents were reported in the last 12 months, 961 of these incidents related to staff. The following areas continue to be our highest reported health and safety incidents affecting staff:

- Incidents of verbal abuse by patients or visitors;

- Incidents of physical abuse by patients or visitors;

- Incidents of threatening behaviour by patients or visitors;

- Injuries caused by contamination, for example sharps injuries;

- Incidents of service provision, for example lack of an interpreter or staffing issues.

Included in the health and safety risk incidents, are 31 incidents reported to the Health and Safety Executive (HSE) under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), 27 of these incidents related to staff.

There have been two visits undertaken by the HSE in the last 12 months, one as part of an inspection programme relating risks associate with sharps injuries and one relating to a RIDDOR reportable incident. As a result of these visits, the Foundation Trust has developed appropriate action plans, which have been agreed with the HSE. No formal enforcement action has been taken against the Foundation Trust.

## Policies for Countering Fraud and Corruption

The Foundation Trust complies with the Secretary of State's directions on counter fraud measures that were issued in 2004.

A programme of proactive work has been carried out during the year by the Foundation Trust's Local Anti-Fraud Specialist and this has linked closely with the Foundation Trust's communications plans.

The Foundation Trust's fraud and corruption policy and a range of related materials are available on the intranet for staff and work has continued to raise the profile of the Local Anti-Fraud Specialist through a range of initiatives.

## Policies Relating to Disabled Employees

The Foundation Trust's Recruitment and Selection Policy ensures full and fair consideration is given to application for employment made by disabled persons by guaranteeing interviews for disabled persons who meet the essential criteria on a person specification.

The Policy on Managing Attendance details the arrangements for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.  The Disabled Staff Network was asked for comments on the review of this policy and their concerns and recommendations were incorporated wherever possible.

The Staff Development Policy covers the arrangements for the training and development of all employees.

## 3.3    NHS Foundation Trust Code of Governance

### 3.3.1    Statement on Compliance with the Code of Governance

Bradford Teaching Hospitals NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a 'comply or explain' basis.  The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

A review of compliance with the Code of Governance was carried out by the Integrated Governance and Risk Committee on 22 April 2016 and reported to the Board of Directors on 12 May 2016.

In the 2014-2015 Annual Report, the Foundation Trust declared that it was not compliant with the following provisions:

**Provision B.1.2: At least half the Board of Directors, excluding the chairperson, should comprise Non-Executive Directors determined by the Board to be independent.**

**Provisions B.2.1 and B.2.3: Nominations committee(s)**

The review in May 2016 concluded that the Foundation Trust is now compliant with these provisions for the following reasons:  At least half of the Board comprises Independent Non-Executive Directors and a Governor Nominations and Remuneration Committee has now been established and met for the first time in February 2016.  Prior to this the process for the appointment or reappointment of Non-Executive Directors was that a Governor Search Committee was set up for each appointment and that Committee was asked to make a recommendation to the Council of Governors concerning the appointment or reappointment. The Nominations and Remuneration Committee will now undertake this role.

The review concluded that the Foundation Trust did not currently comply with:

**A.2.1 – Division of responsibilities between the chairperson and chief executive should be clearly established, set out in writing and agreed by the Board of Directors**

Responsibilities are set out in the respective role descriptions but these have not been formally agreed by the Board of Directors.  This will be rectified early in 2016-2017.

**A.4.2 - Chairperson should hold meetings with the Non-Executive Directors without the executives present.**

Regular meetings have not taken place during the year; however meetings would have been arranged if they have been deemed to be required by the Chairman or at the request of one or more Non-Executive Directors.  A meeting programme will be established in 2016-2017.

**B.6.1 – Performance evaluation of the Board and Committees**

A full performance evaluation of the Board and its Committees has not taken place during the year; however work has been undertaken by Deloitte to review the work of the Audit and Assurance Committee and the Integrated Governance and Risk Committee.   A full evaluation will be carried out during 2016-2017 and will be informed by the outcome of the Foundation Trust's first Well Led Review during the year.

**E.1.6 – Board of Directors should monitor how representative the Foundation Trust's membership is.**

Data on how representative the Foundation Trust's membership is has been reviewed by members Council of Governors but this has not been reported to or reviewed by the Board of Directors.  This will be rectified early in 2016-2017.

### 3.3.2    Council of Governors

The Council of Governors hold a number of statutory duties. These are to:

- Appoint and remove the Chairman and Non-Executive Directors;

- Set the terms and conditions of remuneration of the Chairman and Non-Executive Directors;

- Approve the appointment of the Chief Executive;

- Appoint the external auditor;

- Receive the annual accounts, auditors report and annual report;

- Convene the Annual Members Meeting;

- Be consulted on the forward plans (annual plan) of the organisation;

- Approve any proposed increases in private patient income of 5% or more in any financial year;

- Represent the interests of the Members of the Trust as a whole and the interests of the public;

- May require one or more of the Directors to attend a Governors' meeting to obtain information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance);

- Approve significant transactions;

- Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution;

- Approve amendments to the Trust's Constitution.

The Council of Governors met formally five times in 2015-2016:

- 14 May 2015
- 23 July 2015
- 17 September 2015
- 22 October 2015
- 21 January 2016.

With regard to their statutory roles and responsibilities, Governors have during 2015-2016:

- Received the annual accounts, auditors report and the annual report;

- Received the audit report from the auditors on the quality report and the annual audit 2014-2015;

- Considered and approved the agenda for the annual members meeting;

- Approved the process to be undertaken for the performance review of the Chairman and the Non-Executive Directors;

- Approved amends to the Constitution related to e-voting in line with the model core constitution; the establishment of a standing Nominations and Remuneration Committee and; the inclusion of a Non-Executive Director appointed by the University of Bradford ;

- Reappointed two Non-Executive Directors; Dr Trevor Higgins for a second three-year term and Professor Grace Alderson for a third one year term.  Appointed Ms Selena Ulla as a Non-Executive Director for a three year term.  Approved the appointment of Professor Bill McCarthy as the Non-Executive Director representing the University of Bradford;

- Considered and accepted the annual performance review reports on the Chairman and the Non-Executive Directors;

- Selected the local Quality Report performance indicator, Acute Kidney Injury, as the choice of local indicator for audit, in line with Monitor's requirement;

- Been involved, together with the Board of Directors, in discussions with regard to annual planning and strategy development;

- Considered the annual plan narrative 2015-2016 (May 2015);

- Reviewed and commented on the Strategic and Annual Planning process 2016-2017 (October 2015).

- Been involved, together with the Board of Directors, in a dedicated Strategy development session (a precursor to a sustained consultation in relation to the development of the Trust's five year strategy).

In addition to the delivery of their statutory duties and responsibilities, Governors have focussed on the implementation of the outcomes of the review of the Governors business agenda undertaken in 2014.

The changes to the delivery of the Council of Governors meeting have involved more direct engagement with the Non-Executive Directors; in particular, the Chairs of the Audit Committee, Performance Committee and the Quality and Safety Committee. All Executive Directors have continued to attend the Council of Governors' meetings. This has led to increased and well-received engagement between the Non-Executive Directors and Governors at the Council of Governors meetings and further supported the Governors in their duty to hold the Non-Executive Directors to account for the performance of the Board.

The Chairman has continued to provide a well-received monthly report that serves to keep Governors informed and aware of developments and initiatives at the Foundation Trust. The bulletin includes sign-posting to particular reports discussed at the Board of Directors' meetings that may be of particular interest to Governors. Also included as standard are the Performance and Finance executive summaries. The monthly bulletin further includes opportunities for training and development; links to local health related activities and events and; signposting to national publications related to developments across the NHS in general.

Attention has also been focussed on the development of the Governors' work streams which were established to support the outcomes from a consultation with members regarding the Trust's 2014-2015 Operational Plan. The areas identified for focus were Workforce, Long Term Conditions, Service Developments and Technology. An additional work stream of Stakeholder Engagement has also been a focus in year. One Governor from the Technology work stream has joined the Trust's EPR (Electronic Patient Record) Transformation Board as a representative of the full Council of Governors. Governors from each of the work streams have met with teams, departments and key staff, in varying degrees, to support their understanding of developments at the Trust and comment on initiatives.

The Governors have also supported and actively participated in a number of member/public engagement activities. In May 2015, Living Well with Dementia, organised in partnership with a number of statutory bodies and third sector

organisations across the Bradford District, proved exceptionally popular with both members and the public.  In August 2015, Governors were central to the delivery of our key members' event, 'Bradford Teaching Hospitals: Responding to the challenges ahead'.  In October 2015 Governors also supported the delivery of 'Your Future, Your Health' aimed at young people aged 14 to 19 from across the District.

The development of communications to support the Governors role has involved the inclusion of more dedicated information regarding Governors on the new membership web-site; the development of presentation materials to support Governors stakeholder engagement; streamlining of communications to support Governor nominations and; the inclusion of more Governor related information within The Trust's general communications.

In January 2016, the Chairman and Governors reviewed progress against the changes that had been implemented in year.  The Governors and Chair reviewed, the format for the Council of Governors meetings, changes required to progress the work streams, membership/public engagement events and, more efficient and effective use of Governors time.  The Governors have agreed that:

• From April 2016, the format of the Council of Governors meeting will include presentations on key themes related to major developments at the Trust with a view to supporting increased engagement with members and the public.  The themes identified include Electronic Patient Records, the new Hospital Wing development and, local partnership initiatives such as the developments around Well North;

• The Governors meetings schedule has been streamlined to enable all Governors to inform work stream development and to support internal/external knowledge and skills development;

• A Governors' annual calendar has been developed for 2016-2017 which will see all statutory and non-statutory commitments mapped out to better serve the Governors in managing their involvement and time.  Included within the annual calendar are dedicated days for Governors to meet with staff, teams across the Trust, informed by the outcomes from regulatory reports, Governors' work streams, Board of Directors suggestions and staff invitations;

• The induction programme has been reviewed to include bi-annual opportunities for Governors to undertake site-visits to enable better understanding of the Trust's Capital Programme;

• Communications are being further aligned to support increased direct feedback from Governors to members and the public.

Formal and informal training and development opportunities have continued to be made available to the Council of Governors.  Further, a number of Governors have attended sessions delivered by Governwell (NHS Providers) as part of the national training programme for Governors.  With regard to the development opportunities made available at the Foundation Trust these have included the following sessions:

• Understanding the role of the Quality Report and the selection of a Local Indicator for Audit;
• An Introduction to Electronic Patient Records;

- Navigating the new dedicated membership web-site; Members Zone;

- Understanding the role of the Patient Experience Team;

- Introduction to the work of the Transformation Team;

- Long Term Conditions and the Quality Strategy;

- Social Media with Annie Pool;

- The Launch of the '# hello my name is…' campaign;

- Born in Bradford's 5th Scientific Conference.

Governors participated in a special focus group led by the CQC Inspectors, which was part of the announced CQC Inspection held in January 2016.

Two new Governors, Mr David Walker and Councillor Doreen Lee joined the Council of Governors in November and December 2015 respectively.

Membership has been monitored in year to ensure that it remains representative; however no active membership recruitment has been undertaken given the current size of the Trust's membership.  A new membership development strategy will be developed in 2016-2017 to replace the current membership strategy.

The Annual Members Meeting (AMM) took place in September 2015.  Whilst attendance was improved slightly over the previous year it was still disappointingly low. The delivery of the AMM in 2016 will be agreed with Governors in April 2016.

The Governors and the Trust will seek to further increase stakeholder engagement and development whilst taking into account the needs of our diverse communities coupled with the most effective and efficient use of the available resource.

The composition of the Council of Governors from 1 April 2015 to 31 March 2016 is set out below:

| Public Governors | Name |
| --- | --- |
| Bradford East | Mr David Robertshaw |
| Bradford East | Mr Mohammad Yaqoob |
| Bradford South | Mr Mike Turner (Lead Governor) |
| Bradford South | Mrs Hilary Meeghan |
| Bradford West | Mrs Jean Pitts |
| Bradford West | Mr Abdul Ismail |
| Keighley | Ms Marion Olonade-Taiwo |
| Keighley | Mr Paul Kitching (up to 20 May 2015) |
| Shipley | Mrs Susan Hillas |
| Shipley | Mr Phillip Moncaster (up to 22 April 2015) |
| Shipley | Mr David Walker (from 1 December 2015) |
| **Patient Governors** | |
| (Out of Bradford) Patients | Mr Philip Hodgson |
| (Out of Bradford) Patients | Ms Hardev Sohal |
| **Staff Governors** | |
| Allied Health Professionals and Scientists | Mrs Alison Haigh |
| Medical and Dental | Mr Mark Steward (Vice-Chair) |
| Nursing and Midwifery | Mr Simon Kirk |
| All Other Staff Groups | Ms Ruth Wood |
| **Partner Governors** | |
| Bradford Metropolitan District Council | Cllr Naveeda Ikram (up to 31 July 2015) |
| Bradford Metropolitan District Council | Cllr Doreen Lee (from 1 December 2015) |
| Bradford University | Professor Marina Bloj |
| Leeds University | Dr Andrew Clegg |

**Elections to the Council of Governors**

The first election process of 2015-2016 for two Governor seats opened on Tuesday 25 August 2015 in the following membership constituencies.

- Public Governor Shipley (1 governor vacancy)
- Public Governor Keighley (1 governor vacancy)

The deadline for receipt of nominations was noon on 23 September 2015. There were no nominations received for Keighley. Two nominations were received for Shipley and an election was held. Voting opened on opened on 15 October 2015 and closed on 9 November 2015. Mr David Walker was duly elected as Governor for Shipley and commenced his term on 1 December 2015.

The second election process of 2015-2016 for ten governor seats opened on 27 January 2016 in the following membership constituencies.

- Public constituencies; Keighley (1), Bradford East (2), Shipley (1), Bradford South (1).
- Patient constituency (2).
- Staff constituency: Nursing and Midwifery (1), Medical and Dental (1), Allied Health Professionals and Scientists (1).

The deadline for receipt of nominations was noon on 18 February 2016. No nominations were received for; the public constituencies of Shipley and Bradford South; one seat in the Patient constituency and; the Staff constituencies of Medical and Dental and, Allied Health Professionals and Scientists. Two governors were elected uncontested; Ms Pauline Garnett in the staff constituency for Nursing and Midwifery and Ms Wendy McQuillan as Public Governor, Keighley. Three nominations were received for two seats in Bradford East. Voting opened on 9 March and concludes on 31 March 2016. The new Governors commence in post from 1 April 2016.

The third election process of 2015-2016 for five governor seats opened on 12 March 2016 in the following membership constituencies.

- Public constituencies; Bradford South (1), Shipley (1).
- Patient constituency (1).
- Staff constituency: Medical and Dental (1), Allied Health Professionals and Scientists (1).

The deadline for receipt of nominations was 31 March 2016.

The Foundation Trust confirms that all elections to the Council of Governors have been held in accordance with the election rules as stated in the Constitution.

## Attendance at Meetings of the Council of Governors in 2015-2016

| Name | Governor Status | Representing | 14.05.15 | 23.07.15 | 17.09.15 | 22.10.15 | 21.01.16 | TOTAL |
|------|-----------------|-------------|----------|----------|----------|----------|----------|-------|
| Lord Kamlesh Patel | Chairman | | ✓ | ✓ | ✓ | ✗ | ✓ | 4 of 5 |
| Dr Marina Bloj | Partner Governor | Bradford University | ✗ | ✗ | ✓ | ✓ | ✓ | 3 of 5 |
| Dr Andrew Clegg | Partner Governor | Leeds University | ✗ | ✓ | ✗ | ✓ | ✓ | 3 of 5 |
| Mrs Alison Haigh | Staff Governor | Allied Health Professionals & Scientists | ✓ | ✓ | ✓ | ✗ | ✓ | 4 of 5 |
| Mrs Susan Hillas | Public Governor | Shipley | ✓ | ✗ | ✓ | ✓ | ✓ | 4 of 5 |
| Mr Philip Hodgson | Patient Governor | Out of Bradford | ✓ | ✗ | ✗ | ✓ | ✓ | 3 of 5 |
| Ms Naveeda Ikram | Partner Governor | BMDC | ✗ | ✗ | | | | 0 of 2 |
| Mr Abdul Hamid Ismail | Public Governor | Bradford West | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Mr Paul Kitching | Public Governor | Keighley | ✗ | | | | | 0 of 1 |
| Mr Simon Kirk | Staff Governor | Nursing and Midwifery | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Mrs Doreen Lee | Partner Governor | BMDC | | | | | ✗ | 0 of 1 |
| Ms Hilary Meeghan | Public Governor | Bradford West | ✓ | ✓ | ✗ | ✓ | ✓ | 4 of 5 |
| Ms Marian Olonade-Taiwo | Public Governor | Keighley | ✓ | ✓ | ✓ | ✓ | ✓ | 5 of 5 |
| Ms Jean Pitts | Public Governor | Bradford West | ✓ | ✓ | ✗ | ✓ | ✓ | 4 of 5 |
| Dr David Robertshaw | Public Governor | Bradford East | ✓ | ✓ | ✓ | ✗ | ✓ | 4 of 5 |
| Ms Hardev Sohal | Patient Governor | (Out of Bradford) Patients | ✓ | ✗ | ✗ | ✓ | ✓ | 3 of 5 |
| Mr Mark Steward | Staff Governor | Medical and Dental | ✗ | ✓ | ✓ | ✓ | ✓ | 4 of 5 |
| Mr Mike Turner | Public Governor | Bradford South | ✗ | ✗ | ✗ | ✗ | ✗ | 0 of 5 |
| Ms Ruth Wood | Staff Governor | All Other Staff Groups | ✓ | ✓ | ✗ | ✗ | ✗ | 2 of 5 |
| Mr David Walker | Public Governor | Shipley | | | | | ✓ | 1 of 1 |
| Mr Mohammad Yaqoob | Public Governor | Bradford East | ✓ | ✗ | ✓ | ✓ | ✓ | 4 of 5 |

Denotes period when not a member of the Council.

✓ = attended          ✗ = apologies sent

*It will be noted that a number of Governors were unable to attend some/all of the scheduled meetings during 2015-2016. The Chairman met with individuals concerned (in line with the constitutional requirement) and established there were acceptable reasons provided for non-attendance which in the majority of cases was due to other scheduling conflicts. All Governors have, however, participated in the extensive Governor Work Programme and so remain committed and active members of the Council.*

### 3.3.3 Board of Directors

The Board of Directors is responsible for the day-to-day management of the Foundation Trust and the operational delivery of its services, targets and performance.

**Appointments to the Board of Directors**

| Name | Responsibilities | Appointment date | |
|---|---|---|---|
| | | From | To |
| Professor Lord Patel of Bradford | Chairman | 1 July 2014 | 31 May 2016 |

| Executive Directors | | | |
|---|---|---|---|
| Name | Responsibilities | Appointment date | |
| | | From | To |
| Professor Clive Kay | Medical Director<br>Interim Chief Executive<br>Chief Executive | 1 November 2006<br>1 September 2014<br>11 December 2014 | 31 August 2014<br>10 December 2014<br>Present |
| Mrs Bernie Bluhm | Interim Director of Operational Management and Turnaround | 8 June 2015 | Present |
| Ms Pat Campbell | Director of Human Resources | 1 December 2008 | Present |
| Ms Cindy Fedell | Director of Informatics | 13 September 2013 | Present |
| Dr Bryan Gill | Medical Director | 5 May 2015 | Present |
| Mr Matthew Horner | Director of Finance | 1 November 2011 | Present |
| Mrs Sally Scales | Acting Chief Nurse | 5 March 2016 | Present |
| Ms Donna Thompson | Interim Director of Governance and Corporate Affairs<br><br>Director of Governance and Corporate Affairs | 11 September 2014<br><br>1 February 2015 | 31 January 2015<br><br>Present |

| Former Executive Directors (Directors who resigned or whose term of office ended during the year) | | | |
|---|---|---|---|
| Name | Responsibilities | Appointment date | |
| | | From | To |
| Mrs Jackie Ardley | Interim Chief Nurse | 1 May 2015 | 4 March 2016 |
| Mrs Helen Barker | Chief Operating Officer | 3 June 2013 | 10 May 2015 |
| Ms Juliette Greenwood | Chief Nurse | 22 July 2013 | 30 April 2015 |
| Dr Robin Jeffrey | Interim Medical Director | 1 September 2014 | 4 May 2015 |

| Non-Executive Directors | | | |
|---|---|---|---|
| **Name** | **Responsibilities** | **Appointment date** | |
| | | **From** | **To** |
| Professor Grace Alderson | Non-Executive Director Senior Independent Director | 1 December 2009 1 November 2013 | 30 November 2016 |
| Dr Trevor Higgins | Non-Executive Director Deputy Chair | 21 May 2012 1 November 2013 | 20 May 2018 Present |
| Dr Mohammed Iqbal | Non-Executive Director | 1 February 2015 | 31 January 2018 |
| Professor Bill McCarthy | Non-Executive Director | 1 November 2015 | 31 October 2018 |
| Mr David Munt | Non-Executive Director | 1 November 2013 | 31 October 2016 |
| Mr Amjad Pervez | Non-Executive Director | 1 February 2015 | 31 January 2018 |
| Mrs Selina Ullah | Non-Executive Director | 1 September 2015 | 31 August 2018 |
| Mrs Pauline Vickers | Non-Executive Director | 1 November 2013 | 31 October 2016 |
| Professor James Walker | Non-Executive Director | 1 April 2013 | 31 March 2016 |

## Assessment of Effectiveness

It is a statutory duty of the Board of Governors to appoint and remove the Chairman and the Non-Executive Directors. Therefore, in order to carry out this duty, the Chairman reports to the Governors on the outcome of the annual appraisal with each of the Non-Executive Directors at the July 2015 public meeting of the Council of Governors. The Senior Independent Director then carries out the appraisal of the Chairman, taking a sounding from both the Board of Directors and Council of Governors, to formally report back to the Council of Governors at a public meeting.

Should the Chairman have any concerns regarding the performance of the Non-Executive Directors then he would raise this with the individual and, where necessary, consult the Council of Governors for further action.

## About Our Directors

### Professor Lord Patel of Bradford, OBE

Lord Patel was appointed Chairman of the Bradford Teaching Hospitals NHS Foundation Trust in July 2014.

Lord Patel is a social worker by background and moved into academia establishing the Centre for Ethnicity and Health at the University of Central Lancashire and specialising in research connected to the reduction of health inequalities.

Alongside this work he has held a number of public appointments including Chairman of the Mental Health Act Commission, National Strategic Director with the Department of Health (Race Equality and Mental Health), Non-Executive Director of a number of public bodies in the areas of substance misuse, mental health and social work, including the Care Quality Commission.

He entered the House of Lords in 2006 as an independent peer and was later appointed as a Minister in the Governments Whip's Office in the House of Lords.

Lord Patel will step down on 31 May 2016, in order to move to a role supporting The Rt. Hon Baroness Scotland of Asthal QC, Secretary-General of the Commonwealth of Nations.   The process for appointing his successor has been commenced.  Dr Trevor Higgins, Deputy Chair will become Acting Chair until an appointment is made.

### Professor Clive Kay, Chief Executive

Clive was appointed as Chief Executive Officer in December 2014.

Clive was appointed a Consultant Radiologist in Bradford in 1998, and subsequently Medical Director (2001-06), Deputy Chief Executive in 2013, and Interim Chief Executive in September 2014, all in Bradford Teaching Hospitals NHS Foundation Trust.

Prior to working in Bradford, he spent three years at the Medical University of South Carolina as Visiting Associate Professor of Radiology.

His previous external roles include Chairman of the Royal College of Radiologist's Scientific Programme Committee, Member of Council of the Royal College of Radiologists, and a Member of the Editorial Board of Clinical Radiology.  He is a past Chairman of the British Society of Gastrointestinal and Abdominal Radiology.  He is a Fellow of the Royal College of Radiologists and a Fellow of the Royal College of Physicians of Edinburgh.  He is an Honorary Visiting Professor at the University of Bradford. He is a Lay Member of Council of the University of Bradford.

### Ms Bernie Bluhm, Interim Director of Operations and Turnaround (from 8 June 2015)

Bernie joined the Foundation Trust in June 2015 as the Interim Director of Operational Management and Turnaround.

Bernie has over 30 years' experience working in the NHS before becoming an independent consultant in April 2013.

She qualified as a registered nurse in 1984 and spent several years working in Urgent Care; including two national posts with the Intensive Support Team, working with acute trusts and system partners improving the delivery of urgent care standards.

Bernie has held previous executive Board director roles as a Chief Operating Officer and Deputy CEO. She was the lead on several transformation programmes delivering service improvements in both planned and urgent care.

**Ms Pat Campbell, Director of Human Resources**

Pat is a Chartered Fellow of the CIPD [Chartered Institute of Personnel and Development] and has worked in the NHS since 1986 primarily in HR roles. She has held the position of Director of HR at the Trust since December 2008 having held previous posts of Personnel Manager and Deputy Director of HR.

**Ms Cindy Fedell, Director of Informatics**

Cindy Fedell joined the Foundation Trust in September 2013 as the Director of Informatics, a new role to the Trust.  In addition to this role, Cindy is the Chair of the NHS Providers Informatics Leaders Network.  Cindy is a member of the European Commission's Healthcare Vertical for 5G Technology and of the Computing Industry Advisory Board for the University of Bradford.

Cindy previously worked in Canada where she was at Mount Sinai Hospital in Toronto, an academic tertiary hospital in the top 3.5% of clinical automation, and was a member of the Information and Communication Technology Council of Canada's eHealth group.  Cindy holds Chief Information Officer and Advanced Leadership certificates from the College of Healthcare Information Management Executives and the University of Toronto respectively, as well as degrees from Ryerson University and Lakehead University in Canada. In addition to her roles in acute care, Cindy worked in the private sector for several years as an Informatics Management Consultant advising hospitals on systems design and implementation.

**Bryan Gill, Medical Director (from 5 May 2015)**

Bryan was appointed to the position of Medical Director for Bradford Teaching Hospitals NHS Foundation Trust in May 2015 and became the Responsible Officer for the Foundation Trust in July 2015. Prior to this he held the position of Medical Director for Quality and Governance at Leeds Teaching Hospitals NHS Trust.

Bryan has 10 years' experience at senior medical management level in the Acute Trust sector and has a particular interest and expertise in Quality Improvement, Patient Safety and Medical Workforce.

He was a Consultant in Neonatology for 19 years before going into a full-time medical management role in 2013. He is the immediate past President of the British Association of Perinatal Medicine (2011-2014) and has previously held national roles of Honorary Secretary of BAPM and Chair and Training Advisor for the Royal College of Paediatrics and Child Health. He was the first Lead Clinician for the Yorkshire Neonatal Network (2003-2008). He is a Fellow of the Royal College of Paediatrics and Child Health.

**Mr Matthew Horner, Director of Finance**

Matthew has a degree in Accountancy and Finance and is a qualified member of the Chartered Institute of Public Finance and Accountancy.  His NHS finance career spans over 20 years and covers a variety of finance roles.  He has, for the last 12 years, worked for the Acute Trust in Bradford, progressing from Finance Manager to Deputy Director of Finance. Matthew joined the Board as Acting Director of Finance in November 2011 and was appointed substantive Director of Finance in August 2012.

**Mrs Sally Scales, Acting Chief Nurse (from 5 March 2016)**

Sally joined Bradford Teaching Hospitals NHS Foundation Trust in 2009 as Deputy Chief Nurse, and became Acting Chief Nurse in March 2016.

Sally has over 30 years' experience working in the NHS. She qualified as a registered nurse in 1987 at St James's Hospital in Leeds. She held various clinical roles in a variety of specialties including coronary care, general surgery and urology including Senior Sister in urology, before moving into operational management.

Following experience as a Clinical Service Manager for urology, hepatology and transplantation, Sally worked as Matron in the cancer centre at Leeds, which enabled her to pursue her passion for nursing and the delivery of high quality patient centred care.

In 2007, she was appointed as Lead Cancer Nurse for Leeds Teaching Hospitals NHS Trust and took a leading role in the commissioning and move into the purpose built cancer centre in Bexley Wing at St James's Hospital.

**Ms Donna Thompson, Director of Governance & Corporate Affairs**

Donna initially trained and practiced as a nuclear medicine technologist and undertook a variety of roles working in clinical and radiation physics. She studied health and social care management and obtained a Masters degree from Leeds University. Donna has worked in both senior operational and corporate management roles and was appointed to her current role in February 2015.

**Professor Grace Alderson, Non-Executive Director**

Grace has extensive leadership and management experience in education, the NHS, and in charitable trusts.  Until August 2015, Grace worked at the University of Bradford where in addition to her involvement as a teacher and researcher as Professor of Medical Microbiology, she held a wide range of academic and senior management roles including Dean of Faculty and Senior Pro-Vice-Chancellor.  She is a Chartered

Scientist, Chartered Biologist and a Fellow of both the Institute of Biomedical Science and the Institute of Biology.

Grace became a Partner Governor at the Hospitals Trust in 2004 representing the University of Bradford until her appointment as Non-Executive Director on 1 December 2009.

In addition to her work for the Trust, Grace's other commitments include being a Governor for Dixon's City Academy. She is a member of the Governing Council of Dixon's Academies Charitable Trust, and chairs their Audit committee and is also a member of the Department of Justice's Advisory Committee for North and West Yorkshire. Grace recently completed a four year term as a lay member of the General Dental Council and has also been a trustee for a range of charities including the higher education Equality Challenge Unit and QED-UK and a Board member of two small companies that interface with the health sector.

### Dr Trevor Higgins, Non-Executive Director (Deputy Chair)

Trevor was born and educated in the city. He is the Regional Partnership Director for BT and has enjoyed a diverse career in over forty years with the company - management jobs have ranged from call centre management to senior operations management. In his current role he represents all BT's operational divisions. In his previous role, as BT's Regional Business Manager, he managed 1,200 people with responsibility for a budget in excess of £30m.

He is also Chief Executive of Bradford Breakthrough, Chairman of the Digital Health Enterprise Zone, Board Member of Bradford Chamber Council and a Lay Member of the University of Bradford Council. Educated to post graduate level, in July 2011 he was awarded an Honorary Doctorate as Doctor of Bradford University for services to businesses and communities across the region.

Trevor was appointed as a Non-Executive Director with the Bradford Teaching Hospitals Foundation Trust in May 2012.

### Dr Mohammed Iqbal, Non-Executive Director

Mohammed has considerable personal experience of local, regional and national health issues, having worked in the pharmaceutical/healthcare sector for the last 30 years. He currently works for Novartis as a Healthcare Development Manager operating across West Yorkshire.

Prior to joining the BTHFT Board Mohammed had served as a Lay Member on the Governing Body of the Bradford City Clinical Commissioning Group. He had also served as a Non-Executive Director of Bradford Health Authority.

He is very passionate about Bradford is the Founder of "Bradford Matters"- a new Lobbying Group, he is President of Ahmadiyya Muslim Community in Bradford and a host with Sunrise Radio with a weekly programme focused on Bradford and its development.

**Professor Bill McCarthy, Non-Executive Director
(from 1 November 2015)**

Bill was appointed as a Non-Executive Director with the Bradford Teaching Hospitals Foundation Trust on 1 November 2015.

Bill McCarthy is Deputy Vice-Chancellor (Operations), and Honorary Professor of Health Policy at the University of Bradford. In previous roles he has acted as the Government's Principal Policy Adviser on health reforms and has served on various national bodies including the NHS Constitution Forum, Civil Service capability review panel and the Health and Local Government Strategy Board.

An economist by training, he has held a number of senior public service appointments including Director General in the Department of Health, Chief Executive at City of York Council, Chief Executive of NHS Yorkshire and the Humber, and most recently, National Policy Director, NHS England.

**Mr David Munt, Non-Executive Director**

David Munt trained with Coopers and Lybrand and spent the majority of his executive career with Bradford and Bingley PLC. He was Director of Treasury for the organisation. He took his first NED role in the NHS as Audit Chair with Bradford and Airedale Teaching PCT (2006-11). He has also been Audit Chair for Leeds PCT. Since the PCT has closed, David was Lay Member (Governance) for the Airedale, Wharfedale and Craven CCG and was their Audit Committee Chair.

**Mr Amjad Pervez, Non-Executive Director**

Amjad founded Seafresh/Adams in Bradford over 30 years ago and it is now one of the largest groups of independent specialist catering food service and cash and carry groups in the UK.  Alongside building this successful business, he has committed a lot of time to education and enterprise in Bradford and the wider West Yorkshire region including establishing Asian Trade Link Yorkshire Limited in 1999 which he chaired until last year.

Until recently he was also a Board member of the Leeds City Region Enterprise Partnership.  Amjad is currently a Board member with Bradford Matters, Bradford Breakthrough and The National Asian Business Association.  He is Chair of the Rainbow Trust through which Rainbow Primary Free School is operated which opened in 2012.

Amjad was appointed as a Non-Executive Director with the Bradford Teaching Hospitals NHS Foundation Trust in February 2015.

**Ms Selina Ullah, Non-Executive Director
(from 1 September 2015)**

Selina was appointed as a Non-Executive Director with the Bradford Teaching Hospitals NHS Foundation Trust in September 2015.

She is passionate about people and communities, this has led to her involvement in national, regional and local government; think tanks; charitable foundations and NGOs working on policy formulation, transformation, service modernisation, regulation and governance. Selina has an in depth knowledge of engaging diverse communities in particular 'hard to reach groups.' She has over 25 years of experience of working with charities and the not for profit sector and extensive senior management experience in the public sector – working in health service management, and public policy on high profile issues such as community cohesion, diversity, engaging hard to reach groups, mental health and social inclusion; crime and disorder and counter-terrorism.

Until June 2011, Selina was Assistant Director – Safer and Stronger Communities at Bradford Council. Selina is an advisor to the Joseph Rowntree Foundation, a Non-Executive Director of a national health regulator, Yorkshire and Humber committee member of the Heritage Lottery Fund, Director of Manchester Central Library Development Trust, Chair of the Muslim Women's Council and President of ICLS, an international organisation based in Rome which specialises in intercultural dialogue, participation and leadership. Selina has an extensive career in race relations and is an Advisory Board Member and Trustee of the Ahmed Iqbal Ullah Race Relations Resource Centre and Education Trust based in Manchester Central Library.

**Mrs Pauline Vickers, Non-Executive Director**

Pauline was appointed as a Non-Executive Director with the Bradford Teaching Hospitals NHS Foundation Trust in November 2013.

Pauline is currently working for Royal Mail. She brings a wealth of business and leadership experience gained at board level in a range of commercial, customer and people focused roles across the Royal Mail Group. Educated at Prince Henry's Grammar School, Otley she went on to read Management Science at the University of Manchester Institute of Science & Technology (UMIST), followed by a Post Graduate Diploma in Personnel Training & Development at Leeds Metropolitan University. She is a member of the Institute of Personnel & Development, an accredited coach via Middlesex University and recently completed an Executive Leadership Development Programme at the Oxford Said Business School.

Pauline is committed to supporting diversity and is a member of the Diversity Steering Group for Royal Mail and Chairs the London Women's network to support the success of women within the organisation. She is also a Trustee of the Rowland Hill Fund, a charity that supports Royal Mail employees and pensioners in times of need.

**Professor James Walker, Non-Executive Director**

Professor James Walker is the Professor and Head of Department of Obstetrics and Gynaecology in the University of Leeds since1984. He was born in Aberdeen, grew up in Dundee and graduated from the University of Glasgow. In 1976 his postgraduate training and early years as a consultant were all in Glasgow. He has worked extensively in high risk obstetrics, incident reporting, root cause analysis and risk assessment. He was obstetric advisor to the National Patient Safety Agency, Chairman of the Centre for Maternal and Childhealth Enquiries and Senior Vice-president of the Royal College of Obstetricians and Gynaecology. He is passionate about patient safety and providing care at the time and place that is best for the patient. He works with various medical charities, was the inaugural president of the Ectopic Pregnancy Trust founder member of the Association of Early Pregnancy Units, is medical Director of Action on Pre-ecalmpsia and is the President of the Baby Lifeline training company.

**Former Directors (Directors who resigned or whose term of office ended during the year)**

**Mrs Jackie Ardley, Interim Chief Nurse
(from 1 May 2015 to 4 March 2016)**

Jackie joined the Foundation Trust in May 2015 as Interim Chief Nurse. She is passionate about improving patients and their families experience across health and social care.

Jackie has over 38 years' experience in the NHS as a nurse. She commenced her career in Critical Care, working across the health system in General Nursing, Primary Care and Mental Health and Disabilities.

In 2001 Jackie spent seven years working on national service redesign programmes, leading a number of successful initiatives within a number of roles including Director of Service Improvement and a Regional Director post in Improvement Partnerships.

**Mrs Helen Barker, Chief Operating Officer
(from 3 June 2013 to 10 May 2015)**

Helen has worked in the NHS since 1983 commencing her Orthopaedic nurse training in Bradford prior to undertaking general training and then completing the theatre Nursing course. Helen has been a clinical and operational manager since 2000 across several acute trusts in West Yorkshire. Most recently Helen was a Divisional General Manager at Leeds Teaching Hospitals NHS Trust followed by a brief period as their Director of Performance before taking up post in Bradford in June 2013.

As well as operational responsibilities Helen has managed several large scale transformational changes across health communities as well as within acute trusts and has completed the 'Leading Transformational Change across Yorkshire and the Humber development programme'.

## Ms Juliette Greenwood, Chief Nurse
## (from 22 July 2013 to 30 April 2015)

Juliette started her career in nursing as a pre-registration orthopaedic student in Stanmore, Middlesex and from then went on to complete integrated children and adult nurse training. She went on to develop clinical and professional expertise in the fields of neonatal and children's intensive care nursing care and management working in both tertiary and district general hospitals in London.

As Deputy Chief Nurse at Great Ormond Street Hospital for Children she managed a complex pre and post registration education contract and commissioned a number of new education programmes and roles that had a direct impact on both patient care and also workforce design.

In 2004 Juliette was recruited to the post of Chief Nurse at Barnsley Hospital NHS Foundation Trust, contributing and supporting the leadership and delivery of healthcare within an integrated acute and community foundation trust. Juliette then undertook the post of Chief Nurse at The Rotherham NHS Foundation Trust in October 2011. Her appointment as Chief Nurse in July 2013 to Bradford Teaching Hospital allowed Juliette to return to the complex and stimulating environment of a teaching hospital.

## Dr Robin Jeffrey, Interim Medical Director
## (from 1 September 2014 to 4 May 2015)

Robin was appointed to the position of Interim Medical Director in September 2014. Prior to this he was Deputy Medical Director for Clinical Governance. He has been a Consultant in Nephrology and General Medicine in Bradford since 1994.

He is a member of the Council of the Royal College of Physicians of Edinburgh and Honorary Senior Lecturer at Leeds University.

## Attendance at Meetings of the Board of Directors 2015-2016

| Board Members | 30.04.15 | 28.05.15 | 25.06.15 | 30.07.15 | 10.09.15 | 15.10.15 | 12.11.15 | 10.12.15 | 14.01.16 | 11.02.16 | 10.03.16 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Kamlesh Patel | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 11 |
| Clive Kay | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | 10 of 11 |
| Jackie Ardley | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | | 9 of 10 |
| Helen Barker | ✗ | | | | | | | | | | | 0 of 1 |
| Bernie Bluhm | | | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✗ | 6 of 9 |
| Pat Campbell | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10 of 11 |
| Cindy Fedell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 11 |
| Bryan Gill | | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | 9 of 10 |
| Juliette Greenwood | ✓ | | | | | | | | | | | 1 of 1 |
| Matthew Horner | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 11 |
| Robin Jeffrey | ✓ | | | | | | | | | | | 1 of 1 |
| Sally Scales | | | | | | | | | | | ✓ | 1 of 1 |
| Donna Thompson | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 11 |
| Grace Alderson | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10 of 11 |
| Trevor Higgins | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10 of 11 |
| Mohammed Iqbal | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | 8 of 11 |
| Bill McCarthy | | | | | | | ✗ | ✓ | ✓ | ✓ | ✓ | 4 of 5 |
| David Munt | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | 10 of 11 |
| Amjad Pervez | ✓ | ✗ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | 9 of 11 |
| Selina Ullah | | | | | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | 5 of 7 |
| Pauline Vickers | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✗ | 9 of 11 |
| James Walker | ✗ | ✓ | ✓ | ✗ | ✗ | ✗ | ✓ | ✗ | ✓ | ✓ | ✗ | 5 of 11 |

Denotes period when not a member of the Board.

✓ = attended          ✗ = apologies sent

Meetings of the Board of Directors are also attended by Chris Allcock, Trust Secretary.

### 3.3.4    Audit and Assurance Committee

The Audit and Assurance Committee is a Committee of the Board of Directors. The purpose of the committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

During the year, the work of the Committee has included:

• Approval of the risk based internal audit plan produced by the Foundation Trust's internal auditor, the West Yorkshire Audit Consortium, and review of the results of all audits together with progress reports on the implementation of these audits;

• Approval of the risk based counter fraud plan and review of the work of the Foundation Trust's Counter Fraud Specialist;

• Approval of the audit plan produced by the Foundation Trust's external auditor, KPMG together with progress reports;

• Review of the effectiveness of the external auditor. The Committee considered a checklist covering the robustness of the audit, the quality of delivery and the quality of people and service;

• Review of losses and special payments and tenders awarded by the Foundation Trust;

• Review of the annual financial statements for the Bradford Hospitals Charity and recommendation for their adoption by the Board of Directors;

• Review of the Foundation Trust's annual financial statements and recommendation for their adoption to the Board of Directors. The significant issues that were considered were:

  - Revaluation of Land and Buildings
    During the year a revaluation of land and buildings had been carried out by the District Valuer. This had been identified by the external auditor as a significant audit risk due to the materiality in value and judgement involved. The work carried out by the external auditor had not identified any matters of concern.

  - Provisions for future liabilities
    The external auditor had reviewed the assumptions and judgements underpinning the provisions that had been made and was satisfied that the Trust had overall made a balanced judgement overall based on a cautious approach.

  - Going Concern Status
    The Committee discussed going concern status and agreed that it was appropriate to make the recommendation that the financial statements should be prepared on a going concern basis.

These areas were reviewed with Trust management and the external auditors to ensure that the accounting treatment was appropriate.

- Reference Costs
  The results of an audit of the Foundation Trust's 2014-2015 Reference Costs carried out by Price Waterhouse Coopers were reviewed. The audit concluded that the Foundation Trust was not compliant with Monitor's Costing Guidance; however a range of actions had been put in place to ensure that the 2015-2016 submission, due in July 2016 would be compliant. The Committee was assured that the issues raised did not impact on the financial statements for 2015-2016

Private meetings have been held with both the West Yorkshire Audit Consortium and KPMG during the year. The Committee has sought and been given assurance that the necessary co-operation had been received from Foundation Trust managers and staff. The Committee was also satisfied that there was appropriate liaison and co-operation between internal and external auditors. Representatives from both auditors have attended each meeting and presented details of the work carried out and their main findings.

The Committee's membership during the year has been as follows:

- David Munt - Chair
- Grace Alderson
- Trevor Higgins

The Committee met six times during the year. Attendance at these meetings was as follows:

**Attendance at Meetings of the Audit and Assurance Committee 2015-2016**

| Members | 19.05.15 | 26.05.15 | 28.07.15 | 30.09.15 | 25.11.15 | 02.02.16 | TOTAL |
|---|---|---|---|---|---|---|---|
| David Munt | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 6 of 6 |
| Grace Alderson | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 5 of 6 |
| Trevor Higgins | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 5 of 6 |
| ✓ = attended      ✗ = apologies sent | | | | | | | |

Meetings of the Committee require two members attend to be quorate. The meeting held on 2 February 2016 was not quorate as a result of bereavement. Actions agreed in the meeting were all subsequently approved by those Committee members who were unable to attend.

Audit and Assurance Committee meetings are also attended by Matthew Horner, Director of Finance, Michael Quinlan, Assistant Director of Finance and Chris Allcock, Trust Secretary. The Chief Executive attends at least one meeting per year. Representatives of both internal and external audit also attend meetings.

## External Audit

The external auditor for the Foundation Trust is:

KPMG LLP
1 Sovereign Square
Sovereign Street
Leeds
West Yorkshire LS1 4DA

The auditor was appointed in April 2012 following a procurement exercise led by a working group of the Council of Governors. The appointment is in accordance with the Audit Code for NHS Foundation Trusts, published by Monitor.

The fee for the year is shown below:

| Fee (excluding VAT) | 2015-2016 £000 |
| --- | --- |
| Audit Services – Statutory Audit | 47.7 |
| Other Services | 8.6 |
| **Total** | **56.4** |

Other Services relate to the work mandated by Monitor on the Foundation Trust's Quality Report.

The provision of non-audit services by the external auditor is governed by the Foundation Trust's Policy on the Use of External Audit for Non-Audit Services, which was updated in November 2013.  The main objective of the policy is to ensure that any non-audit service provided by the external auditor cannot impair, or cannot be seen to impair, the objectivity of their opinion on the financial statements.

Any proposal for the use of the external auditors to provide non-audit services is reported to the Audit and Assurance Committee.  There was been one such engagement in 2015-2016 which was in respect of advice in relation to VAT, and the total fee was £30,000.  This was reported to the Audit Committee at the meetings held on 19 May 2015 and 2 February 2016.

## Internal Audit

The Foundation Trust's Internal Audit function is provided by the West Yorkshire Audit Consortium, an NHS Consortium hosted by Calderdale and Huddersfield NHS Foundation Trust. The Consortium provides a full range of internal audit and counter fraud services to a range of NHS clients and other bodies.

The Consortium provides an independent and objective opinion on the degree to which the risk management, control and governance arrangements support the achievement of the organisation's objectives.

Following separate meetings of the West Yorkshire Audit Consortium Management Board and the North Yorkshire Audit Services Alliance Board in late March 2016, plans have been announced for the two audit consortia to merge by June 2016.

### 3.3.5 Performance Committee

The Performance Committee is a Committee of the Board of Directors. The Committee was established in April 2013 and its purpose was to provide scrutiny of performance and financial matters in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors. In fulfilling this purpose, the Committee at all times seeks assurance that patient safety and quality is not compromised by any proposed recovery or action plan.

From January 2016, a separate Finance and Investment Committee was established to specifically review financial matters, raise any concerns or make recommendations and offer assurance to the Board of Directors, and the Terms of Reference of the Performance Committee were amended accordingly.

**Attendance at Meetings of the Performance Committee 2015-2016**

| Members | 30.04.15 | 28.05.15 | 25.06.15 | 30.07.15 | 26.08.15 | 30.09.15 | 28.10.15 | 25.11.15 | 23.12.15 | 27.01.16 | 24.02.16 | 23.03.16 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trevor Higgins (Chair to 31.08.2015) | ✓ | ✗ | ✓ | ✗ | ✓ | | | | | | | | 3 of 5 |
| Pauline Vickers (Chair from 01.09.2015) | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 12 |
| Clive Kay | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | 11 of 12 |
| Jackie Ardley | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | | 9 of 11 |
| Helen Barker | ✗ | | | | | | | | | | | | 0 of 1 |
| Bernie Bluhm | | | ✓ | ✓ | ✗ | ✗ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | 7 of 10 |
| Pat Campbell | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | 10 of 12 |
| Cindy Fedell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | 11 of 12 |
| Bryan Gill | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | 10 of 11 |
| Juliette Greenwood | ✓ | | | | | | | | | | | | 1 of 1 |
| Matthew Horner | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12 of 12 |
| Robin Jeffrey | ✓ | | | | | | | | | | | | 1 of 1 |
| Sally Scales | | | | | | | | | | | ✓ | ✓ | 2 of 2 |
| Donna Thompson | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 10 of 12 |
| Grace Alderson | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8 of 8 |
| Mohammed Iqbal | | | | | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | 6 of 8 |
| Bill McCarthy | | | | | | | | ✗ | ✓ | ✗ | ✗ | ✓ | 2 of 5 |
| David Munt | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8 of 8 |
| Amjad Pervez | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ | ✓ | 8 of 12 |
| Selina Ullah | | | | | | ✗ | ✓ | ✗ | ✓ | ✓ | ✗ | ✓ | 4 of 7 |
| James Walker | ✗ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 9 of 12 |

Denotes period when not a member of the Committee.

✓ = attended        ✗ = apologies sent

Committee meetings are also attended by Chris Allcock, Trust Secretary and James Mackie, Head of Performance.

### 3.3.6 Finance and Investment Committee

The Committee was established in January 2016 and its purpose is to maintain a detailed overview of the Trust's assets and resources in relation to the achievement of financial targets, business objectives and the financial stability of the Trust.

The Committee will provide assurance and, if necessary raise concerns or make recommendations to the Board of Directors. In fulfilling this purpose, the Committee will at all times seek assurance that patient safety is not compromised by any proposed recovery or action plan.

**Attendance at meetings of the Finance and Investment Committee in 2015-2016**

| Members | 27.01.16 | 24.02.16 | 30.03.16 | Total |
|---|---|---|---|---|
| Bill McCarthy (Chair) | ✓ | ✗ | ✓ | 2 of 3 |
| Clive Kay | ✓ | ✓ | ✓ | 3 of 3 |
| Jackie Ardley | ✓ | ✓ | | 2 of 3 |
| Bernie Bluhm | ✓ | ✓ | ✓ | 3 of 3 |
| Pat Campbell | ✓ | ✗ | ✓ | 2 of 3 |
| Cindy Fedell | ✓ | ✓ | ✓ | 3 of 3 |
| Bryan Gill | ✓ | ✓ | ✓ | 3 of 3 |
| Matthew Horner | ✓ | ✓ | ✓ | 3 of 3 |
| Sally Scales | | | ✓ | 1 of 1 |
| Donna Thompson | ✓ | ✓ | ✗ | 2 of 3 |
| Grace Alderson | ✓ | ✓ | ✓ | 3 of 3 |
| Mohammed Iqbal | ✓ | ✓ | ✓ | 3 of 3 |
| David Munt | ✓ | ✓ | ✓ | 3 of 3 |
| Amjad Pervez | ✓ | ✗ | ✓ | 2 of 3 |
| Selina Ullah | ✓ | ✗ | ✓ | 2 of 3 |
| Pauline Vickers | ✓ | ✓ | ✓ | 3 of 3 |
| James Walker | ✓ | ✓ | ✓ | 3 of 3 |
| | Denotes period when not a member of the Committee. | | | |
| | ✓ = attended | ✗ = apologies sent | | |
| Committee meetings are also attended by Chris Allcock, Trust Secretary. | | | | |

### 3.3.7 Quality and Safety Committee

The Quality and Safety Committee is a Committee of the Board of Directors. The purpose of the Committee is to provide detailed scrutiny of the Foundation Trust's arrangements for the management and development of quality and safety in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

**Attendance at Meetings of the Quality and Safety Committee 2015-2016**

| Members | 16.04.15 | 14.05.15 | 11.06.15 | 16.07.15 | 26.08.15 | 30.09.15 | 28.10.15 | 25.11.15 | 23.12.15 | 27.01.16 | 24.02.16 | 30.03.16 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| James Walker (Chair) | X | X | ✓ | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 9 of 12 |
| Clive Kay | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12 of 12 |
| Jackie Ardley | | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | X | ✓ | | 7 of 10 |
| Helen Barker | X | | | | | | | | | | | | 0 of 1 |
| Bernie Bluhm | | | ✓ | X | X | ✓ | ✓ | ✓ | X | ✓ | ✓ | ✓ | 7 of 10 |
| Pat Campbell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | ✓ | 11 of 12 |
| Cindy Fedell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 12 of 12 |
| Bryan Gill | | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 10 of 11 |
| Juliette Greenwood | X | | | | | | | | | | | | 0 of 1 |
| Matthew Horner | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8 of 8 |
| Robin Jeffrey | X | | | | | | | | | | | | 0 of 1 |
| Sally Scales | ✓ | | | | | | | | | | ✓ | ✓ | 3 of 3 |
| Donna Thompson | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | X | 10 of 12 |
| Grace Alderson | ✓ | ✓ | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 11 of 12 |
| Dr Mohammed Iqbal | ✓ | X | X | X | ✓ | ✓ | ✓ | ✓ | ✓ | X | ✓ | ✓ | 8 of 12 |
| Bill McCarthy | | | | | | | | X | ✓ | ✓ | X | ✓ | 3 of 5 |
| David Munt | | | | | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 8 of 8 |
| Amjad Pervez | | | | | ✓ | ✓ | ✓ | X | X | ✓ | X | ✓ | 5 of 8 |
| Selina Ullah | | | | | | X | ✓ | X | ✓ | ✓ | X | ✓ | 4 of 7 |
| Pauline Vickers | | | | | X | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 7 of 8 |

Denotes period when not a member of the Committee.

✓ = attended    X = apologies sent

Committee meetings are also attended by Chris Allcock, Trust Secretary.

### 3.3.8 Integrated Governance and Risk Committee

The purpose of the Committee is to provide assurance to the Board that the arrangements for integrated governance and risk management are robust and effective including scrutiny of the Corporate Risk Register, Board Assurance Framework, the Quality Governance Framework, and compliance with the Monitor Provider Licence. In particular the committee will oversee the process by which corporate governance risks are identified, escalated and managed across the Trust and that the Board are made aware of all significant risks to achieving its corporate strategy and objectives.

**Attendance at meetings of the Integrated Governance and Risk Committee in 2015-2016**

| Members | 14.04.15 | 13.05.15 | 09.06.15 | 14.07.15 | 18.08.15 | 01.10.15 | 29.10.15 | 17.11.15 | 15.12.15 | 20.01.16 | 17.02.16 | 23.03.16 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clive Kay (Chair) | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | 10 of 12 |
| Jackie Ardley | | ✗ | ✓ | ✓ | ✗ | ✗ | ✓ | ✗ | ✗ | ✓ | ✓ | | 5 of 10 |
| Helen Barker | ✗ | | | | | | | | | | | | 0 of 1 |
| Bernie Bluhm | | | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 8 of 10 |
| Pat Campbell | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 11 of 12 |
| Cindy Fedell | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | 10 of 12 |
| Bryan Gill | | ✓ | ✓ | ✗ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | 9 of 11 |
| Juliette Greenwood | ✗ | | | | | | | | | | | | 0 of 1 |
| Matthew Horner | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | 10 of 12 |
| Robin Jeffrey | ✓ | | | | | | | | | | | | 1 of 1 |
| Sally Scales | ✗ | | | | | | | | | | | ✓ | 1 of 2 |
| Donna Thompson | ✓ | ✓ | ✓ | ✗ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✗ | ✓ | 10 of 12 |

Denotes period when not a member of the Committee.

✓ = attended          ✗ = apologies sent

Committee meetings are also attended by Chris Allcock, Trust Secretary.

### 3.3.9 Charitable Funds Committee

The purpose of the Charitable Funds Committee is to give additional assurances to the Board of Directors that the Foundation Trust's charitable activities are within the law and regulations set by the Charity Commissioners for England and Wales and to ensure compliance with the Charity's own governing document.

The Charitable Funds Committee monitors all aspects of the charity's activity with the Foundation Trust as set out within its governing document. During the year the Committee reviewed the income and expenditure of the Fund and approved changes to signatories and the setting up and closure of specific designated sub funds. Other businesses addressed during the year included agreeing the charity's priorities as those described in "Together, putting patients first" to maximise the impact of the charity and its benefits to the beneficiaries, and the decision to not consolidate the charity's annual accounts with those of the Foundation Trust under International Accounting Standard 27.

**Attendance at Meetings of the Charitable Funds Committee in 2015-2016**

| Members | 25.6.15 | 12.11.15 | TOTAL |
|---|---|---|---|
| Kamlesh Patel (Chair) | ✓ | ✓ | 2 of 2 |
| Clive Kay | ✓ | ✗ | 1 of 2 |
| Jackie Ardley | ✓ | ✗ | 1 of 2 |
| Trevor Higgins | ✓ | ✓ | 2 of 2 |
| Matthew Horner | ✓ | ✓ | 2 of 2 |
| David Munt | ✓ | ✓ | 2 of 2 |

Denotes period when not a member of the Committee.

✓ = attended        ✗ = apologies sent

Committee meetings are also attended by Michael Quinlan, Assistant Director of Finance, Hayley Collis, Charity Fundraiser and Donna Thompson, Director of Governance and Corporate Affairs.

### 3.3.10   Other disclosures

**Foundation Trust Membership**

**Membership Constituencies**

Bradford Teaching Hospitals NHS Foundation Trust membership is made up of public, patient and staff membership constituencies.

**Public Membership Constituency**

To be eligible for public membership a person needs to be over the age of 16 years and resident within one of the public constituencies as outlined within the Foundation Trust's Constitution. The public membership constituency is divided into five sub-constituencies which are known as Keighley, Shipley, Bradford East, Bradford South and Bradford West. These constituencies are comprised of the 30 electoral wards within the Bradford Metropolitan District Council (BMDC) area.

For the purposes of Foundation Trust membership the electoral ward a person lives in determines which membership sub-constituency they are registered in. Public members are automatically registered in one of the sub-constituencies as determined by their home postcode.

| Membership sub-constituency | Wards |
|---|---|
| Keighley | Craven, Ilkley, Keighley Central, Keighley East, Keighley West, Worth Valley. |
| Shipley | Baildon, Bingley, Bingley Rural, Shipley, Wharfedale, Windhill and Wrose. |
| Bradford East | Bolton and Undercliffe, Bowling and Barkerend, Bradford Moor, Eccleshill, Idle and Thackley. |
| Bradford South | Great Horton, Queensbury, Royds, Tong, Wibsey, Wyke. |
| Bradford West | City, Clayton and Fairweather, Heaton, Manningham, Thornton, Toller, Little Horton. |

**Patient Membership Constituency**

To be eligible for patient membership a person needs to be over the age of 16 years, have received treatment at Bradford Teaching Hospitals NHS Foundation Trust and live outside the BMDC boundary or, where appropriate, they are the carers of such a patient and act on their behalf.

**Staff Membership Constituency**

To be eligible for staff membership a person needs to be an employee of the Foundation Trust who holds a permanent contract of employment or has worked for the Foundation Trust for at least 12 months.  Contract staff or staff  holding honorary contracts and who have worked at the Foundation Trust for at least 12 months are also eligible for membership.

**Number of Members**

At the year end the Foundation Trust has a total membership of 49,002.  The table below provides a breakdown of membership within each of the main membership constituencies and where applicable the sub-membership constituency within each group.

| Public Membership Constituency Breakdown | FT members | % membership | BMDC total population | % of BMDC population |
|---|---|---|---|---|
| Bradford East | 9,038 | 24% | 116,327 | 22% |
| Bradford South | 8,776 | 24% | 103,508 | 19% |
| Bradford West | 9,109 | 25% | 117,592 | 22% |
| Keighley | 3,079 | 8% | 98,477 | 18% |
| Shipley | 6,913 | 19% | 96,489 | 18% |
| Total Public Membership | 36,915 | | 532,393 | |
| Total Patient Membership | 6,551 | | | |

| Staff Membership Constituency breakdown | FT members | Total eligible staff population | Membership as % of total eligible staff population |
|---|---|---|---|
| Allied Health Professionals and Scientists | 645 | 690 | 93% |
| Nursing and Midwifery | 1,765 | 1,903 | 93% |
| Medical and Dental | 520 | 568 | 92% |
| All Other Staff Groups | 2,606 | 2,725 | 96% |
| Total Staff | 5,536 | 5,886 | 94% |

Newly employed staff members are automatically opted into membership of the Foundation Trust unless they advise that they do not wish to be a member. Employees who are ineligible for staff membership due to the nature of their contracts are offered either public or patient membership of the Foundation Trust as long as they meet the qualifying criteria for those membership constituencies. Staff members who leave employment of the Foundation Trust are offered either public or patient membership of the Foundation Trust as long as they meet the qualifying criteria for those membership constituencies.

### A Summary of the Membership Strategy 2011 to 2015

The Membership Development Strategy 2011 to 2015 set the targets and objectives for membership recruitment. In 2012 the Foundation Trust committed to membership level of at least 40,000. This is the final year for which this strategy applies. A new Trust Strategy is currently being developed and Governors contributed to its development in January/February 2016.

The new Trust Strategy, once completed, will inform the development of our new membership strategy for 2016-2017 onwards.

The current strategy commits the Foundation Trust to delivering a varied, relevant and responsive programme of events and activities that meets the diverse needs and interests of our members. With regard to communications, the Foundation Trust is continuing to work to develop its use of electronic and digital technologies as well as ensuring that the diverse groups within the membership receive appropriate and accessible communications.

**Membership Recruitment, Engagement and Development 2015-2016**

At the beginning of April 2015, total overall membership stood at 49,390. During the year, membership has declined overall by 388 members which equates to a 1% churn rate. This was the same as the churn rate experienced in the previous year. As the Foundation Trust has a high level of members (compared to other Trusts) there were no active recruitment campaigns undertaken however members were provided with opportunities to register as new members in tandem with general membership activities and via our on-line membership joining form. The profile of the membership continues to be monitored with regard to representation. The Foundation Trust is pleased to report that the membership remains representative of the communities served.

All public and patient members continue to have access to a range of membership benefits which include special rates for members in the Foundation Trust's restaurants and access to 'NHS Discounts', an online national discount scheme previously only available to NHS staff.

A number of key events have been delivered by our Foundation Trust and in partnership with other local NHS foundation trusts (Bradford District Care Trust NHS Foundation Trust and Airedale NHS Foundation Trust) alongside other statutory and third sector organisations. The key events delivered in year were:

• Living Well with Dementia in May 2015;

• Bradford Teaching Hospitals: Responding to the challenges ahead in August 2015;

• Annual General Meeting / Annual Members Meeting in September 2015;

• 'Your Future, Your Health' in October 2015.

During this year we have developed and launched a new dedicated membership website, Members Zone at http://bradfordhospitals.uk.engagementhq.com/ providing a 'one-stop-shop' for members and the public in relation to foundation trust membership. We continue to undertake general and targeted membership e-mailings and postal mailings. However we are working to increase the number of members who receive e-communications. As standard, printed communications are distributed across all hospital sites, circulated directly to community based statutory and third sector organisations and, to both local and regional press and media.

Members have also been involved in 'patient and public engagement' activities across the Trust including PLACE (patient-led assessments of the care environment).

**Contact procedures for members who wish to communicate with Governors**

If members have specific issues they wish to raise they are able to contact individual Governors, the Chairman, or the Council of Governors as a whole via a dedicated helpline telephone number or via a dedicated email address or in writing c/o the Foundation Trust Membership Office.

Papers and agendas for Council of Governor meetings are published on the Members Zone / Trust website in advance of the meetings taking place.

Members are advised of these processes through the membership welcome pack, general membership communications, agendas for Council of Governor meetings and via the Foundation Trust's dedicated membership website pages.

## 3.4    Regulatory Ratings Report

Up to and including Quarter One of 2015, Monitor rated Foundation Trusts under its Risk Assessment Framework using two ratings. The ratings were:

- **Continuity of Services Risk Rating**

    Trusts are awarded a rating of 1 to 4 on a quarterly basis, with 1 being the highest risk and 4 being the lowest risk.

- **Governance Risk Rating**

    Trusts are awarded one of the following three ratings on a quarterly basis: Green (no governance concern evident), Description of Issues (Potential material causes for concern) or Red (regulatory action being taken).

After Quarter One of 2015, the ratings in the Risk Assessment Framework were revised to the following:

- **Financial Sustainability Risk Rating**

    The financial sustainability risk rating is the level of financial risk a foundation trust faces to the ingoing delivery of key NHS Services and its overall financial efficiency. The rating ranges from: 1, the most serious risk, to 4, the lowest risk.

    A rating indicating a serious risk does not necessarily represent a breach of the provider licence. Rather it reflects the degree of financial concern that Monitor have about a provider and consequently the frequency with which they monitor it.

- **Governance Rating**

    Foundation Trusts are awarded a governance rating.  The governance rating has three categories:

    - **Green:** Monitor have no evident grounds for concern or they are not undertaking a formal investigation.

    - **Under Review:** Monitor have identified a concern at a trust but not yet taken action; Monitor provide a written description stating the issue(s) at hand.

    - **Red:** Monitor is taking enforcement action.

**Summary and Analysis of Rating Performance**

The Foundation Trust's performance in 2015-2016 and 2014-2015 was as follows:

| 2015-2016 | | | | | |
|---|---|---|---|---|---|
| | **Annual Plan** | **Q1** | **Q2** | **Q3** | **Q4** |
| **Continuity of Service Risk Rating** | 4 | 3 | N/A | N/A | N/A |
| **Financial Sustainability Risk Rating** | N/A | N/A | 2 | 2 | * |
| **Governance Rating** | Green | Green | Green | Under Review | * |

**\*** Ratings not available at the time of preparing this report

| 2014-2015 | | | | | |
|---|---|---|---|---|---|
| | **Annual Plan** | **Q1** | **Q2** | **Q3** | **Q4** |
| **Continuity of Service Risk Rating** | 4 | 4 | 4 | 4 | 4 |
| **Governance Rating** | Green | Green | Green | Green | Green |

Throughout 2014-2015 the Continuity of Risk Rating remained at 4 and the Governance Rating remained Green.

The 2015-2016 Annual Plan review resulted in forecast ratings of 4 for the Continuity of Service Rating and Green for the governance rating for each quarter of 2015-2016. The Quarter 1 Continuity of Services Rating was 3, and Monitor raised concerns about the foundation Trust's higher than planned deficit and lower than planned CIP savings achievement.

At 2015-2016 Quarter 2, the first ratings under the revised Risk Assessment Framework, the Financial Sustainability Risk Rating was 2, which triggered consideration for further regulatory action. Monitor stated that it expected the Trust to address the issues leading to the financial sustainability rating and achieve financial sustainability promptly, but decided not to open an investigation to assess whether the Trust could be in breach of its licence at that stage and the Governance rating remained at Green.

At 2015-2016 Quarter 3, the Financial Risk Rating remained at 2 and Monitor revised the Governance Rating to Under Review as a result of multiple breaches of the AED four hour standard. Monitor stated that it will continue to engage with the Trust to understand the progress being made with the development and implementation of the Trust's operational and financial recovery plan.

2015-2016 Quarter 4 ratings have not been published at the time of preparing this report.

## 3.5    Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's responsibilities as the Accounting Officer of Bradford Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust.  The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the NHS Act 2006, Monitor has directed Bradford Teaching Hospitals 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 Bradford Teaching Hospitals 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;

• ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance; 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 him/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.

**Professor Clive Kay**
**Chief Executive**
**26 May 2016**

## 3.6   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 Bradford Teaching Hospitals 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 Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2016 and up to the date of approval of the Annual Report and Accounts.

### Capacity to handle risk

As the Chief Executive of a large acute teaching hospital Foundation Trust, I recognise that committed leadership in the area of risk management is essential to maintaining the sound systems of internal control required to manage the risks associated with the achievement of corporate objectives and compliance with our terms of authorisation as an NHS Foundation Trust.

To this end I also recognise that diligence and objectivity are personal attributes required to ensure that appropriate structures are in place to gain assurance about the management of risk, from both internal and external sources.

In order to demonstrate this commitment, the Director of Governance and Corporate Affairs  is personally accountable to me for the maintenance and development of the governance framework for the organisation. The Director of Governance and Corporate Affairs is also responsible for risk management within the organisation.

I recognise that effective training is essential in the management of risk and this is demonstrable at all levels within the organisation. At an operational level, the Foundation Trust has in place well developed programmes of generic and specific risk management training. These programmes are aimed at minimising common risks at ward and departmental level.

Risk registers are in place for all corporate and clinical services and are managed via a Trust-wide risk management reporting system. Specialist advisors are available to provide input to these arrangements and generic advice and support is provided by the risk management team.

Learning from good practice and from serious incidents is seen as a primary mechanism for continuously improving risk management systems. In the Foundation Trust these lessons are derived from external guidance, from site visits and from incidents and complaints reported through the hospital's risk management reporting system. All Serious Incidents are reported formally to the Quality and Safety Committee.

**The risk and control framework**

An updated Risk Management Policy, incorporating the risk management framework was approved by the Board of Directors in January 2015.  The Policy provides an overarching framework for the management of risk within the Foundation Trust and applies to both clinical and non-clinical risk management. The overall aim of the Policy is to achieve a culture where risk management and safety is everyone's business, there is open and honest reporting of incidents, a culture that encourages Trust-wide learning and risks are continuously identified, assessed and minimised.

The policy details responsibilities for risk management at all levels throughout the Foundation Trust.  It also includes guidelines for the identification, assessment and monitoring of risks together with guidelines for the use of risk registers and escalation processes.

The Risk Management Policy also sets out the relationship between the risk register and the Board Assurance Framework.  During the year external support from Deloitte has been obtained to further develop the Board Assurance Framework and set out a clearly defined Risk Escalation Framework.

During the year the Directors identified the following to be the key risks that could affect the Foundation Trust in delivering its objectives and complying with its NHS Provider Licence:

1.  We fail to adequately engage with our patients and local population;

2.  Failure to maintain a safe service due insufficient recruitment and retention of staff;

3.  We fail to maintain compliance with CQC regulatory requirements;

4.  We are unable to maintain our financial stability and as a result fail to meet our Monitor licensing conditions;

5.  We fail to successfully implement our new Electronic Patient Record (EPR) system as scheduled.  The EPR project is described at page 168 of the Quality Report;

6.  We are unable to develop and maintain positive relationships with our key external partners;

7.  We fail to develop vertically and horizontally integrated care pathways.

The controls in place and assurance that the controls are effective are monitored by the Board through its quarterly reviews of the Board Assurance Framework. Each risk is assigned to one of the Board's Committees and these Committees also regularly review the controls that are in place.

The Corporate Risk Register is reviewed on a monthly basis by the Integrated Governance and Risk Committee. In view of the importance of the EPR project a separate group, reporting to the Integrated Governance and Risk Committee, has been established to ensure that all risks relating to the project are closely monitored.

The Quality Improvement Strategy was approved by the Board of Directors in March 2015. The strategy sets out the Foundation Trust's strategic direction for improving quality across the three nationally defined components throughout the organisation and in its role across the wider health and social care environment. It provides a framework for the development and delivery of quality improvement initiatives (patient safety, effectiveness and experience) within the Foundation Trust and ensures that they are developed across and throughout patient pathways involving the multidisciplinary team.

This strategy supports the need for and value of both organisation wide programmes and local initiatives. Integral to the strategy is the need to work with local multidisciplinary teams in the delivery of programmes.

This strategy will help develop a culture firmly rooted in the principles of continual learning and improvement. It states that 'We will listen to, enquire, collaborate, adopt and embrace all the available initiatives and information we can to help improve the quality of the care we can give'.

This strategy sets out the overarching objectives for the next three years. It will be supported by detailed annual Safety Improvement Plans which will give information on the priorities for the year. The Safety Improvement Plan will provide information on individual projects and how they support the overall aim of this strategy: a 50% reduction in avoidable harm through the delivery of safe healthcare, of the highest quality, at all times. In addition the strategy will be supported by plans detailing how we are to engage and involve patients in everything we do and how we ensure that people who use our services have a positive experience.

The assurances the Board of Directors and I require to endorse and approve the Annual Governance Statement are derived from internal and external sources of evidence. The governance framework has a key role in monitoring, evaluating, reporting and collating this evidence. This evidence is to a great extent derived from the schedule of reports and reviews that are generated by:

- The operational management and governance systems;

- Internal audit;

- External audit and external reviews.

These reviews and reports have taken the form of:

- Monthly reports to the Board of Directors, for on-going monitoring;

- Annual, or more frequent, internal reports to the Board of Directors, and other key meetings, required by guidance or statute resulting from monitoring processes within the operational management frameworks;

- External reports from inspecting bodies;

- Specific reports on particular focussed key risk issues.

These reports and reviews are generally associated with action plans whose achievement priority is reflected in the risk register and in organisational and personal objectives.

Key internal assurances can be derived from the following reviews by the Board of Directors:

- Self-assessment against the requirements of the Care Quality Commission;

- Routine monitoring returns to Monitor;

- Monitoring of all metrics used by Monitor in its assessment of the Foundation Trust's Continuity of Service / Financial Sustainability and Governance Risk Ratings;

- Performance management monitoring;

- Financial monitoring;

- Claims and complaints;

- Clinical and non-clinical risk management, including health and safety;

- Human resources and service equity;

- Self-assessment against any external investigation/enquiries into the performance of other Trusts;

- Senior Information Risk Owner reporting.

These areas have been covered in statutory, mandatory or advisory reports to the Board of Directors during the last 12 to 15 months, or incrementally on a month-by-month basis.

The responsibility for reporting is a personal requirement of the senior managers with delegated responsibility in these areas. The reports highlights the current status of compliance and residual risk in respect of relevant statute, guidance, targets or good practice in the areas covered, and act as primary internal assurances to the Board of Directors. They also highlight areas where corrective action must be undertaken. In addition, the groups within the governance framework and Board sub-committees have specific delegated responsibilities in monitoring the effectiveness of risk minimisation in the Foundation Trust to support the Board of Directors in endorsing the Annual Governance statement.

Overlaid on this framework are a series of external reports that reinforce the assurance required by the Board of Directors in endorsing the Annual Governance Statement.

The Board of Directors submitted the Corporate Governance Statement for 2015-2016 to Monitor in June 2015, following detailed consideration by the Integrated Governance and Risk Committee.  The risk and control framework outlined above also provides a sound basis for the Board of Directors to understand the issues relating to each of the components of the statement and the sources of assurance that are in place.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.  The Board has ensured that arrangements are in place to ensure that the Foundation Trust complies with the Equality Act 2010.  Approved equality objectives are in place and their achievement is closely monitored.  An equality analysis is carried out for all new and revised policies.  It includes analysis of all nine protected groups and also considers the human rights FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy).  When necessary changes are made where there is evidence that protected groups might be disadvantaged by the policy.

The Board of Directors actively engages with the Council of Governors and the respective public stakeholders in the reporting of the financial and performance management of the Foundation Trust and in the management of risk which impact on them.

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

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.

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

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

The resources of the Foundation Trust are managed within the framework set by the Standing Financial Instructions, and various guidance documents that are produced within the Foundation Trust, which have an emphasis on budgetary control and ensuring that service developments are implemented with appropriate financial controls.

The Board of Directors receives a comprehensive finance report on a monthly basis encapsulating all relevant financial information to allow them to discharge their duties

effectively. The Foundation Trust also provides financial information to Monitor on a quarterly basis.

In view of the increasingly challenging financial environment within which the Foundation Trust operates, the Finance and Investment Committee was established in January 2016.  The aim of the Committee is to provide detailed scrutiny of financial matters in order to provide assurance and, if necessary, raise concerns or make recommendations to the Board of Directors.

The resource and financial governance arrangements are further supported by both internal and external audit to secure economic, efficient and effective use of the resources the Foundation Trust has at its disposal.

The Foundation Trust's financial plan for 2015-2016, which was submitted to Monitor in April 2015, included a planned deficit of £3.5m.  The plan included a Cost Improvement Programme (CIP) savings target of £15.0m. The actual CIP savings for the year were £9.2m.  The overall deficit for the year was £6.5m

The plan for 2016-2017 reflects the control total surplus of £8.8m set by Monitor and will require the achievement of CIP savings of £24.4m.  Delivery of the plan represents a significant challenge to the Foundation Trust.

The Foundation Trust has complied with cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance.

**Information Governance**

Cindy Fedell, Director of Informatics and Senior Information Risk Owner (SIRO) provides a quarterly report to the Board of Directors and ensures that there is an effective information governance infrastructure in place and any information risks are reported. This is an appointment which was required by the NHS to strengthen controls around information risk and security. The Foundation Trust also carries out an annual assessment by means of the Information Governance Toolkit.

The Foundation Trust has its IT equipment fully encrypted and has effective information governance to ensure essential safeguarding of our information assets from all threats.

Dr Bryan Gill, Medical Director and Caldicott Guardian, works closely with the SIRO; particularly where any identified information risks include patient confidentiality or information sharing issues. The SIRO chairs the Information Governance Sub-Committee which reports monthly to the Quality and Safety Committee which reports to the Board of Directors.  The Caldicott Guardian is the Deputy Chair of this Sub-Committee.

During the last financial year, the organisation reported 6 high risks (Level 2) information governance incidents to the Information Commissioner's Office. The Information Commissioner has closed three of these without taking any further action and three are still under review.  A strong emphasis is put on staff awareness around information governance and training to avoid these risks.

The Foundation Trust's Serious Incident Policy incorporates incidents including data loss or breach of confidentiality.

**Annual Quality Report**

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

- **Governance and Leadership**

The Director of Governance and Corporate Affairs leads on matters relating to the preparation of the Foundation Trust's Annual Quality Report.

The Quality and Safety Committee, which is chaired by a Non-Executive Director, ensures an integrated and co-ordinated approach to the management and development of quality and safety at a corporate level in the Foundation Trust.

- **Systems and Processes**

There are systems and processes in place for the collection, recording, analysis and reporting of data which are focused on securing data which is accurate, valid, reliable, timely, relevant and complete.

The effectiveness of the systems of internal control in relation to data in the Quality Report are subject to be review by of internal audit.

Consultation has been carried out with Governors and members of the Foundation Trust to collate the priorities in the Quality Report. Information about the progress against these priorities will be fed back to governors and members.

- **Data use and reporting - Assurance on the quality and accuracy of data**

The Foundation Trust has an internal data quality team and reviews of data quality are also carried out regularly by internal audit.

**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 and the executive managers and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Account 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 of Directors, the Audit and Assurance Committee, Quality and Safety Committee, Performance Committee, Integrated Governance and Risk Committee, and Finance and Investment Committee and plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit Opinion on the effectiveness of the system of internal control was presented to the Foundation Trust's Audit Committee on 17 May 2016. The opinion was that there was significant assurance that there is a generally sound system of internal control, designed to meet the organisation's objectives. However the following reports were issued with limited assurance opinions:

| Ref | Report | Executive Director Lead | Audit & Assurance Committee | Integrated Governance & Risk Cttee |
|---|---|---|---|---|
| BH/24/15 | Flexible Sessions | Director of Operational Mgmt & Turnaround | July 2015 | Aug 2015 |
| BH/02/16 | Standards of Business Conduct | Director of Governance and Corporate Affairs | July 2015 | Aug 2015 |
| BH/10/16 | Complaints | Chief Nurse | Nov 2015 | Jan 2016 |
| BH/12/16 | Safer Staffing | Chief Nurse | Nov 2015 | Jan 2016 |
| BH/17/16 | Central Patient Booking Service (CPBS) | Director of Operational Mgmt & Turnaround | Nov 2015 | Jan 2016 |
| BH/18/16 | Clinical Coding | Director of Informatics | Nov 2015 | Jan 2016 |
| BH/25/16 | iPharmacy and Controlled Drugs | Chief Nurse | Feb 2016 | Feb 2016 |
| BH/26/16 | eRostering Sickness Interface | Director of Human Resources | Feb 2016 | Feb 2016 |
| BH/29/16 | Compliance with Statutory Regulations: Health & Safety/RIDDOR | Director of Governance & Corporate Affairs | Apr 2016 | Mar 2016 |
| BH/30/16 | MRSA Screening | Chief Nurse | Apr 2016 | Apr 2016 |

For these reports detailed lists of prioritised recommendations have been agreed and the implementation of these recommendations will be followed up by internal audit and reported to the Audit and Assurance Committee.

Reports with Limited Assurance opinions are also reviewed by the Integrated Governance and Risk Committee and added to the corporate risk register. Since January 2016, for each internal audit report where a limited assurance opinion is given, the Executive Director responsible has been asked to attend the Audit and Assurance Committee to discuss the action being taken as a result of the audit.

On April 27th 2015 the CQC published the report into the inspection it undertook in relation to regulated services provided by the Foundation Trust in October 2014. The services included in the inspection were: urgent and emergency services, medical care, surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, outpatients and diagnostic imaging and community health inpatient services. The overall rating for the Trust was 'requires improvement.'

The report identified areas where the Trust was required to take compliance actions ('must dos'), which related to the safety, effectiveness, responsiveness and the leadership of services. The Trust was rated as 'good' throughout the caring domain. The Trust provided a detailed action plan in response to the inspection report, which was subsequently signed-off by the CQC.

The response document was shared with the Clinical Commissioning Groups and the Bradford Health and Social Care Overview and Scrutiny Committee. Progress updates have been shared with both organisations throughout the year.

The CQC report provided the Trust with a clear opportunity to engage with and affect required change and improvement across the organisation, some at micro, patient interface level and some in relation to Trust wide, system level.
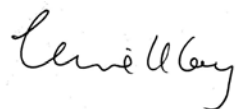
A number of the action plans have been operationalised, some immediately following the inspection.

The Trust has made significant improvements against the compliance actions. Evidence of progress has been discussed and presented to the Quality and Safety Committee.

In January 2016, the CQC carried out a follow-up inspection visit. The Trust is awaiting the draft report, which is expected imminently.

**Conclusion**

The Foundation Trust and its officers are alert to their responsibilities in respect of internal control and have in place organisational arrangements to identify and manage risk.

Professor Clive Kay
Chief Executive
26 May 2016

### 3.6.1 Information Governance Disclosures

The Health and Social Care Information Centre requires that we publish details of personal data related incidents in our Annual Report in the format of two tables as set out below. The first details the serious incidents requiring investigation classified as Level 2 reportable. The second table details the incidents classified at lower level security:

**Table 1**

| Summary of Serious Incident Requiring Investigations Involving Personal Data as reported to the Information Commissioner's Office in 2015-16 | | | | |
| --- | --- | --- | --- | --- |
| **Date of incident (month)** | **Nature of Incident** | **Nature of data involved** | **Number of data subjects potentially affected** | **Notification steps** |
| June 2015 | Unsecure email | Patient level data contained in financial information | 90,000 | Reported to the Information Governance Reporting Tool |
| October 2015 | Lost handover sheet | Patient demographic and limited clinical information | 11 | Reported to the Information Governance Reporting Tool |
| January 2016 | Lost handover sheet and a clinical notes sheet | Patient demographic and limited clinical information | 21 | Reported to the Information Governance Reporting Tool |
| January 2016 | Unauthorised access to health records | Patient demographic and clinical information | 2 | Reported to the Information Governance Reporting Tool |
| February 2016 | Lost handover sheet | Patient demographic and limited clinical information | 21 | Reported to the Information Governance Reporting Tool |
| February 2016 | Email | Financial information about a member of the public | 209 | Reported to the Information Governance Reporting Tool |
| **Further action on informaton risk** | | | | |

**Table 2**

| Summary of Other Personal Data Related Incidents in 2015-16 | | |
| --- | --- | --- |
| **Category** | **Breach Type** | **Total Number of Incidents in this category** |
| A | Corruption or inability to recover data | 0 |
| B | Disclosed in error | 47 |
| C | Lost in transit | 5 |
| D | Lost or stolen hardware | 0 |
| E | Lost or stolen paperwork | 1 |
| F | Non-secure disposal – hardware | 0 |
| G | Non-secure disclosure - paperwork | 21 |
| H | Uploaded to website in error | 0 |
| I | Technical security failing (including hacking) | 0 |
| J | Unauthorised access/disclosure | 6 |
| K | Other | 189 |

## 3.7    Equality Report

Bradford Teaching Hospital NHS Foundation Trust aims to ensure that services we deliver and our employment practices do not discriminate against any individual or groups. The Head of Equality and Diversity leads on the equality agenda in terms of service provision and employment.  The Director of Human Resources oversees the equality agenda and chairs the Diversity Workstream. Professor Grace Alderson is the non-executive equality and diversity champion on the Board of Directors.

**Achievements**

Below are some of the achievements in 2015-16.

**Project SEARCH Bradford**

Project SEARCH began in Cincinnati Children's Hospital in 1996 and is now an internationally renowned programme which provides real employment opportunities to young people with learning difficulties who are aged between 18 and 25 years. The programme increases the employment potential for people with learning difficulties from a national average of 7.7% to 70%. It works by providing three work rotations to the young people (interns), immersing them into the culture of work with five hours on the job experience and two hours tuition and reflection each day. It is based on a programme of systematic instruction – beginning with a small number of tasks, adding on additional tasks when the Intern is ready.

The key partners in the Project are:

- **Southfield School** who are the Project SEARCH Bradford franchise holder who provide a full time tutor, project assistant and resources for the project.

- **HFT** which is a national charity providing supported employment for people with learning difficulties who provide the full time job coach.

- **Bradford Travel Training Unit** who provide one to one support to all Interns to overcome the major barrier of independent travel to work.

- **Bradford Council** who provide the funding for the Job Coach and have a key strategic objective to increase employment rates for vulnerable adults.

We are now in our third year of Project SEARCH. We provide:

- a Base Room (where the Interns, Tutor, Coach and Project Assistant are based),

- internship opportunities and mentors,

- Business Liaison (the Head of Equality and Diversity).

10 young people started Project SEARCH Bradford in September 2015, with nine still on the programme. They are receiving varied work experience in jobs such as administration, IT support services, portering, cleaning and catering. It is hoped that the year spent in Bradford Teaching Hospitals will provide the Interns with the experience, confidence and ability to compete for jobs both inside Bradford Teaching Hospitals and among local employers. One of this year's Interns who had struggled to gain employment, successfully applied to be become an Apprentice with the Trust. As a result she left the programme in March to take up her new role. We had significant achievements with Project SEARCH in 2015-16 which included:

- 66% of the Project SEARCH Interns who graduated in July 2015 have gone on to paid employment.

- Three former Interns were successful in getting jobs with the Foundation Trust.

**Bradford Project SEARCH Business Advisory Committee**

In November 2014 BTHFT set up a Business Advisory Committee (BAC) to develop links with the local business community in Bradford. It currently has senior local business leaders from:

- Barclays Bank
- Bradford District Care Trust
- The Broadway, Bradford
- Midland Hotel
- Wm Morrison Supermarkets plc
- Puddle digital
- University of Bradford

It is chaired by Lord Patel and goes from strength to strength. In April 2015, two of our Interns had their third placement in Midland Hotel and University of Bradford. Both Interns have been successful in gaining employment in the organisations. Our BAC is leading the way in the UK and Europe. The Head of Equality and Diversity has provided support to other Project SEARCH sites who wish to set up their own BAC. In July 2015, she also spoke at an International Conference in Lisbon on the success of Bradford Project SEARCH and the BAC.

**Collaborative working through Bradford and Airedale NHS Equality Group**

The Bradford and Airedale NHS Equality Group was established in September 2011. Its primary aim is to support the four NHS Trusts in the district (Airedale NHS Foundation Trust, Commissioning Support Unit, Bradford District Care Trust and Bradford Teaching Hospitals NHS Foundation Trust) to identify, prioritise and implement equality objectives that will improve the health and wellbeing of people in the district and ensure that employment opportunities exist and do not discriminate against any protected groups. Throughout the Autumn of 2015, we consulted with the membership and more widely in the District to identify new Equality Objectives for 2016-2020. As part of the consultation we received 156 responses to a survey which recommended the priorities for the next four years.

**BME Employment Targets**

An outcome of the collaborative working has resulted in the Trust mirroring the employment target of 35% BME staff which Bradford District Care Trust committed itself to. In February 2015, the Board of Directors set itself a target date of 2025 to achieve a workforce reflective of the local BME working age population of 35%. This is a challenging but achievable target which would require a year on year increase of 1% BME staff to reach the target. Our first six months data is encouraging and shows that we increased the percentage of BME staff from 24.7% to 25.4%. Based on this we are on track to have a workforce that reflects the local population by September 2025. The data for senior managers (Band 8+ Very Senior Managers) is encouraging too. In the six months to September 2015, the percentage of BME staff at this level was raised from 7.6% to 9.1%. Should this increase in percentage continue, the Trust senior management will reflect the local population by March 2023.

The Director of Human Resources and the Head of Equality and Diversity presented a workshop at the NHS Providers Conference on our work to have to workforce that reflects the local population.  As a result of this, we have supported a number of Trusts wishing to replicate our approach.

**Workforce Race Equality Standard (WRES)**

NHS England has agreed a set of Standards to be included in the NHS standard Contract for 2015-2016.  It is intended that the WRES forms the first stage in a process of addressing workforce equality issues.

We published our WRES data in July 2015.  We were able to benchmark our nine metrics data with other Trusts across Yorkshire and Humber.  The analysis showed that we were able to show good results with regard to the relative likelihood of BME staff:

• being appointed;

• entering formal disciplinary;

• accessing non-mandatory training;

• experience of harassment, bullying or abuse from patients, relatives or the public in last 12 months;

• Board reflective of the local population.

We fared less well with regard to the relative likelihood of BME staff:

• in Bands 8-9, Very Senior Manager (including executive Board members and senior medical staff) compared with the percentage of BME staff in the overall workforce;

• experiencing harassment, bullying or abuse from staff in last 12 months;

• believing that trust provides equal opportunities for career progression or promotion;

• discrimination at work from manager/team leader or other colleagues.

Analysis from the 2015 staff survey shows a worsening picture in relation to BME staff experience.  Only 17.4% of respondents were from a BME background equating to 66 staff members.  The Head of Equality and Diversity is working with the Chief Nurse to undertake a survey with all nurses and midwives in the Trust to gain greater insight in to the experience of BME staff.

**Implementing the Equality Delivery System (EDS)**

As part of the review of our Equality Objectives, we sought the views of local community organisations and individuals on the key priorities identified through the EDS.  The EDS remains a key component of the work we undertake on Equality and Diversity and underpins the Equality Objectives described below.

**Performance against Objectives**

In 2012, we agreed seven equality objectives to cover the period 2012-2016 that we are working on jointly across Bradford and Airedale.  Our progress against these objectives is as follows:

## Equality Objectives 2012 - 2016

| Equality Objectives 2012 - 2016 | | | |
|---|---|---|---|
| **No** | **Objectives** | **Progress** | **RAG** |
| 1. | Use EDS effectively to identify key priorities for improvement | The Equality Objectives we set in 2012, where in consultation with the Bradford and Airedale Equality Group who recognised the importance of using the EDS to decide on our Equality Objectives. The EDS continues to be central to our Equality Objectives. | 🟩 |
| 2. | Improve EDS process, year on year | In consultation with local communities through the Equality Panel process and the Bradford and Airedale Equality Group, it was agreed that we should focus on only 10 of the 18 outcomes contained in EDS2. | 🟩 |
| 3. | Ensure that services better meet the needs of trans people | We devised a Trans Equality Policy for patients and staff in March 2013. The policy was tested during a CQC inspection in 2014 and was found to be used effectively by staff in wards and departments. Our policy is used as best practice during other CQC inspections. Our policy was also commended during the Bradford and Airedale Equality Panel process in December 2014. | 🟩 |
| 4. | Make information more accessible | We have not made as much progress on this Objective as we would have liked, a position shared by the vast majority of NHS partners. As a result NHS England has introduced an Accessible Information Standard and Trusts have until July 2016 to comply with the requirements. The Chief Nurses' Office is leading on this Standard. | 🟨 |
| 5. | Improve the access and experience of BME patients and service users | Some work has been undertaken to improve access to our services for Gypsy and Traveller communities. There are pockets of activity across the Trust on improving access but further work is required. | 🟨 |
| 6. | Reduce inequality experienced by BME staff and job applicants. | The experience of BME staff will be reported more fully on an ongoing basis. | 🟨 |
| 7. | Increase the diversity of trust boards / boards of governors & their understanding of equality issues. | We have made significant progress over the past 18 month in relation to Board representation, 29% of the Board are from BME backgrounds. Briefings have been provided to the Board and Governors on equality issues. | 🟩 |

The Equality Objectives were reviewed and updated following the consultation exercise which helped us to determine what our priorities should be for 2016 - 2020.

## Equality Objectives 2016-2020

| Shared Objectives | | |
|---|---|---|
| **No** | **Objectives** | **Rationale** |
| 1. | Carry out a Gender Pay Gap Audit using a recognised audit framework.<br><br>Develop an action plan to address the findings of the audit. | This is a requirement from April 2016. There has been no focus on gender equality in the past 4 years. |
| 2. | To implement the Accessible Information Standard. | This incorporates the priorities identified to improve access and experience for visual and sensory impaired service users and people with learning disabilities.<br><br>The standard is an NHS England requirement for Trusts to implement by July 2016 and monitor beyond. |
| 3. | To improve BME service users access and experience of services.<br><br>Identify four projects over the four years.  One project will focus on  Gypsy and Traveller health inequalities, experiences of maternity services, access to community hospitals. | There needs to be a narrower focus on delivering SMART projects in partnership. These will be defined during the delivery plan development. |
| 4. | To increase awareness of mental health issues and to improve access and experience of mental health service users across the health economy. | This will focus on the specific groups identified in the consultation – perinatal mental health, tackling stigma, women's mental health, particularly BME women, physical health, young people and mental health awareness. |
| 5. | Prepare for the implementation of the Workforce Disability Equality Standard by preparing data and developing and delivering plans to tackle the issues identified. | The NHS Workforce Disability Equality Standard will be introduced in April 2017. Staff Survey results show differences in disabled staffs responses to key equality related questions.<br><br>BTHFT is currently undertaking the Disability Standard self-assessment which will result in a set of actions to improve disabled patient and staff experience and outcomes. |
| 6. | To implement the Workforce Race Equality Standard. | The standard includes all of the key work streams required including a representative workforce, disciplinary, access to training and CPD, BME staff experience and Board representation. |

| No | Objectives | Rationale |
|---|---|---|
| 7. | To implement the recommendations in the Healthy Attitudes Stonewall Study and Equity partnership LGB&T Local Health Needs Assessment. | Over the past four years, there has been no focus among the health economy on the experience of LGB patients or staff. These studies include recommendations for Trusts to improve their services for LGB and T service users and staff. Our existing staff survey sample size precludes us from analysing LGB&T staff experience. |
| **BTHFT specific Equality Objective** | | |
| 8. | To commit to employing at least a third of Project SEARCH Interns who have graduated from the programme. | BTHFT as the employment partner needs to ensure it is providing permanent work opportunities to young people with learning difficulties who have successfully completed the programme. |

## Equality Analysis

The Head of Equality and Diversity meets with the authors of all policy documentation to complete an equality analysis of new and revised policies. Equality Impact Assessment has also been incorporated in to the CIP programme to ensure that any new initiatives or service redesign have taken account of protected characteristics. The Equality Impact Assessment includes analysis of all nine protected groups and also considers the human rights FREDA principles (Fairness, Respect, Equality, Dignity, Autonomy). When necessary changes are made or action taken to mitigate against disadvantage where there is evidence that protected groups might be affected by the policy or QIPP initiative.

## Equality and Diversity Training

- **Training for Senior Managers** – 88.8% of staff in senior management positions have received training on their responsibility to improve performance in the number and positions of staff from all sections of the community in employment and providing tools to reduce bias and in exercising management responsibilities. This training is mandatory for all senior Managers.

- **E-Learning for all staff** – 90.3% of all staff have undertaken a mandatory 20 minute e-learning package. It includes an introduction to bias, equality legislation and highlights the rights and responsibilities that all staff have in relation to equality and diversity both as employees and as service providers.

## Staff Networks

Staff networks for black and minority ethnic staff, disabled staff and lesbian, gay bisexual and Trans (LGBT) staff operate within the Foundation Trust. All the networks are confidential, self-governing groups which provide support and help in raising awareness of issues affecting these staff groups and wherever possible, staff should be given approval to attend meetings during work time.

**Challenges**

Our Equality Objectives identify the challenges that we face in providing services and employment opportunities for people from the protected groups.  Making progress against these will be challenging but we are putting in place realistic targets for achieving the objectives.

**Interpreting Services (Spoken Languages)**

The demand for interpreting services is continuing to increase. The range of languages in which interpreting services are provided is also increasing, with interpreting services provided in over 50 different languages.

2015-2016 – Top 10 languages requested:

| Language | No. of Sessions |
| --- | --- |
| Urdu / Punjabi | 17,330 |
| Czech / Slovak | 5,114 |
| Polish | 3,630 |
| Bengali | 1,961 |
| Arabic | 1,126 |
| Hungarian | 880 |
| Pushto | 664 |
| Russian | 499 |
| Gujerati | 486 |
| Romanian | 391 |

# Quality Report

2015-2016

# 1. Contents

If you require any further information about the 2015–2016 Quality Accounts please contact:

The Foundation Trust Secretary on 01274 36 4946.

## The Foundation Trust achievements in 2015-2016

**Bradford Royal Infirmary**

Became a robotic surgery training centre for cancer, leading the way in this revolutionary procedure for patients with urological cancer.

**Electronic Patient Records (EPR)**

We invested in a new EPR system which will replace paper records and deliver improvements in quality, safety and efficiency.

**Kath Vowden**

The dedicated Nurse Consultant was honoured with a British Empire Medal (BEM) in the 2016 Queen's New Year's Honours for her pioneering work in wound care.

**New £28m hospital wing**

Construction started on the new wing which will revolutionise our estate.

**BRI's Midwives**

Are finalists in the Royal College of Midwives' (RCM) Midwifery Service of the Year 2016 Award.

**Health Library**

Named as the Workplace Provider of the Year at the 4th annual Bradford Mental Health Awards.

**Book award for Bradford surgeon**

An Introduction to Oral and Maxillofacial Surgery 2nd edition co-written by Mr David Mitchell was highly commended at the British Medical.

**Dr Paul Southern**

Was one of four finalists nominated for the Chief Clinical Information Officer (CCIO) Award for Clinical Informatics Leadership organised by E-Health Insider.

**Liz Watson**

Named winner of the Outstanding Multiple Sclerosis (MS) Specialist Nurse of the Year at the QuDoS Awards 2015.

**Drs Steven Lindsay and Paul Sainsbury**

Were UK co-authors on a new international study, published in the New England Journal of Medicine, which provides evidence for an effective treatment for patients with angina who previously would not have been suitable for conventional treatments.

**Launch of new Wheelchair Charter**

Therapy services were chosen as one of just three centres to unveil a new, national initiative championing improvements in wheelchair services across the country.

**Research nurses' success**

Our Clinical Research Nurses beat more than 100 other organisations and made it to the final of the Nursing Times 2015 Awards for introducing a pioneering educational programme into the BSc undergraduate nursing degree course alongside their colleagues at Bradford University.

## The Foundation Trust achievements in 2015-2016

**Dr Alex Brown & the Education Department**

Launched a taster course for students aged 16+ who are considering a career in medicine.The initiative aims to help improve the prospects of local schoolchildren who are academically gifted enough to get into medical school but may not have the opportunity or additional experience to do so.

**Professor John Wright**

Was one of the country's first recipients to collect a new medal recognising the bravery and hard work of thousands of people who volunteered to help tackle Ebola in West Africa when he attended a Downing Street reception.

**The Listening for Life Team**

Celebrated helping their oldest-ever cochlear implant patient to hear again when a 91-year-old patient had his device switched on. The team also made UK history a month later by performing the first cochlear implant procedure on a pregnant patient.

**Launch of new support hub**

St Luke's Hospital became the base for a new integrated intermediate care hub for the city which will help provide health and social care closer to home for elderly patients.

**Stand and sit desks success**

Our innovative Bradford Institute for Health Research achieved national prominence for a pioneering study which looked at how best to combat sedentary behaviour in primary schools.

**Consultant Rachel Pilling and the Bradford Learning Disability Eye Care Team**

Won Vision 2020 UK's Astbury Award for Excellence for the care it offers our eye patients.

**New £2m neonatal unit**

Opened at BRI and invited guests included the parents who helped redesign the new wards.

**HRH The Princess Royal**

Visited BRI to celebrate our Project Search initiative designed to give young people with learning disabilities the opportunities to learn the necessary skills and experience to gain future employment.

# Part 1

## 1. Statement on Quality from the Chief Executive

The Foundation Trust has faced another busy year with extremely challenging financial constraints and unprecedented demand for services, including high levels of demand in emergency services continually throughout the year.

However, despite these challenges our staff have continued to work together to deliver high quality and safe services for all our patients.

The Care Quality Commission (CQC) issued its report on our services in April 2015 and rated us as 'requires improvement'. Our staff responded immediately and rose to the challenge, making rapid and substantial improvements to drive forward the quality, safety, and experience of care that our patients receive.

Recruitment of extra doctors and nurses, the creation of new modern facilities and an unprecedented focus on quality and safety has spearheaded our package of improvements. We received a follow-up visit from the CQC in January 2016 and we are currently awaiting the outcome of that inspection.

Out of the 57 individual ratings awarded that were applicable, the Foundation Trust scored "good" in no fewer than 32 areas; "requires improvement" in 18; and "inadequate" in 7. Together, these ratings translated into an overall score for the organisation as "requiring improvement".

The report underlined that generally "treatment and care followed best practice and national guidance and outcomes for patients were positive"; and that patients had good experiences and were treated with kindness.

One of the important findings that really shone through in the CQC report is that our 5,000 staff and volunteers were judged to be very caring people. Throughout the report there are countless references to the caring, compassionate nature of everyone who works for us – something of which we are all proud.

Where any immediate concerns were raised about services, proactive and effective action was swiftly taken. For example:

- We adopted the British Thoracic Society best practice guidance in a new model of care for patients requiring immediate Bi-Level Non Invasive Ventilation (NIV).

- We strengthened the skills and experience of staff in the stabilisation room used for children waiting to be collected for transfer to another hospital for paediatric intensive care.

The quality report reflects the successes we have achieved and challenges we are determined to overcome, showcasing many outstanding services and initiatives that are at the forefront of best practice and quality.

Some of our achievements over the last twelve months include:

- Our renal unit at St Luke's Hospital joined in a national, ground-breaking project to encourage kidney patients to play a more active role in their health care.

- Our maternity services were shortlisted for the Royal College of Midwives (RCM) Midwifery Service of the Year Award, recognising excellence and innovation in the provision of maternity care.

- The annual NHS Staff Survey revealed that our staff overwhelmingly believed their role made a difference to patients. The 92% score in this category placed us at the top end of results for all acute hospitals in England.

- We launched a new midwife-led project, aimed at providing personalised, one-to-one maternity care to around 400 women living in Bowling, Barkerend, Bradford Moor and Little Horton.

- Bradford Learning Disability Eye Care Service, made up of our specialists and those from Bradford District Care Trust, scooped Vision 20202 UK's Astbury award for excellence in the high quality treatment it provides to patients with learning difficulties.

- In July, our eye clinic team was nominated for the 'Clinical Service of the Year' award as part of the Macular Society's Awards for Excellence, an accolade recognising exceptional practice in the care of people with macular degeneration.

- Nurse Consultant for Acute and Chronic Wound Care was awarded the British Empire Medal (BEM) for services to the advancement of wound management for patients suffering with chronic wounds.

- Sister; Multiple Sclerosis Specialist Nurse was named winner of the Outstanding Multiple Sclerosis (MS) Specialist Nurse of the Year in recognition of her contribution to improving the quality of life and experience of care for those with MS.
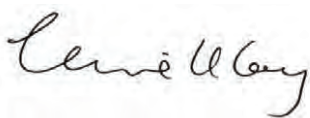
The scale and number of successes we have achieved in 2015-2016 has been outstanding given the very challenging environment we have been working in. The Foundation Trust has demonstrated that we have the capacity and capability to improve safety; break new ground with our approach to transformation and further enhance the experience and care of our patients.

I am pleased to confirm that the Board of Directors has reviewed the 2015-2016 Quality Report and confirm that it is a true and fair reflection of our performance.

We hope that our Quality Report provides you with a clear picture of how important quality improvement, patient safety and patient and carer experience are to us all at the Foundation Trust.

Finally, I would like to extend a sincere thank you to all the staff working at the Foundation Trust who work hard every day to better the lives of patients and the community we serve.

To the best of my belief, the information provided in this report is accurate.

**Professor Clive Kay**
**Chief Executive**

# Part 2

## 2. Priorities for Improvements

**2.1**      **Review of progress against quality priorities for 2015-2016**

2.1.1      In 2014-2015 the Foundation Trust's Quality Report confirmed its continuing focus on the following three key priorities:

Priority 1:      Management of diabetes in the acute environment.

Priority 2:      Meal time experience.

Priority 3:      Communication with patients and public whose first language is not English.

Management of diabetes in the acute environment and meal time experience improvement priorities had rolled over from the previous year; with a new improvement priority added in relation to communication with patients and public whose first language is not English.

2.1.2      Progress against each of the individual priorities for 2015-2016 is shown below.

**2.1.2.1 Prioty 1**



| Quality Domain(s) | Clinical effectiveness<br>Patient safety |
|---|---|
| Improvement priority; 3<br>Improvement priority; 7 | Patient Information<br>Involvement in decisions |
| Descriptor | Management of diabetes in the acute environment |

Aims:

•   To improve the care of patients with diabetes in the acute hospital setting.

•   To improve the knowledge and skills of staff in relation to diabetes.

•   To improve care by standardising nursing care plans, and associated documentation to ensure all relevant aspects of care are provided.

•   To increase the number of patients with diabetes who are referred to the Diabetes Team.

•   To improve information provided to patients.

•   To ensure appropriate basic assessment of patients admitted to hospital.

Actions from 2015:

Continue to increase the number of referrals, monitor progress and take steps to embed all elements into practice and continue to improve compliance in all areas.

Diabetes team referrals:

In our Quality Report for 2014-2015, we provided the graph below showing the increase in the number of referrals over the year.

**No. of referrals to the Diabetes Team**
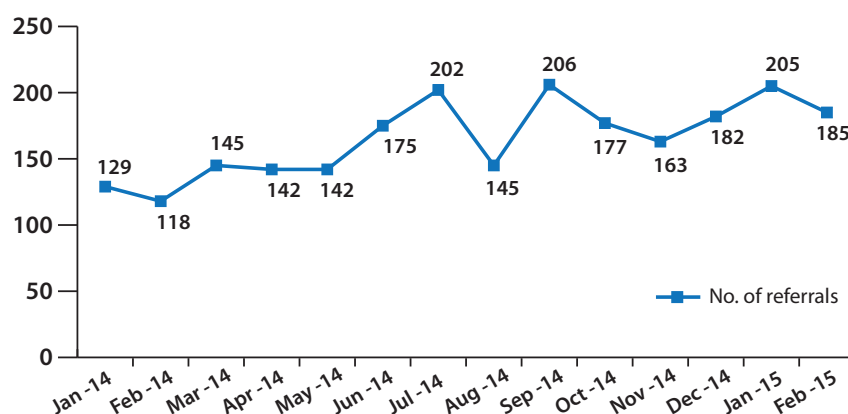


The following graph shows a comparison of the number of referrals to the diabetes team month by month for 2014-2016. Referrals in 2015-2016 remain consistently higher than in 2014-2015, demonstrating the progress that has been made.

**Referrals to the Inpatient Diabetes Team January 2014 to April 2016**
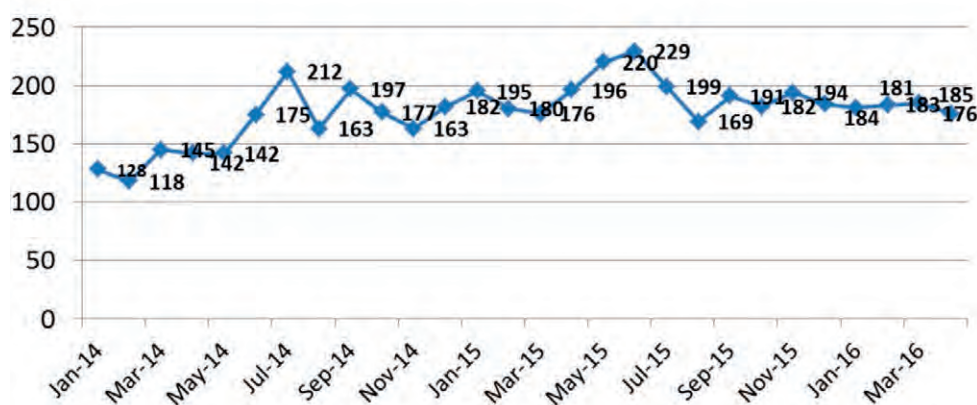


National diabetes inpatient audit 2015:

The National Diabetes Inpatient Audit (NaDIA) is a snapshot audit of diabetes inpatient care in England and Wales. The 2015 National Diabetes Inpatient Audit was carried out in September 2015. It identified 89 in-patients with diabetes at the Foundation Trust. This was equal to 15.7 per cent of the beds audited.

*NB.  In the tables that follow, there are no figures shown for 2014 due to the National audit not being carried out.*

**Visits by specialist teams**

The audit showed that 42 per cent of patients in the Foundation Trust with diabetes were visited by a member of the diabetes team.

The table below shows the percentage of patients with diabetes who were visited by the diabetes team, compared with the average for all other Trusts in England, by year since 2010.

| Audit Year | The Foundation Trust | England |
|---|---|---|
| 2010 | 13.8% | 30.3% |
| 2011 | 22.6% | 30.4% |
| 2012 | 21.2% | 31.6% |
| 2013 | 37.4% | 34.4% |
| 2014 | * | * |
| 2015 | 42.0% | 35.8% |

The figures show that the Foundation Trust has gone from being significantly worse than the average for other Trusts in England in 2010, to significantly better in 2015.

This improvement corresponds with the implementation of "Think Glucose" as part of the 'SAFE!' campaign across the whole Foundation Trust in 2013, when the nurse specialist inpatient diabetes team was expanded.

**Diabetes control**

The audit showed that 62.8 per cent of patients with diabetes in the Foundation Trust reported that they could take control of their diabetes care while in hospital.

The table below shows the percentage of patients with diabetes who reported that they were able to take control of their own diabetes whilst in hospital, compared with the average for all other Trusts in England, by year since 2010. For 2015, the results show that the Foundation Trust was better than the overall England value.

| Audit Year | The Foundation Trust | England |
|---|---|---|
| 2010 | 56.6% | 56.1% |
| 2011 | 58.7% | 57.0% |
| 2012 | 47.4% | 55.5% |
| 2013 | 38.8% | 55.0% |
| 2014 | * | * |
| 2015 | 62.8% | 59.5% |

## Staff knowledge

The audit showed that 90.3 per cent of patients with diabetes in the Foundation Trust reported that all or most of the staff caring for them were aware that they had diabetes and, 80 per cent of patients with diabetes reported that all or most of the staff looking after them had enough knowledge of their diabetes to meet their needs while in hospital.

The table below shows the percentage of patients with diabetes who reported that staff were aware that they had diabetes, compared with the average for all other Trusts in England, by year since 2010. The Foundation Trust scored better than the England value in 2015.

| Audit Year | The Foundation Trust | England |
|------------|---------------------|---------|
| 2010 | 83.1% | 87.6% |
| 2011 | 81.5% | 84.4% |
| 2012 | 62.9% | 81.4% |
| 2013 | 88.7% | 82.0% |
| 2014 | * | * |
| 2015 | 90.3% | 84.3% |

The table below shows the percentage of patients with diabetes who reported that all or most of the staff looking after them had enough knowledge of their diabetes to meet their needs, compared with the average for all other Trusts in England, by year since 2010. Again, the Foundation Trust scores are well above the England value for 2015.

| Audit Year | The Foundation Trust | England |
|------------|---------------------|---------|
| 2010 | 59.3% | 65.1% |
| 2011 | 65.1% | 66.3% |
| 2012 | 70.2% | 68.9% |
| 2013 | 59.0% | 67.3% |
| 2014 | * | * |
| 2015 | 80.0% | 65.5% |

The audit showed that 73.5 per cent of patients with diabetes in the Foundation Trust reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood.

The table below shows the percentage of patients with diabetes who reported that staff were definitely, or to some extent, able to answer their questions in a way that they understood. In 2015, the Foundation Trust faired less favourably compared with the England value.

| Audit Year | The Foundation Trust | England |
|---|---|---|
| 2010 | 59.2% | 82.2% |
| 2011 | 57.0% | 77.9% |
| 2012 | 83.1% | 79.5% |
| 2013 | 69.7% | 79.5% |
| 2014 | * | * |
| 2015 | 73.5% | 81.5% |

The audit showed that 83.8 per cent of patients with diabetes in the Foundation Trust reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital.

The table below shows the percentage of patients with diabetes who reported that they were satisfied or very satisfied with the overall care of their diabetes while in hospital. In 2015, the Foundation Trust scored slightly lower than the England value.

| Audit Year | The Foundation Trust | England |
|---|---|---|
| 2010 | 80.4% | 80.8% |
| 2011 | 85.7% | 84.7% |
| 2012 | 76.8% | 85.7% |
| 2013 | 89.1% | 86.1% |
| 2014 | * | * |
| 2015 | 83.8% | 84.3% |

Staff learning:

The knowledge of our nursing staff is kept up-to-date by them completing mandatory e-learning modules. There are also quarterly meetings for the "Think Glucose" link nurses and a "Think Glucose" session at the nursing training update days. In 2016, this will be supplemented with a newsletter that will include information about learning from incidents and any updates that are relevant.

**Monitoring and progress:**

**Progress:** On plan

**"Think Glucose" audit tool:**

One of the key aims of rolling out this initiative was to ensure appropriate basic assessment of patients admitted to hospital. As part of the admission assessment, the following issues should be ascertained for all patients:

- Whether the patient has diabetes;
- What type of diabetes a patient has;
- Whether their blood glucose level had been recorded in the last 3 months.

It was agreed these must be documented in medical / nursing notes and on handover documents.

A "Think Glucose" audit has been developed and included in the SAFE! Dashboard. A lack of compliance in completing the audit was previously reported from many ward areas. The implementation of an electronic real-time patient feedback and audit system has now been introduced and is fully functional across the Foundation Trust as of January 2016. Initially the system was completed by "Think Glucose" champions every two months, but this is now undertaken quarterly (every 3 months). The audit reviews the above information alongside the use of other "Think Glucose" tools including, care plans, stickers, appropriate blood glucose monitoring forms and availability of the assessment / referral criteria.

The table below shows performance each ward / area.

| Month | 1 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 11 | 12 | 14 | 15 | 18 | 19 | 20 | 21 | 22 | 23 | 24 | 26 | 27 | 28 | 29 | 30 | ICU | YS | F3 | F5 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| May-14 | NA | 97 | NC | NC | NC | NC | 55 | 85 | 67 | 9 | NC | NC | 100 | 85 | NC | 93 | NC | NC | NC | NC | 66 | NC | 69 | NC | NC | 86 | NC | 98 |
| Jul-14 | NA | 100 | NC | 66 | NC | 63 | 45 | 94 | 81 | 97 | 86 | 90 | 83 | 98 | 95 | NC | 96 | NC | NC | NC | 69 | 98 | NC | 66 | NC | 88 | 86 | 100 |
| Sep-14 | NA | 66 | NC | 61 | 100 | 9 | 47 | 30 | 43 | 63 | 67 | NC | 76 | NA | 43 | 27 | 48 | 69 | 91 | NC | 67 | 85 | 64 | 35 | 25 | 72 | 97 | NC |
| Oct-14 | NA | 100 | 76 | 68 | NC | 70 | 94 | 43 | 51 | 77 | 78 | 93 | NC | NA | 72 | 38 | 80 | 77 | 57 | 82 | 92 | 78 | 64 | 83 | 58 | 55 | 94.1 | 98.6 |
| Jan-15 | NA | 97 | NC | 100 | 98 | NR | 85 | 51 | NR | 85 | 100 | 97 | NC | 100 | 69 | 50 | 84 | 81 | NR | NR | NR | 80 | 85 | 33 | 64 | 71 | 98 | NR |
| Apr-15 | NA | 93 | NC | 100 | 45 | NC | NC | 45 | NC | 84 | NC | 100 | 90 | 85 | 62 | 77 | 86 | NC | NC | 68 | 28 | 65 | 68 | NC | 54 | NC | 100 | NC |
| Jul-15 | 45 | NC | 26 | 100 | 78 | 68 | 73 | 57 | 39 | 65 | 85 | 96 | 88 | NA | 47 | 36 | 72 | 75 | 100 | 70 | 53 | 82 | 74 | 26 | 52 | 66 | 95 | NC |

No Audit Data available July 2015 - January 2016. Change to Meridian system for Audit

| Month | AMU | 3 | 5 | 6 | 7 | 8 | 9 | 11 | 12 | 14 | 15 | 18 | 20 | 21 | 22 | 23 | 24 | 26 | 27 | 28 | 29 | 30 | ICU | YS | F3 | F5 | F6 | WWP |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Jan-16 | ND | 97 | 100 | ND | ND | 94 | NC | 80 | 100 | 100 | 95 | 83.7 | 86 | 100 | ND | 95 | 87 | ND | ND | ND | 60 | 80 | ND | 65 | 91 | 92 | ND | ND |
| Apr-16 | 77 | ND | 87 | 90 | ND | 96 | ND | ND | 96 | ND | 82 | No pt | 88 | 94 | 100 | No pt | ND | ND | 99 | ND | ND | ND | 100 | ND | 95 | 89 | 100 | 91 |

| Colour code | |
|---|---|
| | >80 |
| | >60 |
| | <60 |
| NR | Unable to record |
| NC/ND | Not completed/No data |
| No pt | No patients Audit attempted. |

Following the introduction of the electronic real-time patient feedback and audit system (Jan 2016 and April 2016 results) a dramatic improvement in audit results can be seen. However, documenting blood glucose levels and foot checks remain an issue. The data was reviewed at the recent link nurse meeting to identify where improvements must be made. Progress will continue to be monitored in this way.

**Next steps:**

1. Inclusion of the diabetes records into the electronic patient record system (EPR) on wards.
2. Work to improve the safe prescribing of diabetes treatments.
3. Continue to improve care to patients with diabetes in hospital setting.
4. Continue to improve compliance in all areas.

### 2.1.2.2 Priority 2

| Quality Domain(s) | Patient Experience |
|---|---|
| Improvement priority; 1<br>Improvement priority; 5 | Nutrition<br>Dignity and respect |
| Descriptor | Meal time experience |

Aims:



- To improve the overall meal time experience for patients.

- To be able to meet the nutritional requirements of patients with specific needs.

How:

- Continually review menus with support from patients, to provide a choice of dishes that not only caters for nutritional needs, but provides choice to all patients.

- Undertake audits of meal time service and feedback to staff on areas where improvements can be made.

- Hold focus groups with speciality areas in order to provide a service to meet the needs of those patients.

Actions and results:

- Introduction of single portion meals on assessment areas in order to allow greater flexibility and choice to patients. This enables patients to choose the meals they want closer to the meal time.

- New catering folder provided to all wards to ensure that nursing staff are aware of all aspects of the catering service available to patients, including different menus, obtaining meals out of hours etc.

- Introduction of a no-gluten containing ingredients (NGCI)/gluten free menu, which brings together in one format all dishes available to patients who require a gluten free diet.

- Patient satisfaction survey revised, in order to be able to get more meaningful feedback on meal service.

- Participation in the National nutrition and hydration week, with the highlight of the week being the provision of afternoon tea for all inpatients, enabling the Foundation Trust to support an attempt to achieve a Guinness world record for the most afternoon teas served at one time.

Feedback comments

"All of the kitchen staff were very helpful and polite and kind, also how well the meals were prepared and how well I thought the meals were".

"All the food I received was excellent and service was wonderful also the food was also very good and the service from all the food staff was excellent thank you"

"They are wonderful, friendly and very polite, the food was great too. Thank you"

Monitoring and progress:

Progress: On plan.

Meal time experience is monitored through the Trust's Improving Nutrition Group, which reviews all aspects of nutrition, including menus, choice of supplier as well as reviewing satisfaction and continually looking to improve meal service. The group reports into the Foundation Trust Nutrition Steering Group.

Throughout the year the group has reviewed initiatives put in place alongside patient satisfaction scores and aims to have 70% of patients reporting the overall patient meal service as excellent or good.

Outcome:

74% of our patients rate the overall patient meal service as excellent or good.

Next steps 2016-2017:

- Following an evaluation of the finger food menu for dementia patients, carry out a review of the elderly care menus.

- Re-tender of the contract for delivered meals, ensuring that patients are involved in tasting dishes and the final decision.

- Work with other areas such as oncology to design service specific menus.

### 2.1.2.3 Priority 3

| Quality Domain(s) | Patient Experience |
| --- | --- |
| Improvement priority; 3<br>Improvement priority; 7 | Patient Information<br>Involvement in decisions |
| Descriptor | Communication with patients and public whose first language is not English |

Aims:

- To ensure that any barriers to communication are removed for patients whose first language is not English.

- To provide information for staff about when and how to access interpreting services including telephone interpreting, video interpreting, British Sign Language interpreting, translation services and to obtain information in different formats.

- To ensure that staff are aware of best practice when working with interpreters to provide the most effective use of the services when required.

- To provide a prompt and efficient service that is accessible and equitable to all.

## Actions and results:

The Foundation Trust has an interpreting and translation service in place. In 2015-2016 there has been approximately 38,000 interpreting requests covering over fifty languages; over 35,000 of these requests for face to face interpreters were met for non-English speaking patients.

An Interpreting and Translation policy was approved by the Foundation Trust in 2015-2016. This is available on the staff intranet to ensure effective communication with non-English speaking patients, relatives and carers. The policy provides staff with guidance and information about how to access Telephone and Video Interpreting, British Sign Language, Interpreting, Translation services and obtain information in different formats.

Promotion and raising awareness of the Interpreting Services to staff has been carried out through Foundation Trust publications, website information, team meetings and Culture to Culture briefings.

As a result of the work carried out in 2015-2016, the Foundation Trust has:

- Improved communication with patients enabling them to give informed consent to treatments, operations and procedures and proactively participate in their care.

- Increased use of video interpreting.

- Recruited more interpreters to reduce complaints regarding the availability of interpreters in certain languages.

## Monitoring and progress:

The Foundation Trust is committed to ensuring there is effective communication with patients, relatives and carers. Continued monitoring will include audit of activity data and complaints.

## Next steps 2016-2017:

- Include a statement about the availability of services in all patient information resources produced after 1 April 2016.

- Inclusion of agreed questions for all of those who communicate with patients about their preferred method and language.

- Following launch of the Electronic Patient Records (EPR) system, explore the use of new technologies such as on-line chat to provide effective communication with patients.

- Continue to meet the requirements of the Accessible Information Standard.

**2.2     Quality priorities for improvement in 2016- 2017**

2.2.1    The Foundation Trust will continue to focus on a broad range of projects for the coming year. We would however, like to highlight the following key areas of work.

2.2.2    The selection of improvement priorities for inclusion in the Quality Report reflects a review of themes and areas of concern arising from a range of sources including:

- Complaints and Patient Advice Liaison Service (PALS) reports.

- Serious incident and other incident reports.

- National and local patient surveys.

2.2.3    **Safety: Hospital acquired pressure ulcer reduction**

Hospital acquired pressure ulcers are a type of patient harm that is preventable. Indeed, there is evidence that the use of a number of interventions can virtually reduce them to zero. Safety Thermometer data shows that whilst the Foundation Trust performs about average for hospital acquired pressure ulcers, there is an opportunity to improve. To tackle pressure ulcers the Foundation Trust will start a quality improvement project which will involve areas that have the greatest opportunity for pressure ulcer reduction. Our main aim will be to significantly reduce pressure ulcers of all grades.

The intention of this work is to not only reduce hospital acquired pressure ulcers but to also use a project methodology which allows the teaching of quality improvement methodology to large numbers of staff resulting in the further enhancement of a safety culture with staff.

2.2.4    **Effectiveness / Safety: Safer procedures**

The Foundation Trust has identified improving the safety of procedures as a priority for 2016-2017. Having a procedure in a hospital is absolutely vital in ensuring that patients recover from ill health, but, they do not come without risks. It is our job to work as hard as we can to ensure the safety of patients who are undergoing a procedure. We are establishing a Safer Procedure working group who will oversee the development of work that will aim to improve the safety of procedures at the Foundation Trust.

Areas of work will include:

- Safety culture.

- Education.

- Use of information to drive improvement.

- Improving systems of administration and documentation.

### 2.2.5    Experience: Patient, family and carer experience

Improving patient experience is always a focus for the Foundation Trust, indeed two of the priorities that we identified last year related to patient experience. One of those priorities (communication with patients and public whose first language is not English) will be continued to be focussed on this year as part of a wider piece of work on improving patient experience. Over the coming year we will:

- Start a quality improvement project aimed at working with wards and departments to develop tests of change (a test of change is an improvement technique whereby improvement ideas are tested on a small scale to see whether they are useful or not) that will improve the experience of our patients.

- Work with information technology partners to develop ways of understanding the experience our patients, their carers and their families are experiencing on a monthly basis.

- Oversee the work done to improve patient experience at the Foundation Trust through the Patients First Committee.

# 3. Statements of assurance from the Board of Directors

## 3.1 Review of Services

3.1.1 During 2015-2016 the Foundation Trust provided and/or subcontracted 42 relevant health services.

3.1.2 The Foundation Trust has reviewed all the data available to them on the quality of care in 42 of these relevant health services.

3.3.3 The income generated by the relevant health NHS services reviewed in 2015-2016 represents 100% of the total income generated from the provision of relevant services by the Foundation Trust for 2015-2016.

## 3.2 Participation in clinical audits and national confidential enquiries

3.2.1 The Foundation Trust is committed to a programme of continuous improvement supporting its provision of safe, high quality patient care. It understands clinical audit as a professionally led, multi-disciplinary exercise which should be integral to the practice of all clinical teams. The Foundation Trust also believes that clinical audit should not occur in isolation and supports the view that it should be considered both within the context of organisational learning and as a mechanism to provide assurances about the quality of services provided.

3.2.2 The Foundation Trust has a High Priority Clinical Audit Programme that describes both its involvement in the national clinical audit programme and its management of audits that are prioritised at a local level.

3.2.3 During 2015-2016, 41 national clinical audits and 3 national confidential enquiries covered NHS services that the Foundation Trust provides. During that period, the Foundation Trust participated fully in 97.5% of the national clinical audits and 100% of the national confidential enquiries in which it was eligible to participate. The national clinical audits and national confidential enquiries that the Foundation Trust was eligible to participate in during 2015-2016 are described as follows:

**Bradford Teaching Hospitals NHS Foundation Trust's participation in the National Clinical Audit Programme.**

\* Case ascertainment is an important measure of the completeness of data captured for the audit and demonstrates the Foundation Trust's commitment to the audit. The data collection is often compromised by capacity, administrative support for the audit or other factors such as notes not available etc. The Foundation Trust recognises this is an area for improvement and is defining its strategy with this area as a priority.

| Name of audit / Clinical outcome Review Programme | % Case ascertainment* |
|---|---|
| Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP) | 100% |
| Adult Asthma | Not collecting 2015-2016 data |
| Bowel cancer (NBOCAP) | 100% |
| Cardiac Rhythm Management (CRM) | No report published 2015-2016 |
| Case Mix Programme (CMP) | No report published 2015-2016 |
| Child health clinical outcome review programme | No report published 2015-2016 |
| Coronary Angioplasty/National Audit of PCI | No report published 2015-2016 |
| Diabetes (Adult) | 100% |
| Diabetes (Paediatric) (NPDA) | No report published 2015-2016 |
| Elective surgery (National PROMs Programme) | 60.3% |
| Emergency Use of Oxygen | No report published 2015-2016 |
| Falls and Fragility Fractures Audit Programme (FFFAP) | 100% |
| Inflammatory Bowel Disease (IBD) programme | No report published 2015-2016 |
| Lung cancer (NLCA) | 98.7% |
| Major Trauma: The Trauma Audit & Research Network (TARN) | 34% |

| Name of audit / Clinical outcome Review Programme | % Case ascertainment* |
|---|---|
| Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK) | 100% |
| Medical and Surgical Clinical Outcome Review Programme, National Confidential Enquiry into Patient Outcome and Death (NCEPOD) | Acute Pancreatitis - 100% Sepsis - 50% Gastrointestinal Haemorrhage - 100% |
| National Audit of Intermediate Care | Community hospitals – 58% Virtual wards team – 69% |
| National Cardiac Arrest Audit (NCAA) | 100% |
| National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme | 96.47% |
| National Audit of Blood Transfusion (Lower Gastro-intestinal Bleeds) | Did not participate |
| National Complicated Diverticulitis Audit (CAD) | 95% |
| National Emergency Laparotomy Audit (NELA) | 60.96% |
| National Heart Failure Audit | 90% |
| National Joint Registry (NJR) | 95% |
| National Ophthalmology Audit | No report published 2015-2016 |
| National Prostate Cancer Audit | 20% |
| National Vascular Registry | 97% |
| Neonatal Intensive and Special Care (NNAP) | 100% |
| Non-Invasive Ventilation - adults | No report published 2015-2016 |
| Oesophago-gastric cancer (NAOGC) | >90% |
| Paediatric Asthma | No report published 2015-2016 |
| Paediatric Pneumonia | No report published 2015-2016 |
| Renal replacement therapy (Renal Registry) | No report published |

| Name of audit / Clinical outcome Review Programme | % Case ascertainment* |
|---|---|
| [NEW] Procedural Sedation in Adults | 100% (40 cases) |
| Rheumatoid and Early Inflammatory Arthritis | No report published 2015-2016 |
| Sentinel Stroke National Audit Programme (SSNAP) | 88.3% |
| UK Parkinson's Audit (previously known as National Parkinson's Audit) | 100% |
| Vital signs in children | 100% |
| VTE risk in lower limb immobilisation | 100% |

3.2.5   The table above shows the national clinical audits and national confidential enquiries that the Foundation Trust participated in, and for which data collection was completed during 2015-2016, 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.

3.2.6   The reports of 20 national clinical audits were reviewed by the provider during 2015-2016 and actions that the Foundation Trust intends to take to improve the quality of healthcare provided are described as follows:

**Bradford Teaching Hospitals NHS Foundation Trust's intended actions following review of the recommendations from national audits published during 2015-2016**

| Name of audit / Clinical outcome Review Programme | Date of publication | Actions taken |
|---|---|---|
| National Joint Registry Annual report | September 2015 | The Foundation Trust has identified a number of actions following publication of this audit report. Key to the response from the 2014 report was a proactive review and consideration of knee replacement revision surgery and current performance (as the audit included data from 2003 onwards) and this work continues. In addition the newly formed Mortality Sub-committee will review all the outcomes associated with mortality. |
| Heart failure audit report | October 2015 | The Foundation Trust is focusing on improving the amount and quality of data submitted to this national audit. Specialty level governance ensures that performance associated with this audit and the associated performance outcomes is monitored and any issues escalated to senior management. |
| Medical and surgical clinical outcome review programme: National confidential enquiry into patient outcome and death | Just say Sepsis! 2015 | The Foundation Trust is completing the NCEPOD self-assessment tool and is currently developing a suite of actions designed to ensure compliance with the recommendations from the study. The Foundation Trust will undertake a confirmatory audit using the NCEPOD tools to benchmark its' performance against the recommendations once the actions have been implemented. The Foundation Trust has a quality improvement programme already in place in relation to the identification and management of sepsis, and has implemented a new pathway for the management of suspected sepsis. The success of this implementation will be audited in a high priority clinical audit for 2016-2017. |
| | Time to get control 2015 | The Foundation Trust is completing the NCEPOD self-assessment tool and is currently developing a suite of actions designed to ensure compliance with the recommendations from the study. The Foundation Trust will undertake a confirmatory audit using the NCEPOD tools to benchmark its' performance against the recommendations once the actions have been implemented. |

| Name of audit / Clinical outcome Review Programme | Date of publication | Actions taken |
|---|---|---|
| MBRACE – Perinatal Confidential Enquiry | November 2015 | The Foundation Trust is complaint with all the recommendations relevant to us as providers of a maternity service. Our only concern is that our population is very diverse and there can be occasional out of hours interpreting deficits that we need to consider and address. |
| MBRACE – perinatal mortality surveillance report | December 2015 | In the report each Trust and Health Board has been colour coded based on their stabilised & adjusted extended perinatal mortality rate: the Foundation Trust was identified as an outlier with more than 10% higher perinatal mortality than the average for the comparator group. A thorough review of our joint local stillbirth action plan and governance arrangements for monitoring the perinatal mortality rate has been undertaken including an independent review by Public Health of the evidence for and against customised growth charts. Subsequent to this joint work between the Foundation Trust, CCG and Public Health in Nov/Dec 2015 a joint paper was submitted the Foundation Trust's Quality & Safety committee in Jan 2016 outlining and summarising the review process & on-going work relating to our shared stillbirth action plan which aims to try to target specific issues which may be responsible for our perinatal mortality rates. |
| MBRACE – Saving lives, improving mother's care | December 2015 | This national audit did not identify any specific performance concerns. However the Foundation Trust has worked with local and regional maternity networks to strengthen liaison and develop agreed pathways between itself, primary care and mental health services, and we routinely enquire about domestic violence. The Foundation Trust is therefore compliant with these broad recommendations. We have a guideline and systems in place to directly contact Obstetrics for any pregnant women admitted to the accident and emergency department or to elsewhere in the Foundation Trust with medical or surgical conditions in pregnancy. |
| National Bowel Cancer Audit | December 2015 | The Foundation Trust is currently reviewing the recommendations from this report and completing a plan on a page to describe the recommendations and action planning to address them. |

| Name of audit / Clinical outcome Review Programme | Date of publication | Actions taken |
| --- | --- | --- |
| National Cardiac Arrest Audit (NCAA) | Quarterly reports direct to the Trust | Reducing the number of cardiac arrests is a key goal of the organisation and there are work-streams within the Foundation Trust's quality improvement programme and NHS QUEST to improve the quality of care and management of deteriorating patients. The audit also provides specific details of patients where the resuscitation attempt should be reviewed in more detail to ensure and assure the quality of care provided. These individual reviews are undertaken by the Resuscitation Committee as and when they are identified. |
| National COPD Audit | December 2015 | The Foundation Trust is currently reviewing the recommendations from this report and completing a plan on a page to describe the recommendations and action planning to address them. A key improvement in care provision in 2015 related to the establishment of a respiratory high dependency unit. The unit provides specialist care for patients requiring non-invasive ventilation. The unit continues to be subject to a rigorous quality assurance and performance reviewing process, including an external peer review. In addition the Foundation Trust is ensuring that all other recommendations from the audit are considered within specialty clinical governance. |
| National COPD Audit – Pulmonary Rehab | February 2016 | The Foundation Trust has recently received this report and is currently reviewing the recommendations. |
| National Hip Fracture database – mortality | February 2016 | The Foundation Trust reports slightly higher numbers of falls than our peers but our injury rate is lower than expected. We continue to investigate all falls using root cause analysis methodology, and the prevention of falls is a key quality improvement initiative for 2016-2017. |
| National Lung cancer audit | December 2015 | The national audit makes a number of specific recommendations, many of which require change and improvements to the current ways of working. The Foundation Trust is in the process of completing a review of the audit and identifying the correct quality improvement strategies. We are keen to ensure that learning from this audit is considered in light of what we know about the quality and safety of our services, for instance in relation to clinical incidents and any change or improvements planned reflect the findings of both. |

| Name of audit / Clinical outcome Review Programme | Date of publication | Actions taken |
|---|---|---|
| National Neonatal audit | November 2015 | The results of this audit were positive for the Foundation Trust, as such the key challenge will be in maintaining the standards. As described in the report ensuring a two year follow up for all babies born at less than 30 weeks gestation will continue to be a development area for all trusts. |
| National Diabetes in Pregnancy audit | November 2015 | The Foundation Trust is currently reviewing the recommendations from this report and completing a plan on a page to describe the recommendations and action planning to address them. A new guideline supporting the management of diabetes in pregnancy is currently in draft format and is being reviewed in the context of this report prior to ratification. |
| National Prostate Cancer Audit | December 2015 | The Foundation Trust is aware of concerns in relation to the conduct of this audit, specifically in relation to case ascertainment and data quality. These concerns have been escalated to the Medical Director and are subject to an action plan to address them. |
| National vascular register | November 2015 | The Foundation Trust has identified a number of opportunities for change and improvement following consideration of the outcome of this national audit and has implemented an action plan to ensure that the Abdominal Aortic Aneurysm pathway is in line with national targets, a clear focus on the amputation pathway and case ascertainment for the national vascular registry, an analysis of the feasibility of endovascular aneurysm repair and a major amputations audit against NCEPOD standards. |
| Oesophago-Gastric cancer audit | December 2015 | The Foundation Trust is currently reviewing the recommendations from this report and completing a plan on a page to describe the recommendations and action planning to address them. |

| Name of audit / Clinical outcome Review Programme | Date of publication | Actions taken |
|---|---|---|
| Elective surgery (National PROMs Programme) | August 2015 | The Foundation Trust is taking a number of actions in response to the publication of the Patient Reported Outcome Measures (PROMs), these are all integrated into our patient experience portfolio of work which is described within the Quality Report. |
| Rheumatoid and Early Inflammatory Arthritis Audit | January 2016. | The Foundation Trust was identified as an outlier within this audit in relation to the time taken to see patients. As a result a local service review was undertaken and a significant action plan is in place addressing the outcome of this published report and compliance with relevant NICE guidance and quality standards. This action plan is being monitored by the Clinical Audit and Effectiveness Committee and by the Clinical Commissioning Groups. |
| Severe trauma (Trauma Audit & Research Network, TARN) | Reports sent quarterly direct to the Trusts. | The Foundation Trust has systems in place to review the outcomes and any associated actions with this audit. There are key actions being undertaken to improve the case ascertainment rate and the quality of data submitted to this national audit. |
| | Organisational report December 2015 | The organisational report makes a number of key recommendations. The Division of Medicine have identified this as a key area for improvement for 2016-2017 in their forward plan. As with the report from December 2014, the lack of access to psychology services for our stroke patients is highlighted in the report, this is an area where the Foundation Trust has not been able to implement NICE Guidance. The Clinical Commissioning Group are provided with a report on this issue on a quarterly basis. |
| Sentinel Stroke National Audit Programme (SSNAP)* | Clinical audit October 2015 | The Foundation Trust is demonstrating an improvement in achievement in this audit, with improvement activities focusing on, access to thrombolysis, access to specialist assessment and access to the multi-disciplinary team. The Foundation Trust is aware that a lack of a 24/7 stroke nurse responder service leads to low scores for timing of stroke nurse assessment, time to sip testing and time to thrombolysis. A business case has been submitted to support this element of patient care. |

**3.2.7** The reports of 33 local clinical audits and three locally developed audit programmes were reviewed by the Foundation Trust in 2015-2016; the key actions that it intends to take to improve the quality of healthcare provided are described in Appendix A, which includes examples of local audits reported in 2015-2016.

**3.2.8** A more detailed review of the outcomes of the Foundation Trust's local audit programme will be published in its' Annual Clinical Audit report.

## 3.3 Participation in clinical research to improve the quality of care and patient experience

**3.3.1** The Foundation Trust in 2015-2016 is recruiting patients to 156 National Institute for Health Research (NIHR) portfolio projects (figures correct end December 2015).

**3.3.2** The number of patients receiving relevant health services provided or sub-contracted by the Foundation Trust in 2015-2016 that were recruited during that period to participate in NIHR portfolio research was 4698 (figures correct at the end of December 2015).

**3.3.3** Further information on research activity in the Foundation Trust is detailed in section 4.4 of the Quality Report.

## 3.4 The use of Commissioning for Quality Innovation (CQUIN) Framework

**3.4.1** The Commissioning for Quality and Innovation payment framework is an incentive scheme which rewards achievement of quality goals to support improvements in the quality of care for patients. The inclusion of the CQUIN goals within the Quality Account indicates that the Foundation Trust are actively engaged in discussing, agreeing and reviewing local quality improvement priorities with our local Clinical Commissioning Groups.

**3.4.2** A proportion of Bradford Teaching Hospitals NHS Foundation Trust income in 2015-2016 was conditional upon achieving quality improvement and innovation goals agreed between Bradford Teaching Hospitals NHS Foundation Trust and any commissioning partners they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the CQUIN goals for 2015-2016 are available online at:

https://www.england.nhs.uk/wp-content/uploads/2015/03/9-cquin-guid-2015-16.pdf

**3.4.3** A list of Foundation Trust performance against the 2015-2016 CQUIN indicators can be found in the Review of Quality and Performance section.

**3.4.4** The monetary total for the amount of income in 2015-2016 conditional upon achieving quality improvement and innovation goals is £7.12m and the monetary total for the associated payment in 2014-2015 was £6.45m.

## 3.5    Registration with the Care Quality Commission (CQC)

3.5.1    The Foundation Trust is required to register with the Care Quality Commission and its current registration status is 'registered' with no compliance conditions on registration.

3.5.2    The Care Quality Commission has not taken enforcement action against the Foundation Trust during 2015-2016.

## 3.6    Outcome of CQC inspection

3.6.1    On 27 April 2015 the CQC published a report detailing the inspection it undertook in relation to regulated services provided by the Foundation Trust in October 2014. The services included in the inspection were:

-    Urgent and emergency services

-    Medical care

-    Surgery

-    Critical care

-    Maternity and gynaecology

-    Services for children and young people

-    End of life care

-    Outpatients and diagnostic imaging

-    Community health inpatient services.

The Foundation Trust was rated as 'good' throughout the caring domain.  The overall rating for the Foundation Trust was 'requires improvement.'

3.6.2    The report identified areas where the Foundation Trust was required to take compliance actions ('must dos'), which related to the safety, effectiveness, responsiveness and the leadership of services. The Trust provided a detailed action plan in response to the inspection report, which was then signed-off by the CQC.

3.6.3    The response document was shared with the Clinical Commissioning Groups and the Bradford Health and Social Care Overview and Scrutiny Committee. Progress updates have been shared with both organisations throughout the year.

3.6.4    The inspection report was also reviewed to enable the identification of further opportunities for change and improvement. The review was themed to support the program of work underway in the Foundation Trust in relation to understanding and ensuring compliance with the CQC Fundamental Standards. Essentially the report is a source of significant intelligence supporting the answer to the questions 'what do we know about our compliance with Fundamental Standards and how do we know it?'

3.6.5    The CQC report provides the Foundation Trust with a clear opportunity to engage with and effect required change and improvement across the organisation.

3.6.6    A number of the action plans were established, some immediately following the inspection.

3.6.7    Significant progress has been made with the compliance actions and staff have worked hard to implement positive changes to services.

## 3.7    CQC Periodic/Special reviews

In January 2016, the CQC carried out a follow-up inspection visit. The Foundation Trust is awaiting the draft report from the CQC and it is hoped that the CQC has been able to experience positively the work that the Foundation Trust has undertaken over the last nine months.

## 3.8    Duty of Candour

3.8.1    Regulation 20 of The Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, introducing the statutory Duty of Candour for the NHS, came into force on 27 November 2014.  It is designed to ensure that providers are open and transparent with people in relation to care and treatment, specifically when things go wrong and that they provide people with reasonable support, truthful information and an apology.

3.8.2    Healthcare treatment is not risk free. Patients, families and carers usually understand this, and want to know that every effort has been made to put things right, and prevent similar incidents happening again to somebody else. We know that trust in our organisation is directly related to how we respond when things go wrong. Being open is comparatively easy when all is well, but can be far more challenging in cases of actual or possible harm, whether caused by error or when a known and accepted complication occurs during treatment.

3.8.3    The Foundation Trust is committed to making this duty a reality for the people who use our services. We want to ensure there is clear, strong organisational support for staff to supplement their professional and ethical responsibility in being open and honest with patients. We understand that the impact and consequences of mistakes or errors made during the course of care or treatment can affect everyone involved and can be devastating for individual staff or teams; we aim to ensure there is sustained support for staff in reporting incidents and in being open with their patients. Clinicians already have an ethical Duty of Candour under their professional registration to tell patients about any errors and mistakes related to their care.

3.8.4    The Foundation Trust has therefore built on that individual professional duty and is implementing a new policy which places an obligation on the organisation, not just individual healthcare professionals, to be open with patients when harm has been caused. The policy describes how the Foundation Trust will meet its statutory and contractual Duty of Candour.  The intention is to support a culture of openness, transparency and candour between healthcare professionals and patients and/ or their carers when an incident or a prevented incident has occurred (whatever the level of harm caused).

3.8.5　The implementation of the policy has been supported by a Master Class for our clinical leaders and the development of a trust wide education programme that will be launched during early 2016-2017. This will ensure a consistent approach to being open and Duty of Candour, and ensure compliance with statutory, contractual and professional requirements.

3.8.6　We routinely monitor our compliance with the statutory and contractual requirements relating to our Duty of Candour using our incident reporting system and report details of any breaches, their impact and opportunities for change and improvement through both our Quality and Safety Committee and Performance Committee and to our Commissioners.

3.8.7　The Foundation Trust has agreed that our approach to making Duty of Candour a meaningful reality should underpin our commitment to providing high quality of care, understanding and sharing the truths about harm at an organisational as well as an individual level, and learning from them. The principles of meaningful staff engagement, professional accountability and leadership are central both to ensuring we deliver our Duty of Candour and also our drive to continuously learn and improve.

## 3.9　Monitoring and assurance process

3.9.1　The Foundation Trust is required to provide and demonstrate assurance that it complies with regulatory standards of care as described by its external regulators. During 2015-2016 we have reframed and refined our approach to understanding the quality and safety of the care we provide. We want to embed the understanding of regulatory standards, the skills in identifying risks and opportunities for change and improvement and the confidence in implementing and monitoring change within our frontline staff.

3.9.2　As a result we have developed a programme called ProgRESS (which stands for a Programmed Review of Effectiveness, Safety and Sensitivity). A rolling two year programme of review has been developed that will provide routine oversight of the implementation of the fundamental and other regulatory standards in the Foundation Trust. The programme has been designed to use a range of methodologies (for instance clinical audit, analysis of incident reports and complaints, observation, focus groups and interviews with staff and patients).  The programme also provides the capacity to undertake responsive reviews, where issues or potential for learning are identified within the Foundation Trust or by our external stakeholders. Following each review an outcome summit will be held involving all the reviewers and relevant stakeholders. During the summit an objective assessment will be made in relation to compliance with the standard(s) reviewed.  Any risks identified will be escalated within the Foundation Trust as appropriate and assurance sought in relation to their mitigation. Any opportunities for change and improvement and any areas of best practice will also be identified and communicated as appropriate.

3.9.3    We believe that frontline staff engagement in ProgRESS is key to its success. A strategy for supporting frontline staff participating in the reviews has been initiated, and training is provided for those that choose to be involved in the review process. It is also important to us that external stakeholders including commissioners, Healthwatch and patient representative groups will be explicitly involved in both setting priority areas for review and the review process itself.

3.9.4    The programme has been agreed by the clinical executive and its' effectiveness will be monitored through the Trust Improvement Board.

## 3.10    Public response to the Report of the 'Mid Staffordshire NHS Foundation Trust Public Inquiry'

3.10.1    The Foundation Trust included a comprehensive response in the last Quality report to the recommendations made in the 'Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry' undertaken by Robert Francis QC. The recommendations from that report continue to shape our thoughts in the improvement work that we do, as indeed do the recommendations of the Berwick Report "A promise to learn – a commitment to act" written as a response to the original report on Mid Staffordshire NHS Foundation Trust.

3.10.2    A guide for NHS Trusts on establishing the Freedom to Speak Up (FTSU) Guardian role has been published by the Office of the National Guardian.

3.10.2.1 The document sets out guidance for organisations recruiting to the role and also includes initial proposals on how appointed guardians will be supported, which will continue to be developed with guardians to ensure they are fit for purpose.

3.10.2.2 The Foundation Trust will work on establishing a 'Freedom to Speak Up" Guardian. This role will be responsible for creating an environment where staff are encouraged to raise concerns, where lessons are learned from them, and where care can improve as a result.

## 3.11    Relevance of data quality and action to improve data quality

3.11.1    Good quality information underpins the effective delivery of improvements to the quality of patient care. High quality data impacts both positively on patient care and means better patient care and patient safety.

3.11.2    The Foundation Trust has implemented last year's data quality plans by further incorporating the Data Quality Team within the operational divisions.  It continues to expand its data quality tool and usage this year has soared.  This tool provides a method for staff to do near real time data corrections.  This year we also strengthened the governance of data, by setting up a Data Governance Group whose membership includes data owners across the Foundation Trust.  This new governance will not only provide increased understanding of data quality in the organisation, but will govern the organisation's critical data.  With the introduction of the data warehouse and the Electronic Patient Record, the improvements to data governance are timely.

3.11.3 The Foundation Trust will continue to implement data quality initiatives. In this coming year this will include:

- Strengthening of the data quality governance arrangements with now more active and proactive engagement of Information Asset Owners.

- Structured deep dive cleansing exercise on specific areas with historical data issues are in progress to enable clean reporting and support the data migration to the Electronic Patient Record.

- The Foundation Trust will also continue to develop and implement a communication strategy across the organisation to better inform staff of their responsibility to maintain good quality data and get the data right from source.

## 3.12 NHS Number of General Medical Practice Code Validity

3.12.1 The Foundation Trust submitted records during 2015-2016 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics that are included in the latest published data by the Service. The percentage of records in the published data that included patients' valid NHS Number and General Practitioner Registration Code is displayed below. These percentages are equal to or above the national averages.

Percentage of records which included the patient's valid NHS number and General Practitioner Registration Code)

| Record Type | Area | 2015-2016 (April 2015 to January 2016) | 2014-2015 January 2015) | 2013/ 2014 | 2012/ 2013 | 2011/ 2012 |
|---|---|---|---|---|---|---|
| Patients Valid NHS number | Admitted Patient Care | 99.00% | 99.60% | 99.60% | 99.60% | 99.50% |
| | Outpatient Care | 99.00% | 99.40% | 99.40% | 99.40% | 99.80% |
| | A&E Care | 98.00% | 98.50% | 98.60% | 98.40% | 98.30% |
| Patients Valid General Medical Practice Code | Admitted Patient Care | 100% | 99.90% | 100% | 100% | 100% |
| | Outpatient Care | 100% | 100% | 100% | 100% | 100% |
| | A&E Care | 100% | 99.90% | 100% | 100% | 100% |

## 3.13 Information Governance Toolkit attainment levels

3.13.1 The Information Quality and Records Management attainment levels assessed within the Information Governance Toolkit provide an overall measure of the quality of data systems, standards and processes within an organisation. The Foundation Trust's Information Governance Assessment report overall score for 2015 was 81% and was graded green (satisfactory).

## 3.14 Clinical coding error rate

3.14.1   Clinical coding is the process through which the care given to a patient (usually the diagnostic and procedure information) that is recorded in the patient notes and translated into coded data. The accuracy of the coding is an indicator of the accuracy of patient records.

3.14.2   The Foundation Trust was subject to the Information Governance clinical coding audit during the reporting period, and the error rates reported in the latest preliminary published audit for that period for diagnoses and treatment coding (clinical coding) were:

| Coding Field | % incorrect 2015-2016 | % incorrect 2014-2015 | % incorrect 2013-14 | % incorrect 2012-13 |
|---|---|---|---|---|
| Primary Diagnoses Incorrect | 5.50% | 9.00% | 8.00% | 10.45% |
| Secondary Diagnoses Incorrect | 4.80% | 9.47% | 5.90% | 11.82% |
| Primary Procedures Incorrect | 9.10% | 2.00% | 0.70% | 6.45% |
| Secondary Procedures Incorrect | 5.60% | 8.02% | 8.70% | 10.50% |

*The preliminary results will be confirmed with recipt of the formal report*

3.14.3   The audit conducted was based on the methodology detailed in the current Version 8.0 of the Clinical Coding Audit Methodology set out by the Health and Social Care Information Centre (HSCIC) Clinical Classifications Service, using an approved Clinical Coding Auditor. The audit took place on specific specialty/ Health Resource Group (HRG) therefore results should not be extrapolated further than the actual sample audited. The above table shows the proportion of coding errors in which only a subset is made of coders' errors: clinical coders are expected to code within five days after discharge when the auditor is looking at the completed record with all results and usually discharge letters which may not be available at the time of coding.

3.14.4   A number of recommendations to correct coding errors were identified:

1.  Training plan to ensure data extraction skills are now refreshed so that all coding staff are aware of the main types of recorded clinical data for co-morbidity recoding, accurate primary diagnosis and secondary procedures.

2.  Improve clinical awareness of the implications of poor recording around infections to include sepsis and severe sepsis.

3.  Review with Clinicians the need for policy documents to aid the Clinical Coders in accurate code assignment.

4.  A continued auditing and training cycle is recommended at regular intervals including further routine mini audits.

5. Administration errors and medical record filing problems need reporting to the appropriate managers responsible for registering and recording onto the Patient Administration System and within the health record.

## 3.15 Core set of National quality indicators

3.15.1 The Department of Health and Monitor first introduced mandatory reporting of a small, core set of quality indicators in the 2012-2013 Quality Account. The indicators that are relevant to the Foundation Trust for 2015-2016 are reported in Appendix D.

3.15.2 In order to provide assurance on the quality of the data the Foundation Trust has published an internal Information Systems Data Quality Policy on its Intranet, set up governance arrangements to review and improve data quality and acted upon recommendations of internal and external data quality audits.

3.15.3 All of our data reporting processes have standard operating procedures that ensure that whoever is running the process, can refer to the standard operating procedure to ensure the correct processes are followed. The data is then checked for validity and data quality errors, sometimes using the previous period to ensure it is in line with what is expected to be seen, and where this does not occur, is checked by another member of the team to ensure there are no data anomalies.

# Part 3

## 4. Review of quality performance

### 4.1 Quality Management System

4.1.1 Following the publication of the CQC Inspection Report in April 2015 that detailed required actions to be taken and learning points, the Foundation Trust began a whole system review and development process in relation to its quality management system.

4.1.2 The Foundation Trust recognises the importance of having a comprehensive system that enables us to identify, measure, control and improve our core processes. These processes include our governance structures, management and escalation of risk, learning from when things have gone wrong and looking at ways in which we can improve quality and meet our patients' expectations.

4.1.3 As a result a number of changes have been implemented. These include:

- The sub-committees of the Quality and Safety Committee have all been reviewed and have the appropriate Accountability, Terms of Reference, Work Plans and are able to report effectively into the Quality and Safety Committee.

- A revised risk management and escalation framework was developed and its implementation is being supported by a newly established Risk Management Committee.

- A reporting process from Divisions to the sub-committees of the Quality and Safety Committee to ensure that governance is robust from Ward to Board was defined and implemented.

- A baseline assessment of the current position of each Division, Directorate and Specialty in relation to the clinical governance system currently in use, education and training and the management of risk registers was undertaken and support provided to Divisions to develop the systems in place.

- The Foundation Trust Board Assurance Framework has been redeveloped and has been supported by an education and training programme. The management of strategic risk and the operation of the Integrated Governance and Risk Committee has also been revised.

- A quality dashboard has been developed to allow the identification of potential areas of risk within the Foundation Trust and will be implemented in full during 2016-2017.

4.1.4 The quality management system, and in particular the Foundation Trust's governance framework, will be further developed during 2016-2017 including the establishment of an organisational learning and surveillance hub, designed to support the intelligence gathering and information requirements of the quality management system, using innovative tools and techniques to 'horizon scan' for areas of potential problems with

quality and safety. In addition, work is planned that will support the better integration of quality improvement projects and programmes with the governance structure of the organisation.

4.1.5    The Trust is also currently expanding its use of quality improvement methodology running large scale projects aimed at making specific improvements in patient harm. Examples of the methodologies being used in 2015-2016 will be:

- The Institute for Healthcare Improvement Breakthrough Series Collaborative Model: this is a project framework which brings together a number of wards and departments to develop interventions and test them around a specific problem. We are launching one of these projects aimed at reducing pressure ulcers.

- The Model for Improvement: this is a framework based around three simple questions (what are we trying to accomplish, how will we know that a change is an improvement and what changes can we make that will result in an improvement) and the plan, do, study, act cycle. This is a framework that helps teams to develop and test interventions on a small scale and is used widely across healthcare.

## 4.2    National performance measures

4.2.1    The Foundation Trust measures performance against the relevant indicators and performance thresholds set out in Appendix A of Monitor's Risk Assessment Framework (updated August 2015) Publication code: IRG 23/15.

## Performance against indicators and targets for 2015-2016

The Foundation Trust's performance against the relevant indicators and performance thresholds are set out in the table below:

| Area | Indicator | Current Target | 2015-16 | 2014-15 | 2013-14 | 2012-13 | 2011-12 | 2010-11 | 2009-10 |
|------|-----------|----------------|---------|---------|---------|---------|---------|---------|---------|
| Access | Total time in A&E: maximum wait time of 4 hours | >=95% | 93.5% | 95.1% | 96.2% | 95.7% | 95.9% | 96.7% | 98.3% |
| | **Commentary:** The Foundation Trust did not achieve full year delivery of the Emergency Care Standard experiencing many difficult periods throughout the year, with increased volumes of patients and complex cases seen especially in the last quarter of the year. A situation which has been reflected nationally. Overall attendances increased by 1.7% compared to 2014-2015 which is equivalent to an extra 6 patients treated every day however attendances in the last quarter of the financial year increased by 37 patients per day. | | | | | | | | |
| Access | All Cancers: two week wait - First Seen | >=93% | 94.8% | 95.5% | 95.5% | 95.1% | 94.0% | 96.0% | 94.0% |
| | All Cancers: two week wait - First Seen Breast Symptoms | >=93% | 96.4% | 95.3% | 97.1% | 99.8% | 94.4% | 95.5% | 94.4% |
| | Cancer 31 Day standard - First Treatment | >=96% | 98.6% | 98.6% | 98.5% | 98.8% | 96.8% | 97.5% | 98.2% |
| | Cancer 31 Day standard - Subsequent Surgical Treatment | >=94% | 97.4% | 97.2% | 98.1% | 96.2% | 95.3% | 95.4% | 95.8% |
| | Cancer 31 Day standard - Subsequent Drug Treatment | >=98% | 100% | 99.7% | 99.7% | 99.9% | 99.6% | 99.5% | 99.7% |
| | Cancer 62 Day standard - First Treatment | >=85% | 88.7% | 86.3% | 88.8% | 93.3% | 83.7% | 86.9% | 86.6% |
| | Cancer 62 Day standard - Screening | >=90% | 97.1% | 97.0% | 97.2% | 98.8% | 96.2% | 96.5% | 92.2% |
| | **Commentary:** All cancer targets have been achieved for year ending 2015-2016. | | | | | | | | |

| Area | Indicator | Current Target | 2015-16 | 2014-15 | 2013-14 | 2012-13 | 2011-12 | 2010-11 | 2009-10 |
|------|-----------|----------------|---------|---------|---------|---------|---------|---------|---------|
| Access | Referral to Treatment Waiting Times <18 weeks – Incomplete pathway | >=92% | 92.6% | 96.5% | 97.2% | N/A | N/A | N/A | N/A |
| | **Commentary:** The Foundation Trust achieved the Referral to Treatment Incomplete pathways threshold in every month except January 2016 (91.6%) however performance has deteriorated compared to previous years due to a number of factors which include pressures on the elective bed base due to emergency demand and consultant availability either through vacancies or sickness. | | | | | | | | |
| Outcomes | Incidence of MRSA Bacteraemia | 0 | 5 | 7 | 5 | 5 | 2 | 3 | 8 |
| | Incidence of Clostridium difficile | >=51 | 24 | 32 | 43 | 58 | 88 | 87 | 99 |
| | **Commentary:** The Foundation Trust achieved the year end trajectory for Clostridium difficile with 24 attributed cases reported overall which was better than the nationally set threshold. However 5 MRSAs were attributed to the Foundation Trust during the year. This remains a zero tolerance target and the FT continues to apply the associated learning and recommendations from the post infection reviews carried out for all Clostridium difficile and MRSA cases. | | | | | | | | |
| | Data completeness – Community services | 50% in 3 areas | Compliant | Compliant | Compliant | Compliant | N/A | N/A | N/A |
| | **Commentary:** The Foundation Trust is compliant in data completeness for Community services | | | | | | | | |
| | Certification against requirements for people with a learning disability | N/A | Compliant | Compliant | Compliant | Compliant | Compliant | N/A | N/A |
| | **Commentary:** The Foundation Trust is currently compliant against the profile for certification against requirements for people with a learning disability. | | | | | | | | |

Key: ■ Green rating indicates that the target was achieved
■ Red rating indicates that the Foundation Trust failed to meet the target

## 4.3    Local performance indicators

### 4.3.1    How did we decide on the indicators?

4.3.1.1   In determining the quality indicators for inclusion in the 2015-2016 Quality Report we have incorporated Commissioning for Quality and Innovation scheme indicators (CQUIN) to ensure coverage of locally agreed quality and innovation goals as well as nationally defined quality assurance indicators.

4.3.1.2   The inclusion of the CQUIN goals within the Quality Report indicates that the Foundation Trust are actively engaged in discussing, agreeing and reviewing local quality improvement priorities with Bradford City and Districts Clinical Commissioning Groups.

4.3.1.3   National CQUIN goals reflect areas where there is widespread need for improvement across the NHS. Their goal is to encourage local engagement and capability building, but also to share good practice, encourage benchmarking and avoid duplication of effort across the country.

4.3.1.4   A summary of the indicators selected by the Board of Directors in consultation with the lead commissioners and rationale for their selection are outlined in the table below.

## CQUIN Goals and domains

| Goal Name | Description of Goal | Quality Domain | | | |
|---|---|---|---|---|---|
| | | Safety | Effectiveness | Patient Experience | Innovation |
| **Acute Kidney Injury (AKI)** | This CQUIN focuses on AKI diagnosis and treatment in hospital and the plan of care to monitor kidney function after discharge. | | Yes | | |
| **Sepsis** | This CQUIN focusses on patients arriving in the hospital through the Emergency Department (ED) and seeks to incentivise providers to screen for sepsis all those patients for whom sepsis screening is appropriate, and to rapidly initiate intravenous antibiotics, within 1 hour of presentation, for those patients who have suspected severe sepsis, Red Flag Sepsis or septic shock. | Yes | | | |
| **Dementia** | To incentivise the identification of patients with dementia and other causes of cognitive impairment alongside their other medical conditions, to prompt appropriate referral and follow-up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia and support their carers. | | Yes | | |
| **AED diagnosis coding & reducing Mental Health attendances** | Improving recording of diagnosis in AED and reduce the rate of mental health re-attendances at ADE in 2015-2016. | | Yes | | |
| **Falls care** | The Foundation Trust to develop a system to capture and report details of patients who are frequently attending AED with focus on those at risk of falls. | | | Yes | |
| **One Team** | In conjunction with partners, the Foundation Trust to provide and implement a project plan to enable the embedding of the 'One Team' within the Foundation Trust and Bradford District Care Trust. | | Yes | | |
| **Alternative models of follow up for long term conditions** | Lead and participate in a change programme to test alternative models of follow up for long term conditions. | | | | Yes |
| **Optimised, Joined Up Care & Effective Discharge** | Deliver system improvements through the Patient Flow Collaborative – a programme of joint working across organisational boundaries to ensure patients access the right part of the system without delay in a seamless manner. | | Yes | | |
| **7 day approach** | Lead and participate in the agreed change programme for 7 day services across the Health Community | Yes | | | |

### 4.3.2 How are we performing against the CQUIN goals?

4.3.2.1 Within each goal there can be a number of indicators. A summary of our performance against the agreed goals for 2015-2016 are outlined in the following tables.

**Performance against National and CCG CQUIN goals and indicators 2015-2016**

| National or Local Indicator | Indicator Name | 2015-16 | | | | 2015-14 |
|---|---|---|---|---|---|---|
| | | Q1 | Q2 | Q3 | Q4 | |
| NATIONAL | Acute Kidney Injury | | | | | |
| | For patients with AKI detected through the pathology laboratory system (LIMS), and who have survived to discharge summaries of patients. | G | G | G | G | N/A |
| NATIONAL | Sepsis | | | | | |
| | The percentage of patients who met the criteria of the local protocol for sepsis screening and were screened for sepsis and for whom sepsis screening is appropriate. | N/A | G | R | R | N/A |
| | The percentage of patients who present with severe sepsis, Red Flag Sepsis or septic shock to emergency departments and other units that directly admit emergencies and were admminstered intravenous antibiotics within 1 hour of arrival. | N/A | G | G | G | N/A |
| NATIONAL | Dementia | | | | | |
| | Dementia: find, assess, investigate & refer | G | G | G | G | G |
| | Dementia: clinical leadership | G | G | G | G | G |
| | Dementia: Supporting Carers | G | G | G | G | G |
| NATIONAL | A&E diagnosis coding & reducing MH attendances | | | | | |
| | Percentage of A&E records with a valid diagnosis code | N/A | N/A | A | G | N/A |
| | A&E frequent attenders with unspecified nonorganic psychosis as % of all A&E attenders | N/A | N/A | A | G | N/A |
| LOCAL | Falls care | | | | | |
| | Report on A&E frequent attenders due to falls | G | G | G | G | N/A |
| LOCAL | One Team | | | | | |
| | Embed 'One Team' between Trusts | G | G | G | G | N/A |
| LOCAL | Alternative models of follow up for long term conditions | | | | | |
| | Test alternative models fo follow up for long term conditions. | R | N/A | G | G | N/A |
| LOCAL | Optimised, Joined Up Care & Effective Discharge | | | | | |
| | Deliver system improvements through the Patient Flow Collaborative | G | G | G | G | N/A |
| LOCAL | 7 Day approach | | | | | |
| | Lead and participate in the agreed change programme for 7 day services. | G | G | G | G | N/A |

Note: Sepsis - Quarter 3 and Quarter 4 reconciliation still under negotiation with CCG.

| National or Local Indicator | Indicator Name | 2015-16 | | | | 2015-14 |
| --- | --- | --- | --- | --- | --- | --- |
| | | Q1 | Q2 | Q3 | Q4 | |
| NIC dataset | Neonatal Critical Care – reducing clinical variation and identifying service improvement requirements by ensuring data completeness in the 4 NNAP Audit Questions identified. | G | G | G | G | N/A |
| Hep C network | Establish Hep C network working group to produce a map of pathways and a plan for improved partnership working. | R | G | G | G | N/A |
| HIV | Networked HIV arrangements in place and SOPS developed | G | G | G | G | N/A |
| Oncotype DX | More consistent uptake of NICE DG!) recommendations by Hospitals for patients with early breast cancer through use of the Oncotype DX test. | G | G | G | G | N/A |
| QIPP | | G | G | G | G | N/A |

| Green | Achieved | Red | Not achieved |
| --- | --- | --- | --- |
| Amber | Partially achieved / Undecided | Grey | Not applicable |

## 4.4    Research Activity in the Foundation Trust

4.4.1    The Foundation Trust has a strong track record of research.  Over the last ten years research activity has increased by 133% with the majority of that research being on the National Institute for Health Research (NIHR) portfolio.  Research income has increased significantly along with the research workforce to support this.  The Foundation Trust also has an excellent reputation for research performance and is the third highest recruiter within the region for NIHR portfolio research, often exceeding research targets.

Total number of research projects ongoing in each financial year (figures correct 30 November 2015)



**Total number of projects ongoing in year in the Trust**
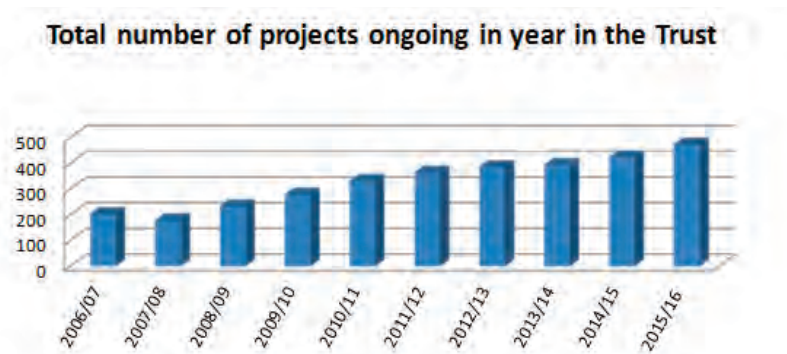
### 4.4.2 Leading centre in Applied Health Research

4.4.2.1 The Foundation Trust has developed and increased its expertise in applied health research over the last decade and now has a reputation of being one of the leading centres in conducting applied health research in the country. This excellence can be attributed largely to three research teams:

### 4.4.3 Academic Unit of Elderly Care and Rehabilitation

4.4.3.1 The Academic Unit of Elderly Care and Rehabilitation has been established for over twenty years and has a national and international reputation in elderly care and stroke research. Work is funded by NIHR, Medical Research Council (MRC), Dunhill Medical Trust and the Stroke Association. Professor Young, who leads the elderly care portfolio, is currently National Clinical Director for Integration and Frail and Elderly Care in NHS England.

4.4.3.2 The Unit's programme of applied health research uses a wide range of methods including randomised controlled trials, systematic reviews (lead on three Cochrane Reviews), cohort studies and qualitative evaluations. Working closely with the Leeds Clinical Trials Research Unit it has implemented one of the largest ever stroke rehabilitation trials (TRACS, published in the Lancet). The Unit's work is supported by strong patient groups and clinical colleagues.

4.4.3.3 Work undertaken addresses key questions such as: care for people susceptible to delirium; the role of medical day hospitals and community hospitals; in-hospital and post-discharge care after stroke; care for patients with dementia, and the support provided to caregivers.

4.4.3.4 Currently large workstreams are being implemented focused on the needs of the frail elderly and residents of care homes. In the former the Unit has established the Community Ageing Research 75+ (CARE 75+) study using an innovative cohort multiple randomised controlled

trial design. The study is recruiting older people aged 75 and over to investigate frailty and disability trajectories and evaluate interventions to improve outcomes. In the latter the research team are working closely with care homes owners, managers, staff and residents to implement a range of projects considering ways to improve the care environment.

4.4.3.5 Colleagues in the Unit have developed and validated an electronic frailty index using existing patient level data in primary care. Through links with the Academic Health Science Network this has now been rolled out to GP practices across the UK allowing them to identify and consider offering treatment options to their frail elderly patients.

4.4.3.6 Given the increasing demographic profile of the population, the team's work makes an important contribution to the development of NHS services.

### 4.4.4 Born in Bradford

4.4.4.1 Established in 2007, the Born in Bradford research programme is one of the largest health research projects in the UK. By focusing on key public health priorities for families and conducting cutting edge research it is exploring the reasons why some people fall ill and others stay healthy. This information is being used to develop and evaluate interventions to improve the lives of families.

4.4.4.2 Over the past five years the Born in Bradford research team have attracted over £10million in research grants from national and international funders. For example, the team have conducted research into the predictors of childhood obesity, adiposity and child growth, allergic diseases, dental health, the impact of environmental influences such as pollution on health, and the impact of vision and cognitive development on educational attainment. They have recently partnered with Bradford Trident in a bid which has won £50million of investment from the Big Lottery, named Better Start Bradford, to implement evidence based interventions to improve the health and well-being of pregnant women and 0-3 year olds in some of the most deprived areas of Bradford.

4.4.4.3 The research team now host two major birth cohort studies: Born in Bradford (BiB) follows the lives of nearly 14,000 children and their parents and in 2016 they launched a new experimental cohort, Born in Bradford's Better Start (BiBBS) which will recruit over 5000 children and their parents with a focus on evaluating early life interventions to improve life outcomes during the first critical years of life. The team harness the power of routine data to follow the health and educational attainment of families.

4.4.4.4 The key to the success of the BIB team lies in their engagement with families, and those working across health and education within this city. They host regular family festivals and scientific conferences in the City. BIB have two artists in residence, a photographer and a poet, who aim to inspire and engage the people of Bradford and disseminate the findings in novel and exciting ways.

### 4.4.5 Quality and Safety Research Team

4.4.5.1 The Quality and Safety research team is a multi-disciplinary team of applied health researchers who deliver research that directly addresses the issues most affecting the NHS. Over the last few years they have developed and evaluated pioneering tools for gaining feedback from patients about the safety of the care that they receive. This work has been funded by an NIHR programme grant and more recently a Health Foundation 'Closing the Gap' grant which they developed in collaboration with the Improvement Team at the Foundation Trust. So novel is this work that the team have received requests to use these tools from researchers and hospital managers as far afield as Brazil and Israel. In November 2015 the Quality and Safety team launched a new thirty month project, with funding from NIHR Health Services and Delivery, to explore the use and usefulness of patient experience feedback. They are working with Leeds Teaching Hospitals NHS Trust, Bradford Teaching Hospitals NHS Foundation Trust and Harrogate NHS Foundation Trust to develop approaches to using patient feedback and testing these ideas in practice.

4.4.5.2 Their second main area of research focuses on promoting behaviour change for patient safety. Following the success of work on improving the safety of nasogastric tubes within the region, the team now run local and national workshops in which people are trained to adopt this approach in their own Trusts. The team have recently turned their attention to Acute Kidney Injury and hope to attract some funding to continue this work.

4.4.5.3 Finally, over the past two years the Quality and Safety team have been pioneering a more positive approach to safety management. This approach, known as positive deviance, searches for examples of excellence and then learns from what teams do to achieve safety. At the moment they are working with two Foundation Trusts to understand how they are able to achieve low readmissions and great patient reported outcomes for their hip and knee operations. Additionally they are identifying elderly medical care wards who consistently score well on the patient safety thermometer and are working with staff to understand how they manage to achieve high levels of safety. As well as providing useful learning these approaches are good for staff morale; everyone likes to know that they are doing an excellent job.

### 4.4.6 Bradford Institute for Health Research and Clinical Research Facility

4.4.6.1 Over the last ten years, the Foundation Trust has invested in its research infrastructure notably the Bradford Institute for Health Research (BIHR) which was created in 2007. The BIHR is a collaborative partnership between this Trust and other local NHS Trusts and primary care, as well as the Universities of Bradford, Leeds and York.

It is the Foundation Trust's Research Division providing a critical mass of research expertise, a focus for our applied health research and accommodation for some of the non-clinical research teams (Born in Bradford, Quality and Safety Research, Academic Unit of Elderly Care and Rehabilitation and the Improvement Academy) as well as some clinical research teams (Gastroenterology, Hepatology, Oncology, Haematology, Head and Neck, Respiratory, Ophthalmology, Infectious Diseases, Diabetes, Paediatrics and Neonatal Medicine).

4.4.6.2    As part of the BIHR facilities, the Foundation Trust also has its own Clinical Research Facility (adjacent to the BIHR building) which opened in 2008 after a £1million renovation project. The Clinical Research Facility (CRF) provides dedicated, high quality out-patient facilities for our researchers to conduct clinical research.

4.4.6.3    Due to the increase in the Foundation Trust's research activity, grant success and partnerships, both the BIHR and CRF have been extended to increase research accommodation and clinical research space for our researchers. A £2million extension was completed in 2011 and £1million extension to the CRF was recently completed in February 2016.

### 4.4.7    Commercial research expansion

4.4.7.1    Recognising the importance of a balanced research portfolio and the ability to offer our patients novel treatment as well as generate research income, an investment has taken place in the last two years to develop the Foundation Trust's ability to engage more in commercial research with industry partners.  This has included investment in staffing (an Associate Director of Research for Commercial Research, a Lead Clinical Research Nurse, additional pharmacist time and business management support) and infrastructure (pharmacy expansion).

### 4.4.8    The Yorkshire & Humber Academic Health Science Network's Improvement Academy

4.4.8.1    The Foundation Trust hosts the Yorkshire & Humber Academic Health Science Network's Improvement Academy (IA) of improvement scientists, patient safety experts, patients and clinicians. The IA aims to ensure evidence-based solutions become routine practice, bring about lasting change using improvement methods, human factors psychology and implementations science; co-create improvement with front-line clinicians, patients and the public; reduce unwarranted variations in outcomes of care; and address professional and geographical isolation through network learning. We therefore have on-site expertise in conducting applied health research as well as the expertise in how to translate research findings into practice.

# 5. Governors and Stakeholder Engagement

## 5.1 Governors

5.1.1 As previously reported in the 2014-2015 Quality Report the Council of Governors established four key work streams following a consultation on the Foundation Trust's Operational Plan with Foundation Trust members and the public.

The four work streams were:

- Long term conditions.
- Workforce.
- Technology.
- Service developments.

5.1.2 During 2015-2016 one Governor from the Technology work stream has joined the Foundation Trust's Electronic Patient Record (EPR) Transformation Board as a representative of the full Council of Governors. Governors from each of the work streams have met with teams, departments and key staff, to support their understanding of developments at the Foundation Trust in relation to these areas and comment on initiatives.

### Next steps

5.1.3 Going forward in 2016-2017 the Governors objectives will be to:

- Deliver two major membership / public events in year with one of these events aimed at young people (to include a focus on jobs and careers, health and wellbeing, training and development and, volunteering).

- Implement changes to the delivery of the Council of Governors meetings to make them more engaging for members and the public with presentations covering four key themes that relate to the Governor work-streams and the Trust's major developments.

- Develop use of the Members Zone web-site to support increased engagement with members / the public.

- Working with the Foundation Trust's Patient and Public Involvement team to increase membership involvement in Patient and Public Involvement activities.

- Increasing the profile of Governors amongst staff, visitors and patients to encourage consultation over matters of material interest to the Foundation Trust and, the development of the Foundation Trust's Strategy.

- Develop more consistent Governor-led communications to members and the public and, our partner organisations.

- Continue to develop opportunities to work in partnership across the district with other organisations that form part of the local health economy.

## 5.2 Stakeholder Engagement

5.2.1 Events have been delivered singly by our Foundation Trust and in partnership with other local NHS Foundation Trusts (Bradford District Care Trust NHS Foundation Trust and Airedale NHS Foundation Trust) and other statutory and third sector organisations.

5.2.2 In year a new dedicated membership website *http://bradfordhospitals.uk.engagementhq.com/* has been launched; providing a 'one-stop-shop' for members and the public in relation to Foundation Trust membership, our Governors and the Governors' work programme.

## 5.3 Membership and Public engagement events delivered in year



5.3.1 Your Future, Your Health; October 2015.

5.3.1.1 This key event, jointly organised by our Foundation Trust alongside other local health providers and commissioners attracted approximately 500 young people aged 14 to 18 from across our district. With a focus on health and well-being, careers and volunteering as well as an opportunity to take part in panel discussions with Chairs and Chief Executives from the five key health organisations; the event proved a huge success.

5.3.1.2 Attracting more than 500 young people the focus included coverage of emotional health and wellbeing, sexual health and relationships, drug awareness, the effects of smoking and drinking and, NHS careers. Young people also had access to Cardiopulmonary Resuscitation (CPR) demonstrations, games and a rap artist who was on hand to develop work based on young people's views of healthcare.

5.3.1.3 A few event facts and figures:

- Approximately 50 young people took part in the 'Any Questions / Any Answers' session.

- 167 staff from a range of organisations came together to deliver the event.

- 200 young people signed up as members of the Foundation Trusts.

- In excess of 90 young people completed a short taster course in CPR delivered by Yorkshire Ambulance Service.

5.3.2 Living Well with Dementia. May 2015:



5.3.2.1 Our Foundation Trust, along with Bradford District Care NHS Foundation Trust, came together with a wide range of local organisations from across the district to deliver a one-day event to coincide with Dementia Awareness Week. This was the first time a district-wide event of this type had been delivered and it was promoted widely. This event recognised the good work taking place across the district to support people in 'living well with dementia'.

5.3.3    Bradford Teaching Hospitals: Responding to the
         challenges ahead:

In August 2015:  Members and the public took advantage of the opportunity to find out more about key developments associated with the Governors' work streams. Importantly, focus included the Foundation Trust's new £28million hospital wing, plans for the introduction of electronic patient records (EPR) and developments that had taken place in relation to the Virtual Ward. During the second part of the event a more formal meeting took place, facilitated by our Chairman. Our Chief Executive provided detailed coverage of the outcomes from the recently published CQC inspection report.

**5.4      Annual General Meeting (AGM)/ Annual Members Meeting (AMM); September 2015:**

5.4.1    The annual report and accounts were presented at the AGM and AMM on 17 September 2015 in accordance with the Constitution.  Immediately following the AGM/AMM the Associate Medical Director for Medical Informatics delivered a well-received presentation on the Foundation Trust's new Electronic Patient Record system.

# 6. Our People

**6.1**    Our people are at the heart of our organisation; without their dedication, commitment and work we could not deliver the care to our patients. We want our staff to excel at putting patients first, wherever they work in the Foundation Trust.



## 6.2    What:

Our staff are to be developed and supported in their roles; to be motivated and engaged and representative of the communities we serve.

## 6.3    How:

- Continued to embed our Personal Responsibility Framework (PRF), our values in our corporate induction, recruitment and appraisal activities.

- Introduced diversity recruitment targets.

- Delivered Project SEARCH, our annual employment programme for young people with learning difficulties ( as detailed in our Annual Report).

- Launched new communication channels including Let's Talk, a weekly news bulletin.

- Carried out work to determine organisational and leadership development needs.

- Developed a new Managing Attendance Policy and recruited a small team dedicated to support managers in this area.

- Continued patient stories at Board meetings and inductions to ensure we keep the patient at the centre of everything we do.

## 6.4    Outcomes:

6.4.1    In the national NHS Staff Survey 2015 our staff said:

- They are motivated and engaged; motivation at work is higher than the national average.

- They feel their role makes a real and positive difference to the way we care for patients placing us in the top 20% performing Acute Trusts.

- They believe they have equal opportunities for career progression or promotion, again placing us in the top 20%.

- They have quality appraisals.

- Fewer than last year suffered from work-related stress.

- Fewer worked extra hours. We are in the best (lowest) 20% of Foundation Trusts.

6.4.1.1  Areas for improvement:

- 28% said they had experienced harassment, bullying or abuse from other members of staff. This has not changed significantly from 2014.

- Only 78% of Black and Minority Ethnic (BME) staff believed they had equal opportunities for career progression or promotion compared to 94% white staff.

- Staff feeling they can contribute towards improvement.

- Staff feeling supported by their managers.

6.4.2    Our Diversity data is encouraging:

- The overall percentage of BME staff increased from 24.7% to 25.4% of the workforce (first six months data).

- For Senior Managers, numbers increased from 7.6% to 9.1% of all Senior Managers.

- Project SEARCH: Eight interns graduated in July 2015 and 10 joined the programme in September 2015. Information on Project SEARCH is detailed in our Annual Report for 2015-2016.

## 6.5 Future work:

- Taking a strategic approach aligning our work on values, culture and leadership.

- Creating an environment where creativity, imagination and innovation can flourish.

- Further work on our Personal Responsibility Framework, encouraging ownership and responsibility through all our work.

- Introducing and supporting leadership development, at every level of our Foundation Trust.

- Increasing capability and confidence of our managers, in particular in managing attendance, stress and wellbeing and addressing bullying and harassment.

- Implementing our new Managing Attendance policy, to improve the health, wellbeing and attendance of our staff.

- Inclusive talent management, initially in recruitment and progression of black and ethnic minority nurses and midwives.

- Continuing the success of Project SEARCH, committing to employ a third of our interns who graduate.

- Partnership working, through the Integrated Workforce Programme supporting the Integration and Change Board in the transformation of health and social care across the system.

- Promoting Bradford – working with the major health, social care, education and private sector providers in how we work together to attract people to live and work in Bradford.

# 7. Safety

**SAFE!**

## 7.1 SAFE! Programme

7.1.1 The Foundation Trust has had a comprehensive Quality Improvement Strategy for a number of years in the form of the SAFE! Programme. The SAFE! Programme has a number of projects and pieces of work associated with it, these are:

- Safety culture – 'above and beyond' and leadership walk rounds.
- Acute kidney injury (AKI).
- Epilepsy.
- The measuring and monitoring of safety.
- Mortality reduction.
- Patient experience of safety through the PRASE project.
- Safer procedures.
- Sepsis.

7.1.2 Over the course of 2015 the Foundation Trust was successful in bidding for £28,000 worth of additional funds through the National Health Service Litigation Authority 'Sign up to Safety' Programme. This has been used in the delivery of the Foundation Trust's Quality Improvement Strategy.

Over the coming year the Foundation Trust is committed to continuing to develop its Quality Improvement Strategy and to growing Quality Improvement capability.

7.1.3 The following sections detail the progress against projects and pieces of work associated with the SAFE! Programme.

## 7.2. Above and beyond:

7.2.1 This project aims to improve our culture through engaging staff in a project that celebrates when staff go 'above and beyond'.

7.2.2 These remarkable members of staff are nominated by their peers, managers or patients. We have been working with Bradford College to use the photography skills of their students to capture images of these incredible members of staff.

7.2.3 The images are all supported by a written statement outlining the reasons that the staff member has been nominated. The staff stories have been printed in a variety of formats including:

- External banners.
- Posters.
- Cardboard cut-outs.
- Pop-up banners.



**Goodloe Rusike**

Goodloe works as a part of the Virtual Ward Team at St. Luke's Hospital. He works closely with patients, visiting their homes to provide care for those who need it most. He has an **outstanding level of care** towards the patients, and will spend **extra time** with them until they are **comfortable.**

Goodloe was **nominated by a patient's daughter** to specifically **recommend Goodloe** for the above and beyond award for **'outstanding care, kindness and sitting with an unwell patient during the night'.** The patient has sadly passed away, but the patients' daughter reports her mother specifically remembered Goodloes care.

7.2.ext4 Funding was awarded from the Bradford Innovation Group to implement this project.

What:        Improve Trust culture by promoting the positive culture that already exists through the use of pictures.

How much:   Increase in number of staff reporting positive culture in staff questionnaire.

By when:     31 July 2016.

Outcome:     In progress + on target.

**Improvements achieved:**

➤ eleven members of staff have been photographed by the Bradford College photographers.

➤ Displays have been placed in prominent positions around the Foundation Trust, for example, outside banners have been placed at hospital entrances.

➤ Initial staff questionnaires have been returned showing some, but limited, improvement in culture.

**Further improvements identified:**

➤ All materials will be displayed throughout the Foundation Trust on a two weekly rota.

➤ Regular staff questionnaires will be sent out to obtain their feedback on how the project is progressing.

➤ An individual photograph will be presented to each nominee.



## 7.3    Leadership walk rounds

7.3.1    A programme of leadership walk rounds was introduced into our Foundation Trust in 2010 to ensure that the Foundation Trust leaders were engaged and visible on the wards. The leadership walk round programme gives wards the opportunity to meet the Executive and Non-Executive Directors face to face and share the good work that they have been doing as well as voice any concerns that they may have. During 2015, thirty-six leadership walk rounds have taken place. Any concerns raised during the leadership walk round are escalated to senior managers who will help resolve the issue.

7.3.2    In 2016 we have one leadership walk round scheduled per week. A review of the structure of the walk rounds is currently taking place to ensure that we continue to get the most out of our Foundation Trust leadership spending time in clinical areas.

## 7.4    Acute Kidney Injury (AKI)

7.4.1    Acute kidney injury (AKI) is a sudden reduction in kidney function. It is common, harmful and often preventable, thus representing a major patient safety challenge for the NHS. AKI occurs in as many as 10-15% of hospital admissions, usually in conjunction with other acute illnesses.

7.4.2    This project is part of the Health Foundation supported 'scaling-up improvement' project. We are working with our Improvement Academy to introduce a bundle of care around AKI which is believed to improve patient care. We are one of four Foundation Trusts participating in this project where sharing our learning and findings is imperative to ensuring continuous improvement.

What:      To implement an effective package of interventions for acute kidney injury and measure the impact of its introduction.

How much: Embedded care bundle on four wards.

By when:    30 November 2016.

Outcome:   In progress + on target.

**Improvements achieved:**

➤ Development of a training package aimed at frontline staff.

➤ Successful implementation of the care bundle on one ward.

➤ Introduction of an Electronic Alerting System that informs the healthcare professional that a patient has an AKI.

➤ Development of educational material including: posters, credit card sized prompts; screen saver and foundation trust-wide communication.

➤ Regular communication with frontline staff regarding progress.

➤ Shared learning events with other partner Foundation Trusts.

AKI data as at 2 March 2016.

| Overall Results | | | |
|---|---|---|---|
| Documented AKI in clinical notes | Yes | No | Percentage |
| | 28 | 11 | 72% |
| Care Bundle entered into notes | Yes | No | Percentage |
| | 14 | 25 | 36% |
| | Completed Bundle elements | Care given but not logged on Bundle | Percentage of care delivered |
| Volume status | 13 | 17 | 77% |
| Meds r/v | 12 | 12 | 62% |
| Urine dip | 8 | 15 | 59% |
| Manage K | 11 | 20 | 79% |
| VBG/ABG | 12 | 17 | 74% |
| Additional tests | 11 | 16 | 69% |
| Fluid balance | 13 | 18 | 79% |
| Contacted renal | 11 | 17 | 72% |
| Fully completed Bundles | | 6 | 43% |

Further improvements identified:

➤ Continued ward engagement and monitoring of compliance.

➤ Spread is being planned to the surgical admissions unit and elderly care wards.

➤ Further spread will be planned for other admission areas including the Accident & Emergency Department.

➤ Further resources developed to promote the project.

➤ Development of ward implementation packs so resources are readily available.

➤ Development of patent information on AKI.

**7.5    Epilepsy:  Referrals**

7.5.1    We are looking at ways to improve the pathway for patients with epilepsy who require follow-up appointments either with a community service or a specialist doctor. By improving the pathway, we hope to improve the patient experience and also ensure that patients have appropriate and timely access to specialists.

What:    To improve compliance with the referral pathway for adult patients attending emergency services with a diagnosis of epilepsy or seizures in patients with known epilepsy.

How much:    70% compliance with referral process.

By when:    31 May 2016.

Outcome:    In progress + on target.

Improvements achieved:

➤ Current pathway has been amended to encourage its use at the start of the patient's journey and throughout. Information about the referral pathway is clearly stated on the pathway.

➤ Education programme to reinforce the referral pathway to frontline staff.

➤ Focus groups with staff to understand any barriers to appropriate and timely referral.

➤ Posters created and displayed in prominent positions reminding staff of the referral pathway.

➤ Introduction of a champion for epilepsy within the Accident and Emergency Department.

Further improvements identified:

➤ Regularly feedback to frontline staff on how we are progressing towards our aim to improve the pathway for patients with epilepsy who require follow-up appointments.

➤ Patient questionnaire to understand how patients using the service feel about the referral process and how it can be improved.

➤ Cards given to patients informing them of what to expect in relation to referrals and contact details of someone who can help with any queries.
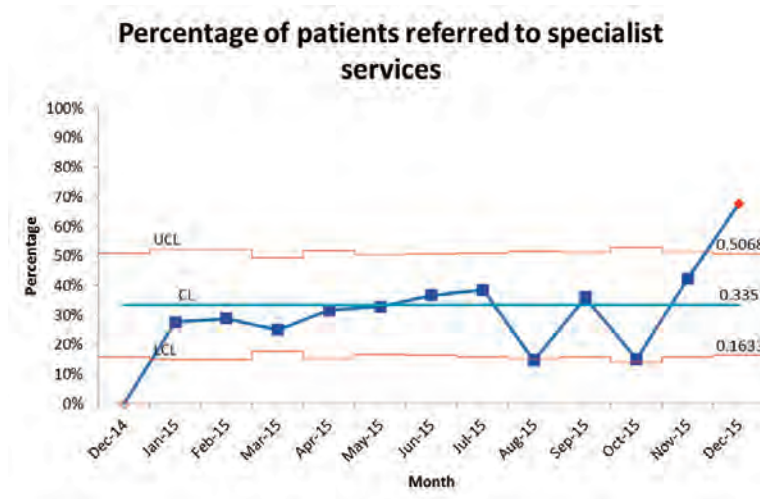


The Foundation Trust is shown with a blue line on the graph and shows a rise in the amount of referrals that have been made in November and December 2015. This means that the project is moving in the right direction.

## 7.6    Measurement and monitoring of safety

7.6.1    This work is funded by the Health Foundation and aims to identify improvements and bring about change, recognise how the NHS can use data to help understand how safe we are and identify opportunities for improvement. The framework being used was developed by Professor Charles Vincent and it breaks safety down into different areas:

- Past harm.

- Reliability.

- Sensitivity to operations.

- Anticipation and preparedness.

- Integration and learning.

**What:**    To test out ideas relating to the different areas of safety.

**How much:**  Two inpatient wards were involved in the sepsis project

**By when:**    September 2016

**Outcome:**    On target

Improvements achieved:

➤ Completion of safety culture surveys with ward teams.

➤ Completion of staff interviews to understand perception of safety.

➤ Ongoing patient feedback collection.

➤ Setting up of regular ward safety meetings.

➤ Implementation of safety huddles.

➤ Delivery of quality improvement training to frontline staff through 'curry night' sessions.

➤ Development of ward safety dashboard to capture daily safety measures.

➤ Learning events to engage teams involved and share learning.



Measurement and Monitoring of safety Framework (Vincent et al 2013)

Further improvements identified:

➤ Case note review of inpatients.

➤ Sustaining and embedding multidisciplinary ward safety meetings.

➤ Development of ward guide to support/improve quality of safety huddles.

➤ Safety huddles happening daily on wards.

➤ Frontline staff review of ward safety dashboards to ensure safety metrics reflects ward requirements.

➤ Frontline staff use of patient feedback to improve safety of care on the wards.

➤ Transfer learning gained widely across the Foundation Trust.

## 7.7 Avoidable mortality

7.7.1 Improving the way we review and learn to change the quality of care

7.7.1.1 The Foundation Trust is reducing mortality by introducing a new co-ordinated approach with a particular focus on understanding and learning from deaths of patients cared for by the Foundation Trust. To do this we have developed a mortality improvement programme.

This programme uses many different measures of mortality which we monitor to ensure that our performance is acceptable. Currently our performance for the two most common measures (standardised hospital mortality index and hospital standardised mortality ratio) is "as expected". These two measures are known as risk adjusted measures as they adjust for the type of patients that use a service. The idea is that these measures can then be used to compare different hospitals that might have very different types of patients (for example inner city compared to rural or suburban).

7.7.1.2 Nationally, NHS England has recommended a standard approach to case note review for patients who die in hospital, this is to ensure that as much learning as possible is gathered from the patient's admission.

7.7.1.3 The Foundation Trust has worked on case note review for over a year and our approach delivers against national standards for mortality surveillance. In addition we have established a series of committees that oversee our processes around mortality and report back to the Foundation Trust through the Quality and Safety Committee.

**What:** The proposed aim is to reduce avoidable deaths at the Foundation Trust.

**How much:** 50%.

**By when:** 2018.

**Outcome:** In progress.

**Improvements achieved:**

➤ The establishment of a governance structure for mortality that oversees the development of mortality improvement work at the Foundation Trust.

➤ A coding project has been developed at the Foundation Trust which aims to ensure that there is an ongoing programme of improvement in the information that we record relating to the patient's stay.

➤ We are working regionally and nationally on initiatives to improve the measurement and recording of the care we give.

➤ We have developed a review process for looking into mortality data.

➤ A mortality dashboard has been developed which shows the Foundation Trust performance for a number of measures.

➤ Centrally from December 2014 to date we have undertaken 120 (7.9%; total deaths to date 1519) reviews of patients who passed away in our care.

➤ From April 2015 to date, we have trained 65 clinicians on the case note review process.

**Further improvements identified:**

➤ Continued development of a standardised mortality review process which will align us with the national guidance soon to be announced.

➤ Ongoing delivery of case note review training sessions to increase capability among frontline clinicians across all relevant adult specialties.

➤ Continued working with the Improvement Academy and Regional Mortality Review Group.

# Risk adjusted Mortality Indicators as at May 2016

| HMSR – National Funnel Plot | SHMI – National Funnel Plot |
|---|---|

**→ Lower is better →** (Trust level)





| HSMR for most recent 12 months is 94 ( as expected) | SHMI for most recent 12 months is 97.25 (as expected) |
|---|---|

## HMSR – By Financial Year

**→ Lower is better →**



Shows performance for HSMR by financial year
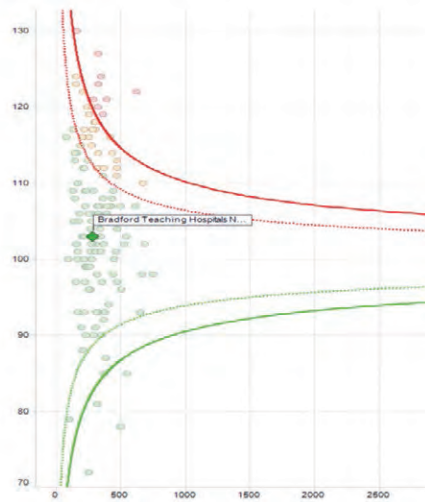
| Weekday HSMR – National Funnel Plot | Un-adjusted Crude Mortality |
|---|---|
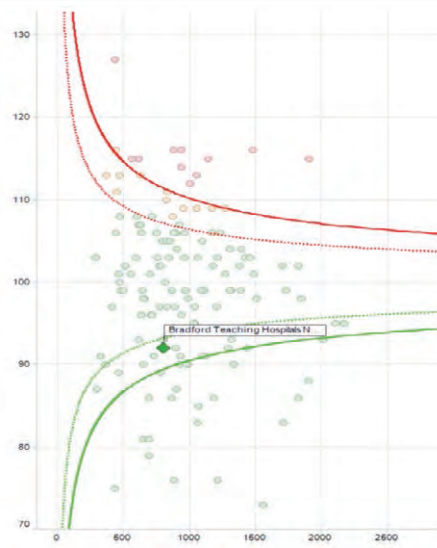
**Lower is better**



**Trust level**

HSMR for most recent 12 months is 91
( as expected)

There wew 114 deaths in March 2016;
unadjusted crude mortality rate 1.19%

| Weekend – National Funnel Plot | |
|---|---|

**Lower is better**



HSMR for most recent 12 months is 103
(as expected)

| Sepsis SMR | Pneumonia SMR |
|---|---|
| SMR for most recent 12 months is 84 ( as expected) | SMR for most recent 12 months is 107 (as expected) |
| Myocardial Infarction SMR | Acute Cerebrovascular Disease SMR |
| SMR for most recent 12 months is 89 (as expected) | SMR for most recent 12 months is 124 (worse than expected) |

Lower is better →

Trust level

| Heart Failure SMR | Hip Fracture SMR |
|---|---|





| | |
|---|---|
| SMR for most recent 12 months is 111 ( as expected) | SMR for most recent 12 months is 94 (as expected) |

| Acute Unspecified Renal Failure SMR | Deaths after Surgery SMR |
|---|---|





| | |
|---|---|
| SMR for most recent 12 months is 99 (as expected) | SMR for most recent 12 months is 129 (as expected). Table shows Trusts within Yorks & Humber. BTHFT is represented by a green diamond |

→ Lower is better →

Trust level

→ Lower is better →

## 7.8 The patient reporting and action for a safe environment (PRASE) project



Putting the patient at the heart of patient safety: implementing a patient measure of safety in partnership with hospital volunteers

7.8.1 The PRASE initiative is pioneering in its approach to involving patients in patient safety improvement based on the feedback they provide that identifies the factors that contribute to patient safety. It is a collaborative quality improvement project funded by the Health Foundation which involves three hospital trusts within the Yorkshire and Humber region - Bradford Teaching Hospitals NHS Foundation Trust (the lead organisation), Barnsley Hospital NHS Foundation Trust and Hull & East Yorkshire Hospitals NHS Trust.

7.8.2 There are various reasons why patients are unable to effectively participate in safety improvement. We recognise the importance of understanding safety from their perspective and this project will be tracking the patients experience using hospital volunteers, which is a novel approach in the NHS. They will collect patient feedback in a standardised way using a validated patient safety questionnaire which is administered on electronic mobile devices.

7.8.3 The project is piloting the implementation of the PRASE approach as well as evaluating its impact and outcomes in terms of improved patient safety and quality of care.

**What:** To establish whether hospital volunteers can successfully collect patient feedback which can be used to make safety improvements in quality and safety of care delivered on the ward.

**How much:**
- Six inpatient wards currently involved: renal; paediatrics; ear, nose and throat (ENT); cardiology; elective orthopaedics; acute elderly care.
- Generation of ward feedback reports which provides patient measures of safety scores and a description of patient reported experiences of safety of care.
- Multi-disciplinary ward action planning meetings to create a ward improvement plan.

**By when:** June 2016.

**Outcome:** On target.

**Improvements achieved:**
➤ Unique opportunity to translate research into routine hospital practice through co-production work with frontline doctors and nurses to ensure it can be applied practically as part of patient safety improvement.

➤ Recruitment and development of a team of PRASE patient safety volunteers.

➤ Development of the PRASE questionnaire 'app'.

➤ Ongoing ward level multidisciplinary action planning meetings to review the ward feedback report.

➤ Creation of a PRASE animation information movie - to increase awareness of PRASE disseminated through the Improvement Academy's website.
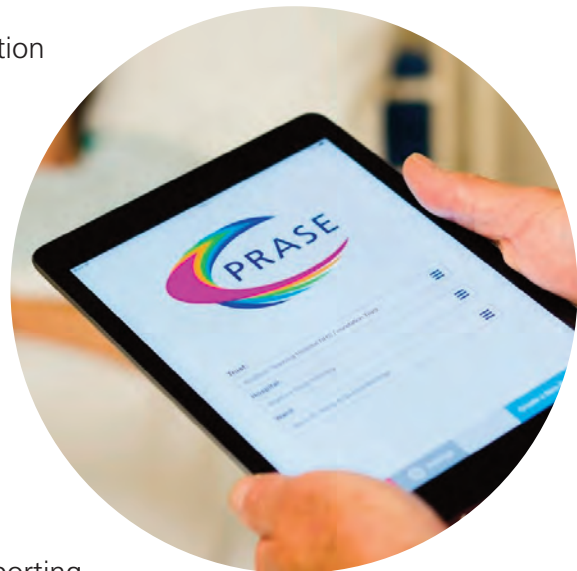
**Further improvements identified:**

➤ Further ward multidisciplinary action planning meetings.

➤ Ongoing development of the PRASE reporting software which will include an interactive front facing reporting website and intuitive ward feedback report template.

➤ Ongoing feedback report generation which will promote a culture of continual improvement.

➤ Wider dissemination and show case of the PRASE work - poster abstract presentation at the International Forum on Quality and Safety in Health Care April 2016

## 7.9    Safer procedures

7.9.1    The World Health Organization (WHO) developed a surgical safety checklist in 2009 with the intention of providing a reliable system for improving surgical processes. The checklist aims to promote safety by standardising aspects of surgical care, reinforcing safety processes, and encouraging open communication between staff. We have been working to ensure that the checklist is being used as intended and that it is meeting its original aims.

**What:**    To improve compliance with the WHO surgical safety checklist and establish safe systems of practice throughout the surgical pathway.

**How much**:    Above 95% compliance with completion of checklist.

**By when:**    31 March 2016.

**Outcome:**    Target reached, continuous monitoring continues.



WHO Surgical Checklist Completion
ALL THEATRES
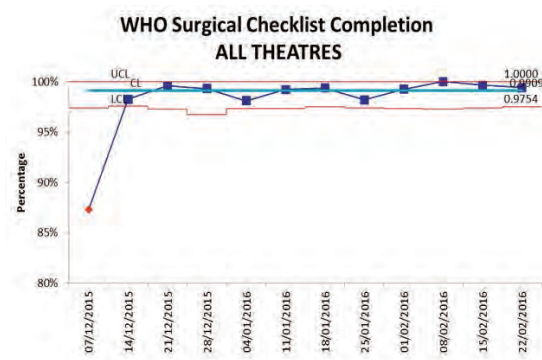
Improvements achieved:

➤ Daily audits taking place on all theatre areas. Any issues identified with completing the checklist are dealt with at the time.

➤ Observational audits of WHO surgical checklist process completed on a monthly basis.

➤ Collaborative working with the Improvement Academy to support training opportunities for theatre staff and share learning across other organisations in the region.

➤ Safer Procedures Group established, led by the Medical Director to highlight areas where improvements can be made and establish working groups to focus on these identified issues.

Further improvements identified:

➤ Feedback from safety culture survey and investigations into results.

➤ Look at the effectiveness of the green band system which is in place to provide further safety nets during surgical procedures.

➤ Review the organisation of the peri-operative care plan (the documentation used for surgical procedures).

➤ Identify and implement best practice in relation to briefing and de-briefing processes.

## 7.10   Sepsis management

7.10.1   Sepsis is a common and potentially life threatening condition triggered by an infection and can lead to multiple organ failure or death if not recognised and treated early. The BUFALO acronym has been developed to aide doctors and nurses in treating patients with sepsis and acts as a reminder of the treatment pathway.

| Elements of BUFALO | Percentage compliance achieved within one hour (Dec15) |
|---|---|
| **B**lood cultures taken | 43% |
| **U**rine input and output chart | 36% |
| **F**luids administered | 54% |
| **A**ntibiotic administration | 36% |
| **L**actate measurements | 75% |
| **O**xygen therapy (if applicable) | 86% |

**What:** to improve full and documented compliance with the sepsis pathway within 1 hour.

**How much:** 50% compliance with BUFALO in AED.

**By when:** 30 September 2016.

**Outcome:** In progress and on target.

**Improvements achieved:**

➤ Awareness raising event throughout the organisation including senior staff ward visits, screen savers, promotional material and key speakers.

➤ Development of an e-learning package for doctors and nurses.

➤ BUFALO acronym used and recognised throughout the organisation.

➤ Sepsis champions identified and engaged in all wards and departments that may treat patients with sepsis.

➤ Sepsis box has been implemented on the Accident and Emergency Department which contains the equipment required to treat and manage sepsis.

➤ A blood culture pack has been designed and is currently being trialled. The blood culture pack contains a sepsis screening tool and sepsis pathway to attach to patients' notes and reminds doctors who are taking blood cultures to think of sepsis as a possibility.
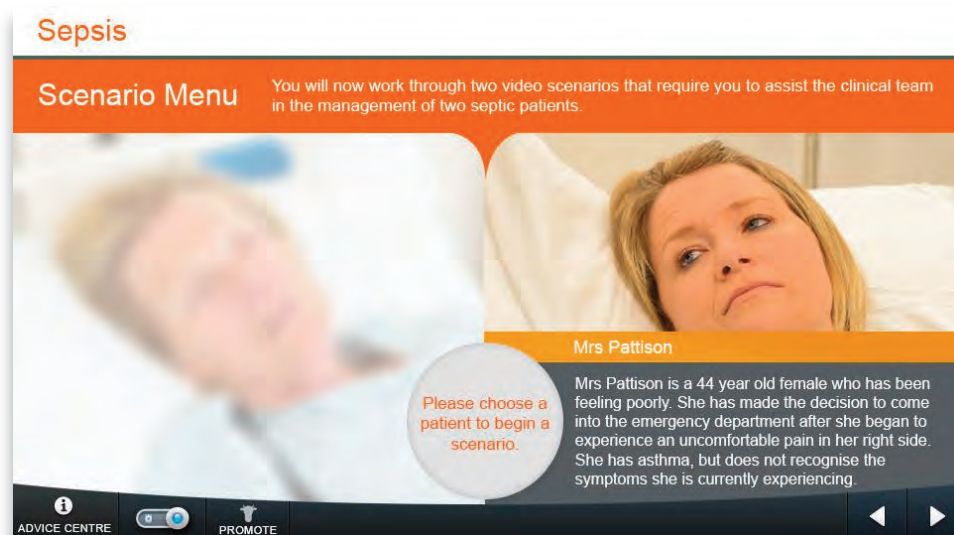


**Further improvements identified:**

➤ Sepsis pathway to be integrated into the new electronic patient record system with prompts for staff when sepsis is suspected.

➤ Further work to identify any barriers and implement changes relating to antibiotic administration.

➤ Launch of e-learning programme March 2016.

# 8. Learning from incidents

8.1     The Foundation Trust is keen to understand why incidents occur, as this understanding is essential to ensure we take the right steps to improve systems, practice and keep patients safe.  Increasingly it is acknowledged that everyone makes mistakes, and that whilst staff come to work with the very best of intentions towards our patients, things will sometimes go wrong. Although it is important for the individuals involved in incidents to reflect and consider what personal learning there might be, it is even more important for the Foundation Trust to continue to improve its systems to help people avoid making mistakes and to provide a safety net when mistakes happen.

8.2     We are pleased to convey that the Foundation Trust has been reported as "good" in the learning from mistakes league published by NHS Improvement (Monitor and the NHS Trust Development Authority).

8.2.1   The league table has been drawn together by scoring providers based on the fairness and effectiveness of procedures for reporting errors, near misses and incidents; staff confidence and security in reporting unsafe clinical practice; and the percentage of staff who feel able to contribute towards improvements at their Foundation Trust.

8.3     One example of learning from incidents is the investment in improving care for patients at risk of falling.  Patient falls are the type of incident most commonly reported.  Whilst most falls resulted in no or minor injury, some resulted in fractures or serious head injury.  There has been an increased emphasis on falls risk assessments being undertaken on admission, with appropriate measures being taken according to the individual patient's needs.

8.4     A further example of learning is the response to the finding that a number of patients had not been invited to outpatient follow up appointments as planned.  The investigation into this matter identified that the Foundation Trust's administrative and reporting systems required improvement.  A comprehensive action plan was developed with implementation being routinely monitored by the Access, Assurance and Improvement Group and monthly reports being provided to the Foundation Trust Improvement Board, the Performance Committee and the Board of Directors.  Through this there is a high degree of confidence that systems have improved and that they will continue to improve.

8.5     The Foundation Trust's Risk Management Team continues to review all reported patient safety incidents and to investigate when serious incidents occur, and when themes and trends are identified, to ensure the organisation continues to learn and improve patient safety.  An overview is maintained by the Risk Management Co-ordination Group, and

potential serious incidents and concerns are raised at the weekly meeting of the Quality of Care Panel, which is chaired by the Medical Director and Chief Nurse.

8.5.1   The Foundation Trust is also proud to be working with Risk Authority of the Stanford University Medical Network, to improve our analysis of information generated by incident reports, complaints and claims, and use design thinking tools and techniques to improve our services.

## 8.6   Never events

Some incidents that occur are serious, largely preventable patient safety incidents that should not occur if the preventative measures have been implemented by healthcare providers. These are defined nationally and called Never Events. It is important to recognise that never events hold a high potential for severe harm or death.

We have had two never events reported in the period 1st April 2015 – 31st March 2016;

• One relating to a misplaced nasogastric tube (still under investigation).

• One relating to a retained object post-surgery.

The Foundation Trust is committed to learning lessons from all incidents, and we take the learning from never events very seriously. Whilst the incident involving a nasogastric tube is still under investigation, initial learning has already been shared with a neighbouring organisation. The never event involving the retained object post-surgery has resulted in the identification of a number of opportunities for strengthening failsafe systems and for change and improvement, which have been implemented. In addition, surgical safety has been identified as a key priority in the quality improvement programme for 2016-2017 as described in this quality report.

# 9. Learning from complaints and PALS issues

9.1   We are committed to using all feedback to learn lessons and improve the care we give. It is vital that the complaints process works for patients to ensure that their concerns are taken seriously; there is also a commitment to provide complainants with answers that are significant and meaningful.

9.2   In August 2015 the West Yorkshire Audit Consortium conducted an internal audit of the Trust's complaints process.  The audit bench marked our Foundation Trust's position against current national guidance on handling NHS complaints; this included recommendations from the Francis Report and the Clwyd Hart Review. The auditors made a number of recommendations for improving the complaints process and we are proud to have achieved full integration of these during the latter half of 2015.

**What:**   Ensuring all formal complaints are acknowledged within three working days and where possible complainants receive their final response from the organisation within twenty five workings days.

**How:**   This has required closer working between the central complaints teams and the Divisions. The acknowledgement process is now managed by the central team and along with an acknowledgement letter, complainants now receive comprehensive information on what to expect from the process and all the support services available.

Work between the complaints team and the investigation leads, particularly the Matrons, has been fruitful in reducing the timeframe for complaint responses.

**Progress – Partially Achieved:**

In August 2015 at the time of the internal audit there were 133 outstanding complaints 70% of which had breached this target. This had fallen to just 45% of the 64 outstanding complaints in January 2016. This is helping to engage the public in the process in a more productive manner and produce the meaningful responses we are aiming for.

**Reduction of Complaints and response times during late 2015**
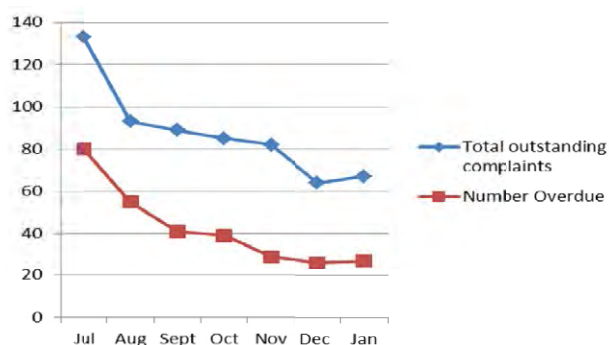
9.3      While there is continuing work towards ensuring compliance with the 25 working day target, there is an understanding that many complaints involve complex and sensitive issues. It is important that the 25 day target does not hinder the quality of investigations; therefore there has been a focus on early and regular communication between investigators and complainants and the flexibility to negotiate appropriate response times.

9.4      Quality of responses remains equally as important; to monitor and reflect the quality of the response issued we are benchmarking results against the uptake of complaints referred to the Parliamentary Health Service Ombudsman (PHSO). The PHSO figures reflect a high standard of responses with nearly 89% of our complaints resolved via the local process. 11% are sent to the PHSO as the complainant is not happy with the outcome of the local process.

### Future Goals:

- As a result of the opening of the new entrance and concourse at Bradford Royal Infirmary, our Patient Advocacy and Liaison Service (PALS) will move in to a new custom built workspace; providing private areas for patients and their families to discuss issues and spend time face to face with our highly skilled team.

- We will improve training for all our frontline staff in handling complaints, this will be delivered in an interactive manner advocating a problem-solving approach. The goal is to support frontline staff and give them the confidence to resolve patient issues as they arise.

- We will roll out redesigned training for complaints investigators focused on writing responses. This will ensure complainants receive responses that are clearly understandable, written in an appropriate empathetic tone and a professional manner.

- We will improve how we communicate by utilising social media to get messages out to patients and families.

- We will introduce a PALS volunteer role, including ward visitors who are able to signpost patients towards solutions or highlight problems to the clinical leaders such as ward sisters at the earliest opportunity.

- We will continue to focus our goals for the implementation of action plans following the resolution of complaints and work at a local level to ensure improvements made due to complaints are monitored in a structured manner.

# 10. Safe Nurse Staffing Levels

10.1 Following a requirement from the Chief Nursing Officer of NHS England and the Care Quality Commission, all hospitals are required to publish retrospective monthly data information through UNIFY about the number of nursing and midwifery staff working on each ward, together with the percentage of shifts meeting safe staffing guidelines.

10.2 This initiative is part of the NHS response to the Francis report which called for greater openness and transparency in the health service.

10.3 We take the care of our patients very seriously and already have a number of robust mechanisms in place to ensure that our wards are safely staffed, including displaying information for patients and visitors in all of our wards, daily staffing reports to board level, weekly staffing meetings with ward sisters and matrons.

10.4 During December 2015 we reviewed all our nurse and midwifery staffing establishments on all inpatient wards and a report of the results was presented to the Board of Directors. The review was undertaken using a range of national staffing tools, triangulated against quality indicators and tested through professional challenge. The review set out to:

- Provide high quality and safe nursing/midwifery care that meets the individual needs of the patients.

- Address compliance with national standards and good practice in relation to nursing / midwifery care.

- Ensure the effective management and mitigation of current and future nursing / midwifery care delivery risks.

The Foundation Trust is proud of the care that it provides, and has ambition to ensure that all the aspects of quality of care (safety, patient experience and clinical effectiveness) provided in all its services are outstanding.

A presentation of the outcomes of the review was given to the Board of Directors which led to a significant investment in nursing to enhance the quality of care delivered.

## 10.5 Actions taken by the Foundation Trust for recruitment:

- In May 2015 the Trust interviewed and offered posts to 36 Philippine nurses - further skype interviews are planned.

- Eight European Union (EU) nurses have secured Staff Nurse posts in the Foundation Trust.

- We have appointed 112 finalist student nurses from the University of Bradford (90 adult and 22 paediatrics), they will take up post from 19 September 2016, and they have been offered a choice of workplace and a buddy to support them in practice.

- Eight candidates were interviewed on 7 March 2015 – all external finalist student nurses.

- The Foundation Trust continues to support the return to practice programme.

- 'woo former nurses back campaign', we have approached retired nurses/senior nurses back to practice, provide refresher courses as required, offer flexible working arrangements or invite them to join the temporary nurse register, (if they are still registered with the Nursing Midwifery Council (NMC) and have a personal identification number (PIN).

- We continue with 'back to nursing in the NHS scheme', to attract qualified nurses currently working in the independent, private and voluntary organisations locally.

## 10.6 Nurse staffing data publication reporting

A monthly report is received by the Board of Directors that provides information on safer nurse staffing data. This report identifies the actual staffing levels in place against what was planned. It identifies areas of discrepancy between the two, and provides an exception report on actions to be taken as a result. This information relates to the staffing levels on all inpatient wards including paediatric and maternity wards.

An example of the information provided in the monthly report to the Board of Directors is as follows:
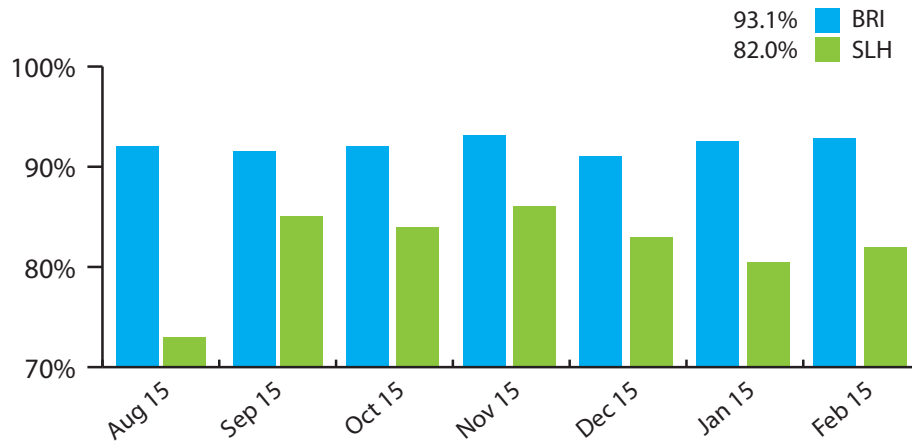
Overall fill rates – February 2016

Below is a table showing the overall fill rates for both day and night shifts in February 2016, by hospital site. It should be noted that community hospitals (CH) appear in the figures for St Luke's Hospital (SLH) as required by the submission of the UNIFY tool.

| Date | Hospital | Day | | Night | |
|------|----------|-----|-----|-------|-----|
| | | Average fill rate- registered nurse / midwife % | Average fill rate- care staff % | Average fill rate- registered nurse / midwife % | Average fill rate- care staff % |
| Feb -16 | BRI | 93.1% | 109.5% | 98.8% | 136.2% |
| Feb -16 | SLH & CH | 82.0% | 166.5% | 101.9% | 149.6% |

## Fill rates for day shifts

The results below show the average fill rates on day shifts by month since August 2015 to February 2016, for registered nurses / midwives.
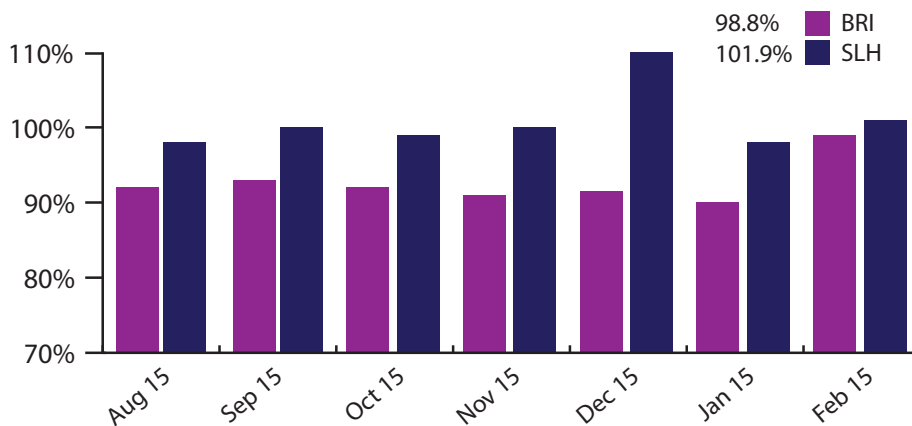
**Average DAY fill rate for registered nurses / midwives.**



## Fill rates for night shifts

The results below show the average fill rates for night shifts by month since August 2015 to February 2016, for registered nurses/midwives.

**Average NIGHT fill rate for registered nurses / midwives.**



## Actions to address staffing fill rates

Robust monitoring remains in place with a daily overview of the staffing on each in-patient area to maintain safety. Where areas have a risk identified regarding staffing, mitigation is put in place and monitored.

Overall Mitigation taken by Heads of Nursing to manage staffing

- Daily ward safety huddles cover and escalate current risks.

- Staffing RAG report completed at 9am every morning by the Matron Team and Head of Nursing and reviewed throughout the day by senior nurses. The staffing report is shared with Foundation Trust Executives each morning, showing risk rating and action taken as a result.

- Staffing and safety concerns escalated to site Matrons / Flow Coordinators and discussed at the daily bed meetings at 10am, 1pm and 4pm; this is shared with Matrons for the affected areas.

- Daily Datix review at the 9am Matron huddle looking at incidents from the previous day and deploying Matrons to review areas to ensure no harm has occurred.

- Matrons feedback to Datix author on actions taken in response.

- Over 7 day length of stay review meeting held weekly which covers incidents and complaints relating to patient flow.

# 11. Safeguarding children

11.1 The profile of safeguarding children at the Foundation Trust remains high, with particular focus during the last year on the re-levelling of staff training requirements to reflect national guidance (Intercollegiate document 2014). Activity remains high both within the Foundation Trust and within the Bradford district, with 484 children currently being subject to child protection plans as of December 2015, many of which have frequented our services at both Bradford Royal and St Luke's Hospital during the past year. The categories are 29 (6%) children for risk of physical abuse, 180 (37%) for neglect, 237 (49%) for emotional abuse and 38 (8%) at risk of sexual abuse.

**11.2 Statutory requirements**

11.2.1 When agencies and individuals are working in the safeguarding arena, Section 11 of the Children's Act places a duty on them to ensure that their functions and any services they contract out to others, are carried out with the purpose to safeguard and promote the welfare of children. The Foundation Trust complies with this requirement by way of submitting a Section 11 declaration.

11.2.2 During 2015 Bradford Safeguarding Children's Board (BSCB) requested, by means of the virtual colleges online Section 11 audit tool (which is a dynamic on-going process), evidenced data for assurance of safeguarding children's arrangements and activity within the Foundation Trust. This was presented to the Performance Management Subgroup of the BSCB, who provide management oversight to BSCB regarding safeguarding arrangements.

11.2.3 The tool has nine standards and agencies are requested to self-rate their current status. After completion, a percentage score is given for each standard and the overall audit. The current position for the Foundation Trust is a score of 95%. Six of the nine standards are fully met and scoring 100% whilst one standard scores 94% and two standards score 80%. Excellent feedback was received for all the standards and clear plans for development were demonstrated.

**11.3 Structure of the safeguarding children team**

11.3.1 The team consists of a Named Nurse and Named Doctor for Safeguarding Children supported by two safeguarding specialist practitioners, two paediatric liaison nurses (one full time, one part time) and a Named Midwife.

**In addition to team operational meetings, we hold fortnightly case discussion meetings to look at all referrals to our team. This has three purposes:**

- Firstly to ensure all actions required have been carried out;

- Secondly to ensure that if further information is needed about the case, it is collected; and

- Thirdly as quality assurance regarding management of cases, and feedback to staff about decisions where required.

11.3.2 The Foundation Trust Safeguarding Children Steering Group meets bi-monthly and is chaired by the Chief Nurse. In addition the Foundation Trust has now formed an Integrated Safeguarding group, where overarching children's and adults safeguarding issues are discussed.

**11.4 Training & supervision**

11.4.1 Safeguarding children will be one of nine core mandatory training requirements going forward. Much work has been carried out in the autumn 2015 to create a robust training strategy which has been ratified by the Foundation Trust Safeguarding Children Steering Group in September. In November it was presented to the Education Committee and was accepted in principle and it is anticipated that re-levelling will all be complete by April 2016. In addition, safeguarding level 1 and 2 will be provided as face-to-face sessions within the Foundation Trust mandatory induction programme.

11.4.2 Safeguarding Supervision is an essential ingredient to good practice and nationally recognised. The Safeguarding Children's Supervision policy has been revised and updated (March 2016), formally recognising its importance in practice within the Foundation Trust. There are a number of formally trained safeguarding supervisors (both medical and nursing) who are available to support staff throughout the organisation, both on a regular basis and during ad hoc sessions. For Consultant Paediatricians, a regular "Peer Review" programme started in September 2015, for case review, as recommended by the Royal College of Paediatrics and Child Health.

**11.5 Trust safeguarding audit**

11.5.1 The safeguarding audit is a specific requirement for ongoing assurance. The team have collated all safeguarding children audits carried out in the Foundation Trust and have created a formal audit strategy for 2016. This includes some particular "hot topics" for example, child and family feedback, staff knowledge of safeguarding and who to contact child sexual exploitation (CSE) and identification of high risk cases in our organisation.

**11.6 Key achievements 2015-2016**

- Safeguarding children's policy procedure and guidance reviewed and updated.

- Female genital mutilation (FGM) policy, procedure and national reporting requirements developed.

- Child sexual assault guideline created and approved.

- development of the safeguarding children's website to hold all policy and procedure information together.

- Flagging system developed to identify looked after children (LAC) and children identified to be high risk (Child Sexual Exploitation) who attend the Foundation Trust.

- development of policy and procedures for receiving information from the Child Protection Review Unit and sending of medical reports for the organisation.

- Shared contribution to the domestic and sexual violence policy.

- Pathway developed to ensure all high risk children identified to be at risk of child sexual exploitation within the district are offered a full sexual health assessment via Trinity at the safeguarding HUB (multi-agency group who manage cases of suspected child sexual exploitation in Bradford).

- Branding and development of own logo of the Safeguarding Children's Team.

- contributed to Bradford Safeguarding Children's Board safeguarding week in October 2014 and October 2015.

- Expansion of Safeguarding Children Team Autumn 2015; includes a second Safeguarding Specialist Practitioner, 1.4 WTE Paediatric Liaison Nurses, and formalisation of the Named Midwife role.

# 12. Safeguarding Adults

**12.0**    **Safeguarding Adults**

12.1       In recognition of the increase in Safeguarding Adults activity within the Foundation Trust, investment in the team has been made to allow for the continued development of work both internally and externally in collaboration with partners in the District. The Safeguarding Adults team now consists of a Named Nurse, two Specialist Practitioners and an Administrator.

12.2       The following information, describes the work that has been carried out within the Foundation Trust.

- Safeguarding adults training development is now delivered in face to face sessions to staff on their Foundation Trust induction.

- The Safeguarding Adults team work closely with the Safeguarding Children's team, attending each other's Safeguarding Committee meetings. The Trust has also established an Integrated Safeguarding Committee to ensure consistent strategic oversight.

- Ongoing development and staff training on the different agendas within safeguarding adults including domestic violence, PREVENT, human trafficking, mental capacity and deprivation of liberty safeguards.

**12.3**    **Work with Partners**

- There is continued attendance at the district-wide Safeguarding Adults Board and subgroups, Domestic and Sexual Violence Board, MARAC (Multi Agency Risk Assessment Conference) and Prevent Safeguarding Meetings.

- Ongoing work with the Local Authority Adult services both within the hospital and the district. Continued work in making enquiries on the Local Authority's behalf when a concern of abuse has been made and working together with the social work department based within the hospital to ensure concerns are responded to in an appropriate and timely manner.

- Ongoing work with support agencies within the district in response to safeguarding issues being raised within the Foundation Trust. An event was held in November 2015 where agencies who provide support to people experiencing domestic violence held a market stall to raise awareness of their services to staff. This was received well and feedback was good. Another event of this type is to be included as part of safeguarding week in October 2016.

### 12.4 Outcome / Progress: Continued increase in Safeguarding Activity.

- There has been a 40% increase in referrals to the Local authority for authorisation of a deprivation of liberty. This is due to a proactive drive to raise awareness through training and improved presence of the team on the wards, as a result of the additions to the Safeguarding Team. Greater visibility of the team has meant they are able to respond to queries promptly and support staff in identifying issues relating a patient's mental capacity.

- Referrals regarding concerns of abuse have also increased again this year, with referrals being received from non-clinical divisions within the Foundation Trust such as Estates and Facilities and Informatics. Again, this is due to the increase in capacity within the Safeguarding Team to be able raise awareness through face to face training delivery.

**Face to Face Training Delivery 2015-2016**
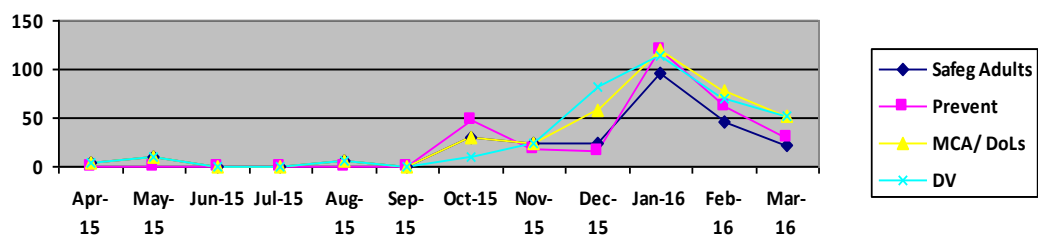


- The Foundation Trust, as part of its work with the Domestic and Sexual Violence Board launched a new policy in November 2015. The launch of the policy was included as part of a District wide event held at City Hall. The policy included routine questioning around domestic violence for staff on return to work from periods of sickness. This acknowledges the significant impact the issue has on people's lives and aims to provide support for staff as well as patients.

- Involvement in the safeguarding week in October 2015, where amongst other topics, a session on PREVENT (the Government's policy on safeguarding people and communities from the threat of terrorism) was held. There is continued work with partner agencies in preparing for the district's safeguarding week in 2016.

**Future work:**

- **Development of training.** As a result of the publication of new national guidance a proposal has been submitted reviewing the training requirements of all Foundation Trust staff. Once approved, there will be a further review of training availability and delivery. This review will look at methods of training delivery such as e-learning, face to face training and the availability of external courses and the accessibility of these for staff.

- Re-organisation of the intranet site to ensure staff have all the necessary information and resources to confidently respond to safeguarding adults concerns as they arise.

- Ongoing participation and involvement with district-wide work to ensure consistent and current practice in recognising and responding to concerns regarding the abuse of patients. Foundation Trust staff are engaged with the delivery of multi-agency safeguarding adults training within the district and continue to attend district wide multi agency groups.

- A review of the national PREVENT Strategy has identified the need to ensure that all staff should take a 'safeguarding' approach when they have concerns about someone being at risk of becoming involved in violent extremism. Data is collated in relation to concerns raised and training delivered in this area and is provided to NHS England on a quarterly basis. Members of the Safeguarding Adults Team provide training to raise awareness of PREVENT.

- A programme of clinical audit has been identified to be undertaken in 2016-2017. Priority areas are recognising safeguarding adults concerns, mental capacity and deprivation of liberty safeguards.

# 13. Patient Experience

**13.1**       **Patients First Sub Committee**

13.1.1       The Patients First Sub Committee is part of our wider Quality Improvement Strategy which aims to ensure we deliver what matters most to our patients. Eleven groups from across the organisation plus divisional teams share learning and best practice to improve the patient experience.

**What:**       To continually improve patient experience.

**When:**       On going.

**Outcome:**   80% of our patients to rate their care as "excellent" or "good".

**Progress:**   On plan.

**Improvements made:**

**1)**       Patient and Visitor Bedside Information Folder. Revised and re-launched in December 2015 to all inpatient areas. Developed in collaboration with service users, it provides important information for patients, family and visitors. It is separated into six sections:

- Your stay in hospital.

- Making decisions about your treatment.

- Keeping you safe and well in hospital.

- Services and facilities for patients and visitors.

- Your health records.

- Extra information and updates.

A full copy of the patient and visitor bedside information folder can be viewed at the address below:

http://www.bradfordhospitals.nhs.uk/patients/during-your-stay/information

2) **Volunteers Group.** Working in partnership with the Quality and Workforce Team to collect patient feedback for the friends and family test.

- A patient experience volunteer role has been created and advertised. Interviews for new volunteers have taken place in February 2016.

- Working in partnership with the Quality and Patient Safety Team, we have facilitated the collection of patient feedback on patient safety issues.

- A team of twenty two volunteers were recruited last summer and have piloted on six wards collecting information on i-pads.

- Central databases generate reports and feedback to wards and departments for action.

- Working in partnership with Elderly Care Team to develop a team of volunteers to support the Reminiscence Café for patients with Dementia. Training for all volunteers roles is provided.

To support patients in end of life who have no family/carers with them when dying, Chaplaincy volunteers will be "handpicked" and a small number (approximately six) will be piloted on certain wards (wards 3, 6, 29 and 30). The aim would be to provide "comfort" to patients in what is appropriate at the time whilst being on their journey alongside them. The emphasis is on the "spiritual" element and not religious however if the patient has requested for a religious perspective, then this would be referred to the appropriate Chaplain. The Volunteers will be specifically trained by the palliative and chaplaincy departments and specific support will be provided.

**Chaplaincy.** Work has progressed to design a new multi-faith prayer facility that will see all faiths accommodated in one central area.

3) **Urology patients.** Urology patients complained about the quality of the pads they were supplied to manage post-operative incontinence after prostate surgery. The pads were poor quality and patients were not reassured they were protected by these pads. Sister on Ward 14 and the Procurement Department have reviewed the pads available and worked with patients to obtain feedback; the result is the product has been changed to something more suitable.

**4)** **Antenatal Screening Service.** The antenatal screening service has been praised for innovative work in relation to developing a screening champion. Within each community team we have a nominated midwife or screening champion who acts as a link between the screening co-ordinator and the community midwives. Their valuable role involves cascading information and training ensuring all team members are up-to-date and confident with new developments within the screening programmes.



They attend the quarterly antenatal and new-born screening meetings and act as a link for all queries and concerns. This new innovation has a positive effect on the women of Bradford as early diagnosis and prompt treatment remains the most effective way of improving the outcome of care.

**5)** **Research Project.** Understanding and enhancing how hospital staff learn from and act upon patient experience data. We are one of three Foundation Trusts collaborating in a new, exciting research project which commenced in November 2015. The research aims to assist hospital staff in interpreting and acting on the patient experience feedback they receive. The research will use qualitative research and quality improvement methods in order to co-design (with staff and patients) a user-friendly 'Patient Experience Improvement Toolkit.

### 13.2    Using patient feedback to improve services

13.2.1    The Foundation Trust actively encourages patients, carers and other service users to give feedback verbally, by post or electronically about their care and experience. Here are a few examples of comments posted on the NHS Choices website and a letter received.

NHS Choices Website comments:

I was admitted to ward 12 for corrective surgery after a failed reconstruction following breast cancer surgery. It was my first experience of NHS treatment and I was very apprehensive.

Staff were obviously extremely busy but the ward seemed to be working efficiently with everyone working as a team.

I could not have wished for better or more attentive care and I was treated with dignity, respect and kindness by all the nursing and medical staff, including theatre and recovery. The ward was immaculately clean. I feel very fortunate to have had such fantastic care.

**Colonoscopy following months of IB**

The staff on the ward who took care of me and prepared me for my first colonoscopy were absolutely amazing. Not only were the staff patient with my endless questions prior to the examination, they were very supportive after the procedure.

Even when I had a little wobble emotionally following my colonoscopy, the nursing staff ensured that they kept me company, cheered me up and most importantly validated my feelings of vulnerability by explaining that I do not have to go through the process of being diagnosed with an IBD alone. I am forever grateful for the care and compassion they showed me.

I would like to thank the endoscopy team at the Gastro Unit in the BRI. I was booked for a colonoscopy earlier in the weekend and had fainted due to dehydration prior to the procedure.

The staff of nurses are the most friendly, supportive and respectful people I have ever seen. They helped me out I, respected my needs and kept checking on me in the recovery ward. I would definitely choose the BRI Gastro Unit if I needed a similar procedure.

**Community midwife service**

Due to have my second child in 2016, so far the consultants, ultra sound scan staff have been brilliant! But can't say the same for the community midwife service. Little or rather virtually no communication, difficult to get hold of, very different from when I had my daughter 8 years ago. They were good once upon a time but this time round I have seen a midwife only twice and I am in my final trimester. Surely this is against any NHS or hospital guidelines.

**Foundation Trust response**

I am very sorry to hear this feedback. We have recently invested in more staff in community to help with the workload. We now provide drop in sessions in most areas of the city so that women can call in for extra appointments or advice. If we can help on an individual level then we would be very happy to review your care so far and hopefully provide better support for the rest of your pregnancy.

## Ward 16

In January 2016, I spent two nights with my 4 week old, who was 6 weeks premature. The window in our room was dodgy, it was locked and closed but still a massive draft coming through. One nurse was amazing and kept giving me blankets, whereas another replied to me that I should stop asking about it as there was nothing they do as it was a very old building, the radiator in our room wasn't on, even though on numerous occasions I kept asking them to feel it. The care was amazing don't get me wrong but the overall attitude from some staff made me and my stay was uncomfortable due to how cold it was. We had two dedicated nurses who was assigned to look after my little girl and they took their role very seriously, they were amazing. The only thing to complain about was how cold it was and how I felt a few nurses had little respect.

## Foundation Trust response

I am really sorry that the attitude of some of the staff, plus the cold draft made your stay uncomfortable, it is not acceptable. Thank you for acknowledging that some of the nurses were excellent and the care that they provided was good. I will discuss this with the Head of Nursing for the service, who will feedback to the team and take appropriate action to make sure that the staff are made aware to learn and improve in future.

## Letter T&A

### Bradford Royal Infirmary has great record of cover at the weekend

*SIR – I am writing concerning an issue that has cropped up about cover of doctors at some hospitals at the weekends. The brilliant Bradford Royal Infirmary has excellent weekend cover as I know because I was a patient for five weeks.*

*My top consultants and the renal team all do their usual rounds of the wards when it is their shift so that the people of Bradford and area get good care when admitted at the weekend. These doctors, nurses and staff work seven days a week and are dedicated to their job and all work hard.*

*Thank you all again for helping me to get to the best of health I can be.*

13.2.2　We seek to respond to any feedback received and if necessary, provide patients with information about complaints procedures and help them to access these. Comments are also shared with teams, to take any action required.

**13.3　Patient and Public Involvement (PPI)**

**What:**　Our aim is to ensure we use a range of effective ways to involve patients and the public at all levels and in all aspects of our work.

**How:**

- All departments and services within the organisation are responsible for making sure that they think about, and plan adequately for patient and public involvement in their services. Support and advice is available from the patient and public involvement lead.

- We have committed to a set of guiding principles for involvement derived from community based involvement which shaped our approach to involvement as set out in the Foundation Trust Quality Improvement Strategy.

- Services often have existing links to specific patient interest groups and organisations, but also work with the PPI lead to set up new involvement mechanisms, or strengthen or refresh existing ones. There has been an increase in 2015-16 in requests for support to develop involvement in a variety of ways.

**Examples include:**

### Childrens' Community Services

- Support and advice on obtaining feedback from parents/carers of children receiving continuing care /respite packages in the home.

### Childrens' Therapies

- Advise and support service to consult with parents regarding development of a new MDT clinic for children with Downs.

### Clinical Research

- Support development of Patient Research Ambassadors initiative.

### Estates

- Source and support patient representatives for Wayfinding Strategy Group.

### Estates

- Plan and delivery involvement of patients to assess need and priority areas for improved induction loop provision.

### Estates/Paediatrics

• Involving children and young people in creating artwork to enhance the environment on existing children's wards and inform design plans for new children's wards.

### Informatics

• Advise, support and run workshop on informatics and IT policy and development of Trust Social Media.

### Neonatal Research Team

• Support /advise research team on development of research peer support network.

### Patient Safety

• Advise on role, recruitment and support of patient volunteers to work alongside researchers on the PRASE project.

### Psychological Services

• Advise and support in set up of a patient involvement group

### Uro-Oncology

• Reviewing patient information and education on Prostate Cancer treatment.

Involvement has also been facilitated by the Foundation Trust itself or as partners with other organisations such as Bradford Metropolitan District Council, for external organisations such as NHS England and the Strategic Clinical Network on areas such as developing a children's charter for the Division of Surgery & Anaesthesia, the development of the NHS Accessible Information Standard and improving the representation of disabled people in involvement opportunities.

**When:**     On-going.

**Outcome:**

• Work to develop wider, stronger links across local communities and to increase the number and diversity of people on the Foundation Trust Involvement Register is on-going and this year has seen an increase in both.

• There has been increased involvement of patients and the public in the creation of information for patients and the public, which has helped to improve the accessibility of information such as the revised Patient & Visitor Information Folder provided on wards and on the Foundation Trust website, the development of more Easy Read materials including information on how to give feedback, make a complaint, or take part in the Friends and Family Test.

- Relationships are being built on a steady basis with community groups and organisations, particularly focusing on groups of people who are excluded or seldom heard. This is reflected in the increased membership of the Involvement Register.

- In 2015 the Patient & Public Involvement team set up a new social media account on twitter @bthft_voice and is planning to develop the use of other social media platforms such as Facebook to provide enhanced opportunities for involvement including virtual consultation and dialogue.

- The increase in requests for support demonstrates increased awareness of the need for and value of patient and public involvement, including moving to more detailed processes such as co-design and involving patients as co-researchers.

**Progress:** On plan

### 13.3    Patient stories

13.3.1    Patient Stories are brief accounts of what people, particularly patients, but sometimes also family members, carers or friends experienced in our hospitals or services. They might be about good or bad experiences of using our services or a mixture of both. Patient Stories help us to identify good practice and what matters to patients and others, and reinforce those positive behaviours and attitudes with our staff. However, they also shine a powerful spotlight on poor experiences of care and so form part of the range of methods we use to identify where improvement is needed, and lead to changes that will benefit patients and others.

**What:**    The Foundation Trust uses these stories in different ways, including presenting one regularly at the start of our Board of Directors' meetings. This is so that people in leadership roles hear regularly, at first hand, about the experiences of care our patients have.

Patient stories can help forge and maintain a connection between an organisation's leaders and their primary purpose; providing high quality, safe care. As this is a public forum the stories can also be heard by members of the Council of Governors or members of the public or press who may attend, and it is therefore a very transparent means of being publicly accountable.

**How:**    Potential patient stories are sourced through a variety of routes including after a complaint has been made, from feedback to us via our "Tell Us What You Think" cards, direct to our clinical or patient experience staff, contact via our website, email or social media channels.

People are invited to take part, are supported to prepare and present their story as appropriate.

Most often the person concerned attends the Board meeting in person, with support, to tell their story in a way they are comfortable with. If someone does not want to or cannot do this, an advocate of their choosing can present it for them, and occasionally the Foundation Trust has used pre-filmed stories involving our own patients or people who have used other NHS services.

In many cases we also offer people the chance to be filmed telling their story so that more staff can benefit and learn. For example they are used to help with education and training of staff, giving feedback to staff and departments, at Trust Grand Rounds and in clinical governance meetings, or in our publications (for example our magazines for the public and staff and on the Open and Honest Care report on our website).

The people whose stories are used choose how they want to take part and how their accounts can be used.

Patient stories provide insight across the wide range of services we offer, and reflect different themes, issues and sections of the local population. In 2015-16 this has included areas and themes such as: elderly care; end of life care; community hospitals; Yorkshire Auditory Implant Service; gynaecology; uro-oncology; the chaplaincy service; Accident and Emergency and the Ambulatory Care Unit; maxillo-facial surgery; gastroenterology day-case unit; orthopaedics and rehabilitation services; provision for disabled patients. Staff involved from the departments or services are invited to attend the meeting, feedback to their teams about the story, and to be involved in identifying improvements or changes and taking these forward.

**When:** On-going

**Outcome:**

It is difficult to measure the outcomes of this type of involvement, both of individual stories and generically. However the Foundation Trust Board of Directors, hearing regular and usually first-hand from patients or their representatives about their experience has been described as being memorable, having personal impact, and keeping a sharp focus on the things that matter to patients and their families. The Board can and do direct learning or further actions to be taken as required as a result of this contact, leading to changes to practice, provision of care and policy. These have sometimes been changes that seem small but are important to patients or their families, but can also be more significant. It gives the Board an opportunity to maintain a connection with the real experiences of patients who use the services for which they are responsible. A library of high impact patient stories is being built to support learning of all staff across the Foundation Trust.

**Progress:** On plan

### 13.4    Friends and Family Test (FTT)

**What:**    To continually use near real-time patient feedback to improve patient experience. The Friends and Family Test (FFT) is a feedback tool to enable people who use NHS services to provide feedback on their experience in real or near real-time. It asks people if they would recommend the services they have used to friends and family if they needed similar care or treatment and offers a range of responses. The Foundation Trust combines the core question with brief follow-up questions to provide more detailed insights. This tool can highlight both good and poor patient experience.

**How:**    Since the initial launch in April 2013, the test has been rolled out in phases to most NHS-funded services in England. It now gives all patients the opportunity to give prompt, quick feedback on their care and treatment. Exactly how and when it is offered varies depending on the context and type of care. For example all day case and in-patients; including children and young people should be offered the chance to take part when they are discharged; it is available at all times to Outpatients and Community Services patients, but may also be offered proactively to them at key points in their diagnosis, treatment and care.

In the last year the Foundation Trust has begun offering different ways to provide this feedback including postcard type forms, SMS text messaging, using a tablet device whilst in the ward or using a link to an online version. Work continues to develop its use, accessibility and potential as a tool to support quality improvement across all areas.

Whilst maintaining a good response rate is vital, the emphasis has shifted to focus on the number of patients who would view their experience positively and so 'recommend us to their family and friends', and to use the qualitative data as a source of insight into what matters to patients and how to improve their experience and quality of care. Divisions report monthly to the Patients First Committee on their performance, themes and actions relating to Friends and Family data.

**When:** On going

**Outcome:**

The Trust has implemented the Friends and Family Test across all divisions and services in accordance with NHS England requirements.

**Progress:** On plan

**Improvements made:**

Bespoke versions of the materials were produced to meet the needs of patients under 16 years old, through consultation with local children and young people.

Further work is being planned to make the materials more accessible to disabled people or people with other communication support needs.

**Specific changes and improvements have been made as a result of feedback, for example:**

• replacing parking meters at St Luke's Hospital which were causing problems, delays and stress to patients with a different model which did not require input of a registration number;

• refurbished a room in Outpatients;

• training Outpatients staff to take blood following several comments about waiting times for blood tests;

• when the Women's Health unit was expanded, a designated room was allocated for women having posterior tibial nerve stimulation therapy to treat overactive bladders, to improve their experience.

| BTHFT FFT Scores | Q1 | | Q2 | | Q3 | | Q4 | | 2015/16 | |
|---|---|---|---|---|---|---|---|---|---|---|
| Area | % of patients | | % of patients | | % of patients | | % of patients | | % of patients | |
| | Recommend | Not Recommend | Recommend | Not Recommend | Recommend | Not Recommend | Recommend | Not Recommend | Recommend | Not Recommend |
| Wards | 99% | 0% | 98% | 1% | 97% | 1% | 96% | 1% | 98% | 1% |
| A&E | 58% | 29% | 69% | 22% | 74% | 15% | 68% | 21% | 70% | 19% |
| Maternity | 97% | 1% | 97% | 1% | 98% | 0% | 98% | 1% | 98% | 1% |
| Day Case | 100% | 0% | 100% | 0% | 99% | 0% | 99% | 0% | 99% | 0% |
| Outpatients | 95% | 2% | 95% | 2% | 95% | 2% | 95% | 2% | 95% | 2% |
| BTHFT Trust Total | 97% | 1% | 96% | 2% | 95% | 2% | 95% | 2% | 96% | 2% |

### 13.5 National patient surveys

13.5.1 Participating in the rolling programme of the Care Quality Commission (CQC), national patient surveys is a mandatory activity which forms a key mechanism for patients and carers to provide us with in-depth, systematic and comprehensive feedback on their experience with us. The results contribute to assessments of NHS performance and are also used for regulatory activities such as registration, monitoring on-going compliance and reviews.

13.5.2 Results of the latest NHS Patient Surveys are published on the CQC website. Each survey page shows England level results and provides access to Foundation Trust level results, including results of earlier surveys.

13.5.3 The Foundation Trust is developing strategies to make sure we make best possible use of the data the surveys provide alongside other patient feedback.

**What:** In 2015-2016 the participating areas were Maternity Services and Adult Inpatient Care.

**How:** All national patient surveys are provided for the Foundation Trust by Patient Perspective working closely with our staff. Provision is made for patients who do not read English, or need other support to take part. An in-depth analysis is provided by Patient Perspective, which is used alongside the CQC analysis to help staff understand the experience of patients and identify areas where improvement or change is needed.

**When:** On-going

**Outcome:**

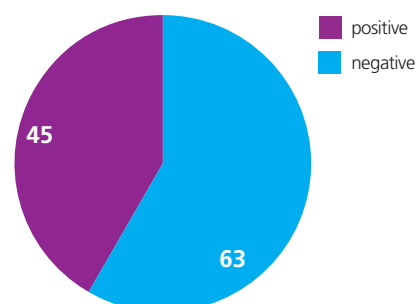**a)** **Maternity Survey 2015**

A total of 420 women who had used Bradford maternity services in February 2015 were sent a 57 question written survey; 139 questionnaires were returned, a response rate of 33%. This is a 5% increase on the 2013 Bradford survey, although the national trend has been a decreased response rate.

A workshop led by Patient Perspective was held to provide staff with better understanding into the findings and to support prioritised action planning for improvement. Work will follow on from this throughout the year, with progress being regularly monitored.

**Statistically significant changes**



Questions improved since 2013
Questions unchanged since 2013
Questions worse since 2013
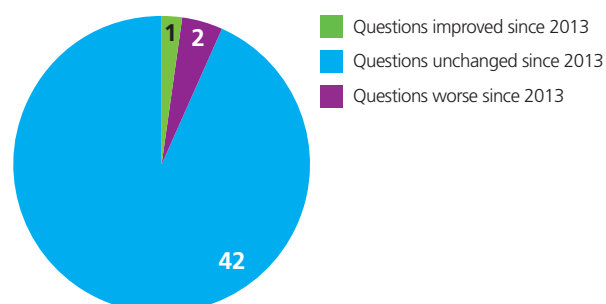
**Number of written comments**



positive
negative

**Maternity survey 2015**

|  | Antenatal care | Labour/ Birth care | Postnatal care | Feeding | Care at home after birth | General comments |
|---|---|---|---|---|---|---|
| **Positive comments** | 4 | 17 | 1 | 2 | 1 | 20 |
| **Negative comments** | 9 | 12 | 11 | 2 | 8 | 21 |

**b)** **Inpatient Survey 2015**

A sample of 1250 eligible adult patients who had received inpatient care during July 2015 was invited to take part in the survey. 475 surveys were returned completed, giving a response rate of 39.6%, a 3.5 % improvement on the 2014 survey.

The Trust scored in the bottom 20% of Foundation Trusts on 29 questions (including the overall rating of experience).

Since the 2014 survey, the Foundation Trust showed a 5% or greater improvement on 1 question score and a 5% or greater reduction in score on 21 questions.

- A workshop led by Patient Perspective is planned to provide staff with better understanding into the findings and to support prioritised action planning for improvement. Work will follow on from this throughout the year, with progress being regularly monitored.

**Statistically significant changes**



1
12
47

Significantly better
No change
Significantly worse
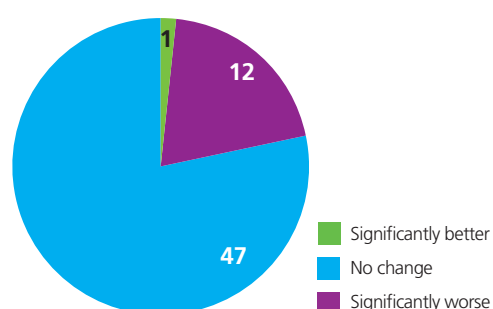
**Number of written comments by type**



566
223
197
146

Particularly good
Could be improved
Other
Total
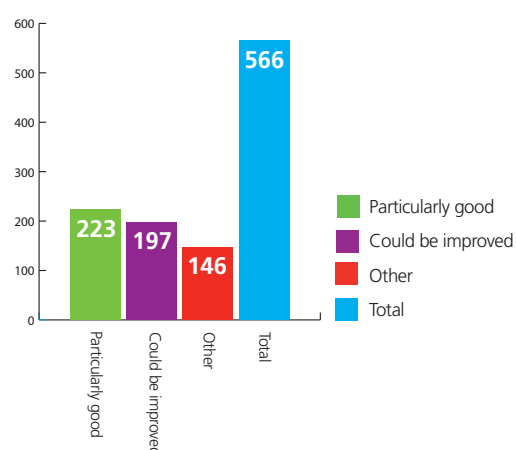
**Progress:** On plan

### 13.6 Patient led assessments of the care environment (PLACE)

**What:** Patient-led assessments of the care environment (PLACE) is a programme the Foundation Trust participates in every year. All providers of NHS funded care are encouraged to be involved in these unannounced assessments which aim to:

- Assess what matters to patients/the public;

- Reporting what matters to patients/the public;

- Ensure that the patient/public voice plays a significant role in determining the outcome.

    Assessments focus on the environment in which care is provided with particular emphasis on:

- Cleanliness (including hand hygiene).

- Staff appearance.

- General condition appearance and maintenance of buildings, fixtures and fittings including safety.

- Access.

- Dementia friendly environments.

- Privacy, dignity and wellbeing.

- Nutrition and hydration (including choice of food and drink and other elements of the food service assessed at the point of service on wards).

**How:** The assessments are undertaken over several months by teams of patient assessors supported by staff facilitators. The Foundation Trust asks all potential patient assessors and staff facilitators to attend training together before taking part in an assessment. All assessing teams include at least two patient assessors and teams must have a minimum ratio of 50% patient assessor representation in each team. Assessors are recruited from a variety of sources, including Healthwatch, voluntary and community groups, the Foundation Trust membership and Council of Governors, the Foundation Trust Involvement Register, local colleges and university, and through communications with the local press, media and Foundation Trust social media.

The Foundation Trust goes beyond the requirements of the formal process, using the opportunity to check on related areas and request action on issues which may not form part of the assessment criteria but which teams consider need to be addressed.

**When:** March – June each year. A modified version of PLACE-LITE is available and will become part of our on-going assurance and improvement programme.

**Outcome:**

Assessments were successfully carried out on all eligible sites. The range of times that assessments were carried out were varied so as to allow people to participate who cannot do so during office hours, and to sample the hospital environment at different times of day.

The number and diversity of people volunteering to be patient assessors improved in several respects in 2015 with more young people and people from BME communities taking part, through pro-active recruitment involved local colleges and local community networks. Unfortunately the number of disabled people declined in 2015 but plans are in place to address this working closely with Bradford Strategic Disability Partnership and Bradford Talking Media.

Results for each site and the Trust overall form the basis of a report to the Board of Directors, including an action plan. An overview of the 2015 results is shown below. The variance from the National Average is shown as a +/- figure in brackets.

### PLACE - overview of 2015 results

| Site /Domain | Cleanliness | Food (changes to scoring may have had negative impact on scores compared to last year) | Privacy, Dignity & Wellbeing (changes to scoring may have had negative impact on scores compared to last year) | Condition Appearance & Maintenance | Dementia Friendly Environment (new domain in 2015) |
|---|---|---|---|---|---|
| **National Average 2015** | **97.57 %** | **88.49%** | **86.03%** | **90.11%** | **74.51%** |
| **National Average 2014** | 97.25% | 88.79% | 87.73% | 91.97% | N/A |
| **BTHFT 2015 - Overall Scores** | 98.10 (+0.53%) | 80.67 (-7.82%) | 85.32 (-0.71%) | 86.31 (-3.8%) | 80.77 (+6.26%) |
| **BTHFT comparison to 2014** | +1.75% | -0.66% | +5.1% | -1.78% | N/A |
| **BRI 2015** | 98.02 (+0.45%) | 78.42 (-10.07%) | 86.92 (+0.89%) | 86.32 (-3.79%) | 82.13 (+7.62%) |
| **BRI comparison to 2014** | + 1.84% | -0.17% | +6.97% | -1.52% | N/A |
| **St Lukes 2015** | 98.38 (+0.81%) | 91.61 (+3.12%) | 76.93 (-9.1%) | 85.11 (-5%) | 76.09 (+1.58%) |
| **St Lukes comparison to 2014** | -0.41% | -4.18% | +8.29% | +3.08% | N/A |
| **Eccleshill 2015** | 98.84 (+1.27) | 95.78 (+7.29) | 80.77 (-5.26) | 86.89 (-3.22) | 71.27 (-3.24) |
| **Eccleshill comparison to 2014** | +1.76 | -3.68 | -1.09 | -5.52 | N/A |
| **Westwood Park 2015** | 99.21 (+1.64) | 97.62 (+9.13) | 73.98 (-12.05) | 89.98 (-0.13) | 66.97 (-7.54) |
| **Westwood Park comparison to 2014** | +0.9 | -1.57 | -2.15 | -4.25 | N/A |
| **Westbourne Green 2015 (not open in 2014)** | 98.55 (+0.98) | 91.83 (+3.34) | 73.33 (-12.7) | 89.74 (-0.37) | 67.15 (-7.36) |

**Progress:** On plan

# 14. Service transformation

**14.1     Summary review 2014-2015**

14.1.1   The central patient booking service, patient administration project and the people places and procurement programme were successfully implemented in April 2015. The remaining programmes were re-scoped and taken forward into 2015-2016 through the patient flow improvement group (PFIG).

**14.2     Transformation team and project management office (PMO)**

**14.2.1   Areas of focus 2015-2016**

14.2.1.1 The focus for the Transformation Team for 2015-2016 was to help set up and support the establishment and delivery of the Patient Flow Improvement Programme. The Foundation Trust Improvement Board (TIB) was established in September 2015 to oversee the Foundation Trust Quality Improvement agenda.

14.2.1.2 Towards the end of 2015 the transformation team appointed a project management office (PMO) lead, and established a project management office and PMO Hub to support the delivery of the 2016-2017 programmes.

14.3     Patient flow improvement group (PFIG)

14.3.1   The PFIG was established in June 2015 to oversee the delivery of six projects making up the programme.

**The objectives of the programme were to:**

• Improve patient flow for both elective and non-elective patients

• Support care closer to home in the community & virtual wards

• Improve admission processes for patients coming into hospital

• Optimise length of stay by improving discharge planning

14.3.2   Transformation managers worked across the Foundation Trust's directorates with managerial and clinical leads for each of the projects within the programme. The overall aims were to improve the patient experience, reduce delays and provide better patient flow.

14.3.3   Across the six projects, significant improvements have been made and various new systems and ways of working were successfully implemented during the course of 2015-2016. Some of these are highlighted through the summaries of the projects below.

**Summary of projects**

### Accident and emergency department (AED) development project

The overall objective of the project was to improve patient experience and flow through AED with prompt triage and assessment as well as timely decisions for discharge, admission or transfer. With increasing demand on emergency departments and the challenges of old buildings it was important to prioritise sustainable delivery of the four hour emergency care standard (ECS) and therefore the focus was centred on meeting the required national and local standards for quality and timely care of patients on an emergency care pathway.

### Development of the assessment model

A 'see & treat' model has been implemented with consultants at the 'front door' eighteen hours per day. There are plans to extend this to twenty four hours as staffing capacity allows and approval has been given to appoint additional nursing resource to support the AED streaming model.

A GP stream has been added to manage patients presenting with conditions more appropriately managed in primary care and as a result has reduced the overall demand on the emergency services.



### Investigation and referral pathways

For patients presenting with the most common conditions there are now revised protocols for blood tests and other investigations. This streamlines the process and ensures all patients get the appropriate tests quickly. Diagnostics investigations that contribute to the decision-to-admit are being carried out within AED.

To support patients who need specialist treatment AED Consultants now have the ability to admit patients directly to a ward when appropriate; the Patient Flow Policy is being reviewed to support this more robustly.

Internal emergency care standards detailed below are now being monitored fortnightly through the AED workstream and also reported fortnightly to the patient flow improvement programme.

### Internal Emergency Care Standards

- % of patients reviewed within one hour.

- % of patients reviewed within four hours.

- % of patients with treatment decision within one hour.

- % of patients discharged or treated with four hours.

### AED review clinics

AED review clinics, where patients have attended as an emergency and are brought back for a review, were looked at in detail. Following this the number of AED review clinics was reduced by two per week. This enabled consultants to be redirected to frontline AED assessments.

### AED redesign

The planning work for the AED redesign is complete. A contractor has now been appointed and work has commenced on phase one with the final build expected to be completed in autumn 2016. Work has commenced to design the new models of care and patient flow for the redesigned unit and this new way of working will be implemented as the new facilities become operational.

### AED future plans

The plans for specialties to have arrangements in place to review AED patients within thirty minutes of referral have been carried forward to 2016-2017.

Additional work is underway within orthopaedics to establish a virtual clinic for patients with simple/stable injuries which do not need specialist review. For patients with fractures that are known to heal well with time and use, no specific treatment is required and routine follow-up is unnecessary. This virtual clinic should reduce the need for a further two review clinics.

> **Specialty In-Reach**
>
> *When patients are admitted for assessment and are found to have specialty specific needs e.g. known heart conditions or impaired kidney function they may also need to be reviewed by a specialist while they are in the general assessment area.*
>
> *Specialists are called upon to offer support as necessary to the medical assessment team, called 'in-reach'. This prevents patients having to be admitted as inpatients to a ward for specialist review or their treatment being delayed due to wider complications.*

The clinical commissioning group are currently commissioning an urgent care centre and this will be carried forward to the 2016-2017 programme if our submission is successful.

**Acute medicine and ambulatory care**

The overall objective of the project was to improve patient flow for acute medical patients admitted to the acute medicine unit (AMU) and the ambulatory care unit (ACU). Knowing that there is a direct link between patient outcomes and early decision making the focus was directed at improving clinical outcomes and the quality of care by ensuring early senior clinical review and consultant review within fourteen hours of admission.

The project aimed to ensure that length of stay (LoS) within AMU was no greater than seventy two hours and that 'specialty in-reach', specialist support for patients on AMU was delivered by key services in a timely manner.

### Ambulatory care development

The ambulatory care unit (ACU), which opened in spring 2015, is an assessment area designed to take direct referrals from GPs and from AED. The unit focusses on patients unlikely to require an overnight stay and prevents 'trolley waits' for acute medical admissions.

The unit is open from Monday to Friday and since opening ACU consultant cover has been extended from 6pm to 7pm.

Protocols have been agreed and implemented to provide ACU access for medical referrals and pathways have been developed to support specialty in-reach access to ACU which has resulted in an increase in the number of patients admitted to the ACU (from 8% to 20% of emergency medical admissions).

The ACU has been shown to improve the quality of care and the outcomes for patients who previously may have waited for extended periods in AED. It also provides a better environment for these patients and reduces the number of patients being admitted as 'less urgent' patients to acute inpatient facilities. Work continues to increase the number of patients treated in ACU with a stretch target of 30% as an aim.

Further work is on-going to develop the staffing model and business case for a seven day service.

## Acute medical unit (AMU) Ward 4

### Refurbishment

Following on from the Ward 1 refurbishment, work has been completed on the link corridor between Ward 1 and Ward 4. Additional work is scheduled for Ward 4 in spring 2016 which will complete the AMU refurbishment.

### Review pathways & medical model

In order to facilitate efficient decision making and reduce delays an initial review of the medical model in AMU has been undertaken.

*Medical Model*

*The Medical Model is a staffing model that puts acute medical physicians at the start of the patient pathway. It has been shown to reduce the need for emergency admission and therefore reduce pressure on acute wards.*

*It takes into account the number of patients normally seen and matches expected activity with the appropriate levels of medical cover.*

*Patients benefit as they are assessed and treated more quickly and are less likely to deteriorate because of waiting for decisions to be made.*

Improvements have been made to the patients' pathways which have resulted in reducing the average length of stay for patients. Consultant cover has been increased to 7pm, seven days a week to facilitate this.

Improved referral processes to AMU from AED and GPs have been put in place to reduce waiting times for patients and improve flow. As in the ACU, protocols for improved specialty in-reach to AMU have been implemented to ensure patient safety and meet demand.

### Future acute medicine and ambulatory care plans

As part of the patient flow policy review further work is required to implement protocols to ensure patients with a stay over seventy two hours are transferred to an appropriate ward.

Additional work to review the medical model will be undertaken during 2016-2017 as part of on-going continuous improvement to deliver emergency care standards. The development of standard operating procedures (SOPs) for assessment and short stay AMU are due for completion April 2016.

## Acute surgery and ambulatory care project

The overall objectives of the project were to:

- Improve capacity within the surgical assessment unit (SAU).

- Support the delivery of the four hour emergency care standard.

- Ensure early senior review and consultant review within fourteen hours.

- Increase the use of ambulatory care pathways for acute surgical patients and;

- Support the delivery of urgent access theatre lists.

## Acute Surgical Medical Model

Development and implementation of a new medical and nursing model has commenced resulting in improved senior medical cover to ensure the review of acute admissions is undertaken within fourteen hours. The nursing model requires further work and will be progressed in 2016-2017.

*Hot Clinics*

*These clinics are designed for patients who do not need to be kept in hospital but are not able to wait for a regular outpatient appointment e.g. patients who require a follow-up in less than a week.*

*Typically the patient is reviewed at the hot clinic and either discharged or a plan is agreed for future management of their condition.*

Doctor rotas have been reviewed to ensure that acute patients in other specialties are reviewed by senior staff and decisions are made promptly to ensure patient safety and reduce unnecessary delays.

### Ambulatory care pathways

Ambulatory care pathways for acute general surgery and urology have been implemented and daily 'hot clinics' have been increased to meet current demand. A further review of capacity will be required in 2016-2017 as the increased confidence in the service is anticipated to increase demand.

Improved recording of hot clinic data has been implemented and further work is being taken forward in the 2016-2017 patient flow programme to improve SAU data recording and coding.

### Future Acute Surgery & Ambulatory Care

Approval has been given for the expansion of the surgical assessment unit, which will double the capacity of the unit from six to twelve beds. This will be completed in 2016-2017.

Further work is required to deliver equal access and processes for AED and GP referrals; this is scheduled for 2016-2017 also.

### Theatres project

The objective of the project was to improve our booking and pre assessment process to increase the number of patients treated. It also aimed to redesign and standardise working practices within theatres, day surgery and pre-operative assessment to enable improved theatre utilisation.

## Theatre productivity

Four eyes insight (FEI) were commissioned in September 2015 to undertake a theatre efficiency project. The FEI team have worked with the Foundation Trust management and clinical teams to support improved productivity and efficiency in theatres; these include improving the equipment repairs process, implementation of weekly scheduling meetings and agreement to implement a dedicated team to transfer patients to and from theatres.

This table below shows an increase in the numbers of patients booked for treatment for the majority of specialties.

**Theatre Productivity Autumn 2015**

| Number of Patients Booking by Specialty | | | |
|---|---|---|---|
| **Booked Activity** | | | |
| **Specialty** | **July / August 2015** | **October / November 2015** | **Difference** |
| ENT | 413 | 484 | +71 |
| Ophthalmology | 511 | 584 | +73 |
| Orthopaedics | 524 | 549 | +25 |
| General Surgery | 473 | 532 | +59 |
| Gynaecology | 292 | 367 | +75 |
| Urology | 330 | 305 | -25 |
| Totals | 2,543 | 2,821 | +278 |

## Pre assessment service review

Following a review of the pre-assessment appointment system improvements have been made resulting in an additional fifteen extra appointment slots available for patients requiring pre-assessment each week. In addition, a more flexible approach has been taken allowing for improved use of slots rather than restricting availability to a single specialty at key times.

## Theatres success story

Following her admission, a patient was at risk of being cancelled on a third occasion. Staff recognised the potential impact this could have had on the patient and rallied to ensure that a list scheduled for the following day was co-ordinated to ensure this lady could have her operation.

"I should like to commend the Nucleus theatre staff, for going the extra mile. This shows the care that we have for our patients, finding ways do the best for them and having consideration for the upheaval that cancelled operations has to their lives."

**Discharge planning and processes project**

The overall objective for the project was to improve discharge planning to reduce patient length of stay (LoS) and to identify and implement appropriate measures to highlight areas for further improvement.

### Discharge planning

A daily review of every patient and their plan for discharge takes place on every ward. This process is called the 'board round'. The 'board round' has been revised and all wards have implemented the revised process to undertake a review all patients by 10 am. All wards should be using expected date of discharge (EDD) as part of the 'board round' process to improve patient flow.

The patient information booklet has been revised along with a discharge checklist to assist with multi-disciplinary team planning of complex discharges. A visual chart above the bed head has also been implemented to support the identification of patients with circumstances or needs that are likely to result in a more complex discharge.

A system for formally recording telephone contact and enquiries from patients (or their carers) following discharge has been developed on the wards. This is to ensure that messages communicated are clear (e.g. medication, mobility, eating advice or queries about follow-up), that safety issues are picked up promptly and this will hopefully prevent readmissions.

### Discharge medication

The prescription tracking system has been successfully trialled and will be rolled out further from February 2016. This enables wards to track progress of medicines for patients to take home (TTOs) without telephoning the pharmacy.

Pharmacy assistant resource has been used to improve delivery times of TTOs to wards and early results show approximately a sixty minute improvement.

### Discharge lounge

The discharge lounge reopened on 2 November 2015. During 2015 patients using the discharge lounge were around 10% of total discharges (60 patients per month).

2016 has already seen an increase in usage with approximately 20% of all discharged patients (120 patients per month) using the facility.

> *Discharge Lounge*
>
> *The Discharge Lounge is based at Bradford Royal Infirmary and is open from Monday to Friday from 8am to 8pm with dedicated nursing staff managing the unit supported by a medical team.*
>
> *The Discharge Lounge is designed for patients who are being discharged from hospital but are not able to leave for non-clinical reasons.*
>
> *Often the patient is waiting for someone to collect them, either a relative or Patient.*

Work continues to increase the number of patients using the discharge lounge and to ensure patients are well supported as they leave hospital.

**Dragons' Den**

To encourage innovation within the Foundation Trust, the Dragons' Den was started in October 2015 where members of staff were invited to present their ideas for their services in front of an Executive audience. So far a range of schemes and initiatives, seventeen in total, have been suggested with some opting to present at the

*Dear all,*

*Thank you very much for the wonderful opportunity we had today to present our project and the overwhelmingly positive and encouraging response. Even though we were nervous, we felt encouraged and motivated by the response from the panel.*

*We are committed to making this project a success and strongly believe that this will go a long way in enhancing families' experience at a particularly difficult time.*

*Warm regards*
*On behalf of the neonatal team,*
*Chakra*

Dragons' Den and sponsorship offered by a variety of the Executive Directors. Some of the suggestions have already been adopted into Improvement Programmes with others in phases of further development.

This has added an element of competition and fun into the investigation and exploration of new ideas and has been well received at all levels.

The process of submitting a suggestion is flexible to accommodate a variety of ideas. These have come from across the Foundation Trust and have ranged from how patients are supported with feeding (service delivery models), to revision of whole service clinic and diagnostic provisions (amalgamation of several disciplines to revolve more appropriately around the patient) and ideas to reduce non-attendance at outpatient appointments.

### Patient Flow Improvement Programme

14.3.4   The 2015-2016 Patient Flow Improvement Programme ends in March 2016; scoping for 2016-2017 has started and is progressing well. A number of projects have work areas that will continue into 2016-2017.

14.3.5   The Patient Flow Policy is being rewritten with careful thought given to each of the areas within the Patient Flow Programme to ensure that:

- Patients are being reviewed appropriately with decisions made and acted on in a timely manner.

- There are clear protocols being included for direct admissions from accident and emergency department (AED) wards.

- Patients with lengths of stay in excess of 72 hours on assessment wards are appropriately transferred to inpatient wards.

- Internal hospital standards are identified, implemented and monitored.

**14.4     Transformation Team focus 2016-2017**

14.4.1   Work is currently on-going to scope out the improvement plan for 2016-2017. In order to deliver this work the Trust Improvement Board has established the seven foundation trust wide improvement programmes detailed below: Each of these seven improvement programmes are led by one of the Executive Team.

- Patient flow improvement programme.

- Workforce improvement programme.

- Outpatient improvement group.

- Going digital improvement programme.

- Estates improvement programme.

- Carter improvement programme.

- Programme for care and quality.

14.4.2   Towards the end of 2015 the Transformation Team established a programme management office (PMO) and a PMO hub for delivery of 2016-2017 programmes. The hub is designed to be a space where all the information relevant to the delivery of the transformation programmes can be shown visually and updated regularly.



14.4.3   The PMO hub is located in a large meeting room at the Bradford Royal Infirmary (BRI) site and the displayed information is reviewed as part of the weekly executive meetings. This enables some of the key information such as the objectives and leads for the programmes to be displayed alongside the performance targets and measurement information. It supports a proactive approach to managing the programmes and the projects they are made up of and, because of the visual displays, shows at a glance the elements of the programmes contributing to the successful delivery in each of the target areas.

# 15. Improved use of technology & e-solutions

15.1    The Foundation Trust will need to make best use of IT through e-solutions if the integration and transformation challenge is to be met successfully. The Foundation Trust appointed a Director of Informatics in 2013 to develop and deliver a clear informatics strategy aimed at addressing the Foundation Trust's needs to support the provision of responsive, high quality and integrated care.

15.2    Subsequently a clinician-led Clinical Informatics Strategy was developed and approved by the Board in 30 July 2014. The Clinical Informatics Strategy defined the focus and priorities for the next three to five years around an electronic patient record (EPR). The purchase of the EPR system was approved by the Board in February 2015. The Foundation Trust has secured a market-leading EPR system that has a track record of making care safer across all care settings. The development of information and technical strategies are now in progress to support clinical areas in the achievement of their quality and performance plans. EPR is the foundation of our programme and a high level of clinical engagement will be crucial to its success.

15.3    Introducing electronic patient records (EPR)

We are improving the way we manage health information:

**We are planning to introduce a new way to store patient records, known as an electronic patient records system (EPR)**

15.3.1    In February 2015, the Foundation Trust announced that it had taken a major step forward, working with Calderdale and Huddersfield NHS Foundation Trust to introduce an electronic patient records system – Cerner Millennium that will help us treat our patients more effectively. The NHS Integrated Digital Care Fund has provided some funding to support this initiative. Development of the system is progressing well.

**15.3.2    What will the introduction of EPR change?**

15.3.2.1 Computers are used to store all kinds of information, from our bank details to our online shopping. The NHS has recognised the benefits of storing information electronically as part of the 'Five Year Forward View'.

> EPR is more than a new computer system. It is helping us to look at how we can make the patient's experience better and improve how we work.

15.3.2.2 At present (before introducing EPR) our patient records are held in a number of different ways, including paper-based notes and computer records on a number of different systems. This means that different sets of information are in different hospital departments, even different hospitals, which could sometimes cause unnecessary delays.

15.3.2.3 Having up to date, accurate information, available to everyone, whenever they need it helps us to offer the best care we can and ensure that patients get the treatment they need. This is why we are introducing a new system. GP practices have been using systems like this for many years and now NHS hospitals and community services want to take advantage of the benefits.

15.3.2.4 This system has been specially designed to help us treat patients more effectively and to give healthcare staff quicker and easier access to up-to-date information about a patient's treatment.

### 15.3.3 What will EPR do?

15.3.3.1 Every time a patient uses one of our services or has an appointment with one of our staff we write down what was discussed, any treatments or advice received and any procedures. This is a patient record. This information is useful for many reasons. It helps clinicians to take advantage of the knowledge of everyone involved in a patient's care. It offers a continuous record so that patients do not need to repeat information to us. It also tells us things like what medicines patients are taking, and any allergies they might have. It also has results of any investigations.

15.3.3.2 With our new EPR system, this information will be held electronically in one place. All hospital staff who are directly involved with a patient's care will have some level of access to the system to enable updates to be done continuously.

### 15.3.4 How will EPR help us to make patient care safer?

15.3.4.1 Having a holistic view of a patient's condition will help clinicians to make better decisions. The intelligent computer system follows best practice 'care pathways' and takes the information clinicians put into it to suggest next steps. Computers can never replace the knowledge and good judgment of a clinician, but it can help to alert us and act as a guiding hand in our work. It could also alert us if a dose of medicine has been missed or a patient is due for an observation or test.

### 15.3.5 How will EPR help to manage the hospital?

15.3.5.1 EPR will hold information about all patients in the hospital. Using the information held, we will be able to see how many patients are in the hospital, where we have empty beds and also when we are expecting to discharge patients.

15.3.5.2 This means that we will be able to manage the flow of patients through the hospital and plan ahead. The system will help us with reporting (internally and externally) as well as supporting audit work. As an advanced scheduling and care management system, what we do in the system will help us deliver care more efficiently.

> We will be able to see how many patients are in the hospital, where we have empty beds and also when we are expecting to discharge patients.

### 15.3.6 Supporting staff through a major change.

15.3.6.1 There will be a lot of support for staff with the introduction of EPR. Initially, members of the EPR programme team are visiting work areas and clinical teams to provide some basic information about the new system and its benefits.
The EPR training team are looking at people's learning needs and may provide additional basic IT training if required.

15.3.6.2 Following this, everyone who needs training will be invited to attend and have the opportunity for hands on learning. We will also be offering informal learning, simulation and drop in opportunities. During the "go live" period we will have a team of people in both Foundation Trusts to give hands-on support as well as fast response on the end of the phone. Each area will also have advanced users within the team who will receive additional training to support colleagues.

15.3.6.3 The Foundation Trust is planning to introduce a lot more computers and devices for staff to use. A full evaluation of this is being undertaken to understand what equipment is required. The computers and other devices that people will use to access EPR will use Wi-fi so that they are as portable as possible, and we are reviewing Wi-fi connectivity as part of the programme.

15.3.7 Will patient records be available to everyone who needs them, 24 hours a day?

15.3.7.1 Clinicians will use EPR to do all of their work, twenty four hours a day, so it is important that access is uninterrupted. Our chosen EPR, Cerner Millennium is used widely across the UK and in other countries and the general experience is that down-time is infrequent. If the system stops working there are several back up plans.
Staff will be able to use a back-up system called '24-7' which will still give access to essential information. In addition to this, 'down-time' procedures will be developed so that clinicians can record important information until the system is working again.

### 15.3.8 Confidentiality

15.3.8.1 Only those directly involved in a patient's care will be allowed access to patient records. To do this they will have been assigned a secure access method which is unique to them (like the card and PIN number used to take money from a bank account). They will have their details recorded for every action that is taken on the system.

15.3.8.2 As an NHS organisation we have a legal duty to protect confidentiality and keep all information secure. The NHS Care Record Guarantee for England, which we work within, says how the NHS will collect, store and allow access to electronic records and choices for how a patient's information is stored and looked at. It has been published by the National Information Governance Board for Health and Social Care (NIGB).

For further information about the EPR programme please contact:
EPR-enquiries@this.nhs.uk, or visit the programme website: www.epr.this.nhs.uk

## 15.4 Improved digital communication

15.4.1 In the past year the Foundation Trust successfully completed several projects to improve communications with primary care. These included the full roll out of electronic communication of discharge summaries and death notifications. In addition we continue to work with the Bradford, Airedale, Wharfedale, and Craven Integrated Digital Care Record Board to ensure integrated care is supported with technology, in particular health records. Following extensive discussions with Bradford and Airedale GPs the parallel paper flow of discharge summaries and outpatient clinic letters being sent to GPs is being stopped, providing efficiencies at both the Foundation Trust and GP practices.

15.4.2 The Foundation Trust continued work on adoption and use of a system to allow more effective management of admissions, discharges and transfers (ADT). This system will ensure that the Foundation Trust makes the most effective use of its capacity by ensuring that bed management data is more readily accessible and can be acted upon promptly. This improves patient flow and will provide a better care experience for patients.

15.4.3 Last year the Foundation Trust revamped its public-facing website and this year the Foundation Trust has worked towards updating its internal intranet that is expected to be in use in a few months' time.  This overhaul will provide a foundation for more effective internal communication, complemented by advancements into social media.

## 15.5. Making information easier to use

15.5.1 The Foundation Trust is moving towards the use of interactive dashboards to monitor performance and quality with specific investments in improvement. The dashboards are providing an easy to understand method of interacting with information that was not available previously. In 2016-2017 dashboards will be deployed and used in group meetings.

15.5.2 To support improved information, the Foundation Trust is also implementing an industry-standard datawarehouse which has passed a technical "go-live" test and will be available for use in 2016. The datawarehouse will underpin the dashboards and will connect with the new electronic patient records (EPR) so that we will have a comprehensive set of information for clinical and management use. This new tool will provide near real-time access to a wealth of administrative and clinical data across the Foundation Trust.

15.5.3 The Foundation Trust implemented tools this past year that collect nurse staffing and patient acuity levels across both adult and paediatric areas. These tools will assist us to understand workloads and staffing levels.

### 15.6 Keeping our technology current for clinical care

15.6.1 The Foundation Trust also updated technical infrastructures to ensure that we do not interrupt clinical care. This included upgrading a number of information systems; more will be done in the next financial year as part of maintenance and improvement.

15.6.2 The Foundation Trust is a leader this year initiating a nine-Trust joint procurement for it's a regional imaging solution. Work is on-going with the Trusts and is expected to provide a solution that will improve the patient experience in imaging regionally, be cost effective, and provide a foundation for networked working.

15.6.3 In 2015-2016, the Foundation Trust is deploying a chemotherapy e-prescribing solution to harness technology in making chemotherapy safer alongside the Electronic Patient Record. This year we implemented a system that will allow us to capture patient feedback in real time in a way that is easy for patients, as well as streamlining portering processes through the implementation of a portering management system.

15.6.4 The Foundation Trust made improvements this year to support the management of patient pathways with the implementation of a new pathway information management tool and online forms to declare and track next steps in a pathway.

# 16. How we keep everyone informed

**16.1**   The last twelve months has seen a number of new initiatives which are improving the way we communicate with our staff and members of the public.

**16.2**   **Social media**

16.2.1   NHS social media pioneer and nurse leader, Anne Cooper, helped us launch our social media campaign. She spoke with staff and patient representatives about how social media can be used to communicate with and involve patients and the public as well as for professional networks. This kick-started our use of Twitter and Facebook to keep people up to date with news, events and allow them to provide feedback on our services.

**16.3**   **#hellomynameis campaign**

# hello my name is…

16.3.1   We also adopted the #hellomynameis campaign across our hospitals and thousands of staff took up the pledge. #hellomynameis is not just about healthcare workers introducing themselves to patients. It is also about seeing the person behind the condition, making a human connection and building trust.

16.3.2   A consultant in elderly medicine at The Mid Yorkshire Hospital NHS Trust, designed the initiative. She has terminal cancer. Through her continued treatment, she developed a unique insight into life as a patient in a hospital. She could not help noticing that, although staff were very professional, not all of them seemed to remember they were dealing with real people rather than anonymous patients.

Based on her experiences of being a patient and a doctor, she launched #hellomynameis and we have been proud to adopt this campaign and make our pledges.

**16.4**   **Weekly bulletins**

16.4.1   A new weekly staff bulletin called Let's Talk was launched and is sent out from the Chief Executive. This bulletin encourages staff to submit stories and share their thoughts. As well as Let's Talk, staff have other access to information through our intranet, monthly core briefings, weekly email updates, individual directorate briefings, screensavers and new staff learn about the Foundation Trust through a new and improved corporate induction.

### 16.5 Listening events

16.5.1 We have continued our programme of listening events with the Chief Executive and Executive Directors. All members of staff are welcome to attend and can ask questions, raise a concern or request information or advice. These open sessions ensure staff are aware of the patient safety, clinical, financial and economic factors affecting our performance.

### 16.6 Local press releases

16.6.1 We continue to celebrate our successes and achievements in local newspapers and on local radio. The organisation has achieved lots of positive media coverage over the last twelve months, a year which has seen our staff make history and propel our work onto the national and international stage.

### 16.7 Information for members

16.7.1 Our Foundation Trust members like to keep up-to-date with our latest developments and a new website was developed to engage with the local community and support better engagement and involvement between our governors, members and the public.
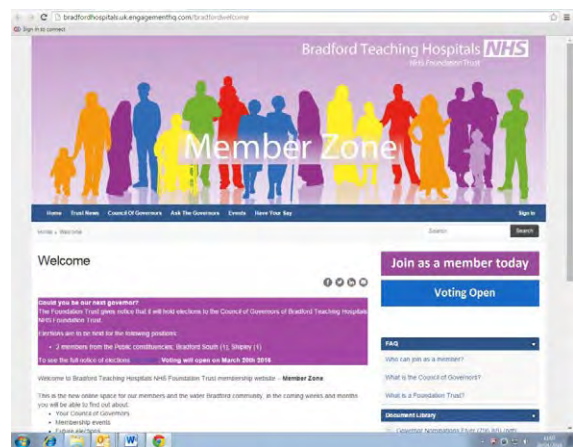
## Statements from Clinical Commissioning Group, Healthwatch and Overview and Scrutiny Committee

Bradford Teaching Hospitals NHS Foundation Trust has fulfilled its duty in providing a copy of their 2015-2016 Quality Report to the relevant Clinical Commissioning Groups, Bradford and District Healthwatch Group and the Health Overview and Scrutiny Committee.

The Foundation Trust has received the following statements in response:

**NHS**

**NHS Bradford City CCG**
**NHS Bradford Districts CCG**
Douglas Mill
Bowling Old Lane
Bradford BD5 7JR

Tel: 01274 237290
Fax: 01274 237453

**Bradford City and Bradford Districts Clinical Commissioning Group Feedback on: Bradford Teaching Hospitals NHS Foundation Trust Quality Account 2015/16**

On behalf of Bradford City and Bradford Districts Clinical Commissioning Groups (CCGs), I am delighted to provide feedback to Bradford Teaching Hospitals NHS Foundation Trust (BTHFT) on its Quality Account 2015-16.

Following the Care Quality Commission (CQC) inspection in January 2015 and report published in April 2015, BTHFT received a CQC overall rating of requires improvement. 2015/16 has been a challenging year for the Trust and I note how much progress has been made against the key areas identified by the CQC and how hard staff have worked to achieve this progress.
This is noteworthy given the difficulties experienced in recruitment to key staffing roles, and the pressures the Trust has faced with the increase in attendances to the Accident and Emergency (A&E) department compared to 2014/15.

I also welcome the opportunity for staff from the Bradford CCGs to be involced in the Trust's improvement plans, where appropriate, and appreciate the transparency of the conversations that have taken place between key individuals of both organisations to enable a greater level of assurance.

I note the immediate and on-going actions taken in response to the CQCs concerns. These included actions to improve outpatient referral to treatment, the care of patients requiring non-invasive ventilation, and the stabilisation of children.

We await the next CQC report following their focused follow-up visit (January 2016) and will continue to support BTHFT in implementing further recommendations.

BTHFT continues in its aspiration of service quality improvement and has demonstrated improvements over 2015/16 regularly engaging with staff and patients throughout this period. The Quality Account provides many examples of these improvements.

The Trust has identified Priority Goals for improvement for 2016/17, many of which are continuations from 2015/16.

During 2015/16 the majority of the quality priorities were met, the following areas were particularly noteworthy:

- A continued focus on improving the management of diabetes in the acute care environment through the think glucose campaign and through an increase in the number of patients visited by a member of the diabetes team. The CCGs particularly welcomed engagement in the CCGs structured collaboration for diabetes is a good example of the Trusts commitment to working with tis strategic partners in the district.

- Improved patient satisfaction scores on patient mealtime experience has resulted from the introducing a gluten-free menu and participating in a nutrition and hydration week.

  We note that 74% of patients have rated meal services as good or excellent. I understand that further improvements will include a review of elderly care menus and a specific oncology menu.

- Improved communication with patients whose first language is not English enabling them to give informed consent to treatments and to participate in their care, which in turn resulted in a reduced number of complaints.

**BTHFT has identified its priorities for quality improvement for 2016/17.**
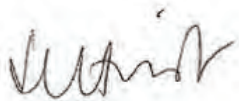**The CCG welcomes the three priority areas, namely:**

- Safety:hospital-acquired pressure ulcer reduction

- Effectiveness / safety: safer procedures

- Experience:patient, family and carer experience

**The Quality / Account provides details of other activities that complement the achievement of the 2016/17 priorities including:**

- The steps being taken by BTHRT to make best use of Information Technology, e.g by the creation of a Trust Data Governance Group which will oversee actions to improve clinical coding following the information governance audit, which highlighted areas for improvement in coding patient care. The Trust's forthcoming Implementation of an Electronic Patient Records system (autumn 2016) is also expected to deliver significant improvements in the accuracy and quality of data and underpin safety and efficiency in patient care. These measures are welcomed by the CCGs.

- The continued improvements to patient flow through the hospital system especially in A&E and in the new ambulatory care unit.

- The Trust's significant contribution to research activities is acknowledged in the account, BTHFT continues to lead nationally in conducting applied research, hosting the Yorkshire and Humber Academic Health Science Networks Improvement Academy. Trust research focused on the needs of the frail elderly and residents of care homes resulted in an electronic frailty index to analyse frailty and disability which has now been rolled out to GP practices across England allowing them identify better treatment options for frail elderly patients. The CCGs commend the Trust research teams ongoing work of this type.

- The CCGs welcome the ongoing use of leadership walk-rounds and the use of various initiatives such as the trust SAFE programme to progress improvements in care and services. In 2016/17, I would welcome rapid CCG inclusion in the Trust's leadership walk-rounds.

Improving patient engagement and experience are acknowledged within the Quality Account: the Trust has taken steps to involve and respond to patient suggestions and concerns. Although many compliments are received about BTHFT services, some patients do not always experience the service and care they expected. The CCGs note that the CQC maternity survey (2015) results were more negative than positive, with the Trust's maternity services in the bottom 20% of Trusts nationally on 15 questions. The Trust will pursue improvements in these areas during 2016 working with health and social care partners in this area.

- The CCGs acknowledge the Trust's actions in response to staff survey results, both to retain and develop a talented workforce, and to address bullying and harassment. Along with other West Yorkshire providers, the Trust is taking active steps to recruit and retain staff through a variety of workforce initiatives but it continues to struggle to recruit in a number of key areas and is affected by the current agency cap.

- BTHFT reported two Never Events during 2015/2016 and whilst it is clear that significant work is underway to improve patient safety, specific reference to Never Events should be made in the account.

- We note the Trusts reduced performance against the Sentinel Stroke National Audit Programme date suggesting poor outcomes for the residents of Bradford. We understand, however, your difficulties in recruiting appropriately skilled workforce to meet these outcomes providing a sustainable service in West Yorkshire.

- The Bradford CCGs would like to compliment the Trust's engagement in supporting the CCGs strategic programmes to improve the health of the Bradford population.
We look forward to continuing to work in partnership with BTHFT in delivering high quality, effective care for our patients.

- We would also welcome building on the current level of engagement in the development and execution of the systems Sustainability and Transformation Plan for Bradford and the region to reduce the care quality gap.

- Finally I am required to confirm that the Bradford CCGs have reviewed the Quality Account and believe that the information published provides a fair and accurate representation of the Trust's achievements over the last year and its commitment continuously to improve the quality of patient care. The statements of Assurance has been completed, providing evidence that the Trust has engaged in initiatives linked to quality improvement, placing the specific health needs and diversity of the local population central to everything they do.

- I can also confirm that the Bradford CCGs have taken reasonable steps to validate the accuracy of information provided within this Quality Account and can confirm that the information presented appears to be accurate and fairly interpreted: the Quality Report demonstrates a high level of commitment to quality improvement: we commend and support the positive approach taken by BTHFT.

**Helen Hirst**
**Chief Officer**
**NHS Bradford City CCG and NHS Bradford District CCG**

As previously reported in our 2014-2015 Quality Report, the Healthwatch Group advised they were no longer reviewing Quality Reports.

In April 2016, following receipt of our draft 2015-2016 Quality Report, the Health Overview and Scrutiny Committee verbally advised us that as they communicate, engage and provide regular feedback to the Foundation Trust throughout the year, they would not be providing comments on our 2015–2016 Quality Report.

**Statement of directors' responsibilities in respect of the quality report**

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

Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support data quality for the preparation of the Quality Report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual (ARM) 2015-2016 and supporting guidance;

- 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 2015 to May 2016

    - papers relating to Quality reported to the Board over the period April 2015 to May 2016

    - feedback from the commissioners dated 05/05/2016

    - feedback from governors dated 12/05/2016

    - feedback from the local Healthwatch organisation dated N/A

    - feedback from the Overview and Scrutiny Committee dated N/A

    - the Foundation Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009 dated 25/05/2016

    - the latest national in-patient survey dated 08/06/2016

    - the latest maternity survey dated 15/12/2015

    - the latest national staff survey dated 03/03/2016

    - the Head of Internal Audit's annual opinion over the Foundation Trust's control environment dated 17/05/2016

    - Care Quality Commission Intelligent Monitoring Report dated 29/05/2015

- the Quality Report presents a balanced picture of Bradford Teaching Hospitals NHS Foundation Trust's performance over the period covered;

- the performance information reported in the Quality Report is reliable and accurate;

- there are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;

- the data underpinning the measures of performance 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 manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.
(published at www.monitor.gov.uk/annualreportingmanual).

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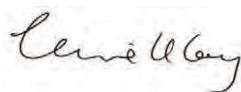
**By order of the Board**

26/05/2016

**Professor Lord Patel of Bradford OBE,**
Chairman

26/05/2016

**Professor Clive Kay,**
Chief Executive

## Independent Auditor's Report to the Council of Governors of Bradford Teaching Hospital on the Annual Quality Account

Independent Auditor's Report to The Council Of Governors of Bradford Teaching Hospitals NHS Foundation Trust On The Quality Report

We have been engaged by the Council of Governors of Bradford Teaching Hospitals NHS Foundation Trust to perform an independent assurance engagement in respect of Bradford Teaching Hospitals NHS Foundation Trusts Quality Report for the year ended 31 March 2016 (the Quality Report) and certain performance indicators contained therein.

### Scope and subject matter

The indicators for the year ended 31 March 2016 subject to limited assurance consist of the following two national priority indicators (the indicators):

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period: and

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge

### 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 and supporting guidance issued by Monitor.

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

- The Quality Report is not prepared in all material respects in line with the criteria set out In the NHS Foundation Trust Annual Reporting Manual and supporting guidance;

- The Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2015/16 (the Guidance) and

- The indicator 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 supporting guidance and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and supporting guidance and consider the implications for our report if we become aware of any material omissions.

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

- Board minutes and papers for the period April 2015 to May 2016

- Papers relating to quality reported to the Board over the period April 2015 to May 2016

- Feedback from commissioners

- Feedback from governors

- The Trust's complaints report published under regulation 18 of the local authority social services and NHS complaints regulations 2009

- The national patient survey published in May 2015

- The national staff survey published in February 2016

- The 2015/16 Head of Internal Audit's annual opinion over the Trust's control environment and

- The May 2015 CQC Intelligent Monitoring Report

We have not been able to review consistency with feedback from the local Healthwatch organisation or the Overview and Scrutiny Committee. This feedback was requested by the Trust on the 12 February and 20 April 2016 but not received by the date of this report.

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

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

This report, including the conclusion, has been prepared solely for the Council of Governors of Bradford Teaching Hospitals NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2016, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Bradford Teaching Hospitals NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

## Assurance work performed

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

• Evaluating the design and implementation of the key processes and controls for managing and reporting the indicator

• Making enquiries of management

• Testing key management controls

• 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 and supporting guidance to the categories reported in the Quality Report: and

• Reading the documents

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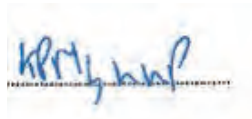
The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary.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

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Bradford Teaching Hospitals NHS Foundation Trust.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2016:

- 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 and supporting guidance.

- The Quality Report is not consistent in all material respects with the sources specified in the Guidance: and

- The indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and supporting guidance and the six dimensions of data quality set out in the Guidance.

26th May 2016

**KPMG LLP**
Chartered Accountants
1 St Peter's Square
Manchester
M2 3AE

**Appendices**

**Appendix A: National Clinical Audits for inclusion in Quality Accounts 2015 – 2016**

| Title of audit | Report produced | Actions |
|---|---|---|
| **Audits undertaken to assure the implementation of action plans developed from the result of serious incident investigations** | | Three audits have been undertaken to assure the implementation of action plans developed from the result of serious incident investigations. The audits demonstrated variable compliance with the action plans which was addressed locally. They also highlighted the need to improve how action plans are articulated to ensure that they are easily audited for their effectiveness. |
| **Audits to assure compliance with CQC Essential Standards** | | The Foundation Trust manages a program of audits, as described in its high priority audit plan, which is designed to provide assurance in relation to CQC fundamental standards. The actions associated with each audit are managed at local workstream level but with a corporate overview of the outcomes and actions. The Foundation Trust is actively reviewing this programme of audits in relation to the application of the CQC's fundamental standards to the regulated activities. |
| **SAFE! Programme/Quality Improvement Programme** | | The Foundation Trust has implemented a structured program of audits within the SAFE! Programme, the actions of which are managed within the governance structure of the programme. Clinical audit has predominantly been used to confirm implementation of quality improvement initiatives. Any patient safety incidents that are identified during the audit process are reported to the risk management team and investigated as appropriate. |
| **Medical management of early miscarriage** | April 2015 | The actions that were taken to address the findings and recommendations of this audit are to:<br>• review and update the medical management of early miscarriage guideline accordance with the NICE recommendations.<br>• the audit found a higher uptake of conservative management and hence increased length of inpatient stay with new regime. Therefore, the medical management protocol and procedure were reviewed and changed accordingly. |
| **Bedside Transfusion Practice and Patient Observations** | April 2015 | The key recommendation from this audit was to continue to reinforce good practice during mandatory transfusion training and competency assessments in relation to preparing to administer blood to patients.<br>• discussed audit results as part of the transfusion key assessor forum for dissemination to the key assessor's clinical colleagues.<br>• continued to encourage staff to attend yearly mandatory transfusion training. |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Head Injury – Accident and Emergency Department** | December 2015 | A number of actions were planned to address the findings of their audit including:<br>• increase completion of head injury pathway.<br>• performed neuro-observations at appropriate frequency.<br>• clinical supervisors to establish competency of the non-training middle grade doctors.<br>• ensured quality of care, documentation was maintained and/or improved following of EPR. |
| **HMDS Referral Case Audit 2014** | November 2015 | This audit compared the diagnosis in Bradford with the "gold standard" diagnosis from the HMDS. The audit findings indicate 100% accuracy of diagnosis of both benign and malignant lymphoid conditions on initial histological examination in the BRI.<br>• in 78% of cases the exact diagnosis confirmed by the HMDS was made.<br>• there were no cases of benign/malignant or malignant/ benign diagnostic mismatch.<br>The recommendation was to repeat this audit on an annual basis. |
| **Audit of temporal artery biopsies from 01/10/14 to 30/09/15** | October 2015 | The key recommendations from this audit findings are:<br>• to assess whether biopsy result affected/influenced patient management.<br>• correlate the audit results with clinical findings. |
| **Audit of liver biopsies histopathology reports** | December 2015 | The audit findings suggested that standards of reporting of liver biopsies in Foundation Trust are generally excellent. However, a number of actions are being taken to address the recommendations of this audit are:<br>• to take more care to ensure sufficient description of the background liver histology in targeted biopsies where necessary.<br>• continuous work is required to maintain this high standard of reporting.<br>• to conduct a re-audit in a year time. |
| **Drug monitoring compliance 2015** | December 2015 | As a result of this audit, the importance of motivational interviewing to support compliance was highlighted, to complement actions related to the implementation of electronic monitoring. |
| **Cardiology Consent Audit** | October 2015 | The actions that are being taken to address the findings and recommendations of this audit are:<br>• all CMTs to undergo training by SpR/Consultant early in their placement for all common cardiological procedures.<br>• mini-cex to be performed prior to independent consenting.<br>• for elective cases initial consent in outpatient clinic with patient information to be given and repeat consent when admitted.<br>• emergency consent are fully compliant with identification of all risks and benefits. |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Myocardial Perfusion Physicist Reporting (Extended Role) Audit 201** | September 2015 | The audit report recommended improving the continuous professional development programme for physicist and to carry on the extended role for another year. |
| **Safeguarding Families document transfer between maternity and the neonatal unit** | October 2015 | This audit was aimed to review the transfer of identified safeguarding information for baby's being transferred to the neonatal unit (NNU) following delivery, where safeguarding concerns existed. <br><br>The actions are:<br>• to repeat the audit in April 2016.<br>• results of the audit shared at the lessons learned event, and displayed on the safeguarding children website with the recommendations.<br>• organise a lessons learned event for information sharing throughout the Trust, but particularly within NNU and maternity services to encourage the transfer of information. |
| **Discharge Letters Documentation** | November 2015 | A number of actions are planned to address the findings of this audit including:<br>• organise a brief teaching session for junior doctors, part of their induction programme to highlight the importance of putting adequate information in the discharge summaries.<br>• to review the current template improving areas such as contact number, clear diagnosis without abbreviations, weight, clear plans for hospital follow-up and GP follow-up, investigation recording, documenting that information has been given to patient etc.<br>• to repeat the audit in a year time. |
| **Children's Community Team Physiotherapy Suction Pathway Re-Audit** | October 2015 | The audit findings suggested that there was a steady rise in numbers in the referrals and hence it was recommended to make enough money available to buy suction machine in a timely fashion and not when there is a crisis of need.<br>• all families need to sign an equipment loan form when being loaned a suction machine.<br>• Foundation Trust to find a system to recoup any financial loss or equipment or damage to equipment from the families. |
| **Audit of intercostal chest drain insertion** | October 2015 | As a result of this audit the Foundation Trust has redesigned a new monitoring chart where it could document that the guide wire has been removed. The audit results had been sent to relevant areas.<br>The audit will be repeated in September 2016. |
| **Audit of Excision Depth and single v's multiple samples (pieces)** | June 2015 | The aim of the audit is to assess the unit's performance in relation to national treatment targets set. The audit findings suggested that the Foundation Trust has shown a considerable improvement on the previous audit figures by 11%.<br>This audit will be repeated in June 2016. |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Adequacy of discharge summaries for paediatric patients in BRI** | November 2015 | A number of actions are planned to address the findings of this audit including:<br>• organise a brief teaching session for junior doctors as part of their induction programme to highlight the importance of putting adequate information in the discharge summaries.<br>• to review the current template improving areas such as contact number, clear diagnosis without abbreviations, weight, clear plans for hospital follow-up and GP follow-up, investigation recording, documenting that information has been given to patient etc.<br>• to repeat the audit in a year time. |
| **Emergency Contraception Usage** | July 2015 | The aim of this audit was to ensure the Foundation Trust meeting the auditable standards set out by the Faculty of Sexual and Reproductive Health.<br><br>As a result of this audit, the Foundation Trust reviewed the way patients are offered testing in clinical practice resulting increased uptake of STI screens offered to patient attending for emergency contraception and increased uptake of quick starting on method. It was also suggested to recall for those patients attending for emergency contraception, due to window periods may be too soon to test; use text reminder service. |
| **Audit of Prescription Charts on ward 15 - June 2015** | May 2015 | The audit findings suggested that Foundation Trust oncology ward is performing well to minimise the risk of any untoward incident and the prescribing practice is safe.<br>Actions were identified to:<br>• develop a poster to reinforce the safer practice.<br>• re-audit to measure performance. |
| **Collection and receipt of blood onto the clinical area** | August 2015 | A number of actions were planned to address the findings of this audit including:<br>• continue to include the correct procedures and information needed on completing the collection slip accurately in relevant blood transfusion training.<br>• continue updating training dates on the intranet so they are made available to staff across the trust to book onto training promptly.<br>• aim to review and update key assessors on a yearly basis to ensure they are competent to assess staff in their clinical department in the relevant competencies.<br>• a local audit to interrogate a sample of collection slips to determine whether there are being completed effectively and utilised throughout the transfusion process.<br>• re-audit date: March 2018. |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Prescribing Audit In Neonatal Unit Re-audit (Cycle 8)** | June 2015 | From the audit findings it was recommended that to:<br>• ensure medicine units are clear and legible for all prescriptions.<br>• rounding up appropriately when prescribing antibiotics i.e. = 165mg = 1.6mls and not 1.65ml.<br>• for postnates-checking the antibiotics and signing it after administration. Also to document in the notes along with the time given.<br>• sign along with the date when stopping the antibiotics.<br>• consider introducing a front sheet or a column on the nurses' sheet to write all the courses of antibiotics received with start and stop dates in premature babies or babies with prolonged stay. |
| **Post Natal Bladder Management** | October 2015 | As a result of this audit the Foundation Trust updated intrapartum partogram to include fluid balance charts, time, volume and method of bladder emptying etc. The action was also taken for regional cases to have foley's catheter during intrapartum.<br>A number of other actions were also identified during the postnatal period including:<br>• updating local guidelines and to include enhanced recovery programme.<br>• providing bladder scanning training for staff, involving urogynaecology nurses<br>• patient to document own volumes and times with instructions, provide patient information leaflet and jug.<br>• updating postnatal care plan grid. |
| **Early Expression of Breast Milk for Preterm Babies** | October 2015 | The action taken following this audit was developing a care plan to support expression and piloted on neonatology unit.<br>Other actions were to:<br>• recruit a Breast Feeding Support Worker.<br>• re-audit in summer 2016. |
| **An Audit of the Investigation of Urinary Tract Infections in Children** | October 2015 | The aim of this audit was to evaluate the current practice of paediatric urinary tract infection at the Foundation Trust and evaluating the use of radiological investigations and adherence to current NICE guidelines. The audit information shared with clinicians.<br>The actions were taken following the audit were:<br>• reinforcing the NICE guidelines.<br>• introducing DMSA following US for recurrent Urinary Tract Infection for more than 3 years routinely.<br>• re-audit to close the cycle. |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Lilac Clinic Safeguarding documentation Audit 2015** | May 2015 | The audit results showed that staff were making considerations for providing care for under 18 year olds and using the dedicated pro-forma in the majority of the cases as recommended in the previous audit. The result of the audit was shared with the team. |
| | | As a result of this audit the Foundation Trust has taken s number action to: |
| | | • ensure staff using the pro-forma for all patients under 18 who attend for services. |
| | | • ascertain if staff need further support or training on key areas of the pro-forma. |
| | | • considering any required amendments to the form following consultation with staff. |
| | | • liaise with medical illustrations to format the under 18's pro-forma and following the decision by the Matron, to either make the form available to order as a standalone document add to the existing Lilac pathway. |
| | | • consideration by clinic and administration staff on a way to secure the Lilac pathway in the medical records in all cases, to prevent the loss of confidential information from the medical notes. |
| **Badger transfer letter standards** | June 2015 | The findings from this audit were shared across the division. The results suggested that there were clear benefits to badgernet as poor documentation impacts quality of care for patients. |
| | | The actions from this audit were to use existing network guidance and to improve written transfer communication in the region by providing local training sessions. |
| **Patient Consent (Trust)** | April 2015 | As a result of the findings from this audit the Foundation Trust taken actions to: |
| | | • provide adequate training for junior doctors to consent for procedures during their induction programme. |
| | | • emphasise during induction, the list of procedures that they can consent for and train accordingly. |
| | | • plan re-audit in April 2015. |
| **The use of Methotrexate in suspected ectopic pregnancy** | November 2015 | A number of actions were identified from the results of this training including: |
| | | • edit guideline to cover HCG intervals to be at least 48 hours apart on 3 consecutive measurements. |
| | | • increasing staff awareness of importance of NEWS for women with PUL. |
| | | • devising a pathway to reduce incidence of missed consent and ease re-audit. |
| | | • using procedure specific consent form to improve documentation of side effects and precautions, specifically to avoid pregnancy for 4 months following methotrexate. |

| Title of audit | Report produced | Actions |
| --- | --- | --- |
| **Reasons given by patients for cancelling appointments** | April 2015 | This audit was carried out as part of a service improvement program to reduce DNA and cancellations within psychology services. The results of the audit suggest that clinicians may need to work more flexibly in delivering psychological therapies. In response to the recommendations, a discussion of the implementation of routinely offering telephone consultations to patients when they cancel was held at department meeting. It was also recommended to re-audit of cancellation reasons. |
| **Diabetes Nurse Prescribing Audit** | July 2015 | The audit has not identified that any changes need to be recommended to practice.  The diabetes nursing teams need to continue prescribing within their areas of clinical competence. |
| **Neonatal hypothermia** | June 2015 | The audit highlighted the fact that delayed cord clamping and skin to skin contact have become 'the norm' in midwifery practice. A number of actions were taken in response to the outcome of this audit, which are: <ul><li>reviewing audit form to prevent misinterpretation and encourage completion by staff.</li><li>reconfigure 'cold baby' audit form to include practices surrounding delayed cord clamping.</li><li>re-audit during colder months of the year.</li></ul> |
| **Aetiological investigations for children and young people with permanent hearing loss** | April 2015 | The audit was undertaken to evaluate the current practice of offering Level 1 aetiological investigations for children with permanent hearing loss and to compare it against the national guidelines published jointly by British Association of Paediatricians in Audiology and British Association of Audio-vestibular Physicians. Actions taken by the Foundation Trust are: <ul><li>documented reasons for families refusing investigations.</li><li>considered reviewing clinical practice once the revised national guidelines are established.</li></ul> |
| **Surgical site specific infection for caesarean sections** | May 2015 | The audit report led to the development of an action plan covering: <ul><li>accurate recording of data on Medway.</li><li>obtain wound swab in suspected wound infection.</li><li>while in doubt, to commence broad spectrum antibiotics awaiting swab results is appropriate however to obtain and chase swab results is essential to avoid prolonged and unnecessary use of antibiotics.</li></ul> |
| **Non-EPI DWI to assess for residual or recurrent cholesteatoma** | April 2015 | In response to the outcome of this audit the Foundation Trust intends to ensure that: <ul><li>using DWMRI as an alternative to second look procedures following CAT will be considered.</li><li>if DWMRI is requested post modified radial mastoid surgery the area of concerns and previous surgery on the request card will be clearly identified.</li></ul> |

| Title of audit | Report produced | Actions |
|---|---|---|
| **Sexual History taking at Trinity Centre, Bradford** | June 2015 | The outcome of this audit showed much improvement due to the changes made from previous audit and improved per-forma's. However, it was recommended for further clear documentation and a re-audit. |
| **Re-Audit of the Management of HIV in Pregnancy at Bradford Royal Infirmary in Accordance with the British HIV Association Guidelines for the Management of HIV Infection in Pregnant Women 2014** | May 2015 | As a result of this audit the Foundation Trust actioned to ensure all HIV women are offered a GTT and documented on medway. A discussion had been taken in place the difference between the local and national guidelines with regards to serial scanning with the gold star multi-disciplinary team. |

## Appendix B : Glossary of definitions

| List of Abbreviations | |
|---|---|
| ACU | Ambulatory care unit |
| ADT | Admission discharges and transfers |
| AED | Accident & emergency department |
| AKI | Acute kidney injury |
| AMU | Acute medicine unit |
| BiBBS | Born in Bradford's better start |
| BME | Black and minority ethnic |
| BPT | Birthrate plus tool |
| BUFALO | This is an acronym for the 6 key aspects of sepsis care |
| C. diff | Clostridium difficile - a type of bacteria |
| CHD | Congenital heart disease |
| CHR-UK | Child health review - UK |
| CMACE | Confidential enquiry into maternal and child health |
| CEM | College of emergency medicine |
| COPD | Chronic obstructive pulmonary disease |
| CPBS | Central patient records |
| CQC | Care quality commission |
| CQUIN | Commissioning for quality and innovation |
| CRF | Clinical research facility |
| CSE | Child sexual exploitation |
| CT | Computed tomography |
| DH | Department of health |
| DNA | Did not attend appointment |
| DVT | Deep vein thrombosis |
| EDD | Expected date of discharge |
| EPR | Electronic patient records |
| FFT | Friends and family test |
| FGM | Female genital mutilation |

| List of Abbreviations | |
|---|---|
| **HAPU** | Hospital acquired pressure ulcer |
| **HASU** | Hyper-acute stroke unit |
| **HCAI** | Healthcare associated infections |
| **HF** | Heart failure |
| **HMB** | Heavy menstrual bleeding |
| **IBD** | Inflammatory bowel disease |
| **IM&T** | Information management and technology |
| **LOS** | Length of stay |
| **MARAC** | Multiagency risk assessment conference |
| **MBRACE-UK** | Mothers and babies: Reducing risk through audits and confidential enquiries across the UK (formerly CMACE) |
| **MEWS** | Modified early warning score |
| **MINAP** | Myocardial ischaemia national audit project |
| **MRC** | Medical research council |
| **MRSA** | Methicillin resistant staphylococcus aureus |
| **MUST** | Malnutrition universal screening tool |
| **NBOCAP** | National bowel cancer audit programme |
| **NCAA** | National cardiac arrest audit |
| **NCAPOP** | National clinical audit and patient outcomes programme |
| **NCEPOD** | National confidential enquiry into patient outcome and death |
| **NCI** | National confidential inquiry |
| **NEWS** | National early warning score |
| **NHFD** | National hip fracture database |
| **NHS** | National health service |
| **NHSBT UK** | NHS blood and transplant UK transplant registry |
| **NHSLA** | NHS litigation authority |
| **NICE** | National institute of clinical excellence |
| **NIHR** | National institute for health research |
| **NIV** | Non-invasive ventilation |
| **NLCA** | National lung cancer audit |
| **NNAP** | Neonatal intensive and special care |

| List of Abbreviations | |
|---|---|
| **NPDA** | National paediatric diabetes audit |
| **NPSA** | National patient safety agency |
| **NPS** | Net provider score |
| **PALS** | Patient advice and liaison service |
| **PATP** | Pre-operative assessment and theatres project |
| **PICANet** | Paediatric intensive care audit network |
| **POMH** | Prescribing in mental health services |
| **PPI** | Patient and public involvement |
| **PPPP** | People, places and procurement programme |
| **PRF** | Personal responsibility framework |
| **PROMS** | Patient reported outcome measures |
| **QA** | Quality account |
| **QIPP** | Quality, innovation, productivity and prevention |
| **RCA** | Root cause analysis |
| **RCOG** | Royal college of obstetrics and gynaecology |
| **RCPCH** | Royal college of paediatrics and child health |
| **RF** | Rhesus factor |
| **SI** | Serious incident |
| **SLA** | Service level agreement |
| **SOPs** | Standard operating procedures |
| **SSNAP** | Sentinel stroke national audit programme |
| **SUS** | Secondary uses systems |
| **TIA** | Transient ischaemic attack |
| **VAWG** | Violence against women and girls |
| **VTE** | Venous thromboembolism |
| **WRES** | Workforce race equality standard |

## Appendix C : Glossary of mandated indicators

**To assist the readers of the Quality Report we have included the following definitions of the mandated indicators:**

| Indicator | Description | Criteria | Source |
|---|---|---|---|
| **Referral to Treatment (RTT) 18 week wait** | The NHS Constitution provides patients with the legal right to start consultant-led treatment within a maximum of eighteen weeks from referral for non-urgent conditions. | The Referral to Treatment (RTT) operational standards are that 90 per cent of admitted and 95 percent of non-admitted patients should start consultant-led treatment within 18 weeks of referral. In order to sustain delivery of these standards, 92 per cent of patients who have not yet started treatment should have been waiting no more than 18 weeks. | Data is submitted monthly to NHS England by all providers of NHS-funded, consultant-led services, through Unify2. Unify2 is the online tool used by NHS England for the collection and sharing of NHS performance data. NHS commissioners review and sign off the data and NHS England performs central validation checks to ensure good data quality. |
| **A&E waits** | This indicator required to be reported by the Risk Assessment Framework: Percentage of A&E attendances where the service user was admitted, transferred or discharged within 4 hours of their arrival at an A&E department. | Operating standard of 95%. | NHS Standard Contract 2016-2017. |

# Appendix D : Core set of National quality indicators domain information

| Domain | Indicator | Available reported positions for 2014-2015 | National Average | Where Applicable – Best Performer | Where Applicable – Worst Performer | Trust Statement | Currently reported position for 2013/2014 | Currently reported position for 2012/2013 | Currently reported position for 2011/1012 |
|---|---|---|---|---|---|---|---|---|---|
| **Preventing people from dying prematurely** | SHMI value and banding | SHMI value = 0.971 | 1 | The Whittington Hospital | North Tees and Hartlepool NHS Foundation Trust | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. Improving patient outcomes has been a focus of the SAFE! Strategy which is the Quality Improvement Strategy. | 0.963 Band 2 As expected | 0.999 Band 2 As expected | 0.953 Band 2 As expected |
| | (July 2014 – June 2015) | Band 2 As expected | Band 2 As expected | SHMI Value = 0.661 | SHMI Value = 1.209 | The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation of a range of Quality Improvement Projects. | | | |
| | | | | Band 1 | Band 3 | | | | |
| **Enhancing quality of life for people with long-term conditions** | % patients deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period. | Combined Rate - 18.7 | 26.11 | Better than expected | Worse than expected | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Foundation Trust has an advisory palliative care team available to the wards which sees approximately 60 patients per month. | Combined Rate - 18.7 | | |
| | | | | Imperial College Healthcare NHS Trust - combined rate 52.9 | The Whittington Hospital - combined rate 0.0 | The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by taking steps to improve the recognition of patients that are in the last years of life, improving the sharing of information between primary and secondary care relating to palliative care patients and implementing the five priorities for the care of the dying. | | | |

| Domain | Indicator | Available reported positions for 2014-2015 | National Average | Where Applicable – Best Performer / Worst performance | Trust Statement | Currently reported position for 2013/2014 | Currently reported position for 2012/2013 | Currently reported position for 2011/1012 |
|---|---|---|---|---|---|---|---|---|
| **Helping people recover from episodes of ill health or following injury** | Patient reported outcome scores for groin hernia surgery (2014-2105 provisional data, most recent full year of data available) | 0.102 (Not an outlier) | | | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation of a working group aimed at improving the safety of procedures taking place at the Foundation Trust. | 0.091 (Not an outlier) | 0.086 (Not an outlier) | 0.114 (Not an outlier) |
| | Patient reported outcome scores for varicose vein surgery (2014-2105 provisional data, – most recent full year of data available) | 0.053 (Not an outlier) | | | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to safer procedures. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation of a working group aimed at improving the safety of procedures taking place at the Foundation Trust. | 0.104 (Not an outlier) | 0.098 (Not an outlier) | 0.085 (Not an outlier) |
| | Patient reported outcome scores for hip replacement surgery (2014-2105 provisional data, – most recent full year of data available) | 0.439 Not an outlier) | | | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Foundation Trust has undertaken a programme of work relating to safer procedures. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation of a working group aimed at improving the safety of procedures taking place at the Foundation Trust. | 0.416 (Not an outlier) | 0.39 (Negative) | 0.371 (Negative) |

| | Patient reported outcome scores for Knee Replacement Surgery (2014-2105 provisional data, – most recent full year of data available) | 28 day readmission rate for patients aged 0 – 15 | 28 day readmission rate for patients aged 16 or over | Responsiveness to inpatients' personal needs: CQC national inpatient survey score (2014-2015 data) |
|---|---|---|---|---|
| **Domain** | | Helping people to recover from episodes of ill health or following injury | | Ensuring that people have a positive experience of care |
| **Available reported positions for 2014-2015** | 0.341 (Not an outlier) | The data made available to Trusts for reporting has not been updated since last year's Quality Account. | The data made available to Trusts for reporting has not been updated since last year's Quality Account. | 74.5% |
| **National Average** | | | | 76.6% |
| **Where Applicable – Best Performer** | | | | N/A |
| **Where Applicable – Worst performance** | | | | N/A |
| **Trust Statement** | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Foundation Trust has undertaken a programme of work relating to safer procedures. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation of a working group aimed at improving the safety of procedures taking place at the Foundation Trust. | | | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Foundation Trust has undertaken a programme of work relating to improving patient experience through the Patient First Committee. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation work through the Patient First Committee aimed at improving the experience of our patients. |
| **Currently reported position for 2013/2014** | 0.321 (Not an outlier) | (2011/12) 8.04% | (2011/12) 12.38% | 75.2% |
| **Currently reported position for 2012/2013** | 0.297 (Not an outlier) | (2010/11) 7.23% | (2010/11) 11.93% | 71.5% |
| **Currently reported position for 2011/1012** | 0.289 (Not an outlier) | (2009/10) 6.94% | (2009/10) 11.16% | 74.2% |

| | Indicator 1 | Indicator 2 |
|---|---|---|
| **Currently reported position for 2011/1012** | 67.0% | 96.40% |
| **Currently reported position for 2012/2013** | 71.0% | 96.70% |
| **Currently reported position for 2013/2014** | 68.0% | 96.7% |
| **Trust Statement** | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Foundation Trust has undertaken a programme of work relating to improving patient experience through the Patient First Committee. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation work through the Patient First Committee aimed at improving the experience of our patients. | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons – This is a former national CQUIN which has been embedded into business as usual processes for many years. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continuous monitoring of performance down to Ward level with actions taken to address underperforming areas. |
| **Where Applicable – Worst performance** | Isle of Wight NHS Trust (acute sector) (46%) | N/A |
| **Where Applicable – Best Performer** | Northumbria Healthcare NHS Foundation Trust (85%) | N/A |
| **National Average** | 68.8% | 96.0% |
| **Available reported positions for 2014-2015** | 66.3% | 97.9% |
| **Indicator** | Percentage of staff who would recommend the provider to friends or family needing care (2015 Staff Survey) | % of admitted patients risk-assessed for Venous Thromboembolism Quarter 4 2014-2015 (January to March 2015) |
| **Domain** | | **Treating and caring for people in a safe environment and protecting them from avoidable harm** |

| | Rate of C.difficile per 100,000 bed days | Rate of patient safety incidents per 100 admissions (Apr14 – Sep15) *High Reporters Should be shown as better |
|---|---|---|
| **Currently reported position for 2011/1012** | 41.9 (count of Trust apportioned cases = 87) | 5.7 (number of incidents occurring 3292) |
| **Currently reported position for 2012/2013** | 42 (count of Trust apportioned cases = 87) | 5.9 (number of incidents occurring 3533) |
| **Currently reported position for 2013/2014** | 28.4 (count of Trust apportioned cases = 58) | 6.11 (number of incidents occurring 3753) |
| **Trust Statement** | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data shows that there has been a gradual reduction in CDI rate since 2012/3 but in 2014/5 it remained higher than the mean rate for England. The reduction has been following a number of improvements the Trust has made overseen by the Infection Prevention and Control Committee. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by continued actions to further reduce C.Difficile infection (CDI), with improvements to discharge cleaning after CDI cases, further measures in antimicrobial stewardship and actions to ensure lessons learnt from post-infection reviews are completed. Data from the 3rd quarter of 2015/6 shows that the rate was lower than the mean for England. The CDI reduction programme will continue. | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, the Trust continues to promote a culture of open and honest reporting and endorses a fair blame culture so that all opportunities for learning are identified. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this outcome, and so the quality of its services, by encouraging a culture of voluntary reporting, by endorsing a fair blame culture and making all efforts to learn from all patient safety incidents. |
| **Where Applicable – Worst performance** | The Royal Marsden 62.2 (37 Trust apportioned cases) | Dorset County Hospital NHS Foundation Trust (1.2) |
| **Where Applicable – Best Performer** | Liverpool Womens 2.6 (1 Trust apportioned cases) | Lewisham and Greenwich NHS Trust (16.8) |
| **National Average** | 15.1 | Not Given |
| **Available reported positions for 2014-2015** | 24.4 (46 Trust apportioned cases) | 5.9 (number of incidents occurring 3598) |
| **Indicator** | Rate of C.difficile per 100,000 bed days | Rate of patient safety incidents per 100 admissions (Apr14 – Sep15) *High Reporters Should be shown as better |
| **Domain** | | **Treating and caring for people in a safe environment and protecting them from avoidable harm** |

| | Rate of patient safety incidents per 100 admissions that resulted in severe harm or death* (Apr 14 - Sep 15)* High reporters should be shown as better | Inpatient Friends and Family Test (December 2015 Data) | Accident and Emergency Friends and Family Test (December 2015 Data) |
|---|---|---|---|
| **Currently reported position for 2011/1012** | 1.0 (count of incidents = 33) (Oct 2011 – March 2012) | | N/A |
| **Currently reported position for 2012/2013** | 0.6 (count of incidents = 22) (Oct 2012 – March 2013) | 67 Friends and Family Test Score (December 2013) | 47 Friends and Family Test Score (December 2013) |
| **Currently reported position for 2013/2014** | 0.16 (count of incidents = 6) (April – Sept 2013) | 99% percentage recommended (December 2014) | 61% percentage recommended (December 2014) |
| **Trust Statement** | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons, the Trust continues to promote a culture of open and honest reporting and endorses a fair blame culture so that all opportunities for learning are identified. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this outcome, and so the quality of its services, by encouraging a culture of voluntary reporting, by endorsing a fair blame culture and making all efforts to learn from all patient safety incidents. | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to improving patient experience through the Patient First Committee. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation work through the Patient First Committee aimed at improving the experience of our patients. | The Bradford Teaching Hospitals NHS Foundation Trust considers that this data is as described for the following reasons. The Trust has undertaken a programme of work relating to improving patient experience through the Patient First Committee. The Bradford Teaching Hospitals NHS Foundation Trust has taken the following actions to improve this rate, and so the quality of its services, by the implementation work through the Patient First Committee aimed at improving the experience of our patients. |
| **Where Applicable – Worst performance** | Dorset County Hospital NHS Foundation Trust (0) | Sheffield Children's NHS Foundation Trust (73%) | Royal Devon and Exeter NHS Foundation Trust (100%) |
| **Where Applicable – Best Performer** | Isle of Wight NHS Trust (0.37) | Royal Berkshire NHS Foundation Trust (99%) | North Middlesex University Hospital NHS Trust (58%) |
| **National Average** | Not Given | 95% | 87% |
| **Available reported positions for 2014-2015** | 0.25 (count of incidents = 9) | 98% | 71% |
| **Indicator** | Rate of patient safety incidents per 100 admissions that resulted in severe harm or death* (Apr 14 - Sep 15)* High reporters should be shown as better | Inpatient Friends and Family Test (December 2015 Data) | Accident and Emergency Friends and Family Test (December 2015 Data) |
| **Domain** | | Ensuring that people have a positive experience of care | Ensuring that people have a positive experience of care |

# Bradford Teaching Hospitals NHS Foundation Trust

# Annual Accounts

# for the year ended 31 March 2016

*CONTENTS*

**NATIONAL HEALTH SERVICE ACT 2006**

**DIRECTION BY MONITOR, IN RESPECT OF FOUNDATION TRUSTS' ANNUAL REPORTS AND THE PREPARATION OF ANNUAL REPORTS**

Monitor, in exercise of powers conferred on it by paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, hereby directs that the keeping of accounts and the annual report of each NHS Foundation Trust shall be in the form as laid down in the annual reporting guidance for NHS Foundation Trusts within the NHS Foundation Trust Annual Reporting Manual, known as the FT ARM, that is in force for the relevant financial year.

Signed by authority of Monitor

Name: Jim Mackey (Chief Executive)

Date: November 2015

**INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST**

**Opinions and conclusions arising from our audit**

# 1    *Our opinion on the financial statements is unmodified*

We have audited the financial statements of Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2016. These financial statements comprise the Statement of Comprehensive Income, Statement of Financial Position, and Statement of Changes in Taxpayers' Equity, Statement of Cash Flows and related notes. In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2016 and of the Trust's income and expenditure for the year then ended;  and

- the financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

## 2    *Our assessment of risks of material misstatement*

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follows. The risk relating to the valuation of land and buildings is consistent with prior years.

*Valuation of land and buildings - £148 million (*£137 million in 2014/15)

*Refer to the Audit and Assurance Committee Report within section 3 of the Trust's Annual Report and Accounts 2015/16, section 1.6 of the Trust's accounting policies (Note 1 to the Accounts) and Property, plant and equipment financial disclosures at Note 8 to the Accounts.*

**The risk:** Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (DRC).  There is significant judgment involved in determining the appropriate basis (EUV or DRC) for each asset according to the degree of specialization, as well as over the assumptions made in arriving at the valuation. In particular the DRC basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation. Further, replacement cost is decreased if VAT on replacement costs is recoverable due to the transfer of assets to a property management subsidiary and so an assumption is required as to whether recovery will be made.

The Trust commissioned a desktop revaluation of land and buildings as at 31 March 2016 from an independent valuer, which resulted in an increase of £11.1 million in the total carrying value of its assets.

**Our response**:  In this area our audit procedures included:

assessing the qualifications and expertise of the independent valuer and considering the terms of engagement of, and the instructions issued to, the valuer to check their

- consistency with the Trust's accounting policies for the valuation of property, plant and equipment;

- confirming that the information provided to the valuer, including details of in-year capital expenditure on land and buildings, changes in use of buildings, and details of land area and floor space, was complete, relevant and accurate;

- considering the appropriateness of the valuation bases and assumptions applied by the valuer, in particular the use of cost indices and the basis of using modern equivalent asset value for assets valued using the depreciated replacement cost basis of valuation. We also considered whether the assumptions made by the valuer in relation to the treatment of VAT and the use of alternative sites were consistent with local geography and service provision requirements and complied with guidance issued by the Department of Health and HM Treasury;

- assessing, in the light of our knowledge of the Trust's assets and changes in market conditions, whether the selection of assets covered by the interim valuation covered all assets at risk of significant change in value since the previous full valuation;

- undertaking work to understand the basis upon which any revaluations and impairments to land and buildings had been identified and classified by the Trust and ensuring the recognition of these gains and losses in the financial statements complied with the requirements of the FT ARM; and

- considering the adequacy of the disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

## 3      Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £6.5 million (£7 million in 2014/15), determined with reference to a benchmark of operating income (of which it represents 1.75% (1.9% in 2014/15)). We consider operating income to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.325 million (£0.35 million in 2014/15), in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was performed at the Trust headquarters at Bradford Royal Infirmary.

## 4      Our opinion on other matters prescribed by the Code of Audit Practice is unmodified

In our opinion:

- the parts of the Remuneration and Staff Reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and

- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

## 5      We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK&I) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our audit and the directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or

- the section describing the work of the audit committee does not appropriately address matters communicated by us to the audit committee.

Under the Code of Audit Practice we are required to report to you if in our opinion:

- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2015/16, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

- the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

In addition we are required to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in respect of the above responsibilities.

## Certificate of audit completion

We certify that we have completed the audit of the accounts of Bradford Teaching Hospitals NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.

## Respective responsibilities of the accounting officer and auditor

As described more fully in the Statement of Accounting Officer's Responsibilities, the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

## Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

## Respective responsibilities of the Trust and auditor in respect of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

## Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The C&AG determined this criterion as necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

**The purpose of our audit work and to whom we owe our responsibilities**

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

26 May 2016

*Trevor Rees for and on behalf of KPMG LLP, Statutory Auditor*
*Chartered Accountants*
*1 St Peter's Square*
*Manchester*
*M2 3AE*
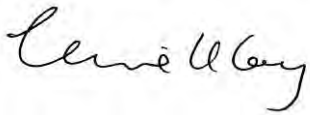
## *FOREWORD TO THE ACCOUNTS*

These accounts for the year ended 31 March 2016 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the Foundation Trust) under paragraph 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor, the independent regulator of NHS Foundation Trusts has, with the approval of the Treasury, directed.

Signed:

Name: Professor Clive Kay (Chief Executive)
Dated: 26 May 2016

## *STATEMENT OF COMPREHENSIVE INCOME*

|  | Note | 2015/16 £000 | 2014/15 £000 |
|---|---|---|---|
| Operating income | 2.1 | 369,877 | 364,576 |
| Operating expenses | 3.1 | (373,017) | (359,492) |
| **OPERATING SURPLUS** | | **(3,140)** | **5,084** |
| **FINANCE COSTS** | | | |
| Finance income | 5 | 286 | 256 |
| Finance expense – financial liabilities | 6.1 | (247) | (142) |
| Finance expense – unwinding of discount on provisions | 14.2 | (43) | (52) |
| Public Dividend Capital dividends payable | 6.2 | (3,384) | (3,309) |
| **NET FINANCE COSTS** | | **(3,388)** | **(3,247)** |
| **SURPLUS / (DEFICIT) FOR THE YEAR** | | **(6,528)** | **1,837** |
| Other comprehensive income | | | |
| Impairments | 15.1 | (698) | 0 |
| Revaluation | 15.1 | 11,868 | (741) |
| **TOTAL COMPREHENSIVE INCOME FOR THE YEAR** | | **4,642** | **1,096** |

All income and expenses shown relate to continuing operations.
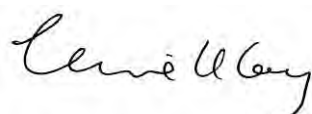
The notes on pages 11 to 46 form part of these accounts.

## STATEMENT OF FINANCIAL POSITION

| | Note | 31 Mar 2016 £000 | 31 Mar 2015 £000 |
|---|---|---|---|
| **Non-current assets** | | | |
| Intangible assets | 7.2 | 7,313 | 3,084 |
| Property, plant and equipment | 8.2 | 174,803 | 155,784 |
| Trade and other receivables | 10.1 | 532 | 569 |
| **Total non-current assets** | | **182,648** | **159,437** |
| **Current assets** | | | |
| Inventories | 9 | 3,550 | 3,958 |
| Trade and other receivables | 10.1 | 18,188 | 14,087 |
| Cash and cash equivalents | 16.1 | 66,227 | 67,490 |
| **Total current assets** | | **87,965** | **85,535** |
| **Current liabilities** | | | |
| Trade and other payables | 11 | (43,929) | (47,223) |
| Borrowings | 13 | (2,048) | (1,145) |
| Provisions | 14.1 | (1,649) | (2,844) |
| Other liabilities | 12 | (6,519) | (5,891) |
| **Total current liabilities** | | **(54,145)** | **(57,103)** |
| **Total assets less current liabilities** | | **216,468** | **187,869** |
| **Non-current liabilities** | | | |
| Borrowings | 13 | (29,364) | (5,413) |
| Provisions | 14.1 | (8,517) | (8,883) |
| Other liabilities | 12 | (990) | (1,110) |
| **Total non-current liabilities** | | **(38,871)** | **(15,406)** |
| **Total assets employed** | | **177,597** | **172,463** |
| | | | |
| **Financed by taxpayers' equity** | | | |
| Public Dividend Capital | | 120,435 | 119,943 |
| Revaluation reserve | 15.1 | 49,598 | 38,428 |
| Income and expenditure reserve | | 7,564 | 14,092 |
| **Total taxpayers' equity** | | **177,597** | **172,463** |

These accounts together with notes on pages 7 to 46 were approved by the Board of Directors on 26 May 2016.


Signed:


Name: Professor Clive Kay (Chief Executive)
Dated: 26 May 2016

### STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

| | Total £000 | Public Dividend Capital £000 | Revaluation reserve (see note 15.1) £000 | Income and expenditure reserve £000 |
|---|---|---|---|---|
| **Taxpayers' equity at 1 April 2015** | **172,463** | **119,943** | **38,428** | **14,092** |
| Deficit for the year | **(6,528)** | 0 | 0 | (6,528) |
| Impairments | **(698)** | 0 | (698) | 0 |
| Revaluations – property, plant and equipment | **11,868** | 0 | 11,868 | 0 |
| Revaluations – intangible assets | **0** | 0 | 0 | 0 |
| Public Dividend Capital received | **492** | 492 | 0 | 0 |
| **Taxpayers' equity at 31 March 2016** | **177,597** | **120,435** | **49,598** | **7,564** |
| | | | | |
| **Taxpayers' equity at 1 April 2014** | **169,692** | **118,268** | **39,169** | **12,255** |
| Surplus for the year | **1,837** | 0 | 0 | 1,837 |
| Revaluations – property, plant and equipment | **(721)** | 0 | (721) | 0 |
| Revaluations – intangible assets | **(20)** | 0 | (20) | 0 |
| Public Dividend Capital received | **1,675** | 1,675 | 0 | 0 |
| **Taxpayers' equity at 31 March 2015** | **172,463** | **119,943** | **38,428** | **14,092** |

## *STATEMENT OF CASH FLOWS*

| | 2015/16 £000 | 2014/15 £000 |
|---|---|---|
| **Cash flows from operating activities** | | |
| Operating surplus / (deficit) from continuing operations | (3,140) | 5,084 |
| **Non-cash income and expense** | | |
| Depreciation and amortisation | 9,600 | 8,984 |
| Impairment | 93 | 1,720 |
| (Gain) / loss on disposal | 63 | 25 |
| Non-cash donations / grants credited to income | (12) | (20) |
| (Increase)/decrease in trade and other receivables | (4,151) | (867) |
| (Increase)/decrease in inventories | 408 | (181) |
| Increase/(decrease) in trade and other payables | (1,907) | 2,723 |
| Increase/(decrease) in other liabilities | 508 | 896 |
| Increase/(decrease) in provisions | (1,604) | (2,105) |
| **NET CASH GENERATED FROM/(USED IN) OPERATIONS** | **(142)** | **16,259** |
| **Cash flows from investing activities** | | |
| Interest received | 286 | 256 |
| Purchase of intangible assets | (5,114) | (1,820) |
| Purchase of property, plant and equipment | (18,144) | (14,615) |
| **Net cash used in investing activities** | **(22,972)** | **(16,179)** |
| **Cash flows from financing activities** | | |
| Public Dividend Capital received | 492 | 1,675 |
| Other loans received | 0 | 0 |
| Loans received from the Department of Health | 26,000 | 2,300 |
| Loans repaid to the Department of Health | (1,000) | (1,000) |
| Other loans repaid | (146) | (358) |
| Interest paid | (198) | (142) |
| Public Dividend Capital dividend paid | (3,297) | (3,479) |
| **Net cash generated from/(used in) financing activities** | **21,851** | **(1,004)** |
| Increase/(decrease) in cash and cash equivalents | (1,263) | (924) |
| Cash and cash equivalents at 1 April | 67,490 | 68,414 |
| **Cash and cash equivalents at 31 March** | **66,227** | **67,490** |

*NOTES TO THE ACCOUNTS*

**Note 1 Accounting policies and other information**

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the FT ARM which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow IFRS and HM Treasury's FReM 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.

**1.1 Accounting convention**

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

**1.2 Consolidation**

These accounts are for the Foundation Trust alone as there are no subsidiaries, associates, joint ventures or joint operations.

The Foundation Trust has not consolidated the financial statements with Bradford Hospitals Charity (the Charity), charity registration number 1061753, on the grounds of materiality. The name of the charity changed from 'Bradford Teaching Hospitals NHS Foundation Trust Charitable Fund' in August 2014, with no change being made to the objectives of the charity.

The Foundation Trust is the Corporate Trustee of the Charity and is governed by the law applicable to trusts, principally the Trustee Act 2000 and the Charities Act 1993, as amended by the Charities Act 2011. The Foundation Trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee, which administers the funds on behalf of the Corporate Trustee.

**1.3 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 Foundation Trust is contracts with NHS commissioners in respect of health care 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 years, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The Foundation Trust contracts with NHS commissioners following Monitor and NHS England's National Tariff Payment System methodology. The income associated with incomplete spells (spells which begin in one financial year but are incomplete at the year-end date) is matched to the appropriate financial year. The element relating to the financial year in which the spell began is included at an estimated value, and is recorded as incomplete in receivables in the current year.

The NHS Operating Framework 2009/10 introduced CQUINS which provides the opportunity for the Foundation Trust to receive incentive income, over and above contracted income, by demonstrating compliance with a number of quality indicators agreed with NHS Commissioners. Income is recognised when the Foundation Trust's commissioners determine that the quality indicators have been achieved.

**1.4 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 annual accounts to the extent that employees are permitted to carry forward leave into the following period.

**NHS Pension Scheme**

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State in England and Wales. It is not possible for the Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers' pension cost contributions are charged to operating expenses as and when they become due. The NHS Pension Scheme (England and Wales) Resource Account is published annually and can be found on the Business Service Authority - Pensions Division website at www.nhsbsa.nhs.uk/pensions.

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

**Auto-enrolment / NEST Pension Scheme**

On 1 April 2013, the Foundation Trust signed up to an alternative pension scheme, NEST, to comply with the Government's requirement for employers to enrol all their employees into a workplace pension scheme, to help people to save for their retirement.

From April 2013, any employees not in a pension scheme were either enrolled into the NHS Pension Scheme or, where not eligible for the NHS Scheme, into the NEST Scheme. Employees are not entitled to join the NHS Pension Scheme if they:

•       are already in receipt of an NHS pension;
•       work full time at another trust; or
•       are absent from work due to long-term sickness, maternity leave, etc. when the statutory duty to automatically enrol applies.

The Foundation Trust is required to make contributions to the NEST pension fund for any such employees enrolled, 1% from 1 April 2014, rising to 2% in October 2017 and 3% in October 2018.

Employees are permitted to opt out of the auto-enrolment, either the NHS Pension Scheme or NEST, if they do not wish to pay into a pension, but they will lose the contribution made by the Foundation Trust.

In the financial year to 31 March 2016, the Foundation Trust made contributions totalling £14,000 into the NEST fund (31 March 2015 £13,000).

**1.5 Expenditure on other goods and services**

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

### 1.6 Property, plant and equipment

**Recognition**

PPE is capitalised where:

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

Additionally PPE is capitalised where individual items:

- have a cost of at least £5,000;
- form 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
- form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, where the value is consistent with that of grouped assets.

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 PPE 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. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the SoCI in the year to which they relate.

Land and buildings are subsequently 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 of land and buildings are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors Valuation Standards. The last full asset valuations were undertaken by the District Valuer Service, part of the Valuation Office Agency of HM Revenue and Customs, March 2016 at the prospective valuation date of 31 March 2016. An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 or IFRS 5.

The valuations are carried out primarily on the basis of depreciated replacement cost on a modern equivalent asset basis for specialised operational property and existing use value for non-specialised operational property.

For non-operational properties, including surplus land, the valuations are carried out at open market value. Any new building construction or an enhancement to an existing building or building related expenditure of greater than, or equal to, £1,000,000 will necessitate a formal impairment valuation.

Plant, machinery and equipment are carried at depreciated historic cost as a proxy for fair value with indices applied to all equipment with an original cost in excess of £100,000.

**Subsequent expenditure**

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

**Depreciation**

Items of PPE are depreciated to their residual values over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Freehold land is not depreciated.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset, as assessed by the Foundation Trust's professional valuers.

PPE are depreciated on a straight line basis over the estimated lives, which are:

| | |
|---|---|
| Engineering plant and equipment | 5 – 15 years |
| Vehicles | 7 years |
| Office equipment, furniture and soft furnishings | 7 – 10 years |
| Medical and other equipment | 5 – 15 years |
| IT equipment | 4 – 10 years |
| Buildings, installations and fittings | 15 – 60 years |

The assets' residual values and useful lives are reviewed, and adjusted if appropriate, at each SoFP date. An asset's carrying amount is written down immediately to its recoverable amount if the asset's carrying amount is greater than its estimated recoverable amount.

Assets in 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 sales proceeds (if any) and the carrying amount of the asset and is recognised in the SoCI.

**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 SoCI 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 (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable

to that asset before the impairment. In 2015/16 the impairment is £791,000 and 2014/15 there was an impairment of £1,720,000.

An impairment arising from a loss of economic benefit 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.

**De-recognition**

Assets, intended for disposal, are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
    - management are committed to a plan to sell the asset;
    - an active programme has begun to find a buyer and complete the sale;
    - the asset is being actively marketed at a reasonable price;
    - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
    - the actions needed to complete the plan indicate it is unlikely that the plan will be 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 de-recognised when all material sale contract conditions have been met.

PPE which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

**Donated, government grant and other grant funded assets**

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

The donated and grant funded assets are subsequently accounted for in the same manner as other items of PPE.

**1.7 Intangible assets**

**Recognition**

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

**Internally generated intangible assets**

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

Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

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

There was no such expenditure requiring capitalisation at the SoFP date. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS Foundation Trusts disclose the total amount of research and development expenditure charged in the SoCI separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

**Software**

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of PPE. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

**Measurement**

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

Subsequently, intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for PPE.

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

**Amortisation**

Intangible assets are amortised on a straight line basis over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The estimated lives fall between 4 and 10 years.

**1.8 Government and other grant funded revenue**

Government grants are grants from Government bodies other than income from NHS commissioners for the provision of services. Where a grant is used to fund revenue expenditure, it is taken to the SoCI to match that expenditure.

**1.9 Inventories**

Pharmacy inventories are valued at weighted average historical cost. Other inventories are valued at the lower of cost and net realisable value using the FIFO method.

Provision is made where necessary for obsolete, slow moving inventory where it is deemed that the costs incurred may not be recoverable.

## 1.10 Financial instruments

### 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 Foundation Trust's 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 Foundation Trust becomes a party to the contractual provisions of the instrument.

### De-recognition

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

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

### Classification and measurement

Financial assets are categorised as 'loans and receivables'. Financial liabilities are classified as 'other financial liabilities'.

### 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 Foundation Trust's loans and receivables comprise cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs. In all cases, the fair value is the transaction value. Any long term receivables that are financial instruments require discounting to reflect fair value, using the effective interest method. The effective interest rate discounts exactly the estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the SoCI.

### Cash and cash equivalents

Cash and cash equivalents comprise cash at bank and in hand and are classified accordingly in the annual accounts.

Cash, bank and overdraft balances are recorded at the current values of these balances in the Foundation Trust's cash book. These balances exclude monies held in the Foundation Trust's bank account belonging to patients (see 'third party assets' below). Account balances are only off-set where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts are recorded as, respectively, 'interest receivable' and 'interest payable' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

For the purposes of the Statement of Cash Flows, cash and cash equivalents are classified as above.

**Financial liabilities**

All financial liabilities are recognised initially at fair value. In all cases the fair value is the transaction value net of transaction costs incurred.

They are included in current payables except for amounts payable more than 12 months after the SoFP date, which are classified as non-current payables.

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 PPE or intangible assets is not capitalised as part of the cost of those assets.

**Impairment of financial assets**

At the SoFP date, the Foundation Trust assesses whether any financial assets 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 SoCI as a movement in the allowance account for credit losses and the carrying amount of the asset is reduced through the use of a provision for impaired receivables. Where it becomes apparent that the asset will not be recovered, it is subsequently written off, by removing the amount from the provision for impaired receivables and the carrying amount of the financial asset.

**1.11 Leases**

**Finance leases**

Where substantially all risks and rewards of ownership of a leased asset are borne by the Foundation Trust, the asset is recorded as PPE and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease. Thereafter the asset is accounted for as an item of PPE.

The annual rental is split between the repayment of the liability and a finance cost over the life of the lease. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to finance costs in the SoCI. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

**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 deducted from the lease rentals and charged to operating expenses over the life of the lease.

The Foundation Trust has reviewed all current leases and decided that there are no material finance leases. Hence all leases are shown as operating leases.

**1.12 Provisions**

The Foundation Trust recognises a provision:

- where it has a present legal or constructive obligation of uncertain timing or amount;
- for which it is probable that there will be a future outflow of cash or other resources; and

- where a reliable estimate can be made of the amount.

The amount recognised in the SoFP is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 1.55% (2014/15: 1.50%) in real terms, except for early retirement provisions and injury benefit provisions which both use the HM Treasury's pension discount rate of 1.37% (2014/15: 1.30%) in real terms.

**Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Foundation 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 Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Foundation Trust is disclosed at note 14.1 but is not recognised in the Foundation Trust's accounts.

**Non-clinical risk pooling**

The Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Foundation 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.

**1.13 Contingencies**

Contingent assets (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

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

**1.14 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 Foundation Trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets (including lottery funded assets), (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

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

**1.15 Value Added Tax**

Most of the activities of the Foundation Trust are an exempt VAT supply 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 both intangible assets and PPE. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

**1.16 Corporation Tax**

The Foundation 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 a power for the Treasury to disapply the exemption in relation to the specified activities of a trust (s519A (3) to (8) ICTA 1988), but, as at 31 March 2015, this power has not been exercised. Accordingly, the Foundation Trust is not within the scope of corporation tax.

**1.17 Foreign exchange**

The functional and presentational currencies of the Foundation Trust are sterling.

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

Where the Foundation Trust has assets or liabilities denominated in a foreign currency at the SoFP date:

- monetary items are translated at the spot exchange rate on 31 March;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

**1.18 Third party assets**

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Foundation Trust has no beneficial interest in them. However, they are disclosed in note 16.1 to the accounts in accordance with the requirements of HM Treasury's FReM.

**1.19 Losses and special payments**

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the NHS 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 NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

**1.20 Accounting standards issued but not yet adopted in the NHS**

There are a number of accounting standards that are issued but not yet effective. A table is shown at the end of these accounts, which lists these standards (note 23). These accounts do not reflect any of these standards.

**1.21 Critical accounting estimates and judgements**

The preparation of the financial information, in conformity with IFRS, requires management to make judgements, estimates and assumptions that affect the application of policies and the reported amounts of income and expenses and of assets and liabilities. The estimates and assumptions are based on historical experience and other factors that are believed to be reasonable under all the circumstances.  Actual results may vary from these estimates. The estimates and assumptions are reviewed on an on-going basis. 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.

The estimates and judgements that have had a significant effect on the amounts recognised in the annual accounts are outlined below.

**Income estimates**

In measuring income for the year, management have taken account of all available information. Income estimates that have been made have been based on actual information related to the financial year.

Included in the income figure is an estimate for open spells, patients undergoing treatment that is only partially complete at midnight on 31 March 2016. The number of open spells for each medical specialty is taken and multiplied by the average specialty price and adjusted for the proportion of the spell which belongs to the current year.

The income figure also includes an estimate for Maternity Pathways, where payments have been made for antenatal and postnatal care at the start of these pathways.  The advance payment has been recognised in the annual accounts based on the number of weeks' care that remains to be provided to the patients after 31 March 2016.

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 not received until future periods, when the claims have been settled, an estimate must be made as to the collectability.

**Expense accruals**

In estimating expenses that have not yet been charged, management have 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.

**Impairment of property, plant and equipment**

In accordance with the stated policy on asset valuation, a full asset valuation exercise was undertaken by the District Valuer Service, part of the Valuation Office Agency of HM Revenue and Customs, during March 2016 at the prospective valuation date of 31 March 2016.

Specialised property has been valued at depreciated replacement cost on a modern equivalent asset basis in line with Royal Institute of Chartered Surveyors standards.  Land has been valued having regard to the cost of purchasing notional replacement sites in the same locality as the existing sites.

**Recoverability of receivables**

In accordance with the stated policy on impairment of financial assets, management have assessed the impairment of receivables and made appropriate adjustments to the existing allowance account for credit losses.

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rates as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

**Note 2 Operating income**

**Note 2.1 Operating income**

|  | Note | 2015/16 £000 | 2014/15 £000 |
|---|---|---|---|
| **Income from activities** |  |  |  |
| Elective income |  | 58,235 | 55,618 |
| Non elective income |  | 82,508 | 83,900 |
| Outpatient income |  | 57,435 | 55,474 |
| Accident and emergency income |  | 13,699 | 13,310 |
| Other NHS clinical income | 2.2 | 114,052 | 114,594 |
| Private patient income |  | 1,049 | 1,095 |
| Other clinical income |  | 5,696 | 4,783 |
| **Total income from activities** |  | **332,674** | **328,774** |
| **Other operating income** |  |  |  |
| Research and development |  | 10,531 | 9,751 |
| Education and training |  | 15,211 | 15,470 |
| Charitable and other contributions to expenditure |  | 12 | 20 |
| Provider to provider income | 2.3 | 3,919 | 4,117 |
| Catering income |  | 1,247 | 1,234 |
| Car parking income |  | 1,452 | 1,287 |
| Other income | 2.4 | 4,831 | 3,923 |
| **Total other operating income** |  | **37,203** | **35,802** |
| **Total** |  | **369,877** | **364,576** |

Income in respect of staff costs where accounted on gross basis

The Terms of Authorisation set out the mandatory goods and services that the Foundation Trust is required to provide (commissioner requested services). The majority of the income from activities shown above is derived from the provision of commissioner requested services other than other non-commissioner requested clinical income and private patient income.

**Note 2.2 Other NHS clinical income**

Other NHS clinical income comprises of, in the main, cost per case items (£39m), community based services (£23.6m), the maternity pathway payments (£22m), direct access services (£10m), CQUINS (£5.6m), renal services (£5.6m), system resilience funding (£3.2m), cochlear services (£2.6m) and distinction awards (£0.8m)

**Note 2.3 Provider to provider income**

Provider to provider income relates to services provided by the Foundation Trust to other trusts or commissioners. Income recorded under this heading relates to areas including ear, nose and throat, ophthalmology and plastic surgeons working at Calderdale and Huddersfield NHS Foundation Trust, Airedale NHS Foundation Trust and other NHS Trusts (£2.8m). Other staffing recharges cover nurses (£0.6m), phlebotomists, physiotherapists, occupational therapists and other professions allied to medicine (£0.2m). This income also includes the provision of administration/information technology services (£0.2m), radiation protection and other technical services (£0.2m) to other NHS Trusts and commissioners.

**Note 2.4 Other income**

Other income in the main relates to pharmacy sales (£2m), service transformation projects (£0.8m), diagnostic & therapeutic services (£0.7m), patient safety/safeguarding (£0.3m), staff accommodation rentals (£0.2m), IT funding (£0.2m) and charitable funding (£0.2m).

**Note 2.5 Segmental analysis**

The CODM is the Board of Directors because it is at this level where overall financial performance is measured and challenged. The Board of Directors primarily considers financial matters at a trust wide level. The Board of Directors is presented with information on clinical divisions but this is not the primary way in which financial matters are considered.

The Foundation Trust has applied the aggregation criteria from IFRS 8 operating segments because the clinical divisions provide similar services, have homogenous customers, common production processes and a common regulatory environment. Therefore the Foundation Trust believes that there is one segment and have reported under IFRS 8 on this basis.

**Note 3 Operating expenses**

**Note 3.1 Operating expenses**

| | 2015/16 £000 | 2014/15 £000 |
|---|---:|---:|
| Services from NHS Foundation Trusts | 1,505 | 639 |
| Services from NHS trusts | 6,408 | 6,296 |
| Services from CCG's and NHS England | 3 | 149 |
| Services from other NHS bodies | 25 | 9 |
| Purchase of health care from non NHS bodies | 1,014 | 342 |
| Employee expenses – executive directors | 929 | 1,004 |
| Employee expenses – non-executive directors | 182 | 156 |
| Employee expenses – staff | 237,198 | 229,409 |
| Drug costs | 38,504 | 35,071 |
| Supplies and services – clinical (excluding drug costs) | 33,428 | 34,399 |
| Supplies and services – general | 4,420 | 4,281 |
| Establishment | 4,229 | 4,810 |
| Research and development – (not included in employee expenses) | 4,008 | 2,303 |
| Transport – (business travel only) | 411 | 371 |
| Transport – (other) | 0 | 15 |
| Premises | 15,604 | 14,792 |
| Increase/(decrease) in provision for impaired receivables | 304 | (344) |
| Change in provisions discount rate | (21) | 155 |
| Drugs inventories consumed | 239 | 0 |
| Rentals under operating leases – minimum lease receipts | 2,315 | 2,551 |
| Depreciation on property, plant and equipment | 8,757 | 8,286 |
| Amortisation on intangible assets | 843 | 698 |
| Impairment of PPE | 93 | 1,720 |
| Audit services – statutory audit | 57 | 70 |
| Other auditor remuneration (external auditor only) | 40 | 0 |
| Clinical negligence | 7,151 | 7,368 |
| Loss on disposal of property, plant and equipment | 63 | 25 |
| Legal fees | 152 | 282 |
| Consultancy costs | 2,332 | 1,218 |
| Training, courses and conferences | 742 | 761 |
| Patient travel | 22 | 46 |
| Car parking and security | 18 | 19 |
| Redundancy – (not included in employee expenses) | 166 | 0 |
| Early retirements – (not included in employee expenses) | 0 | 0 |
| Hospitality | 15 | 61 |
| Insurance | 141 | 147 |
| Other services, e.g. external payroll | 970 | 1,119 |
| Losses, ex gratia and special payments – (not included in employee expenses) | 127 | 151 |
| Other | 623 | 1,113 |
| **Total** | **373,017** | **359,492** |

**Note 3.2 Operating leases**

|  | 2015/16 | 2014/15 |
|---|---|---|
|  | £000 | £000 |
| Minimum lease payments | 2,315 | 2,551 |
| **Total** | **2,315** | **2,551** |

**Note 3.3 Future minimum lease payments**

|  | 2015/16 | 2014/15 |
|---|---|---|
|  | £000 | £000 |
| - not later than one year | 3,509 | 3,038 |
| - later than one year and not later than five years | 1,563 | 1,254 |
| **Total** | **5,072** | **4,292** |

The Foundation Trust leases in the main comprise of buildings, medical equipment, motor vehicles and other equipment.

Buildings relates to leases held in Community Health Partnerships Limited for accommodation acquired through Transforming Community Services.

All medical equipment currently held under lease is leased under NHS Purchasing and Supply Agency agreements. These make no provision for any contingent rentals. They are silent on renewal and purchase options and do not comprise escalation clauses. The framework they provide is consistent with an operating lease arrangement.

Motor vehicles and other equipment currently held under lease are leased under agreements specific to the lessor concerned. None of the agreements currently in force make provision for any contingent rentals nor comprise escalation clauses.

There was no intention from the inception of any of the current leases that any of the leased equipment would be purchased outright either at the end of, or at any time during, the lease terms.

**Note 3.4 Limitation on auditor's liability**

For the year ended 31 March 2016, the limitation on auditor's liability is £1,000,000 (31 March 2015: £1,000,000).

|  | 2015/16 | 2014/15 |
|---|---|---|
|  | £000 | £000 |
| Limitation on auditor's liability | 1,000 | 1,000 |

**Note 4 Employee expenses**

**Note 4.1 Employee expenses**

|  | 2015/16 | 2015/16 | 2015/16 | 2014/15 |
|---|---|---|---|---|
|  | Total | Permanent | Other | Total |
|  | £000 | £000 | £000 | £000 |
| Salaries and wages | 185,141 | 170,470 | 14,671 | 182,935 |
| Social security costs | 13,550 | 13,550 | 0 | 13,481 |
| Pension costs – defined contribution plans, employer's contributions to NHS Pensions | 21,299 | 21,299 | 0 | 20,974 |
| Agency / contract staff | 18,329 | 0 | 18,329 | 13,252 |
| **Total** | **238,319** | **205,319** | **33,000** | **230,642** |
| Included within : |  |  |  |  |
| Costs capitalised as part of assets | 192 | 192 | 0 | 229 |

All employer pension contributions in 2015/16 and 2014/15 were paid to the NHS Pensions Agency.

Included in the above figures are the following balances for executive directors:

|  | 2015/16 | 2014/15 |
|---|---|---|
|  | £000 | £000 |
| Directors' remuneration | 1,316 | 1,058 |
| Employer pension contributions in respect of directors | 128 | 115 |

**Note 4.2 Average number of employees**

|  | 2015/16 | 2015/16 | 2015/16 | 2014/15 |
|---|---|---|---|---|
|  | Total | Permanent | Other | Total |
|  | WTE | WTE | WTE | WTE |
| Medical and dental | 667 | 667 | 0 | 655 |
| Administration and estates | 1,617 | 1,562 | 55 | 1,614 |
| Healthcare assistants and other support staff | 722 | 569 | 153 | 717 |
| Nursing, midwifery and health visiting staff | 1,682 | 1,583 | 99 | 1,693 |
| Scientific, therapeutic and technical staff | 601 | 601 | 0 | 596 |
| Agency and contract staff | 301 | 0 | 301 | 248 |
| Other | 3 | 3 | 0 | 3 |
| **Total** | **5,593** | **4,985** | **608** | **5,526** |
| of which |  |  |  |  |
| Number of employees engaged on capital projects | 4.97 | 4.97 | 0 | 6.53 |

**Note 4.3 Exit package cost band**

| | 2015/16 | 2014/15 |
|---|---|---|
| | Total number of exit packages by cost band | Total number of exit packages by cost band |
| <£10,000 | 3 | 9 |
| £10,001 - £25,000 | 1 | 0 |
| £25,001 - £50,000 | 1 | 1 |
| £50,001 - £100,000 | 0 | 0 |
| **Total** | **5** | **10** |

**Note 4.4 Exit packages: non-compulsory departure payments**

| | 2015/16 Agreements Number | 2015/16 Total value of agreements £000 |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 0 | 0 |
| Contractual payments in lieu of notice | 3 | 30 |
| **Total** | **3** | **30** |

| | 2014/15 Agreements Number | 2014/15 Total value of agreements £000 |
|---|---|---|
| Voluntary redundancies including early retirement contractual costs | 1 | 29 |
| Contractual payments in lieu of notice | 9 | 34 |
| **Total** | **10** | **63** |

**Note 4.4 Early retirements due to ill health**

| | 2015/16 £000 | 2015/16 Number | 2014/15 £000 | 2014/15 Number |
|---|---|---|---|---|
| Number of early retirements on the grounds of ill-health | | 10 | | 5 |
| Value of early retirements on the grounds of ill-health | 551 | | 293 | |

**Note 4.5 Analysis of termination benefits**

| | 2015/16 £000 | 2015/16 Number | 2014/15 £000 | 2014/15 Number |
|---|---|---|---|---|
| Number of cases | | 0 | | 0 |
| Cost of cases | 0 | | 0 | |

**Note 5 Finance income**

| | 2015/16 £000 | 2014/15 £000 |
|---|---|---|
| Interest on bank accounts | 61 | 95 |
| Interest on loans and receivables | 225 | 161 |
| **Total** | **286** | **256** |

Interest receivable relates to interest earned with the Government Banking Service and the National Loans Fund.

**Note 6 Finance costs and Public Dividend Capital dividend**

**Note 6.1 Finance costs - interest expense**

Interest payable amounted to £247,000 (2014/15: £142,000). This is interest due on the following loans taken from the Department of Health.

| Date Total Loan Taken | Duration of Loan | Total Loan Amount (£000) | Remaining Amount to Withdraw (£000) | Amount Repaid (£000) | Balance Outstanding (£000) | Total Interest (£000) |
|---|---|---|---|---|---|---|
| 21 January 2009 | 10 Years | 10,000 | 0 | 7,000 | 3,000 | 106 |
| 20 June 2016 | 20 Years | 20,000 | 1,500 | 0 | 18,500 | 107 |
| 19 September 2016 | 8 Years | 16,000 | 6,200 | 0 | 9,800 | 32 |
| | | **46,000** | **7,700** | **7,000** | **31,300** | **245** |

There was also a £2,000 interest payment to HMRC.

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2015/16 or 2014/15.

**Note 6.2 Public Dividend Capital dividend**

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 Foundation Trust, is payable as PDC dividend. See accounting policy 1.14 for an explanation of how this dividend is calculated.

The amount payable this year is £3,384,000 (2014/15: £3,309,000), which is 3.50% of the year's average relevant net assets of £172,390,000 less average daily cleared cash balance £75,694,000 (2014/15: £76,524,000) at 3.50%.

**Note 6.3 Losses and special payments**

NHS Foundation Trusts are required to record cash and other adjustments that arise as a result of losses and special payments. These losses to the Foundation Trust will result from the write off of bad debts, compensation paid for lost patient property, or payments made for litigation claims in respect of personal injury. In the year the Foundation Trust has had 166 (2014/15: 146) separate losses and special payments, totalling £270,000 (2014/15: £391,000). The bulk of these were in relation to bad debts and ex gratia payments in respect of personal injury.

Losses and special payments are reported on an accruals basis but excluding provisions for future losses. There were no individual cases exceeding £100,000.

**Note 7 Intangible assets**

**Note 7.1 Intangible assets (software licences)**

| | 2015/16 £000 | 2014/15 £000 |
|---|---|---|
| **Valuation / gross cost at 1 April** | **8,684** | **6,547** |
| Additions – purchased / internally generated | 5,073 | 2,326 |
| Additions - donations of physical assets (non-cash) | 0 | 0 |
| Revaluations / (impairments) | 0 | (189) |
| **Gross cost at 31 March** | **13,757** | **8,684** |
| | | |
| **Amortisation at 1 April** | **5,601** | **5,072** |
| Provided during the year | 843 | 698 |
| Revaluations/ (impairments) | 0 | (169) |
| **Amortisation at 31 March** | **6,444** | **5,601** |

**Note 7.2 Intangible assets financing (software licences)**

| | 2015/16 £000 | 2014/15 £000 |
|---|---|---|
| **Net book value** | | |
| Net book value – purchased at 31 March | 7,296 | 3,052 |
| Net book value – donated at 31 March | 17 | 32 |
| **Net book value at 31 March** | **7,313** | **3,084** |

All assets classed as intangible meet the criteria set out in IAS 38 (2) in terms of identifiability, control (power to obtain benefits from the asset), and future economic benefits (such as revenues or reduced future costs). The cost less residual value of an intangible asset with a finite useful life is amortised on a systematic basis over that life, as required by IAS 38 (97).

**Note 8 Property, plant and equipment**

**Note 8.1 Property, plant and equipment 2015/16**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and POA | Plant and machinery | Transport equipment | Information technology | Furniture and fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/Gross cost at 1 April** | 200,587 | 16,862 | 118,210 | 1,968 | 597 | 47,593 | 358 | 14,677 | 322 |
| Additions – purchased | 16,750 | 0 | 2,463 | 0 | 11,077 | 1,339 | 0 | 1,871 | 0 |
| Additions – donated | 12 | 0 | 0 | 0 | 0 | 12 | 0 | 0 | 0 |
| Impairments charged to Operating Expenses | (93) | 0 | (93) | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged to Revaluation Reserve | (698) | 0 | (698) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassification | 0 | 0 | 1,682 | 0 | (1,682) | 0 | 0 | 0 | 0 |
| Revaluation | 7,451 | 0 | 7,451 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (2,842) | 0 | 0 | 0 | 0 | (2,289) | (297) | (221) | (35) |
| **Valuation/Gross cost at 31 March** | 221,167 | 16,862 | 129,015 | 1,968 | 9,992 | 46,655 | 61 | 16,327 | 287 |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April** | 44,802 | 0 | 0 | 0 | 0 | 33,816 | 351 | 10,350 | 285 |
| Provided during the year | 8,757 | 0 | 4,390 | 36 | 0 | 2,678 | 1 | 1,650 | 2 |
| Revaluation surplus | (4,417) | 0 | (4,381) | (36) | 0 | 0 | 0 | 0 | 0 |
| Disposals | (2,778) | 0 | 0 | 0 | 0 | (2,224) | (299) | (220) | (35) |
| **Accumulated depreciation at 31 March** | 46,364 | 0 | 9 | 0 | 0 | 34,270 | 53 | 11,780 | 252 |

**Note 8.2 Property, plant and equipment financing 2015/16**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and POA | Plant and machinery | Transport equipment | Information technology | Furniture and fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned | 172,154 | 16,862 | 126,728 | 1,968 | 9,992 | 12,014 | 8 | 4,547 | 35 |
| Government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Donated | 2,649 | 0 | 2,278 | 0 | 0 | 371 | 0 | 0 | 0 |
| **Net book value at 31 March** | **174,803** | **16,862** | **129,006** | **1,968** | **9,992** | **12,385** | **8** | **4,547** | **35** |

No assets were held under finance leases and hire purchase contracts at the SoFP date (31 March 2015: £ nil).

No depreciation was charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts (31 March 2015: £nil).

There are no restrictions imposed by the donors on the use of donated assets.

**Note 8.3 Property, plant and equipment 2014/15**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and POA | Plant and machinery | Transport equipment | Information technology | Furniture and fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **Valuation/Gross cost at 1 April** | **200,987** | **19,780** | **117,170** | **2,364** | **3,142** | **45,226** | **358** | **12,625** | **322** |
| Additions – purchased | **15,151** | 0 | 4,063 | 0 | 6,266 | 2,622 | 0 | 2,200 | 0 |
| Additions – donated | **20** | 0 | 0 | 0 | 0 | 20 | 0 | 0 | 0 |
| Impairments charged to Operating Expenses | **(1,720)** | (200) | (1,520) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassification | **0** | 0 | 8,811 | 0 | (8,811) | 0 | 0 | 0 | 0 |
| Revaluation | **(13,229)** | (2,718) | (10,314) | (396) | 0 | 330 | 0 | (131) | 0 |
| Disposals | **(622)** | 0 | 0 | 0 | 0 | (605) | 0 | (17) | 0 |
| **Valuation/Gross cost at 31 March** | **200,587** | **16,862** | **118,210** | **1,968** | **597** | **47,593** | **358** | **14,677** | **322** |
| | | | | | | | | | |
| **Accumulated depreciation at 1 April** | **49,621** | **0** | **7,971** | **395** | **0** | **31,646** | **347** | **8,980** | **282** |
| Provided during the year | **8,286** | 0 | 4,231 | 51 | 0 | 2,507 | 4 | 1,490 | 3 |
| Revaluation surplus | **(12,508)** | 0 | (12,202) | (446) | 0 | 243 | 0 | (103) | 0 |
| Disposals | **(597)** | 0 | 0 | 0 | 0 | (580) | 0 | (17) | 0 |
| **Accumulated depreciation at 31 March** | **44,802** | **0** | **0** | **0** | **0** | **33,816** | **351** | **10,350** | **285** |

**Note 8.4 Property, plant and equipment financing 2014/15**

| | Total | Land | Buildings excluding dwellings | Dwellings | Assets under construction and POA | Plant and machinery | Transport equipment | Information technology | Furniture and fittings |
|---|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| Owned | 153,200 | 16,862 | 116,088 | 1,968 | 597 | 13,315 | 7 | 4,326 | 37 |
| Government granted | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Donated | 2,584 | 0 | 2,122 | 0 | 0 | 462 | 0 | 0 | 0 |
| **Net book value at 31 March** | **155,784** | **16,862** | **118,210** | **1,968** | **597** | **13,777** | **7** | **4,326** | **37** |

**Note 9 Inventories**

|  | 31 Mar 16 | 31 Mar 15 |
| --- | --- | --- |
|  | **£000** | **£000** |
| Theatre consumables | 644 | 717 |
| Other consumables | 1,070 | 1,162 |
| Drugs | 1,745 | 1,984 |
| Buildings and engineering | 91 | 95 |
| **Total** | **3,550** | **3,958** |

**Note 10 Receivables**

**Note 10.1 Trade receivables and other receivables**

|  | 31 Mar 16 | 31 Mar 15 |
| --- | --- | --- |
|  | **£000** | **£000** |
| **Current** | | |
| NHS receivables | 10,889 | 6,989 |
| Other receivables | 1,035 | 750 |
| Provision for impaired receivables | (770) | (622) |
| Prepayments | 2,133 | 1,711 |
| Interest receivable | 5 | 5 |
| Other receivables – revenue | 4,895 | 5,166 |
| PDC dividend receivable | 1 | 88 |
| **Total** | **18,188** | **14,087** |
| | | |
| **Non-current** | | |
| Other receivables – revenue | 532 | 569 |
| **Total** | **532** | **569** |

**Note 10.2 Provision for impairment of receivables**

|  | 2015/16 | 2014/15 |
| --- | --- | --- |
|  | **£000** | **£000** |
| **At 1 April** | **622** | **1,035** |
| Increase in provisions | 714 | 381 |
| Amounts utilised | (156) | (69) |
| Unused amounts reversed | (410) | (725) |
| **Total** | **770** | **622** |

**Note 10.3 Analysis of impaired receivables**

|  | 2015/16 | 2014/15 |
|---|---|---|
|  | £000 | £000 |
| **Ageing of impaired receivables** | | |
| 0 – 30 days | 146 | 12 |
| 30 – 60 days | 39 | 65 |
| 60 – 90 days | 23 | 6 |
| 90 – 180 days | 126 | 120 |
| Over 180 days | 436 | 419 |
| **Total** | **770** | **622** |
| | | |
| **Ageing of non-impaired receivables** | | |
| 0 – 30 days | 13,101 | 12,566 |
| 30 – 60 days | 1,851 | 291 |
| 60 – 90 days | 781 | 375 |
| 90 – 180 days | 940 | 423 |
| Over 180 days | 1,277 | 379 |
| **Total** | **17,950** | **14,034** |

**Note 11 Trade and other payables**

|  | 31 Mar 16 | 31 Mar 15 |
|---|---|---|
|  | £000 | £000 |
| **Current** | | |
| NHS payables – revenue | 6,925 | 6,929 |
| Amounts due to other related parties – revenue | 2,998 | 3,024 |
| Other trade payables – capital | 1,900 | 3,336 |
| Other taxes payable* | 4,450 | 4,385 |
| Other payables | 1,760 | 1,635 |
| Accruals | 25,896 | 27,914 |
| PDC dividend payable | 0 | 0 |
| **Total** | **43,929** | **47,223** |

*Other taxes payable were presented as amounts due to other related parties – revenue as at 31 March 2016.

**Note 12 Other liabilities**

|  | 31 Mar 16 | 31 Mar 15 |
|---|---|---|
|  | £000 | £000 |
| **Current** | | |
| Other deferred income | 6,519 | 5,891 |
| | | |
| **Non-current** | | |
| Other deferred income | 990 | 1,110 |

**Note 13 Borrowings**

|  | 31 Mar 16 | 31 Mar 15 |
| --- | ---: | ---: |
|  | £000 | £000 |
| **Current** | | |
| Loans from Department of Health | 1,973 | 1,000 |
| Other loans | 75 | 145 |
| **Total** | **2,048** | **1,145** |
| | | |
| **Non-current** | | |
| Loans from Department of Health | 29,327 | 5,300 |
| Other loans | 37 | 113 |
| **Total** | **29,364** | **5,413** |

**Note 14 Provisions**

**Note 14.1 Provisions for liabilities and charges**

|  | Current 31 Mar 16 £000 | Current 31 Mar 15 £000 | Non-current 31 Mar 16 £000 | Non-current 31 Mar 15 £000 |
| --- | ---: | ---: | ---: | ---: |
| Legal claims | 0 | 0 | 0 | 0 |
| Agenda for Change | 69 | 75 | 2,413 | 2,323 |
| Restructuring | 0 | 0 | 0 | 0 |
| Continuing care | 321 | 423 | 0 | 0 |
| Equal pay | 649 | 715 | 1,941 | 2,236 |
| Redundancy | 0 | 0 | 0 | 0 |
| Other | 610 | 1,631 | 4,163 | 4,324 |
| **Total** | **1,649** | **2,844** | **8,517** | **8,883** |

Agenda for Change provisions include provisions for unresolved national and local bandings for several job profiles and unresolved enhancement pay claims.

Continuing care provisions relate to contractual issues for service provision from suppliers and commissioners.

Equal pay claims relate to a provision for claims relating to employment contracts.

Additionally, the other category contains amounts due as a result of third party and employee liability claims. The values are based on information provided by the NHS Litigation Authority, NHS Business Services Authority and NHS Pensions and have previously been reported in legal claims.

There is also a provision within this section resulting from obligations arising from research activities committed to by the Trust through Bradford Institute for Health Research.

As at 31 March 2016 £109,142,000 is included in the provisions of the NHS Litigation Authority in respect of clinical negligence liabilities of the Foundation Trust (31 March 2015: £53,727,000).

**Note 14.2 Provisions for liabilities and charges analysis**

| | Total | Other legal claims | Agenda for change | Restructuring | Continuing care | Equal pay | Redundancy | Other |
|---|---|---|---|---|---|---|---|---|
| | £000 | £000 | £000 | £000 | £000 | £000 | £000 | £000 |
| **At April 2015** | 11,727 | 0 | 2,398 | 0 | 423 | 2,951 | 0 | 5,955 |
| Change in the discount rate | (21) | 0 | 0 | 0 | 0 | 0 | 0 | (21) |
| Arising during the year | 543 | 0 | 0 | 0 | 0 | 87 | 0 | 456 |
| Utilised during the year – cash | (521) | 0 | (61) | 0 | 0 | (66) | 0 | (394) |
| Reversed during the year | (1,605) | 0 | 145 | 0 | (102) | (382) | 0 | (1,266) |
| Unwinding of discount | 43 | 0 | 0 | 0 | 0 | 0 | 0 | 43 |
| **At 31 March 2016** | 10,166 | 0 | 2,482 | 0 | 321 | 2,590 | 0 | 4,773 |
| **Expected timings of cash flows:** | | | | | | | | |
| -not later than one year | 1,649 | 0 | 69 | 0 | 321 | 649 | 0 | 610 |
| -later than one year and not later than five years | 8,517 | 0 | 2,413 | 0 | 0 | 1,941 | 0 | 4,163 |
| **Total** | 10,166 | 0 | 2,482 | 0 | 321 | 2,590 | 0 | 4,773 |

**Note 15 Revaluation reserve movement**

**Note 15.1 Revaluation reserve movement – 2015/16**

| | Total revaluation reserve £000 | Revaluation reserve – intangibles £000 | Revaluation reserve – property, plant and equipment £000 |
|---|---|---|---|
| Revaluation reserve at 1 April | 38,428 | 50 | 38,378 |
| Impairment | (698) | 0 | (698) |
| Revaluation | 11,868 | 0 | 11,868 |
| Revaluation reserve at 31 March | **49,598** | **50** | **49,548** |

**Note 15.2 Revaluation reserve movement – 2014/15**

| | Total revaluation reserve £000 | Revaluation reserve – intangibles £000 | Revaluation reserve – property, plant and equipment £000 |
|---|---|---|---|
| Revaluation reserve at 1 April | 39,169 | 70 | 39,099 |
| Revaluation | (741) | (20) | (721) |
| Revaluation reserve at 31 March | **38,428** | **50** | **38,378** |

**Note 16 Cash and cash equivalents**

**Note 16.1 Cash and cash equivalents**

| | 2015/16 £000 | 2014/15 £000 |
|---|---|---|
| **At 1 April** | **67,490** | **68,414** |
| Net change in year | (1,263) | (924) |
| **At 31 March** | **66,227** | **67,490** |
| Broken down into: | | |
| Cash at commercial banks and in hand | 17 | 33 |
| Cash with the Government Banking Service | 66,210 | 67,457 |
| **Cash and cash equivalents as in SoFP and SoCF** | **66,227** | **67,490** |

Third party assets held by the Foundation Trust at 31 March 2016 were £3,000 (31 March 2015: £3,000)

**Note 16.2 Pooled budgets**

The Foundation Trust is not party to any pooled budget arrangements in 2015/16 or 2014/15.

## Note 17 Contractual capital commitments and events after the reporting period

### Note 17.1 Contractual capital commitments

Commitments under capital expenditure contracts at the reporting date were £21,740,000 (31 March 2015: £32,242,000).  The Foundation Trust has capital commitment for a number of capital strategy schemes such as the New Hospital Wing and Electronic Patient Records.

### Note 17.2 Events after the reporting period

There are no disclosable events after the reporting period.

## Note 18 Contingent liabilities / assets

The Trust has undertaken an assessment of potential severance costs associated with future transformational change plans, which could generate a contingent liability in the region of £706,000 (31 March 2015: £nil).

## Note 19 Related party transactions

### Note 19.1 Related party transactions

The Foundation Trust  is a public interest body authorised by Monitor, the Independent Regulator for NHS Foundation Trusts.

During the year none of the Board members nor members of the key management staff, nor parties related to them, has undertaken any material transactions with the Foundation Trust.

The Register of Interests for the Council of Governors for 2015/16 has been compiled in accordance with the requirements of the Constitution of Bradford Teaching Hospitals NHS Foundation Trust.

The Department of Health is regarded as a related party.  During the year the Foundation Trust has had a number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department.  The entities with which there were material transactions are listed below.

All transactions were for the provision of healthcare services, apart from expenditure with NHS Litigation Authority, who supplied legal services.

The Foundation Trust has also received capital payments from a number of funds held within the Charity, the trustee of which is the Foundation Trust. Furthermore, the Foundation Trust has levied a management charge on the Charity in respect of the services of its staff. The Charity accounts have not been consolidated into the Foundation Trust's accounts (see note 1.2).

**Note 19.2 Related party balances**

| | Income £000 | Expenditure £000 |
|---|---|---|
| **Value of transactions with other related parties 2015/16** | | |
| Airedale NHS Foundation Trust | 1,347 | 1,067 |
| Bradford City Council | 1,625 | 324 |
| Bradford District Care NHS Foundation Trust | 2,608 | 1,222 |
| Bradford Hospitals Charity | 141 | 0 |
| Calderdale and Huddersfield NHS Foundation Trust | 1,313 | 1,002 |
| Community Health Partnerships | 0 | 744 |
| Department of Health | 3,442 | 0 |
| Health Education England | 15,137 | 12 |
| HM Revenue and Customs | 0 | 13,550 |
| Leeds Teaching Hospitals NHS Trust | 1,203 | 8,261 |
| NHS Airedale, Wharfedale And Craven CCG | 12,203 | 8 |
| NHS Blood and Transplant | 23 | 1,633 |
| NHS Bradford City CCG | 57,645 | 38 |
| NHS Bradford Districts CCG | 177,316 | 281 |
| NHS Calderdale CCG | 3,874 | 0 |
| NHS East Lancashire CCG | 1,115 | 0 |
| NHS England – North East Commissioning Hub | 2,089 | 0 |
| NHS England – Yorkshire and the Humber Commissioning Hub | 11,418 | 0 |
| NHS England – Yorkshire and the Humber Local Office | 48,417 | 0 |
| NHS Greater Huddersfield CCG | 2,707 | 0 |
| NHS Leeds West CCG | 3,560 | 0 |
| NHS Litigation Authority | 0 | 7,151 |
| NHS North Kirklees CCG | 2,740 | 0 |
| NHS Pension Scheme | 0 | 21,299 |
| NHS Property Services | 0 | 1,175 |
| NHS Shared Business Services | 0 | 445 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 3,269 | 99 |
| Other NHS Bodies | 4,697 | 601 |

|  | Income £000 | Expenditure £000 |
|---|---:|---:|
| **Value of transactions with other related parties 2014/15** | | |
| Airedale NHS Foundation Trust | 971 | 649 |
| Bradford City Council | 4,236 | 1,561 |
| Bradford District Care NHS Trust | 1,962 | 938 |
| Bradford Hospitals Charity | 97 | 0 |
| Calderdale and Huddersfield NHS Foundation Trust | 899 | 290 |
| Community Health Partnerships | 0 | 622 |
| Department of Health | 2,949 | 2,054 |
| Health Education England | 14,772 | 0 |
| HM Revenue and Customs | 0 | 13,506 |
| Leeds Teaching Hospitals NHS Trust | 942 | 7,995 |
| NHS Airedale, Wharfedale And Craven CCG | 11,145 | 0 |
| NHS Blood and Transplant | 26 | 1,565 |
| NHS Bradford City CCG | 56,493 | 29 |
| NHS Bradford Districts CCG | 179,351 | 262 |
| NHS Calderdale CCG | 3,668 | 0 |
| NHS East Lancashire CCG | 1,102 | 0 |
| NHS England – North East Commissioning Hub | 0 | 0 |
| NHS England – Yorkshire and the Humber Commissioning Hub | 0 | 0 |
| NHS England – Yorkshire and the Humber Local Office | 55,455 | 0 |
| NHS Greater Huddersfield CCG | 2,793 | 0 |
| NHS Leeds West CCG | 3,872 | 0 |
| NHS Litigation Authority | 0 | 7,356 |
| NHS North Kirklees CCG | 2,204 | 0 |
| NHS Pension Scheme | 0 | 20,974 |
| NHS Property Services | 0 | 1,236 |
| NHS Shared Business Services | 0 | 439 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 3,427 | 74 |
| Other NHS Bodies | 6,522 | 661 |

| | Receivables £000 | Payables £000 |
|---|---|---|
| **Value of balances with other related parties at 31 March 2016** | | |
| Airedale NHS Foundation Trust | 831 | 662 |
| Bradford City Council | 48 | 23 |
| Bradford District Care NHS Foundation Trust | 1,140 | 151 |
| Bradford Hospital Charity | 90 | 0 |
| Calderdale and Huddersfield NHS Foundation Trust | 1,600 | 167 |
| Community Health Partnerships | 0 | 163 |
| Department of Work and Pensions | 1,973 | 63 |
| HM Revenue & Customs | 930 | 4,450 |
| Leeds Teaching Hospitals NHS Trust | 401 | 2,008 |
| NHS Airedale, Wharfedale And Craven CCG | 267 | 5 |
| NHS Bradford City CCG | 0 | 831 |
| NHS Bradford Districts CCG | 0 | 2,577 |
| NHS England - Core | 17 | 0 |
| NHS England – Lancashire and the Greater Manchester Local Office | 17 | 0 |
| NHS England – North East Commissioning Hub | 259 | 0 |
| NHS England – Yorkshire and the Humber Commissioning Hub | 2,464 | 894 |
| NHS England – Yorkshire and the Humber Local Office | 2,051 | 0 |
| NHS North Kirklees CCG | 606 | 0 |
| NHS Pension Scheme | 0 | 2,934 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 364 | 12 |
| Other NHS Bodies | 873 | 651 |

| | Receivables £000 | Payables £000 |
|---|---|---|
| **Value of balances with other related parties at 31 March 2015** | | |
| Airedale NHS Foundation Trust | 661 | 147 |
| Bradford City Council | 17 | 20 |
| Bradford District Care NHS Trust | 595 | 315 |
| Bradford Hospital Charity | 55 | 0 |
| Calderdale and Huddersfield NHS Foundation Trust | 828 | 62 |
| Community Health Partnerships | 0 | 350 |
| Department of Work and Pensions | 1,973 | 56 |
| HM Revenue & Customs | 385 | 4,385 |
| Leeds Teaching Hospitals NHS Trust | 190 | 2,926 |
| NHS Airedale, Wharfedale And Craven CCG | 99 | 203 |
| NHS Bradford City CCG | 185 | 808 |
| NHS Bradford Districts CCG | 676 | 1,325 |
| NHS England Core | 95 | 0 |
| NHS England – Lancashire and Greater Manchester Local Office | 17 | 0 |
| NHS England – North East Commissioning Hub | 0 | 0 |
| NHS England – Yorkshire and the Humber Commissioning Hub | 0 | 0 |
| NHS England – Yorkshire and the Humber Local Office | 685 | 0 |
| NHS North Kirklees CCG | 174 | 0 |
| NHS Pension Scheme | 0 | 2,968 |
| Sheffield Teaching Hospitals NHS Foundation Trust | 1,004 | 16 |
| Other NHS Bodies | 1,854 | 691 |

**Note 20 Private Finance transactions**

The Foundation Trust is not party to any Private Finance Initiatives. There are therefore no on-SoFP or off-SoFP transactions which require disclosure.

**Note 21 Financial instruments**

IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Foundation Trust actively seeks to minimise its financial risks. In line with this policy, the Foundation Trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

**Liquidity risk**

The Foundation Trust's net operating costs are incurred under three year agency purchase contracts with local CCGs, which are financed from resources voted annually by Parliament. The Foundation Trust receives such contract income in accordance with PbR, which is intended to match the income received in year to the activity delivered in that 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 quarterly corrections made to adjust for the actual income due under PbR.

The Foundation Trust currently finances its capital expenditure from internally generated funds and funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the Foundation Trust can borrow, both from the Department of Health Financing Facility and commercially, to finance capital schemes. Financing is drawn down to match the spend profile of the scheme concerned and the Foundation Trust is not, therefore, exposed to significant liquidity risks in this area.

**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 NHS England, CCGs and statutory bodies and therefore the credit risk is negligible.

The Foundation Trust's 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;
- UK registered banks directly regulated by the FSA ; and
- UK registered building societies 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 between £3,000,000 and £12,000,000.

**Price risk**

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

**Note 22 Financial assets and liabilities**

**Note 22.1 Financial assets by category**

|  | 31 Mar 16 | 31 Mar 15 |
|---|---|---|
|  | £000 | £000 |
| **Assets as per SoFP at 31 March** | | |
| Trade and other receivables excluding non-financial assets | 16,427 | 13,094 |
| Cash and cash equivalents at bank and in hand | 66,227 | 67,490 |
| **Total** | **82,654** | **80,584** |

**Note 22.2 Financial liabilities by category**

|  | 31 Mar 16 | 31 Mar 15 |
|---|---|---|
|  | £000 | £000 |
| **Liabilities as per SoFP at 31 March** | | |
| Borrowings excluding finance lease and PFI liabilities | 31,412 | 6,558 |
| Trade and other payables excluding non-financial liabilities | 43,929 | 47,223 |
| Provisions under contract | 6,945 | 8,649 |
| **Total** | **82,286** | **62,430** |

All financial liabilities fall within "other financial liabilities".

**Note 22.3 Fair values**

For all of the Foundation Trust's financial assets and financial liabilities, fair value matches carrying value.

**Note 22.4 Maturity of financial liabilities**

|  | 31 Mar 16 | 31 Mar 15 |
|---|---|---|
|  | £000 | £000 |
| In one year or less | 47,262 | 51,019 |
| In more than one year but not more than two years | 8,895 | 7,194 |
| In more than two years but not more than five years | 7,594 | 2,280 |
| In more than five years | 18,535 | 1,937 |
| **Total** | **82,286** | **62,430** |

**Note 23 Accounting standards that have been issued but have not yet been adopted**

The following accounting standards have been issued but have not yet been adopted. The Foundation Trust cannot adopt new standards unless they have been adopted in the FT ARM issued by Monitor.

The FT ARM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies. In some cases, the standards may be interpreted in the FT ARM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation.

At this stage and subject to any interpretation by the FT ARM, we do not envisage a material impact on the Trust's financial statements.

| Change published | Published by IASB | Financial year for which the change first applies |
|---|---|---|
| IFRS 11 (amendment) – acquisition of an interest in a joint operation | May 2014 | Not yet EU adopted. Expected to be effective from 2016/17. |
| IAS 16 (amendment) and IAS 38 (amendment)- depreciation and amortisation | May 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IAS 16 (amendment) and IAS 41 (amendment) – bearer plants | June 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IAS 27 (amendment) – equity method in separate financial statements | August 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of asset | September 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception | December 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IAS 1 (amendment) – disclosure initiative | December 2014 | Not yet EU adopted. Expected to be effective from 2016/17 |
| IFRS 15 Revenue from contracts with customers | May 2014 | Not yet EU adopted. Expected to be effective from 2017/18 |
| Annual improvements to IFRS: 2012-15 cycle | September 2014 | Not yet EU adopted. Expected to be effective from 2017/18 |
| IFRS 9 Financial Instruments | July 2014 | Not yet EU adopted. Expected to be effective from 2018/19 |

***ACRONYMS***

| | |
|---|---|
| CCG | Clinical Commissioning Group |
| CODM | Chief Operating Decision Maker |
| CQUINS | Commissioning for Quality and Innovation |
| CSU | Commissioning Support Unit |
| DH | Department of Health |
| EU | European Union |
| FIFO | First In, First Out |
| FT ARM | NHS Foundation Trust Annual Reporting Manual |
| FReM | Financial Reporting Manual |
| FSA | Financial Services Authority |
| HMRC | Her Majesty's Revenue and Customs |
| IAS | International Accounting Standards |
| IASB | International Accounting Standards Board |
| ICTA | Income and Corporate Taxes Act |
| IFRIC | International Financial Reporting Interpretations Committee |
| IFRS | International Financial Reporting Standards |
| NEST | National Employment Savings Trust |
| NLF | National Loan Fund |
| NHS | National Health Service |
| NHSLA | National Health Service Litigation Authority |
| PbR | Payment by Results |
| PDC | Public Dividend Capital |
| POA | Payment on account |
| PPE | Property, Plant and Equipment |
| SoCI | Statement of Comprehensive Income |
| SoCF | Statement of Cash Flows |
| SoFP | Statement of Financial Position |
| VAT | Value Added Tax |
| WTE | Whole Time Equivalents |