Bradford District Care
NHS Foundation Trust

Bradford District Care NHS Foundation Trust

Annual Report and Accounts 2015/16

You & Your Care
www.bdct.nhs.uk

Contents

The Annual Report and Accounts 2015/16 has been published alongside the Quality Report 2015/16. Both are available on **www.bdct.nhs.uk/our-publications**

Foreward

Chair and Chief Executive

Welcome to the Trust's Annual Report and Accounts for the period 1 May 2015 to 31 March 2016, our first since becoming a Foundation Trust (FT)*.

The last 12 months has seen significant financial pressures across the whole of the NHS including mental health and community providers, which for us, has meant a tightening of our financial position. Some of the freedoms previously associated with becoming a FT have largely disappeared and together with reductions in social care budgets, and competition for resources means we have a constant challenge to deliver the services we aspire to. 2016/17 will be no different. Even though the challenges are significant, we remain focused on 'You and Your Care', working with diverse communities to provide outstanding care. We believe the challenges can only be met through concerted effort and understanding between commissioners, providers, communities and the individuals we serve.

The wider health and social care landscape has also continued to change during 2015/16 with greater emphasis placed upon new ways of working to meet the triple aim of financial balance across the system, maintaining access and service quality and developing new service models. Our Board is playing a significant leadership role in the West Yorkshire Urgent and Emergency Care Vanguard and, closer to home, is working in alliance with local providers to re-design services and meet the needs of our commissioners.

Progress made in the last couple of years preparing for FT status has provided our staff with the confidence to identify new innovative pathways of care to meet the changing demands on our services. Our Quality Report provides many examples of how our staff have worked together with service users, carers and partners to provide the right care locally when people need it.

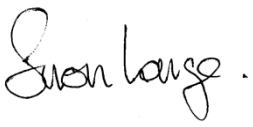
As a new FT, we welcomed our new Council of Governors, who bring wide experience, new perspectives and great commitment to improving health and social care services. We look forward to working with them through 2016/17.

Having a reputation as an excellent employer with a positive culture around wellbeing helps to ensure we have a motivated and committed workforce. We have been identified as one of eleven exemplar organisations nationally who are having a positive impact on staff wellbeing and engagement. Our staff work incredibly hard and we are pleased that so many have been personally recognised through regional and national awards for the quality of their work.

Likewise we have a dedicated and strong group of volunteers and service users and carers who give their time freely to support the work of the Trust and who play a huge part in improving the quality and experience of our services.

We would like to thank everyone across the Trust for the hard work and commitment they have given throughout the year.

Michael Smith
Chair



Simon Large
Chief Executive

*The reporting period covers an eleven month period from the date of FT authorisation. A separate one-month set of accounts has been produced by the Trust for April 2015.

Introduction

Introduction

Bradford District Care NHS Foundation Trust (BDCFT or the Trust) is a provider of award winning mental health, learning disabilities and community health services to a growing population of 580,000 people across a diverse district comprising urban and rural Bradford, Airedale and Craven. The population is one of the most multicultural in Britain with over 100 languages. Localities in Bradford are amongst the most deprived in the country reflected in higher than average demand for health services and reduced life expectancy.

Bradford District Care Trust was established in 2002 as a specialist Care Trust under section 5 of the National Health Service and Community Care Act 1990 and section 45 of the Health and Social Care Act 2001. Following a detailed assessment by Monitor (from 1 April 2016 now part of the organisation known as NHS Improvement) the independent regulator of Foundation Trusts (FTs), the Trust was authorised as a FT from 1 May 2015 and became known as Bradford District Care NHS Foundation Trust.

The Trust employs over 2,800 staff who provide healthcare and specialist services to the people living in Bradford, Airedale, Wharfedale and Craven. Our care and clinical expertise is spread over 50 sites and over the last year we provided 61 different services. These services can be divided into four main areas:

- health services;
- learning disability services;
- community health services (including children's services); and
- dental services.

Our main clinical sites are situated at Lynfield Mount Hospital, Bradford and the Airedale Centre for Mental Health, Steeton, whilst our Trust Headquarters is based at New Mill, Saltaire. The Trust also owns and leases a range of community properties including Horton Park Centre, Fieldhead Business Centre, Somerset House, Meridian House, and the Craven Centre at Skipton Hospital.

Our vision, values and strategic aims

Our vision is: 'Working with diverse communities to provide outstanding care'.

This reflects that our services may go beyond our historic Bradford, Airedale and Craven boundaries as we explore opportunities with new communities to stay competitive in the longer term. It also reflects that our patch covers different ethnic groups, different locations (rural and urban), different ages and people with different care needs (mental or physical health, or both). In support of this vision we recognise the need to focus on service user, patient and staff satisfaction and have put the statement 'You and Your Care' at the centre of everything we aim to achieve.

Trust values

Alongside 'You and Your Care', we have made a commitment to how the Trust and its staff will behave. This is set out in a set of values developed through a process involving many staff, patients and other stakeholders. Our staff work hard to promote these values:

Respect

- We value people as individuals, working with them to achieve their goals.
- We treat people with dignity and kindness.
- We embrace diversity and celebrate difference.
- We make sure that nobody is excluded, discriminated against or left behind.

Openness

- We encourage and demonstrate honest communication.
- We ensure everyone has a voice.
- We speak up when things go wrong.
- We are open to change and new ways of working.

Improvement

- We make best use of our resources to deliver best value.
- We adopt a 'right first time' approach and learn from our mistakes, acting promptly to put them right.
- We all take personal responsibility, challenging and supporting each other to find better ways of doing things.
- We embrace improvement in all its forms, from the small personal acts that make people's lives better to full scale service improvements.

Excellence

- We provide high quality, safe and effective services, delivered with compassion and kindness.
- Our service users and carers come first in everything we do.
- We are customer focused and deliver on our promises.
- We use and develop the expertise of our staff to provide the best possible service user and carer experience.

Together

- We work best through teamwork celebrating our successes together.
- We view service users and carers as part of our team, welcoming and acting on their feedback for our continued improvement.
- We work well with our partners for the benefit of the communities we serve.
- We make time for service users, carers and our colleagues.

We believe that our values, together with You and Your Care, captures the underpinning values of the NHS as enshrined in the NHS Constitution and we work to promote these with all our staff.

Vision wheel

The Trust's vision wheel shows how our vision, aims and values are translated into powerful statements describing improved benefits and outcomes for patients, service users and carers. We have four key aims to help deliver this vision which are:

- To provide a top quality service.
- To achieve excellence in patient experience.
- To ensure great relationships between the Trust, its staff and stakeholders.
- To deliver excellent value for money.

Performance report

National context

The NHS has experienced unprecedented financial challenges during 2015/16 which are expected to continue in the near future. National leaders of the NHS have been clear that stabilising provider sector finances is critical to ensure overall NHS financial sustainability moving into 2016/17. The number of acute provider organisations in financial deficit suggests the challenges being faced are systemic (rather than purely 'performance') and the whole NHS is being challenged to act collaboratively in order to restore financial balance. These financial challenges also affect mental health and community providers and we have also seen a number of reports that will also have an impact on our services in the future.

The Five Year Forward View for Mental Health Taskforce Report signifies the first time there has been a strategic approach to improving mental health outcomes across the health and care system, in partnership with the health arm's length bodies. The report sets out recommendations to help achieve the ambition of parity of esteem between mental and physical health. Priority actions include:

- access to 24/7 urgent mental health care which mirrors access to urgent physical health care;
- mental health out of area placements for acute care to be reduced and eliminated as quickly as possible;
- people experiencing a first episode of psychosis to have access to a NICE-approved care package within 2 weeks of referral;
- implementing a major drive to reduce suicide by 10% by 2020/21;
- supporting more women each year to access evidence-based specialist mental health care during the perinatal period;
- increasing access to evidence-based psychological therapies;
- greater access to high-quality mental health care for young people; and
- more support for people living with mental health problems to find or stay in work.

In addition, the independent Crisp Commission reported on the issues facing patients in England needing acute care for mental health problems. Key recommendations included:

- the introduction, by October 2017, of a maximum waiting time of four hours for admission to an acute psychiatric ward for adults or acceptance for home-based treatment following assessment;
- phasing out the practice of sending acutely ill patients long distances for non-specialist treatment by October 2017;
- more investment in home-based treatment, information systems and staff; and
- that patients and carers are enabled to play a greater role in their own care as well as in service design, provision, monitoring and governance.

The Trust has already eliminated out of area placements and maintaining this achievement will be essential in 2016/17. Most of the other recommendations of the above reports are encompassed within our 2016/17 quality goals set out in the Quality Report with specific plans to (i) increase access to psychological therapies via a 'wellbeing college' approach and (ii) improve services for people experiencing a first episode of psychosis which is already at an advanced stage.

Overview of performance

Our operational plan for 2015/16 set out plans to address the significant financial and service challenges facing the Trust. The plan aimed to ensure that we:

- continued to generate efficiencies and savings to maintain services;
- implement significant changes across the workforce in terms of roles and skills mix; and
- sustained a healthy, productive and motivated workforce so we were able to attract and retain talented individuals.

To deliver our operational plan during 2015/16 we adopted three strategic aims;

- **Be great in our patch:** ensuring patients and local commissioners recognise the Trust as the provider of choice for great experience, high quality, value for money, physical and mental community care services to the people of Bradford, Airedale and Craven thereby consolidating and growing the Trust's position in the local market.
- **Adapt to the new commissioning landscape:** driving and influencing change whilst recognising the difference between commissioners and building on the consensus for a localised service which reflects the health improvement priorities of communities and enables a realignment of resources and opportunities across primary and community care.
- **Develop business opportunities:** both by identifying and delivering local integrated care pathways in partnership with the acute sector, social services and the third sector that enables the Trust to develop new service models and approaches to integrated care and by extending the service offer beyond the Trust's patch where opportunities arise that meet with the Trust's expertise and brand.

Our strategic aims formed the foundation of all of our work. They are embedded in clinical practice and drive innovation and best practice throughout the organisation.

The Trust recognises the opportunity that is presented by its position as the main provider of community services to the local population; the current tough economic climate and challenging market factors demand a different type of community response, one that comprises more productive community capacity and joined up health and social care pathways to support the needs of a growing local population.

This presents an unprecedented requirement for the whole health and social care system to work together in different ways. The Trust's Chief Executive is deputy chair of the Integration and Change Board (ICB), the delivery and governance vehicle established with support from providers and commissioners across health and social care to bring about the transformational change to services that the Five Year Forward View sets out.

Our operational plan for 2015/16 set out service development plans grouped under five programmes which together aimed to deliver the Trust's vision and strategic direction. A brief commentary on achievement against these plans is presented below:

Programme goals	Achievement in 2015/16
1. Achieving integrated community healthcare	Good progress has been made against the agile programme roll-out plan despite the additional requirements linked to the Commissioning Support Unit exit. Device delivery was achieved ahead of schedule, a range of support material and training have been made available to staff and certain tangible benefits, such as a reduction in car mileage costs, are being realised. Work is underway to develop a productivity dashboard that will track agile benefits at team level and issues such as connectivity, accessibility to records and productivity savings are monitored closely through the Change Programme Board.
2. Meeting the need for 24/7 adult and older people's mental health care	We have worked closely with the local authority, the police and other agencies to develop the local Crisis Care Concordat across the district. Our First Response service has provided 24/7 access to urgent mental health and social services and has been recognised by NHS England as a national exemplar. Our mental health nurses work closely with people who attend local A&E departments with a mental health crisis and we have worked in partnership with MIND in Bradford to provide a safe place for people experiencing acute mental distress out of office hours. First Response, together with a redesign of our Intensive Home Treatment service, has helped the Trust to eliminate out of area placements during 2015/16. During the year we completed a major capital project around the refurbishment of the Dementia Assessment Unit, our specialist dementia ward (see further details in the Quality Report 2015/16).

Programme goals	Achievement in 2015/16
3. Extending the inpatient care portfolio	The Trust extended its inpatient care by marketing a further four additional beds in its Assessment and Treatment Unit. Changes in national policy around learning disability services meant that these beds were not purchased by out of area commissioners during 2015/16. The Daisy Hill Intensive Therapy Centre for women experiencing severe and complex mental health problems opened in June 2015 with the facility experiencing below expected occupancy levels. This was closely monitored during 2015/16 by the Board and its Finance, Business and Investment Committee.
4. Developing new services to enhance care pathways	Working with local commissioners, the Trust successfully developed Bradford and Airedale Neurological Development Service (BANDS), an assessment and diagnosis service for adults with autism spectrum disorders.
5. Enabling strategic change	The Trust has developed its in-house commercial expertise to help prepare for suitable tender opportunities and is looking to develop further partnership approaches in 2016/17. The Trust has also worked hard to reduce its bank and agency staff costs and deliver an estates strategy that supports agile working whilst reducing the overall number of properties owned or leased by the Trust.

2015/16 – the year at a glance

Many of our key service developments are covered in the Quality Report 2015/16. Here is just a selection of some of the other events that took place during 2015/16 reflecting the breadth of our work:

- **May 2015: Living Well with Dementia event:** Working jointly with Bradford Teaching Hospitals Foundation Trust, this was the first time a district-wide event of this kind had taken place within the district. The event consisted of a well-being café, workshops and stalls from partner organisations helping to promote local services that could support people with dementia.
- **June 2015: Nursing celebration event:** Our annual event for nursing staff focused around the theme 'The Smallest Things Make the Biggest Difference'. The audience was privileged to hear Matt King OBE as the key-note speaker, who described his personal journey after being paralysed from the neck down in a rugby accident. He asked the audience to recognise the fear and total dependency of people when they are ill and how seemingly small actions and words can have a massive negative or positive effect on a person's recovery.
- **July 2015: Long service awards:** Non-Executive Directors hosted the annual awards with 58 members of staff who were celebrating either 25 or 40 years' service in the NHS. Board members paid tribute to the loyalty, dedication, skills and commitment of the workforce that were present.
- **August 2015: Opening of Dementia Assessment Unit:** the opening of the new unit was attended by around 250 people, made up of staff, Governors, partners and members of the public and brought really positive feedback about our new unit. The new state of the art facilities, which were developed alongside staff, services users and carers, includes personalised memory boards outside each bedroom and the use of reminisce artwork across the unit.
- **September 2015: Annual members meeting:** our first meeting since becoming a FT was held at Bradford City Football Club to present the Annual Report and Accounts and receive questions from Governors, members and the general public. Over 80 people attended the meeting and listened to progress during the year and our plans for the future.
- **October 2015: 'Your Future – Your Health': district-wide event for young people:** The Trust led local partners in answering a challenge set by young people at a Barnardo's meeting to 'do something for young people'. The result was a major event at Bradford City Football Club open to 14-17 year olds across our area, entitled 'Your Future, Your Health'. All three NHS providers, local commissioners, Barnardo's and the Bradford Youth Development Partnership joined together to deliver the event. 22 schools were represented with around 500 young people attending. There were around 40 different stalls and experiences for students to interact with over 100 healthcare professionals and volunteers around four key themes: to learn about

healthy lifestyles, find out about a career in the NHS, opportunities to participate in local communities or debate with senior leaders about the NHS. Our Chair, Mike Smith said 'this has been a superb event and a tremendous example of collaboration between local health organisations'.

- **November 2015: NHS Leadership Awards:** the Trust was recognised in the Yorkshire and Humber Leadership awards in three categories – Patient Champion of the Year, Diversity Champion and Board of the Year.
- **December 2015: impact of flooding at New Mill:** the Trust Headquarters at New Mill suffered extensive damage in the Boxing Day floods with a number of services on the lower ground floor having to relocate to other sites. Thanks to the hard work of staff and contractors working extensively over the Christmas break, the Trust ensured that services users were unaffected by the disruption.
- **January 2016: CQC return visit:** The CQC visited the Trust to follow up on progress since its full inspection in June 2014 with a particular focus on the two areas around improvements to the Health Based Place of Safety suites and embedding the continuous care medical model. The inspection visited a number of wards at our two inpatient sites, reviewing evidence and interviewing Directors against the safe and well-led domains. A final report from the CQC was received in May 2016 confirming an overall rating of 'Good'.
- **February 2016: Zero Suicide conference:** An internationally acknowledged expert on developing the "Zero Approach" to Suicide Prevention, David Covington, from the USA was amongst the guest speakers with over 160 people attending from a range of NHS Trusts across West Yorkshire, West Yorkshire Police, West Yorkshire Fire and Rescue, Yorkshire Ambulance Services, Local Authorities, Universities and Voluntary agencies. The event shared good practice within all agencies and discussed gaps and solutions in reducing suicides across West Yorkshire as part of the West Yorkshire Urgent and Emergency Care Vanguard.
- **March 2016: Opening of Carers Hub:** The launch of the new Carers Hub provides vital support for people in the district caring for loved ones. The new hub, which is based at Horton Park Health Centre, is the first step in developing a district wide support network for carers and will make a real difference to people caring for family and friends. It offers them a space for one-to-one support, access to professional and clinical staff and will provide information on relevant topics and health awareness sessions.

Enhanced quality governance reporting

The Trust implements a robust system of quality governance, directed by the Board whose primary concern is to maintain and improve the quality of services provided. Our system of quality governance provides evidence and assurance against the Monitor Well-Led Framework and is further described in the Quality Report 2015/16.

The main elements of quality governance can be described as follows:

- ensuring required standards are achieved;
- investigating and taking action on sub-standard performance;
- planning and driving continuous improvement;
- identifying, sharing and ensuring delivery of best-practice; and
- identifying and managing risks to quality of care.

We strive to implement effective quality governance arrangements to ensure that existing quality issues are examined and addressed, and to provide the opportunity for staff at all levels to generate and implement new ideas to drive innovation and development. It is through effective quality governance processes that the Trust can drive quality improvement and seek and obtain assurance that high quality services are being delivered.

The Trust undertakes an annual self-assessment against the elements of the Monitor Well-Led Framework and (as with all FTs) will be formally assessed by an external organisation every three years (by 2018). The self-assessment is conducted via a 'Forward to Excellence' session which ensures that the Board and senior management team are fully engaged in the assessment process. This approach ensures wider ownership and understanding of the assessment and associated plan hence supporting the embedding of the well led framework requirements.

Any areas for development identified through this assessment are included in the Quality Governance Improvement Plan which is monitored routinely by the Quality and Safety Committee which is charged with seeking assurance that actions are implemented and leading to improvements.

In addition to the self-assessment outlined above, the Trust has undertaken a number of approaches to governing the quality of services during 2015/16 including the following:

- full external review of the functioning of the Quality and Safety Committee;
- self-assessment against the Care Quality Commission 5 themes of Safe, Caring, Responsive, Effective, Well Led;
- further roll out of the Board Quality and Safety walkabout process;
- refresh and re-launch of the 15 Steps Challenge approach;
- implementation of the Sign up to Safety Campaign; and
- quality Impact Assessment of all transformational projects and cost improvement plans.

Each of these approaches provides the Trust with assurance on the quality of governance arrangements and / or services provided and results in actions for improvement being identified (where required) and implemented.

Stakeholder relations

We have worked closely with the three local Clinical Commissioning Groups (CCGs) - Bradford City, Bradford Districts and Airedale, Wharfedale and Craven (AWC) CCGs - who were the main commissioners of the Trust's health care services in 2015/16. With the changes in the commissioning landscape we have also continued to develop relationships with other commissioners such as NHS England (who commission dental and low secure services), the City of Bradford Metropolitan District Council (BMDC) (for school nursing, health visiting and substance misuse services) and Cumbria CCG (for mental health services in Craven). During the eleven months of 2015/16 operating as a FT we received an income of £123.6m to invest in healthcare services.

In response to changes in national policy, the Trust has also been actively involved in a number of new models of care. We have contributed to the Airedale and Partners Vanguard (looking at improving the quality of life and end of life experience of nursing and care home residents living in Bradford, Airedale, Wharfedale, Craven and East Lancashire) and have taken a lead role in the mental health element of the Urgent and Emergency Care Vanguard for West Yorkshire (to improve and strengthen crisis response, as the needs of these patients impact across the entire urgent and emergency care system). In addition, we have worked with other providers and the two local GP alliances to start to develop new pathways of care and have been involved in developing both the local and West Yorkshire Sustainability and Transformation Plans.

Performance analysis

2015/16 was an extremely successful year and the Trust performed well against a range of national and local performance indicators. Our performance is externally assessed against a wide range of national targets and standards. A more detailed narrative about performance against our quality of care is covered in the Quality Report 2015/16.

Our performance against key Monitor indicators is outlined below (including comparative performance from the previous year). Performance against national targets is reviewed by the Board of Directors on a monthly basis through key performance indicators within the Integrated Performance Report (IPR). Board Committees review performance in further detail through the use of individual Committee performance dashboards.

The Executive Management Team (EMT) meets weekly, and Executive Directors and Deputy Directors meet monthly (known as 'the Directors meeting') to oversee quality and performance issues. In addition, Business Units and Corporate Departments are responsible for the delivery of their own financial and other performance targets, which is monitored through Business Unit performance meetings, attended by Executive Directors and chaired by the Chief Executive.

Monitor indicators	2015/16 target	2015/16 performance	2014/15 performance	Trust position
RTT dental 18 week waits – incomplete pathways (number of patients who have waited 18 weeks or less / number of patients waiting)	92%	93.7%	100%	Achieved target
Mental health delayed transfers of care	<=7.5%	0%	1.1%	Achieved target

Monitor indicators	2015/16 target	2015/16 performance	2014/15 performance	Trust position
Admission to inpatients services had access to Crisis Resolution Home Treatment Teams	95%	98.3%	99.5%	Achieved target
New psychosis cases by Early Intervention Teams	95%	147.2%	115.9%	Achieved target
Early intervention in Psychosis (EIP) – people experiencing a first episode of psychosis treated with a NICE approved care package within 2 weeks of referral*	50% (target applicable from 1 April 2016)	73%	New target	Achieved target
CPA patients receiving follow-up contact within 7 days of discharge	95%	95.7%	98.5%	Achieved target
CPA patients having formal review within 12 months	95%	95.9%	96.5%	Achieved target
People with common mental health conditions referred to the IAPT programme to be treated within 6 weeks**	60% by Quarter 4	88.4%	New target	Achieved target
People with common mental health conditions referred to the IAPT programme to be treated within 18 weeks**	80% by Quarter 4	97.6%	New target	Achieved target
Access to health care for people with a learning disability	6 Green	6 Green	6 Green	Achieved target
Data completeness referral to treatment information	50%	66.6%	63%	Achieved target
Data completeness referral information	50%	92.5%	92.1%	Achieved target
Data completeness treatment activity information	50%	99.7%	99.7%	Achieved target
Data completeness: identifiers (MHMDS Part 1)	97%	99.6%	99.4%	Achieved target
Data completeness: outcomes for patients on CPA (MHMDS Part 2)	50%	79.5%	83.55	Achieved target

* This figure is the initial Q4 Trust Submission to Monitor.
** IAPT figures are taken from national publications - pending year end publication from the HSCIC.

During 2015/16, the Board amended the format of the IPR and requested further information to reflect additional reporting requirements. The key changes presented to the Board during the year were:

- a more detailed summary of performance providing headline information by each section;
- revised safer staffing information;
- Friends and Family / patient experience information;
- new indicators against IAPT performance (by locality);
- financial sustainability risk ratings; and
- agency price cap data.

Financial performance

Financial performance 2015/16

This section and the Annual Accounts have been prepared in line with relevant guidance, including the Annual Reporting Manual for NHS Foundation Trusts 2015/16 and under a direction issued by Monitor under the National Health Service Act 2006. Our accounts are fully compliant with accounting practice required through International Financial Reporting Standards (IFRS). The Trust's accounting policies are set out in the Annual Accounts and have been consistently applied over the period.

This is the first year in which the Trust has prepared NHS FT Accounts. The Trust was authorised by Monitor with effect from 1 May 2015, consequently our FT Accounts and this Annual Report cover the 11 months since our authorisation. The exception is the Remuneration Report which covers the twelve months to 31 March 2016. NHS Trust Accounts for the one month prior to authorisation have been prepared and submitted separately to NHS Improvement.

Financial performance for the 11 months ending 31 March 2016

The Trust has delivered a deficit of £787k for the 11 months ending 31 March 2016, which includes charges for technical impairments of £2,009k that have been charged to expenses. Excluding these exceptional costs the Trust achieved a surplus of £1,222k which is in line with the planned surplus. The Trust had turnover of £123.6 million for the 11 months ending 31 March 2016 and generated an overall surplus of £1.2m (1%) for the period as shown opposite:

Income and expenditure performance for the period ending 31 March 2016

	Month 2-12 £000
Income from activities	113,114
Other operating income	10,482
Total income	**123,596**
LESS:	
Operating expenses	(121,012)
Interest paid and received	119)
Public dividend capital	(1,243)
Surplus / (Deficit)	**1,222**

Income

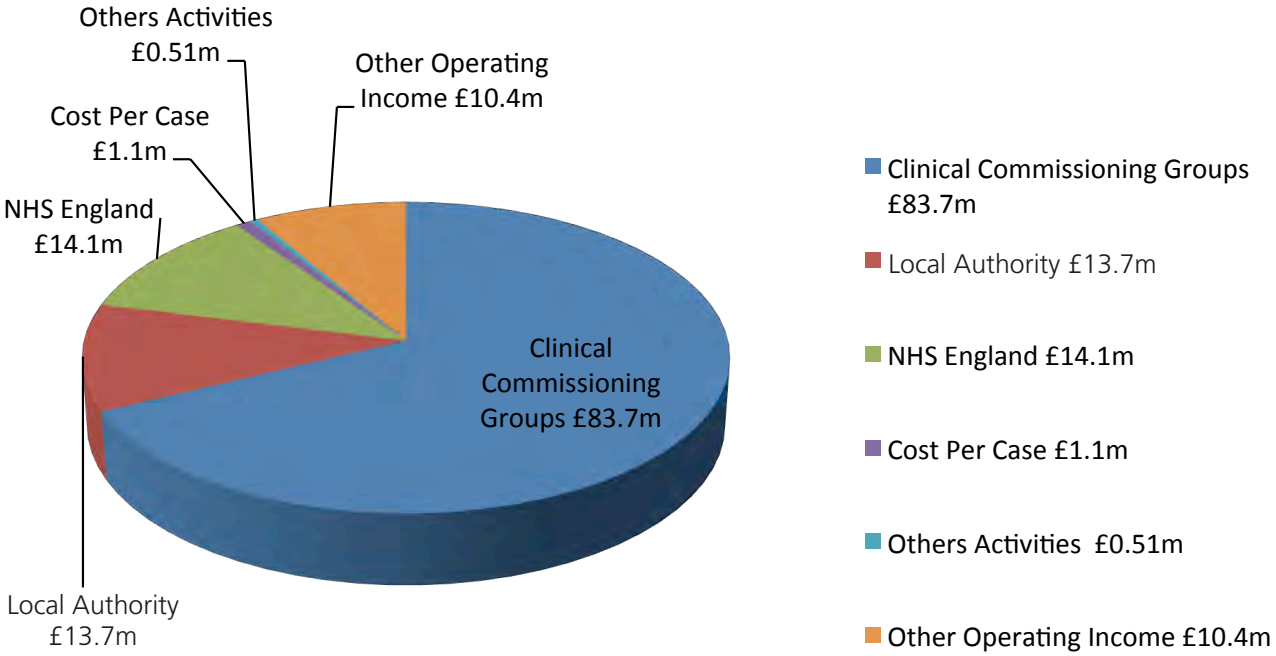
Income from activities of £113.1m included:

- 74.8% from healthcare contracts with Clinical Commissioning Groups, including our 3 local commissioners; Bradford City, Bradford Districts and Airedale, Wharfedale and Craven Clinical Commissioning Groups;
- 12.1% from local authorities, including Public Health Grant funded contracts with Bradford Metropolitan District Council (for Health Visiting, Family Nurse Partnerships, School Nursing, Substance Misuse Services and Oral Health Promotion); and
- 12.4% from healthcare contracts with NHS England for Low Secure Mental Health, Community Dental Services and for providing Vaccinations and Immunisations.

Whilst most contracts with Commissioners were fixed or 'block', 2.5% (or a maximum of £2.5 million) was linked to achievement by the Trust of a series of National and Local quality indicators or CQUINs. The Trust achieved 96% of CQUIN indicators and income in 2015/16. Income from Clinical Commissioning Groups included cost per case income of £940k relating to Intensive Therapy Centre, Psychiatric Intensive Care Unit and Mental Health Inpatient activity. NHS England income included £256k volume based vaccination and immunisation payments.

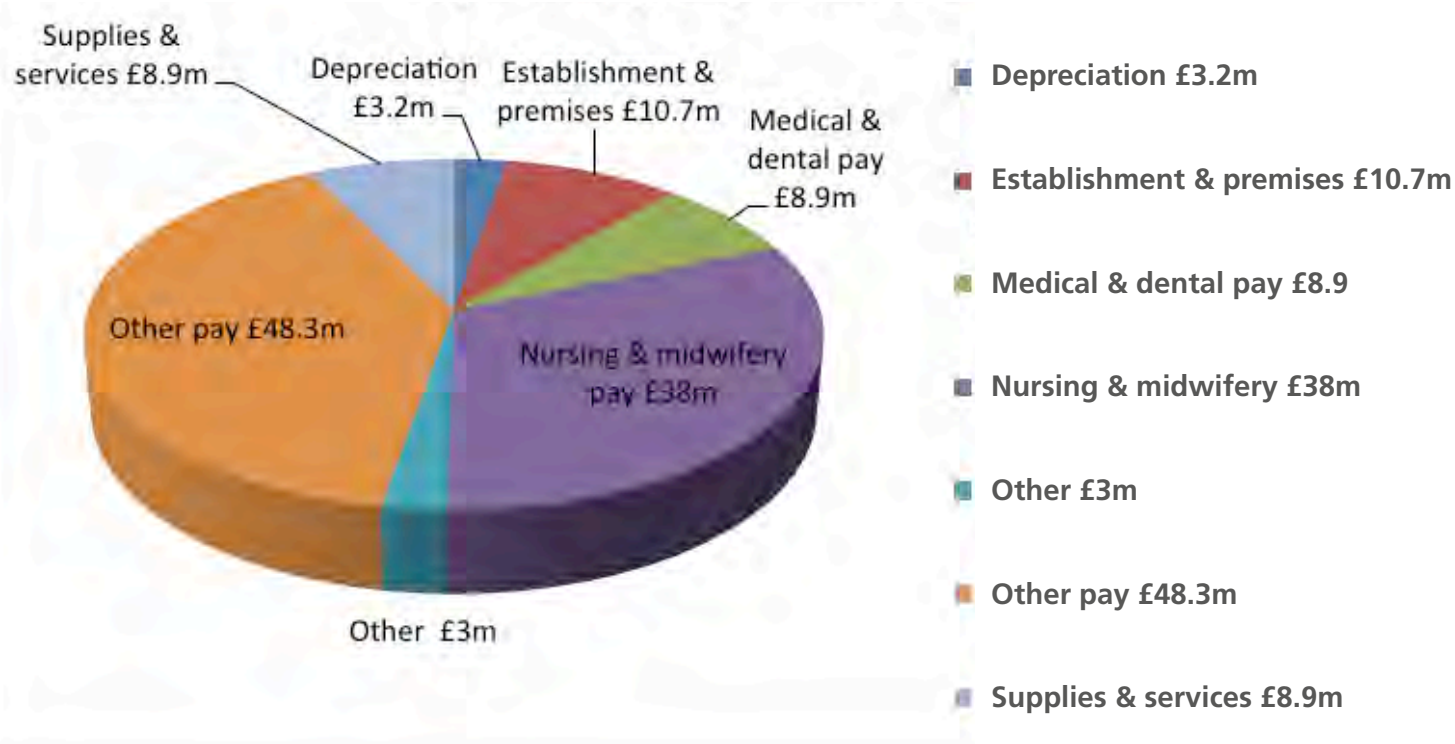
The following chart analyses all sources of Trust income:

Source of income



Expenditure
Operating expenses were £121,012k. The largest driver of costs was employee costs at £95,157k as the table below illustrates:

Operating expenditure



Monitor risk rating
Despite a challenging year the Trust has achieved all requirements included within our 2015/16 annual plan. Financial performance is assessed by our regulator; Monitor, using the Financial Sustainability Risk Rating. This replaced Continuity and Sustainability Risk Ratings from August 2015 and added two new measures; the Income and Expenditure Margin and Income and Expenditure Margin Variance from Plan, to existing Liquidity and Capital Servicing metrics.

The Trust's 2015/16 plan supported delivery of an overall risk rating of 4 under revised Financial Sustainability Risk Ratings. The Trust has achieved an end of year score of 4 which represents the maximum score achievable. Excluding revaluations and impairments, the Trust generated a surplus of £1.2m in the 11 months to 31 March 2016, which was in line with our plan agreed with Monitor. Our performance against the requirements set by Monitor is shown in the table below.

Financial sustainability risk rating

	Plan		Actual		Weight	Outcome
Risk ratings	Metric	Score	Metric	Score		
Income & expenditure margin	1.03%	4	1.00%	4	25%	Green
Income & expenditure margin variance	nil	4	-0.03%	3	25%	Green
Capital servicing capacity	3.41	4	3.41	4	25%	Green
Liquidity	21.8 days	4	20.5 days	4	25%	Green
Overall risk rating	**4**	**4**	**4**	**4**		

Improving efficiency and ensuring value for money

The Trust is continuously striving to improve efficiency in its use of resources by reviewing systems and pressures, valuating skill mix, optimising the use of capacity and ensuring best value through robust procurement practices. In the 11 months to 31 March £6.4m of our cost base was saved through a variety of ongoing schemes.

The Trust over achieved against a challenging savings target of £5.9 million during the 11 months ending 31 March 2016, representing full delivery of the plan. This delivered £6.0 million (102%) as set out in the original programme and £0.4million (7%) through mitigations and substitutions.

Key areas requiring mitigation included lower than planned trading income from the Trust's new Intensive Therapy Centre which opened in June 2015. Under performance was mitigated by over performance or substitution in other areas.

Capital expenditure

The Trust had a capital budget of £3.3 million for the 11 months May 2015 to March 2016 with actual expenditure of £3.2 million.

The capital programme delivered a number of notable schemes including:

- Major re-development of inpatient accommodation at Daisy Hill House, including a Dementia Assessment Unit which secured 'gold' accreditation by Stirling University.
- A programme to refurbish Moorlands View; the Trust's inpatient accommodation for Low Secure Mental Health service users, which commenced during 2015/16 and will complete during quarter one of 2016/17.
- Investment in accommodation changes to allow 'out of hours' First Response and District Nursing staff to be co-located at the Trust's 24:7 Lynfield Mount Hospital site.
- Prioritised investment in accommodation at Daisy Hill House for a new internal staff bank function to support wider actions planned to reduce our reliance on agency staff and associated premium costs.
- Other areas of investment include information technology and programmes to ensure our ongoing compliance with relevant regulatory safety requirements.

The Trust planned and maintained a positive cash balance throughout the year with a balance of £16.8 million as at 31 March 2016. Cash has accumulated over a number of years, including the proceeds from a number of assets disposals as part of an ambitious estate rationalisation plan. This will fund future investment in our estate and technologies that will support the continued provision of sustainable services.

Financial governance - treasury management

As a FT, the Trust is able to generate income by investing cash. Following national changes to the calculation of Public Dividend Capital (PDC) in 2013/14, the Trust has maintained the majority of cash balances within the Government Banking Service (GBS). Maintaining our positive cash position has facilitated a financial gain in savings in PDC payments that greatly outweigh any returns on investment that could have been secured elsewhere. The Trust manages its working capital balances aiming to make payments on due dates in line with the NHS Better Payment Practice Code. The Trust's cash balance was sufficient to meet its operational and capital outgoings throughout the financial year.

Late Payment of Commercial Debts (Interest) Act

In the 11 months to 31 March 2016, the Trust made no payments under the Late Payment of Commercial Debts (Interest) Act 1998.

Valuation of assets

The Trust requested an independent estate valuation by the District Valuer during 2015/16. This follows a similar review undertaken in 2014/15. In doing so, the appropriate impairments and revaluation impacts have been reflected within the Trust's accounts.

The revaluation resulted in additional impairments of £2,809k mainly for enhancements to assets and a decrease in the value of buildings, resulting in a net reversal of impairments and revaluation increase of £2,601k. The net total of £208k was recognised as a loss in year. This meant that a charge of £2,009k was made to the Statement of Comprehensive Income resulting in a deficit of £787k being recorded for the year.

This deficit does not impact on the underlying viability of the Trust, and any losses through revaluations or impairments are discounted in terms of the financial risk ratings used by the Trust's regulator, Monitor.

Auditor remuneration

External Audit fees were £60,500 for the 11 months to 31 March 2016 and incorporate fees relating to the

Trust's Annual Accounts and Quality Accounts. The fee for independent examination of the Trust's Charitable Fund Accounts was £1,485.

Accounting information and Directors' statement
The accounts are independently audited by KPMG LLP as external auditors in accordance with the National Health Service Act 2006 and Monitor Code of Audit Practice. As far as the Directors are aware, all relevant audit information has been fully disclosed to the auditor. No relevant audit information has been withheld or made unavailable and there have been no undisclosed post balance sheet events.

The Trust made no political or charitable donations during the 11 months ending 31 March 2016.

Accounting policies for pensions and other retirement benefits are set out in Note 8 to the full accounts and details of senior managers' remuneration can be found on page 38 of the Annual Report.

Better payment practice code
The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the 11 months ending 31 March 2016 was as follows:

	11 months ending 31 March 2016	
	Number of Invoices	Value of Invoices
NHS Creditors:		
Total bills paid	987	£6,369,905
Total bills paid within target	887	£6,370,780
Percentage of bills paid within target	**89.87%**	**100.01%**
Non-NHS Creditors:		
Total bills paid	15372	£33,250,843
Total bills paid within target	13615	£30,937,933
Percentage of bills paid within target	**88.57%**	**93.04%**

Overseas operations
The Trust does not currently undertake any operations overseas.

Going concern disclosure
Through the financial statements and financial performance indicators the Trust can demonstrate a robust underlying financial position. The 2016/17 operational plan provides for a surplus of £1.3m; 1% of turnover. The Directors' view is that the Trust is a going concern and can make the disclosure as recommended by the accounting standards board that:

"After making enquiries the Directors have a reasonable expectation that the 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".

Non-NHS income disclosures
The Trust has met the requirement under the NHS Act 2006 (as amended by the Health and Social Care Act 2012) that requires that the income from the provision of goods and services for the purposes of the health service in England are greater that the Trust's income from the provision of goods and services for any other purposes. There has been no impact from 'other' income on the Trust's provision of goods and services for the purposes of the health service in England.

Financial outlook for 2016/17
The Trust faces a challenging financial year in 2016/17 and expects the following strategic issues may impact the Trust, with potential to impact and our future financial viability:

- Further reductions in NHS and social care funding as a result of the economic downturn which are likely to require efficiencies of between 4% and 5% for the foreseeable future.
- Anticipated re-procurement of a number of services commissioned from the Trust by the local authority, including Children's and Substance Misuse Services funded from reducing national Public Health Grants to councils and Community Dental and Low Secure Mental Health Services commissioned by NHS England.
- Achieving challenging cost improvements, including agency staff cost reductions particularly in relation to medical staff locums and other shortage professions.
- The need to work with health and social care partners to develop a five year Sustainability and Transformation Plan, to stabilise NHS finances and address issues relating to 'health and wellbeing' and 'care and quality'. This recognises that incremental change by individual organisations will no longer be sufficient to meet the financial challenge facing the NHS. Partners will collaborate to re-design sustainable care pathways across providers, which are patient-centred, offer good outcomes and value for money.
- The Trust is collaborating with West Yorkshire partners (NHS Providers of Mental Health Services) to re-design care pathways; identifying and implementing best practice.

- Options to re-design inpatient provision, including the future of the Intensive Therapy Centre in the light of trading risks and reduced financial freedoms as organisational control totals to support NHS provider sector sustainability are in place.
- Continuing to improve clinical record keeping and data quality to ensure information systems support evidence of good quality care and the introduction of care packages, pathways and payments for mental health services.
- The Trust's ability to develop new and enhanced service offers and work with commissioners to re-design care pathways and provide new and more cost effective packages of care.

Every health and care system is required to produce a five year Sustainability and Transformation Plan (STP); an ambitious local blueprint to accelerate implementation of the NHS Five Year Forward View.

Plans are due to be submitted in June for the five years ending 31 March 2021 and will be externally assessed in July 2016.

The Trust is part of a local Bradford, Airedale and Craven STP which is part of a wider West Yorkshire STP.

Planning locally is supported by existing governance arrangements and strategic local leadership for health and social care via a Chief Executive-led Integration and Change Board, chaired by the Council's Chief Executive. Partners have a vision to develop an Accountable Care System, across the primary-secondary care interface and the health-social care interface.

Development of the local STP is being overseen by the Health and Wellbeing Board via the Integration and Change Board and with clear links to the wider West Yorkshire STP.

Cost improvement plans

In 2016/17, our overall cost improvement requirement is £5.8 million, or just over 4.4%. This requirement is driven by national efficiency requirements of 2% on all NHS Commissioner contracts, Public Health Grant reductions impacting the Trust's contracts with the local authority and the need to finance local cost pressures.

To meet this requirement, the Trust plans to deliver a combination of traditional cost reductions and transformational efficiency programmes.

Capital programme

Estates Schemes:

The Trust's Estates Strategy provides a key strategic reference point for the 2016/17 capital plan in the coming year and specifically focuses on:

- developing a new energy centre and replace essential heating main infrastructure at the Lynfield Mount Hospital Site;
- completing the refurbishment of low secure mental health services inpatient accommodation at our Lynfield Mount Hospital Site; and
- ensuring compliance with national standards and the requirements of our regulators.

Information management & technology schemes:

The Trust's capital programme also supports £1m key enhancements in information management & technology infrastructure, systems and developments to support new and more efficient ways of working including Agile Working.

The capital programme is aligned to the Trust's long-term financial plan and provides for capital expenditure of £3.9 million in 2016/17 (subject to national clarification in relation to any necessary capital restraint).

Consistent with the Trust's Estates Strategy capital developments will be designed to incorporate more sustainable technology, e.g. LED lighting. Other core enabling priorities include supporting service transformation including key agile working programmes that will reduce our reliance on estate through greater use of information management and technology.

Accountability report

Accountability report

Trust Board

The Trust is led by a Board of Directors which exercises it functions effectively, efficiently and economically. It is a unitary board consisting of a Chair, Non-Executive Directors, Chief Executive and Executive Directors. The role of the Board is to:

- set the overall strategic direction of the Trust;
- regularly monitor performance against agree goals;
- provide effectively financial stewardship through value for money, financial control and financial planning;
- ensure that the Trust provides high quality, effective services; and
- promote good communications with the people we serve.

The composition of the Board is in accordance with the Trust's Constitution, providing a structure to enable it to fulfill its statutory duties and meet the conditions of its operating licence. All Non-Executive Directors are considered to be independent.

The Board of Directors meets monthly (with the exception of August) and discharges its day-to-day management of the Trust through the Chief Executive, individual Executive Directors and senior staff through a scheme of delegation which is approved by the Board.

The Board receives an integrated performance report at each Board meeting measuring performance against national and local targets relating to finance, quality and governance indicators. Where there is any deviation from plan, exception reports are presented for consideration of any necessary remedial action. The integrated performance report has, over the year, been refined to reflect new targets or other areas requested by the Board to ensure it monitored new areas of performance.

Individual Board member performance is reviewed through a formal appraisal process whereby the Chair appraises the Chief Executive and Non-Executive Directors, the Chief Executive appraises the Executive Directors (with reports sent to the Board's Remuneration Committee) and the Senior Independent Director seeks views from other Board members on the performance of the Trust Chair (to supplement the NTDA's own formal appraisal). In November 2015, the Chair submitted a new process to involve the Council of Governors in his own appraisal and that of the Non-Executive Directors. The Board undertakes an evaluation of its own effectiveness. The next review is scheduled for June 2016 to coincide with external feedback, which will be used at the Board of Directors' time-out in July 2016. The time-out will also consider the Well-Led Framework; no external evaluation has been undertaken since authorisation as a FT in May 2015.

Listed below is the attendance at Board meetings held during the year.

Board member	Attendance
Michael Smith (Chair)	13/13 meetings
Simon Large (Chief Executive)	13/13 meetings
Rob Vincent (Deputy Chair)	13/13 meetings
David Banks	12/13 meetings
Sue Butler	13/13 meetings
Ralph Coyle	10/13 meetings
Nadira Mirza	11/13 meetings
Derrick Palmer	8/8 meetings
Zulfi Hussain	1/1 meeting
Nicola Lees	13/13 meetings
Helen Bourner*	5/5 meetings
Sandra Knight	12/13 meetings
Andy McElligott	13/13 meetings
Liz Romaniak	12/13 meetings
Paul Hogg**	13/13 meetings

*secondment to Programme Director role for the Airedale and Partners Vanguard in August 2015

** attends Board meetings as a member of the Executive Management Team

Details of directorships and interests of all Board members can be found at Appendix 1.

Board committees

The Board discharges its responsibilities through a number of Committees. The main duties of each Committee are set out below. Each Committee undertakes an annual evaluation and submits an Annual Report to the Board. These reports are considered by the Board as assurance against the wider context of the Annual Report. At each Board meeting there is also a written report highlighting any significant issues from Committees and Committee minutes are circulated to all Board members. The Trust Secretary attends all Committee meetings, with the exception of the Remuneration Committee, as part of his corporate governance role. Information on the Remuneration Committee is contained separately in the Remuneration Report.

Audit Committee

The Audit Committee is responsible for the Trust's systems of internal control. It provides the Board with an independent and objective review of financial and corporate governance, risk management, external and internal audit programmes. It is responsible for making sure the Trust is well governed. Taking a risk-based approach, the Committee has worked to an annual plan covering the main elements of the Assurance Framework. The Committee has appointed external auditors (KPMG LLP) and internal auditors (West Yorkshire Audit Consortium). The Committee comprises solely of Non-Executive Directors, supported by the Director of Finance, Contracting and Estates, Trust Secretary and senior staff from the Finance Directorate. The Committee met five times during 2015/16 and its membership changed during the year to reflect changes in Non-Executive portfolios as shown:

Membership	Attendance
Derrick Palmer (Chair until end of October 2015)	3/3 meetings
David Banks (Chair from November 2015)	5/5 meetings
Rob Vincent	2/2 meetings
Sue Butler	3/3 meetings
Nadira Mirza	1/1 meetings

The Audit Committee is authorised by the Trust Board to investigate any activity within its terms of reference. This includes:

- Reviewing the 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.
- Ensuring that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- Reviewing the work and findings of the external auditors and considering the implications and management's responses to their work.
- Satisfying itself that the organisation has adequate arrangements in place for countering fraud and shall review outcomes of counter fraud work.

During the year, the Audit Committee has:

- Reviewed and approved the Internal Audit Strategy, operational plan and its detailed programme of work.
- Considered its membership of the West Yorkshire Audit Consortium and the ongoing financial and legal liabilities associated with this.
- Considered the opinions given on Internal Audit reports and, where limited assurances have been presented, put in place further scrutiny or review of the actions recommended.
- Considered the Head of Internal Audit Opinion on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes.

In relation to working with the external auditors, the Audit Committee has:

- Received technical updates informing the Committee about changes in accounting practices, reports from the CQC, Monitor, NHS England and the Charity Commission relevant to the Trust. During the year these reports have widened to include more social care issues reflecting the changes in the health landscape and the direction of travel set out in the 5 Year Forward View. The Committee has used the technical updates to raise issues and feed into the monthly Chief Executive's report to the Board.

- Considered and approved the external auditor's annual plan, which was based on a risk-based approach and linked to the Trust's preparations for FT status.
- Received the audit of the Trust's financial statements and auditor's opinion.
- Considered the external auditor's Annual Audit Letter, summarising the key issues arising from the external audit work during the year.
- Offered the external auditors the opportunity of meeting the Committee independently in the absence of Executive Directors and have met the Chair of the Committee outside formal Committee meetings.
- Advised the Council of Governors about its role in the appointment of the external auditors and that the Trust Board did not believe this service should be re-tendered at this stage, given its recent authorisation as an FT.

As well as providing independent audit functions KPMG LLP also provided professional services to aid VAT recovery by the Trust during 2015/16. Fees included in the Trusts accounts were £10,000 for the full year to 31 March 2016. This service is contracted and provided entirely separately from the work undertaken by the firm's independent audit team and is also subject to periodic review by the Trust's Internal Auditors.

Quality and Safety Committee

The Quality and Safety Committee has responsibility to monitor, review and report to the Board the adequacy of the Trust's processes in the areas of clinical governance and where appropriate facilitate and support existing systems operating across the Trust. This includes the monitoring of incidents and complaints, clinical policies, research and development, clinical audit and service improvements. On becoming a FT, the Board agreed this Committee should meet more frequently (from two monthly to six weekly meetings) and the membership of the Committee was reduced to solely Board members, with officers of the Trust in attendance. In response to a request from Monitor, the Board of Directors commissioned a peer review about the effectiveness of its Quality and Safety Committee processes by the Chief Executive of Tees Esk and Wear Valley NHS Foundation Trust. The report concluded that the Committee had a strong focus on assurance with several examples of excellent practice as well as some further opportunities for improvement.

A number of minor changes to the Committee were introduced as a result of recommendations in the report.

Membership	Attendance
Sue Butler (Chair)	7/8 meetings
Rob Vincent	5/5 meetings
Nadira Mirza	4/8 meetings
Andy McElligott	8/8 meetings
Nicola Lees	4/8 meetings
Paul Hogg	6/8 meetings

Finance, Business and Investment Committee

The Finance, Business and Investment Committee has responsibility for monitoring financial performance of the Trust against plan (reporting any proposed remedial action to the Board as necessary) considering the Trust's medium to longer term financial strategy and providing an oversight of the development and implementation of financial systems across the Trust. The Committee met eight times during 2013/14.

Membership	Attendance
David Banks (Chair until November 2015)	8/8 meetings
Rob Vincent (Chair from December 2015)	3/3 meetings
Ralph Coyle	6/8 meetings
Sue Butler	2/3 meetings
Michael Smith	5/8 meetings
Simon Large	6/8 meetings
Liz Romaniak	7/8 meetings
Sandra Knight	8/8 meetings
Helen Bourner	3/3 meetings
Paul Hogg	6/8 meetings

Mental Health Legislation Committee

The Mental Health Legislation Committee has a wide cross section of attendance comprising Non-Executive and Executive Directors, an Associate Hospital Manager, senior clinicians and service user and carer representatives. The Committee has responsibility to monitor, review and report to the Board on the adequacy of the Trust's processes relating to all mental health legislation. The Committee meets on a quarterly basis and met four times in 2015/16.

Membership	Attendance
Ralph Coyle (Chair)	4/4 meetings
Derrick Palmer	2/2 meetings
Nadira Mirza	2/4 meetings
Rob Vincent	1/1 meetings
Andy McElligott	4/4 meetings
Nicola Lees	4/4 meetings
Paul Hogg	3/4 meetings

Nominations Committee

The Nominations Committee has the responsibility to review the structure, size and composition of the Board and, where necessary, be responsible for identifying and nominating for appointment candidates to fill posts within its remit. All Non-Executive Directors are members of this Committee, which met three times in 2015/16. Its key responsibility in 2015/16 was to agree the criteria used for selection of a new Non-Executive Director, by the Council of Governors, through its own Nominations Committee. The Trust adopted an open advertising approach for the role and was supported by an external search consultancy during the appointment process.

In line with the Trust's Constitution, two members of the Board (Michael Smith (Chair) and Nadira Mirza (Non-Executive Director)) were members of the Governor-led Nominations Committee who interviewed shortlisted candidates and made a recommendation of appointment to the Council of Governors.

Membership	Attendance
Michael Smith (Chair)	3/3 meetings
David Banks	1/3 meetings
Sue Butler	2/3 meetings
Ralph Coyle	0/3 meetings
Derrick Palmer	0/1 meetings
Nadira Mirza	3/3 meetings
Rob Vincent	2/3 meetings
Zulfi Hussain	1/1 meetings

Charitable Funds Committee

The Charitable Funds Committee oversees the Trust's charitable activities and ensures it is compliant with the law and regulations set by the Charity Commissioners for England and Wales. The Board is responsible for this area but this Committee looks in detail at charitable matters and works with the Charity Commissioners where necessary. It met twice in 2015/16.

Membership	Attendance
Rob Vincent (Chair until end of October 2015)	1/1 meetings
Nadira Mirza (Chair from November 2015)	2/2 meetings
Ralph Coyle	1/2 meetings
Simon Large	1/2 meetings
Nicola Lees	2/2 meetings
Paul Hogg	2/2 meetings

Division of responsibilities of Chair and Chief Executive

A clear statement outlining the division of responsibilities between the Chair and the Chief Executive has been approved by the Board at its meeting on 3 September 2015. As a result of the Board's discussion, the statement also now includes reference to the role of Non-Executive and Executive Directors.

The Chair's primary objectives for 2015/16 were to:

- Ensure the Board has a clear view of the important strategic and operational issues facing the Trust and devotes proper time and consideration to these priorities.
- Ensure the new Council of Governors is well organised, supported and engaged in informing and addressing these priorities.
- Refresh the stakeholder engagement strategy/ plan in line with the Trust's priorities and lead the programme of engagements at local, regional and national level.

The Chief Executive's primary objectives for 2015/16 were to:

- Ensure the efficient and effective use of resources across the organisation in delivering the best quality services and the highest standards of safety.
- Ensure that appropriate control systems are in place to deliver objectives and manage risk.
- Support and encourage continuous improvement and transformation across all clinical and support functions.
- Engage across the health and care system to assess the risks and opportunities for the Trust, influence the thinking of system leaders and provide direction in shaping new models of care.
- Develop strong working relationships with other provider organisations and assess potential for co-creation of service developments and tender opportunities.

- Display inspirational leadership and role model behaviours in keeping with the vision and values of the Trust setting an expectation of high standards and performance.

Council of Governors

The Trust has a Council of Governors who is responsible for representing the interests of the members of the Trust, partner organisations within the local health economy and the wider community served by the Trust. The Council of Governors holds the Board to account for the performance of the Trust including acting within the terms of its operating licence.

The size of the Council of Governors was determined following a public consultation about the Trust's plans to become a Foundation Trust. Currently, the Council of Governors consists of 15 Public, five Staff and seven Appointed Governors - see the map below which shows the seven constituencies of our public membership area. The Council of Governors meet quarterly and receive a performance report from the Chief Executive and updates from Governor-led Committees.

Information about when Governors were elected/ appointed, the constituency/organisation they represent and any declared interests can be found at Appendix 2. There have been no elections during 2015/16 as the Trust was only authorised as a FT from 1 May 2015. At its meeting in February 2015, the Council of Governors agreed an annual process to evaluate its own effectiveness which will commence in May 2016 and be reported in August 2016.

During the year, Governors have been involved in the annual planning process, established a task and finish group to communicate views to the Board of Directors about the content of the Trust's quality goals and have provided feedback on the Annual Plan at bespoke briefing sessions.

The Council of Governors has not, during the financial year, exercised their powers under paragraph 10C of schedule 7 of the NHS Act 2016, to require any Director to attend a Council of Governors meeting. Both Executive and Non-Executive Directors regularly attend Council of Governors meetings and present on agenda items.

Governor induction and training
The general duties of the Council of Governors are outlined in the Trust's Constitution. Governors are also provided with a written document explaining their duties within the Governor induction pack. During 2015/16, the Trust provided Governors with formal induction to undertake their role and bite size training is provided in response to Governor requests – this year presentations have included topics on the role of internal and external auditors, quality accounts, the annual planning process and risk management.

Governor Committee meetings
The Council of Governors has established three Committees in order to carry out its functions. Membership and terms of reference for each Committee was approved at the Council of Governors meeting in May 2015.

Nominations Committee
The Nominations Committee is responsible for the process of appointing Non-Executive Directors (including the Chair), when a vacancy arises. The Committee consists of five members comprised of three Governors and two members of the Board of Directors (at least one of whom will be a Non-executive Director). The Committee met once as a Committee (and once as an interview panel) to select a new Non-Executive Director. The Council of Governors approved the appointment of Dr Zulfi Hussain at its meeting in February 2016.

Remuneration Committee
The Remuneration Committee is responsible for ensuring an appropriate level of remuneration and allowances for the Chair and Non-Executive Directors of the Trust Board. In September 2015, the Committee received a report about the remuneration levels of the Chair and other Non-Executive Directors at a meeting. The Committee agreed that the information contained within the report provided sufficient objective external benchmarking information to support their decision making and did not consider it necessary to consult external professional advisers to market test the remuneration levels. The Council of Governors' was assured by the approach taken and evidence received and agreed the revised allowances at its meeting in November 2015.

Membership Development Committee
The Membership Development Committee is responsible for developing the membership of the Trust and representing the interests of members. During the year it has met five times with a focus on reviewing the existing Membership Strategy, action planning around increasing and engaging the public membership, and ensuring the membership is representative of the population the Trust serves. The Committee submitted a revised Membership Strategy which has been approved by the Council of Governors and the Board of Directors. The key action has been to bring together disparate levels of engagement and create one common membership for service users, patients and carers, volunteers and champions, young people, clinical and non-clinical staff.

Governor attendance
Further information about individual members of the Council of Governors and attendance at Governor meetings is listed below:

Governor	Council of Governors	Remuneration Committee	Nominations Committee	Membership Development Committee
David Spencer (Lead Governor)	4/4	1/1	-	5/5
Colin Perry	4/4	-	2/2	-
Mahfooz Khan	2/4	-	-	3/5
George Dean	2/4	-	-	-
Michelle Eggett	4/4	1/1	-	4/5
Sandra McIntosh	4/4	-	-	3/3
Wafaa Nawaz	1/4	-	-	-
Kevin Russell	4/4	-	-	5/5
Amanda Martin-Richards	4/4	1/1	-	4/5
Barry Eccles (Deputy Lead Governor)	4/4	-	1/2	-
Nicholas Smith	3/4	-	-	3/3
Hazel Chatwin	2/4	-	-	1/2
Sarah Jones	4/4	1/1	-	-
Ann West	4/4	-	-	4/5
Hayley Lomas	4/4			
Noel Waterhouse	3/4	-	-	3/5
Liz Howes	4/4	-	-	-
Debbie Cromack	2/4	-	-	-
Cathy Woffendin	4/4	1/1	-	-
Valery Convery	4/4	-	2/2	2/5
Cllr Nussrat Mohammed	3/4	-	-	-
Cllr Mike Gibbons	1/3	-	-	-
Cllr Carl Lis	2/4	-	-	-
Steve Oversby	2/4	-	-	-
Yasmin Khan	1/4	-	-	-
Naseem Khan	1/1	-	-	-
Mohammed Shabir	0/3	-	-	-
Shirley Congdon	3/4	-	-	-

Resolution of disputes between the Council of Governors and Board of Directors
The Code of Governance requires the Trust to hold a clear statement explaining how disagreements between the Council of Governors and the Board of Directors would be resolved. This is included in Annex 6 of the Trust Constitution (Standing Orders for the Council of Governors).

During the year, the Chair and Board of Directors have promoted effective communication with the Council of Governors through the following:

- Governor induction;
- Chair and Chief Executive meetings with Staff Governors;
- Chief Executive attends the quarterly Council of Governor meetings. Non-Executive Directors attend the meetings on a rotational basis and Executive

Directors attend as appropriate to answer questions about specific papers;

- Chair's attendance at Governor Committees;
- Chair and Lead Governor meetings;
- Friday Folder to Governors (a weekly newsletter to Governors on key activities across the Trust);
- active participation of the Senior Independent Director;
- Committee Chairs attendance at Council of Governors meetings; and
- Nominations Committee meetings.

Membership information

The Trust's membership strategy aims to ensure the membership is representative of the local communities. The strategy contains three key objectives. These relate to:

- the recruitment of a representative membership;
- the engagement of members in the work of the Trust; and
- obtaining views from the Trust's members and the public about the services provided by the Trust.

These objectives are underpinned by a number of actions which detail how the objectives will be achieved. These include actions relating to the recruitment of younger people, the development and publication of a Trust-wide calendar of engagement events and the establishment of procedures whereby members are invited to provide their views to Governors. A copy of the strategy is available from the Membership office.

Governors and the Board receive reports which provide details about the age, profile and ethnicity of the membership. This data helps the Trust to determine the focus of future membership recruitment efforts. Following consideration by Governors and Directors, the latest strategy contains an objective relating to the recruitment of members aged 14-21.

Anyone aged 14 or above can become a member of the Trust by completing a membership application form. This is available via the website at: https://secure.membra.co.uk/bradfordapplicationform/

A copy can also be requested from the Foundation Trust office via email at ft@bdct.nhs.uk or by telephone on: 01274 363552.

During the year, members have been invited to attend a number of membership engagement events including membership talks about specific healthcare conditions, the Annual Members' Meeting and Governor Awareness events and the majority of these have been well attended. The programme of membership events for 2016 is currently being considered and once approved, Governors will have an opportunity to engage the membership at future membership events.

Public and staff membership data

Public constituency	No of members/percentage of membership (rounded)
Age (years):	
0-16	71
17-21	680
22+	8401
Not Stated	597
Ethnicity:	
White	5633
Mixed	210
Asian or Asian British	3091
Black or Black British	480
Other	115
Not Stated	220

Public constituency	No of members/percentage of membership (rounded)
Socio-economic groupings (working age population):	
AB	2080
C1	2615
C2	2145
DE	2822
Gender analysis:	
Male	3834
Female	5882
Not stated	33

Membership Profile at 31 March 2016

Representativeness by constituency area:

Public areas	Population	Minimum no. of members	Current membership	% of Total membership base – rounded	No of governors
Bradford North	115,242	20	1,996	21	3
Bradford South	103,508	20	1,270	13	3
Bradford West	118,677	20	2,184	22	3
Shipley	96,489	20	1,130	12	2
Keighley	98,477	20	1,141	12	2
Craven	55,540	10	477	5	1
Rest of England	N/A	5	1,546	16	1

Public Membership as at 31 March 2016

Staff membership:

Area	Minimum no. of members	Current membership	% of total staff membership	No of governors
Clinical	10	1,839	74	3
Non-Clinical	10	663	26	2

Staff Membership as at 31 March 2016

Appointment of the Lead Governor
The process for the appointment of Lead Governor requires Governors to put their name forward and provide a supporting statement. These names and statements are put forward to the full Council of Governors as an election and the Governors vote for who they would like as their Lead Governor. The Council of Governors followed this process and appointed Mr David Spencer as Lead Governor from 13 August 2015. Mr Barry Eccles was elected as Deputy Lead Governor.

Report by Lead Governor
The role of the Lead Governor is to:

- undertake the Vice-Chair of Governors role (leading the Council of Governors in exceptional circumstances when it is not appropriate for the Chair or another Non-Executive to do so);
- collate the input of Governors for the Senior Independent Director or Chair regarding annual performance appraisals of the Chair and Non-Executive Directors;
- act as a point of contact and liaison for the Chair and Senior Independent Director;
- chair informal governor only meetings; and
- raise issues with the Chair and Chief Executive on behalf of other Governors and act as a point of contact with Monitor or the CQC, where necessary.

Report from David Spencer, Lead Governor
Since becoming a Foundation Trust in May 2015, the Governors have been actively involved in a variety of meetings and events to become more familiar with the services provided and help to contribute to the work of the Trust. Governors have benefitted from an excellent in-house induction programme and accredited training from the NHS Providers' GovernWell programme, both of which provided a useful foundation for understanding the statutory role. In addition, the Chair held individual meetings with each Governor who completed a skills audit to identify knowledge, skills and experience that would be useful in carrying out our duties.

We have established three Governor-led Committees aimed at setting the remuneration of the Non-Executive Directors, recruitment and appointment of Non-Executive Directors (when there is a vacancy) and discussing how Governors can engage with existing members and recruit new ones. The Membership Development Committee has been very active in discussing the importance of membership, how Governors can better represent members and identify a focus of work for the next two years. This resulted in the production of a new Membership Strategy which was approved by the Council of Governors in February and by the Board of Directors in March, focusing on creating a different membership offer that builds upon wider engagement work already occurring across the Trust.

During the year, and in response to comments made by Governors, the Trust established a regular communication process – the Governors' Friday Folder – to share important information from the Chair and Chief Executive. This has included reminders of key diary dates, invitations to other events, national policy updates, regional and national awards received by staff, and advance notice and advice on issues appearing in the media.

As part of our role in holding the Non-Executive Directors to account, the Chair has encouraged Governors to attend public Trust Board meetings. A number of Governors have attended and found it useful in helping them to understand the way the Board works and the issues facing the Board of Directors. Governors receive a summary of the issues from each Board meeting, in the form of Board in Brief, through the Governors' Friday Folder and the Chair provides a formal report on Board matters at each Council of Governors' meeting. We also have an open invitation to attend Board Committee meetings and some Governors have also taken the opportunity to attend these meetings where issues are discussed in more detail.

The Governors have also been active in representing the Trust at a number of events. We have been involved in recruiting members throughout the year including at the 'Your Future, Your Health' event for young people, university and college recruitment fairs and the district wide dementia awareness event. A number of Governors have attended the Trust's programme of Membership Talks, where senior clinicians have presented information about different healthcare conditions, and also been involved in the '15 Steps Challenge' programme. These 15 Steps service visits help the Trust understand what high quality care looks like from the perspective of a service user or carer, and identify both good practice and areas of potential improvement. Similarly, some Governors have also been part of Patient Led Assessment of the Care Environment (PLACE) visits, which look at issues affective the physical environment

such as cleanliness, the quality of food and drink, and whether people are treated with privacy and dignity.

During the year we have also worked with the Board of Directors on the Annual Plan and the Quality Report. Governors established a working group to help review the Trust's quality goals, contributed to the members' survey, and selected one indicator from the 2015/16 quality goals for review by external audit (which was the number and quality of carer's assessments undertaken by the Trust). The Governors have also been involved in two workshops and briefed about the content of the Annual Plan and how we could be involved in promoting key messages across local communities.

As Lead Governor, I have held regular monthly meetings with the Chair to help set the agenda of Council of Governors' meetings, discuss wider Governor-related issues and suggest ways of developing closer relationships with Directors. We have established our own Governor-only meetings where we have discussed issues affecting Governors, prepared for Council meetings and have invited Board members to come and present on specific areas of interest. There has been no occasion for the Council of Governors to contact either Monitor or the CQC since FT authorisation.

I believe the Governors have built a strong foundation during our first year as a FT and we look forward to using our experiences across a number of projects and work streams in the coming year.

Remuneration report

Annual report on remuneration

The Remuneration Committee comprises exclusively of Non-Executive Directors and has delegated authority from the Board to decide appropriate remuneration and terms of service for the Chief Executive and Executive Directors including all aspects of salary, provision for other benefits including pensions and cars, arrangements for termination of employment including redundancy and other contractual terms.

The Committee also has a key role in:

- reviewing pay, terms and conditions for the most senior staff below executive director level;
- the applicability of any national agreements for staff on local terms and conditions or pay arrangements that are not determined nationally;
- receiving information on the outcome of Clinical Excellence Awards Rounds and any new proposals;
- reviewing and approving all redundancy business cases and any proposed payments to staff that do not fall within contractual entitlements e.g. settlement agreements; and
- reviewing Trust strategies and proposals around pay and reward including FT freedoms, flexibilities and options.

Attendance at Remuneration Committee meetings is shown below:

Membership	Attendance
Michael Smith (Chair)	3/3 meetings
Nadira Mirza	3/3 meetings
David Banks	1/2 meetings
Sue Butler	1/1 meetings
Ralph Coyle	1/2 meetings
Derrick Palmer	1/1 meetings
Rob Vincent	2/2 meetings
In attendance	
Simon Large	1/1 meetings
Sandra Knight	2/2 meetings

Sandra Knight, Director of Human Resources and Organisational Development, provides advice and guidance to the Committee and the Committee is provided with administrative support by the PA to the Chief Executive and Chair.

The pay framework for the Executive Directors and Chief Executive was developed in conjunction with Capita in 2007. A decision was made by the Committee to defer any review of this pay framework until the Trust achieved FT status. The Trust became a FT on 1 May 2015. During the year, the Committee reviewed the salaries of the Executive Directors and Chief Executive using benchmarking information from the national e-Reward report and the NHS Providers' Benchmarking report.

The report enabled the Committee to ensure Executive Director salaries were fair as well as being sufficient to attract, retain and motivate Directors of the quality required to run the organisation successfully but to avoid paying more than is necessary. The Committee decided to move from an incremental pay scale to remunerating Directors and the Chief Executive on a spot salary in line with the benchmark evidence.

This would be reviewed annually. No other external support or advice was sought by the Committee during 2015/16.

Performance review process

In June 2016, the Committee will consider a report from the Chief Executive on the outcome of his end-of-year reviews with Directors in relation to their personal objectives as well as a report from the Chair on the Chief Executive's performance. The Committee will consider proposed objectives for the Directors and Chief Executive for 2016/17 and the Trust's approach to remuneration for the coming year reviewing available benchmark information to ensure pay remains competitive. The Trust does not propose introducing any team performance objectives and related bonus scheme at this stage. We are required to indicate in our annual report the expenses paid to our Directors in the financial year and the sum paid in 2015/16 was £18,800 to ten Directors (against a total of £10,600 in 2014/15 to ten Directors). The expenses paid to five Governors in the same financial year was £600, with 22 not claiming any expenses. There was no comparable figure for 2014/15 as Governors were only appointed on 1 May 2015.

Senior managers' remuneration policy/pay framework

The pay policy framework remains that the terms and conditions for staff reflect nationally determined arrangements under Agenda for Change. The Committee has agreed to wait for the outcome of the national review of the employer-based Clinical Excellence Award scheme before taking any decisions about the Trust's future approach. The Committee's wish that the scheme rewards clinical excellence linked to delivery of the Trust's strategic goals, values and contribution to leadership and service transformation remains.

During the year, the Committee approved five business cases for termination of employment on the grounds of redundancy at a senior level. This reflects the Trust's policy to reduce management costs to protect front-line services, involving the streamlining of both support and operational services at senior management level and to introduce new management arrangements. There were no significant awards made to past senior managers.

Details of appointment dates for Non-Executive and Executive Directors of the Trust are included in Appendix 1. Non-Executive Directors are usually appointed for a three-year term and can be re-appointed for further terms up to a maximum of nine years; however, it is the view of the Chair, that Non-Executive Directors should serve a maximum of eight years other than in exceptional circumstances. There are no Executive Directors appointed on fixed term contracts. All Executive Directors are subject to a six month notice period, no provision for compensation for early termination is included in staff contracts and any provision for compensation for termination would be considered on an individual basis by the Committee.

Accounting policies for pensions and other retirement benefits and details of senior employees' remuneration can be found below and are also set out in note 8 to the accounts. Apart from Non-Executive Directors who are appointed for a fixed-term, no other Directors of the Trust are appointed on fixed term contracts; therefore, there are no unexpired terms and contracts do not contain provision for early termination of a contract. The information contained on pages 36-37 relating to the salary and pension entitlements of senior managers within the Trust is subject to audit and is taken from the Trust's accounts for 2015/16.There is one officer in the Trust at Executive level who is paid more than £142,500 following benchmarking review of that role as part of the review of remuneration for that type of role in similar Trust's nationally. One Director has been seconded to another Trust to support the Airedale and Partners Vanguard work. This Director has since been successful in being appointed to an Executive Director at another local NHS provider and left BDCFT on 30 April 2016.

Non-executive director remuneration

In November 2015, the Council of Governors considered a proposal on Chair and Non-Executive Director remuneration from its Remuneration Committee which had reviewed benchmark evidence of Non-Executive Director remuneration using the e-Reward and NHS Providers reports. The Committee supported the finding that the basic rate being paid was not within the market range when compared to such roles in similar Trusts for the same time commitment. It was felt that the current level of allowance did not reflect the additional complexities, challenges and level of responsibility faced by Non-Executive Directors in a FT.

The recommendation of the Remuneration Committee, approved by the Council of Governors, was that there was a rationale to increase the level of remuneration from £6,157 to £12,500 per annum based on ensuring a fair and competitive market rate for this role and

ensuring the ability to attract, recruit and retain high calibre Non-Executive Directors. The same rationale was applied to the Chair's remuneration which was uplifted from £21,105 to £42,500 per annum.

Service contract obligations
Following the introduction of the Fit and Proper Persons Requirements (FPPR) for Executive Directors and Non-Executive Directors, Regulation 5 of the Health and Social Care Act, the Trust continues to discharge its responsibility in ensuring that existing and new role holders, are reviewed against the FPPR standards and has incorporated this following the initial self-declaration into the appraisal process also ensuring inclusion in employment contracts.

Leadership and management
This year has seen some changes to the Trust's leadership and management arrangements. During the year, the Trust's Commercial Director was seconded to Airedale NHS Foundation Trust to support the Care Home Vanguard. This has resulted in a review of Director level portfolios and a streamlining of arrangements around the Trust's Project Management Office (PMO) which has transferred to the Deputy Chief Executive/Director of Nursing and Operations' portfolio. The appointment of a new role to the PMO arrangements (Head of Business and Service Development) will strengthen our ability to grow the business. The role will work closely with service leads to scope commercial opportunities.

The informatics portfolio is currently managed by an interim Chief Information Officer, accountable to the Chief Executive. A future IMT structure is being developed as part of the development of the Trust's digital strategy and a structure will be confirmed in 2016/17. The Trust Secretary is the Senior Information Risk Owner.

During the year changes were also made to the Deputy Director structure at operational level to ensure strong and effective strategic and operational management, responsiveness to commissioner requirements and a proactive approach to service transformation. Deputy Director roles in operations were restructured and streamlined and the roles that supported them, resulting in a reduction in the overall costs of the operational structure whilst ensuring a strong service focus. The review resulted in a restructuring of portfolios to create a new Children's Directorate, a Specialist Inpatient Directorate, a Directorate focused on Acute and Community Mental Health Services and an Adult Physical Health and Community services Directorate. Corporate Directorates have been structured to ensure dedicated support to these service Directorates. A strong Deputy Director structure continues to allow Directors to focus on building and managing strategic and partner relationships, and to lead the transformation agenda.

Through 2015/16, this has been supported by arrangements at service line level to provide a framework where medical and clinical leads, heads of service, service managers and governance leads work together and carry responsibility at service level to deliver the changes required to achieve transformation.

In the coming year, the Chair and Chief Executive will jointly review the Trust Board structure to ensure it has the appropriate capacity, skills and experience in place to support ongoing fitness for purpose. The Board continues to work to increase the diversity of leadership both within the wider organisation and within the Board itself. The resignation of one of the Non-Executive Directors provided an opportunity to secure a high calibre appointee from the local BME community using a positive action approach. At its meeting in March 2016 the Committee reviewed the composition of the Board as two other Non-Executive Director's terms of office expired on 2 May 2016. The Committee agreed to recommend to the Council of Governors the re-appointment of Dr Sue Butler for a second term. The retirement of the other Non-Executive Director and the resignation of the Commercial Director meant that the composition of the Board would be five Non-Executive Directors, five Executive Directors and a Non-Executive Chair.

The Trust has in place a robust workforce/organisation development strategy and associated leadership framework - Leading for Excellence - aimed at ensuring a strong talent pool of engaging, values based, inspirational and transformative leaders with the skills, behaviours, attitudes and resilience to meet the challenges facing the organisation. Key programmes include the Engaging Leaders Programme which over 300 of the Trust's middle and senior leaders have attended and the Moving Forward Programme targeted at Band 5 and 6 BME aspiring senior leaders of the future. The Board's Nominations Committee working alongside the Remuneration Committee has a key role in ensuring that there is a talent pipeline of senior leaders who are able to grow and develop into senior leadership roles and who are part of the organisation's succession plan.

Remuneration information

The components of the remuneration policy for Executive Directors are as follows:

Component	Narrative
Pay	In order to attract and retain talented individuals capable of delivering the strategy, periodic comparisons are made with the pay of equivalent posts in similar Trusts. Following the Trust's authorization as a Foundation Trust in May 2015, benchmarking took into account comparable NHS Foundation Trusts.
Pension related benefits	Pension related benefits relate to arrangements set out by the national NHS Pension scheme.
Performance related pay	Given the focus on teamwork and periodic pay benchmarking referenced above, Executive Directors do not receive performance related pay.

The components of the remuneration policy for Non-Executive Directors are as follows:

Component	Narrative
Pay	In order to attract and retain high caliber Non-Executive Directors, periodic comparisons are made with the pay of equivalent posts in similar Trusts. Following the Trust's authorization as a Foundation Trust in May 2015, benchmarking took into account comparable NHS Foundation Trusts.
Pension related benefits	Non-Executive Directors are not eligible for pension related benefits under the NHS Pension scheme.
Performance related pay	Non-Executive Directors do not receive performance related pay.

Details about the remuneration levels for 2015/16 are provided below, divided into the 11 months in which the Trust operated as a Foundation Trust, and the one month (April 2015) prior to authorisation as a Foundation Trust. Also included is information about the relationship between the highest paid Director of the Trust and the median remuneration of the organisation's workforce.

Audited Remuneration Report for 2015/16 - The information below relates to the full year for 2015/16 i.e. includes one month as an NHS Trust prior to authorisation as a Foundation Trust and eleven months post authorisation (1 May 2015 to 31 March 2016).

Salary and allowances:

Name and Title	2015/16			
	Salary	* Expense payments (taxable) to nearest £100	All pension-related benefits***	Total
	(Bands of £5000) £ 000	Rounded to nearest £100	(Bands of £2,500) £ 000	(Bands of £5,000) £ 000
M Smith - Chairman	40 - 45	100		40 - 45
D Palmer - Non Executive Director (to 31.10.15)	5 - 10	100		5 - 10
R Coyle - Non Executive Director	10 - 15	100		10 - 15
N Mirza - Non Executive Director	10 - 15			10 - 15
S Butler - Non Executive Director	10 - 15			10 - 15
R Vincent - Non Executive Director	10 - 15			10 - 15
D Banks - Non Executive Director	10 - 15	100		10 - 15
Z Hussain - Non Executive Director (from 1.3.16)	0 - 5			0 - 5
S Large - Chief Executive	150 - 155	100	165 - 167.5	315 - 320
L Romaniak - Director of Finance, Contracting & Facilities	110 - 115		112.5 - 115	225 - 230
S Knight - Director of Human Resources & Organisational Development	95 - 100	1,800	80 - 82.5	180 - 185
P Hogg - Trust Secretary	80 - 85	3,900	0	75 - 80
N Lees - Deputy Chief Executive/Director of Nursing	115 - 120	6,100	82.5 - 85	200 - 205
A McElligott - Medical Director	130 - 135	6,400	45 - 47.5	175 - 180
H Bourner - Commercial Director ****	95 - 100	100	0	95 - 100

Name and Title	2014/15			
	Salary	Expense payments (taxable) to nearest £100	All pension-related benefits	Total
	(Bands of £5000) £ 000	Rounded to nearest £100	(Bands of £2,500) £ 000	(Bands of £5,000) £ 000
M Smith - Chairman	20 - 25	200		20 - 25
D Palmer - Non Executive Director (to 31.10.15)	5 - 10	400		5 - 10
R Coyle - Non Executive Director	5 - 10	200		5 - 10
N Mirza - Non Executive Director	5 - 10			5 - 10
S Butler - Non Executive Director	5 - 10			5 - 10
R Vincent - Non Executive Director	5 - 10			5 - 10
D Banks - Non Executive Director	5 - 10	200		5 - 10
Z Hussain - Non Executive Director (from 1.3.16)				
S Large - Chief Executive	135 - 140	200	7.5 - 10	140 - 145
C Stubley - Director of Finance, Contracting & Facilities (to 28.4.14)	5 - 10		5 - 7.5	10 - 15
L Romaniak - Director of Finance, Contracting & Facilities (from 11.4.14)	95 - 100		120 - 122.5	215 - 220
S Knight - Director of Human Resources & Organisational Development	85 - 90	1,200	0	80 - 85
P Hogg - Trust Secretary	80 - 85	500	0	75 - 80
N Lees - Deputy Chief Executive/Director of Nursing	105 - 110	3,900	0	60 - 65
A McElligott - Medical Director	125 - 130	3,700	12.5 - 15	140 - 145
H Bourner - Commercial Director	95 - 100	100	12.5 - 15	110 - 115

NOTES:

* Expense payments relate to taxable travel allowances and to benefits in kind relating to lease cars.

** The Trust has made no payments (current or long term) for performance pay or bonuses.

***Pension benefits only relate to Officer Scheme membership and do not include any practitioner i.e. GP pension benefits. This is only applicable to the Medical Director.

****Full year values are required to be reported for the Commercial Director who is on secondment to Airedale NHS Foundation Trust, who have reimbursed agreed salary and expenses from 9th September 2015.

In respect of pension related benefits, taking one year compared to the next, due to the number of factors affecting both the benefits accrued in-year and the movement in Cash Equivalent Transver Value (CETV) it is not possible to define which factor has led to those changes. Factors that can affect the reported pension related benefits are; relevant Total Pensionable Pay (TPP) which can be affected cost of living inflation or salary deductions via salary sacrifice schemes; length of service of a pensionable employee and whether they have reached the maximum permissable contributions; which of the two current schemes being operated within the NHS and the affect of the resulting protection arrangements employed by

All pension related benefits in the table above are adjusted for inflation at the CPI rate of 1.2% in 2015/16 (2.7% in 2014/15).

Audited Remuneration Report for 2015/16 - The information below relates to the full year for 2015/16 i.e. includes one month as an NHS Trust prior to authorisation as a Foundation Trust and eleven months post authorisation (1 May 2015 to 31 March 2016).

Pension Benefits:

Name and title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in Pension Lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2016 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2016 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2015 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2016 £000
S Large - Chief Executive	7.5 - 10	22.5 - 25	60 - 65	180 - 185	1,033	175	1,221
L Romaniak - Director of Finance, Contracting & Facilities	5 - 7.5	10 - 12.5	35 - 40	95 - 100	428	79	512
S Knight - Director of Human Resources & Organisational Development	2.5 - 5	10 - 12.5	35 - 40	110 - 115	709	99	816
P Hogg - Trust Secretary	0 - 2.5	0	25 - 30	75 - 80	440	2	448
N Lees - Deputy Chief Executive/Director of Nursing	2.5 - 5	12.5 - 15	50 - 55	160 - 165	920	91	1,022
A McElligott - Medical Director	2.5 - 5	0 - 2.5	20 - 25	65 - 70	345	38	387
H Bourner - Commercial Director	0 - 2.5	2.5 - 5	20 - 25	70 - 75	427	23	455

NOTES:

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

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

On 16 March 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0% to 2.8%. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. CPI inflation of 1.2% has been used in accordance with NHS Business Services Authority guidance in 2015/16 (2.7% in 2014/15).

No Director has a stakeholder pension.

Pension benefits only relate to Officer Scheme membership and do not include any practitioner i.e. GP pension benefits. This is only applicable to the Medical Director.

Fair Pay Multiple - Median Pay

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid director in Bradford District Care NHS Foundaton Trust in the financial year 2015/16 was £150,000 - £155,000 (2014/15 £135,000 to £140,000). This was 5.4 times (2014/15 - 4.9 times) the median remuneration of the workforce which was £28,180 (2014/15 - £28,180).

The median salary has been calculated by using the salary costs as set out below for all employees as at 31 March 2016. Where employees work part time, the salary cost has been grossed up to the full time equivalent salary. The calculation does not include bank or agency staff as these staff are engaged on a need to cover a shift basis rather than a full time equivalent basis. Information on the annual salary costs for individual bank and agency staff is not available. Any other form of proxy methodology to calculate a salary cost would not be deemed to provide a fair representation of the median salary of the organisation.

In 2015/16 no employees (2014/15 - two) received remuneration in excess of the highest paid director. Remuneration ranged from £14,000 to £155,000 (2014/15 £14,000 to £143,000). Total remuneration includes salary and benefits in kind but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. In 2015/16, the highest paid director was the Chief Executive.

The median pay in 2014/15 included a non-consolidated 1% pay award. This was replaced by a consolidated pay award of 1% in 2015/16. This has resulted in there being no change in the median pay.

	2015/16	2014/15
Mid Point of the banded remuneration of the highest paid director	152,500	137,500
Median Total Remuneration (£)	28,180	28,180
Ratio	5.4	4.9

Other remuneration information
The Trust is required to report on other remuneration related information. Exit packages for 2014/15 and 2015/16, and off payroll expenditure are shown in the tables below. Expenditure on consultancy costs in 2015/16 was £522,000.

Exit packages 2015/16

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	1	1	2
£10,001 - £25,000	1	0	1
£25,001 - £50,000	5	0	5
£50,001 - £100,000	3	0	3
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	**10**	**1**	**11**
Total resource cost	**£396, 000**	**£3,000**	**£399,000**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

Exit packages in 2015/16 include redundancies relating to Substance Misuse, Health of Men and Health on the Streets Services, which were decommissioned in July and August 2015. One further package relates to an internal Trust-wide service review. These were provided for in 2014/15.

Exit packages 2014/15

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	6	3	9
£10,001 - £25,000	9	3	12
£25,001 - £50,000	2	2	4
£50,001 - £100,000	0	5	5
£100,001 - £150,000	0	0	0
£150,001 - £200,000	1	0	1
>£200,000	0	0	0
Total number of exit packages by type	**18**	**13**	**31**
Total resource cost	**£389,000**	**£457,000**	**£846,000**

Exit packages: non-compulsory departure payments 2015/16

	Agreements (number)	Total Value of Agreements (£000s)
Voluntary redundancies including early retirement contractual costs	0	0
Contractual payments in lieu of notice	1	3
Total	**1**	**3**

As a single exit package can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in the exit packages table above which will be the number of individuals.

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:

	Number
Number of existing engagements as of 31 March 2016	5
Of which:	
Number that have existed for less than one year at the time of reporting	2
Number that have existed for between one and two years at the time of reporting	1
Number that have existed for between two and three years at the time of reporing	2
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

Confirmation that all existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

For all new off-payroll engagements between 1 April 2015 and 31 March 2016, for more than £220 per day and that last longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2015 and 31 March 2016	1
Number of the above which include contractual clauses giving Bradford District Care NHS Foundation Trust the right to request assurance in relation to income tax and National Insurance obligations	1
Number for whom assurance has been requested. The Trust obtains assurance annually in September and assurance will be sought in September 2016 for all contracts in place.	0
Of which:	
Number for whom assurance has been received	0
Number for whom assurance has not been received	0
Number that have been terminated as a result of assurance not being received	0

In any cases where, exceptionally, the Trust has engaged without including contractual clauses allowing it to seek assurance as to their tax obligations - or where assurance has been requested and not received, without a contract termination - the Trust should set out the reasons for this.

Where an individual leaves after assurance is requested but not yet received, for whatever reason, except where the deadline for providing assurance has not yet been received.

Personal details of all engagements where assurance is requested but not received, for whatever reason, except where the deadline for providing assurance has not yet passed, should be passed to to HMRC's tax evasion hotline.

Instances where the Trust is still waiting for information from the individual at the time of reporting should be reported as Number for whom assurance has not been received. The Trust obtains assurance annually in September and assurance will be sought in September 2016 for all contracts in place.

Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the year	0
Number of individuals that have been deemed "board member and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	7

Staff report

Workforce overview

Last year we employed over 2,800 clinical and non-clinical staff, all of whom contributed to providing high quality care in our inpatient wards and across our community services. Our staff have worked hard to provide 'joined up care' through integrating mental health and physical health services providing care locally and at the point of need.

Our workforce strategy and plan underpins the achievement of our vision, recognising our staff are the Trust's most valuable asset coming in direct contact with patients, carers, partners and accounting for 70% of costs. The workforce plans ensure staff are equipped with the right skills, behaviours, competencies and leadership to excel in delivering high quality, safe, value for money services that meet the needs of our local communities.

During 2015/16, the Trust set a number of workforce goals based around workforce planning, leadership, staff engagement, diversity and health and wellbeing. During the year the Trust has:

- rolled-out of ESR Manager/Staff Self Service, enabling staff to keep their employee records up to date and for managers to access real time workforce data to support workforce planning decisions;
- provided HR/OD support around agile working to over 1,400 community based staff across 30 services and 150 teams;
- run a second cohort of 150 managers on the Engaging Leaders programme to develop leaders from Band 6 and above to deliver cultural change across the Trust;
- developed and launched the Moving Forward programme, a specific leadership programme for Black and Minority Ethnic (BME) staff focusing on career development, networking, developing confidence and positive self-belief;
- continued to implement the BME Employment Strategy, which was first ratified in April 2014;
- invested in coaching and mentoring, with a further five coaches trained; since January 2015 the Trust's internal coaching community has been active in supporting over 30 new coaching relationships;
- brought back in-house the Employee Health and Wellbeing Service, with a focus on broadening the service to include fast track access to physiotherapy, occupational therapy and a range of programme to help reduce stress and anxiety;
- procured a new e-rostering system for 2016/17 to support the safer staffing agenda; and
- introduced plans for a managed staff bank service in 2016/17 to help reduce agency costs and meet the new targets introduced by our regulators.

Workforce analysis

An analysis of average staff numbers with permanent and other staff is broken down by occupation group (medical staff, nursing staff) below:

Average number of employees	2015/16 Total number	2015/16 Permanent number	2015/16 Other number
Medical and dental	89	65	24
Ambulance staff	0	0	0
Administration and estates	624	599	25
Healthcare assistants and other support staff	392	378	14
Nursing, midwifery and health visiting staff	1,024	1,000	24
Nursing, midwifery and health visiting learners	0	0	0
Scientific, therapeutic and technical staff	366	349	17
Healthcare science staff	0	0	0
Social care staff	0	0	0
Agency and contract staff	228	0	228
Bank staff	100	0	100
Other	0	0	0
Total average numbers	**2,823**	**2,391**	**432**
Of which number of employees (WTE) engaged in capital projects	5	3	2

A breakdown by gender of directors, other senior employers and employees employed by the Trust is set out below:

Category	Female	Male
Directors	4	2
Other senior employees	50	18
Employees	2,333	542
Total	2,387	562

Workforce targets

The Trust has a number of workforce targets that are monitored by the Board to assess performance including mandatory training and appraisal rates. Performance compared to the previous year is shown below:

Internal Board indicators	2015/16 target	2015/16 performance	2014/15 performance	Trust Position
Mandatory training (excluding information governance compliance)	80%	91.9%	82.7%	Achieved target
Information Governance training	95%	96.5%	83.7%	Achieved target
Staff receiving appraisal	80%	83.1%	81.5%	Achieved target
Labour turnover	10%	11.6%	9.7%	Not achieved

Sickness absence

The Trust Board has recognised that sickness absence can have a detrimental impact on the organisation from both a quality and a financial perspective and reducing sickness levels has been a key strand of the Trust's workforce strategy for a number of years. The Trust continues to undertake a wide range of initiatives aimed at reducing sickness and is also mindful not to create a culture of 'presenteeism' as if staff do attend work when they are unwell it can often result in longer periods of sickness absence. The Trust is one of 11 providers leading a national programme to improve the health and wellbeing of NHS staff, introducing exercise classes, physiotherapy, smoking cessation and access to confidential counselling for staff and their families.

Information on sickness absence is extracted from national data information and the figures are presented as calendar year figures, in accordance with the Annual Reporting Manual. Details of the number of staff days lost are shown below:

Staff sickness absence	Total number 2014/15	Total number 2015/16
Total days Lost	28,526	27,483
Total staff years	2,380	2,486
Average working days lost	11.99	11.1

Staff policies and actions applied during the financial year.
The Trust has a number of policies in place that supports good governance and senior management has taken a number of actions during the year to strengthen these policies:

Policies applied during the financial year for giving full and fair consideration to applications for employment made by disabled persons, having regard to their particular aptitudes and abilities.
The Trust has a comprehensive recruitment and selection policy which conforms to the Equality Act 2010 and ensures that full and fair consideration is given to applications received from disabled persons. The Trust also has achieved the Positive about being Disabled accreditation which includes the pledge to offer an interview to all applicants with a disability who meet all the essential criteria for a job vacancy. Recruiting managers receive training on the Trust's approach to recruitment to ensure that selection decisions are taken in a fair and equitable manner. In addition the Trust's Service user and Carer Involvement Strategy, has ensured a greater involvement in the recruitment and selection process and decision making of service user, patient and carer representation.

Policies applied during the financial year for continuing the employment of, and for arranging appropriate training for, employees who have become disabled persons during the period.
The Trust requests medical advice where reasonable adjustments are required to be implemented to ensure employees can continue to work where they have a long term or enduring condition. Dedicated HR Advisers ensure that there is on-going and proactive engagement and discussion between the employee and line manager to ensure that the appropriate support, including training, is put in place as quickly as possible. It is also worth highlighting that the Trust is one of eleven sites nationally identified as being an exemplar NHS Trust for its work relating to employee health and wellbeing support.

Policies applied during the financial year for the training, career development and promotion of disabled employees.
The Trust's annual appraisal process provides the opportunity to discuss and agree support for any career progression, training and development needs for all employees. Our policies are equality impact assessed at the point of development to ensure all equality strands are assessed and evidenced prior to policy implementation.

Reasonable adjustments can be made to accommodate the needs of disabled staff attending training e.g. access to a loop.

Actions taken in the financial year to provide employees systematically with information on matters of concern to them as employees.
The Trust deploys a range of strategies to provide staff with information on matters that may be of concern to them. This ranges from weekly e-communications and Board in Brief (team cascade) to more formal meetings involving staff side representatives when changes occur within the Trust which have a direct impact on the workforce – organisational changes for example – and has a formally agreed consultation process, including the completion of equality impact assessments.

Actions taken in the financial year to consult employees or their representatives on a regular basis so that the views of employees can be taken into account in making decisions which are likely to affect their interests.
The Trust meets formally with staff-side representatives on a regular basis through a range of formal meetings and through formally agreed consultation processes, including the completion of equality impact assessments where required. The Trust engages and cascades information through a range of formats across its workforce via one to ones, team briefings, weekly electronic communications, newsletters and via its intranet pages called Connect. The Trust utilises the Equality Data System to report on its commitments to equality. Wider consultation and engagement exercises are undertaken by the Trust including the annual staff survey which is used to determine action plans to affect a stepped change in employee satisfaction levels based on staff engagement, a rolling programme of culture conversations, where Directors meet with staff, Board quality and safety walkabouts in service and a range of service development and quality engagement forums.

Actions taken in the financial year to encourage the involvement of employees in the NHS foundation trust's performance.
The Council of Governors, who comprise clinical and non-clinical staff as well as the staff side representatives are briefed on a regular briefings about the Trust's performance such as finances and workforce KPIs and encouraged to give their feedback

and ideas. In addition, staff are briefed via team brief on the Trust's planning processes and performance at the beginning of the financial year and then throughout the year. Team brief encourages staff to feedback ideas and comments.

Information on health and safety performance and occupational health.
Health and Safety is governed through the Trust Health and Safety Committee and meets quarterly to identify actions and plan progress against Trust requirements. The Trust has brought its Occupational Health service in house from June 2016 and has developed a range of bespoke interventions to support its health and wellbeing requirements for the workforce including fast track physiotherapy, health and resilience support, proactive fitness and wellbeing initiatives such as weight management, exercise classes and an interactive mindfulness app.

Regular reports on performance for both health and safety and occupational health are discussed regularly at committee meetings – for example the Health and Safety Committee and the Workforce Transformation Steering Group.

Information on policies and procedures with respect to countering fraud and corruption.
The Trust has revised and implemented the Standards of Business Conduct, Bribery, Gifts, Hospitality and Outside Employment policy and procedure. The Trust has issued and updated its declaration of interest process for all employees to continue to assess and mitigate any risks identified.

Wider recognition of our staff
Thanks to the commitment and expertise of our staff, we have once again been recognised as a leading organisation across a number of clinical and non-clinical areas. The number of staff being shortlisted, or winning, regional or national awards continues to increase each year.

Clinical awards	Non-clinical awards
Palliative Care team - BMJ Team of the Year (national winner)	Gold Award, RoSPA Occupational Health & Safety Awards
Janet Irving, Student Mentor of the Year – Nursing Times Award	Food Services team – HefmA team of the Year
UNICEF Stage 3 Breastfeeding Award	Board of the Year and provider Trust of the year (finalists) – HSJ Awards
Primary Care Wellbeing service (shortlisted) – Clinical Team of the Year (Long term conditions), General Practice Awards	Board of the Year – Regional Leadership Awards, Yorkshire and the Humber
Emma Kergon, District Nurse – Queen's Nurse Award	Payroll team – Public sector award, Payroll World Awards
First Response service (high commended in two categories) – Positive Practice Awards	Tracey Corner, Patient Champion of the Year – Regional Leadership Awards, Yorkshire and the Humber
Improving physical/mental health team (highly commended) – Positive Practice Awards	Lisa Wright, Diversity Champion of the Year Regional Leadership Awards, Yorkshire and the Humber
Dementia Assessment Unit (commended – Innovation in Mental Health Health Business Awards)	Friends & Family Test Champion of the Year (shortlisted) – NHS England Awards
Dementia Assessment Unit – , Gold Accreditation award for dementia-friendly design	
First Response service – Nursing Times Awards	

Our own staff awards celebration – You're A Star Awards, now in its seventh year – is held for staff to nominate colleagues for their exceptional contribution towards providing high quality care. Sponsored by Sovereign Health Care, over 60 nominations were honoured at the Bradford Hotel.

YASA winners	Description of service
Quality	Physical health and wellbeing clinics – introducing blood pressure and hear checks for those with serious mental illness.
Patient Experience	Dawn Langwade, Specialist Clinic Nurse – working with people with learning disabilities.
Value for Money	Dental Anxiety and Management service – working with patients that would otherwise have to have treatment under a general anesthetic.
Relationships	Ward 24, Specialist Dementia Assessment Unit – creating a caring and accessible service for acutely unwell dementia patients.
You and Your Care Award	Maureen Myers, Volunteer Health Champion – leading a number of therapeutic activities such as walking, singing and other community-led activities.

Staff partnerships
The Trust has a positive relationship with its staff side representatives. The Staff Partnership Forum, which is jointly chaired by the Staff Side Chair and the Chief Executive, meets on a quarterly basis to discuss strategic issues that may impact on staff. Since becoming a Foundation Trust, staff governors and staff side representatives have been keen to collaborate whenever possible and meet to share information relevant to the Trust's workforce.

Listening to our staff
The Trust recognises the importance of listening to staff to help improve the quality of our services and has a number of different mechanisms which involves Board members. Quality and safety and walkabouts have been a long established process where Board members visit services to talk to groups of staff about quality and safety issues. Each service is sent a letter to confirm any actions to follow up and Non-Executive Directors report on walkabouts at each Board meeting. Culture conversations continue to be run across the Trust on a regular basis, led by Executive Directors. This approach of Directors meeting with groups of staff has helped to increase the visibility and accessibility of the Executive team – something that staff had specifically asked for. Feedback from the culture conversations continues to be positive, with staff particularly appreciating the opportunity to discuss key issues with a member of the Executive team feeling that the issues raised are being listened to and that they are empowered to deal with the issues raised by themselves or with their colleagues.

Staff survey
Staff satisfaction and engagement are key to delivering high quality, values-based care and are directly associated with patient experience and outcomes. Staff are our key resource, the engagement, satisfaction and health and well-being of the workforce are critical to optimal performance and enabling achievement of our vision and strategic objectives. The staff survey is an important means of providing workforce assurance and highlighting areas for improvement actions.

The Trust wide results, corporate actions, and processes and timescales for communication and action planning at local level have been cascaded through the team briefing mechanisms and through e-update and the intranet. The survey results have been shared with the Staff Partnership Forum members to gain their support in communicating the results and action planning. Reports for each area

have been shared with managers for feedback and discussion with staff and to jointly agree two or three actions that will make a difference using existing meeting structures. Deputy Directors will monitor and oversee this process.

Progress in communicating and action planning locally with staff will be supported by HR Business Partners and reviewed through the monthly directorate performance meetings and through management supervision arrangements. Communication, development and implementation of a local action plan will be an expected part of team leaders' objectives for the coming year. Progress in implementing corporate actions will be through the Workforce Transformation Steering Group reporting to the Executive Management Team.

Key priorities for the Trust will continue to be:

- workplace stress and wellbeing;
- equality and diversity;
- management, leadership and team leader development; and
- staff satisfaction.

As a result of the re-categorisation of NHS Trusts in the 2015 Staff Survey, reporting on benchmarked results in top/bottom 20% is no longer available. Benchmark comparisons are expressed as average, better than average or worse than average. The Trust is:

- better than average for 16 out of 32 key findings;
- average for 14 key findings; and
- worse than average for two key findings.

In relation to **staff engagement** the overall score has improved (3.84 compared to 3.76 in 2014) which compares favourably to the National Average of 3.81 (the higher the score the better).

The three key findings that make up the engagement score show that the Trust is better than average for two of them: staff motivation at work (an increase to 4.0 compared to 3.9 in 2014), staff ability to contribute towards improvements at work (an increase to 75% from 72% in 2014) and average for staff recommendation of the trust as a place to work or receive treatment; (despite this increasing from 3.62 in 2014 to 3.73 in 2015, the higher the score the better).

Staff experience has improved in the following areas: Improvement in staff engagement; Staff motivation at work; Percentage of staff suffering work related stress in last 12 months; Percentage of staff appraised in last 12 months; Staff recommendation of the organisation as a place to work or receive treatment. We have seen a deterioration in staff experience around the percentage of staff working extra hours.

The response rate for 2015 was 51% compared to 47% in 2014.

Areas of improvement from the prior year and deterioration .

The **greatest improvements** since 2014 are in the four key findings:

- KF4 staff motivation at work (an increase from 3.9 to 4, the higher the score the better).
- KF17 percentage of staff suffering work related stress in last 12 months (a decrease from 45% to 41%, the lower the score the better).
- KF11 percentage of staff appraised in last 12 months (an increase from 89% to 94%, the higher the score the better), also appears within the 5 highest ranking scores above.
- KF1 staff recommendation of the organisation as a place to work or receive treatment (increase from 3.62 to 3.73, the higher the score the better).

The one key finding (that is directly comparable) that has deteriorated since the 2014 survey is:

- KF16 percentage of staff working extra hours (an increase from 65% in 2014 to 72% in 2015, the lower the score the better).

Top 4 ranking scores

The combined mental health/learning disability and community trusts in England (of which there are 29) were placed in order from 1 (the top ranking score) to 29 (the bottom ranking score). For each of the 32 key findings, BDCFT's **four highest ranking scores** are as follows:

- KF30 fairness and effectiveness of procedures for reporting errors, near misses and incidents (3.87 compared to an average of 3.72, the higher the score the better), not comparable to 2014 results.
- KF15 percentage of staff satisfied with the opportunities for flexible working patterns (63% compared to an average of 56%, the higher the score the better), not comparable to 2014 results.
- KF11 percentage of staff appraised in last 12 months (94% compared to an average of 91%, the higher the score the better), directly comparable to 2014 (in which we were 89%).
- KF31 staff confidence and security in reporting unsafe clinical practice (3.76 compared to an average of 3.70, the higher the score the better), updated and not directly comparable to 2014 results.

Bottom 4 ranking scores
The 4 key findings for which the Trust compares **least favourably** are listed below:

It is worth noting that of these; only two are ranked worse than average when compared to MH/LD/ community trusts in England (first two listed), the remaining two are ranked as average.

- KF20 percentage of staff experiencing discrimination at work in the last 12 months (12% in 2015 compared to 11% in 2014, the lower score the better), directly comparable to 2014 results.
- KF21 percentage of staff believing that the organisation provides equal opportunities for career progression or promotion (85% in 2015 which is an improvement on 84% in 2014, the higher the score the better), directly comparable to 2014 results.
- KF10 support from immediate managers (3.84 compared to a national average for combined trusts of 3.86, the higher the score the better), updated key finding and not directly comparable to 2014 results.
- KF2 staff satisfaction with the quality of work and patient care they are able to deliver (3.83 compared to a national average for combined trusts of 3.89, the higher the score the better), not directly comparable to 2014 results.

Action plans to address concerns
It is clear from the survey results that there are many high scoring areas and also improvements in certain areas. However, the survey also provides important feedback on areas that the organisation needs to pay attention to if it is to look after the health and wellbeing of its workforce and thereby its patients. In light of the feedback from staff it is proposed that corporately the Trust continues to focus on development interventions in the following areas:

- **Workplace stress and wellbeing.** The Trust has been recognised as an exemplar Trust around health and wellbeing and is implementing Simon Steven's health and wellbeing initiative for staff as one of 11 Trusts around the country. Closer working will continue between HR and the Trust's in-house Occupational Therapy department alongside continued access to Workplace Options (Employee Assistance Programme), work based health checks for the over 40's and provision of weight management advice and exercise opportunities.
- **Management, leadership and team leader development.** A range of leadership and management development opportunities are available and described through the Leading for Excellence framework. Engaging Leaders focuses on building leadership capacity and capability, supporting a continued, positive culture shift towards an authentic, engaging leadership which values difference, inclusion and partnership and challenges behaviours, attitudes and actions to deliver this.
- **Staff satisfaction.** A time out is planned with Directors and deputies to agree the key expectations senior leaders have and the conditions leaders need to create to support effective working relationships to grow behaviours in a digital organisation.

Regulatory ratings
The Trust submits a quarterly return to Monitor made up of two elements: a financial sustainability risk rating; and a governance risk rating.

Financial sustainability risk rating
There are four elements to the calculation of the Financial Sustainability Risk Ratings (FSRR). These are:

- **Capital service cover:** Metric currently weighted at 25% and shows how many times income covers the servicing of capital costs.
- **Liquidity:** Metric currently weighted at 25% and shows how liquid the Trust is in respect of days' operating expense cover.
- **I & E margin:** Metric currently weighted at 25% and shows normalised surplus as a % of income.
- **I & E margin variance from plan:** Metric currently weighted at 25% and shows I & E Margin actual compared to planned.
- **Overall rating:** Aggregate rounded average of all metrics.

Governance risk rating
The governance rating indicates the degree of concern about the governance of the Trust, including any steps regulators are taking to investigate and/or any actions being taken. A rating is generated by considering the following information:

- performance against selected national access and outcomes standards;
- outcomes of CQC inspections and assessments relating to the quality of care provided;
- relevant information from third parties;

- a selection of information chosen to reflect organisational health; and
- the degree of financial sustainability risk and other aspects of risk relating to financial governance and efficiency.

Trust performance
The Trust has planned to achieve a rating of 4 for each quarter of the financial year 2015/16. Overall performance has been a 4 (lowest risk) for all quarters in the financial year 2015/16. There are no prior year comparators as the Trust became a FT on 1 May 2015 when the risk ratings became an integral part of performance monitoring as a Foundation Trust.

2015/16	Annual plan	Q1*	Q2	Q3	Q4
Financial sustainability risk rating	4	4	4	4	4
Governance rating	Green	Green	Green	Green	Green

*The Financial Sustainability Risk Ratings came into effect in quarter 2 of the financial year 2015/16. For the first quarter of the financial year 2015/16, the Continuity of Services Rating was in place which incorporated the Capital Service Cover Metric and the Liquidity Metric only.

Disclosures report – FT Code of Governance
The Trust has applied the principle 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 upon the principles of the UK Corporate Governance Code issued in 2012. Areas of disclosure are covered in the Accountability Report section. The Trust is able to comply with the Code in all areas except the following:

Requirements	Explanation
D.1.1: Performance-related elements of the remuneration of Executive Directors.	The Trust does not operate any performance-related bonus scheme for Executive Directors.
D.2.3: Consultation of external professional advisers to market test the remuneration of Non-Executive Directors.	The Trust did not use an external professional adviser in its most recent remuneration exercise but did take into account remuneration levels provided by NHS Providers of comparable FTs.

Equality and diversity
In 2012 we published our first set of Equality Objectives under the new Specific Duties of the Equality Act 2010. These objectives were agreed with the local voluntary sector and shared with local NHS providers Bradford Teaching Hospitals Foundation Trust and Airedale NHS Foundation Trust. The objectives set out what we wanted to enhance over the following four years and included 'improving access to mental health services for women', 'improving access and experience of service users with visual and sensory impairments, language and literacy issues' and 'improving the access and experience of Black and Minority Ethnic (BME) service users'.

We have just reviewed progress on those four year equality objectives and published a headline report on our website. Some highlights of that work include implementing the NHS England Accessible Information Standard and the health fare engagement event and subsequent report held with the Gypsy and Traveller community with Leeds GATE.

We have also recently won regional leadership recognition from the NHS Yorkshire and Humber Leadership Academy for our BME Diversity in Employment Strategy. The strategy aims to increase the representation of BME staff in the workforce to 35% at all levels which is the same as the working age population in Bradford. The strategy includes

a number of important objectives including: the setting of a target and measurable key performance indicators; the development and delivery of a development programme for BME staff which ran successfully in 2015 and is called Moving Forward; engaging local BME young people in work experience at the organisation to promote the NHS and our Trust as an employer of choice; and to train cultural excellence training to our senior staff.

In April 2016 the Trust launched the new set of priorities for equality. These are once again shared with our local health partners and based on feedback. They continue the work started over the past four years adding in more detail, aligning it to national standards and benchmarks and ensuring progress can be measured. These objectives are included below. For more information in this work please visit the Trust website equality pages.

	Objective
1.	Carry out a Gender Pay Gap Audit using a recognised audit framework. Develop an action plan to address the findings of the audit.
2	To implement the NHS England Accessible Information Standard.
3.	To improve BME service users access and experience of services. BDCFT to identify 4 projects over the 4 years through the panel process and evidence collected as part of the review of the 2012 – 2016 Equality Objectives.
4.	To increase awareness of mental health and to improve access and experience of mental health service users across the health economy.
5.	Prepare for the implementation of the Workforce Disability Equality Standard by preparing data and developing and delivering plans to tackle the issues identified.
6.	To implement the Workforce Race Equality Standard.
7.	To implement the recommendations in the Healthy Attitudes Stonewall Study and Equity partnership LGB&T Local Health Needs Assessment.
8.	To improve the access and experience of older people and people facing rural isolation

Modern Slavery and Human Trafficking Act 2015/16 annual statement
Bradford District Care NHS Foundation Trust offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

The Section 54 of the Modern Slavery Act 2015 requires all organisations to set out the steps the organisation has taken during the financial year to ensure that slavery and human trafficking is not taking place in any of its supply chains, and in any part of its own business.

The Trust recognises its responsibilities to comply with the UK Modern Slavery Act 2015 and implement a strategic approach to managing business risk in relation to human rights and slavery breaches that the legislation seeks to protect. The Trust conforms to the NHS Employment Check Standards within its workforce recruitment and selection practices and national procurement frameworks for temporary resourcing requirements with its Managed Service Provider contract arrangements. The strategic approach incorporates work to analyse the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

Simon Large
Chief Executive

Michael Smith
Chair

Date: 26 May 2016

Statement of Accounting Officer's responsibilities for preparing the financial statements of Bradford District Care 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.

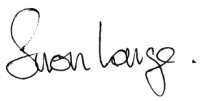
Under the NHS Act 2006, Monitor has directed Bradford District Care NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bradford District Care 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.



Simon Large
Chief Executive

Date: 26 May 2016

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 an acceptable 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 District Care NHS Foundation Trust, to evaluate the probability 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 District Care 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
The Trust has a Risk Management Policy and Procedure which provide a robust framework for the management of risk. The Risk Management Strategy has recently been reviewed to further develop our systems and processes over the next three years and clearly outlines the responsibilities for risk. The revised strategy will see the introduction and development of the Trust's risk appetite and related statement.

Risk is managed across all services as an integral element of our corporate and clinical governance processes. The risk register is maintained on our electronic database Safeguard, which enable all departments to identify, assess and manage their own risks. Should risk not be able to be managed it will be escalated and managed at the appropriate management level.

There is a comprehensive programme of training available for staff. Risk management training is presented in the corporate induction programme and for all staff a refresher session is available to attend every quarter of each year. Risk and safety workshops are delivered across the services as required, these are bespoke workshops that review risk and incident data for the related service and explore how we can improve our safety through the use and application of the risk process. Risk guardians responsible for their local risk register and incidents managers responsible for the validation of incident reports have a specific refresher programme which is also available every quarter of each year. Ad hoc training sessions are available and provided on request normally tailored to the requirement of the request. The overall compliance level for staff attending required risk management training is over 85%.

I have overall accountability for ensuring an effective risk management system is in place within the Trust and I have delegated responsibility for the overall co-ordination of risk management to the Medical Director.

In addition:

- the Medical Director leads on clinical risk management, medicines management and safe standards of medical practice, and the compliance against Care Quality Commission standards;
- the Director of Nursing/Deputy Chief Executive ensures the effective application of risk management across clinical and operational services and leads specifically on safeguarding and infection prevention;
- the Director of Finance, Contracting and Estates leads on financial and information risk management and manages risk in relation to the development, management and maintenance of the Trust estate and matters relating to fire safety;
- the Director of Human Resources and Organisational Development leads on risks associated with workforce capacity, retention of staff and absence management; and
- the Trust Secretary is the Senior Information Risk Owner (SIRO).

The Medical Director ensures an effective overall approach to risk management including the development of the Risk Management Strategy and specifically the identification, assessment and management of risks through the risk management policy and procedure. A supporting system for managing risk has been established by the Medical Director with support from the Deputy Director of Quality and Governance and the Risk and Resilience Manager. There are also clearly defined risk and clinical governance structures within directorates.

The Trust supports staff on responsible risk taking and acknowledge that such action may not have predictable or definite successful outcomes provided the decisions are made responsibly with reference to the principles of good professional policy, practice and protocol.

As part of the wider review of the Trust's Risk Management Strategy, the Board and Senior Leadership Team held a Forward-to-Excellence workshop in December 2015 to examine risk appetite, which generated significant interest and several new ideas in relation to organisational approaches to risk. The Risk Management Strategy was reviewed by EMT and Directors in February 2016 and approved by the Quality and Safety Committee in March 2016. The Board of Directors ratified the new Risk Management Strategy in April 2016.

The risk and control framework

The Board recognises a clear responsibility for delivery of high quality and safe patient care to the local community alongside providing a safe working environment for our staff. As a Trust we consider the management of risk a pivotal and integral part of our daily work.

Risk management is an iterative process designed to:

- identify, assess, prioritise and mitigate risk to support the successful achievement of the organisation's policies, aims and objectives and,
- evaluate the likelihood of those risks being realised and to manage them efficiently, effectively and economically.

Risk management is embedded throughout the Trust in alignment with the governance structure and incorporates Board Committees, locality quality and safety committees and risk guardians.

Live, dynamic risk registers are in place across the Trust with risk guardians responsible for the caretaking of their registers. The structure for risk registers spans a number of management levels including team registers and all teams and services have appropriate access to their risk registers. The risk registers are facilitated through a web based system from which all risk guardians can 'view only' all risks across the Trust to promote transparency, openness and learning. Where risk cannot be managed locally there is a formal escalation process which is supported by a notification system which automatically ensures that management are informed immediately of escalated risk.

Risk action plans are developed to reduce, eradicate and/or mitigate the risk to an acceptable level by ensuring that the controls in place are fit for purpose, effective and efficient.

Business Units, services and teams have quality and safety meetings or groups where new and current risks are discussed, debated and reviewed. Potential catastrophic risks are brought to the urgent attention of Directors for escalation as soon as they are identified.

The Trust takes a proactive approach in terms of risk prevention and deterrent, with numerous mechanisms in place that contribute to the prevention of risk these include:

- policies, procedures and protocols
- proactive risk assessments
- service reviews
- learning from previous errors
- embedding good practice
- involving service users in discussions on risk
- board quality and safety walkabouts

The Trust has been ranked as one of only 18 providers across England that have been given a rating of 'outstanding' around openness and transparency under a new 'Learning from Mistakes League' launched by Monitor and the NHS TDA in March 2016. Data for 2015/16 - which is drawn from the 2015 NHS staff survey and from the National Reporting and Learning System (NRLS) - gives providers scores 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 Trust.

Quality governance arrangements

The Trust has had a Quality Strategy in place since 2014 which ensures compliance with Monitor's Well-led Framework, and is overseen by the Board's Quality and Safety Committee. The Committee seeks assurance on behalf of the Board, including evidence and compliance against those standards reported to the Committee associated with CQC registration requirements.

Data security

Information governance and data security risks are monitored through the Information Governance Group (IGG) and assessed using the Information Governance Toolkit. The IGG membership comprises the SIRO (Chair), Caldicott Guardian, Chief Information Officer and lead information governance officers. The IGG

meets every two months and reports quarterly on any information governance issues to the Technology Board.

Board assurance framework and corporate risk register

The Board Assurance Framework (BAF) and the Corporate Risk Register (CRR) define and assess the principle strategic and operational risks against the Trust's strategic priorities. The Trust Board reviewed the CRR and all significant risks on a quarterly basis during 2015/16. Risks on the CRR are allocated to responsible committees for review twice a year, where committee members debate the progress of the risk and make challenge if there is reason.

Risks are identified and assessed proactively in advance of the risk occurring or reactively once a related incident or near miss has occurred. The Trust provides numerous tools to assist with risk assessment for different situations such as health and safety assessment tools and clinical risk assessment tools, both generic and specific. Individual assessments are also carried out for both staff and patients (including safeguarding issues). Risks identified by community team, outpatient, ward services are logged on the appropriate local risk register by the responsible risk guardian.

In terms of the Trust's risk profile, current major risks are identified on the CRR and future / potential risks on the BAF.

The current major risks identified on the CRR are as follows:

- agile working programme not fully embraced, embedded and implemented;
- poor recording of clusters leading to below 95% target cluster performance;
- IM&T capacity and systems;
- national shortage of Band 5 qualified nurses leading to unfilled vacancies with higher than anticipated bank/agency spend and potential quality impacts; and
- commissioners re-procurement activity and potential for decommissioning with contracts lost to competitors*.

Of the above risks, one marked with an asterix was added during 2015/16. Two risks relating to (a) occupied bed days and (b) IM&T issues were downgraded from the CRR but remained on another risk register. IM&T capacity continues to be an issue on the CRR.

A quality report for all logged risks is presented to Directors every quarter and the CRR and all significant risks are reported every month for review and discussion, with appropriate further action being identified as appropriate.

The key potential risks to the Trust's strategy identified in the BAF have remained static during the financial year. In 2015/16, the presentation of the BAF and the CRR were presented on a quarterly basis to align with quarterly monitoring reports for Monitor - a review of the BAF scheduled to be completed during 2015/16 has been delayed until Quarter 1 of 2016/17. The strategic risks in the BAF are as follows:

Board Assurance Framework (strategic risks)	
Consolidate our market share	Gap between demand for services and capacity, adversely affecting quality, safety, financial position, relationships and reputation Failure to deliver service transformation and organisational change, resulting in non-delivery of quality and financial benefits in full and on schedule Worsening economic position resulting in higher tariff reduction, cost pressures or higher inflation than planned, adversely affecting financial position, quality and safety Failure to respond fully to quality challenges: inability to meet the expectations of staff, patients and the public, losing the opportunity to understand and improve quality and adversely affecting relationships and reputation
Adapting to the health and social care landscape	Failure to secure benefits from leadership of health and social care economy integration and change agenda Failure to organise and deliver services around commissioners' requirements
Developing business opportunities	Failure to secure new business revenues Failure to redesign the Trust's business model to support integration and change Failure to respond successfully to competition

Compliance with NHS foundation trust condition 4 – NHS Foundation Trust governance arrangements

The Trust Board has continued to ensure that there are:

- effective Board and Committee structures;
- clear responsibilities for its Board, Committees reporting to the Board and for staff reporting to the Board and those Committees; and
- clear reporting lines and accountabilities throughout the organisation.

The Board confirms that it has prepared a 'comply or explain' document against the Code of Governance to record where the Trust has not followed the guidance or where an action plan is required to ensure compliance.

Potential and identified risks, which may impact on external stakeholders and key partners such as local authorities, other NHS trusts, voluntary organisations and service users are managed through structured mechanisms and forums such as the Overview and Scrutiny Committees, contract negotiation meetings, Council of Governor meetings and service user forums.

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

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.

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

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

The Trust's Operational Plan is approved by the Board of Directors and monitored in detail by the Board of Directors on a monthly basis through key performance indicators (including those required by Monitor) within the Integrated Performance Report (IPR). Board Committees review performance in further detail through the use of individual Committee performance dashboards. The Trust's resources are managed within an approved framework set by the Board, which includes Standing Financial Instructions (SFIs), were reviewed by the Audit Committee in September 2015. Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

The Executive Management Team (EMT) meets weekly, and Executive Directors and Deputy Directors meet monthly (known as 'the Directors meeting') to oversee strategy, business delivery and quality and performance issues. In addition, business units and corporate departments are responsible for the delivery of their own financial and other performance targets, which is monitored through business unit performance meetings, attended by Executive Directors and chaired by the Chief Executive.

Internal Audit undertakes a review and reports on the risk management processes annually, reporting to the Audit Committee. This Committee has a timely reporting process in place to ensure that identified actions from audit reports are progressed to satisfactory conclusion through the implementation of the agreed recommendations. Internal Audit's opinion for 2015/16 (based upon and limited to the work performed) was that significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

In terms of deterrents against fraud, the Trust has a very proactive nominated Local Counter Fraud Specialist provided via the West Yorkshire Audit Consortium, who is fully accredited by the NHS Counter Fraud and Security Management Service. The Audit Committee approved the Annual Counter Fraud Plan for 2015/16 in March 2015 and received regular updates on progress of counter fraud work during the year. Areas of work during the year have included: an ongoing programme of presentations to staff about fraud, attendance at Safeguarding Forums, and participation in the National Fraud Initiative aimed at preventing and detecting employee and supplier fraud.

Information governance
Data and information supports the delivery of quality patient care through effective service delivery, improved patient experience and patient safety. For data to be used as a foundation for business decision making and delivering high quality care, it must be accurate, complete, reliable, appropriate and accessible at the point of care. The Trust has continued with a number of established systems and processes in 2015/16 to ensure that data and information is robust:

- Internal Audit annual review of a selection of key performance indictors reported to the Board - providing assurances to Audit Committee.
- Information Assurance Frameworks (IAFs) for dashboards produced for the Trust Board, Quality and Safety and Mental Health Legislation Committee. IAFs detail the definition, data source, calculation method, data quality rating and rational for inclusion of all key performance indicators.
- External review and challenge as part on ongoing work with commissioners in relation to contractual data quality and information at regular monthly joint meetings, linking to Trust monthly Locality Performance Meetings.
- External review of mandated key performance indictors in the Quality Account, reported by KPMG to Audit Committee.
- Bi-annual data and information assurance report submitted to Audit Committee in June and November 2015. This assurance process was been reviewed and given overall significant assurance by Internal Audit in February 2015.

Breaches of data security
Lapses are reported internally through the web based incident reporting system (IR-e) and notified immediately to the Information Governance (IG) & Records Manager for logging on the Serious Incidents Requiring Investigation section of the Information Governance Toolkit and with the Trust's Serious Incident Lead where appropriate. Incident data is regularly reported to and monitored by the IG Group. 69 (at Level 1) were reported to the IG Toolkit and investigated. There were no cases at Level 2 logged on the Trust's Serious Incident system during 2015/16. The Trust reported no IG breaches to the Information Commissioner's Office (ICO) in the year 2015/16.

Between 1 April 2015 and 31 March 2016 there were 180 IG incidents reported on HSCIC's incident management system. There were no incidents at level 2 or above for the period 2015/16, as shown below:

Level 0 120
Level 1 69
Level 2 0

Summary of other personal data related incidents

Category	Breach type	Total
A	Corruption or inability to recover electronic data	0
B	Disclosed in error	25
C	Lost in transit	3
D	Lost or stolen hardware	3
E	Lost or stolen paperwork	21
F	Non-secure disposal – hardware	0
G	Non-secure disposal – paperwork	1
H	Uploaded to website in error	0
I	Technical security failing (including hacking)	1
J	Unauthorised access/disclosure	14
K	Other	1

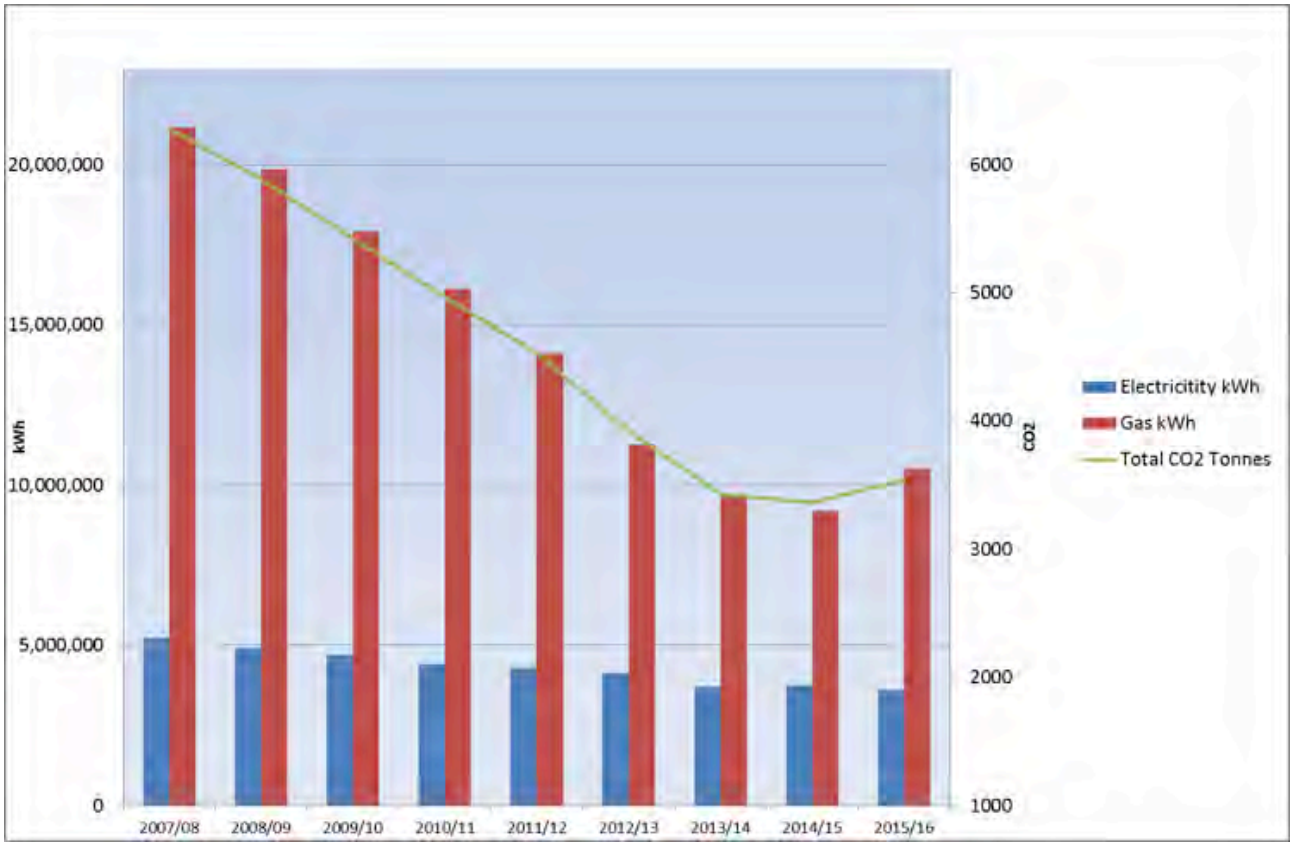
Sustainability report

Carbon reduction and energy efficiency

The UK has a carbon emissions target to reduce emissions by 80% by 2050. As the largest employer in the UK, the NHS has an important input to this target and each NHS organisation has been tasked with identifying how it can make a local contribution towards improving its own sustainability and energy reductions.

In response to this challenge we work hard to reduce our ongoing energy usage. We are now using 31% less electricity and 50% less gas compared with our historic baseline energy use. We are also emitting 2,740 fewer tonnes of carbon dioxide per year, a 44% reduction in our historic baseline emissions, as shown in the consumption table and trend chart below (the slight increase in gas consumption reflects the warmer environment provided in the new Dementia Assessment Unit for vulnerable older people).

Chart showing annual gas and electricity use and carbon emissions



	Electricity			Gas				
	kWh	Conversion Factor	CO_2 Tonnes	kWh	Conversion Factor	CO_2 Tonnes	Total CO^2 Tonnes	CO2 Reduction from Base Year
2007/08	5246000	0.43	2256	21163000	0.19	4021	6277	
2008/09	4915000	0.43	2113	19861000	0.19	3774	5887	6%
2009/10	4700000	0.43	2021	17921000	0.19	3405	5426	14%
2010/11	4425000	0.43	1903	16130000	0.19	3065	4967	21%
2011/12	4305000	0.43	1851	14114000	0.19	2682	4533	28%
2012/13	4140884	0.43	1781	11270934	0.19	2141	3922	38%
2013/14	3708351	0.445	1650	9679725	0.18404	1781	3432	45%
2014/15	3763976	0.445	1675	9195738	0.184	1692	3367	46%
2015/16	3610932	0.445	1607	10503047	0.184	1933	3540	44%

This year the Energy and Environment team has been working in conjunction with external transport planning consultants to develop a diverse range of sustainable travel products and guidance.

These include:

- overarching sustainable travel plan until 2020;
- site by site active travel guides;
- secure bike storage at five sites;
- electric vehicle charging points at three sites;
- 'live' maps showing public transport routes;
- an interactive website (still in development); and
- personal travel plans and bespoke route maps.

The Trust also now has a small fleet of pure electric vehicles, used by Maintenance and Food services, and other support services are moving towards electric vehicles when their current leases expire. The annual travel survey identified some interesting changes in staff behaviour, including a significant shift to bus, train and walking commutes, especially at New Mill. The Trust has also finalised plans for a new high efficiency boiler plant and calorifiers in the energy centre on the Lynfield Hospital site. The plant will be installed Spring/Summer 2016.

These innovations offset increased energy use arising from, e.g. more intensive use of our properties, new state of the art dementia services, and the further roll-out of technology so that, overall, our energy consumption continues to reduce.

Display energy certificate performance

Display Energy Certificate (DEC) performance continues to be a priority for NHS Trusts. A performance rating of 100 (grade D) is considered to be typical performance compared with other buildings of the same type and use.

We have eight properties requiring annual DECs (over 1,000m2 of floor area). Of these, six are above the typical performance rating and we are focusing our energy efficiency programmes on the two remaining sites.

The Trust also has seven properties over 500m2 floor area, requiring DECs every 10 years. These were completed in 2012. Six of these seven properties already have performance ratings better than 100 (grade D). At the remaining property (New Ridge) energy data includes the therapeutic pool and does not reflect the buildings use. This site is earmarked for disposal. From July 2015, properties over 250m2 also required DECs every 10 years. The Trust has two buildings in this category and both have performance ratings better than 100 (Grade D). Of 17 buildings covered by Display Energy Certificate requirements 14 already have performance ratings better than 100 (grade D).

Waste

The Trust waste contract for business wastes (offices & office kitchens) covers all occupied properties and is classed as a 100% recycling contract. The high quality wastes go for true recycling and the low quality waste (wastes contaminated with food, drink or glass) go for energy production, resulting in zero business wastes going to landfill.

Local housekeeping staff ensure that recycling requirements are achieved by keeping an eye on waste segregation and leaving information leaflets if problems are found (primarily food wastes in the office clear bags). The Trust has recycling contracts and systems in place for almost all other waste types such as batteries, shredded paper, card, plastics, metals, glass, food oils from the LMH kitchens, toners and ink cartridges where applicable. All electrical wastes (including mobile phones and IT) are recycled, with usable equipment being sent for reuse and damaged equipment being broken down so that the component metals can be reused.

Under the 2011 Waste Hierarchy Regulations, wastes must be recycled or reused in preference to disposal. To comply with the regulations and avoid disposal and recycling costs Trust staff can now, with approval from line management, take unwanted equipment for personal reuse. Wastes that are not recused or recycled are passed to charities. The Trusts clinical wastes are split into incineration grades and autoclave grades. The separate disposal of autoclave wastes reduces costs and produces significantly less CO2. In partnership with the clinical waste contractor, Trusts in the Northern Clinical Waste Consortium are involved in a two-year Pilot project to build a plant which will produce electricity by burning some types of Healthcare waste. The plant will be fuelled with uninfected clinical waste (tiger bags) and will divert this waste from landfill, achieving zero waste to landfill at the Trust.

The Trust's Food Services department has installed aerobic waste food digesters in its kitchens to treat and dispose of food wastes that would otherwise be washed to sewer. The food digesters reduce the Trusts impact on the environment, and are user friendly with a low carbon footprint converting the food waste into 'grey' waste waters going to sewer.

Sustainable travel plan
Many of the Trust's services are provided by staff working in the community, resulting in a significant environmental impact from transport. As a consequence the Trust is committed to preventing pollution and encouraging active travel choices (e.g. public transport, walking and cycling) as well as making infrastructure available for electric car users to charge their vehicles. Following the installation of bike and electric charging infrastructure, and the development of a suite of sustainable travel documents, in the coming year the Trust will host sustainable travel roadshows at key sites to showcase electric cars and bikes, introduce subsidised public transport opportunities and share access to online and paper travel guidance.

Initial responses from staff have been very encouraging with many colleagues joining active travel forums, requesting free cycling training and donating bikes. As further initiatives are rolled out staff will be able to access live public transport information and ask questions via a unique sustainable travel email travelplan@bdct.nhs.uk.

Sustainable procurement
In partnership with Airedale NHS Foundation Trust Supplies department, the Trust has developed a new Sustainable Procurement Strategy which is awaiting final approval. The overarching aim is to ensure that the goods, works and services we purchase are manufactured, delivered, used and managed at end-of-life in a safe and socially and environmentally responsible manner and that the associated risks are appropriately managed.

Carbon reduction commitment Energy Efficiency Scheme (CRC)
The CRC Energy Efficiency Scheme is a mandatory energy saving and carbon, emissions reduction scheme for the UK. Duties under the scheme are based on total energy usage. The Trust's sustained reduction in energy use means we have no duties under the Scheme. Our annual consumption is below the qualifying threshold.

EU ETS – Greenhouse Gas Allowance Trading Scheme
Under the EU Emissions Trading Scheme (ETS), large emitters of carbon dioxide within the EU must monitor their CO2 emissions and annually report them. The Trust's sustained reduction in carbon dioxide emissions means we have no Duties under the Scheme. Our annual consumption is below the qualifying threshold.

Significant sustainability projects for 2016/17
- **New high efficiency boilers (Lynfield Mount)** will be installed Spring/Summer 2016 providing more efficient heat delivery alongside self-generation from solar panels on Daisy Hill House.
- **Sustainable travel roadshows** will be rolled out at a number of key sites to encourage active travel, and alternative fuels. Staff will be able to test drive electric cars and bikes, and take advantage of public transport incentives and awareness raising treats.
- **Sustainable Development Management Plan (SDMP)** The Trust will work with external consultants Ricardo Energy & Environment to produce a sustainable development management plan and aligned policy and strategy. The Trust recognises that sustainability has a major part to play in the way we manage and deliver services. Ultimately, a more sustainable Trust will benefit our patients, by freeing up funds that can be redirected back into preventative and frontline health care services.

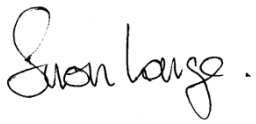
Annual accounts

Foreword to the accounts

Bradford District Care NHS Foundation Trust

These accounts, for the period ended 31 March 2016, have been prepared by Bradford District Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

(The Trust was approved as a Foundation Trust on 1st May 2015. The accounts represent the 11 month period from 1st May 2015 to 31st March 2016).



Name **Simon Large**
Job title **Chief Executive**
Date **27 May 2016**

Statement of comprehensive income

		2015/16
	Note	**£000**
Operating income from patient care activities	3	112,956
Other operating income	4	10,640
Total operating income from continuing operations		**123,596**
Operating expenses	5, 7	(121,012)
Operating surplus/(deficit) from continuing operations		**2,584**
Finance income	10	40
Finance expenses	11.1	(159)
PDC dividends payable		(1,243)
Net finance costs		**(1,362)**
Surplus for the year before impairments accounted for through statement of comprehensive income		**1,222**
Impairments charged to statement of comprehensive income	6	(2,009)
Surplus/(deficit) for the period		**(787)**
Other comprehensive income		
Will not be reclassified to income and expenditure:		
Impairments	6	(427)
Revaluations	14.1	2,228
Total comprehensive income/(expense) for the period		**1,014**

For the period to 31 March 2016, the Trust's surplus is £1.2m excluding the exceptional item of £2m in respect of an impairment of non-current assets. Further details in respect of this impairment can be found at note 6.

Statement of financial position

	Note	31 March 2016 £000
Non-current assets		
Property, plant and equipment	12	53,654
Total non-current assets		**53,654**
Current assets		
Inventories	15	18
Trade and other receivables	16	4,966
Cash and cash equivalents	17	16,748
Total current assets		**21,732**
Current liabilities		
Trade and other payables	18	(13,924)
Borrowings	19	(344)
Provisions	21	(138)
Total current liabilities		**(14,406)**
Total assets less current liabilities		**60,980**
Non-current liabilities		
Trade and other payables	18	-
Borrowings	19	(3,061)
Provisions	21	(533)
Total non-current liabilities		**(3,594)**
Total assets employed		**57,386**
Financed by		
Public dividend capital		34,579
Revaluation reserve		16,235
Other reserves		10,196
Income and expenditure reserve		(3,624)
Total taxpayers' equity		**57,386**

The notes on pages 97 to 119 form part of these accounts.

Statement of changes in equity for the period ended 31 March 2016

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
At start of period for new FTs	**34,579**	**14,434**	**10,196**	**(2,837)**	**56,372**
Surplus/(deficit) for the period	-	-	-	(787)	(787)
Impairments	-	(427)	-	-	(427)
Revaluations	-	2,228	-	-	2,228
Taxpayers' and others' equity at 31 March 2016	**34,579**	**16,235**	**10,196**	**(3,624)**	**57,386**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income.

Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve
This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Other reserves
Other reserves of £10,196,000 represent the value of assets from the former Bradford Community NHS Trust [which dissolved to become Bradford District Care Trust]. The assets were excluded from the initial PDC for the Trust and therefore need to be shown as 'Other Reserves'.

Income and expenditure reserve
The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Statement of cash flows

		2015/16
	Note	£000
Cash flows from operating activities		
Operating surplus/(deficit)		575
Non-cash income and expense:		
Depreciation and amortisation	5.1	3,177
Impairments and reversals of impairments	6	2,009
(Increase)/decrease in receivables and other assets		3,245
Increase/(decrease) in payables and other liabilities		(315)
Increase/(decrease) in provisions		(1,524)
Net cash generated from operating activities		**7,167**
Cash flows from investing activities		
Interest received		38
Purchase of property, plant, equipment and investment property		(3,116)
Net cash generated (used in) investing activities		**(3,078)**
Cash flows from financing activities		
Capital element of PFI, LIFT and other service concession payments		(295)
Interest paid on PFI, LIFT and other service concession obligations		(161)
PDC dividend paid		(1,335)
Net cash generated (used in) financing activities		**(1,791)**
Increase in cash and cash equivalents		**2,298**
Cash and cash equivalents at start of period for new FTs		**14,450**
Cash and cash equivalents at 31 March	**17.1**	**16,748**

Notes to the Accounts

Note 1
Accounting policies and other information

Basis of preparation
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.

Accounting convention
These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Going concern
These accounts have been prepared on a going concern basis.

Note 1.1
Interests in other entities
The Trust does not hold any interests in other entities, associates, joint ventures or joint operations.

From 2013/14, NHS Trusts were required to consolidate the results of Charitable Funds over which they considered they had the power to exercise control in accordance with IAS27 requirements. The Trust is not required to consolidate because the value of the Bradford District Care Trust Charitable Fund is not material.

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.

Note 1.2
Income
Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the trust is contracts with commissioners in respect of health care services.
Where income is received for a specific activity which is to be delivered in a subsequent financial year, 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.

Note 1.3
Expenditure on employee benefits

Short-term employee benefits:
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs:
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities.

Therefore, the scheme is accounted for as a defined contribution scheme.
Employer's pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Note 1.4
Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.5
Property, plant and equipment

Recognition:

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the trust;
- it is expected to be used for more than one financial year; and
- the cost of the item can be measured reliably.
- the item has cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement:

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management.

All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- land and non-specialised buildings – market value for existing use
- specialised buildings – depreciated replacement cost

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

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 of IFRS 5.

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

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

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the FT ARM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating 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 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. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's 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 property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Private Finance Initiative (PFI) transactions:
PFI transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. In accordance with IAS 17, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

a) Payment for the fair value of services received;

b) Payment for the PFI asset, including finance costs; and

c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received
The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability
A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Useful Economic lives of property, plant and equipment:
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives are shown in the table below:

	Min life years	Max life years
Land	-	-
Buildings, excluding dwellings	1	60
Plant & machinery	1	20
Transport equipment	1	5
Information technology	1	5
Furniture & fittings	1	5

Finance leased assets (including land) are depreciated over the shorter of the useful economic life or the lease term, unless the FT expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

Note 1.6
Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the trust and where the cost of the asset can be measured reliably.

The Trust has no intangible assets.

Note 1.7
Revenue government and other grants
Government grants are grants from government bodies other than income from commissioners or NHS trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The Trust has no grants from government bodies.

Note 1.8
Inventories
Inventories are valued at the lower of cost and net realisable value using the first-in, first-out cost formula. This is considered to be a reasonable approximation to fair value due to the low levels and turnover of stocks.

Note 1.9
Financial instruments and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the 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 or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

All other financial assets and financial liabilities are recognised when the 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 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 "fair value through income and expenditure", loans and receivables.

Financial liabilities are classified as "fair value through income and expenditure".

Financial assets and financial liabilities at "fair value through income and expenditure"
Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term.

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.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly 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 Statement of Comprehensive Income.

Financial liabilities
All financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Determination of fair value:
For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from quoted market prices.

Impairment of financial assets:
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure" 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.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

Note 1.10
Leases

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases
Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.11
Provisions
The NHS 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 a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS 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 NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 32 but is not recognised in the NHS foundation trust's accounts.

Non-clinical risk pooling
The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under

which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.12
Contingencies
Contingent liabilities are not recognised 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.

The Trust has no contingent liabilities.

Note 1.13
Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS 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 NHS 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.

Note 1.14
Value added tax
Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.15
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 2016, this power has not been exercised. Accordingly, the Foundation Trust is not within the scope of corporation tax.

Note 1.16
Foreign exchange
The functional and presentational currencies of the 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 trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

- monetary items (other than financial instruments measured at "fair value through income and expenditure") 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 Statement of Financial Position 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.

Note 1.17
Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Note 1.18
Losses and special payments
Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS Foundation Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

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

Note 1.19
Transfers of functions [to / from] [other NHS bodies / local government bodies]
For functions that have been transferred to the Trust from another NHS / local government body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

For functions that the Trust has transferred to another NHS / local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The net [loss / gain] corresponding to the net [assets/ liabilities] transferred is recognised within [expenses / income], but not within operating activities. Any revaluation reserve balances attributable to assets de-recognised are transferred to the income and expenditure reserve. [Adjustments to align the acquired function to the Foundation Trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.]

Note 1.20
Early adoption of standards, amendments and interpretations
No new accounting standards or revisions to existing standards have been adopted early in 2015/16.

Note 1.21
Standards, amendments and interpretations in issue but not yet effective or 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-14	None of the changes shown to the left have yet been EU adopted. Expected to be effective from 2016/17.
IAS 16 (amendment) and IAS 38 (amendment) – depreciation and amortisation	May-14	
IAS 16 (amendment) and IAS 41 (amendment) – bearer plants	Jun-14	
IAS 27 (amendment) – equity method in separate financial statements	Aug-14	
IFRS 10 (amendment) and IAS 28 (amendment) – sale or contribution of assets	Sep-14	
IFRS 10 (amendment) and IAS 28 (amendment) – investment entities applying the consolidation exception	Dec-14	
IAS 1 (amendment) – disclosure initiative	Dec-14	
IFRS 15 Revenue from contracts with customers	May-14	
Annual improvements to IFRS: 2012-15 cycle		
IFRS 9 Financial Instruments		

Note 1.22
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.

Trust management are not aware of any critical judgements that require disclosure. Key assumptions which have been used for estimation purposes are included within the relevant notes to the accounts.

Note 2
Operating Segments
Under IFRS 8, the Trust is required to disclose financial information across significant operating segments, which reflect the way management runs the organisation.

A significant segment is one which:-

- represents 10% or more of the income or expenditure of the entity;
- has a surplus or deficit which is 10% or more of the greater, in absolute amount, of the combined surplus of all segments reporting a surplus, or the combined deficit of all segments reporting a deficit; or
- Has assets of 10% or more of the combined assets of all operating segments.

In respect of the Trust's activities, there are no significant operations generating turmover greater than 10%, or having assets of 10% or more of the total assets. The Trust, therefore, considers itself to operate with one segment, being the provision of healthcare services.

The Board of Directors primarily considers financial matters at a Trust wide level.

Note 3.1 Income from patient care activities (by nature)

	2015/16
	£000
Mental health services	
Cost and volume contract income	1,140
Block contract income	61,490
Community services	
Community services income from CCGs and NHS England	36,495
Community services income from other commissioners	13,831
Total income from activities	**112,956**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2015/16**
	£000
CCGs and NHS England	98,633
Local authorities	13,765
Other NHS Foundation trusts	558
Total income from activities	**112,956**
Of which:	
Related to continuing operations	112,956

Note 3.3 Overseas visitors (relating to patients charged directly by the Trust)
The Trust had no chargeable overseas visitors in the financial year 2015/16.

Note 4 Other operating income

	2015/16
	£000
Research and development	544
Education and training	2,693
Non-patient care services to other bodies	6,091
Reversal of impairments	373
Other income	1,312
Total other operating income	**11,013**
Of which:	
Related to continuing operations	11,013

Other income is analysed as follows:	
	2015/16
	£000
Estates	256
Staff contributions to employee benefit schemes	214
Catering	43
Insurance claims received	500
Other	299
Total other income	**1,312**

Note 4.1 Income from activities arising from commissioner requested services

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

	2015/16
	£000
Income from services designated (or grandfathered) as commissioner requested services	81,431
Income from services not designated as commissioner requested services	42,538
Total	**123,969**

Note 4.2 Profits and losses on disposal of property, plant and equipment

The Trust has not disposed of any property, plant or equipment during the period to 31 March 2016.

Note 5.1 Operating expenses

	2015/16
	£000
Services from NHS foundation trusts	1,770
Services from NHS trusts	28
Purchase of healthcare from non NHS bodies	636
Employee expenses - executive directors	867
Remuneration of non-executive directors	112
Employee expenses - staff	94,260
Supplies and services - clinical	3,795
Supplies and services - general	1,131
Establishment	2,752
Research and development	661
Transport	186
Premises	7,358
Change in provisions discount rate(s)	8
Drug costs	1,385
Rentals under operating leases	379
Depreciation on property, plant and equipment	3,177
Impairments	2,382
Audit fees payable to the external auditor	
audit services- statutory audit	49
other auditor remuneration (external auditor only)	22
Clinical negligence	106
Legal fees	130
Consultancy costs	518
Internal audit costs	106
Training, courses and conferences	534
Patient travel	22
Car parking & security	3
Redundancy	44
Early retirements	8
Hospitality	28
Insurance	170
Losses, ex gratia & special payments ***	562
Other	205
Total	**123,394**
Of which:	
Related to continuing operations	123,394

On 26 December 2015 lower ground floor office accommodation at the Trust's New Mill site in Saltaire flooded to a depth of 1.2 metres. This caused significant loss of equipment and damage to engineering infrastructure and building fabric. Business continuity planning commenced immediately the flood water subsided, enabling access to the lower ground floor and including relocating staff and services from that accommodation. Costs for all reinstatement and refurbishment work are being finalised but will span 2015/16 and 2016/17 financial accounting periods.

The Trust has insurance cover that will support reinstatement costs. These represent the 'notional' value should the Trust have decided to return staff 'as was' to lower ground floor accommodation. Due to the height of flood waters and possibility of recurring water ingress a decision was made to relocate staff offices to higher levels or alternate sites and to utilise lower ground floor space to accommodate meeting room provision. Insurance cover will not be available for this and further more preventative work which therefore features in the Trust's annual financial plan for 2016/17.

As referenced in accounting policy note 1.9, a revaluation decrease that does not result from a loss of economic value or service potential, e.g. as a result of the annual revaluation exercise, is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit, e.g. site disposal or change in use, should be taken to expenditure.

An increase arising on revaluation is taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

The table below illustrates the key impacts of the 2015/16 impairments arising from the annual District Valuer revaluation exercise described above.

Total costs included in the 2015/16 accounts relating to the flood amount to £500k, the insurance company has covered £500k and the insurance excess of £40k is reflected in the position above.

*** The majority of costs for the flood damage will be incurred in 2016/17. Those elements that will not be covered by the Trust's Insurers have been included in the 2016/17 capital plan; estimated to be in the region of £627k.

Note 5.2 Other auditor remuneration

	2015/16
	£000
Other auditor remuneration paid to the external auditor:	
Audit-related assurance services (Quality Accounts)	12
All taxation advisory services	10
Total	**22**

Note 5.3 Limitation on auditor's liability

The limitation on auditors' liability for external audit work is £1m (2014/15: £0m).

Note 6 Impairment of assets

	2015/16
	£000
Net impairments charged to operating surplus / deficit resulting from:	
Changes in market price charged to operating expenses	2,382
Changes in market price credited to income in respect of impairment reversals	(373)
Total net impairments charged to operating surplus / deficit	**2,009**
Impairments charged to the revaluation reserve	427
Total net impairments	**2,436**

As referenced in accounting policy note 1.9, a revaluation decrease that does not result from a loss of economic value or service potential, e.g. as a result of the annual revaluation exercise, is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit, e.g. site disposal or change in use, should be taken to expenditure.

An increase arising on revaluation is taken to the revaluation reserve, except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

The table below illustrates the key impacts of the 2015/16 impairments arising from the annual District Valuer revaluation exercise described above.

Property, Plant & Equipment	Reversal of Impairments	Impairments	Total
	£000	£000	£000
Buildings excluding dwellings:			
Daisy Hill House (Building housing the Dementia Assessment Unit & Intensive Therapy Centre)	0	1,952	1,952
Moorlands View (Building housing Low Secure Mental Health Services)	0	324	324
Total	**0**	**2,276**	**2,276**

Note 7 Employee benefits

			2015/16
	Permanent	Other	Total
	£000	£000	£000
Salaries and wages	69,193	374	69,567
Social security costs	4,983	-	4,983
Employer's contributions to NHS pensions	9,085	-	9,085
Agency/contract staff	-	12,289	12,289
Total gross staff costs	**83,261**	**12,663**	**95,924**
Recoveries in respect of seconded staff	-	-	-
Total staff costs	**83,261**	**12,663**	**95,924**
Of which			
Costs capitalised as part of assets	170	64	**234**

Note 7.1 Retirements due to ill-health

During 2015/16 there were three early retirements from the Trust agreed on the grounds of ill-health (none in the period ended 1 May 2015). The estimated additional pension liabilities of these ill-health retirements is £148k.

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	2015/16
	£000
Salary	834
Taxable benefits	17
Performance related bonuses	0
Employer's pension contributions	103
Total	**954**

Full year values are required to be reported for the Commercial Director, who was on secondment to Airedale NHS Foundation Trust from 9 September 2015.

Further details of directors' remuneration can be found in the remuneration report.

Note 8
Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Auto-enrolment / National Employment Savings Trust (NEST) Pension Scheme

On 1 July 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 Trust

In the period to 31 March 2016, the Trust made contributions totalling £6k into the NEST fund (Contributions of £7k were made for the full year of 2015/16 and contributions of £6k were made for 2014/15).

Note 9 Operating leases

This note discloses costs and commitments incurred in operating lease arrangements where the Trust is the lessee.

Note 9.1 Bradford District Care NHS Foundation Trust as a lessee

	2015/16
	£000
Operating lease expense	
Minimum lease payments	379
Total	**379**

	31 March 16
	£000
Future minimum lease payments due	
- not later than one year;	497
- later than one year and not later than five years;	592
- later than five years	-
Total	**1,089**

Note 10 Finance income

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

	2015/16
	£000
Interest on bank accounts	40
Total	**40**

Note 11.1 Finance expenditure

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

	2015/16
	£000
Interest expense	
Main finance costs on PFI and LIFT schemes obligations	159
Total	**159**

Note 11.2 The late payment of commercial debts (interest) Act 1998

	2015/16
	£000
Interest expense	
Amounts included within interest payable arising from claims made under this legislation	-
Compensation paid to cover debt recovery costs under this legislation	-

Note 12.1 Property, plant and equipment - 2015/16								
	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at start of period as FT	**11,316**	**34,383**	**3,378**	**927**	**350**	**12,948**	**418**	**63,720**
Additions	-	1,512	1,336	111	-	282	-	**3,241**
Impairments	-	(2,809)	-	-	-	-	-	**(2,809)**
Reclassifications	-	4,714	(4,714)	61	(61)	-	-	-
Revaluations	-	(563)	-	-	-	-	-	**(563)**
Valuation/gross cost at 31 March 2016	**11,316**	**37,237**	**-**	**1,099**	**289**	**13,230**	**418**	**63,589**
Depreciation at start of period as FT	**-**	**1,639**	**-**	**517**	**265**	**7,161**	**340**	**9,922**
Provided during the year	-	1,525	-	82	4	1,531	35	3,177
Reversals of impairments	-	(373)	-	-	-	-	-	(373)
Revaluations	-	(2,791)	-	-	-	-	-	(2,791)
Accumulated depreciation at 31 March 2016	**-**	**-**	**-**	**599**	**269**	**8,692**	**375**	**9,935**
Net book value at 31 March 2016	**11,316**	**37,237**	**-**	**500**	**20**	**4,538**	**43**	**53,654**
Net book value at 1 May 2015	**11,316**	**32,744**	**3,378**	**410**	**85**	**5,787**	**78**	**53,798**

Note 13.1 Property, plant and equipment financing - 2015/16								
	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2016								
Owned	10,276	32,824	-	500	20	4,538	43	48,201
On-SoFP PFI contracts and other service concession arrangements	1,040	4,413	-	-	-	-	-	5,453
NBV total at 31 March 2016	**11,316**	**37,237**	**-**	**500**	**20**	**4,538**	**43**	**53,654**

In line with the relevant accounting standard (IAS 16) the accumulated depreciation relating to revalued assets (buildings excluding dwellings) has been written back to the gross costs of assets to bring the closing gross value in line with the valuation amount. This can be summarised:-

	£000
Revaluation of assets	2,228
Write-back of depreciation	(2,791)
Net revaluation (gross cost)	**(563)**

Note 14.1 Revaluations of property, plant and equipment

All land and buildings were revalued for the first time on a Modern Equivalent Asset basis in 2009/10; using valuations provided by the District Valuer.

Professional valuations are carried out on an annual basis by the District Valuer of the Revenue and Customs Government Department. The valuations are carried out in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury.

Until 31 March 2008, the depreciated replacement cost of specialised buildings was estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued. HM Treasury agreed that NHS Trusts must apply the new valuation requirements by 1 April 2010 at the latest. The Trust first applied these requirements during 2009/10, using valuations provided by the District Valuer.

The effective date of the valuations provided by the District Valuer is 31 March 2016, and the affect of changes is summarised in the following table.

	£000
Net impairments charged to operating surplus / deficit resulting from:	
Changes in market price	(2,009)
Total net impairments charged to operating surplus / deficit	**(2,009)**
Impairments charged to the revaluation reserve	427
Total net impairments	**2,436**
Revaluations charged to the revaluation reserve	2,228
Total net movement in property, plant and equipment following revaluation	**(208)**

Asset lives were reviewed by the District Valuer during 2015/16 as part of the revaluation exercise, as they had been during 2014/15.

The key impacts of this were to change residual fixed asset lives for Trust assets to those shown in the table in Note 1.5.

Note 15 Inventories

	31 March 2016
	£000
Energy	18
Total inventories	**18**

Note 16.1 Trade receivables and other receivables

	31 March 2016
	£000
Current	
Trade receivables due from NHS bodies	2,291
Provision for impaired receivables	(57)
Prepayments (non-PFI)	1,680
Accrued income	129
Interest receivable	2
VAT receivable	254
Other receivables	667
Total current trade and other receivables	**4,966**

Note 16.2 Provision for impairment of receivables

2015/16	2015/16
	£000
At start of period for new FTs	**75**
Amounts utilised	(18)
At 31 March	**57**

Note 16.3 Analysis of impaired receivables

	Other receivables
Ageing of impaired receivables	£000
90- 180 days	8
Over 180 days	49
Total	**57**

Ageing of non-impaired receivables past their due date	
0 - 30 days	1,260
30-60 Days	173
60-90 days	139
90- 180 days	478
Over 180 days	93
Total	**2,143**

Note 17.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2015/16
	£000
At start of period for new FTs	**14,450**
Net change in year	2,298
At 31 March	**16,748**
Broken down into:	
Cash at commercial banks and in hand	58
Cash with the Government Banking Service	16,690
Total cash and cash equivalents as in SoCF	**16,748**

Note 17.2 Third party assets held by the NHS Foundation Trust

Bradford District Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016
	£000
Bank balances	20
Total third party assets	**20**

Note 18.1 Trade and other payables

	31 March 2016
	£000
Current	
Receipts in advance	38
NHS trade payables	5,651
Amounts due to other related parties	20
Capital payables	125
Social security costs	811
Other taxes payable	728
Other payables	5,409
Accruals	1,123
PDC dividend payable	19
Total current trade and other payables	13,924

Note 19 Borrowings	
	£000
Current	
Obligations under PFI, LIFT or other service concession contracts (excl. lifecycle)	344
Total current borrowings	**344**
Non-current	
Obligations under PFI, LIFT or other service concession contracts	3,061
Total non-current borrowings	**3,061**

Note 19 Finance Leases

Note 20.1 Bradford District Care NHS Foundation Trust as a lessor

Future lease receipts due under finance lease agreements where Bradford District Care NHS Foundation Trust is the lessor: The Trust has no finance lease receivables.

Note 20.2 Bradford District Care NHS Foundation Trust as a lessee

Obligations under finance leases where Bradford District Care NHS Foundation Trust is the lessee.
The only finance leases which the Trust holds are accounted for as on statement PFI schemes.

Note 21.1 Provisions for liabilities and charges analysis					
	Other legal claims	Re-structurings	Redundancy	Other*	Total
	£000	£000	£000	£000	£000
At 1 May 2015	**-**	**-**	**-**	**-**	**-**
At start of period for new FTs	**201**	**336**	**874**	**784**	**2,195**
Change in the discount rate	-	-	-	8	**8**
Arising during the year	32	-	159	9	**200**
Utilised during the year	(69)	(34)	(361)	(36)	**(500)**
Reversed unused	(106)	(302)	(628)	(196)	**(1,232)**
At 31 March 2016	**58**	**-**	**44**	**569**	**671**
Expected timing of cash flows:					
- not later than one year;	58	-	44	36	**138**
- later than one year and not later than five years;	-	-	-	144	**144**
- later than five years.	-	-	-	389	**389**
Total	**58**	**-**	**44**	**569**	**671**

*Other reflects provisions for injury benefits. Injury Benefits provisions of £569k (prior year £588k) have been based on information on the liability for 4 individuals provided by the NHS Pensions Agency.

Provisions for legal claims shown above include employer's liability claims managed on the Trust's behalf by the NHS Litigation Authority equivalent to £58k.

The Trust has accounted for a new redundancy provision of £44k in 2015/16 relating to an internal review of PALs and Substance Misuse.

Provisions that have been reversed during 2015/16 include the redundancy provisions for CAMHS healthy minds, as recurrent funding has been secured for the service in 2016/17. Furthermore, services that transferred to NHS Property Services were done so under TUPE transfers and no staff were subject to redundancy.

The discount rate used in the calculation of the above provisions changed during 2015/16, from 1.3% in 2014/15 to 1.37% as at 31 March 2016. The impact of this change is to increase the liability and generate a charge to expenditure of £8k. The change is required by a change in HM Treasury guidance.

Note 21.2 Clinical negligence liabilities

At 31 March 2016, £699k was included in provisions of the NHSLA in respect of clinical negligence liabilities of the Trust.

Note 22 Contingent assets and liabilities

	31 March 2016
	£000
Value of contingent liabilities	
NHS Litigation Authority legal claims	(27)
Gross value of contingent liabilities	**(27)**
Amounts recoverable against liabilities	-
Net value of contingent liabilities	**(27)**
Net value of contingent assets	**700**

The £27k NHS Litigation Authority (NHSLA) contingent liability shown above is the calculated member liability for third party insurance claims.

The Trust has a contingent asset relating to an overage clause relating to the disposal of the Moor Lane site to a residential property developer in 2012. The estimated value of the contribution from the overage clause at 31 March 2016 is £700k.

The overage clause becomes automatically payable upon the final sale of all properties on the Moor Lane site, or if the Trust elects to end the process when 4 months has passed since a dwelling is sold. The current estimate is that the final property will be sold around June 2016 with related overage deposited with the Trust by August 2016.

Note 23 Contractual capital commitments

	31 March 2016
	£000
Property, plant and equipment	300
Total	**300**

Note 24 Defined benefit pension schemes
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.

Note 25 On-SoFP PFI, LIFT or other service concession arrangements
The Trust has two PFI schemes which are on the Statement of Financial Position.

Park Road Medical Centre
This finance lease has been in operation since 1997/98 and is for a period of 25 years until 2022/23. The current value of the total liability for this lease is £403k . The lease is treated as an asset of the Trust and has been subject to revaluations and depreciation in accordance with Trust policies. The current net book value for Park Road Medical Centre is £599k. The Trust has the option to purchase at 2 years prior to the 20th and 25th years.

Horton Park Health Centre
This lease has been in operation since 2000/01 and is for a period of 25 years until 2025/26. The current value of the total liability for this lease is £3,002k. The lease includes a unitary payment for the provision of building maintenance, facilities management, services and insurance.

The asset is treated as an asset of the Trust and has been subject to revaluations and depreciation in accordance with Trust policies. The current net book value for Horton Park Health Centre is £4,854k. The Trust has the option to purchase at the end of the lease.

The Trust has the following obligations in respect of the finance lease element of on-statement of Financial Position PFI and LIFT schemes:

	31 March 2016
	£000
Gross PFI, LIFT or other service concession liabilities	**4,180**
Of which liabilities are due	
- not later than one year;	501
- later than one year and not later than five years;	1,892
- later than five years.	1,787
Finance charges allocated to future periods	(775)
Net PFI, LIFT or other service concession arrangement obligation	**3,405**
- not later than one year;	344
- later than one year and not later than five years;	1,444
- later than five years.	1,617

Note 25.1 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust's total future obligations under these on-SoFP schemes are as follows:

	31 March 2016
	£000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	5,980
Of which liabilities are due:	
- not later than one year;	701
- later than one year and not later than five years;	2,692
- later than five years.	2,587

Note 25.2 Analysis of amounts payable to service concession operator

This note provides an analysis of the trust's expenditure in 2015/16:

	31 March 2016
	£000
Unitary payment payable to service concession operator	159
Consisting of:	
- Interest charge	159
Total amount paid to service concession operator	**159**

Note 26 Off-SoFP PFI, LIFT and other service concession arrangements

The Trust does not have any Off SOFP PFI schemes.

Note 27 Financial instruments

Note 27.1 Financial risk management

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.

Credit risk

The Foundation Trust receives the majority of its income from CCGs, Local Authority, NHS England, and statutory bodies and so 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:

- Trust Commercial Bank a limit of £10 million;
- institutions with a Standard & Poor rating at least A-1 have a limit of £5 million;
- institutions with a Moody's rating at least P-1 have a limit of £5 million; and
- institutions with a Fitch rating at least F1 have a limit of £5 million

Surplus cash is generally held in a Government Banking Service (GBS) account. Any significant surplus cash is generally invested with the National Loans Fund (NLF) as permitted by HM Treasury. Attendant risks are not therefore assessed to be significant.

Liquidity risk

The Foundation Trust's net operating costs are incurred under purchase contracts with local CCGs, NHS England and Local Authority commissioners which are financed from resources voted annually by Parliament. The Foundation Trust receives contract income via block contract arrangements, which is intended to match the income received in year to the activity delivered in that year. The Foundation Trust receives cash each month based on annually agreed contract values.

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.

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. The Trust is not exposed to signifcant liquidity risk.

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

Foreign currency risk
The Foundation Trust does not hold any foreign currency income, expenditure, assets or liabilities.

Note 27.2 Financial assets

	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	2,846	-	-	-	2,846
Cash and cash equivalents at bank and in hand	16,748	-	-	-	16,748
Total at 31 March 2016	**19,594**	**-**	**-**	**-**	**19,594**

Note 27.3 Financial liabilities

	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Obligations under PFI, LIFT and other service concession contracts	3,405	-	3,405
Trade and other payables excluding non financial liabilities	12,379	-	12,379
Provisions under contract	627	-	627
Total at 31 March 2016	**16,411**	**-**	**16,411**

Note 27.4 Maturity of financial liabilities

	31 March 2016	31 March 2015
	£000	£000
In one year or less	12,817	-
In more than one year but not more than two years	411	-
In more than two years but not more than five years	1,581	-
In more than five years	1,602	-
Total	**16,411**	**-**

Note 27.5 Fair values of non-current financial assets at 31 March 2016

The Trust did not hold any non-current assets at 31 March 2016.

Note 27.6 Fair values of non-current financial liabilities at 31 March 2016

	Book value	Fair value
	£000	£000
Provisions under contract	533	533
Other - Obligations under PFI, LIFT and other service concession contracts	3,061	3,061
Total	**3,594**	**3,594**

Note 28 Losses and special payments

	2015/16	
	Total number of cases	Total value of cases
	Number	£000
Losses		
Cash losses	1	-
Bad debts and claims abandoned	1	9
Stores losses and damage to property *	2	500
Total losses	**4**	**509**
Special payments		
Compensation payments	7	49
Ex-gratia payments	15	4
Total special payments	**22**	**53**
Total losses and special payments	**26**	**562**
Compensation payments received *		500

*The Trust has reported one instance of a loss or compensation payments that exceeds £300k which relates to losses, and reimbursement related to the Boxing Day floods. The Trusts has recevied insurance reimburesment of an equal and opposite amount of £500k that will reimburse the costs in 2015/16. A full note is provided in note 5.1 with regards to the flood.

Note 29 Prior period adjustments
There are no prior period adjustments.

Note 30 Events after the reporting date
Directors took the decision to close the Intensive Therapy Centre to new admissions on 20 April 2016. This followed a Board decision to progress final urgent discussions with different commissioners to try to secure a sustainable occupancy level for the unit; this was not successful. A meeting to brief staff took place on 21 April 2016. Following a review of current vacancies the Trust is optimistic of being able to redeploy all staff.

Auditor's statement

KPMG

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BRADFORD DISTRICT CARE NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 Our opinion on the financial statements is unmodified

We have audited the financial statements of Bradford District Care NHS Foundation Trust for the 11 months 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 11 months to 31 March 2016; 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 risk of material misstatement that had the greatest effect on our audit was as follows:

Valuation of land and buildings - £48.5 million

Refer to page 26 (Audit Committee), Note 1.5 accounting policy and Note 9.1 property, plant and equipment

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 specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. 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. The Trust commissioned a full revaluation of land and buildings as at 31 March 2016 from an independent valuer.

Our response: In this area our audit procedures included:

- assessing the competence, capability, objectivity and independence of the Trust's external valuer and considering the terms of engagement of, and the instructions issued to, the valuer for consistency with the Trust's accounting policies for the valuation of property, plant and equipment and also RICS Valuation Professional Standards;
- confirming the appropriateness of any amendments made by management to the information received from the valuer before being incorporated in the financial statements;
- comparing the price index used by the valuer to those used by valuers performing similar work at other NHS bodies;
- critically assessing, in the light of our knowledge of the Trust's assets and circumstances during the year, whether any further impairments needed to be recognised beyond those identified by the external valuer;

- substantiating additions to land and buildings by confirming value to third party valuation certificates;
- undertaking work to understand the basis upon which any revaluations and impairments to land and buildings had been classified by the Trust and determining whether the recognition of these gains and losses in the financial statements complied with the requirements of the FT ARM; and
- reviewing disclosures related to the revaluation and impairments to land and buildings and whether they complied with the requirements of the FT ARM. .

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £2m determined with reference to a benchmark of income from operations (of which it represents 1.7%). We consider income from operations to be more stable than a surplus-related benchmark.

We report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £100k 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's head office in Saltaire.

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 Report 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 period 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 Directors' Report 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.

KPMG

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 District Care 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

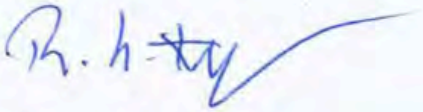
We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General (C&AG), as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources 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 11 months ended 31 March 2016.

KPMG

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.



Rashpal Khangura
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
Sovereign Square,
Leeds
26 May 2016

Appendices

Appendix 1

Information about the Board of Directors

Board member	Period of appointment	Date of interest	Declarations of interest	Knowledge and experience
Michael Smith	17 September 2012 to 16 September 2016	2007 2011	Chair of 'Dark Horse' Theatre Company - A theatre company for professional actors with Learning Disabilities, Huddersfield Trustee of Thornton Grammar School Trust, Bradford - representing BDCT	Former Director of Human Resources, Yorkshire Water and head of Procurement and Supply Chain. Qualifications: BA and MBA.
Simon Large	From 18 September 2006	January 2012	Trustee of Bulls Foundation - a local charity providing social inclusion and engagement around sports	Former Director of Operations, Performance and Planning at Bolton, Salford and Trafford mental health Trust and Director of Mental health at Wigand Bolton Health Authority. Qualifications: RMN, BSc and MBA.
Rob Vincent CBE	1 March 2013 to 28 February 2017	2012 2013 2013	Director of New Ing Consultants Chair of Kirklees Theatre Trust - Undertakes some community theatre work Director of Dartmouth Residential	For Chief executive of Kirklees and Doncaster Councils, Local Government adviser to the Department of Health's Public Health Transitions team. Qualifications: Degrees in Civil Engineering and Civil design, MRTPI, FRSA.
David Banks	1 December 2013 to 30 November 2017	1998 1990	25% shareholder in ProTurn Limited (private company) Partner in David Banks Associates	Chartered account with substantial experience of helping businesses through rapid change. Various senior roles across the private sector including Finance Director and Non-Executive Chair of Zytronic PLC, founding Director of ProTurn Ltd. Qualifications: FCA.

Sue Butler	3 May 2012 to 2 May 2016	2011 2012 2012 2015	Senior Consultant at Agencia Consulting Ltd Sole Trader - Performance Development coach Trustee Ilkley and District U3A Secretary, Soroptimist International of Ilkley	Former medical Director of a Primary Care Trust and former GP with over 20 years' experience. Qualifications: BSc, MRCGP.
Ralph Coyle	3 May 2012 to 2 May 2016	2004 2011	Trustee/ Director of Scarborough Museums Trust Member of the Court, Leeds University	Former Legal Adviser and Company Secretary of Yorkshire Tyne Tees Television Holding PLC, Company Secretary at CANAL and former partner at Rollits Solicitors. Qualifications: LLB, LLM.
Nadira Mirza	1 April 2015 to 31 March 2017	2000 2011 2014	Ishico Lighting Distributors (Owner) Chair of Governors and Trustee, University Academy, Keighley Director of Student & Academic Services	Extensive experience of the voluntary and academic sectors with experience of a number of NHS and educational Boards, nationally and internationally. Qualifications: BA, FRSA.
Derrick Palmer*	1 December 2011 to 30 November 2015	2009 2013 2013 2014	Governor Heptonstall Junior School Non-Executive Member Audit Committee Land Registry Non-Executive Director Audit Committee Bradford University Governor Calderdale College	Former finance Director, Bradford community Housing Trust and has held a number of senior roles in both public and private sectors. Qualifications: CIPFA, FIoD, FCMI.
Zulfi Hussain	1 March 2016 to 28 February 2019	2016 2016 2016 2016 2016	Director of Zanji Ltd T/A Deeva Restaurant Director of Pavilion Café, Bradford Director of Global promise Ltd (Social Enterprise) Director of Global Synergy Solutions Ltd Trustee of Yorkshire Cancer Research	

Nicola Lees	From 2 August 2010		None	Former Network Director, Greater Manchester West NHS Foundation Trust, Associate Director, Adult Forensic Services, Bolton, Salford and Trafford NHS Trust. Qualifications: RMN, PGDip, MSc.
Helen Bourner**	From 2 April 2013		None	Former Commercial and Corporate Development Director at Warrington and Halton Hospitals NHS Foundation Trust and former Regional Director of Hilton Hotels Group. Qualifications: MA, HND.
Sandra Knight	From 14 May 2007		None	Former Director of Corporate Development at Bradford & Airedale Primary Care Trust and director of Corporate Development, Bradford City teaching primary Care Trust. Qualifications: BA, MA, MSc, PGCE, FCIPD.
Andy McElligott	From 1 April 2012		None	Over 20 years NHS experience including 14 years as a GP, former medical Director of Bradford & Airedale Primary Care Trust. Qualifications: MB, ChB.
Liz Romaniak	From 1 August 2014		None	Former Deputy Director of Finance, Bradford District Care Trust and various senior finance roles across Yorkshire as both a provider and commissioner. Qualifications: ACMA.

***Retired 30 October 2015**
****secondment to Programme Director role for the Airedale and Partners Vanguard in August 2015**

Appendix 2

Information about the Council of Governors

All elected Governors were elected for a 3 year period of office from 1 May 2015 to 30 April 2018. Contact details for Governors are contained on the website: http://www.bdct.nhs.uk/our-council-of-governors

Appointed constituency

Governor	Date of interest	Registered political party membership	Interests	Comments
Cllr Carl Lis	April 2015	Member of the Skipton and Ripon Conservative Party	Councillor, Craven District Council	Conservative Party
Cllr Naseem Shah		Member of the Labour Party and Unite the Union. Parliamentary candidate for Bradford West		
Mohammed Shabir				
Cllr Nussrat Mohammed	September 2015	Member of the Labour Party.		
Cllr Mike Gibbons	August 2015	Member of the Conservative Party	Chair of Keighley and Ilkley Conservative Association	
Shirley Congdon	April 2015	None	Member of Local Education and Training Board (LETB), Yorkshire and Humber	
Stephen Oversby	April 2015	None	Director, Barnardo's	Registered charity
Yasmin Khan	April 2015	None	Yasmin's spouse is the Chair of Bradford Health Watch and the Chief Executive of CNET	

Bradford East constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Amanda Martin-Richards	April 2015	None	Foster Carer, City of Bradford Metropolitan District Council	
Kevin Russell	April 2015 April 2015 November 2015	Member of the Labour Party	Chairman, Mindworks Volunteer Community Health Champion, Champions Show the Way	Voluntary organisation. Provides information to employers about mental health in the workplace. A service provided by the Trust.
Waafa Nawaz	April 2015	None	Director, Cepheus Procurement Solutions Ltd Trustee, Naye Subah	Sole Director of this Private Limited Company Provides daycare and a support service for women with mental health difficulties.

Bradford South constituency

Name	Date of interest	Registered political party membership	Interests	Comments
George Deane	April 2015	None	Chair, Black Health Forum Daughter will shortly commence work at the Trust.	A voluntary organisation which aims to reduce health inequalities.
Michelle Eggett	April 2015 February 2016	None	Student representative at Bradford University. Volunteer mentor/ study coach at Centrepoint	Centrepoint is a charity for young people who are homeless or at risk of homelessness.
Sandra McIntosh	April 2015	Member of the Labour Party	None	

Bradford West constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Colin Perry	April 2015	None	Trustee, Bradford and Airedale Mental Health Advocacy Group	A user-led mental health service.
David Spencer	April 2015	Member of the Conservative Party	Chair, Patient Participation Group, Kensington Partnership, Kensington Health Centre, Bradford	A GP Multi-Practice
Mahfooz Khan	April 2005	None	Client Liaison Officer, Legal Marketing Services	A private company that deals with claims relating to industrial deafness.

Craven constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Hazel Chatwin	April 2015	None	Vice Chair, Craven Community and Voluntary Services (CVS) Member of Healthwatch Bradford and District Member of Healthwatch, North Yorkshire	An organisation which provides support to community and voluntary organisations in Craven.

Keighley constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Barry Eccles	April 2015	None	None	
Nicholas Smith	April 2015 November 2015	None	None Investigating the potential provision of a WRAP service to the Trust	

Rest of England constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Hayley Lomas	April 2015	None	Governor, Royds Hall Community School, Huddersfield Magistrate, Bradford Magistrates Courts Independent Monitoring Board Member, HM Prison New Hall	A community school for 4-16 year olds. A prison for women

Shipley constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Ann West	May 2015	Member of the Green Party	None	
Sarah Jones	April 2015	None	Director, Bolsover Property Ltd Director, Toekomst UK	Property investment company Financial and non-financial investment company

Staff constituency

Name	Date of interest	Registered political party membership	Interests	Comments
Cathy Woffendin	April 2015	None	None	
Debbie Cromack	April 2015	None	None	
Liz Howes	April 2015	None	Director, Huddersfield Counselling Service	Private Limited Company
Noel Waterhouse	April 2015	None	None	
Val Convery	April 2015	None	None	

Appendix 3

Feedback on the Annual Report

It is important our Annual Report is easy to read and understand and is available in a variety of versions including other languages and large print. In producing the Annual Report we have used guidance from the Department of Health and looked at how other Trusts have reported on their own performance.

We would value your feedback on this year's report. Please complete the feedback form below and post the page to the address shown below. Alternatively you may email your comments to communications@bdct.nhs.uk

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
The information in this report was easy to understand					
There was enough information about the Trust and its services					
There was enough information about the Trust and its achievements					
There was enough information about the Trust's finances The layout of the document was clear					

Please post any feedback to:
Communications Department
Bradford District Care NHS Foundation Trust
New Mill, Victoria Road, Shipley
BD18 3LD

Or telephone: 01274 228173

Bradford District Care NHS
NHS Foundation Trust

You & Your Care
www.bdct.nhs.uk

Published July 2016 Pin: 00518v1