Bradford Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts 2021/22

Bradford Teaching Hospitals NHS Foundation Trust

Annual Report and Accounts
2021/22

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1. INTRODUCTION

1.1. WE ARE BRADFORD

Bradford Teaching Hospitals NHS Foundation Trust (the Trust) was created on 1 April 2004. It serves a local population of around 530,000 and employs over 6,400 people working across six sites.

Our mission at Bradford Teaching Hospitals NHS Foundation Trust is "to provide the highest quality healthcare at all times".

We are one of the few hospitals around the country which delivers care, teaching and research – both clinical research and applied health research. To do well in any one of these domains is an achievement. It is an even greater challenge to excel in all three, but that is our ambition.

We strive for excellence and are committed to learning from, and leading, best practice to make sure we are delivering quality care. We aim to have a workforce representative of the communities we serve so we're the best place for our patients and our people. To this end, we have a vision for the Trust that describes our ambition and where we want to be as an organisation.

Our vision is "to be an outstanding provider of healthcare, research and education, and a great place to work."

Our values sum up who we are as an organisation. They are:

- *we care*
- *we value people*
- *we are one team*

We all work together to bring these values to life in our everyday work – whether we are working with patients or each other, *We are Bradford.*

2. PERFORMANCE REPORT

2.1. OVERVIEW OF PERFORMANCE

2.1.1. PURPOSE OF SECTION

This section aims to provide sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

2.1.2. STATEMENT FROM THE CHIEF EXECUTIVE ON PERFORMANCE

2021/22 was one of the toughest years in the history of the Trust. Our staff continued to experience the relentless challenges of the COVID-19 pandemic first-hand, delivering care above and beyond any expectation of our era.

And with the rapid rise in COVID-19 transmissions as a result of the Omicron variant, we can be forgiven for having a sense of déjà vu.

But we entered the year with a genuine belief that things were going to get better. Vaccines were making a difference and there was much to look forward to. Yet again, we have witnessed incredible compassion, strength and unity from our colleagues, our partners and our communities.

Many people have lost their lives to COVID-19, but well over 4,400 patients who were admitted to our hospital with COVID-19 recovered and were discharged home after surviving this terrible virus.

This year we started developing the Trust's new corporate strategy – our roadmap for the next five years. It sets out not just what we'll do but what sort of organisation we want to be. A place that's inclusive and kind, as well as innovative and ambitious.

Above all, we want to make sure we focus on the things that really matter to our people, our patients, and our place.

One of the developments that has accelerated during the pandemic is the way we provide hospital care at home – known as virtual care. We've already won national awards for this in Children's Services and in Care of the Elderly. Our ambition now is to spread the approach right across all our services.

We call it the "Virtual Royal Infirmary", and this programme is helping us improve patient experience, make best use of our resources – and even reduce our carbon footprint.

This year, our very first ever green summit took place virtually. Building on our excellent track record for sustainability, staff pledged "no more blah, blah, blah" to turn good intentions into action on our mission to net zero carbon emissions. Our first green fleet vehicle hit the roads around Bradford Royal Infirmary (BRI) and we opened two new state of the art cycle compounds, there and at St Luke's Hospital.

We are proud to have played a part in medical and scientific breakthroughs in the race to find a COVID-19 vaccine. This year, once again, we brought a world-first clinical trial to Bradford. We were chosen as one of only a handful of sites to launch the Cov-Boost study – the first in the world to provide vital data on the impact of a third dose of the COVID-19 vaccine. What's more, we were the first study site, across the world, to go live.

Through our work on research and in clinical trials, we – and the many volunteers from our local communities – are very proud to have contributed to the success of the vaccination and booster programme.

We continued to see a high number of COVID-19 patients in hospital throughout the year and there was no down-time for our staff. But we consistently kept at the job of caring for our patients and received a wellbeing boost in October when it was time for us all to "Thrive".

We launched our one-stop shop for everything our colleagues need to help in caring for their own health, wellbeing and development. Called Thrive, we created an ethos, a community, and a culture to ensure the Trust is a place where everyone can be their best and thrive at work and beyond.

And in a ground-breaking move for the NHS, we unveiled, to national acclaim, our new cross-belief (multi-faith) Spiritual, Pastoral and Religious Care (SPaRC) team after a review of our Chaplaincy services. SPaRC aims to offer a service to everyone, regardless of race, religion, ethnicity or belief while a patient or employee in one of the Trust's family of hospitals.

Our staff continued to get national recognition for their efforts during the pandemic. Claire Chadwick, Nurse Consultant and Director for Infection Prevention, was awarded an MBE for her services to the NHS during the pandemic.

Our innovative Plaster team's "cracking" idea to help patients look after their casts scooped a national award. Their brainwave was to put a simple QR code – a type of barcode that can be read by smartphones – on casts, which links patients to a whole raft of useful information. It wowed judges at the Nursing Times Awards and won the Technology and Data in Nursing prize.

Our Palliative Care Team was named Workforce Team of the Year in the Nursing Times Workforce Awards. The team was recognised for its development of our virtual end of life ward.

And our anaesthetic team were honoured for meeting standards of "the highest quality care", receiving the prestigious Anaesthesia Clinical Services Accreditation (ACSA) which is the Royal College of Anaesthetists' peer review scheme that recognises patient experience, patient safety and clinical leadership.

'Act as One' is the way all of us across the Bradford District and Craven Health and Care Partnership operate together. Supported by governance and shared decision making, together we design, develop and deliver integration across care pathways which better meet the needs of our population. Our vision is to help keep people 'happy, healthy at home.'

Despite the ongoing pressures of the COVID-19 pandemic and the huge effort to support the COVID-19 vaccination programme, we have maintained a focus on delivering for our people. Both those living and working in our communities, and our health and care colleagues across the NHS, local authorities, voluntary and community sector organisations and independent care organisations.

We have made great strides in transforming our hospital sites to improve patient care. We opened a new £7m acute surgical unit to improve the environment and experience of surgical patients. And a new £2.4m high dependency unit opened at our A&E department, providing negative pressure rooms for critically ill patients and those with infectious illnesses.

Three state-of-the-art operating theatres were also unveiled at BRI after a major refurbishment worth almost £4.5million. The ultramodern, hi-tech spaces form part of a five theatre suite, now known as our Bronte theatres.

As the youngest city in Europe, with 29% of our population under 20 and nearly a quarter under 16, the need for local healthcare services will continue to grow. This year we submitted a funding bid for a future new hospital in Bradford. We are working with our health partners, Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust, on a series of planned developments across the city and district to provide modern "Fit for the Future" healthcare facilities.

We want to create modern health and care facilities that support our people and our citizens by securing safe, efficient and fit for purpose hospitals and healthcare for generations to come. We are excited by the opportunity that could be presented to us to really transform the way care is provided for our patients and their families.

2.1.3. Purpose and activities of the Foundation Trust

All foundation trusts are required to have a constitution, containing detailed information about how they will operate. The purpose of the Trust is set out in its constitution[1] as follows:

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

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

- *the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness, and*
- *the promotion and protection of public health."*

[1] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/11/BTHFT-Constitution-July-2021.pdf

In short, the purpose of the Trust can be summarised in its vision which is *"to be an outstanding provider of healthcare, research and education; and a great place to work".*

We have five strategic objectives that provide the link between our vision and the actions required to deliver it. They are to:

1. provide outstanding care for patients;
2. deliver our financial plan and key performance targets;
3. be in the top 20% of NHS employers;
4. be a continually learning organisation; and
5. collaborate effectively with local and regional partners.

These objectives frame the practical steps we take to help deliver our Trust vision and implement our clinical service strategy.

Progress against the objectives is reported through the dashboard reports which are presented to the relevant Academies and to the Board at each meeting.

"*A commitment to our patients: our Clinical Service Strategy 2017-2022*"[2] was published in September 2017 and sets out how we will develop our clinical services to meet the health needs of the people of Bradford and West Yorkshire. It outlines how we work with partners to provide new, flexible models of care, tailored to meet the needs of patients and their families. It draws on discussions with our clinicians and staff, commissioners, Healthwatch, our Trust governors and other local stakeholders, and was written following service user feedback.

As is the case with the rest of the NHS, the Trust faces many challenges due to a combination of a difficult financial climate, ageing population, rising public expectations, medical cost inflation, regulatory requirements and the competing demands for a specialist workforce.

In addition, Bradford and its surrounding district have a set of circumstances leading to significant growth in demand for health and care services, over and above the projections seen elsewhere. Population growth at each end of the age spectrum is significant and - when coupled with other factors such as pockets of deprivation, poor diet and housing - creates a challenging set of issues.

The last year has again been hugely impacted by the need to maintain services and respond to a global pandemic. We have had to support our workforce in providing direct care for those most adversely affected by the disease; and we have continued to be an active partner in delivering the COVID-19 vaccination programme.

During 2020/21 we developed a plan for the year ahead - 'People, Partners and Place'[3]. This plan reflects some of the behaviours which have been emphasised through the pandemic such as embedding kindness and support for Ethnic Minority colleagues, as well as new ways of working which have been adopted, including digital advancements.

The plan also refers to the 'Act as One' approach[4] which has been adopted by health and care partners across Bradford district and Craven. The aim is to ensure an integrated approach to deliver the plan for health and care - Happy, Healthy at Home. We play an active role in this partnership – our Chief Executive is the Chair of the Bradford Health and Care Partnership Board and three of the seven priority programmes are led by one of our executive directors (access to healthcare, diabetes and respiratory).

[2] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2018/02/bthft_clinical_service_strategy_2017-2022-20170920084540.pdf
[3] https://www.bradfordhospitals.nhs.uk/ppp/
[4] https://www.bradfordhospitals.nhs.uk/working-with-our-partners/

A new, longer term corporate strategy has been developed during 2021/22 ('Our Patients, Our People, Our Place and Our Partners'), and will be launched in spring 2022. This strategy builds on our previous corporate strategy and 'People, Partners and Place', recognising our role within the Bradford District and Craven Health and Care Partnership.

In terms of the operational leadership structure, the Trust implemented a Clinical Business Unit (CBU) model in 2019, with operational managers and clinical leaders working in partnership to harness the expertise, innovation and creativity of all staff to deliver improved outcomes for patients and improved operational and financial performance (see figure 1).

Figure 1 - Clinical business units

Planned Care Group			
Access	**Children's services**	**Women's services**	**Urinary tract and vascular**
• Adult outpatient department services • Corporate access team • Central patient booking service • Phlebotomy • Medical records • Cancer team	• Paediatric medicine • Paediatric surgery • Paediatric community services • Child development • Neonatal services	• Obstetrics • Gynaecology	• Urology • Vascular • Renal
Musculo-skeletal, Plastics & Skin	**Theatres and day case**	**Head and neck**	**Critical care/anaesthetics and pain**
• Skin • Trauma and orthopaedics • Orthotics • Plastics • Dermatology • Rheumatology • Breast surgery	• Theatres • Day case • Inpatient waiting list team • Westwood Park Diagnostic and Treatment Centre • Pre-operative assessment	• Ear, nose and throat • Oral and maxillofacial surgery • Ophthalmology • Orthodontics • Macular • Restorative Dentistry • Clinical Prosthetics • Audiology	• Anaesthesia • Critical care • Pain • Sleep • Decontamination

Unplanned Care Group			
Urgent and emergency care	**Virtual**	**Elderly and intermediate care**	**Digestive diseases and general surgery**
• Emergency department • Ambulatory care unit/clinical decisions unit • Acute medical unit • Short stay ward • Site management/ Command Centre	• Virtual services project • Virtual diagnostics	• Elderly medicine • Intermediate care • Community hospitals - Westwood Park and Westbourne Green • Stroke • Elderly virtual ward • Multi-agency discharge team • Neurology	• Gastroenterology • Hepatology • Colorectal/upper gastrointestinal • Endoscopy • General surgery • Surgical assessment unit
Specialist medicine	**Radiology and imaging**	**Haematology, oncology and palliative care**	**Therapies**
• Cardiology • Respiratory • Infectious diseases and HIV service • Diabetes /endocrine	• Radiology imaging • Medical physics • Radiation protection • Pennine Breast Screening • Medical illustration and interpreting services	• Medical oncology • Clinical oncology • Haematology and Haematology Oncology/Palliative care • Blood sciences and pathology intravenous • Mortuary • Transfusion services	• Psychology • Dietetics • Physiotherapy/Occupational Therapy • Speech and language

2.1.4. History of the Trust and statutory background

On 1 April 2004, Bradford Teaching Hospitals NHS Trust was authorised to become an NHS Foundation Trust by Monitor, the then Independent Regulator of NHS Foundation Trusts, under Section 6 of the Health and Social Care (Community Health and Standards) Act 2003[5].

The Trust is an integrated Trust that provides acute, community, inpatient and children's health services. The acute services are provided from the Bradford Royal Infirmary site.

In addition to Bradford Royal Infirmary, the Trust has five further sites at St Luke's Hospital, Westbourne Green, Westwood Park, Shipley, and Eccleshill Community Hospital and serves a population of around 530,000 people from Bradford and the surrounding area. We have approximately 600 acute beds, employ over 6,400 members of staff, and have more than 500 volunteers supporting our services, and we have been delighted to welcome some volunteers back during this year following a pause during the pandemic. In 2021/22 our Trust services delivered 5,525 babies, performed 13,102 operations in theatre and handled 423,154 outpatient appointments. We had 108,503 attendances at our Emergency Department.

2.1.5. Key issues, opportunities and risks affecting the Trust

The Trust uses a Board Assurance Framework (BAF) as a tool for the Board of Directors to assure itself of, or describe the confidence that it has about, the successful delivery of its strategic objectives. The principal risks described in the BAF are based on a collective assessment by the executive directors. The mitigation of these risks is scrutinised by the non-executive directors at Board meetings. The strategic risk profile underpinning the BAF is directly influenced by high scoring risks identified by wards, specialties, care groups or corporate departments which may impact the effective delivery of the strategic objectives.

The highest scoring principal risks that the Trust has been exposed to during 2021/22 relate to the ability to maintain the quality of services and operational performance, and to recruit and retain an effective and engaged workforce. These risks have remained high throughout the year due to the impact of COVID-19. Mitigations include ongoing quality oversight processes, quality improvement programmes, Infection Prevention and Control processes, operational improvement plans, and our Outstanding Maternity and Outstanding Theatres programmes.

Further details, including the Trust's highest scoring operational risks as at April 2022 are described in the Performance Analysis (section 2.2.2.4).

Through responding to the pandemic, the Trust has identified opportunities for learning and improvement. These are outlined in more detail in our report 'Learning from the COVID-19 pandemic – a Bradford Teaching Hospitals perspective'[6].

The Trust has played a key role in the development of integrated services within the Health and Care Partnerships for West Yorkshire, and Bradford District and Craven, in order to ensure that the requirements of the Health and Care Bill are implemented in 2022/23. The Trust has also capitalised on opportunities as part of the West Yorkshire Association of Acute Trusts (WYAAT), for example by finding joint solutions to addressing fragile services.

The BAF was maintained by the executive directors throughout the year and presented to the Board of Directors at each meeting. Therefore, the Board of Directors was routinely provided with oversight of the identification, analysis and management of risk to the delivery of the strategic objectives. Key controls were identified and together with their associated assurance are

[5] https://www.legislation.gov.uk/ukpga/2003/43/contents
[6] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/08/BTHFT-Learning-from-COVID.pdf

presented in the BAF. The Board therefore has had clear sight of significant risks and ensured actions were prioritised appropriately. Further details regarding the Trust's risk management arrangements are included in the Annual Governance Statement (section 3.8).

2.1.6. GOING CONCERN DISCLOSURE

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.

2.1.7. SUMMARY OF PERFORMANCE

2.1.7.1. Performance summary

During the 2021/22 Financial Year, the Trust has been working to improve its performance against the core contractual targets, including those indicated within the NHS Oversight Framework 2021/22. Part of this work has been the restart and recovery of elective services following the impact of COVID-19.

The table below describes the results achieved against some of the targets, identified as part of the NHS Oversight Framework for 2021/22. Further analysis is included later in the report but highlights are captured here.

Figure 2 - Monthly results achieved against selected NHS Oversight Framework 2021/22 KPIs

KPI	4 Hour Emergency Care Standard	62 day Cancer first treatment	18 weeks RTT Incomplete	MRSA infections	Summary Hospital-Level Mortality Indicator
Apr-21	85.02%	81.00%	69.56%	1	103.46
May-21	83.54%	80.60%	71.85%	0	104.45
Jun-21	82.45%	75.00%	72.00%	0	103.52
Jul-21	76.05%	79.50%	69.70%	0	103.31
Aug-21	79.73%	82.00%	66.38%	2	103.23
Sep-21	75.78%	68.60%	64.12%	1	103.72
Oct-21	76.38%	76.90%	62.69%	0	102.58
Nov-21	75.54%	81.40%	64.98%	0	103.59
Dec-21	73.29%	87.98%	64.20%	0	104.50
Jan-22	72.83%	68.40%	66.28%	1	
Feb-22	75.51%	74.20%	68.25%	0	
Mar-22	74.08%	78.44%	67.98%	0	
2021/22	**77.58%**	**78.23%**	**70.85%**	**5**	**104.50***
2020/21	88.46%	74.97%**	63.23%	6	104.79

* Latest available Summary Hospital-Level Mortality Indicator (SHMI) is Jan-21 to Dec-21
**March 2020/21 year end position (78.72%) updated to YTD position (74.97%) to allow for comparison against 2021/22 YTD position

During the second half of 2021/22 the COVID-19 pandemic had a significant impact on the Trust's operational performance. The increase in cases due to the Omicron variant impacted on bed

availability, staff absence and the ability to run elective surgery. This delayed plans to reduce referral to treatment (RTT) waiting times and exacerbated pressures seen across urgent and emergency care during winter. Despite these challenges the Trust continued to prioritise the most urgent patients for surgery. All patients on the waiting list for surgery were reviewed by their consultants and contacted to inform them of their expected wait time and the actions that needed to be taken should they become concerned or their condition deteriorated.

The care we provided for cancer patients continued to improve in 2021/22 with 78.23% of patients treated within 62 days compared to 74.97% in the previous year. Wait time for first appointment remained above the 93% national standard to be within two weeks and the new measure of informing patients of whether they have cancer or not within 28 days met the 75% target at 81.99%. The number of patients waiting beyond 62 days on a cancer pathway reduced to 18 by March 2021 which was in line with the priorities set by NHS England and Improvement (NHSE/I) and a significant improvement on the peak of 177 in July 2020.

Quality of Care has been at the forefront of the Trust's activities during this time with our continued focus on building on our success and continuously improving the patient and service user experience. Despite the challenges on clinical services due to the emergent Omicron variant the Trust has continued to have oversight of quality with weekly meetings of the Quality of Care Panel to facilitate the review of quality and safety issues on a real time basis which includes the oversight of patient safety events, patient experience and the identification of learning and improvement opportunities.

Quality metrics have continued to be monitored at the re-named Quality and Patient Safety Academy. This broader remit presents the Trust with an opportunity to embed all elements of the National Patient Safety Strategy along with our ethos of a culture of safety, fairness and transparency. These quality metrics are currently being reviewed and broadened in consultation with clinical teams to support ownership and accountability at the point of care delivery which supports our nursing accreditation programme and our participation in the national Magnet4 Europe research programme. This is an international nursing quality accreditation programme which promotes a participative shared governance and leadership model which empowers nurses at every level. The Trust also re-launched its learning from deaths and mortality work in September 2021, strengthening links with the new Medical Examiner role increasing the number of patient deaths being reviewed to 100%.

2.1.7.2. Finance summary

To facilitate the NHS's response to the pandemic, NHSE/I retained an interim financial framework for providers and commissioners throughout 2021/22. The established financial regime remained suspended with the simplified framework designed to ensure providers received sufficient cash to facilitate the required response to the pandemic and restart its elective programme. Normal contractual arrangements with commissioners were suspended and replaced with a centrally defined block funding mechanism not directly linked to activity levels.

The Trust was required to deliver a breakeven position to contribute to the West Yorkshire Integrated Care System's (ICS) overall break even target set by NHSE/I. The Trust has reported a £9.0m deficit for 2021/22. However, this includes a £9.6m impairment to the value of land and buildings asset, and an adjustment for depreciation on donated assets and donations for capital purchases. NHSE/I excludes these adjustments from its assessment of a Trust's operating results, and when these are removed the relevant margin for the year is a surplus of £1.4m which is £1.4m better than the planned breakeven position. This improvement in the operating position is largely attributed to reduced variable expenditure on elective work due to the suppression of this activity by the ongoing pandemic response and the inability to spend in full the funding received to deliver this work.

Figure 3 - Income and Expenditure Position Including Impairment

	20/21	21/22 plan	21/22 Actual	21/22 Variance to Plan	Change vs 20/21
Operating Income (including Top-up)	494.0	509.7	533.7	24.0	39.8
Operating expenditure	(475.3)	(493.1)	(513.4)	(20.3)	(38.1)
EBITDA	**18.7**	**16.6**	**20.3**	**3.7**	**1.7**
Non-Operating Expenditure	(18.4)	(16.6)	(19.7)	(3.1)	(1.3)
Impairment	0.6	(0.1)	(9.6)	(9.5)	(10.2)
Surplus / (deficit)	**0.9**	**(0.1)**	**(9.0)**	**(8.8)**	**(9.8)**

Figure 4 - Income and Expenditure Position Excluding Impairment and Depreciation on Donated Assets and Donations

	20/21	21/22 plan	21/22 Actual	21/22 Variance to Plan	Change vs 20/21
Operating Income (excluding Top-up)	471.7	505.5	527.7	22.2	56.0
Operating expenditure	(475.3)	(493.1)	(513.3)	(20.2)	(38.0)
EBITDA	**(3.6)**	**12.4**	**14.4**	**2.0**	**18.0**
Non-Operating Expenditure	(17.7)	(16.6)	(19.7)	(3.1)	(2.0)
Impairment	0.6	(0.1)	(9.6)	(9.5)	(10.2)
Margin excluding Top-up	**(20.7)**	**(4.4)**	**(14.9)**	**(10.5)**	**5.8**
Remove impairment	(0.6)	0.1	9.6	9.5	10.2
Remove depreciation on donated assets and donations for capital purchases	(1.0)	0.0	0.7	0.7	1.7
Margin on control total basis	**(22.3)**	**(4.2)**	**(4.6)**	**(0.4)**	**17.7**
Top-up Funding	22.3	4.2	6.0	1.8	(16.2)
Margin including Top-up on control total basis	**(0.0)**	**(0.0)**	**1.4**	**1.4**	**1.4**

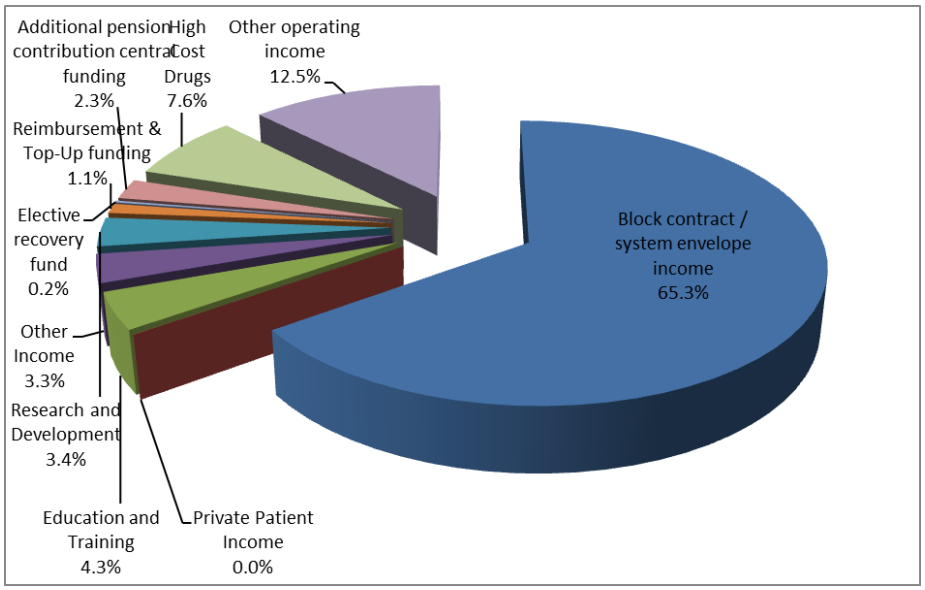
Income

The total income reported for the 2021/22 financial year was £533.7m, which is split as follows:

- Block contract - £348.2m
- Other clinical income - £80.3
- High cost drugs - £40.7m
- Other operating income - £24.5m
- Training and Education income - £21.9m
- Research and Development - £18.0m

A more detailed breakdown of income in 2021/22 is provided in figure 5.

Figure 5 - Breakdown of income for 2021/22



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

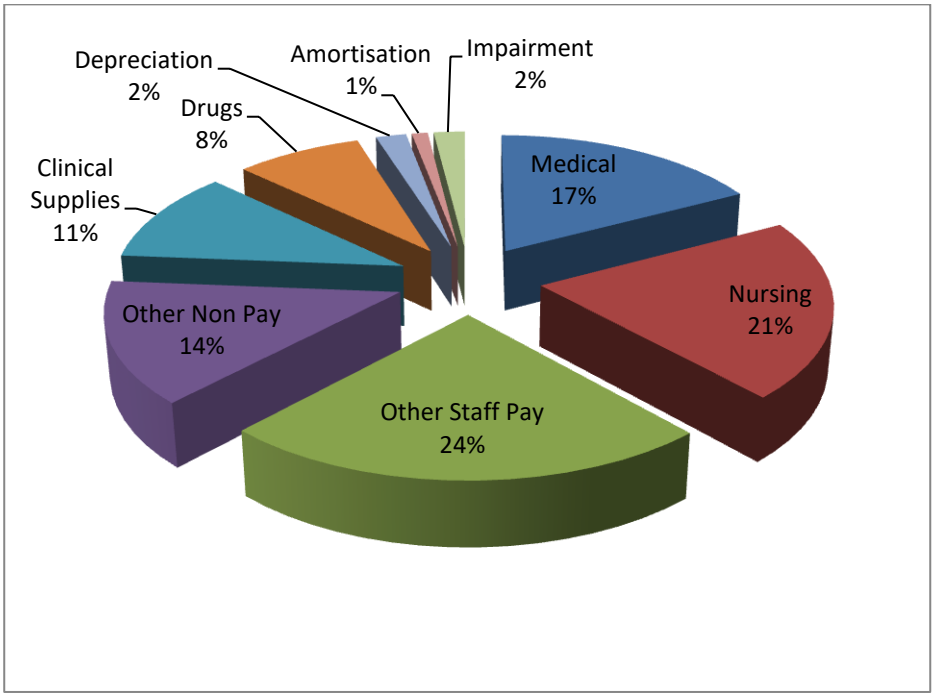
Expenditure

Including the impairment and donations for capital purchases, the total expenditure reported for 2021/22 was £542.7m, which is split as follows:

- Payroll bill for employed and agency staff: £332.3m;
- Non-Pay costs including drug costs: £180.3m;
- Depreciation, amortisation and Public Dividend Capital: £19.4m;
- Impairments (nil cash impact): £10.6m.

A more detailed breakdown of expenditure in 2021/22 is provided in figure 6.

Figure 6 - Breakdown of expenditure for 2021/22



2.2. PERFORMANCE ANALYSIS

2.2.1. MEASUREMENT OF PERFORMANCE

Performance Monitoring

Performance Monitoring defines the processes used by the Trust to both report information externally to meet our regulatory and contractual requirements, and review internally to assure the organisation is delivering against Key Performance Indicators (KPIs) and Strategic Objectives.

The Trust is regulated primarily by NHSE/I and the Care Quality Commission (CQC). It has contractual relationships with NHS commissioning bodies such as NHS England (NHSE) and our local Clinical Commissioning Groups (CCGs). The Trust has made monthly submissions to these bodies throughout 2021/22.

The Trust continually measures its performance against a wide variety of measures, including but not limited to:

- NHS System Oversight Framework KPIs
- NHS Use of Resources KPIs
- National contract quality measures
- Quality measures agreed with local commissioners
- Internally agreed performance measures

The Trust is contractually obliged to provide regular Performance Monitoring and Assurance reports to NHSE/I and NHS Commissioning organisations and continues to meet these obligations. These reports include daily, monthly and quarterly reports, and have also included ad hoc reports when requested.

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

- NHS System Oversight Framework
- NHS Data Dictionary definitions
- NHS contract technical guidance

The Board of Directors retains overall responsibility for ensuring systems and controls are in place that are sufficient to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. The Board Assurance Framework governs these assurance processes.

The Board Assurance Framework provides assurance that the performance of the organisation is systematic, consistent, independently verified, and incorporated within a robust governance framework.

The Board Assurance Framework also allows that:

- Relevant KPIs are defined and selected to provide assurance against all regulatory and contractual requirements.
- Relevant KPIs are defined and selected to provide assurance against all strategic organisational objectives.
- The Board of Directors carries ownership and oversight of all selected KPIs.
- The Board of Directors actively sets targets, tolerances and thresholds for the effective management and monitoring of risk and uncertainty.

BTHFT Performance Improvement Framework

The Trust also has a Performance Monitoring and Improvement Framework that provides systems and processes to ensure that current performance information is visible throughout the organisation, from Ward-to-Board. It also provides clear lines of accountability and escalation throughout the organisation.

The Framework is aligned to a model of learning, improvement and assurance. The overall aim of improving performance is to deliver better outcomes for patients and this is at the heart of how the Trust approaches these activities.

The approach to learning, improvement and performance monitoring supports delivery of the Trust's strategic objectives with:

- Alignment of service plans and ambitions to overarching objectives
- Measures that are relevant in the context of these plans
- Progress and improvements being considered in this same context
- Shared principles throughout the organisation (vertical and horizontal alignment)

It also supports adherence to CQC quality domains and considers performance in the broadest sense with:

- Holistic views and correlation across sometimes separated domains
- Key lines of enquiry used to structure conversations
- Improvement plans with timescales and measurable benefits

Performance information is used daily across the organisation to support decision making. Weekly reviews are in place to track selected KPIs and an Academy structure which supports the Board Assurance Framework meets monthly to ensure learning and improvement is driving the agenda forward. Clinical Business Units (CBUs) replicate these approaches and regular Executive Team and CBU Leadership Team meetings are scheduled where the breadth of performance and delivery against plans can be discussed with a balance between assurance sought and support given.

2.2.2. Analysis of Performance

2.2.2.1. Quality of Care, Access and Outcomes

Quality Objectives

We continue to be proud of the Quality of Care that we deliver to our patients. Following the CQC inspection in 2019 we were rated overall as Good. All of the 'Must Do' actions identified have been completed and the Trust continues to monitor progress against the 'Should Do' actions through the 'Moving to Outstanding' monthly meeting.

Despite the continued challenges of the COVID-19 pandemic through the dedication and tenacity of our staff we remained committed to providing the highest quality of healthcare at all times and our Act as One programme has continued to make progress in tackling health inequalities by prioritising patients whose need is most as our services recover following the pandemic.

The Quality Priorities are assigned to the appropriate academy where regular reports are received from the leads providing updates and progress. The Quality Dashboard has been under review to ensure the appropriate qualitative and quantitative metrics have been identified to support our improvement work. The granularity of the priorities are addressed at the relevant working group which report to the Academies on a monthly basis.

We identified four quality priorities to focus on during the last year:

1. Improve the management of deteriorating patients by embedding the use of the electronic application co-designed with our industry partner to show real-time and actionable data based on the national guidance in relation to the timing and escalation of physiological observations known as NEWS2 (National Early Warning Score) and other clinical factors to support early intervention and escalation.
2. Improve patient experience by further developing and 'Embedding Kindness' that was developed during 2020.
3. Continue to reduce the number of still births by continuing with our 'Outstanding Maternity Services' transformation programme.
4. Advance equality, diversity and inclusion (ED&I) by consulting and engaging with our staff and communities as part of a 3 year strategic ED&I strategy.

Mortality Data

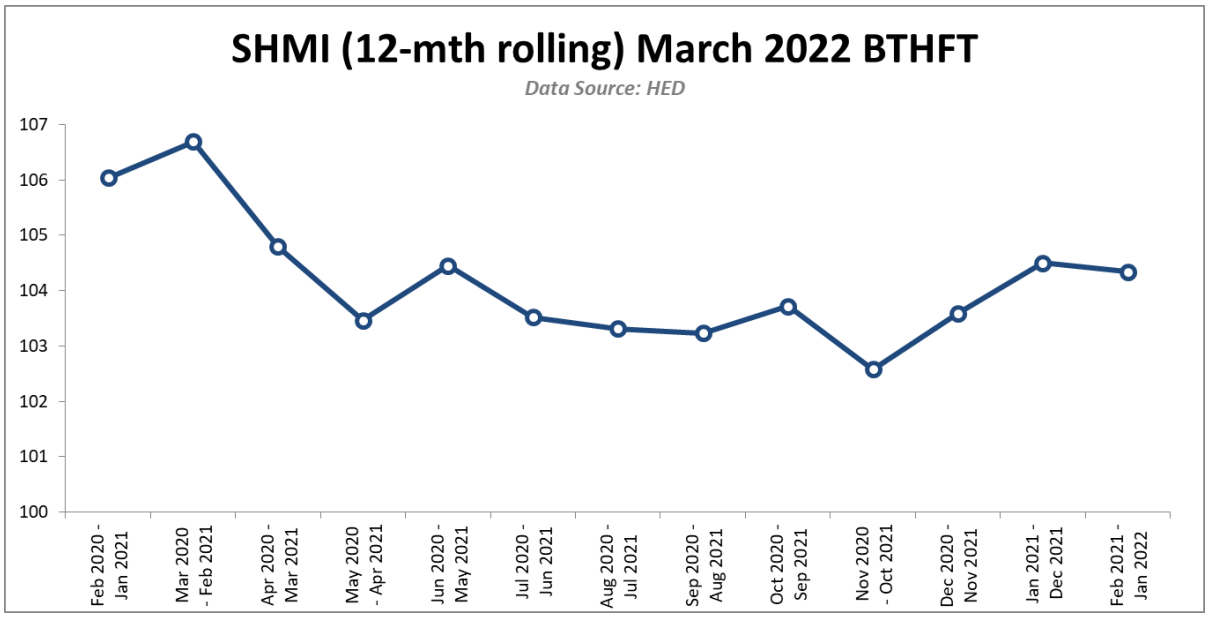
The Summary Hospital-Level Mortality Indicator (SHMI) is the ratio between the actual number of patients who die during or within 28 days of hospitalisation at the Trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. A value greater than 100 means that the patient group being studied has a higher mortality level than the NHS average.

Figure 7 – Summary Hospital-Level Mortality Indicator

SHMI 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
Feb 2020 - Jan 2021	106.04	64,167	1,423	1,341.95
Mar 2020 - Feb 2021	106.69	61,727	1,375	1,288.77
Apr 2020 - Mar 2021	104.79	61,555	1,345	1,283.53
May 2020 - Apr 2021	103.46	63,666	1,406	1,358.94
Jun 2020 - May 2021	104.45	65,541	1,468	1,405.39
Jul 2020 - Jun 2021	103.52	66,814	1,469	1,419.07
Aug 2020 - Jul 2021	103.31	67,375	1,480	1,432.59
Sep 2020 - Aug 2021	103.23	67,838	1,489	1,442.38
Oct 2020 - Sep 2021	103.72	68,487	1,497	1,443.27
Nov 2020 - Oct 2021	102.58	69,373	1,483	1,445.75

Dec 2020 - Nov 2021	103.59	70,670	1,524	1,471.22
Jan 2021 - Dec 2021	104.50	71,517	1,565	1,497.58
Feb 2021 - Jan 2022	104.34	71,814	1,566	1,500.90

Figure 8 – Summary Hospital-Level Mortality Indicator – 12 Month Rolling



The current available Healthcare Evaluation Data (HED) covers a 12-month period from January 2021 – December 2021 with our current SHMI value being 104.5 which is within the expected range. Over the 12-month period our average SHMI value was 104.2. Whilst we have been consistently above a value of 100, indicating that we have a higher mortality rate than the NHS average for patient during or within 28-days of hospitalisation, it is important to note that SHMI is not an indication of avoidable deaths or of quality of care.

On analysis we have identified a discrepancy in our medical coding which means our data is skewed for six Clinical Computing Software groups (CCS) in the SHMI which may have a negative effect in our SHMI figures. Further work is being undertaken to understand and rectify the discrepancy.

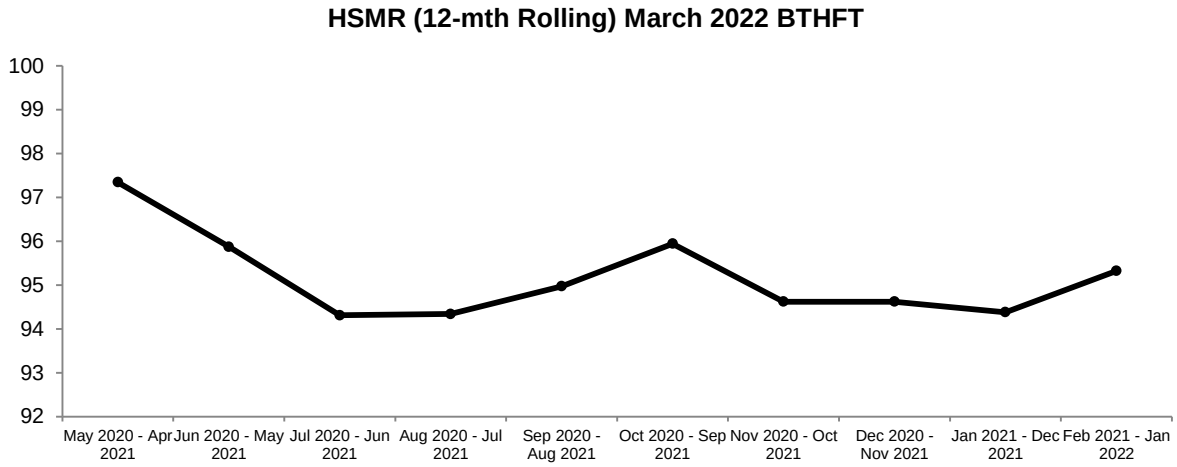
Hospital Standardised Mortality Ratio (HSMR) is the ratio of observed deaths to the expected number of in-hospital deaths at the end of a continuous inpatient (CIP) spell. A value greater than 100 means that the patient group being studied has a higher mortality level than the NHS average. Unlike the SHMI which is capped at 28 days, the HSMR considers the entire period a patient had continuous inpatient care.

Figure 9 – Hospital Standardised Mortality Ratio data

HSMR 12-month rolling	Indicator Value	Number of Discharges	Number of Observed Deaths	Number of Expected Deaths
May 2020 - Apr 2021	97.34	27,921	838	860.91
Jun 2020 - May 2021	95.87	29,115	846	882.42
Jul 2020 - Jun 2021	94.31	29,994	834	884.31
Aug 2020 - Jul 2021	94.34	30,650	846	896.71
Sep 2020 - Aug 2021	94.97	31,158	855	900.24
Oct 2020 - Sep 2021	95.94	31,485	868	904.78
Nov 2020 - Oct 2021	94.62	31,910	853	901.52
Dec 2020 - Nov 2021	94.62	32,626	860	908.94

Jan 2021 - Dec 2021	94.38	32,987	865	916.47
Feb 2021 - Jan 2022	95.32	33,174	869	911.7

Figure 10 – Hospital Standardised Mortality Ratio data



The current available HED data covers a 10-month period from April 2021 to January 2022 with our current HSMR value being 95.32 with our average value across the period being 95.17. Throughout the period reported our HSMR values show we have been consistently better than the national NHS mortality average for patients during their continuous inpatient care. The implication of this is that we have fewer patient deaths than the national average when we consider continuous inpatient care.

As with our SHMI, on analysis we have identified a discrepancy in our medical coding which means our data is skewed for one CCS in the HSMR data HSMR figures.

Healthcare Associated Infection

The Infection Prevention and Control Board Assurance Framework (IPC BAF) was developed during the COVID-19 pandemic to support all healthcare providers to effectively self–assess their compliance with Public Health England (PHE) and other COVID-19 related infection prevention and control guidance and to identify risks and mitigating actions. The IPC BAF was revised in December 2021 to include an assessment of the Trust's ability to comply with seasonal respiratory infections including COVID-19.

Nationally published data from NHSE/I up to 27 February 2022 reported that the proportion of cases being diagnosed =>8 days after admission was 20.1%, the regional data for North East and Yorkshire was 18.4%. Nationally the proportion of cases being diagnosed =>15 days after admission was 11.2%; the regional data for North East Yorkshire was reported as 9.7%.

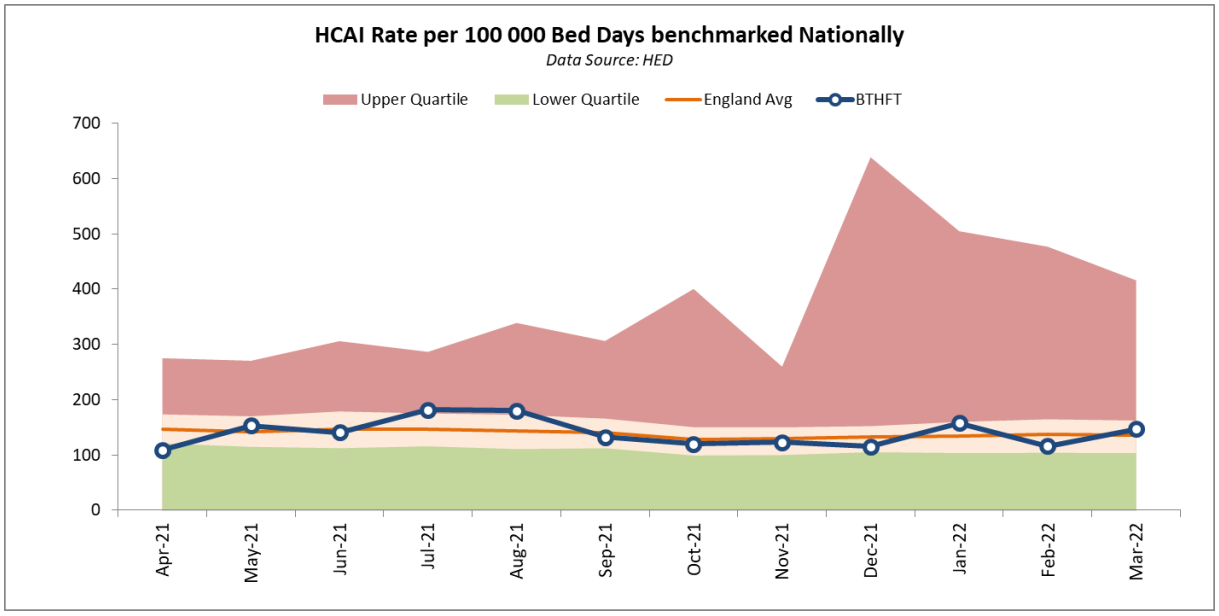
Post infection reviews (PIR) are completed for any hospital acquired COVID-19 cases with learning shared through the Trust's patient safety incident reporting processes.

We have seen an increase in the number of Methicillin Resistant Staphylococcus Aureus (MRSA) infections with no common link to ward or clinical team. A thematic analysis of case was undertaken at the end of quarter 2 which identified that the patients were complex with multiple co-morbidities; however, the insertion of medical devices was identified as a common route of these infections. An improvement response plan was implemented which included further training using the Aseptic No Touch Technique for line insertion.

The latest information available on Healthcare Evaluation Data (HED) in relation to infection rates shows the Trust's position for MRSA and Methicillin Sensitive Staphylococcus Aureus (MSSA)

bacteraemia, Clostridioides difficile (CDI) and E. coli, in relation to the national distribution for each of these infections. The data highlights that the Trust is equal to or below peers' median for CDI and E.coli, but above the median for MRSA, MSSA healthcare acquired infections.

Figure 11 – Healthcare Associated Infections Rate per 100 000 Bed Days 2021/22



Patient Experience

Work in relation to Patient Experience has gone from strength to strength over the past year. Some of the highlights are as follows:

- The embedding kindness project which evolved from the Patient Experience Strategy has been shared with NHS England receiving National and local interest #embeddingkindness.
- Strong links with our new Organisational Development Team has enabled us to develop our thinking around civility in the workplace and wellbeing in relation to kindness. Patient Experience have representation at the Workplace Civility Board to ensure that key messages and work streams work alongside and complement each other.
- Work with the national group Ageing Without Children (AWOC) has resulted in a 'Kindness Conference' being planned later this year.
- The SPaRC service (formally chaplaincy) has received national recognition and awards for their pioneering new model of working.
- The Trust has been working towards obtaining Veteran Accreditation status, planned for summer 2022.

This rewarding and exciting work has led to national nominations for Leadership awards for members of the Patient Experience team.

During the past year the Trust's approach to spiritual support has also been reviewed. This has enabled us to consider how we care for all. The new Bradford model SPaRC (Spiritual, Pastoral, and Religious Care) focuses on collaborative working with patients and their families and becoming part of the wider hospital team. The model is underpinned by 7 anchors:

- Equality
- Person Centred care
- Belief Based care
- Spiritual and reflected Spaces
- Collaborative practice

- Professional Practice and Data
- Data and Organising

The model has been well received by staff and patients and has received regional awards, generated national interest including the NHS England Review Committee who consider our model as an example of inclusivity. The SPaRC team, in collaboration with the University of Bradford, have also developed an IT Application for staff and patients. This provides a plethora of resources and information and is due to be launched in spring 2022.

The Carers Passport and care plan was launched towards the end of 2021 alongside a carer's charter. The Carers Passport is designed to support Carers and ensure they are supported throughout a patient's hospital admission. The passport is supported by the Lead Nurses for Dementia and the Lead Nurse for learning disabilities. Feedback has been positive so far. An audit of compliance and usage will be conducted late 2022.

The patient and public involvement team continue to work on a number of projects to enable positive engagement to take place and changes to be made as a direct result of feedback. For example; working with partner agencies to gain feedback from service users with Special Educational Needs and Disability (SEND) in our community paediatric department; working with our local Healthwatch team regarding service user experience of virtual appointments, and contributing to the City of Bradford Metropolitan District Council's stakeholder group for people with visual and hearing impairment visiting our sites to enable future improvements to be made.

Friends and Family Test (FFT)

The overall Trust position score from FFT at time of reporting is a score of 83% of patients scoring the Trust as 'very good' or 'good'.

Overall the Trust has received 30,409 FFT results, with SMS text messaging making up the majority of this. The table below shows the breakdown of responses.

Figure 12 – Friends and Family Test Responses 2021/22

Response	Percentage	Number of times response selected
Very good	68.24%	20,751
Good	14.77%	4,491
Neither good nor poor	4.85%	1,476
Poor	4.84%	1,471
Very poor	3.93%	1,195
Don't know	3.37%	1,025

In previous years annual reporting scores used a different metric of 'would recommend' and 'would not recommend', it is therefore not possible to make direct comparison.

CQC surveys

During 2021/22 the Trust has taken part in the mandated CQC surveys (Urgent and Emergency Care, Inpatient survey, Children's and Young People and Maternity surveys).

The Trust has much to celebrate with the success of the 2020 Urgent and Emergency Care CQC survey results. The Health Service Journal (September 2021) reported that the Trust was the most improved hospital from 2018-2020 in their results. This is a credit to all the hard quality improvement work that has taken place to improve Patient Experience.

Improvements noted in 2020 relate to:

- Privacy at reception.

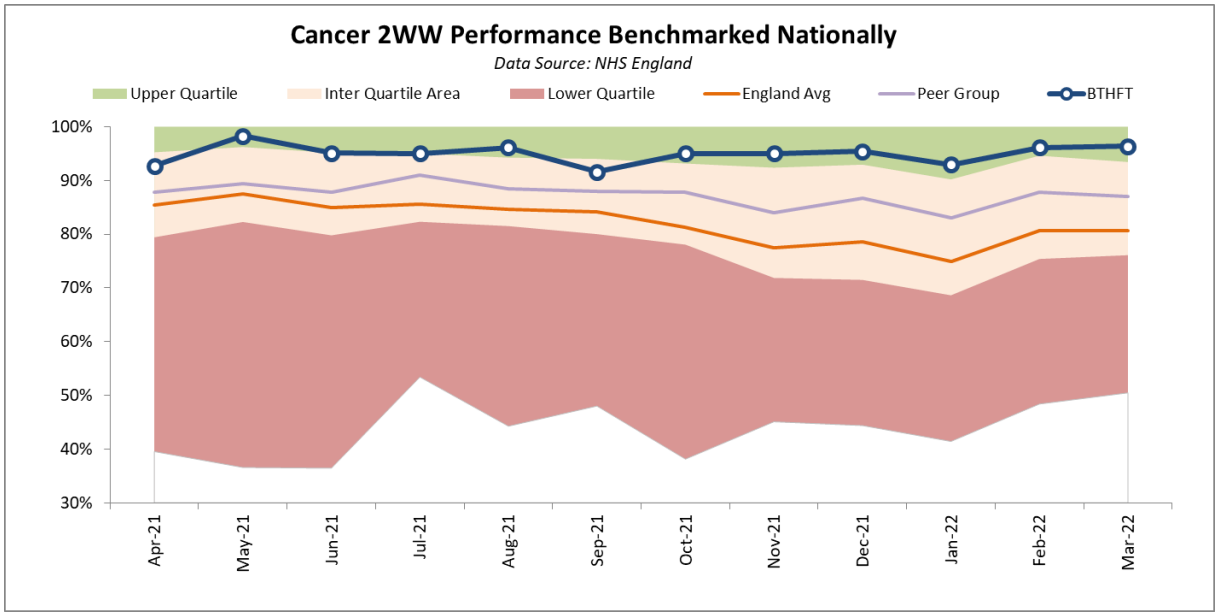
- Reduced wait time to see a clinician.
- Overall length of visit.
- Confidence in clinicians.
- Cleanliness of the department.
- Dignity and respect.

Access Key Performance Indicators

Cancer 2 Week Wait

Patients referred to us on Fast Track pathways have received an excellent service from the Trust during 2021/22, with performance consistently above the 93% target for those first seen within two weeks. This compares favourably to other Trusts in England.

Figure 13 – Cancer 2 Week Wait Performance 2021/22



This has been driven by increased analytical support to decision-makers, early escalation of capacity and demand changes, and the implementation of the faster diagnosis standard and timed pathways resulting in reduced time to first seen.

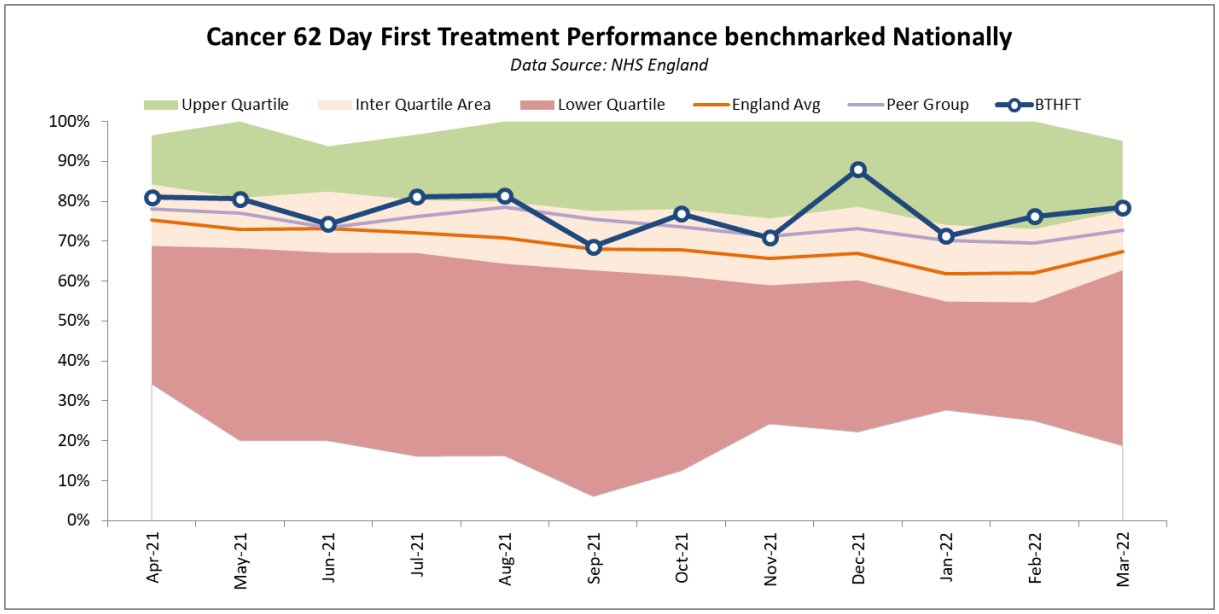
These improvements have been delivered against an increase of 4,219 (32.13%) 2 Week Wait (2WW) referrals compared to 2020/21 and 649 (3.89%) compared to the pre-COVID-19 levels seen during 2019/20. All tumour groups monitor demand on a daily basis in order to respond quickly to any further surges.

Cancer 62 Day First Treatment

During 2021/22 clinical prioritisation has been used to ensure the most urgent cases are treated first. As a result of this and improvements in diagnosis by day 28, the Trust has significantly reduced the number of patients waiting longer than 62 days to 18 in March 2022, which had grown as a result of the COVID-19 pandemic to a high of 177 in June 2020.

As a result of reducing the number of patients already beyond day 62, the Trust anticipates that it will be able to achieve the 85% target for the 62 day First Treatment standard during 2022/23.

Figure 14 – Cancer 62-Day First Treatment Performance 2021/22

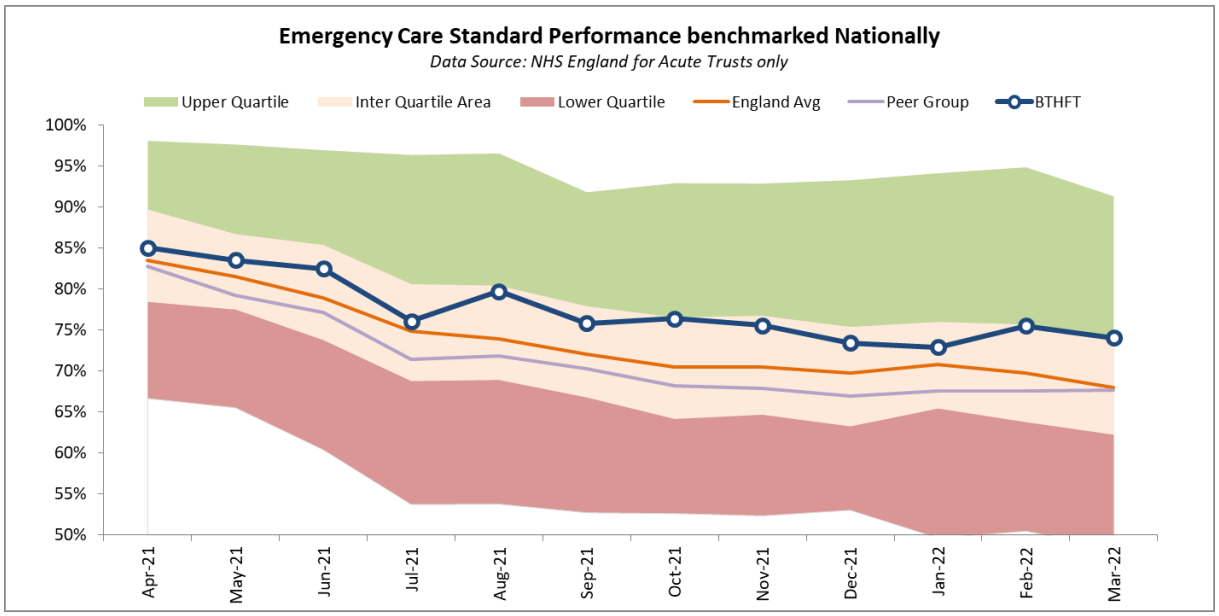


In addition to sustaining the improvements already achieved, the Trust has an ambitious programme of work relating to Cancer pathways which will include continued roll out of optimal pathways and pathway analysis, alongside transformational change in line with Cancer Alliance priorities.

Emergency Care Standard

2021/22 has been a challenging year for our Urgent and Emergency Care departments with an increase in COVID-19 demand during winter which has resulted in bed pressures and increased staff absence. Daily attendances have been in line with historic averages and seasonal trends but infection prevention and control measures add an extra layer of complexity.

Figure 15 – Emergency Care Standard Performance 2021/22



The transformational changes made within the Emergency Department, and with the flow of patients into and out of this unit, prior to and during the COVID-19 pandemic have meant the Trust has performance comparatively better than peers and the average for acute Trusts in England.

The Trust has focussed on all parts of the urgent care pathway and has monitored a range of KPIs during 2021/22 to support continuous improvement efforts. The introduction of Same Day Emergency Care units and changes to ambulatory pathways are reducing overnight spells. The inclusion of Therapy teams within the already strong multi-disciplinary discharge processes highlighted the Trust as one of the best performing with regards to ensuring patients who no longer need to be in hospital are safely discharged each day.

Learning from the state of the art Command Centre, which utilises Trust data in easy to digest visuals for speedy decision making, further improvements are planned by embedding similar principles within the Emergency Department and across the admission wards at Bradford Royal Infirmary. Strong leadership with good data will be at the heart of further improvement across Urgent and Emergency Care.

Ambulance Handover

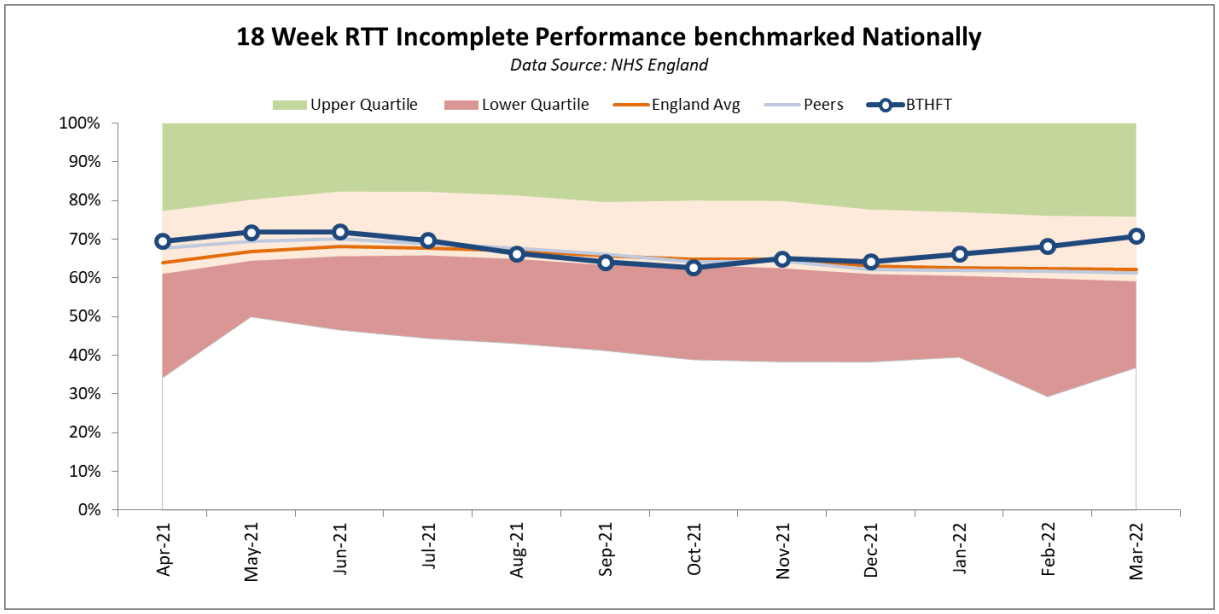
A national priority for 2021/22 was to work with Ambulance Trusts to reduce the delay seen in releasing ambulance crews after they bring a patient to an Emergency Department. This is an area where Bradford Royal Infirmary has been highlighted as having higher than average delays and significant effort has been applied to improving this.

The Emergency Department has been remodelled during 2021/22 with additional footprint available for ambulance handovers during peak periods which was a problem previously. Joint working between Yorkshire Ambulance Service (YAS) and the Trust's ED team has introduced new operating procedures, increased self-handover, and easier flow from the ambulance assessment area to other areas based on clinical presentation. Performance at BRI during the final quarter of 2021/22 has been better than peer average within the YAS footprint.

Referral to Treatment

Referral to Treatment (RTT) performance deteriorated during the first half of 2021/22 but remained above or in line with the England average. Performance improved in the last quarter of 2021/22 as activity levels increased following increased theatre capacity (see chart below).

Figure 16 – 18 Week Referral to Treatment Performance 2021/22



As a result of the COVID-19 pandemic, the Trust waiting list size peaked in October 2021 at its highest recorded level of over 37,000 patients compared to 25,700 in March 2020 just prior to the pandemic. Alongside an increase in activity levels supported by the independent sector, the Trust endeavoured to reduce unnecessary demand on services through effective referral triage processes and promoting the use of Advice and Guidance to primary care colleagues.

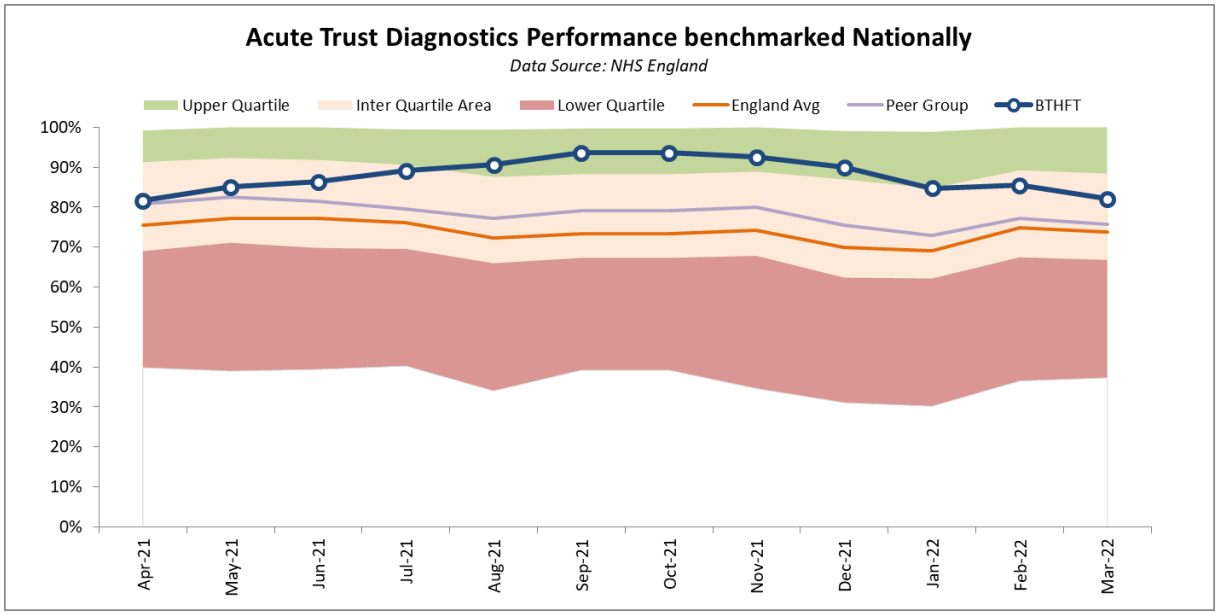
Patient Initiated Follow Ups (PIFU) has been promoted to reduce unnecessary appointments and further support waiting list reductions. The use of telephone and video consultations also increased which helped maintain progression towards treatment and reduced unnecessary attendance to outpatient clinic settings.

Throughout 2021/22, as theatre capacity was prioritised for patients with high clinical priority including those with cancer, the number of patients waiting over 104 weeks with a lower priority increased to its highest recorded level. In response the Trust has run weekly meetings which ensured regular review by clinical teams and the expediting of treatment plans whenever operating capacity has increased. The number is now reducing and will be cleared to zero during the first quarter of 2022/23.

Diagnostic Waiting Times

The Trust made excellent improvement during 2021/22 for those patients referred to us for routine diagnostic services, with performance in the best 25% of Trusts from August 2021 onwards. The unexpected loss of an MRI scanner in December 2021 has resulted in a slight deterioration but a replacement has been secured and performance is expected to improve.

Figure 17 – Acute Trusts Diagnostics Performance 2021/22



Performance for patients on Fast Track pathways, which includes all cancer referrals, has been sustained at above 90% for a two week turnaround from request to report being available. This is an important part of the Trust's overall ability to meet the Cancer Wait Time standards and an operational priority which will continue into 2022/23.

2.2.2.2. Preventing Ill Health and Reducing Inequalities

See section 2.2.7.

2.2.2.3. People and Leadership Capability

Our objective is to develop leaders at all levels, through creating an environment of continuous learning and improvement, where our people excel at putting patients first. To develop our leaders we need to be clear of the qualities, behaviours, skills and attributes we want.
We want our leaders at every level to:

- Lead by example and demonstrate our values.
- Communicate well – listen, influence and give regular feedback.
- Make continuous quality improvement.
- Develop themselves, holding themselves to account for their performance.

We want those who lead others to provide clear vision and direction; think strategically at a system level and plan ahead, being proactive rather than reactive. We want them to engage with their team, listen to their ideas and involve them in decisions that affect them. Throughout 2021, we have developed and launched three Leadership Development Pathways created for individuals at various levels of their development, all designed to follow on from each other and build on learning. We also have developed and launched a series of skills based workshops which run regularly. These include:

- Challenging Conversations;
- REACT Mental Health Conversation Training;
- Time2Talk – Appraisals;
- Wellbeing Conversations;
- You as an authentic leader;
- You as a compassionate leader;
- You as an inclusive leader;
- Embracing change;
- Recruitment and Selection;
- Managing health and wellbeing and attendance; and
- Understanding emotional intelligence.

In 2022/23, we will develop and launch a fourth Leadership Pathway ‘Advancing Leaders’ for those in Senior Leadership roles. We will also host a start of year conference for our leaders. This will offer a space for them to recognise and reflect on what has collectively been achieved over the last two and a half years and provide time to refuel and reboot both personally and professionally.

Looking After Our People

Civility

Civility in the workplace is a key theme for 2022/23 and it is a priority to reduce the proportion of staff who say they have personally experienced harassment, bullying or abuse at work. In order to do this, we have established a Civility Project Board which has agreed three key priorities. These are:

- Developing a new behaviour framework / civility code;
- Civility awareness campaign; and
- Increasing manager confidence and capability in having difficult conversations.

A Civility Advisory Panel has also been established. Approximately 12 members of staff have volunteered to be part of this group and share their own lived experience of civility in the workplace. This is essential in shaping the civility programme and ensuring it adds value.
As part of our ongoing work-plan, the Harassment and Bullying policy is one of our priorities to be reviewed, alongside other key HR policies.

Health and Wellbeing

Health and Wellbeing also remains a key priority. We know that the COVID-19 pandemic has impacted on our people and will continue to do so. Alongside our regular 'Wellbeing Wednesday' newsletter which focuses on staff health and wellbeing support locally, regionally and nationally, we encourage all staff to have a Wellbeing Conversation with their manager or a trusted colleague. Wellbeing conversations were launched in June 2021 and a suite of webinars were developed and are being delivered to both managers and staff on the process of having a wellbeing conversation. These focus on having an open and honest conversation about our health and wellbeing through curious questions and compassion.

During the last year, we have also recruited a Specialist Occupational Therapist who offers therapeutic 1-1 support for staff with issues such as fatigue management, stress awareness, relaxation and sleep hygiene and Clinical Psychologist support is also now available from the Workplace Health and Well-Being Centre for staff who are experiencing more complex psychological problems such as moderate anxiety, depression, Obsessive Compulsive Disorder (OCD) or Post Traumatic Stress Disorder (PTSD) which have a direct impact on work. In addition to this the Psychology department also provide support to Teams.

A Menopause network has been set up to support our staff across the Trust and Hälsa Wellbeing have been commissioned to host a number of menopause support sessions. We have developed a series of menopause pages which are on the Thrive intranet platform and host regular pop up events across Trust sites to inform staff of what support is available.

This year has seen a real focus on encouraging staff to have their COVID-19 vaccinations and boosters.

Over the next year, we aim to reintroduce more face to face wellbeing support such as lunchtime walks, classes and group sessions.

Thrive Programme

As we develop into an Outstanding Trust, it's essential that our staff feel valued and invested in and that they feel supported in caring for their health, wellbeing and development. We are creating a community where everyone can learn, grow and reach their full potential; a place where they feel heard, are always treated with dignity and respect and are trusted to do their job.

Our 'Thrive' approach is our commitment to make this a reality.

By investing in Thrive we will create an employee brand that is recognisable and will continually reiterate the employee offer at BTHFT. This includes the wellbeing support, development opportunities, and rewards and recognition initiatives that staff are entitled to as important and valued members of the team. A good employee brand can increase employee engagement levels which in turn can lead to improved performance.
The first step in embedding Thrive was the launch of a unique intranet platform which was launched in October 2021. It has been designed to be easy to navigate and accessible from personal devices. This enables staff to seek out wellbeing resources, learn about development opportunities, explore staff benefits and have their voice heard at a time and in a way that is flexible for them.

Flexible Working

The Trust Flexible Working Policy has been updated in line with s33 NHS Terms and Conditions, including the right to make a request from day 1 and removing the limit on the number of requests which can be made per year. We continue to promote Flexible Working across the organisation, for example including regular communications and using the Let's Talk staff newsletter.

Over the next year we aim to review our internal process for making Flexible Working requests, enhancing the use of updated ESR features to develop effective recording and reporting (including both formal and informal requests).

We are also looking to develop manager training related to flexible working to be embedded within appraisal and health and wellbeing conversations.

Belonging in the NHS

Mediation Service

An internal Mediation service has been developed and is now up and running. A range of material around mediation has been developed and shared on the website.

Staff Networks

This year, there has been considerable focus on reviewing and refreshing the work of our staff equality networks to ensure these are 'thriving' and in line with the national ambitions for staff networks. Our staff networks will be re-launched as part of National Staff Network Day which is celebrated on 11 May 2022. A range of material has been developed to promote the networks and to raise awareness of their role and remit. We believe staff equality networks are a key building block to the Trust's diversity and inclusion agenda where staff can share their lived experiences and effectively influence the Trust's diversity and inclusion agenda.

Workforce Race Equality Standard (WRES)/ Workforce Disability Equality Standard (WDES) and Gender Pay Gap

We continue to build on the work in raising the profile of the wider equality, diversity and inclusion agenda. In terms of disability, the promotion of disability equality and the disability leave policy will be a key aim moving forward in ensuring adequate considerations are being made around reasonable adjustments and our disabled staff are supported and feeling valued at work. In terms of race equality, civility in the workplace with focus on inclusion and belonging will be a key feature going forward.

In terms of Gender Equality across the Trust, engagement with a range of staff has been progressed via the Gender Reference Group and a number of areas are being explored and actioned. These are:

- Increase engagement with aspiring females and representation of women in senior management roles. Exploring potential "blockers" for women progressing.
- Address the underrepresentation of men at all levels in the organisation and challenge the traditionally female role stereotypes
- Promote a culture of flexible working

International Women's Day was celebrated on 8 March 2022, and as part of this we organised and delivered a successful Women in Leadership Panel event featuring senior women in positions of leadership within the Trust to offer their personal, reflective and inspirational professional journeys. Our diverse panel shared their inspiring career journeys, the obstacles they overcame and their biggest achievements.

2.2.2.4. Risk Profile

The Trust considers both strategic and operational risks. Principal (strategic) risks are included in the Board Assurance Framework (BAF) and operational risks are recorded on the electronic risk register system (Datix).

All risks on the BAF as at quarter 4 of 2021/22 are presented in a matrix, shown in figure 18, together with their overall risk rating and risk appetite level. There have been no changes to the principal risks throughout the year and the highest scoring risks relate to maintaining the quality of services, recruiting and retaining an effective and engaged workforce and operational performance, due to the ongoing impact of COVID-19. This has impacted on the Trust's ability to achieve its strategic objectives in these three areas, however progress has been made, for example, the Clinical Outcomes Group has been re-launched and learning from deaths work has progressed well including thematic review of all Hospital Onset COVID-19 Infection (HOCI) deaths. Performance Improvement plans are also being implemented in the areas of Referral to Treatment (RTT), cancer and urgent and emergency care.

There have been no significant risks that have impacted on the Trust's objectives to deliver its financial plan, be a continually learning organisation or collaborate effectively with local and regional partners.

Figure 18 - Principal risk matrix for quarter 4 2021/22

		Overall risk rating				Risk appetite[#]
	Principal Risk	Initial	Residual	Target	Current	
1	Failure to maintain the quality of patient services	16	8	4	12	Minimal
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	15	Seek
3	Failure to maintain operational performance	20	6	6	16	Cautious
4	Failure to maintain financial sustainability	6	6	6	6	Open
5	Failure to deliver the required transformation of services	12	8	8	8	Open
6	Failure to deliver the benefits of strategic partnerships	12	6	6	9	Seek
7	Failure to maintain a safe environment for staff patients and visitors	12	6	4	12	Cautious
8	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	8	6	8	Cautious
9	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	12	8	6	8	Open

Key:
*Risk score: 0 = lowest risk score, 25 = highest risk score
[#]Risk appetite:
Avoid – avoidance of risk and uncertainty is a key organisational objective;
Minimal – we have a preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential (a positive outcome as a result of taking or accepting risk);
Cautious – We have a preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward;
Open – We are willing to consider all potential delivery options and choose, while also providing an acceptable level of reward;
Seek – we are eager to be innovative and chose options offering potential higher business rewards;
Mature – we are confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust.

Up to November 2021, risks which were deemed to be significant from a strategic perspective were reported through the strategic risk register and were aligned to the principal risks on the BAF. During the year, the strategic risk register has included risks relating to elective capacity, EU exit, cyber security and various risks relating to staffing, including sickness absence, vacancies, retention and the need to move staff due to the impact of COVID-19.

In November, we introduced a new escalation process which involves all risks scoring 15 and above being escalated to the Executive Team, Academies and Board via the high level risk register.

As at April 2022, the high level risk register contains 22 risks, seven of which are scored at 20. These seven risks are described below; mitigating actions have been developed and are recorded on the high level risk register, along with the details of the action plan lead and the date for completion of these actions. Covid-19 has continued to have an impact on the Trust in terms of staffing and operational pressures. The critical infrastructure risk was also raised last year and remains as a high level risk. The other key risks reported last year relating to the maternity service, endoscopy capacity and appropriate treatment of patients with a mental health diagnosis have reduced in score and are managed and monitored within the relevant teams.

The high level risk register is monitored each month at meetings of the executive team and at the relevant Academy, where the effectiveness of mitigating actions is considered.

- *Three risks relate to the inability to maintain safe staffing levels as a result of the sustained Covid-19 pandemic (one relates to the Trust's planned care group, one relates to the unplanned care group and one relates to the corporate level). These risks are being mitigated and managed through a wide range of actions including nurse staffing reviews and seeking additional investment where required, regular risk and safety huddles, close monitoring of staffing levels on a daily basis and escalation of issues as appropriate, and use of bank staff and flexible workforce to fill vacant shifts.*
- *If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, then there may be a failure of estates infrastructure, engineering systems, and/or building fabric, resulting in a significant impact on business continuity. There is a risk that children and young people admitted to children and adult wards in mental health crisis have variation in their practice/care. To manage this risk, a programme of backlog maintenance work has been developed, phased and prioritised, a current facet survey inspection is being undertaken to identify and allocate funding resources, and Planned Preventative Maintenance is undertaken as per HTM/Statutory and good practice guidance to maintain buildings and building services plant and equipment.*
- *There is a risk of Major or Catastrophic harm to patients due to COVID-19 driven operational pressures. Again a wide range of actions are in place to manage this risk, including escalation procedures, operational support through the Command Centre, regular staffing meetings and longer terms actions such as the implementation of the Outstanding Decision Making programme.*
- *There is a risk of harm to patients and the organisation from delays in processing histopathology samples, with potential of having an impact on delayed diagnosis and treatment pathways. This risk is being managed through the use of locum support, outsourcing of work as and when required, and substantive staff covering additional sessions.*

2.2.3. DELIVERING A NET ZERO HEALTH SERVICE

The Trust is committed to NHS England's 'Delivering a Net Zero National Health Service', which has targets of reducing carbon emissions from hospital operations (Scope 1 and 2) by 80% by 2032 and net zero carbon emission by 2040 and becoming a net zero healthcare provider by 2045.

As a healthcare provider, employer and purchaser of goods and services, the Trust recognises that it has a significant impact on the local and wider environment and acknowledges its role in promoting sustainability and improving environmental performance.

The NHS Sustainable Development Assessment Tool (SDAT) has been withdrawn but a recent light touch review of the framework identified that the Trust has improved its overall SDAT score by over 20**%** in the last two years. This exceeds the Trust's original planned sustainability improvement by 14%.

Figures 19 and 20 illustrate that the Trust has reduced its hospital operational carbon emissions (Scope 1 and 2) by 22% in the past decade. The main contributor to the Trust's current carbon footprint is burning of natural gas for heating, hot water and onsite generation of electricity.

Figure 19 – Hospital Operational Carbon Emissions (Scope 1 and 2) has reduced by over 22% over the last decade

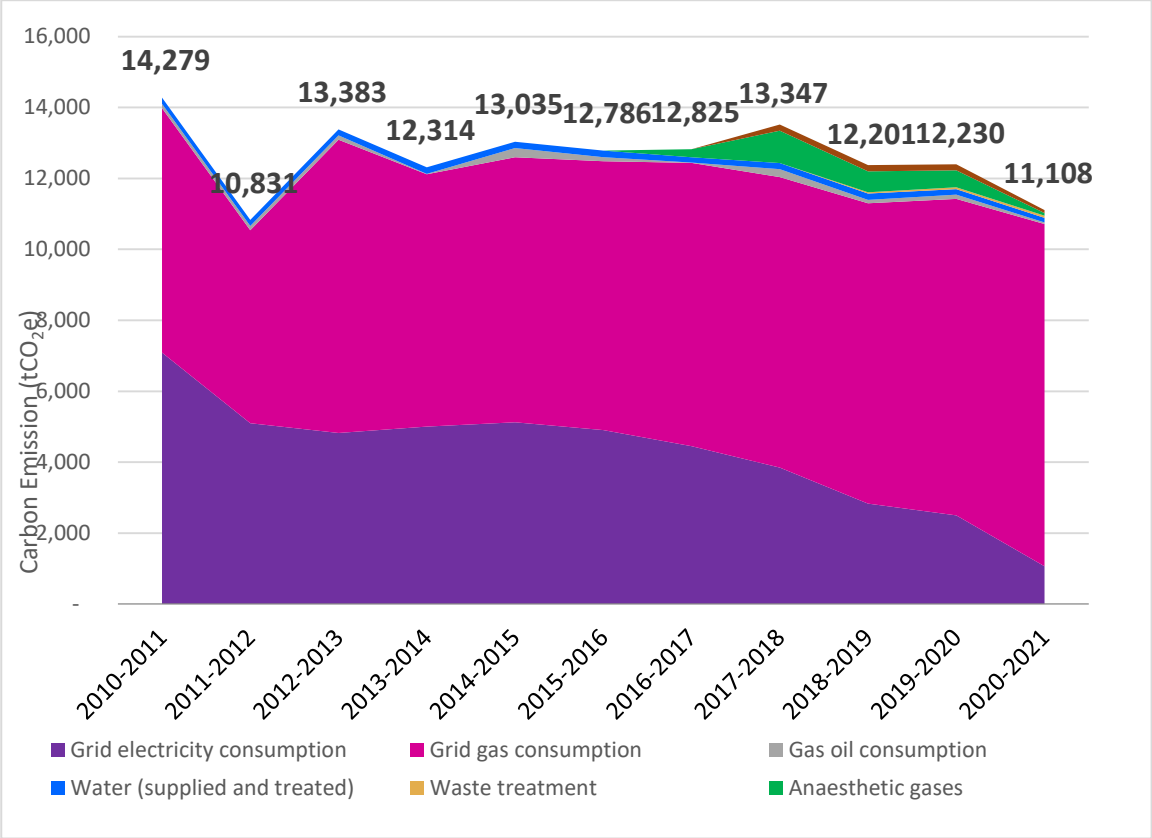


Figure 20 – Carbon emissions performance for each of the *Delivering a net zero NHS carbon footprint* parameters

Delivering a Net Zero NHS Parameters	2010/2011 tCO_2e	2020/2021 tCO_2e	% Change
Grid electricity consumption (market -based)	7,090[7]	1,064	-85%
Grid gas consumption	6,894	9,651	+40%
Gas oil consumption	121	44	-63%
Water (supplied and treated)	175	129	-26%
Waste treatment	0*	62	n/a*
Anaesthetic gases	0*	74	n/a*
Business travel	0*	84	n/a*
Total (market-based for 2020/21)	**14,280**	**11,108**	**-22%**

**The Trust is continually improving its data collection methodology to provide carbon footprint transparency and this is the reason for zero data returns for some parameters*

The Trust also submits data annually for the Estates Returns Information Collection (ERIC), which is a mandatory collection for all NHS trusts. The Trust is in the top four out of forty peer acute teaching trusts for site energy consumed per occupied floor area; water consumed per occupied floor area and carbon emissions per occupied floor area.

[7] Included for comparison purposes

This continual improvement is a result of the successful delivery of objectives as outlined in the Trust's Green Plan. Success over the past year includes:

- Installation of a 25 kWp solar panel array at the Bradford Royal Infirmary site;
- Investing in the Trust's first electric commercial road vehicle for the grounds and gardens team;
- First Trust in the region to discontinue the use of Desflurane (which is an anaesthetic gas with the highest global warming potential);
- Significant investment from Bradford Hospitals' Charity to promote active travel by installing two secure cycle compounds at Bradford Royal Infirmary and St Luke's Hospital and changing facilities at Bradford Royal Infirmary;
- Hosting the Trust's first Green Summit during the week of COP 26;
- Over half a million electronic letters were sent out by the Trust, saving 5.7 tonnes of CO_2e.

2.2.4. Social, Community, Anti-Bribery and Human Rights: Issues and Policies

The Trust has forged strong links with the local communities it serves. We work in partnership with other local health economy partners on shared equality objectives and consult with the local community on our progress. These issues are very important to the Trust so we have opted to include a full Equality Report in section 3.4. This covers employment, training and hate crime reporting. Information about the Trust's anti-fraud, bribery and corruption policy can be found in section 3.3.2 on Staff Policies and Actions.

2.2.5. Events since year end

The Care Quality Commission (CQC) undertook an unannounced visit at the Trust on Wednesday 20 April 2022, as part of a wider system review of urgent and emergency care. At the time of writing the Trust is not yet in receipt of the report from the CQC.

2.2.6. Overseas Operations

The Trust has no overseas operations.

2.2.7. Disclosure on equality of service delivery

2.2.7.1. How the Trust has had due regard to the aims of the public sector equality duty

The public sector equality duty forms part of the Equality Act 2010 and requires us, as an NHS public sector organisation, to have due regard to the need to:

- Eliminate discrimination, harassment and victimisation
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it
- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it

In July 2020 we revised our approach and methodology to equality impact assessments including the template, guidance and documentation. This has been welcomed by managers across the Trust as it has simplified the process. As a result of this we will look to increase the number of completed equality impact assessments, especially where there is a service review being conducted which impacts on our workforce, our patients and the communities that we serve. This will allow us to continue to ensure that the equality duty is built into the day-to-day business of our organisation. We will continue to publish equality impact assessments in line with our contractual and legal requirements.

2.2.7.2. Equality of service delivery: data

We collect data about age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation as part of a number of patient feedback measures. Examples of where this data is collected include the NHS Friends and Family Test[8], feedback from our patient experience service[9] which includes almost 1500 patient contacts in the last year, and national Care Quality Commission (CQC) surveys[10] in which the Trust participates.

The Friends and Family Test data is used to help inform service delivery and improvements in care to the diverse communities we serve.

2.2.7.3. Equality of service delivery: activities by the Trust to promote equality of service delivery

In January 2021, as part of our commitment in advancing workforce equality and to tackling the wider population health inequalities within the district, we launched our strategic Equality and Diversity Council (EDC). The group comprises of key members from across the Trust's core functions, along with individuals who have a pivotal role to play in influencing change both across our organisation and within the wider community. As Executive Sponsor for Diversity and Inclusion across the Trust and the Trust Lead for population health inequalities within the District, our Chief Executive Mel Pickup is demonstrating the Trust's commitment to this agenda by chairing and leading this important meeting.

The pandemic has left us with a significant challenge in addressing both existing and new health inequalities. We are fortunate in that we already have an established Act as One programme which operates across the entirety of Bradford District and Craven. It brings together partners from across our 'place' (Bradford District and Craven) to deliver our ambition of ensuring our local population remain 'happy, healthy at home'. The work being done through the Access to Care work stream which contributes to the overall Act as One programme aims to:

- improve access to health and care for the communities we serve;
- remove the barriers that create inequalities to accessing care; and
- ensure our people receive the right care in the right place first time.

In addition to the work being undertaken at place level there are a number of initiatives undertaken with our own Patient Experience and Chief Nurse Team to promote the equality of service in relation to all protected characteristics as defined by the equality act 2010. The nine protected characteristics are age, gender, disability, sexual orientation, religion and belief, race, transgender, pregnancy & maternity, marriage & civil partnership. We are learning continually from patient feedback and complaints, and our lead for equality, diversity and inclusion is involved in the review of any complaints pertaining to equality and diversity issues.

A few examples of our work to promote equality of service delivery include:

- We are working with recognised partners to provide comprehensive guidance about access to our sites. This includes bespoke mapping of our premises in terms of accessibility as well as locations of patient and visitor toilets and changing facilities.
- During the pandemic the Trust set up and engagement meeting with community groups. This has evolved to a formal monthly meeting with representation from member organisations from across our community.

[8] https://www.nhs.uk/using-the-nhs/about-the-nhs/friends-and-family-test-fft/
[9] https://www.bradfordhospitals.nhs.uk/patients-and-visitors/patient-experience/
[10] https://www.cqc.org.uk/publications/surveys/surveys

- We adhere to the Accessible Information Standard[11] and provide information in different formats which include easy read, large print braille, and text-phone for hearing and speech difficulties. Our interpreting services provides written and verbal translations where required and support clinic appointments.

The Trust is aware how sensory impairment in any form can have a significant impact on a person's life and wellbeing for them, their families and loved ones. Our local statistics in Bradford suggest that out of a population of 542,100: ref-Office of National Statistics (2020) Estimated population data for Bradford.[12]

- 83,500 have Hearing Loss
- 3,531 have sight impairment
- Between 220-3,136 have combined hearing and sight impairment

A significant amount of these people within our community will access our services for care and treatment or as a relative of a loved one.

During 2021/222 the Trust and specifically the EDI and Patient and Public Involvement team have worked with City of Bradford Metropolitan District Council (CBMDC) Joint Sensory Support Group via membership of the Steering Group to influence local strategy and work with other stakeholders to influence change and gain assurance against work already carried out within the Trust.
This work has included onsite visits to Trust premises to carry out "walk about visits" from people who have hearing and sight impairment, to test these improvements and make recommendation for changes. With the support of the Estates and Facilities Team, action plans have been developed to address areas for improvement. Positive feedback was received from the visiting guests about the accessible features we already have in place. Much of the latter work supports the Accessible Information Standard and complements the PLACE (Patient Led Assessment of the Care Environment) National programme, which the Trust participates in.

The Trust continues to work with AcessAble[13]. The Trust partnered with AccessAble a number of years ago to create detailed access guides for all of the Trust's hospitals. These guides are 100 per cent facts, figures and photographs that provide useful information about how best to access the Trust for people with individual requirements. This covers things from parking to hearing loops, walking distances and accessible toilets. These guides are under continual review and update for accuracy.

Signed

Mel Pickup
Chief Executive
21 June 2022

[11] http://www.england.nhs.uk/ourwork/accessibleinfo/
[12] https://ubd.bradford.gov.uk/about-us/population/
[13] https://www.bradfordhospitals.nhs.uk/patients-and-visitors/accessible-information

3. ACCOUNTABILITY REPORT

3.1. DIRECTORS' REPORT

The Board of Directors consists of people with the range of experience and expertise necessary to steward the Trust. They provide the vision, oversight and encouragement required for the Trust to thrive. They make decisions collectively according to the Reservation of powers to the Board and scheme of delegation[14] (March 2022), they each share the same responsibility and liability. The chairman and the non-executive directors are accountable to the Council of Governors.

The Board of Directors is responsible for all aspects of the operation and performance of the Trust, and for its effective governance. This includes setting the corporate strategy and organisational culture, taking those decisions reserved for the Board, and being accountable to our stakeholders for those decisions. The Board is responsible for the preparation of the annual report and accounts. The Board considers whether the annual report and accounts, taken as a whole, are fair, balanced, and understandable. It provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The scheme of delegation[15] sets out the matters reserved for the Board of Directors in full.

In 2021/22, the Board of Directors included the following positions: Dr Maxwell Mclean - Chairman, Ms Selina Ullah - Deputy Chair and Senior Independent Director (until August 2021), Ms Julie Lawreniuk, Deputy Chair and Senior Independent Director (from September 2021) and Professor Mel Pickup, Chief Executive.

All directors are required to meet the standards of the 'fit and proper persons requirement[16]' and to make annual declarations. The register of declarations of interests[17] provides details of external directorships and other positions of authority held by the directors of the Trust and is made publicly available on the Trust's website.

Our constitution[18] was last approved by the Board and the Council in July 2021.

Further information about the Board of Directors[19] is available on our website or, from the Associate Director of Corporate Governance/Board Secretary at:

- email: corporate.governance@bthft.nhs.uk
- telephone to 01274 382993; or
- in writing to Corporate Governance Office, Trust Headquarters, Chestnut House, Bradford Royal Infirmary, Bradford, Duckworth Lane, Bradford BD9 6RJ.

The directors confirm that the Trust complies with the cost allocation and charging guidance issued by HM Treasury and there were no declarations of donations to political parties during the year.

[14] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2022/05/Reservation-of-Powers-to-the-Board-and-Scheme-of-Delegation-Jan22.pdf
[15] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2022/05/Reservation-of-Powers-to-the-Board-and-Scheme-of-Delegation-Jan22.pdf
[16] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-19-fit-proper-persons-employed
[17] https://bthft.mydeclarations.co.uk/declarations
[18] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/11/BTHFT-Constitution-July-2021.pdf
[19] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/

3.1.1. The Board of Directors

The Board of Directors is legally responsible for the day-to-day management of the Trust and is accountable for the operational delivery of our services, targets and performance as well as defining and implementing our strategy. It has a duty to ensure the provision of safe and effective services for our service users, which it does by having in place effective governance structures, and by:

- establishing and upholding the Trust's values and culture;
- setting the strategic direction;
- ensuring the Trust provides high quality, safe, and effective services
- promoting effective dialogue with the Trust's local communities and partners;
- monitoring performance against Trust objectives, targets, measures and standards;
- providing effective financial stewardship; and
- ensuring high standards of governance are applied across the Trust.

Full details regarding the Board's responsibilities, as required to be disclosed under the NHS Foundation Trust Code of Governance[20], are available on page 29 of this annual report.

The Chairman is responsible for ensuring that the Board of Directors focuses on the strategic development of the Trust and that robust governance and accountability arrangements are in place. The Chairman of the Trust chairs both the Board of Directors and the Council of Governors and ensures there is effective communication between the two bodies and that, where necessary, the views of the governors are taken into account by the Board.

Whilst the executive directors individually are accountable to the Chief Executive for the day-to-day operational management of the Trust, they are, along with the non-executive directors, part of the unitary Board. They all share corporate responsibility and liability for ensuring that the Trust operates safely, effectively and economically. They do this by making objective decisions in the best interests of the Trust. The non-executive directors assure themselves of performance by holding the executive directors to account for the achievement of the agreed goals, objectives, targets and measures.

The Board has set out the Trust's vision and values[21] alongside the mission of providing the highest quality healthcare at all times. In March 2022 the Board approved our new corporate strategy for 2022-2027 titled 'Our Patients, Our People, Our Place and Our Partners'. Our new strategy will be published in the spring of 2022. It explains how we will work towards our vision to be an "outstanding provider of healthcare, research and education and a great place to work". We are proud to be part of the Bradford District & Craven Health and Care Partnership, with a shared ambition to act as one to keep people happy, healthy at home.

The Board is made up of individuals who have the appropriate balance of skills, experience, independence and knowledge to enable the Board to discharge its duties and responsibilities effectively. It provides leadership in a transparent manner, subscribes to the Trust's values, and adheres to the accepted standards of behaviour in public life, including the seven principles of public life more commonly referred to as the 'Nolan Principles'. The make-up of the Board is prescribed within the Trust's constitution.

Figure 21 shows the Non-Executive members of the Board in 2021/22.

[20] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf
[21] https://www.bradfordhospitals.nhs.uk/our-trust/our-vision-and-values/

Figure 21 - Non-Executive Directors 2021/22

Name	Role	Term start	Term end
Dr Maxwell Mclean	Chairman	01/05/2019	30/04/2025
Professor Janet Hirst	Non-Executive Director	13/09/2021	12/09/2024
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	01/08/2022
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2022
Ms Sughra Nazir	Non-Executive Director	20/01/2022	19/01/2025
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2023
Mr Barrie Senior	Non-Executive Director	01/12/2017	30/11/2023
Ms Selina Ullah	Non-Executive Director	01/09/2015	31/08/2021
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2023

In September 2021 Professor Janet Hirst was appointed as a Non-Executive Director following her nomination by the School of Medicine, University of Leeds and approval of the nomination by the Council of Governors. Ms Selina Ullah concluded her second term in August 2021. Ms Sughra Nazir was welcomed as a new Non-Executive Director in January 2022 following the approval of her appointment by the Council of Governors. The reappointment of the Chairman for a second term from 1 May 2022 to 30 April 2025 was considered and approved by the Council of Governors in October 2021 following the receipt of a recommendation from the Governors' Nominations and Remuneration Committee in September 2021.

Figure 22 shows the Executive members of the Board in 2021/22.

Figure 22 - Executive Directors 2021/22

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer / Deputy Chief Executive	12/10/2020	Present
Ms Pat Campbell*	Director of Human Resources	01/12/2008	Present
Ms Karen Dawber	Chief Nurse	29/08/2016	Present
Mr John Holden	Director of Strategy and Integration Interim Chief Executive Director of Strategy and Integration / Deputy Chief Executive	22/08/2016 01/04/2019 01/05/2018	01/05/2018 31/10/2019 Present
Mr Mark Holloway*	Director of Estates and Facilities	12/11/2020	Present
Mr Matthew Horner	Acting Director of Finance Director of Finance	01/11/2011 01/08/2012	01/08/2012 Present
Dr Paul Rice*	Chief Digital and Information Officer	01/01/2021	Present
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
**Non-voting Executive Director*			

Board profiles

The Board continuously reviews its make-up to determine gaps in skills and knowledge that would support the Board in achieving the Trust objectives. Recommendations have been made during the year to the Governors' Nominations and Remuneration Committee regarding new appointments and reappointments. This is reported on further under section 3.2.3.3 Governors' Nominations and Remuneration Committee (for non-executive directors).

The division of responsibilities between the Chairman of the Trust and Chief Executive was last confirmed by the Board of Directors on 27 May 2020.

The Board of Directors considers annually the independence of the Board and for 2021/22 it confirms that it considers all the Non-Executive directors (including the Chair) to be independent in character and judgement.

The Board has considered the declarations[22] made by Ms Julie Lawreniuk and Mr Barrie Senior with regard to 'close family ties with any of the trust's advisors, directors or senior employees' and, considered the declaration made by Professor Janet Hirst who is 'an appointed representative of the Trust's university medical/dental School'.

The Board has assured itself that there are no relationships or circumstances which could affect or appear to affect, the director's judgment.

Non-Executive Directors

Dr Maxwell Mclean, Chairman

Maxwell joined the Trust on 1 May, 2019 from Bradford City Clinical Commissioning Group (CCG), where he had been lay member for patient and public involvement and vice-chair of the governing body since 2012. While in this role he was particularly keen on championing the involvement of patients in influencing how the CCG commissioned services. He also chaired the CCG's joint quality committee, primary care commissioning committee and the communications, equality and engagement group. Maxwell retired from his position as West Yorkshire Police's senior detective in 2010, after more than 30 years' service. As head of the Homicide and Major Enquiry Team, he oversaw all major criminal investigations in the county and led on partnership working with a variety of local and national agencies tackling crime in some of the most deprived communities. He led nationally for the police service on tackling domestic abuse and made significant national and international improvements in responses to domestic violence and child protection. In 2015, Maxwell graduated from the University of Huddersfield with a PhD after studying the ways in which coroners carry out their duties. His work on criminology and coroners' services has been published in various academic journals. Maxwell lives in Bradford with his wife and three children, who were all born in the city.

Professor Janet Hirst, Non-Executive Director

Janet is Professor in Maternal Healthcare and Head of the School of Healthcare in the Faculty of Medicine and Health at the University of Leeds. She leads a talented team of staff who deliver undergraduate and postgraduate pre-registration education for nursing (adult, child and mental health), midwifery, social work and psychotherapy/counselling; as well as postgraduate and

[22] https://bthft.mydeclarations.co.uk/home

professional development for pharmacists, advanced clinical practitioners and other NHS workforce priority areas. She has an underpinning background in clinical nursing and midwifery and a strong academic grounding (applied to health) having held posts within the NHS and at the University of Leeds as an applied health researcher, educator, leader and manager. Her academic and educational activities centre the quality of maternal care. Janet also has a track record in developing research capacity amongst undergraduate and postgraduate students across healthcare professions. Janet has a strong sense of equality and inclusion and is interested in career pathways as a means to optimise everyone's' experience of health and wellbeing within communities, families and as individuals by generating and disseminating knowledge through the highest quality health and social care professional education and applied health and social care research.

Mr Mohammed Hussain, Non-Executive Director

Mohammed works at senior level in a portfolio career spanning national regulation, education, national healthcare technology and service redesign. He is the Senior Clinical Lead for Live Services at NHS Digital. In this role he is responsible for leading a multidisciplinary clinical team which is tasked with ensuring that NHS Digital's services have the appropriate clinical assurance and governance. Mohammed has been working in national clinical informatics roles since 2009, delivering services such as the Electronic Prescription Service, NHS Mail, Summary Care Records and more across England. He is also a Founding Fellow of the Faculty of Clinical Informatics. Mohammed was a Council Member on the General Pharmaceutical Council, the pharmacy regulator, and is a Fellow of both the Royal Pharmaceutical Society and the Association of Pharmacy Technicians UK, both awards recognising distinction for services to the profession of Pharmacy. He has previously held roles as a lecturer practitioner at the University of Leeds, and a pharmaceutical advisor for the NHS in Leeds. He is currently a member of the Expert Advisory Board for the School of Pharmacy at Bradford University. Mohammed continues to practice as a pharmacist alongside his other duties at NHS Digital, the Trust and NHS England. He is passionate about health technology, championing diversity and delivering excellent clinical care.

Ms Julie Lawreniuk, Non-Executive Director

Qualified accountant Julie became a Non-Executive Director with the Trust in September 2019. She was born and educated in Bradford and still lives in the city. She is passionate about Bradford and a supporter of the local football club. Julie has a Master's degree in Finance and Accountancy, and prior to joining the Trust was Deputy Chief Officer and Chief Finance Officer for the three Bradford District and Craven Clinical Commissioning Groups. She brings a wealth of NHS experience, with a career that has spanned over 27 years working across a number of NHS organisations including both providers and commissioners and covering a variety of senior

leadership roles. Julie also worked in the private finance sector for 11 years before joining the NHS in 1992. She is also a Board member at Incommunities.

Ms Sughra Nazir, Non-Executive Director

Sughra is Director and a management consultant supporting the health and social care sector with care quality, safeguarding and regulatory compliance. She is an associate with the Social Care Institute for Excellence and is currently contracted by the NMC. She is a serving Parish Councillor and currently Vice Chair for the Sandy Lane Parish Council.

Her previous roles include working for the Care Quality Commission as an inspector and as a National Provider Relationship Lead. Sughra has also served as a Governor with Bradford District Care Foundation Trust and has held Non-Executive Director and Operations and Compliance Director positions with adult social care organisations.

Drawing on her regulatory background and 28 years health and social care experience, Sughra has addressed care provider conferences and written for trade journals on improving care quality, achieving outstanding CQC ratings and meeting the needs of diverse communities. Sughra is a member of a number of national diversity and disability networks and has particular interest in improving maternity, children with disabilities, learning disability and dementia services.

A lifelong Bradfordian, Sughra qualified as a social worker in 1997 and is very passionate about supporting the Trust to deliver the best patient experience and outcomes.

Mr Jon Prashar, Non-Executive Director

Jon is the group head of diversity and inclusion at the Places for People group. He has over 30 years of experience of working in the public, private and voluntary sectors and a background in construction, organisational development and training, with a wealth of experience in building relationships and promoting equality and inclusion. Jon has focused on designing and delivering best practice. He is adept at designing new operational processes and delivering robust communication plans to ensure that employees, service users, contractors and partners promote equality and harness the opportunities created by diversity. He is a board member of the Housing Diversity Network, a member of Homes England Equality and Diversity Board and a board member of Leeds and Yorkshire Housing Association. Jon has a visual impairment and considers himself to be the very lucky owner of a guide dog.

Mr Altaf Sadique, Non-Executive Director

Altaf is the Founder and Managing Director of Gane Data, a Leeds-based technology firm established in 1995. For the past 25 years Gane Data has successfully delivered major projects for global retail businesses and public sector organisations, including healthcare providers. Its solution and product focus has included healthcare virtualisation and patient flow management technology for NHS trusts, internet-enabled cloud computing platforms for the London 2012 Olympics, and customer-centred connected retail platforms. Core areas of Gane Data's research include the future internet and 5G Public Private Partnership, the Internet of Things and connected supply chains for the Falsified Medicines Directive.
Altaf also has experience of collaborative healthcare research and innovation funded by the European Commission and the UK's Technology Strategy Board. He was born and bred in Yorkshire and enjoys travel, poetry and music.

Mr Barrie Senior, Non-Executive Director

Barrie was appointed a non-executive director and chairman of the Audit Committee at the Trust on 1 December, 2017. Barrie was born, educated, and qualified as a chartered accountant in Bradford. He is a Fellow of the Institute of Chartered Accountants in England and Wales (FCA). His career to date spans partnership roles with two major accounting firms, finance and corporate development director roles with two significant Yorkshire-based PLCs, and non-executive director and audit committee chairman positions. For five years prior to joining the Trust, Barrie was non-executive director and chairman of the Audit Committee at Yorkshire Ambulance Service NHS Trust.

Ms Selina Ullah, Non-Executive Director, Deputy Chair and Senior Independent Director (until 31 August 2021)

Selina was appointed a Non-Executive Director at the Trust in September 2015. She is passionate about people and communities, which has led to her involvement in national, regional and local

government, think tanks, charitable foundations and NGOs working on policy formulation, transformation, service modernisation, regulation and governance. Selina has in-depth knowledge of engaging diverse communities, with a particular focus on hard-to-reach groups. She has over 25 years of experience of working with charities and the not-for-profit sector and extensive senior management experience in the public sector working in health service management and public policy on high profile issues such as community cohesion, diversity, mental health and social inclusion, crime and disorder and counter-terrorism. Until June 2011, Selina was assistant director for Safer and Stronger Communities at Bradford Council. She is also an advisor to the Joseph Rowntree Foundation, a non-Executive director at a national health regulator, Yorkshire and Humber committee member at the Heritage Lottery Fund, director of Manchester Central Library Development Trust, chair of the Muslim Women's Council and president of ICLS, an international organisation based in Rome which specialises in intercultural dialogue, participation and leadership. Selina has extensive experience in the field of race relations and is an advisory board member and trustee of the Ahmed Iqbal Ullah Race Relations Resource Centre and Education Trust based at Manchester Central Library.

Ms Karen Walker, Non-Executive Director

Karen has spent 30 years in the Customer Services industry, gaining a wealth of experience spanning financial services, utilities and telecoms at brands such as telephone and online bank First Direct, Centrica and Virgin Media. She is currently Director of Strategy and Change at the Independent Parliamentary Standards Authority, the independent regulator of MPs' pay and business costs, and is responsible for developing and delivering a three-year strategy that creates a customer-focused culture and a sustainable, efficient and seamless service for the UK's 650 MPs and their staff. She has a background in operational and change leadership, culture change, regulation, credit management and customer service excellence and is renowned for developing purposeful customer-centric cultures to drive advocacy and great customer outcomes, breaking down barriers to service excellence. Karen has a keen interest in people and customers and firmly believes valued people value customers. She is looking forward to translating her experience into helping Bradford achieve great patient outcomes and service excellence. Yorkshire born and bred, Karen enjoys being outdoors and spends most of her spare time at the side of a rugby pitch, supporting her son and keeping the players safe in her role as Club Welfare Officer at Siddal ARLFC.

Executive Directors

Professor Mel Pickup, Chief Executive Officer

Initially training as a nurse Mel undertook a variety of clinical and managerial roles joining her first Board as Director of Nursing in 2001. Mel continued to work at Board level, taking on a wider portfolio of Director responsibilities, first in Rotherham and then Wrightington Wigan and Leigh NHS Trust becoming Chief Nurse, Director of Operations and Deputy CEO before taking up her first CEO role in 2007. Mel has been CEO in three NHS Foundation Trusts – joining Bradford in November 2019. Mel has a wide breadth of experience and an excellent reputation as a clinician and a leader and a strong track record of building successful collaborations across Health and care sectors. In addition to her role as CEO of the Trust Mel is also the Place Lead/Accountable Officer for the Bradford District and Craven – 'Act as One' Health and Care Partnership one of the five places in the West Yorkshire Health & Care Partnership.

Mr Sajid Azeb, Deputy Chief Executive and Chief Operating Officer

Saj has worked across several NHS organisations and has significant experience of dealing with complex service issues through the various operational and strategic management roles he has held over his 20-year career within the NHS. Prior to joining Bradford Teaching Hospitals NHS Foundation Trust, he worked at Leeds Teaching Hospitals. Having joined the NHS in a clinical capacity in 2000, he moved into a career in NHS Management in 2003, while at the same time undertaking a Masters degree in Business Administration. Saj is an experienced leader and has skills across performance, budgetary, personnel and service development functions. He is a highly regarded individual and has established an excellent reputation for service delivery among clinical and management colleagues both at a local and regional level.

Ms Pat Campbell, Director of Human Resources

Pat is a Chartered Fellow of the CIPD (Chartered Institute of Personnel and Development) and has worked in the NHS since 1986, primarily in HR roles. She has held the position of director of HR at the Trust since December 2008, having previously held the positions of personnel manager and deputy director of HR.

Ms Karen Dawber, Chief Nurse

Karen was appointed Chief Nurse at the Trust in August 2016. She was formerly the Director of Nursing at Warrington and Halton Hospitals NHS Foundation Trust, and has nine years' experience as an executive director across three foundation trusts. An experienced nurse and service manager, she started her career as a paediatric nurse at Manchester Children's Hospital before moving into general management and transformational work. Karen is passionate about patient quality and the impact that well-led and motivated staff have on the care we are able to give to patients. She was named in the inaugural list of Health Service Journal's LGBT leaders and takes a keen and active interest in the equality and diversity agenda.

Mr John Holden, Deputy Chief Executive and Director of Strategy and Integration

John was appointed Director of Strategy and Integration at the Trust in August 2016 and, in April 2017, Deputy Chief Executive. From 1 April 2019 to 31 October 2019 John was Acting Chief Executive. He spent most of his career in senior roles at the Department of Health and NHS England, has shaped strategy at national level, and was responsible for leading NHS England's policy on a range of issues, including the Academic Health Science Networks and the review to decide the national provision of Congenital Heart Services. In previous roles John was responsible for NHS quality regulation, Foundation Trust policy, major capital investment programmes, and project management of the comprehensive spending review to secure NHS funds from the Treasury. From 1995 to 1996, John was Private Secretary to the Secretary of State for Health. He studied at the universities of York and California and holds an MBA from Manchester Business School. John was appointed to lead on developing and integrating services which deliver new models of care in the Bradford district and across the wider West Yorkshire region, ensuring the Trust continues to provide high quality care which meets the needs of the local population.

Mr Mark Holloway, Director of Estates and Facilities

Mark is an experienced estates and facilities professional and has worked at several NHS organisations as director and in senior leadership roles throughout his career.

A qualified building services engineer, Mark has led a range of estate transformational programmes including service modernisation, strategic estate modelling and regional estate integration.

He has developed a range of estate strategies and large multi-million-pound capital development programmes including LIFT (Local Improvement Finance Trust), private finance initiative (PFI) and hospital re-build schemes. He has been involved with pioneering a range of ward-based service transformation programmes to improve patient-focused care and service delivery at ward level. He is passionate about creating the best possible patient care environments and hospital support service delivery.

Mr Matthew Horner, Director of Finance

Matthew has a degree in Accountancy and Finance, and is a qualified member of the Chartered Institute of Public Finance and Accountancy. His NHS finance career spans over 30 years and covers a variety of finance roles. For the last 20 years, he has worked for the Trust in Bradford, progressing from Finance Manager to Deputy Director of Finance. Matthew subsequently joined the Board as Acting Director of Finance in November 2011, and was appointed substantive Director of Finance in August 2012.

Dr Paul Rice, Chief Digital and Information Officer

Paul Rice has joined Bradford and Airedale NHS foundation trusts from his role as Regional Director of Digital Transformation for NHS England and Improvement in the North East and Yorkshire. He has been the senior responsible owner for substantial national digital transformation programmes relevant to hospital electronic patient records, mental health, transforming primary care, maternal and child health. Paul was formerly the Director of the Long-Term Conditions programme in Yorkshire and Humber with a focus on Telehealth. He has been a Primary Care Trust director, a transformation director in the NHS Modernisation Agency and a policy lead in the Department of Health. He has published and spoken widely on the challenges and opportunities to deliver new service models using assistive technology/telehealth/information technology. He is passionate about inclusive digital transformation, ensuring diversity of interest and experience hugely influences care. Paul holds a BA degree in Law and Accounting (Manchester), a Masters in Informatics Leadership (Imperial) and a Doctorate in Medical Law and Bioethics (Manchester). He is also a graduate of the Said Business School (Oxford), where he completed the Major Projects Leadership Academy, and a Fellow of the British Computing Society. Paul is a trustee of Yorkshire Cancer Research and a volunteer fundraiser with Macmillan Cancer Support.

Dr Ray Smith, Chief Medical Officer

Ray was appointed to the position of Chief Medical Officer at Bradford Teaching Hospitals NHS Foundation Trust in December 2020. He trained at Leeds University Medical School, qualifying in 1988. His first job as a junior doctor was in Bradford the same year. Ray went on to train in Medicine and Anaesthetics in the Yorkshire region and Portland, Oregon. He became a Consultant Anaesthetist at Bradford Teaching Hospitals in 1998, and has since gone on to hold a number of management roles within clinical risk management and service delivery. Prior to his appointment to the role of Chief Medical Officer, he held the Associate Medical Director and Deputy Chief Medical Officer for Professional Medical Standards roles. He holds a particular interest in developing and supporting all Trust staff.

Attendance at meetings of the Board of Directors during 2021/22

During 2021/22 our governance framework was adapted as we responded to the pandemic. A new governance model signalling revised governance arrangements and responsibilities, first agreed in autumn 2020, has been further developed and implemented. Further details are in the Annual Governance Statement in section 3.8.5.7.

Board meetings have continued to take place bi-monthly. However, in light of government restrictions on groups of people meeting, our meetings of the Board of Directors took place virtually, and were not accessible to the public. To address this, since November 2020 the recordings from the meetings have been published online[23], along with annotated agendas. Figure 23 reports on the number of meetings attended by Board members in-year.

[23] https://www.youtube.com/watch?v=byqce5yiQTA

Figure 23 - 2021/22 Board of Directors attendance

Board Member	Role	Meetings Attended
Professor Mel Pickup	Chief Executive Officer	4 of 6
Mr Sajid Azeb	Deputy Chief Executive / Chief Operating Officer	6 of 6
Ms Pat Campbell	Director of Human Resources	6 of 6
Ms Karen Dawber	Chief Nurse	6 of 6
Professor Janet Hirst	Non-Executive Director	4 of 4
Mr John Holden	Deputy Chief Executive / Director of Strategy and Integration	6 of 6
Mr Mark Holloway	Director of Estates and Facilities	6 of 6
Mr Matthew Horner	Director of Finance	5 of 6
Mr Mohammed Hussain	Non-Executive Director	4 of 6
Ms Julie Lawreniuk	Non-Executive Director	6 of 6
Dr Maxwell Mclean	Chairperson	5 of 6
Ms Sughra Nazir	Non-Executive Director	2 of 2
Mr Jon Prashar	Non-Executive Director	5 of 6
Dr Paul Rice	Chief Digital and Informatics Officer	6 of 6
Mr Altaf Sadique	Non-Executive Director	6 of 6
Mr Barrie Senior	Non-Executive Director	6 of 6
Dr Ray Smith	Chief Medical Officer	6 of 6
Ms Selina Ullah	Non-Executive Director	2 of 2
Ms Karen Walker	Non-Executive Director	6 of 6

The meetings are also routinely attended by the Associate Director of Corporate Governance / Board Secretary.

Committees and Academies of the Board of Directors

In line with statutory requirements the Board of Directors has a (Board) Nominations and Remuneration Committee (further details on the activities of this committee are available on in section 3.2.3.2) and an Audit Committee (AC). The work of the AC is detailed further in this chapter. In addition, the Board has established a Charitable Funds Committee, A Quality and Patient Safety Academy, a Finance and Performance Academy and a People Academy**.** The terms of reference for all Board committees and academies are available as part of the Board of Director Standing Orders[24].

In March 2020 the Board of Directors established an Executive/Non-Executive Regulation Committee (more commonly referred to as the Regulation and Assurance Committee) as a pragmatic response to ensure appropriate governance during the Covid-19 pandemic. The remit of the committee was to provide the Foundation Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the controls associated with the delivery of the Trust's Strategic Objectives. With the resumption of the Board of Directors meetings and establishment of the Academies, and to avoid duplication, it was agreed that the Regulation and Assurance Committee should be dis-established. In July 2021 the functions of the Regulation and Assurance Committee were transferred to the Board of Directors. From July 2021 the Academies reported directly to the Board and, since September 2021 all Academies have been chaired by a Non-Executive Director.

Reports from the AC and Committee and Academy Chairs are presented at the Open Board of Directors and to the Council as part of the Council of Governor meetings.

[24] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/10/BoD-Standing-Orders-approved-July-2021.pdf

Audit Committee

The purpose of the AC is to provide an independent and objective view of internal control to the Board of Directors and the Accountable Officer. It provides assurance regarding the comprehensiveness and the reliability of assurances on governance, risk management, the control environment and the integrity of financial statements.

The matters to be considered by the AC are included within the Terms of Reference (contained within the Board Standing Orders) which are reviewed annually and approved by the Board of Directors.

With regard to the work of the AC during 2021/22, the committee considered and reviewed the following reporting from Internal Audit and Counter Fraud:

- Annual Counter Fraud Report
- Annual Head of Internal Audit Opinion
- Annual Internal Audit performance review
- Anti-Fraud Bribery and Corruption Policy
- BH/25/2022 Fixed Term Contracts – limited assurance report
- BH/26/2022 Consent – limited assurance report
- BH/27/2022 ReSPECT– limited assurance report
- BH/29/2022 Process and Harm Free Care; Nutrition and Hydration – limited assurance report
- Counter Fraud Annual Report 2020/21
- Counter Fraud Plan 2021/22
- Counter Fraud progress reports
- Follow up of Internal Audit Recommendations
- Internal Audit Charter
- Internal Audit Progress Reports
- Policies and procedures for all work related to Counter Fraud
- Update on recommendation from BH/42/20 - Nursing Assessments and Care Plans
- Update on recommendations from Bh/48/19 - Asset Management; Stock, Stores and Inventory
- Monthly insight reports from The Internal Audit Network (TIAN)

The committee considered and reviewed the following reporting from the Trust;

- Annual Accounts 2020/21
- Annual Governance Statement 2020/21
- Annual Report 2020/21
- Appropriateness of single source tenders
- Assurance - Key IT Systems
- Assurance of the EPR System
- Assurance Report: Charitable Funds Committee
- Assurance Report: Regulation and Assurance Committee
- Assurance Reports from Committees/Academies:
- Audit Committee Annual Report to Board
- Audit committee annual self-assessment
- Board Assurance Framework and High Level Risk Register / Risk Management Strategy Updates
- Business Continuity Planning
- Charitable Funds Annual Report and Accounts 2019/20
- Charitable Funds ARA 2019/20 Letter of Representation:
- Clinical Audit Annual Report
- Clinical Audit high priority work-plan
- Clinical IT Applications - Assurance
- Corporate Governance Statement (provider licence)

- Cyber Security update
- Data Quality (DQ) Assurance
- Declarations of Interest – Annual Report
- Draft Letter of Representation 2020/21
- Effective Management of Clinical Risks arising from Financial Pressures
- Emergency Preparedness, Resilience and Response
- Exception reports: Schedules of losses and special payments
- Freedom to Speak Up annual report 2020/21
- Governance Review updates
- ISA 260: 2019/20 Charitable Funds ARA
- Pathology Joint Venture third party assurance
- Policy on Policies review
- Production of the Quality Account
- Progress on Charitable Funds Annual Report and Accounts 2020/21
- Proposed changes to Scheme of Delegation/Standing Financial Instructions
- Quality Management System
- Standing Orders - proposed changes
- Trust's annual self-certification as to the compliance with the conditions of the NHS provider licence

The committee considered and reviewed the following reporting from the external auditors:

- Annual External Audit performance review
- Auditor's Annual Report 2020/21
- Delay in certification – External Audit Annual Report 2020/21
- External Audit Plan 2021/22
- Sector update and benchmarking

In-year, the committee considered and approved the following items:

- Internal audit plan
- External audit plan
- BTHFT Annual Report and Accounts 2020/21
- Audit Committee Annual Report to Board
- Audit Committee annual self-assessment, terms of reference and work plan 2021/22

Throughout 2021/22 the committee considered the following significant risks highlighted by the external auditor, Deloitte LLP.

- Capital expenditure
- Management override of controls

The minutes from the meetings of the AC, along with reports from its Chair highlighting the key items for discussion, are routinely presented at the public meetings of the Board of Directors and to the Council of Governors. These documents are available on the Trust website.

In-year, the AC also held private meetings with internal audit (Audit Yorkshire) and the external auditor (Deloitte).

The committee's membership has been as follows:

- Mr Barrie Senior, Non-Executive Director, Committee Chair
- Ms Selina Ullah, Non-Executive Director (until 31 August 2021)
- Ms Sughra Nazir, Non-Executive Director (from February 2022)
- Mr Jon Prashar, Non-Executive Director

- Ms Julie Lawreniuk, Non-Executive Director

The committee met six times during the year. Attendance at these meetings is detailed in figure 24.

Figure 24 - 2021/22 Audit Committee attendance

Audit Committee Membership	Meetings attended
Mr Barrie Senior, Audit Committee Chair	6 of 6
Ms Julie Lawreniuk, Non-Executive Director	5 of 6
Ms Sughra Nazir, Non-Executive Director	1 of 1
Mr Jon Prashar, Non-Executive Director	6 of 6
Ms Selina Ullah, Non-Executive Director	4 of 4

Audit Committee meetings are also attended by the Director of Finance, a Deputy Director of Finance and, the Associate Director of Corporate Governance / Board Secretary. The Chief Executive Officer attends at least one meeting per year to present the Annual Governance Statement. Representatives of both Internal and External Audit also routinely attend meetings.

3.1.2. Better Payment Practice Code

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

Figure 25 - Better Payment Practice Code

	2021/22		2020/21	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in-year	54,783	266,372	47,126	211,628
Total non-NHS trade invoices paid within target	50,462	238,149	44,171	195,963
Percentage of non-NHS trade invoices paid within target	92%	89%	94%	93%
Total NHS trade invoices paid in-year	1,587	19,763	1,849	16,293
Total NHS trade invoices paid within target	1,392	14,495	1,666	14,320
Percentage of NHS trade invoices paid within target	88%	73%	90%	88%

We aim to improve transactional processing to pay creditors within this target whilst maintaining a balance on appropriate authorisation and validation of invoices. Adherence to the code has marginally reduced over the past 12 months for both NHS and non-NHS invoices. This was a result of a temporary system issue at the Trusts outsourced provider and performance is expected to improve next year.

As at 31 March 2022, the total liability to pay interest due to failing to pay invoices within 30 days was nil (31 March 2021: nil).

3.1.3. NHS Improvement's well-led framework

Our approach to quality and quality governance is presented in detail in the Annual Governance Statement in section 3.8.

Patient care

The Care Quality Commission (CQC) undertook an unannounced visit at the Trust on Wednesday 20 April 2022, as part of a wider system review of urgent and emergency care. The formal report will be received in due course. The most recent published inspection report relates to the inspection that was undertaken by the CQC in December 2019 (the report being published on 9

April 2020). The Trust's rating for the well-led domain[25] is 'good'. The reasons for this can be read in their report on the CQC website[26].

In recognition of the unprecedented pressures on the NHS during the pandemic, the CQC suspended its routine inspection regime. However, regular virtual engagement meetings continued throughout the year to provide assurance of the effectiveness of actions being taken to address the findings of the CQC inspections in 2020 and 2018 and external well-led reviews undertaken in 2016 and 2017. These meetings also provide an opportunity to address any patient enquiries made directly to the CQC as well as open and transparent dialogue relating to challenges of the on-going COVID-19 pandemic and the impact of services and share innovation and improvements made to services.

Stakeholder relations

During 2021/22, we have continued to work closely with our partners across West Yorkshire including:

- **West Yorkshire Association of Acute Trusts (WYAAT)**

Working closely with our partners in WYAAT we aim to improve care for patients and deliver efficiencies through a number of joint projects spanning areas such as procurement, workforce and radiology. During 2021/22, activities have included the development of proposals for a new model of care for Non-Surgical Oncology, and joint work to reduce the backlog of elective waiting lists and recover elective services.

- **Joint Ventures (JVs)**

We are consolidating the progress made in the established JVs (Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP) with Airedale NHS Foundation Trust and Harrogate and District NHS Foundation Trust to deliver laboratory based pathology services. These Joint Ventures continue to deliver benefits including economies of scale, shared expertise and delivering high quality diagnostic services to other primary and secondary care providers.

Connected Local Care

- **Integrated Care System (ICS)**

We have continued to work in partnership as part of the West Yorkshire Health and Care Partnership (the integrated care system - ICS), through our participation in shared programmes of work and our contribution to the development of plans for the future of integrated care, in line with the proposals set out in the Health and Care Bill. The plans will put the ICS on a statutory footing from 1 July 2022, and mean changes for the way in which it works and the way in which we work with our partner organisations. Work has continued to prepare partners across the ICS for the forthcoming changes, which will be formally implemented from July 2022, subject to the Health and Care Bill receiving Royal Assent.

- **The Bradford District and Craven "place"**

Within Bradford District and Craven the Wellbeing Board sets the overall direction, and coordinates action between each of our strategic partnerships to maximise our impact on all the factors that influence our social, economic, and environmental wellbeing. The Health and Care Executive Board leads the coordinated planning and delivery of our local health and care system, via our

[25] https://www.cqc.org.uk/guidance-providers/nhs-trusts/what-we-will-inspect-nhs-trusts
[26] https://api.cqc.org.uk/public/v1/reports/edcfb304-14c0-4e3e-8557-de663e8533f0?20210113203413

Bradford District and Craven Health and Care Partnership. Our Bradford District and Craven Health and Care Partnership arrangements already include:

- shared system committees focused on quality, and finance and performance
- a clinical forum ensuring clinical and professional views are heard, and clinical leadership is embedded in all parts of our partnership
- coordinated action on the critical enabling functions of our health and care system – our workforce, our use of technology, data, and our physical estate
- 'Act as One' system transformation programmes addressing access to care, mental health, children's health and wellbeing and the illnesses which have the greatest impacts on the lives of people in our District.

The Trust has participated in the programme of work being undertaken in order to plan and prepare for the anticipated changes in responsibility associated with the Health & Care Bill, including the establishment of the Bradford District & Craven Partnership Board as a Committee of the Integrated Care Board (ICB).

Each place based partnership must have arrangements which provide strategic leadership of place and ensure clear and aligned leadership and line management of place-based staff. Our Chief Executive Mel Pickup has been appointed as the 'Place Leader' for Bradford District & Craven.

Our current partnership arrangements are underpinned by the Strategic Partnering Agreement (SPA), which documents the way we work together, how we reach decisions collectively, and confirms our shared ambition. The SPA was most recently reviewed in spring 2021. The SPA is currently being updated again to reflect the proposed partnership governance and decision making arrangements, ensuring alignment with the constitution of the West Yorkshire ICB, and preparing for the anticipated changes in responsibility from the CCG to the ICB.

3.1.4. Fees and charges (income generation)

The Trust's income generation activities aim to achieve profit, which is then used in patient care. None of these schemes exceed £1 million nor are they sufficiently material to warrant separate disclosure. The revenues and expenditure relating to these are included in the annual accounts.

3.1.5. Charitable donations

During 2021/22, Bradford Hospitals' Charity[27] received £302,000 in income. The total income has been invested across our Charity's four funds, which are: children and young people (which includes neonatal), elderly and dementia, cancer,and our sunshine fund (which is everything else).

Our BIG Neonatal Appeal[28] has seen money invested in improving facilities for families visiting their babies in our neonatal unit. Funds have been invested across the board to support patient, their families and our staff through the purchase of equipment, training, research and projects which go over and above what the NHS provides.

3.1.6. Income disclosures

As required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust confirms that the income it received from the provision of goods and services for the purposes of the health service in England is greater than the income it received from the provision of goods and services for any other purpose. Furthermore, the generation of

[27] https://bradfordhospitalscharity.org/
[28] https://bradfordhospitalscharity.org/big-neonatal-appeal/

“non-NHS related income” does not impact adversely on the quality of healthcare services delivered by the Trust.

Signed

Mel Pickup
Chief Executive
On behalf of the Board of Directors
21 June 2022

3.2. REMUNERATION REPORT

3.2.1. ANNUAL STATEMENT

Annual statement from the Chairman of Bradford Teaching Hospitals NHS Foundation Trust's Nominations and Remuneration Committee

I am pleased to present the Directors' Remuneration report for the financial year 2021/2022. The Nominations and Remuneration Committee is established by the Board of Directors, with primary regard to executive directors' remuneration and terms and conditions of service.

The report is divided into two parts:

- senior managers' remuneration policy;
- the annual report on remuneration, which includes details about directors' service contracts, and sets out governance matters such as committee membership, attendance and the business undertaken by the Committee.

Major decisions on remuneration

The Committee met twice in the year and agreed that the Director of Estates & Facilities should become a formal member of the executive management team and a non-voting member of the Board of Directors.

In respect of remuneration the committee chose not to award an annual pay increase to executive directors in the light of Ministers' recommendations on the 2021/22 annual pay increase for very senior managers received in September 2021. The committee also made decisions on pay following benchmarking reviews, and earn back clauses in line with contracts of employment during the course of the year.

Signed

Dr Maxwell Mclean
Trust Chairman and Chair of the Nominations and Remuneration Committee for Directors
21 June 2022

3.2.2. SENIOR MANAGERS' REMUNERATION POLICY

Figure 26 - Executive directors' remuneration policy

Element of policy	Purpose and link to strategy	How operated in practice	Maximum opportunity	Changes to remuneration policy from previous year
Base Salary	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced executive directors.	As determined by salary band. New directors are appointed on a spot salary. Previously it was the norm to appoint on a three-point salary band. If a director is not appointed to the maximum point on their salary scale any incremental increase in pay is based on them displaying exceptional performance which is tied in with the Trust meeting its regulatory and corporate objectives. Progression is annually earned. In determining the appropriate starting salary, the committee considers: • Guidance on pay for very senior managers in NHS trusts and foundation trusts – NHSI 2018 • Salary levels for similar positions through the Foundation Trust and Association of UK University Hospitals (AUKUH) networks • Individual skills and experience • 'Established' pay ranges in acute NHS Trusts and Foundation Trusts published by NHSI • Cost of living increases awarded in line with any pay award made to senior staff on agenda for change terms of conditions. No annual bonuses are paid • Any opinion received by NHSE/I These factors are taken into account when setting and reviewing the salaries of staff who earn over £150,000. The contract of employment authorises deductions from salary any amount owed to us including but not limited to any overpayment or rent.	Increments, if awarded, are set at £5,000. The committee on occasion will also recognise changes in the role, and/or duties of a director and salary progression for newly appointed directors.	Awaiting publication of VSM Framework on pay before revising policy.
Benefits (table)	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced executive directors.	Pension related benefits only	As per NHS Pension Scheme regulations	No change

Element of policy	Purpose and link to strategy	How operated in practice	Maximum opportunity	Changes to remuneration policy from previous year
Pension	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced executive directors.	The standard NHS Pension Scheme is operated	As per NHS Pension Scheme regulations	No change

Figure 27 - Non-executive directors' remuneration policy

Position	Remuneration	Policy
Chairperson remuneration	£55,145	The remuneration for all non-executive directors and the chairperson is reviewed by the Governors' Nominations and Remuneration Committee (NRC). At the Governors NRC on 21 September 2021 remuneration wasdiscussed in reference to the current benchmarking information available from NHS Providers and guidance[29] published in July 2021 proposing a 'remuneration structure for NHS provider chairs and non-executive directors. The Chair's remuneration was also considered by the NRC in September 2021. There was no change to the level of Chair remuneration. The Council of Governors received and approved the recommendations from the NRC that there would be no change to the remuneration of the non-executive directors and Chair for 2021/22 and the rate would remain the same asthat agreed for the previous year. There are no additional fees payable for other duties and no other items that are considered to be remunerationin nature. Non-executive directors do not receive pensionable remuneration.
Non-executive director	£13,785	

[29] https://improvement.nhs.uk/resources/remuneration-structure-nhs-provider-chairs-and-non-executive-directors/

Policy on payment for loss of office

Where loss of office is on the grounds of redundancy, it is calculated in line with Agenda for Change terms and conditions. Loss of office on the grounds of gross misconduct would result in a dismissal without payment of notice.

The figures included in the accounts show there were no compulsory redundancy paymentsmade in 2021/22 for loss of office.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust has not consulted with employees when determining its remuneration policy for executive directors. The Trust takes into account available benchmarking data and the guidance on pay for very senior managers published by NHSE/I to enable us to recruit and retain the best people.

3.2.3. ANNUAL REPORT ON REMUNERATION

3.2.3.1. Service contracts

Senior manager contracts contain a notice period of three or six months dependent on role and when the appointment was made. Permanent contracts are issued unless there is a requirement for a specific fixed term role. Contracts are dated with the first day of appointment, the dates of which are as set out in the Board of Directors section of the Directors' report, at 3.1.

3.2.3.2. Nominations and Remuneration Committee (for directors)

The Board of Directors has established a Nominations and Remuneration Committee. Its responsibilities include consideration of matters relevant to the appointment, remuneration and associated terms of service for executive directors. The committee is also responsible for making any recommendations about any local pay arrangements not covered by nationalterms and would be responsible for approving the running of any mutually agreed resignation scheme (MARS) or voluntary redundancy scheme.

The committee comprises the Chairman and all non-executive directors. The Chief Executive is in attendance and will discuss Board composition, succession planning, remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to her own performance or remuneration. The Director of Human Resources (HR) is in attendance and will provide employment advice and guidance as necessary. She withdraws from the meeting when any discussions are held with regard to her performance or remuneration. The Director of HR also acts as committee secretary.

The committee met twice during the year. No new recruitment took place during 2021/22 in respect of Executive appointments. The committee chose to make the Director of Estates & Facilities a formal member of the executive management team and a non-voting member of the Board of Directors. Full Fit and Proper Person checks were undertaken to enable this to happen.

In respect of remuneration decisions the committee agreed the salary of the Director of Estates & Facilities. The committee was presented with a paper on current salaries and the salary profile of executive director salaries with an ongoing commitment to address the gender pay gap. In the light of this and relevant benchmarking data the committee agreed

to an increase in remuneration for the Director of HR. The committee also, on the recommendation of the Chairman, agreed that there was no requirement to trigger the earn back arrangements in respect of the Chief Executive's remuneration. In the light of the letter received which detailed Ministers' recommendations on 2021/22 annual pay increases for Very Senior Managers of 8 September 2021, the committee chose not to apply an annual pay increase to Executive Directors in 2021/22.

Figure 28 - Attendance and membership during 2021/22

Board NRC membership	Meetings attended
Dr Maxwell Mclean, Chairman	2 of 2
Ms Selina Ullah, Non-Executive Director	1 of 1
Mr Barrie Senior, Non-Executive Director	2 of 2
Mr Jon Prashar, Non-Executive Director	2 of 2
Ms Julie Lawreniuk, Non-Executive Director	2 of 2
Mr Mohammed Hussain, Non-Executive Director	2 of 2
Mr Altaf Sadique, Non-Executive Director	2 of 2
Ms Karen Walker, Non-Executive Director	2 of 2
Professor Mel Pickup (in attendance), Chief Executive	1 of 2
Ms Pat Campbell (in attendance), Director of HR	2 of 2

3.2.3.3. Governors' Nominations and Remuneration Committee (for non-executive directors)

The Governors' Nominations and Remuneration Committee (NRC) is a sub-committee of the Council of Governors charged with developing and presenting recommendations to the Council of Governors with regard to non-executive director (NED) appointments, reappointments and their remuneration in line with the governors' statutory duties.

In accordance with the terms of reference the committee is expected to meet at least quarterly in-year. During 2021/22 the NRC met a total of five times (four routinely scheduled meetings and one extraordinary meeting). The meetings are chaired by Dr Maxwell Mclean. Where a conflict arises with regard to the meeting Chair, there is a process in place for the committee to appoint a replacement chair from amongst the Governor members of the NRC.

Figure 29 - Membership and meeting attendance for 2021/22

Governors NRC membership	Meetings Attended
Dr Maxwell Mclean, Chairman	5 of 5
Mr Dermot Bolton, Public Governor	4 of 5
Mr Mark Chambers, Public Governor	4 of 5
Professor Alastair Goldman, Partner Governor	4 of 5
Ms Wendy McQuillan, Public Governor	4 of 5
Ms Hardev Sohal, Patient Governor	2 of 5
Mr David Wilmshurst, Public Governor	5 of 5

The remit of the committee is detailed within the committee terms of reference. The terms of reference for the committee are considered and approved by the Council of Governors annually and are available here[30].

[30] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/06/Terms-of-Reference-for-the-Council-of-Governors-approved-Jan-2021.pdf

The NRC has an annual work programme which is reviewed and agreed annually by the NRC. In-year the committee has dealt with the following business:

- Considered the appointment of a new NED to replace Ms Selina Ullah
- Review of NED job description, person specification and terms and conditions
- Confirmed approval of the appointment of Ms Julie Lawreniuk[31] as Deputy Chair and Senior Independent Director by the Board
- Considered the outcomes from the NRC Committee review for 2021/22
- Reviewed the NRC Terms of Reference
- Sought clarity on the appointment of Bradford University NEDs
- Discussed outcomes of the NED and Chair Appraisals
- Developed recommendations to the Council on NED Remuneration
- Developed recommendations to the Council on Chair Remuneration
- Developed recommendations to the Council on the reappointment of the Chair and the Chair terms and conditions
- Considered the time commitment of NEDs
- Considered the outcome of the NED appraisals table of impact
- Approved the content of the Governors NRC annual review for 2022/23
- Developed recommendations to the Council on the Chair / NED Appraisal Process 2022
- Developed recommendations regarding NED Reappointments

In-year, following recommendations from the Governors Nominations and Remuneration Committee the Council of Governors has:

- Approved the appointment of Professor Janet Hirst[32], Non-Executive Director, nominated by the School of Medicine, University of Leeds from 13 September 2021 to 12 September 2024
- Approved the appointment of Ms Sughra Nazir[33], Non-Executive director from 20 January 2022 to 19 January 2025
- Approved the reappointment of the Chairman, Dr Maxwell Mclean[34] for a further term of three years effective from 1 May 2022 to 30 April 2025.

With the support of the Trust the NRC has with regard to the new appointment of Ms Sughra Nazir:

- Developed the brief for the NED appointment.
- Confirmed the appointment of Gatenby Sanderson, Executive Search Agency, to assist with the appointment.
- Agreed the job description and person specification along with a schedule for the appointment process.
- Confirmed the interview process which involved a governor led stakeholder panel.
- Confirmed the members of the interview panel.
- Presented the recommendation for the appointment to the Council of Governors in October 2021 where it was approved.

With regard to Gatenby Sanderson:

- There are no other services provided to the Trust during the financial year by Gatenby Sanderson.

[31] https://www.bradfordhospitals.nhs.uk/doctors/julie-lawreniuk/
[32] https://www.bradfordhospitals.nhs.uk/doctors/janet-hirst/
[33] https://www.bradfordhospitals.nhs.uk/doctors/sughra-nazir/
[34] https://www.bradfordhospitals.nhs.uk/doctors/maxwell-mclean/

- Gatenby Sanderson was appointed following consultation with the Governors Nominations and Remuneration Committee and the Trust Procurement Team following the selection of an external agency via the 'Crown Commercial Services framework'.
- The Governors' Nominations and Remuneration Committee scrutinised all applications presented for the role of Non-Executive Director, determined the long-listing and determined the shortlisting for the post. In this regard it satisfied itself that the advice received within the bounds of the brief provided to Gatenby Sanderson was objective and independent. The FPP requirements and references for Ms Sughra Nazir were managed by the Trust's HR department.
- The fees paid to Gatenby Sanderson are subject to commercial confidentiality however the charges fall within the bounds of those provided as part of the 'Crown Commercial Services framework'.

3.2.3.4. Disclosures required by Health and Social Care Act

Salaries over £150,000

There was no new appointment made in 2021/22 where a salary was over £150,000, neither was there any pay increase given which took a salary above £150,000.

Expenses claimed by directors

The total number of directors holding office during 2021/22 was 19 (the number in 2020/21 was 22). The number of directors receiving expenses during 2021/22 was six (the number in 2020/21 was five). The aggregate sum of expenses paid to directors in 2021/22 was £1,729 (in 2020/21 was £3,805).

Expenses claimed by governors

The total number of governors holding office during 2021/22 is 15 (the number in 2020/21 was 20). The number of governors receiving expenses during 2021/22 is nil (the number in 2020/21 was one). The aggregate sum of expenses paid to governors in 2021/22 is nil (in 2020/21 it was £108).

Figure 30 - Remuneration of senior managers 2021/22 (subject to audit

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

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long term performance related bonuses	All pension related benefits	Total
2021/22	(Bands of £5,000)	(to the nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
Maxwell Mclean (Chairman)	55 - 60	0	0	0	0	55 - 60
Mel Pickup (Chief Executive)	220 - 225	0	0	0	65.0 - 67.5	285 - 290
John Holden (Director of Strategy and Integration / Deputy Chief Executive)	145 - 150	0	0	0	42.5 - 45.0	185 - 190
Sajid Azeb (Chief Operating Officer/ Deputy Chief Executive)	135 - 140	0	0	0	77.5 - 80.0	215 - 220
Karen Dawber (Chief Nurse)	135 - 140	0	0	0	20.0 - 22.5	160 - 165
Ray Smith (Chief Medical Officer)	200 - 205	0	0	0	250.0 - 252.5	455 - 460
Matthew Horner (Director of Finance)[35]	145 - 150	0	0	0	70.0 - 72.5	220 - 225
Patricia Campbell (Director of Human Resources)	120 - 125	0	0	0	80.0 - 82.5	200 - 205
Paul Rice (Chief Digital & Information Officer) [36]	130 - 135	0	0	0	97.5 - 100.0	230 - 235
Mark Holloway (Director of Estates and Facilities)	115 - 120	0	0	0	92.5 - 95.0	210 - 215
Altaf Sadique (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Karen Walker (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Selina Ullah (Non-Executive Director)[37]	5 - 10	0	0	0	0	5 - 10
Barrie Senior (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Jon Prashar (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Julie Lawreniuk (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Mohammed Hussain (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15

[35] Matthew Horner (Director of Finance) - left the NHS Pension Scheme on 31 December 2021

[36] Paul Rice (Chief Digital and Information Officer) - In addition to this role, Paul Rice is also the Chief Digital & Information Officer at Airedale NHS Foundation Trust. A recharge at 40% was made by Airedale NHS foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust.

[37] Selina Ullah (Non-Executive Director) - until 31 August 2021

Janet Hirst (Non-Executive Director)[38]	5 - 10	0	0	0	0	5 - 10
Sughra Nazir (Non-Executive Director)[39]	0 - 5	0	0	0	0	0 - 5

[38] Janet Hirst (Non-Executive Director) - from 13 September 2021
[39] Sughra Nazir (Non-Executive Director) - from 20 January 2022

Figure 31 - Remuneration of senior managers 2020/21 (subject to audit)

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

Name and title 2020/21	Salary and fees (bands of £5,000) £000s	All taxable benefits (to the nearest £100) £00s	Annual performance related bonuses (bands of £5,000) £000s	Long-term performance related bonuses (bands of £5,000) £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Maxwell Mclean (Chairman)	55 - 60	0	0	0	0	55 - 60
Mel Pickup (Chief Executive)	220 - 225	0	0	0	160.0 - 162.5	380 - 385
John Holden (Director of Strategy and Integration/Deputy Chief Executive)	145 - 150	0	0	0	82.5 - 85.0	230 - 235
Sandra Shannon (Chief Operating Officer/Deputy Chief Executive)[40]	100 - 105	0	0	0	22.5 - 25.0	125 - 130
Sajid Azeb (Chief Operating Officer/DeputyChief Executive)[41]	60 - 65	0	0	0	30.5 - 32.5	95 - 100
Karen Dawber (Chief Nurse)	145 - 150	0	0	0	32.5 - 35.0	180 - 185
Bryan Gill (Chief Medical Director)[42]	175 - 180	0	0	0	0	175 - 180
Ray Smith (Chief Medical Officer)[43]	50 - 55	0	0	0	65.0 - 67.5	115 - 120
Matthew Horner (Director of Finance)	145 - 150	0	0	0	25.0 - 27.5	170 - 175
Patricia Campbell (Director of Human Resources)	115 - 120	0	0	0	2.5 - 5.0	120 - 125
Cindy Fedell (Chief Digital and Information Officer)[44]	70 - 75	0	0	0	45.0 - 47.5	115 - 120
Paul Rice (Chief Digital & Information Officer)[45]	30 - 35	0	0	0	12.5 - 15.0	45 - 50

[40] Sandra Shannon (Chief Operating Officer/Deputy Chief Executive) - Chief Operating Officer until 31 October 2020, Deputy Chief Executive from 16 November 2020to 31 January 2021

[41] Sajid Azeb (Chief Operating Officer) - from 12 October 2020 and in addition Deputy Chief Executive from 12 April 2021

[42] Bryan Gill (Chief Medical Director) - retired 31 December 2020

[43] Ray Smith (Chief Medical Officer) - from 1 January 2021

[44] Cindy Fedell (Chief Digital and Information Officer) - until 30 September 2020. In addition to this role, Cindy Fedell was appointed as the Chief Digital & Information Officer at Airedale NHS Foundation Trust from June to September 2020. Bradford Teaching Hospitals NHS Foundation Trust re-charge 40% of costs to Airedale NHSFoundation Trust for this role.

[45] Paul Rice (Chief Digital and Information Officer) - from 1 January 2021. In addition to this role, Paul Rice was appointed as the Chief Digital & Information Officer atAiredale NHS Foundation Trust from January to March 2021. A recharge at 40% was made by Airedale NHS foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust.

Mark Holloway (Director of Estates and Facilities)[46]	30 - 35	0	0	0	12.5 - 15.0	45 - 50
Altaf Sadique (Non-Executive Director)[47]	0 - 5	0	0	0	0	0 - 5
Karen Walker (Non-Executive Director)[48]	0 - 5	0	0	0	0	0 - 5
Selina Ullah (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Barrie Senior (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Jon Prashar (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Julie Lawreniuk (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Mohammed Hussain (Non-Executive Director)	10 - 15	0	0	0	0	10 – 15
Laura Stroud (Non-Executive Director)	0	0	0	0	0	0
Trudy Feaster-Gee (Non-Executive Director)	0	0	0	0	0	0

Note: The value of pension benefits accrued during the year is calculated as the real increase in pension multiplied by 20, less the contributions made by theindividual. The real increase excludes increases due to inflation or any increase or decrease due to a transfer of pension rights.
This value derived does not represent an amount that will be received by the individual. It is a calculation that is intended to provide an estimation of thebenefit being a member of the pension scheme could provide.

The pension benefit table provides further information on the pension benefits accruing to the individual. As non-executive members do not receivepensionable remuneration, there are no entries in respect of pensions for non-executive members.

[46] Mark Holloway (Director of Estates and Facilities) - from 12 November 2020
[47] Altaf Sadique (Non-Executive Director) - from 1 December 2020
[48] Karen Walker (Non-Executive Director) - from 1 January 2021

Figure 32 - Pension entitlements of senior managers 2021/22 (subject to Audit)

Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2022	Lump sum at pension age related to accrued pension at 31st March 2022	CETV at 1st April 2021	Real increase in CETV	CETV at 31st March 2022
2021/22	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)			
Mel Pickup (Chief Executive)	2.5 - 5.0	0 - 2.5	100 - 105	235 - 240	1,951	82	2,074
John Holden (Director of Strategy and Integration / Deputy Chief Executive)	2.5 - 5.0	0 - 2.5	65 - 70	140 - 145	1,278	56	1,361
Sajid Azeb (Chief Operating Officer)	2.5 - 5.0	5.0 - 7.5	40 - 45	70 - 75	494	51	567
Ray Smith (Chief Medical Officer)	12.5 - 15.0	25.0 - 27.5	85 - 90	205 - 210	1,518	263	1,818
Karen Dawber (Chief Nurse)	0 - 2.5	(0 - 2.5)	45 - 50	95 - 100	811	21	854
Matthew Horner (Director of Finance)[49]	2.5 - 5.0	0 - 2.5	60 - 65	125 - 130	1,036	63	1,120
Patricia Campbell (Director of Human Resources)	2.5 - 5.0	5.0 - 7.5	55 - 60	140 - 145	1,129	94	1,246
Paul Rice (Chief Digital & Information Officer)	5.0 - 7.5	7.5 - 10.0	45 - 50	90 - 95	749	95	867
Mark Holloway (Director of Estates and Facilities)	5.0 - 7.5	7.5 - 10.0	25 - 30	45 - 50	320	62	400

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

[49] Matthew Horner (Director of Finance) - left the NHS Pension Scheme on 31 December 2021

3.2.3.5. Fair pay multiples (subject to audit)

NHS foundation trusts are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the lower quartile, median and upper quartile remuneration of the organisations workforce.

The banded remuneration of the highest paid Director in the Trust in the financial year 2021/22, was £222,500 (2020/21: £222,500). There has been no change between years (2020/21 6.3% reduction). Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. No performance pay or bonus payments were made to the highest paid Director.

For employees of the Trust as a whole, excluding the highest paid director, the range of remuneration in 2021/22 was from £222,500 to £7,500 (2020/21: £222,500 to £7,500). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by the full time equivalent number of employees) between years is 3.83%. No employees received remuneration in excess of the highest-paid director in 2021/22. No performance pay or bonus payments were made in year.

The remuneration of the employee at the 25th percentile, median and 75th percentile is set out below. The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.

Figure 33 - Pay Ratio Information

2021/22	25th percentile	Median	75th percentile
Salary component of pay	£20,330	£31,534	£39,467
Total pay and benefits excluding pension benefits	£20,330	£31,534	£39,467
Pay and benefits excluding pension: pay ratio for highest paid director	10.9: 1	7.1: 1	5.6: 1

2020/21	25th percentile	Median	75th percentile
Salary component of pay	£19,737	£30,615	£38,694
Total pay and benefits excluding pension benefits	£19,737	£30,615	£38,694
Pay and benefits excluding pension: pay ratio for highest paid director	11.3: 1	7.3: 1	5.8: 1

Signed

Mel Pickup
Chief Executive
21 June 2022

3.3. STAFF REPORT

3.3.1. ANALYSIS OF STAFF COSTS AND NUMBERS (SUBJECT TO AUDIT)

Figure 34 - Staff Costs 2021/22 (subject to audit) (£'000)

Staff Costs	Permanently employed	Other	2021/22 Total	2020/21 Total
Salaries and wages	255,210	642	255,852	243,348
Social security costs	24,369	0	24,369	24,523
Apprenticeship Levy (pay element)	1,276	0	1,276	1,196
Pension cost - defined contribution plans employer's contributions to NHS pensions	28,543	0	28,543	29,598
Pension cost - employer contributions paid by NHSE on provider's behalf	12,500	0	12,500	12,001
Temporary staff - agency/contract staff	0	10,079	10,079	8,267
Total gross staff costs	**321,898**	**10,721**	**332,619**	**318,934**

Figure 35 - Average number of employees Whole Time Equivalent for 2021/22 (subject to audit)

	Total Number	Permanent Number	Other Number
Medical and dental	881	873	8
Administration and estates	1,882	1,778	104
Healthcare assistants and other support staff	714	712	2
Nursing, midwifery and health visiting staff	2,044	1,610	434
Scientific, therapeutic and technical staff	777	768	9
Other	3	3	0
Total average numbers	**6,301**	**5,744**	**557**
Of which, number of employees (WTE) engaged on capital projects	9	9	0

Figure 36 - Average number of employees Whole Time Equivalent for 2020/21

	Total Number	Permanent Number	Other Number
Medical and dental	843	837	6
Administration and estates	1,892	1,796	96
Healthcare assistants and other support staff	712	710	2
Nursing, midwifery and health visiting staff	2,061	1,626	435
Scientific, therapeutic and technical staff	766	756	10
Other	2	2	0
Total average numbers	**6,276**	**5,727**	**549**
Of which, number of employees (WTE) engaged on capital projects	9	9	0

Figure 37 – 31 March 2022 distribution of staff, male and female (subject to audit)

At 31 March 2022 – headcount figures, excluding agency and contract and bank staff			
Group	Female	Male	Total
Directors	8	11	19
+Senior Managers	268	144	412
Other Employees	4,730	1,312	6,042
Total	**5,006**	**1,467**	**6,473**

Figure 38 – 31 March 2021 distribution of staff, male and female

At 31 March 2021 – headcount figures, excluding agency and contract and bank staff			
Group	Female	Male	Total
Directors	6	10	16
Senior Managers	258	149	407
Other Employees	4,748	1,296	6,044
Total	**5,012**	**1,455**	**6,467**

Figure 39 - Sickness Absence Data 1 January 2021 – 31 December 2021

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2021	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE-Days Available	FTE-Days recorded Sickness Absence
5,694	82,605	14.5	2,078,254	134,004

The Department for Health and Social Care Group Accounting Manual 2021/22[50] requires that sickness absence data be reported by each individual body in their annual report. The sickness absence figures are reported on a calendar year basis, rather than for the financial year. This is because we are obliged to use only the published statistics which are produced using data from the ESR Data Warehouse. The sickness absence rate for the period 1 January 2020 to 31 December 2020 was 6.38%.

Information about staff turnover for 2021/22 is also available on the website of NHS Digital[51]

3.3.2. STAFF POLICIES AND ACTIONS

Disability equality and disability leave policy

In line with our contractual obligations and as part of our wider activity on the Workforce Disability Equality Standard (WDES) we have in place a disability equality and disability leave policy[52] which is available to all staff on our intranet. As part of the policy implementation, training to accompany the policy was developed and delivered to a range ofmanagers across the Trust, including colleagues from human resources and organisational development.

The disability equality and disability leave policy has been in place for 2 years now, and feedback received so far has been very positive. We are now engaging with members of our Enable Staff Equality Network (staff with a disability or long term health condition), with HR and managers across the Trust around the scheduled review of the policy. Further training will be rolled out during 2022. This had been put on hold due to new COVID-19 pressures. Further work is being developed with the aim of raising the profile of disability equality across the Trust. For example, the diversity census exercise was rolled out in March 2021 with some detailed communications about the benefits of equality monitoring

[50] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2021-to-2022
[51] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
[52] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/05/PP56-2019-Disability-Equality-and-Disability-Related-Leave-Policy.pdf

and why it's important to have such information, we will continue to share this information with staff throughout 2022/2023. There is particular focus in increasing our disability declaration rates across the Trust.

Trans equality policy

The revised Trans equality policy was approved on 3 August 2020 and we continue, as a Trust, to develop our understanding and support for LGBT+ colleagues and patients through the ongoing roll out of the Rainbow Badge training/ pledge. We are also currently working to refresh and re-invigorate our LGBT+ staff equality network to ensure it is thriving in line with national ambitions for staff equality networks.

Activities during the year to improve the diversity and inclusiveness of the workforce

Details of equality, diversity and inclusion activity and impact can be found in the Equality Report at section 3.4.

Actions taken to inform on matters of concern, consult with, and involve employees

In what was another difficult year we made every effort to ensure that our staff were regularly communicated with, were consulted and that relevant and up to date information was easily available.

As examples, the equality, diversity and inclusion team have held a series of open invitation question and answer sessions around the COVID-19 vaccine and the vaccine mandate for NHS staff, bringing in a series of expert panellists to answer questions, generate useful discussion and help alleviate any concerns. All COVID-19 related information has been made available on the Trust Intranet.

Following the launch of the new THRIVE site for staff, our Chief Executive Mel Pickup has started to host regular "THRIVE live" question and answer sessions for staff. These are open invitation meetings with staff via Microsoft Teams where updates are given, and staff are free (openly or on an anonymous basis) to engage with our Chief Executive Officer and ask any questions or raise any concerns.

A Wellbeing Wednesday bulletin continues to be published every week and has proved very popular, incorporating a wide range of resources signposted to staff both interms of local and national resources and events.

Our consultation forums with staff side were held virtually and regular meetings were held between the Director of HR and our partnership lead to ensure that any staff concerns couldbe dealt with quickly. We re-launched our appraisal process so that this was a 'conversation'which focussed on wellbeing, what was new, what's next, and signposting to support services so the well-being of staff was front and centre.

Our staff network activity has been strong throughout the year. This is reported on in more detail in section 3.4.

Health and safety performance

The Health and Safety department has refocused its priorities during 2021/22 as a result of the pandemic. The Health and Safety department has undertaken numerous risk assessments, safe systems of work, COVID-19 security audits as well as stepping into alternative roles required for the unique situation.

During 2021/22 the Health and Safety department undertook a gap analysis to evaluate and refocus health and safety in relation to legislation and they identified gaps to facilitate continued improvement. The gaps identified have provided the Trust with an overall level of compliance with health and safety and an organisational action plan has been developed.

In 2022/23 the Health and Safety department will continue to mitigate any risks identified and review compliance with legislation. The main focus will be on achieving the actions identified by the organisational action plan.

Occupational Health

Over the last 12 months occupational health has continued to focus on assisting managers and staff to work safely throughout the pandemic by ensuring risk assessments are refined and isolation and return to work guidance is regularly reviewed to reflect National guidance. Occupational Health worked closely with colleagues in HR, managers and staff across the Trust to prepare for the introduction of Regulations requiring COVID-19 vaccination as a condition of deployment. We have provided adjustment advice for staff with long-COVID-19 symptoms to enable successful returns to work as well as offering on-going support where required.

We have enhanced access to psychological support by recruiting a Specialist Occupational Therapist offering therapeutic 1-1 support for staff with issues such as fatigue management, stress awareness, relaxation and sleep hygiene. Group sessions have also been made available offering staff short, practical self-help techniques when dealing with stress and overwhelm in the work place. Two clinical psychologists now provide support from the Workplace Health and Wellbeing Centre to staff that are experiencing more complex psychological problems such as moderate anxiety, depression, OCD or PTSD which have a direct impact on their ability to work.

Counter Fraud and Corruption

See section 3.5.5.2.

3.3.3. STAFF SURVEY

3.3.3.1. Staff Engagement

Our vision is to be an outstanding provider of healthcare, research and education, as well as agreat place to work. We know that if staff are happy in their place of work that this has a direct impact on their performance and therefore on patient experience and outcomes.

The COVID-19 pandemic has continued to affect staff engagement. A significant number of staff have had to work differently, many in unfamiliar areas and the pressure on staff – both in and out of work - has been relentless.

These factors will have impacted on engagement generally and also on responses to specific themes within the staff survey such as ‘morale’, ‘we are safe and healthy’, ‘we work flexibly’ and ‘we are a team’.

Over the last year, we have launched ‘Thrive’ – a one stop shop for all the things that staff need to know/are entitled to as a member of staff at the Trust. This includes wellbeing support, development opportunities, rewards and benefits, and opportunities for staff to have their say on what matters to them. Thrive is an online portal that all staff can access via laptop/smartphone/tablet and in the first 5 months, Thrive has had over 28,000 views.

However, we want to make sure that Thrive is much more than just a portal. We have been running Thrive roadshows at all Trust sites so that staff have access to face to face contact and opportunities to find out what is available to them as a valued member of staff. We have also continued to invest in staff facilities with the opening of a new central staff change facility at BRI and state of the art cycle hubs at BRI and St Luke's Hospital (SLH).

Alongside the launch of Thrive, we have also focused particularly on increasing employee voice opportunities. This has led to the creation of a group of staff engagement champions, 'Staff Engagers' – who provide a link into services. They offer real time feedback about what is going on in their area and also spread awareness of corporate / organisational activities. We have also launched 'Thrive Live' which is a monthly question and answer session with the Chief Executive and Executive Team. This enables staff to ask any question they may have and increases the visibility of leadership. We also participate in the quarterly People Pulse Survey.

We have also maintained our focus on wellbeing – with our weekly Wellbeing Wednesday newsletter signposting to local, regional and national support. A Specialist Occupational Therapist offers therapeutic 1-1 support for staff with issues such as fatigue management, stress awareness, relaxation and sleep hygiene and a Clinical Psychologist is also now available from the Workplace Health and Well-Being Centre for staff who are experiencing more complex psychological problems such as moderate anxiety, depression, OCD or PTSD which have a direct impact on work. Another focus has been on menopause support to staff with the production of new guidance to managers, on-line wellbeing sessions for staff to join in to and the creation of a support network.

3.3.3.2. NHS staff survey

The NHS staff survey is conducted annually. This year there was a significant improvement in the Trust's staff engaging with the survey compared to previous years with more staff than ever before taking the opportunity to have their say. The response rate to the 2021 survey was 47.2% compared to 44% for the 2020 survey despite the challenges with staff engagement presented by the pandemic.

This year, the survey has been grouped into nine themed areas. For the first time, results have been aligned to the seven elements of the People Promise which means statistical analysis against 2020 results is not always possible. However, two further elements are also included - staff engagement and morale – both of which can be compared against 2020 data.

In summary, we are above average in one of the nine themed areas: we are always learning. We are the same as the average score for four of the themed areas: we are recognised and rewarded, we each have a voice that counts, staff engagement and morale. We are slightly below average in four (3 of these areas by 0.1) of the themed areas: we are compassionate and inclusive, we are safe and healthy, we work flexibly and we are a team.
Scores for each indicator together with that of the survey benchmarking group which is comprised of Acute and Acute and Community NHS Trusts is presented below:

Figure 40 - NHS Staff Survey People Promise Indicators Scores

People Promise Theme	Trust Score 2021	Benchmark Score 2021
We are compassionate and inclusive	7.1	7.2
We are recognised and rewarded	5.8	5.8
We have a voice that counts	6.7	6.7

We are safe and healthy	5.8	5.9
We are always learning	5.3	5.2
We work flexibly	5.8	5.9
We are a team	6.4	6.6

An additional two themes included engagement and morale, for these areas a year-on-year comparison is possible and is shown below.

Figure 41 - NHS Staff Survey Indicator Scores

	2021 Trust score	2021 benchmark score	2020 Trust score	2020 benchmark score	2019 Trust score	2019 benchmark score
Engagement	6.8	6.8	7.1	7.0	7.2	7.0
Morale	5.7	5.7	6.3	6.2	6.4	6.1

The table below shows our Trust scores and benchmarking data for the indicators that were part of the 2020 and 2019 staff survey.

Figure 42 - NHS Staff Survey Indicator Scores 2019 and 2020

	2020 – Trust Score	2020 Benchmark Score	2019 – Trust Score	2019 – Benchmark Score
Equality, diversity and inclusion	8.9	9.1	9.0	9.0
Health and Wellbeing	6.0	6.1	6.1	5.9
Immediate Managers	6.7	6.8	7.0	6.8
Morale	6.3	6.2	6.4	6.1
Quality of Care	7.6	7.5	7.6	7.5
Quality of Appraisals	n/a	n/a	5.7	5.6
Safe Environment – Bullying and Harassment	7.9	8.1	8.1	7.9
Safe Environment – Violence	9.5	9.5	9.5	9.4
Safety Culture	6.8	6.8	6.9	6.7
Staff Engagement	7.1	7.0	7.2	7.0
Team Working	6.5	6.5	6.8	6.6

The survey has highlighted the following key priority areas for particular focus over the next year:

- Improving staff engagement levels and morale – a focus on supporting each other, ensuring the organisation is a compassionate place to work;
- Increasing awareness of the BTHFT 'Thrive' offer;
- Reward and recognition – a focus on staff feeling that they are valued for what they do;
- Teamwork - a focus on team effectiveness and the role of line managers; and
- Ensuring that staff feel confident and safe to speak out if there is something that needs to change.

We also aim to improve the indicator scores for 'we are compassionate and inclusive', 'we are safe and healthy', 'we work flexibly' and 'we are a team' in line with the benchmarking group. An action plan is under development to ensure priorities and actions are clear and

timely objectives are set. These will be monitored on a quarterly basis through People Academy.

3.3.4. TRADE UNION FACILITY TIME

Figure 43 - The total number of employees who were relevant union officials during 2021/22

Number of employees who were relevant union officials during the relevant period	64
Full-time equivalent employee number	57.03

Figure 44 - Percentage of time spent on facility time

Percentage of time	Number of employees
0%	31
1-50%	32
51%-99%	0
100%	1

Figure 45 - Percentage of pay bill spent on facility time

Total cost of facility time	£28,689
Total pay bill	£332,278,537
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.009%

Paid Trade Union Activities

The Trust has a Facilities for Staff Organisations Policy which sets out clear procedures on time off for trade union duties. This recognises the valuable work undertaken by trade unions working in partnership with the Trust. The Trust is committed to partnership working; partnership working brings significant benefits to patient care and staff engagement. The Facilities for Staff Organisations Policy requires Trade Union representatives to record their time off under these Regulations and time off is recorded using e-Roster and by completing a form, all time recorded is uploaded to ESR. This information then facilitates the production of reports on time off for trade union duties.

3.3.5. CONSULTANCY AND OFF-PAYROLL ARRANGEMENTS (SUBJECT TO AUDIT)

When considering the employment of workers off-payroll, the Trust completes an Employer Status Indicator test that can be found on HMRC's website. Any engagements deemed by the test to constitute employment must be paid through payroll. The Trust also requires all roles required in statute, such as the Chief Executive, Chief Nurse, Medical Director and Director of Finance, to be on payroll.

The Trust did not engage in any off-payroll worker engagements at any point during the year ended 31 March 2022 earning £245 per day or greater.

The Trust did not engage off-payroll board member, and/or, senior officials with significant financial responsibility, between 1 April 2021 and 31 March 2022.

In 2021/22 the Trust spent £1,025,005 on consultancy (£984,560 in 2020/21).

3.3.6. EXIT PACKAGES (SUBJECT TO AUDIT)

Figure 46 - All exit packages 2021/22

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Exit package cost band (including any special payment element)			
<£10,000	1	1	2
£10,000 - £25,000	1	1	2
£25,001 - 50,000	0	0	0
£50,001 - £100,000	0	0	0
£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	**2**	**2**	**4**
Total resource cost (£)	£17,900	£19,000	£36,900

Figure 47 - All exit packages 2020/21

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Exit package cost band (including any special payment element)			
<£10,000	0	4	4
£10,000 - £25,000	0	1	1
£25,001 - 50,000	0	0	0
£50,001 - £100,000	0	0	0
£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	**0**	**5**	**5**
Total resource cost (£)	£0	£35,000	£35,000

Figure 48 - Exit packages, non-compulsory departure

	2021/22 Agreement number	2021/22 totalvalue of agreements £000	2020/21 agreement number	2020/21 totalvalue of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	4	£16,000
Exit payments following employment tribunals or court orders	2	£19,000	1	£19,000

Non-contractual payment requiring HM Treasury (HMT) approval	0	0	0	0
Total	2	£19,000	5	£35,000
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

3.3.7. GENDER PAY GAP

See section 3.4.3. of the Equality Report.

3.4. EQUALITY REPORT

In what has been a difficult few years for so many, there have equally been great advances in the equality, diversity and inclusion (EDI) agenda at the Trust. We have developed new and effective ways of engaging and consulting with our diverse staff, patients and communities and the global pandemic has shone a light on existing issues of inequality and provided opportunity to address these with unprecedented vigour, both on a national, regional and local basis.

Establishing our Equality and Diversity Council

In January 2021; as part of our commitment in advancing workforce equality and to tackling the wider population health inequalities within the district we launched our strategic Equality and Diversity Council (EDC). The group comprises of key members from across the Trust's core functions, along with individuals who have a pivotal role to play in influencing change both across our organisation and within the wider community. As Executive Sponsor for Diversity and Inclusion across the Trust and the Trust Lead for population health inequalities within the District our Chief Executive Mel Pickup is demonstrating the Trust's commitment to this agenda by chairing and leading this important meeting. All three of our established staff equality networks have representation and a real voice in this key strategic decision making forum which has become well established over the last 12 months. This work ensures equality, diversity and inclusion is high on the agenda for the whole organisation and ensures the principles of EDI are at the core of all our functions for our workforce and for the patients andcommunities we serve.

Staff engagement

Considerable efforts have been made again over the last twelve months to engage with staff across the Trust. In particular, there have been a number of targeted virtual and face-to-face Q&A events aimed at staff that have queries or concerns about the COVID-19 vaccine. Whilst we have opened these safe space discussion forums to all staff we have been mindful of the disproportionate impact of COVID-19 and the proposed vaccine mandate on some of our diverse members of staff. By holding virtual webinars we were able to engage with much larger numbers of staff. The sessions have been facilitated by the Head of Equality, Diversity and Inclusion along with members of the Executive Management Team and respected clinical practitioners as 'panel experts' who have listened,and provided reassurance and support on the challenges and concerns raised in relation to COVID-19 and vaccine hesitancy.

Launch of the Trust Mediation Service

Our staff survey results consistently tell us that we need to take action to address issues of dignity and respect in the workplace. We know that as an NHS Trust we are not an outlier in this respect, but are keen to ensure that we adopt best practice approaches in addressing this issue and developing a culture of dignity and respect in the workplace. Further information about the Trust' approach to "Civility in the Workplace" can be found in section 3.3.3 above (Staff Survey). One building block to supporting this culture change is the launch of a new Workplace Mediation Service designed to support staff in resolving workplace conflict at an early stage and in reaching mutual understandings to improve working relationships for the future. The service has been set up and is co-ordinated by the equality, diversity and inclusion team, with 7 staff who are trained, accredited workplace mediators. Following a soft launch of the service early in 2022 a formal launch is planned for May 2022.

Further development of the EDI branding

A new Trust-wide diversity and inclusion strapline was developed in 2020 in consultation with our staff equality networks and wider staff. This signals a positive commitment to embedding and mainstreaming diversity and inclusion in everything we do. We also launched a new intranet site for staff which provides a central hub for all information, guidance and latest news relating to EDI. We continue to ensure that this strapline and branding is present in all Trust communications relating to EDI reinforcing our message that "we value diversity and champion inclusion".

Local, regional and wider Integrated Care System (ICS) activity

We are involved and engaged with several local, regional and wider ICS activities, including:

- Bradford District and Craven (BD&C) Health and Social Care Integrated People Board (IPB):
- Public Sector Equalities Working Group
- West Yorkshire Health and Care Partnership Race Equality Network
- BD&C equality impact assessment, vaccination roll out programme

Project SEARCH

Project SEARCH is a transition to work programme committed to transforming the lives of young people with learning disability and autism in Braford. The Trust works in partnership with Bradford College, as the Education Provider and HFT, who are a national charity who offer job coaching and follow on support for the young people with Project SEARCH. Project SEARCH is now in its 9th year at the Trust. Excluding the coming year's cohort, there have been 57 graduates to date. 42 of the 57 who have graduated have found paid employment (74%). 33 of these found employment of a minimum of 16 hours and within 9 months of completing the programme, the other 9 either found employment after 9 months from completion, or of up to 16 hours employment. 18 found employment within the Trust.

Interpreting Services

Our interpreting services team supported people on no fewer than 50,437 occasions, and in over 50 different languages. It meets the needs of non-English speakers and British Sign Language users, primarily through face-to-face interpreting. We also provide support using telephone and video, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through our team. During the pandemic, we have been providing more support through telephone and video interpreting services to non-English speakers. The top 10 languages requested are shown below

Figure 49 - Top 10 languages requested through interpreter services

Language	Number of requests
Urdu/Punjabi	24,440
Czech/Slovak	6,782
Polish	3,830
Arabic	2,964
Bengali	2,801
Hungarian	1,380
Kurdish	1,005
Pushto	961
Romanian	853
Gujarati	603

3.4.1. STAFF EQUALITY

Workforce Targets

In September 2022 we were proud to report that we achieved our target of having a workforce that mirrors the local community in terms of ethnicity – having set a challenging, but achievable, target of 35% staff from an Ethnic Minority background by September 2025.

Based on our current trajectory we expect to not only meetour target but exceed it by just over 4%.

We are now focussing our efforts on ensuring we have 35% Ethnic Minority representation at all levels of the organisation, as among Band 8+ colleagues this continues to be more of a challenge and currently stands at 14.5%. Despite having Ethnic Minority representation on our Executive ManagementTeam and increased representation on our Trust Board, we will be exploring more of a positive action and targeted engagement approach in the development of both our existing Ethnic Minority staff and in how we recruit to senior leadership roles. We have extended this focus to other groups within the workforce who are currently under-represented at senior management levels which includes those with a disability or long term health condition and aspiring female leaders.

A range of initiatives are now in place to accelerate our progress against these ambitions. Such initiatives include: reciprocal mentoring; and diverse staff representation on recruitment and selection panels for all posts at band 8a and above; and a proactive approach to recruiting diverse staff, considering positive action and targeted recruitment approaches.

Overhaul of the Recruitment and Selection Policy and Practices

Following the overhaul of our Recruitment and Selection Policy and practices in 2021 we are also developing a recruitment and selection toolkit for job applicants using best practice examples to highlight ways in which the Trust will promote equality, diversity and inclusion in its recruitment practices. The recruitment and selection training for managers has also been reviewed and refreshed in line with the updated policy and to ensure all recruiting managers are effectively trained to ensure our recruitment practices are inclusive.

Launch of BTHFT Reciprocal Mentoring Scheme

In 2020 our reciprocal mentoring scheme was launched and then was paused a number of times due toCOVID-19 priorities. However, the application process has now been successfully re-opened, with plans under way to officially launch the scheme in June 2022. In our first tranche of applicants we have taken a positive action approach in targeting Ethnic Minority staff and those with a disability or long term health condition to be paired with members of our Executive/ Non-Executive Team.

Leadership Development for our diverse staff

We continue to focus our efforts in supporting and encouraging senior colleagues from diverse backgrounds on various leadership development programmes. Notable successes include:

- Two senior Ethnic Minority staff successfully joined the WY&H BAME Fellowship. We are seeing positive outcomes from this fellowship leading to internal and external promotions.
- Successful launch of our very first REACH external mentoring programme in partnership with Saxton Bampfylde (Global Executive Search Consultants). Five members of staff from an Ethnic Minority background were matched with suitable mentors from outside the NHS to help them reach their potential through a series of one to one meetings and coaching discussions. We received positive feedback from this scheme reporting significant personal development, an evident increase in confidence and clarity about their career direction. Three of the five participants were successful in attaining a promotion within the NHS.
- Development of the Trust' Reciprocal Mentoring Scheme (as above).

With our continued focussed efforts in raising the profile of EDI across the Trust, we will continue to ensure our workforce reflects the communities that we serve across all levels of the organisation.

3.4.2. WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

Our data submissions for the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) were made by 31st August 2021 as per our contractual requirements.

This year's action plans for both WRES and WDES will continue to develop some of the focussed objectives from last year and with a few key additions that if addressed in detail and positively, will have a significant impact. In doing this, it is anticipated that this will bring about positive change across the Trust resulting in an improvement in our WRES and WDES indicators.

We have also successfully rolled out the Sunflower Lanyard scheme (providing support for people with hidden disabilities), with lanyards now available for staff, patients and visitors who need them.

In July 2021 we launched our first ever disability equality video which was produced by the Enable staff equality network and then in December 2021 we were successful in our bid to obtain £15k funding from the WDES Innovation fund. This will be used to develop a Disability Inclusion Project to further raise the profile of disability equality in the Trust. Our EDI team are once again working with the Enable Staff Equality Network and Project

Search to co-produce a travelling photography and video exhibition/ living library's carousel which will be launched at the 11th May Staff Networks Day celebration event.

Our staff networks have been instrumental in the development of both our WRES and WDESaction plans, which were again grouped into five themes to reflect both the WRES/WDES requirements and our BTHFT People Strategy, including the NHS People Plan,which places significant focus and attention to the wider system diversity and inclusion agenda.

3.4.3. GENDER PAY GAP

On 31 March 2021 77.23% of our workforce was women and 22.77% were men. Our mean ordinary pay gap as at March 2021 was 23.63%. Since we began to report our Gender Pay Gap in 2018 (as at March 2017) when our GPG was 31.34%, we have seen improvement; however, the Trust still has work to do to reduce the gap that exists. This year we have seen a decrease in our mean average pay gap (by 2.73%), a decrease in our median average pay gap (by 2.29%) and a decrease in our mean average bonus pay gap (by 2.29%). The median average bonus pay gap has stayed the same at 33.33%. We have also seen a 1% increase in women in the upper quartile (higher paid staff), a 2% increase in women in medical and dental roles and a 1% increase in men in admin and clerical roles (one area where men are currently under-represented).

A number of focus groups were held in 2021 to further explore our Gender Pay Gap data and through co-production a detailed Gender Equality Action Plan was developed. These focus groups were led by the Director of HR who has become a Gender Equality Champion. There is still work to do and a gender equality reference group has been established to explore some of the data and in more detail and accelerate progress. Our current action plan focusses on addressing issues in the following key areas:

- Increasing engagement with aspiring females and representation of women in senior management roles. Exploring potential "blockers" for women progressing into senior management roles.
- Addressing the underrepresentation of men at all levels of the organisation and challenging the traditionally female role stereotypes.
- Promoting a culture of flexible working.

In March 2022 we held our first International Women's Day virtual event. This was an uplifting and inspirational panel event where we celebrated the achievements of some of our successful female leaders from diverse backgrounds helped to raise the profile of gender equality at the Trust. Following on from the success of this event we are planning to hold a series of gender equality masterclasses on a range of subjects, ensuring we also highlight the role of men in gender equality.

3.4.4. EQUALITY AND DIVERSITY TRAINING

The diversity and inclusion unit have worked closely with the organisational development team during 2021/2022 to co-produce EDI related courses which focus on inclusive and compassionate leadership and civility in the workplace. We are in the process of developing some training around anti-racism in response to the call for action from the Chief People Officer for NHS England. A number of focus groups took place during 2021 to ensure the training is aligned to address key areas of priority. The training will be developed in conjunction with our Race Equality Staff Inclusion Network to ensure we incorporate case studies to bring understanding and empathy.

Our Recruitment and Selection training has been refreshed to provide clear direction from an equality, diversity and inclusion perspective. We have employed a trainer to provide some intensive training to line managers to ensure all line managers who are involved in recruitment and selection are comprehensively trained. We are on target to achieve this target with 22 classes taking place from January to March 2022 and with 152 managers receiving the refreshed training so far. Delegates have said they have enjoyed discussions around unconscious bias and feel they have been encouraged to think more deeply about the impact of discrimination in the recruitment and selection process and how they can prevent this.

We continue to roll out our staff induction, ensuring the right messages are being given in terms of our diversity and inclusion agenda and how we link this agenda to patient care and patient experience agenda and will be working to review and re-launch our EDI training for line managers during 2022/2023.

3.4.5. STAFF ADVOCATES

Our staff advocacy service was launched in 2018 aimed at ensuring staff feel supported in the workplace and there is a sense of belonging and respect. This is now an established way of providing support to staff who have issues relating to, for example, discrimination, harassment and bullying or workplace conflict. It helps us to identify “hot spot” areas that may require additional action or focus to improve the working lives of staff. Building on this success; review of the Staff Advocacy Service is currently under way and we are working on aligning this activity with a Civility awareness campaign which also involves development of a new behavioural framework, training, policy review and raising awareness around Hate Crime.

3.4.6. STAFF NETWORKS

This year’s Workforce Race Equality and Workforce Disability Equality Standard action plans have focussed on staff engagement, in ensuring our staff equality networks are thriving in line with national ambitions for staff networks and have a real voice in the organisation.

There is recognition and acknowledgement that our leaders and managers play a vital role increating an organisational culture which values diversity and promotes a culture of dignity and respect. To ensure that they can drive this forward we need to create leadership development opportunities around the diversity and inclusion agenda with aim of bringing thediversity agenda to life, where lived experiences of our staff can be shared in an open and safe space and uncomfortable but important conversations can take place. Each of our three staff networks now has a place on our newly formed EDC and also the Trust’s People’s Academy, providing this platform for sharing their experiences and more importantly influencing the EDI agenda at a strategic level.

BTHFT has three established staff equality networks (“RESIN”: Race Equality Staff Inclusion Network, “Enable” Network for staff with a disability or long term health condition and “LGBT+” Staff Equality Network). For each staff equality network, a core group of staff have been identified to work alongsidethe diversity and inclusion unit to explore and examine the national ambitions for staff networks and to align network activity to ensure each staff network is ‘thriving’.

Our equality, diversity and inclusion team have been working with network members to review and refresh their terms of reference, develop core group role descriptors and a new recruitment process for core group members. The Staff Equality Networks will be re-launched on 11th May 2022 to coincide with the National Day for Staff Networks and will

develop their work plans to ensure they are aligned to our WRES/ WDES action plans and our EDI objectives.

3.4.7. EQUALITY OBJECTIVES

Our Head of Equality, Diversity and Inclusion is currently reviewing our equality objectives to ensure they are aligned with the recently refreshed corporate objectives, the objectives of the Equality and Diversity Council and other key areas of focus. The refreshed equality objectives will form part of our dedicated three-year EDI strategy which will be accompanied by an implementation plan. Engagement with a range of Trust staff, patients and communities has already taken place to inform the development of the objectives and strategy with further engagement planned prior to its launch in 2022.

3.4.8. MODERN SLAVERY

We fully support the government's objectives to eradicate modern slavery but do not meet the requirements for producing an annual slavery and human trafficking statement as set outin the Modern Slavery Act.

3.5. NHS FOUNDATION TRUST CODE OF GOVERNANCE

3.5.1. STATEMENT OF COMPLIANCE

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

In May 2022, the Board of Directors reviewed our compliance with the NHS Foundation Trust Code of Governance to identify any areas for further development.

The review concluded that, with regard to the provisions in the Code to which "comply or explain" is applicable, the Trust is compliant with all those provisions.

Appendix 1 provides a guide to the location within this Annual Report of the disclosures required under the Code and those additional disclosures required by NHS England and Improvement (NHSE/I) as described within their Annual Reporting Manual 2020/21.

3.5.2. GOVERNANCE AND ORGANISATIONAL ARRANGEMENTS

The basic governance structure of all NHS Foundation Trusts includes members, a Council of Governors, and a Board of Directors.

This structure is well developed at the Trust and is set out in our Foundation Trust Constitution[53].

3.5.3. OUR FOUNDATION TRUST MEMBERSHIP

Membership strengthens the links between healthcare services and the local community; it is voluntary, free of charge and obligation. Members can give their views on relevant issues to

[53] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/11/BTHFT-Constitution-July-2021.pdf

help improve the experience for patients, visitors and staff. Our Trust membership is made up of public, patients and staff. All members are required to be at least 16 years old.

During the year, local people and those accessing our services as a patient or carer, or those with any other connection to our Trust, have been able to become a member of the Trust by completing the online membership form[54].

Public membership: Our public membership is divided into six sub-constituencies which cover Keighley, Shipley, Bradford East, Bradford South, Bradford West and 'rest of England and Wales'. With the exception of our staff, postcode will determine membership constituency.

Patient (out of Bradford) membership: Patients, or the carers of patients, who live outside of our Bradford district can join our patient membership constituency.

Staff membership: Our staff membership constituency is divided into four groups. These cover nursing and midwifery, medical and dental, allied health professionals and scientists, and 'all other staff groups' (administration and clerical staff, estates and facilities staff and some members of staff who provide additional clinical services).

Number of members

Figure 50 highlights our membership at the start of the year and at the end showing changes in between. The previous year's information is also provided for comparison.

Figure 50 - Membership for the period 2021/22. Figures for comparison included for 2020/21

Membership size and movements		
Public constituency	**2021/22**	**2020/21**
At year start (April 1)	35,143	35,488
New members	20	33
Members leaving	367	378
At year end (March 31)	34,796	35,143
Patient constituency	**2021/2022**	**2020/21**
At year start (April 1)	6,176	6,237
New members	3	1
Members leaving	75	62
At year end (March 31)	6,104	6,176
Staff constituency	**2021/2022**	**2020/21**
At year start (April 1)	5,725	5,532
New members	310	333
Members leaving	170	140
At year end (March 31)	5,865	5,725

[54] https://secure.membra.co.uk/bradfordteachingapplicationform/

Figure 51 - Analysis of Public and Patient Membership 2021/22

Analysis of Public and Patient membership		
	As at 31 March 2022	
Public constituency	**Number of members**	**Eligible membership (Bradford Metropolitan District Council population)**
Age (years):		
17-21	7 (0%)	33,839 (6%)
22+	34,212 (100%)	373,719 (69%)
Ethnicity:		
White	24,990 (73%)	352,317 (67%)
Mixed	32 (0%)	12,979 (3%)
Asian or Asian British	9,101 (27%)	140,149 (27%)
Black or Black British	86 (0%)	9,267 (2%)
Other	16 (0%)	7,740 (1%)
Gender analysis		
Male	15,635 (45%)	267,723 (49%)
Female	18,983 (55%)	275,083 (51%)
Patient constituency	**Number of members**	**Eligible membership**
Age (years):		
0-16	0	N/A
17-21	0	N/A
22+	6,058	N/A

The analysis excludes:
- 577 public members with no dates of birth,
- 571 members with no stated ethnicity
- 178 members with no gender
- 46 patient members with no dates of birth

Membership representation, engagement and communications

Representation

In year public and patient membership has declined overall by 406 members (1%) leaving the Trust with a total public and patient membership of 40,900 at 31 March 2022. 23 new members have joined the Trust in year.

The number of members within the 16-21 age group is under-represented and our age groups from 22 years onwards are over-represented by 41%. With regard to ethnicity the Trust is fairly well represented in relation to the majority of the communities served. With regard to gender the trust is over-represented by 4% with regard to female members however this is not significant when compared to the Bradford Metropolitan District Council (BMDC) female population. We have no members reporting that they are transgender.

The profile of the membership is also monitored to determine whether it reflects our population from a socio-economic perspective using the 'National Readership Survey (NRS) grades system' which focusses on occupation. With regard to the NRS system our membership remains, on the whole, reasonably well representative of the communities we serve who form part of groups C1 (2% under-represented in membership) and C2 (approximately 2% over-represented in our membership). For Groups A and B the margin is higher within our membership than within the local population at approximately 5% and, for groups D and E we are under-represented within our membership by approximately 5%.

Figure 52 - Socio-Economic profile of our BTHFT Membership as at 31 March 2022

The following classifications based on the occupation of the chief income earner within a household have been applied to our membership. As at 31 March 2022 our Public membership reflects the following compared to our local population (BMDC).

	Public Membership	% of Membership	Base (BMDC)	% of Base (BMDC) area	% of National Base
ONS Classifications	**34,804**	**99.92%**	**205,794**	**100%**	**100%**
AB: Higher managerial roles, administrative or professional. Intermediate managerial roles, administrative or professional.	7,405	21%	34,019	16%	27%
C1: Supervisory or clerical and junior managerial roles, administrative or professional.	9,478	27%	59,454	29%	28%
C2: Skilled manual workers.	7,909	23%	42,699	21%	20%
DE: Semi-skilled and unskilled manual workers. State pensioners, casual and lowest grade workers, unemployed with state benefits only.	9,975	29%	69,622	34%	25%

Further information about social grade data is available here[55].

For 2022/23 the Membership Plan Delivery Group will be scrutinising the socio-economic profile information to inform planned recruitment activities.

Member and public engagement

Work to develop the Trust's Membership Plan was restarted in July 2021. The Board of Directors approved the plan in November 2021 following consultation with the Council of Governors in October 2021. The plan sets out a series of objectives for the Trust, to continue to maintain, grow and engage with its membership, including the actions that it will take to meet these objectives. Three core themes were identified and the objectives and subsequent actions are centred on the following themes:

- Engagement/Involvement
- Communication
- Recruitment

The plan is published on the Trust website and is available here[56]. Whilst the Membership Plan Delivery Group was established in December 2021 to oversee the implementation of the plan, its work was delayed due to the nationally directed Trust response to the Omicron Variant (COVID-19) and as such held its first meeting in March 2022. This group will meet quarterly and report to the Board of Directors and the Council of Governors bi-annually on progress with regard to the Plan.

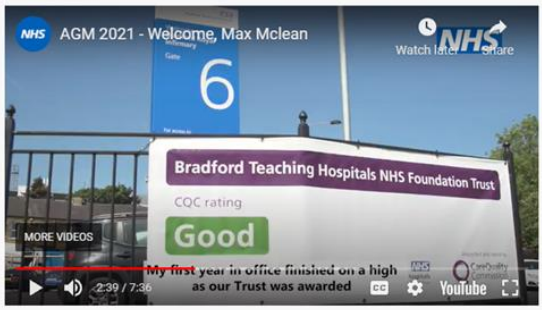
During 2021/22 face to face engagement/involvement activities continued to be stood down in response to the pandemic. The Trust did hold a virtual annual members meeting/annual

[55] https://pamco.co.uk/how-it-all-works/interview-and-questionnaire/social-grade/
[56] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2022/01/BTHFT-Membership-Plan-2022-Approved.pdf

general meeting[57] (AGM/AMM) on 12 October 2021 to present the annual report and accounts 2020/21 to our members and the public.

Welcome

Dr Max Mclean, Chairman



Annual Report 2020/21

Professor Mel Pickup, Chief Executive

Our Annual Accounts 2020/21

Mr Matthew Horner, Director of Finance

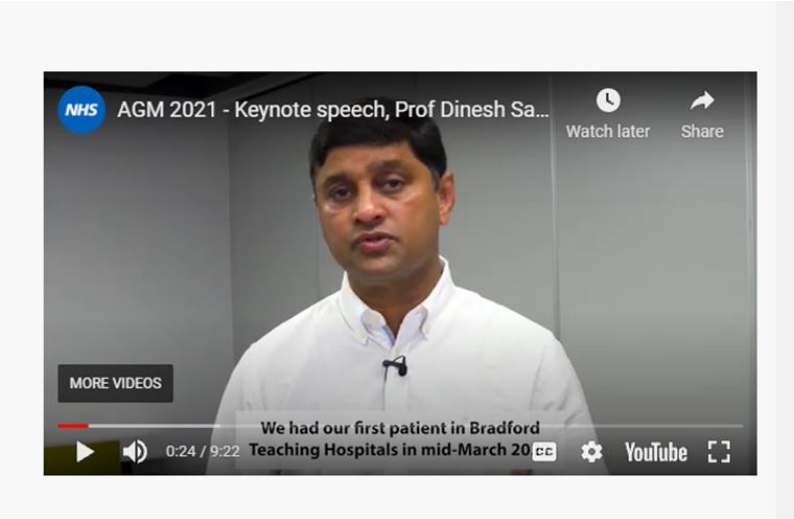
Our Governors and Membership

Mr David Wilmshurst, Vice-Chair of the Council of Governors

Opportunities were provided in advance and after the 'event' for questions to be submitted by members and the public for which responses were provided by the Chief Operating Officer/Deputy Chief Executive, Sajid Azeb[58].

[57] https://www.bradfordhospitals.nhs.uk/agm2021/
[58] https://www.youtube.com/watch?v=E6-rh4uLmSA

A key element of the event was the delivery of our keynote presentation[59] from our Trust's renowned Respiratory Consultant, Professor Dinesh Saralaya who remains at the forefront of vaccine and drug trials in the fight against COVID-19. He shared with our members and the public how this work has helped to shape the response world-wide to saving lives.



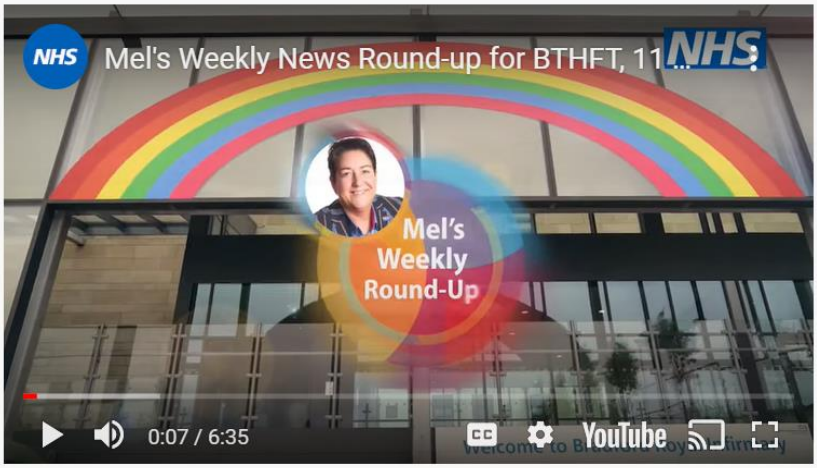
Council meetings have continued to take place quarterly in year. These have been delivered virtually. All meetings are recorded and members and the public are able to access the recordings, which are posted online shortly following the meeting, on the Trust's YouTube channel here[60]. Annotated agendas to guide viewers are available here[61] alongside the meeting papers. The links to view these are circulated via our membership communications. The papers and agendas for council of governor meetings are published on the Trust's website in advance of the meetings taking place.

Communications

We have continued to improve our communications with our members and the public in year through the routine provision of our membership e-newsletters and quarterly bulletins[62]. These are also provided in easy-read versions.

[59] https://www.youtube.com/watch?v=zl0TqMjVaKU&t=1s
[60] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw
[61] https://www.bradfordhospitals.nhs.uk/our-trust/cog-meetings/
[62] https://www.bradfordhospitals.nhs.uk/our-trust/membership-news/

Members and the public have also been provided with links to 'Mel's weekly news round ups[63]. Each week these videos provide the very latest information on how our hospitals have coped with COVID-19 and, importantly, key developments aimed at improving our services.



General and targeted emails alongside the e-bulletins have continued to be sent to members to publicise and seek nominations for our governor elections which were due to commence in January 2022. As a result communications from NHSE/I in December 2021 declaring a Level 4 National Incident to support the preparation of the NHS our Governor elections were deferred until March 2022. The election results are reported on in full at section 3.5.4.2 Election processes held in-year.

Contact procedures for the membership

If members have specific issues they wish to raise they are advised to contact the council of governors or the membership office via any of the following methods:

[63] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw

- General membership email: members@bthft.nhs.uk
- Governors' email: governors@bthft.nhs.uk
- Post: The Trust Membership Office, Trust Headquarters, Chestnut House, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ
- Telephone: 01274 364794

Becoming a member

To join as a member of our Foundation Trust please visit this link[64].

3.5.4. COUNCIL OF GOVERNORS

The Council of Governors is an integral part of the governance structures that exist in all NHS foundation trusts.

The role of the council of governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors and to represent the interests of NHS foundation trusts members and of the public. Governors are elected from the foundation trust's membership and most of the seats on a council of governors have to be held by elected public and patient governors (where a trust has patient governors).

3.5.4.1. Composition of the Council of Governors

There are 20 seats on our Council of Governors with 13 seats available for public and patient governors, four seats available for staff governors and three seats available for partner governors (to represent our key stakeholder organisations).

Figure 53 provides details of the Trust's Council members in-year, the constituency, group or organisation they represent, their terms of office and a record of their attendance at the four formal meetings held in-year.

Figure 53 - Members of the Council of Governors during 2021/22

Public Governors (elected)		Term start date	Term end date	Meetings attended 2020/21
Ms Stella Hall	Bradford East	04/2019	05/2022	3 of 4
Mr Kursh Siddique	Bradford East	05/2019	05/2022	4 of 4
Mr Dermot Bolton	Bradford West	12/2019	11/2022	3 of 4
Mr Ibrar Hussein	Bradford West	05/2021	04/2024	2 of 3
Mr Adrian Cresswell	Bradford South	05/2021	04/2024	2 of 3
Mr David Wilmshurst	Shipley	12/2019	11/2022	4 of 4
Ms Caroline Chapman	Shipley	05/2021	04/2024	3 of 3
Ms Wendy McQuillan	Keighley	04/2019	05/2022	4 of 4
Mr Amit Bhagwat	Rest of England and Wales	12/2019	12/2021	0 of 0
Patient Governors (elected)				
Ms Hardev Sohal		04/2019	05/2022	4 of 4
Mr Mark Chambers		12/2019	12/2022	3 of 4
Staff Governors (elected)				
Ms Pauline Garnett	Nursing and Midwifery	04/2019	10/2021	2 of 2

[64] https://secure.membra.co.uk/bradfordteachingapplicationform/

Dr Kavitha Nadesalingam	Medical and Dental	03/2020	12/2021	2 of 2
Ms Helen Wilson	AHPS	12/2019	11/2022	3 of 4
Ms Ruth Wood	All Other Staff Groups	03/2020	02/2023	3 of 4
Partner Governors (appointed by our stakeholders)				
Professor Anne Forster	University of Leeds	05/2021	04/2024	2 of 3
Professor Alastair Goldman	University of Bradford	06/2019	05/2022	4 of 4
Cllr Tariq Hussain	BMDC	06/2019	05/2022	4 of 4

Lead Governor	*Ms Wendy McQuillan*
Vice Chair of the Council of Governors	*Mr David Wilmshurst*

The maximum term length for a Governor is three years. Governors can serve a maximum of nine consecutive years in total (generally equivalent to three full term lengths). Profile information about all of our Governors[65] is available on our website.

3.5.4.2. Election processes held in-year

An election process to recruit to vacancies in the following constituencies was launched on 15 February 2021.

- Bradford South (two vacancies)
- Bradford West (one vacancy)
- Shipley (one vacancy)

Elections were held in Bradford West and in Shipley. Two candidates for Bradford South were elected unopposed however one of the nominees stood down shortly after the conclusion of the elections.

The new Governors joining the Council in May 2021 were:

- Ms Caroline Chapman, Public Governor Shipley
- Mr Ibrar Hussein, Public Governor Bradford West
- Mr Adrian Cresswell, Public Governor Bradford South

An election process to recruit to vacancies in the following constituencies was launched on 7 March 2022.

- Bradford East (2 vacancies)
- Bradford South (1 vacancy)
- Keighley (2 vacancies)
- Patient (1 vacancy)
- Rest of England and Wales (1 vacancy)
- Staff: Medical and Dental (1 vacancy)
- Staff: Nursing and Midwifery (1 vacancy)

Elections were held in Bradford East and in the Staff constituency for the Medical and Dental group. Two candidates were elected unopposed in Keighley and, in the Staff constituency for the Nursing and Midwifery group. No nominations were received for; the remaining Keighley vacancy, Bradford South, the Patient constituency and the 'Rest of England and Wales' constituency.

[65] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/

The new Governors joining the Council from May 2022 (subject to the completion of the necessary 'fit and proper persons' investigations) are:

- Mr Khalid Choudhry, Public Governor Keighley
- Ms Heather Jacklin, Public Governor Bradford East
- Ms Kathryn Simons-Porter, Public Governor Bradford East
- Sister Raquel Licas, Staff: Nursing and Midwifery
- Dr John Bolton, Staff: Medical and Dental

The election processes described above have been undertaken in accordance with the rules outlined in appendix one of the Trust's Constitution and were managed by the Returning Officer, Ms Ciara Hutchinson, Civica Election Services, The Election Centre 33 Clarendon Road London, N8 0NW.

3.5.4.3. Council of Governors' Register of Interests

All governors are required to comply with the Council of Governors' Code of Conduct and declare any interests that may result in a potential conflict of interest in their role as governor. The interests are publicly available on our website here[66] as part of the Trusts declarations of interest register. The latest extract from the register is also included with the papers at each Council of Governors meeting. In addition, the register can be obtained from the Associate Director of Corporate Governance/Board Secretary via the following methods:

- Email: members@bthft.nhs.uk
- Post: The Foundation Trust Membership Office, Trust Headquarters, Chestnut House, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ
- Telephone: 01274 364794

3.5.4.4. Council of Governors Statutory Duties and responsibilities

The Council of Governors hold a number of statutory duties and responsibilities. The powers of the governors are established under statute. The Council of Governors may not delegate any of its powers to a committee or sub-committee; however, it may appoint a committee to assist in carrying out its functions.

The statutory duties of the Council of Governors are to:

- appoint and remove the Chairman and non-executive directors;
- set the terms and conditions and remuneration of the Chairman and non-executive directors;
- approve the appointment of the Chief Executive;
- appoint the external auditor;
- receive the Annual Accounts, Auditor's Report and Annual Report;
- convene the Annual Members' Meeting;
- be consulted on the forward plan (annual plan) of the organisation;
- approve any proposed increases in private patient income of 5% or more in any financial year;
- represent the interests of the Members of the Trust as a whole and the interests of the public;

[66] https://bthft.mydeclarations.co.uk/

- require one or more of the directors to attend a governors' meeting to obtain information about the Trust's performance of its functions or the director's performance of their duties (and for deciding whether to propose a vote on the Trust's or Director's performance);
- approve significant transactions;
- approve an application by the Trust to enter into a merger, acquisition, separation or dissolution; and
- approve amendments to the Trust's Constitution.

3.5.4.5. Council of Governors Nominations and Remuneration Committee

The Council of Governors has established a Governors' Nominations and Remuneration Committee that meets at least quarterly to deal with the appointment and/or reappointments of non-executive directors and the appointment/reappointment of the Chairman. Their purview includes remuneration, terms of office and NED/Chairman annual performance evaluation. The Remuneration Report under section 3.2.3.3 includes a report on the work of the Governors' Nominations and Remuneration Committee in-year.

3.5.4.6. Council of Governors' meetings

During 2021/22 the Council of Governors' meetings have routinely included the delivery of key presentations, and agenda items that have elicited challenge and supported discussion between governors and directors on the following key matters:

- Consultation on the development of the Trust's new Corporate Strategy
- Update on Integrated Care System and Place Developments
- Development of the Membership Plan
- Update on Moving Bradford Forwards (Strategic Outline Case)
- Reports from the Chief Executive regarding the Trust's response to COVID-19; and from key Executives regarding;
    - Quality of Services
    - Operational Planning and the reconfiguration and restart of services
    - Staffing including health and well-being

The agendas and papers including the minutes for the Council of Governors[67] meetings are available on our website.

With regard to their statutory duties and responsibilities the Council has, during 2020/21;

- Received the Annual Accounts, Auditor's Report and the Annual Report;
- Approved the remuneration of the Non-Executive Directors;
- Appointed Ms Sughra Nazir[68] as a Non-Executive Director following the term-end of Ms Selina Ullah.
- Approved the appointment of Professor Janet Hirst[69] as the nominated Non-Executive Director by the Leeds School of Medicine, University of Leeds.
- Approved the reappointment of the Chairman, Dr Maxwell Mclean[70], for a second term (May 2022 to April 2025) and his associated Remuneration and Terms & Conditions.

[67] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/
[68] https://www.bradfordhospitals.nhs.uk/doctors/sughra-nazir/
[69] https://www.bradfordhospitals.nhs.uk/doctors/janet-hirst/
[70] https://www.bradfordhospitals.nhs.uk/doctors/maxwell-mclean/

- Received the report from the Chairman on the outcome of the appraisals process of the Non-Executive Directors;
- Received regular reports from the Governors Nominations and Remuneration Committee (NRC) on the business conducted by the NRC;
- Approved amendments to the Constitution[71].

The Council of Governors has also received, reviewed and/or approved the:

- Council of Governors' Standing Orders;
- terms of reference for the Council of Governors;
- terms of reference for the Governors' Nominations and Remuneration Committee;
- appointment process for the non-executive directors (including the Chairman appointment process);
- terms and conditions for non-executive director appointments made in-year;
- Council of Governors Engagement Policy;
- Quarterly Chairman's reports;
- Governors' Code of Conduct;
- quarterly Nominations and Remuneration Committee reports;
- process for appointment of a chairman/non-executive director/associate non-executive director;
- Non-executive director terms and conditions;
- Chair reappointment terms and conditions
- Nominations and Remuneration Committee Membership;
- annual general meeting/annual members meeting agenda review and establishment of governor planning group;
- Governors' code of conduct;
- Governors' annual evaluation and, skills and knowledge audit;
- Governor induction programmes;
- Quarterly reports from the Board Committees and Academy Non-Executive Director Chairs.
- Confirmed the appointments of the Vice-Chair of the Council of Governors and the Lead Governor.

To support the delivery of their duties Council members have also, in year, been invited to attend in-depth Executive-led briefing sessions covering;

- The Trust's redeveloped Chaplaincy service;
- BTHFT Operational and Financial Operational Plan 2021/22;
- Operational Performance in relation to Key Performance Indicators and;
- Our plans for a Digital Future and Working with Airedale NHSFT.

3.5.4.7. Directors' attendance at the Council of Governors meetings

Executive and Non-Executive Directors routinely attend the meetings of the Council of Governors.

In 2021/22 the Council of Governors has not exercised its "power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance or its functions or the directors' performance of their duties".

[71] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/11/BTHFT-Constitution-July-2021.pdf

3.5.4.8. Governors' effectiveness

In April 2022 the Council considered the outcomes of the Governors Annual Evaluation and the Trust, in conjunction with the Council, developed an action plan to address those areas identified as requiring improvement. As part of the review of effectiveness the Council also considered the size of the Council of Governors and determined that at 20 members, it was adequate. The key areas requiring focus, and a summary of the actions taken in response, are identified below.

- Representing the interests of the FT members and the local population: Governors were integrally involved with the development of the new membership plan as part of the development group. The plan was reviewed by the Council in October 2021 and approved by the Board in November 2021. The implementation of the plan was stalled in January 2022 in response to the directive from NHSI/E to stand down all non-essential activity. The Membership Plan Delivery group involving Governors and a Non-Executive Director has now commenced work. The Trust also commissioned a bespoke learning and development session for all Council members in February 2022 covering 'Membership and Public Engagement.' The Council meeting agenda's now also include as a regular item 'Matters raised with Governors by members, patients and the public'.

- Input into operational planning and strategy development: Governors have been consulted on the development of the new BTHFT Corporate Strategy on regular occasions in year. Members, public and staff were also invited to provide their feedback on the Strategy via a survey in July/August 2021. A progress report on the strategy was provided by the Director of Strategy and Integration in October 2021 at the Council of Governors meeting. The new Trust Strategy was approved in principle by the Board in January 2022 and is expected to be published early in 2022/23.

- Annual (operational planning): NHSE/I published operational planning guidance in March 2021 and the Trust held a session with the Council on 13 May 2021 with the Director of Finance and the Chief Operational Officer. For the 2022/23 planning round the Trust will be meeting with the Council in April 2022 to discuss the draft plan prior to its submission as a Place based plan in May 2022.

- Development of stronger relationships between the non-executives and governors: Dr Maxwell Mclean, Chairman, has routinely met with governors on an informal basis four times in-year to explore areas of concern, ascertain Governor views and feedback from their activities within their communities, areas of development and items they would like to see included on the Council of Governors meeting agendas.

  Four informal sessions between Governors and Non-executive directors have been held and these focus on matters discussed at Committee and Academy meetings and how Non-Executive Directors are holding the Executive Directors to account. These sessions continue to prove beneficial in support of Non-Executive Directors and Governors in developing their relationships. The Chairman routinely provides a summary of the discussions at the Council of Governor meetings.

- Holding the non-executives individually and collectively to account for the performance of the Board: Governors, on a voluntary basis, have the opportunity to observe at the Board's Academies, Committees and Board meetings. Non-Executive Directors are routinely present at the Council meetings and the Council is in receipt of the Chair reports from the Academies and Committees. The Governors are presented with the Annual Report and Accounts and the Trust Quality Account. The Council further

determines the Chair and NED Appraisal process and is in receipt of reports on the outcomes. To further support Governors understanding of 'holding to account', the Trust has commissioned a bespoke development session on 'Holding to Account' from NHS Providers who deliver the national learning and development programme for Governors. The session has been rescheduled from March 2022 to June 2022.

- Review of the Governors Induction programme and supporting Governors to deliver on their range of statutory duties and responsibilities: A Governor working group was established in year for the Council to review the programme. The revised individual and collective induction programme was approved by the Council in July 2021. The revised induction programme is now in use. As part of our Trust induction programme all new Governors are required to undertake the Core Skills training and development session delivered by NHS Providers.

Governors also continue to be in receipt of the agenda for Board meetings which is circulated in tandem with the circulation of papers to Board members and prior to publication on the Trust's website. Access to the Board papers including the confirmed minutes from the previous Board meetings[72] is available on our website.

3.5.4.9. Governor engagement with patients, visitors, and staff

Engagement activities have been stood down in-year as a result of the pandemic in line with the national guidance from NHS England/Improvement. A virtual annual general meeting/annual members meeting (AGM/AMM) was launched on-line on 12 October 2021. The Governors were integral to the planning and delivery of the programme for the AGM/AMM. Mr David Wilmshurst, Vice-Chair of the Council of Governors presented the Governor and Membership report[73]. This was supplemented by the publication of the Governor Highlights Report for 2020/21 Your Guide to our Year[74].

3.5.4.10. External engagement

Governors are active within a range of third sector and statutory organisations that form part of the local health economy and these relationships inform their engagement with the Board of Directors. Governors have also attended or been involved in engagement activities

[72] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/
[73] https://www.youtube.com/watch?v=F8qmkzlMZzE&t=2s
[74] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/10/HG2833-BTH-AGM-202021-Governor-Highlights4.pdf

specific to their role as governors. In-year this has included Governors' attendance or involvement in:

- National Governors' Conference, FOCUS, delivered by NHS Providers;
- Engagement LIVE 2021 event providing opportunities to understand more about membership and engagement activities.
- Bi-annual Governors Virtual Workshops delivered by NHS Providers
- Recruitment process for the Independent Chair of the Bradford District and Craven Partnership Board.

3.5.4.11. Governors' learning and development

Members of the Council have attended learning and development sessions delivered by Governwell (NHS Providers) as part of the national training programme for governors.

In support of key outcomes from the Governors Skills and Knowledge Audit and the Governors Annual Evaluation completed earlier in the year, the Corporate Governance team has arranged for the delivery of three bespoke development sessions to be provided by Governwell. These include:

- 'NHS Business and Finance Skills'
- 'Member and Public Engagement'
- 'Accountability'

3.5.4.12. Communicating with governors

There has been continued focus on the methods of communication with governors to ensure that they are in receipt of information that supports their understanding and knowledge of developments at the Trust at all levels. The Trust has been encouraging governors to support the dissemination of good news stories to the individuals, groups and organisations they are associated with. The methods of communication include:

- A quarterly Chairman's Bulletin from Dr Maxwell Mclean to ensure that governors are kept abreast of key developments, at the Trust and externally, as well as a key in-depth focus on Trust performance in selected areas. This important bulletin also includes news items and briefings from a range of statutory and non-statutory organisations which has included CQC, NHSE/I and NHS Providers.
- Routine receipt by Governors of all press releases;
- Access to the Trust's 'Let's Talk' weekly communication to staff;
- Ensuring issues of critical importance are flagged with Governors prior to press releases being circulated;
- Receiving the links to the regular Chief Executive videos, 'Mel's weekly news round ups'[75], which provide the latest information on how our hospitals have coped during the pandemic and, importantly, how we are still continuing to work towards improving our services.

Members and the public are able to communicate with the Council of Governors via the following methods.

- Email: governors@bthft.nhs.uk

[75] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw

- Post: c/o The Foundation Trust Membership Office, Trust Headquarters, Chestnut House, Bradford Royal Infirmary, Duckworth Lane, Bradford BD9 6RJ

- Telephone: 01274 364794

3.5.5. AUDIT AND COUNTER FRAUD SERVICES

3.5.5.1. External audit

The external auditor for the Trust is:

Deloitte LLP
One Trinity Garden
Broad Chare
Newcastle-upon-Tyne
NE1 2HF

Deloitte LLP was reappointed as the external auditor by the Council of Governors on 23 April 2020.

Figure 54 - External audit fees

Fee (excluding VAT)	2021/22 £000	2020/21 £000
Audit of Trust	64	62
Value for money	13	20
Additional fees	0	0
Total audit services – statutory audit	**77**	**82**
Audit of Charity	12	6
Total	**89**	**88**

3.5.5.2. Internal audit and counter fraud service

Internal audit and counter fraud services are provided by Audit Yorkshire. The Director of Finance sits on the Audit Yorkshire Board which oversees Audit Yorkshire at a strategic level.

An internal audit charter formally defines the purpose, authority and responsibility of internal audit activity. This document was last updated, reviewed and approved by the Audit Committee in July 2021.

In-year the Audit Committee approved the planning methodology to be used by internal audit to create the Internal Audit Plan for 2021/22, and gave formal approval of the Internal Audit Operational Plan in April 2021. The Internal Audit Operational Plan has notbeen fully delivered in-year as a result of the Trust responding to the pandemic. As a result a number of audits have been deferred to 2022/2023.

The conclusions as well as all findings and recommendations of finalised internal audit reports are shared with the Audit Committee. The committee can, and does,challenge internal audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary. Executive of limited or low assurance level report are asked to attend the Audit Committee to provide further assurance.

A system is in place whereby all internal audit recommendations are shared with the Director of Finance on a monthly basis which are then shared with other Executives. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Executive Management Team and the Audit Committee on at least a quarterly basis. This has continued to be an area of focus by the committee during the year and Trust management has worked hard with the support of internal audit to ensure that the process for responding to internal audit recommendations has been improved. This is evidenced by the significant reduction in the number of outstanding recommendations as at year end which was supported by the implementation of a new internal audit software system.

The Counter Fraud Plan was reviewed and approved by the Audit Committee in April 2021. The local counter-fraud specialist (LCFS) presented regularreports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

The counter fraud policy is implemented via a well-publicised zero tolerance approach to fraud. There are regular newsletters sent out to all staff covering fraud of all kinds. The newsletter promotes fraud awareness and vigilance while encouraging staff to report suspected fraud via the established routes. The message is relayed by informing and involving staff to get them to assist in its prevention and deterrence.

This message is reinforced in the Trust's counter fraud internet section which features the details of the LCFS and to how report fraud in a variety of ways. Staff are also given the opportunity to engage with counter fraud at induction when they are sent a welcome email by the LCFS and supplied all appropriate contact details. Fraud Masterclasses have taken place throughout the year and presentations are delivered on specific fraud topics in addition to the distribution of fraud prevention notices from the Counter Fraud Authority and other fraud alerts.

3.6. NHS SYSTEM OVERSIGHT FRAMEWORK

3.6.1. INTRODUCTION

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

- quality of care, access and outcomes;
- preventing ill health and reducing inequalities;
- finance and use of resources;
- people; and
- leadership and capability.

Based on information from these themes, providers are segmented from one to four, where four reflects providers receiving the most support, and one reflects providers with maximum autonomy. A foundation trust will only be in segments three or four where it has been found to be in breach or suspected breach of its licence.

3.6.2. SEGMENTATION

NHS Improvement has placed the Trust in segment two which maintains the rating achieved in 2020/21. This category is for providers that have been offered targeted support because there are concerns in relation to one or more of the themes.

This segmentation information is the Trust's position at 31 March 2022. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website[76].

See section 2.2.2.

3.7. STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the chief executive's responsibilities as the accounting officer of Bradford Teaching Hospitals NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement.
NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Bradford Teaching Hospitals NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Bradford Teaching Hospitals NHS foundation trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

In preparing the accounts and overseeing the use of public funds, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* (and the *Department of Health and Social Care Group Accounting Manual*) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy and
- prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also

[76] https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/

responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.
As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

Mel Pickup
Chief Executive
21 June 2022

3.8. ANNUAL GOVERNANCE STATEMENT

3.8.1. INTRODUCTION

Under the NHS Act (2006) all NHS entities are required to prepare an annual governance statement. The statement considers internal controls and reports on any significant issues that have arisen during the financial year, including information and quality governance. The Chief Executive signs the document which forms part of the Annual Report.

3.8.2. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 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*.

3.8.3. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2022 and up to the date of approval of the annual report and accounts.

3.8.4. CAPACITY TO HANDLE RISK

The Trust is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental element of its governance framework and system of internal control. We recognise that healthcare provision, and the activities associated with caring for patients, employing staff, providing premises and managing finances are all, by their very nature, risk activities and will therefore involve a degree of risk. These risks are present on a day-to-day basis throughout the Trust. We take action to manage risk to a level which is tolerable. We acknowledge that risk can rarely be totally eradicated, and a level of managed residual risk will be accepted.

Risk management is therefore an intrinsic part of the way we conduct business, and its effectiveness is monitored by both our performance management and assurance systems.

As Chief Executive, I am the Accounting Officer for the Trust. I have overall responsibility for ensuring effective risk management arrangements are in place. I am supported by the Director of Strategy and Integration and Chief Medical Officer, who are the lead directors for risk management and the Associate Directors of Quality and Corporate Governance who develop and manage the corporate approach to the management of risk, including the risk management strategy and the use of the BAF. I routinely use the BAF, the Trust's high level risk register, internal audit, the local counter fraud service, and external audit to ensure proper arrangements are in place for the discharge of our statutory functions, as well as to detect and to act upon any risks and to ensure that the Trust can discharge its statutory functions in a legally compliant manner.

As Chief Executive, I have delegated some key responsibilities to other executive directors as shown at figure 55.

Figure 55 - Executive directors' key responsibilities

Role	Executive director Lead
Accounting Officer	Chief Executive
Allegations against professionals	Director of Human Resources
Caldicott Guardian	Chief Medical Officer
Controlled drugs	Chief Medical Officer
Corporate governance	Director of Strategy and Integration
Digitisation	Chief Digital and Information Officer
Doctors in difficulty	Chief Medical Officer
Emergency planning	Chief Operating Officer
End of life	Chief Nurse
Equality and diversity	Director of Human Resources
Fire safety	Director of Estates and Facilities
Freedom to Speak Up	Chief Nurse
Fundamental standards of quality and safety (CQC)	Chief Executive
Health and safety	Director of Estates and Facilities

Role	Executive director Lead
Infection prevention and control	Chief Nurse
Learning from deaths	Chief Medical Officer
Patient safety	Chief Medical Officer Chief Nurse
Responsible Officer	Chief Medical Officer
Senior Information Risk Owner	Chief Digital and Information Officer

The directors of the Trust, individually and collectively, also have responsibility for providing assurance in relation to the risks associated with the Trust's strategic objectives and regulatory compliance to the Board of Directors.

I am accountable to the chairperson of the Trust for my performance and to NHS Improvement/NHS England (NHSI/E) for the performance of the Trust.

All executive directors' report to me and the executive team is held to account for its performance through regular one-to-one meetings with me, individual annual performance reviews and through challenge from the non-executive directors.

The non-executive directors are accountable to the chairperson. They are expected to hold the executive directors to account and to use their skills and experience to make sure that the interests of patients, staff and the Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust particularly in relation to risk and assurance.

The Trust provides a comprehensive mandatory training programme. Training is also delivered centrally and within individual clinical business units/specialties.

During 2021/22, the quality team have provided incident reporting and risk management training in response to staff needs. Whilst there is an acknowledgement of significant pressure on staff the Trust has continued to reinforce the requirements of the mandatory training policy, and the duty of staff to complete training deemed mandatory for their role and is a key element of the annual appraisal process. In 2022/23, a risk management training needs analysis will be undertaken and updated training will be designed and delivered to ensure that the revised Risk Management Strategy is embedded across the organisation.

We have continued with our focus on developing awareness and skills in relation to high quality and focussed risk assessment and business continuity planning amongst clinical and non-clinical staff. These skills have been invaluable during these unprecedented times to enable our services and staff to respond to the clinical needs of patients.

The NHS has a key role in responding to large scale emergencies and major incidents and throughout 2021/22 the emergency planning team has worked to ensure that the Trust is adequately prepared for any such events. We have in place plans that are substantially compliant with the requirements of the NHS England Emergency Planning Resilience and Response Core Standards (2015) and associated guidance.

During 2021/22 the submission date for the core standards was 29 October 2021. The Trust's return was submitted by the deadline. The Trust declared a 'Substantially Compliant' position, with compliance in relation to 46 out of 48 standards. An action plan has been

developed to detail how the Trust will achieve compliance in relation to the two partially compliant standards (Standard 20: Duty to maintain plans - Shelter and evacuation; and Standard 68: CBRN - Staff training for Chemical, Biological, Radiation or Nuclear incident decontamination).

The Board of Directors recognises that it has a legal duty to ensure, as far as is reasonably practicable, the health, safety and welfare of all patients, employees, contractors and members of the public who access the Trust's services or use the Trust's premises. Compliance with the Health and Safety legislative framework, under which the Trust operates, is reflected in our current policies. The policies provide an overarching framework for the management of risk across all areas of the Trust and are applicable to both clinical and non-clinical risk management. We have a Health, Safety & Resilience Committee, which reports to the People Academy and ensures that it has all other health and safety related committees in place.

The effectiveness of our implementation of our BAF was audited by our internal auditors, Audit Yorkshire, during 2021/22 who found there was significant assurance relating to the processes we have in place. It was noted that the Trust has plans in place to introduce a new BAF template and to fully review its strategic risks including the associated controls, assurances and gaps. The updated BAF is due to be agreed by the Board in July 2022. The Trust has worked with the Good Governance Institute (GGI) in the development of the BAF and associated risk management strategy. As part of this, the GGI facilitated a risk management workshop for the Board on 9 February 2022.

3.8.5. THE RISK AND CONTROL FRAMEWORK

3.8.5.1. Our strategic approach to risk management

We are committed to strengthening an organisational philosophy that ensures risk management is aligned to strategic objectives, clinical strategy, business plans and operational management systems.

We recognise that the specific function of risk management is to identify and manage risks that threaten our ability to meet our strategic objectives. We are clear, therefore, that understanding and responding to risk, both clinical and non-clinical, is vital in making the Trust a safe and effective healthcare organisation.

We identify risk whether as a missed opportunity or a threat, or a combination of both, and assess the significance of a risk as a combination of probability and consequences of the occurrence.

All our staff have a responsibility for identifying and minimising risk. This is achieved within a progressive, honest and open culture where risks, mistakes and incidents are identified quickly and acted upon in a positive way.

Our Risk Management Strategy 2019-2025 was approved by the Board of Directors in January 2019. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored, and managed appropriately. It defines how risks are linked to one or more of our strategic or operational objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust. During 2021/22 the Trust's Risk Management Strategy has been reviewed to ensure that it remains fit for purpose. The updated Strategy is due to be presented to the Board for approval in July 2022.

Risk identification, assessment, management and escalation sources include workplace risk assessments, analysis of incidents, complaints, claims, external safety alerts, the 'Freedom to Speak Up' initiative, and assessments of compliance with other standards, targets and indicators.

There is an expectation that risk assessment is a key feature of all normal management processes. All areas of the Trust have an ongoing programme of risk assessments, which inform our risk registers. Risks are evaluated using the Trust risk matrix which contributes to decision making in the context of risk appetite and risk tolerance. We rate these risks on a scale from 1-25, where 25 is the highest risk. Risks are appropriately graded and included on the risk register.

3.8.5.2. Strategic risk management

Strategic risks are recorded on the Board Assurance Framework (BAF). The purpose of the BAF is to assure the Board that the Trust is mitigating the identified significant risks to the delivery of its strategic objectives adequately and that there are no significant gaps in assurance.

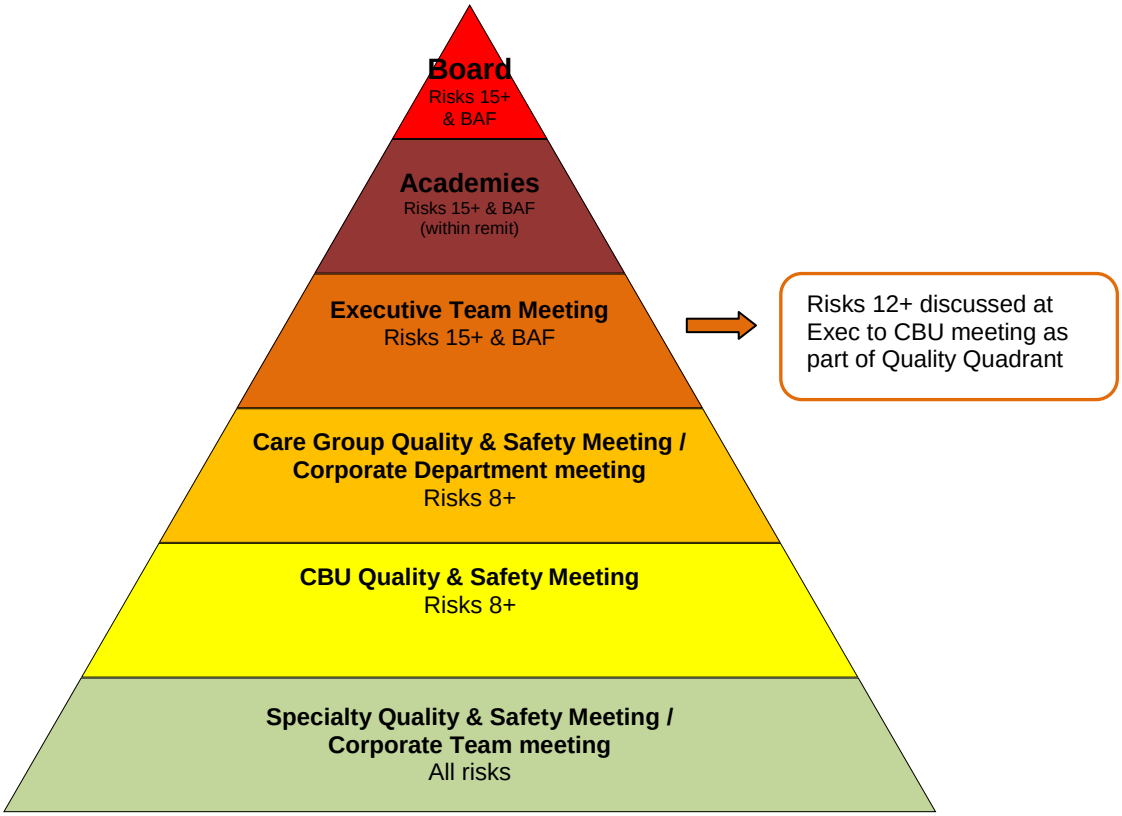
The Board of Directors is responsible for identifying strategic risks. The BAF is reviewed and monitored by the Executive Team and Board six times per year. From 2022/23, our Academies will also review the strategic risks within their remit six times per year and provide assurance to the Board that the risks are being managed appropriately.

3.8.5.3. Operational risk management

We use a single electronic risk management system to record our operational risks (Datix), which links all key risk elements (including incident reporting, complaints, and claims and inquest management). All of these elements are used to inform the risk register, which is also held on Datix.

In November 2021, a new risk escalation process was introduced, to ensure that risks are escalated by their score, rather than those which are deemed to be strategic. The escalation framework is outlined in figure 56 below.

Figure 56 - Risk escalation framework



We manage risks at Board, Academy, Executive, corporate department, CBU and specialty level. Risks are escalated and de-escalated through these different levels depending on the **current** risk score. Any risks with a current score of 15 or above are reported to the Trust Executive Team for discussion. If the Executive Team agree that the risk is scored at 15 or above from a Trust-wide perspective, it is included on the High Level Risk Register.

The High Level Risk Register is a dynamic document which is constantly changing as actions are taken addressing high risk issues for the organisation. New risks are added as they are identified.

The High Level Risk Register is fully reviewed every month at the Executive Team Meeting alongside a summary of the key changes and progress against mitigating actions. High Level Risks are assigned to one or more of the three academies or the Board (as appropriate), who will have oversight of the actions being taken to mitigate the risks. At each meeting the Academies review the High Level Risks within their remit. The purpose of these reviews is to provide assurance to the Board that all relevant risks are appropriately recognised and that all appropriate actions are being taken on appropriate timescales where risks are not appropriately controlled.

The Board receives and reviews the full High Level Risk Register (risks graded as 15 and above) at each meeting. The Board also receives details of the discussions held at the Executive Team Meeting via the risk report, and at the Academies via the Chairs' reports.

Risks scoring 12 and above are reported as part of the CBU to Executive meetings, to provide the Executive team with an overview of risks which have the potential to become high level risks.

3.8.5.4. Risk appetite

The Board of Directors has a defined risk appetite statement (see figure 57), which is aligned to the strategic objectives of the organisation, determining the amount of risk considered desired (both opportunistic related to delivery of the strategic objectives) and tolerated (usually related to operational risk). The Board is in the process of reviewing its risk appetite statement and an updated statement will be presented to the Board for approval in July 2022.

Figure 57 - Our risk appetite

At a meeting of the Trust's Board of Directors on the 9th January 2020 the Trust's strategic objectives were used, alongside the principal risks managed by the organisation, as a framework to support the outcome of the review of the Trust's risk appetite by its Board committees. The Board of Directors recognises that the Trust's long-term stability and continued development of effective relationships with our patients, their families and carers, our staff, our community, and our strategic partners is dependent upon the delivery of our strategic objectives. It also recognises that the "Requires Improvement" rating applied to the Trust by the CQC in 2018 continues to have an influence on the risk appetite of the organisation. However, the Board of Directors believes that our risk appetite appropriately reflects the progress that the Trust has made in implementing and assuring its Clinical Strategy 2017-2022 and its associated strategies and plans and is fully aligned to our ambition. A balanced approach has been taken to reviewing the specific areas of risk associated with each strategic objective by the Board committees and the Board of Directors itself, and without exception, there is a minimal appetite in relation to any risks to patient safety, staff safety or regulatory compliance.

3.8.5.5. Risk profile

Our risk profile is described in section 2.2.2.4 (Performance Analysis).

3.8.5.6. Quality governance

A revised Quality Governance Framework was approved by the Executive Team on 4 April 2022. The Quality Governance Framework sets out a model for quality governance that is supported by the alignment of a centralised team of Quality and Patient Safety Facilitators to the CBU operational structure. These posts will in effect support the CBU managerial and leadership triumvirate in the same way that Finance and Human Resource Business partners currently support CBUs. This will ensure that all CBUs are supported equally, quality governance arrangements are aligned to current national strategies, are fit for purpose to support the organisation as well as the revised regulation and commissioning arrangements as they are implemented.

The revised Quality Governance Framework seeks to ensure that CBUs are able to perform effectively, enabling clear information flow, escalation and accountability within the CBU and through to Board and back to wards and departments. These post holders, as experts in quality, patient safety and risk management, will support a standardised approach to enable each CBU to discharge their governance responsibilities by supporting monthly CBU Quality and Safety meetings against a standardised agenda and terms of reference based around the Care Quality Commission's 5 regulatory domains, Safe, Effective, Caring, Responsive and Well Led. This will include a review of the CBU risk register, identifying new and emerging risks as well as a review of current mitigation and relating scores. Discussions will then lead to the identification of risks that will require escalation to executives if scoring 12 or above.

Compliance with CQC requirements is monitored through the Trust's Moving to Outstanding meetings which are chaired by the Chief Executive. The Trust participates in regular liaison meetings with representatives of the CQC.

Details relating to the quality of performance information are included in section 3.8.8 below.

3.8.5.7. Management of risks to compliance with the NHS Foundation Trust licence condition 4 (FT Governance)

Compliance with the FT Code of Governance and NHS Provider Licence is formally reviewed on an annual basis. This was last carried out by the Executive Management Team and reported to the Board of Directors in May 2022. The review concluded that the Trust was compliant with all requirements and no risks were identified. The Trust's governance arrangements are described below, including the changes made in 2021/22.

During 2021/22, the Trust has continued to embed its Academy governance model, which was developed and introduced in the latter half of 2020/21. Academies were introduced to focus on learning, improvement and assurance in relation to quality and patient safety; people; and finance and performance. The Terms of Reference and work plans were approved in March 2021.

The Audit Committee's Terms of Reference were also reviewed to ensure that its role within the revised governance structure was clear. It was re-named as the 'Audit Committee' rather than 'Audit & Assurance Committee' to avoid any confusion with the role of the academies and the Regulation & Assurance Committee.

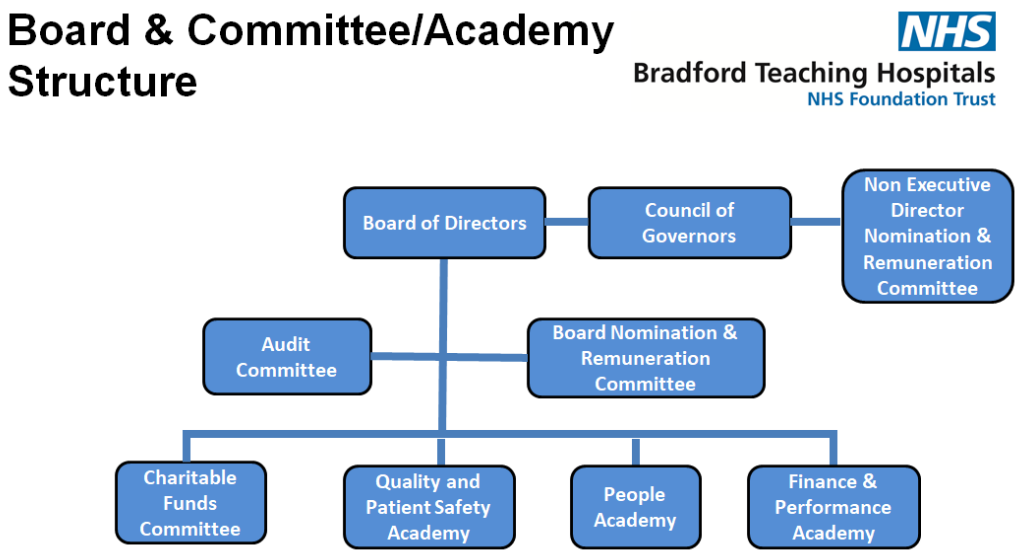
Interim reviews of the academies were undertaken in July 2021, and the outcome was reported at the academy meetings on 28 July 2021. The feedback in relation all three academies was largely positive and members thought that the meetings were working well. There were some comments around the membership of each academy, and the inclusion of external stakeholders at Quality & Patient Safety Academy meetings, which will be considered. The importance of ensuring that the academies have appropriate focus on learning and improvement was also highlighted. There was also some feedback around the length and format of meetings.

In light of these positive findings it was agreed that the academies would continue in their current format. An annual review of the academies was undertaken in May 2022.

A Regulation & Assurance (R&A) Committee was also introduced as an interim measure during 2020, to mitigate the governance risks at a time when we were unable to have regular Board and Committee meetings due to the pressure of the pandemic, and it was subsequently included in the revised governance structure. As we resumed "normal business" with a full suite of Academies and Board meetings, it was agreed to disestablish the R&A Committee and revert to using the Board as the cornerstone of our governance model with a clear line of sight to academies responsible for learning, improvement and assurance. As they were now reporting directly to the Board rather than the R&A Committee, it was agreed that all academies would be chaired by a Non-Executive Director. This change was implemented from September 2021.

The current governance structure is outlined at figure 58.

Figure 58 - Governance structure



The **Board** has overall responsibility for performance of the Trust – its three key roles are to formulate strategy, ensure accountability, and shape culture.

The focus of the **Audit Committee** is to seek assurance on the relevance and robustness of governance **structures** and assurance **processes,** on which the Board places reliance.

The role of the **academies** is to seek assurance, ensure learning and drive improvement in relation to their respective areas of responsibility. They have a broad membership to ensure that there is input from across the Trust and to enable learning and improvements to be shared widely. Four non-executive directors sit on each academy, two of whom act as the Chair and Deputy Chair.

Quality & Patient Safety Academy - the academy's role relates to all aspects of quality and is aligned to the NHS Patient Safety Strategy[77] and national quality standards. Several clinical working groups report to the Academy to provide assurance that safety, clinical outcomes, patient safety and patient experience across the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services.

People Academy - the academy's role relates to the effectiveness of the people management arrangements for the Trust. The academy seeks assurance of compliance with legal and regulatory requirements relating to people, oversees the delivery of action plans, for example relating to the staff survey and Workforce Race Equality Standard, and monitors a range of metrics including safe staffing levels, sickness absence and turnover. Working groups have been set up to align with the commitments within the NHS People Plan, and these report to the Academy on a regular basis. The Health, Safety & Resilience Committee also reports to the People Academy.

Finance and Performance Academy – the academy's remit includes the management of assets and resources in relation to the setting and achievement of financial targets, business objectives and the financial stability of the Trust, and the effective management of all performance-related matters. It has oversight of the development of the Trust's financial and

[77] https://www.england.nhs.uk/patient-safety/the-nhs-patient-safety-strategy/

business plans, performance against national standards, contractual indicators and trust-defined indicators, including benchmarking data where appropriate to ensure that opportunities for learning and improvement are identified.

The Board receives a Chair's report and supporting documents from each of the academies, to provide assurance and enable issues to be escalated where required.

3.8.5.8. Assuring the validity of the Corporate Governance Statement

The Trust undertakes a full self-assessment against the NHS Provider Licence conditions on an annual basis. The assessment for 2021/22 was reviewed by the Board on 12 May 2022 and it was confirmed that the Trust can provide evidence of compliance with all Licence conditions. The assessment against Licence Condition FT4 (NHS Foundation Trust Governance Arrangements) forms the Corporate Governance Statement. The Trust will publish a Corporate Governance Statement on its website by 30 June 2022.

3.8.5.9. Embedding risk management in the activity of the organisation

Risk management is embedded within the Trust at all levels, with risks being considered by specialties, clinical business units, care groups and corporate departments. This will be enhanced by the introduction of the revised Quality Governance Framework in 2022/23.

3.8.5.10. Public stakeholder involvement in risk management

The Board of Directors actively engages with the Council of Governors and our respective public stakeholders in the reporting of the financial and performance management of the Trust and in the management of risks which impact on them. The Council of Governors is a key mechanism in ensuring that our public stakeholders are involved in the understanding and contextualisation of risk. The Council meets formally four times per year and receives reports and updates on performance, quality and safety. The Board of Directors meets in public and all papers are available on our website. During 2021/22 we developed a new membership plan which includes a number of actions to enhance our member engagement and communication activities.

I lead the Trust's executive team in developing positive relationships with stakeholder partners including CCGs, local authority, and other partner organisations across Bradford and across the region through the West Yorkshire Association of Acute Trusts (WYAAT) to support the detection and management of system-wide risk and ensure that patients are provided with the highest possible care within the resources available.

We directly participate in the Bradford District Wellbeing Board, the Health and Social Care Scrutiny Committee and Safeguarding Boards, as well as a range of other forums for service planning, performance and contracting.

On a wider footprint, the Trust is a partner organisation within the West Yorkshire Health and Care Partnership (the Integrated Care System) and is working with others within health and social care to implement key elements of the acute and out of hospital health and social care strategy.

3.8.5.11. Workforce and staffing assurance

On behalf of the Board, the People Academy seeks assurance that the Trust has robust workforce strategies and staffing processes that are safe, sustainable and effective. Reports are also presented to the Board to ensure that the information and discussions are open and transparent. The Nursing Workforce Board Assurance Framework was presented to the Board in March 2022, and is now a standing item on People Academy agendas. Throughout

2021/22, the Academy has also received updates relating to the Trust's response to the NHS People Plan, updates on our nursing recruitment and retention plans, and nurse staffing data. A strategic nurse staffing review was presented to the Academy in April 2022; the Academy was supportive of the proposed changes to the establishment which were subsequently approved by the Board. The Academy has also reviewed the workforce planning submission which forms part of the 2022/23 operational plan.

3.8.5.12. Data security

The Chief Digital and Informatics Officer and Senior Information Risk Owner (SIRO) ensures that there is effective information governance in place. The Caldicott Guardian in the Trust is the Chief Medical Officer. The Caldicott Guardian works closely with the SIRO, particularly where there are any identified information risks relating to patient data.

The Trust ensures effective information governance through a number of mechanisms, including education, policies and procedures, IT controls, and IT vulnerability testing, and by demonstrating annual compliance with the Data Security Standards of the Data Protection and Security Toolkit (DSPT). The Trust has also been awarded the international governance standard for IT and Data Security ISO27001.

3.8.5.13. CQC registration requirements

The Trust is fully compliant with the registration requirements of the CQC.

3.8.5.14. Register of interests

The Trust has published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS[78] guidance.

3.8.5.15. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme[79], 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.

3.8.5.16. Equality and Diversity

Control measures are in place to ensure that all the Trust complies with its obligations under equality, diversity and human rights legislation.

3.8.5.17. Carbon Reduction

The Trust has undertaken risk assessments and ***has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener***

[78] https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/
[79] https://www.nhsbsa.nhs.uk/nhs-pensions

NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

It should be noted that the NHS has throughout 2021/22 continued to operate under an interim financial regime during the period of the pandemic. As such, many of the normal funding arrangements have been suspended, the need to deliver efficiencies has been reduced on a temporary basis and interim internal financial governance arrangements have been maintained to facilitate agile responses to the pandemic.

We have a range of tools and an effective governance infrastructure to ensure resources are used economically, efficiently and effectively. This includes monthly finance and performance reports to the Finance and Performance Academy supporting the use of a finance and performance dashboard. The Board of Directors uses an integrated dashboard, alongside detailed reports to support key metrics in general and by exception, and the BAF to assure and ensure that the Trust is using resources effectively. The Trust also provides financial information to NHS England/Improvement, the Integrated Care System and local 'place' Health Care Partnership on a monthly basis.

Our resources are managed within the framework set by the Standing Financial Instructions, and various guidance documents (which include the performance management and accountability framework together with the budgetary management framework), which have an emphasis on budgetary control, effective deployment of resources and financial management and ensuring that service developments are implemented with appropriate financial controls.

Usually, we have a risk based three-year audit plan with our internal auditors. Due to the impact of the pandemic on both the 2020/21 and 2021/22 plan, we agreed a one-year plan for 2021/22, and have now agreed a three-year plan from 2022/23 onwards. We use the audits regularly to evaluate our effective use of resources.

Our external auditors are required to satisfy themselves that we have made proper arrangements for securing economy, efficiency and effectiveness in our use of resources. This is assessed in a separate value for money audit which seeks to validate our position in this respect and reports any significant weaknesses identified. The External Auditors Annual Report produced in August 2021 (relating to the 2020/21 financial year) reported that they had not identified any significant weaknesses in the Trust's VfM (value for money) arrangements, and so did not report any recommendations in respect of significant weaknesses. They also commented that they were satisfied that the Trust has sufficient arrangements in place to ensure both financial sustainability and to improve economy, efficiency and effectiveness for the size and function of the Trust.

We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance to the extent this has been possible during the interim COVID-19 financial regime under which the NHS has been operating since April 2020.

To ensure that any cost improvement schemes - developed through the care group, clinical business unit and departmental structure - do not impact adversely on the quality of patient care, a Trust approved quality impact assessment process is led by the Chief Medical Officer and the Chief Nurse. This ensures that any schemes identified as having high risks to patient safety have controls or mitigation in place before they are commenced or are not commenced at all. In addition, there is a retrospective review of all schemes where the risk was assessed as low, to ensure that there were no unintended adverse outcomes.

In 2019 NHSI/E rated the Trust's use of resources as 'good'.

Normal financial control and governance arrangements have recommenced for 2022/23, which will require the reintroduction of robust performance management arrangements and the delivery and tracking of financial improvement opportunities to meet the stretching targets set nationally and at an ICS level. The Trust will endeavour to meet this challenge, but recognises the risk faced when seeking an operational response, in light of the operational pressures faced over recent years which are continuing into 2022/23. The ability to refocus capacity and capability, when faced with workforce, operational and pandemic pressures will be a challenge and will need to be managed and monitored carefully throughout the year.

3.8.7. INFORMATION GOVERNANCE

During the last financial year, we have had no externally reportable incidents where personal data has been compromised. The ICO has previously confirmed it believes there are no systemic problems related to incidents in the Trust reported to them previously. The SIRO (Senior Information Risk Officer) and Caldicott Guardian are fully briefed on all reportable incidents, and any recommendations from the ICO are taken on board. In the event of notification of any action planned by the ICO all senior individuals involved would be fully briefed and actions agreed in close liaison with the ICO. A strong emphasis continues to be put on staff awareness around information governance and training to reduce information risk and avoid breaches generally.

Details of data security and protection incidents (personal data breaches) are set out in the tables below. Figure 59 confirms there were no externally reportable incidents. Figure 60 details all information governance incidents classified at lower-level security to 31/03/2022.

Figure 59 - Personal data breaches reported to ICO 2021/22

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentiallyaffected	Notification steps
None	N/A	N/A	N/A	N/A

Figure 60 - Other personal data incidents 2021/22

Category	Breach type (ICO categorisation)	Total number of incidents in this category	
Confidentiality	Unauthorised or accidental disclosure	14	Data emailed to wrong recipient
		23	Data posted/faxed to wrong recipient
		07	Failure to redact data
		08	Verbal disclosures
		18	Accessing records
Availability	Unauthorised or accidental loss	24	Loss or theft of paperwork
		14	Data left in insecure location
Availability	Unauthorised or accidental destruction	N/A	Insecure disposal of paperwork
Integrity	Unauthorised or accidental alteration	34	Other principle seven failure (information incorrect on patient record)

3.8.8. DATA QUALITY AND GOVERNANCE

We have ensured that there are systems and processes in place for the collection, recording, analysis, and reporting of data. Robust controls are in place to continually

evaluate data and ensure it remains accurate, valid, reliable, timely, relevant, and complete on use. These controls are visible via a Trust-wide data quality framework. All data collection and information systems used to record pathway data, clinical activity and/or administrative information across the Trust are within the scope of these controls which assure data across the entire lifecycle, from the point of capture through to disposal.

High quality data is a fundamental requirement for the Trust to conduct its business efficiently and effectively. We are committed to a 'right first time' approach to data quality which applies to all areas: patient care; service development and transformation; corporate governance; and operational and performance management. High quality data is crucial to enable the right decisions to be made regarding patient care.

It is particularly important for us to assure the quality and accuracy of elective waiting time data. We have a range of governance mechanisms to ensure that data generated, collected and used, both internally and externally, is subject to an appropriate level of scrutiny, validation procedures and assurance processes. This includes; data quality 'kite marking' of all Board dashboard indicators, service sign-off processes for mandatory reports, and an annual rolling improvement plan.

Priority data quality issues are monitored via an online accessible dashboard and reported back into operational weekly access and performance meetings.
Although paused during the pandemic, the Data Governance Board (DGB) is in the process of being re-established and will meet quarterly.

The data quality strategy, remit and performance have oversight from the Board of Directors' Audit Committee. The DGB ensures controls related to the maintenance of business critical and master data are appropriate and effective, ensuring subsequent reports, analyses, and decision-making are based on high quality, accurate and reliable data.

The Data Quality (DQ) Issue resolution group has reformed with subject matter panel experts sourced from Corporate Access Team, Informatics Business Intelligence, Informatics DQ, Education and Training team and Clinical Informatics. This group will review and agree actions needed to resolve issues, identify process or configuration changes required, undertake a risk assessment of process failures and assess training requirements and targeted support. This group will report into the Data Governance Board.

An EPR Data Quality Prevent, Correct and Clear model is currently being progressed to support the Data Quality Policy enabling the 'right first time' aim by implementing a tiered infrastructure for operational teams to follow that will enable prevention, correctional locally with support corporately for complex corrections and clear, minimising risk of backlog growths, delays to patient care and improved activity recording.

Virtual data quality drop-in sessions are available for administrative and clinical staff to raise issues and focus on priorities relating to error prevention, correction and validation at an operational level.

Our data quality maturity is assessed on a bi-annual basis through a standard model, reported and approved by the DGB through to the Audit Committee and Quality Academy. Formal education and training programmes support appropriate use of our key information systems for new starters (clinical and administrative) and refresher training is available for priority areas. The Business Intelligence data quality improvement team offers bespoke training support through drop-in sessions, and one-to-one engagement workshops for operational staff focusing on areas for improvement (approximately 70 delivered per annum).

3.8.9. REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors and its committees and plan to address weaknesses and ensure continuous improvement of the system is in place.

In support of this:

- The Head of Internal Audit Opinion on the effectiveness of the system of internal control was presented to the Trust's Audit Committee on 24 May 2022. The opinion was that 'significant assurance can be given that there is a good system of governance, risk management and internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'.
- Internal audits have provided a range of assurance levels, from limited to high assurance. For each internal audit report where a limited assurance opinion is given, the executive director responsible is asked to attend the Audit Committee to discuss the action being taken as a result of the audit. For all internal audit reports, detailed lists of prioritised recommendations are agreed, and the implementation of these recommendations is followed up by internal audit and reported to the Audit Committee.
- The BAF and risk registers provide me with assurance of the effectiveness of the controls being used to manage the risks to the organisation in achieving its strategic objectives and that they have been regularly reviewed. The internal audit of the BAF carries an opinion of significant assurance.
- Through the use of an integrated dashboard the Board and its Academies routinely review contemporaneous and quality assured data in relation to quality, finance, performance, workforce and strategic partnerships.
- The Audit Committee reviews the system of integrated governance, risk management and internal control, across the whole of the organisation's activities - both clinical and non-clinical. The committee maintains an oversight of general risk management structures and ensures appropriate information flows to the Audit Committee in relation to the Trust's overall internal control and risk management position. In carrying out this work the committee primarily utilises the work of internal audit, external audit and other assurance functions, but it is not limited to these audit and assurance functions. It also seeks reports and assurances from Directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- The CQC undertook a well-led inspection in December 2019 at which the Trust was rated as 'good' overall.

Conclusion

No significant internal control issues have been identified which have caused an impact on the completion of this Annual Governance Statement.

Consideration was given to:

- the Trust's financial services provider NHS Shared Business Services[1] (SBS) receiving a qualified audit opinion in line with the requirement of the ISAE 3402 Standard. The qualification relates to two areas of audit testing. The first relates to a chart of accounts update request being completed outside the agreed timeframes. As such this this doesn't affect the Trust's control environment. The other qualification related to maintenance of SBS's estate. Assurance has been provided that measures have been put in place to mitigate these issues.
- the Trust's workforce management provider (Electronic Staff Record (ESR)) receiving a qualified audit opinion in line with the requirement of the ISAE 3000 Standard. The exceptions identified by the service auditor have been reviewed, and it is not considered that there are any associated risks that will have an impact on the Trust.

Signed in respect of the Annual Governance Statement and the Accountability Report.

Mel Pickup
Chief Executive
21 June 2022

[1] https://www.sbs.nhs.uk/

4. APPENDICES

4.1. APPENDIX 1 – CODE OF GOVERNANCE DISCLOSURES

The specific set of disclosures required to be included in the Annual Report to meet the requirements of the Foundation Trust Code of Governance and the additional requirements of the NHSI Annual Reporting Manual are listed below along with the section identifying where they are located within this Annual Report.

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
Board and Council of Governors	A.1.1	The schedule of matters reserved for the board of directors should include a clear statement detailing the roles and responsibilities of the council of governors. This statement should also describe how any disagreements between the council of governors and the board of directors will be resolved. The annual report should include this schedule of matters or a summary statement of how the board of directors and the council of governors operate, including a summary of the types of decisions to be taken by each of the boards and which are delegated to the executive management of the board of directors.	3.1.1 3.5.4
Board, Nomination Committee(s), Audit Committee, Remuneration Committee	A.1.2	The annual report should identify the chairperson, the deputy chairperson (where there is one), the chief executive, the senior independent director (see A.4.1) and the chairperson and members of the nominations, audit and remuneration* committees. It should also set out the number of meetings of the board and those committees and individual attendance by directors. Part of this requirement is also contained within paragraph 2.22 as part of the directors' report. ** This requirement is also contained in paragraph 2.41 of the Annual Reporting Manual (ARM) as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.*	3.1.1 3.2.1 3.2.3.2
Council of Governors	A.5.3	The annual report should identify the members of the council of governors, including a description of the constituency or organisation that they represent, whether they were elected or appointed, and the duration of their appointments. The annual report should also identify the nominated lead governor.	3.5.4.1
Council of Governors	n/a	The annual report should include a statement about the number of meetings of the council of governors and individual attendance by governors and directors.	3.5.4.1
Board	B.1.1	The board of directors should identify in the annual report each non-executive director it considers to be independent, with reasons where necessary.	3.1.1
Board	B.1.4	The board of directors should include in its annual report a description of each director's skills, expertise and experience. Alongside this, in the annual report, the board should make a clear statement about its own balance, completeness and appropriateness to the requirements of the NHS foundation trust.	3.1.1
Board	n/a	The annual report should include a brief description of the length of appointments of the non-executive directors, and how they	3.1.1

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
		may be terminated	
Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	3.2.3.2
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	n/a
Chair/Council of Governors	B.3.1	A chairperson's other significant commitments should be disclosed to the council of governors before appointment and included in the annual report. Changes to such commitments should be reported to the council of governors as they arise, and included in the next annual report.	3.1.1
Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	3.5.4.9
Council of Governors	n/a	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2) (aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	3.5.4.7
Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chairperson, has been conducted.	3.2.3.3. 3.5.4.8. 3.8.4. 3.8.5.7.
Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	n/a
Board	C.1.1	The directors should explain in the annual report their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's Performance, business model and strategy. Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report). See also ARM paragraph 2.95.	3.1.1
Board	C.2.1	The annual report should contain a statement that the board	3.8.3

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
		has conducted a review of the effectiveness of its system of internal controls.	
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report:) if it has an internal audit function, how the function is structured and what role it performs; or) if it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes.	3.5.5.2
Audit Committee/ Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	n/a
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	3.1.1 3.5.5.2
Board/Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	n/a
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	3.5.4.8
Board/Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	3.5.3
Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	3.5.3
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of	3.5.3

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
		members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members.	
Board/Council of Governors	n/a	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possibly seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors' interests which are available to the public, an alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report. See also ARM paragraph 2.22 as directors' report requirement.	3.1.1

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2022

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

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NATIONAL HEALTH SERVICE ACT 2006

***DIRECTIONS BY MONITOR* IN RESPECT OF NHS FOUNDATION TRUSTS' ACCOUNTS**

Monitor, with the approval of the Secretary of State, in exercise of powers conferred on it by paragraphs 24(1A) and 25(1) of Schedule 7 to the National Health Service Act 2006 (the '2006 Act'), hereby gives the following Directions:

1. Application and interpretation

(1) These Directions apply to NHS foundation trusts in England.

(2) In these Directions:

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

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

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

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

(b) "the NHS foundation trust" means the NHS foundation trust in question.

2. Form and content of accounts

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

3. Annual accounts

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

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

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

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

4. Annual accounts: Statement of accounting officer's responsibilities

(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

5. Annual accounts: Foreword to accounts

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

Signed by the authority of Monitor
Signed:

Name: Steve Powis (Interim Chief Executive)
Dated: February 2022

1 INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST

2 Report on the audit of the financial statements

3 Opinion

In our opinion the financial statements of Bradford Teaching Hospital NHS Foundation Trust (the 'Foundation Trust'):

- give a true and fair view of the state of the Foundation Trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the statement of comprehensive income;
- the statement of financial position;
- the statement of changes in taxpayers' equity;
- the statement of cash flows; and
- the related notes 1 to 23.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice and applicable law. Our responsibilities under those standards are further described in the auditor's responsibilities for the audit of the financial statements section of our report.

We are independent of the Foundation Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's (the 'FRC's') Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

4 Conclusions relating to going concern

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

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

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the Foundation Trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts , which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the Foundation Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Foundation Trust without the transfer of the Foundation Trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the Foundation Trust and its control environment, and reviewed the Foundation Trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of non-compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the Foundation Trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the Foundation Trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team including relevant internal specialists such as valuations, and IT regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- determination of whether an expenditure is capital in nature is subjective: we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of year-end capital accruals to supporting documentation and assessed whether the capitalised expenditure is recognised in the correcting accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management and internal audit concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- enquiring of the local counter fraud specialist and review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

5 Report on other legal and regulatory requirements

6 Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

7 Matters on which we are required to report by exception

8 Use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006, we are required to report to you if we have not been able to satisfy ourselves that the Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the Foundation Trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the Foundation Trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the Foundation Trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the Foundation 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 Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in December 2021, as to whether the Foundation Trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the Foundation Trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2022 by the time of the issue of our audit report. Other findings from our work, including our commentary on the Foundation Trust's arrangements, will be reported in our separate Auditor's Annual Report.

9 Annual Governance Statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

10 Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- 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; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the Foundation Trust, or a director or officer of the Foundation Trust, is about to make, or has made, a decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the Foundation Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

11 Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Bradford Teaching Hospital NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards 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 Boards as a body, for our audit work, for this report, or for the opinions we have formed.

Paul Hewitson (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle, United Kingdom
21 June 2022

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2022 issued on 21 June 2022 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2022 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2022 issued on 21 June 2022, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2022 issued on 21 June 2022, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

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

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Bradford Teaching Hospitals NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Paul Hewitson (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle upon Tyne, United Kingdom
27 September 2022

12 FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2022 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the NHS foundation trust) in accordance with paragraph 24 and 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.

Signed:

Name: Mel Pickup (Chief Executive)
Dated: 21 June 2022

13 STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2022

	Note	2021/22 £000	2020/21 £000
Operating income from patient care activities	2.1	469,323	422,366
Other operating income	2.1	64,399	71,605
Operating expenses	3.1	(538,787)	(489,373)
OPERATING SURPLUS / (DEFICIT)		**(5,065)**	**4,598**
FINANCE COSTS			
Finance income	5	46	0
Finance expense	6.1	(317)	(371)
Public dividend capital dividends payable	6.2	(3,598)	(3,329)
NET FINANCE COSTS		**(3,869)**	**(3,700)**
Other losses		(41)	(25)
SURPLUS / (DEFICIT) FOR THE YEAR		**(8,975)**	**873**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairment (losses) / reversal of impairments	15.1	2,323	(9,381)
Revaluation gains	15.1	2,391	443
TOTAL COMPREHENSIVE (EXPENDITURE) FOR THE YEAR		**(4,261)**	**(8,065)**

All income and expenses shown relate to continuing operations.

The notes on pages 14 to 55 form part of these accounts.

14 STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2022

	Note	31 Mar 2022 £000	31 Mar 2021 £000
Non-current assets			
Intangible assets	7.1	12,050	11,067
Property, plant and equipment	8.2	208,345	192,402
Trade and other receivables	10.1	1,939	2,183
Total non-current assets		**222,334**	**205,652**
Current assets			
Inventories	9	7,982	8,095
Trade and other receivables	10.1	21,164	20,355
Cash and cash equivalents	16.1	81,139	75,015
Total current assets		**110,285**	**103,465**
Current liabilities			
Trade and other payables	11	(84,588)	(68,048)
Borrowings	13.1	(3,107)	(3,117)
Provisions	14.1	(964)	(880)
Other liabilities	12	(16,732)	(14,612)
Total current liabilities		**(105,391)**	**(86,657)**
Total assets less current liabilities		**227,228**	**222,460**
Non-current liabilities			
Borrowings	13.1	(16,636)	(19,688)
Provisions	14.1	(4,342)	(4,725)
Other liabilities	12	(4,360)	(2,779)
Total non-current liabilities		**(25,338)**	**(27,192)**
Total assets employed		**201,890**	**195,268**
Financed by taxpayers' equity			
Public Dividend Capital		151,216	140,333
Revaluation reserve	15.1	52,912	49,706
Income and expenditure reserve		(2,238)	5,229
Total taxpayers' equity		**201,890**	**195,268**

These accounts together with notes on pages 14 to 55 were approved by the Board of Directors on [insert date].

Signed:

Name: Mel Pickup (Chief Executive)
Dated: 21 June 2022

15 STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2022

	Total £000	Public Dividend Capital £000	Revaluation reserve (see note 15.1) £000	Income and expenditure reserve £000
Taxpayers' equity at 1 April 2021	**195,268**	**140,333**	**49,706**	**5,229**
(Deficit) for the year	**(8,975)**	0	0	(8,975)
Other transfers between reserves	**0**	0	(1,508)	1,508
Net impairments	**2,323**	0	2,323	0
Revaluations – property, plant and equipment	**2,391**	0	2,391	0
Public dividend capital received	**10,883**	10,883	0	0
Taxpayers' equity at 31 March 2022	**201,890**	**151,216**	**52,912**	**(2,238)**
Taxpayers' equity at 1 April 2020	**188,829**	**125,829**	**60,415**	**2,585**
Surplus for the year	**873**	0	0	873
Other transfers between reserves	0	0	(1,771)	1,771
Net impairments	**(9,381)**	0	(9,381)	0
Revaluations – property, plant and equipment	**443**	0	443	0
Public Dividend Capital received	**14,504**	14,504	0	0
Taxpayers' equity at 31 March 2021	**195,268**	**140,333**	**49,706**	**5,229**

Information on Reserves

Public dividend capital

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

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 expenditure. 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.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

16 STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2022

	Note	2021/22 £000	2020/21 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(5,065)	4,598
Non-cash income and expense			
Depreciation and amortisation	3.1	15,789	14,653
Net Impairments	3.6	10,600	751
Income recognised in respect of capital donations (cash and non-cash)	2.1	(1,004)	(1,347)
Decrease in trade and other receivables		353	8,561
(Increase) / decrease in inventories		113	(125)
Increase in trade and other payables		13,501	20,316
Increase in other liabilities		3,701	7,750
Increase / (decrease) in provisions		(257)	1,181
Net cash flows from operations		**37,731**	**56,338**
Cash flows from investing activities			
Interest received		46	10
Purchase of intangible assets		(4,965)	(3,417)
Purchase of property, plant and equipment and investment property		(29,712)	(15,288)
Sale of property, plant and equipment and investment property		0	16
Receipt of cash donations to purchase capital assets		78	114
Net cash flows used in investing activities		**(34,553)**	**(18,565)**
Cash flows from financing activities			
Public dividend capital received		10,883	14,504
Movement in loans from the Department of Health and Social Care		(3,052)	(3,052)
Interest paid on DHSC loans		(369)	(414)
Public dividend capital dividend paid		(4,516)	(3,414)
Net cash flows from financing activities		**2,946**	**7,624**
Increase/(decrease) in cash and cash equivalents		6,124	45,397
Cash and cash equivalents at 1 April		75,015	29,618
Cash and cash equivalents at 31 March	16.1	**81,139**	**75,015**

NOTES TO THE ACCOUNTS

17 Note 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of all NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2021/22 issued by the Department of Health and Social Care. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

17.1 Accounting convention

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

17.2 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Interest in other Entities

Joint Venture

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

In 2015/16 the NHS foundation trust entered into two joint venture limited liability partnerships Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP. The NHS foundation trust currently holds a 33.33% equity investment in both organisations, with losses limited to £1 each, with Airedale NHS Foundation Trust and Harrogate and District NHS Foundation Trust (from October 2019). The joint ventures have been established to deliver and develop laboratory based pathology services. In applying the equity method the Trust will not show any grouped transactions from the Joint Ventures until such a time that their profits outweigh their losses.

NHS Charitable Funds

The NHS foundation trust has not consolidated the financial statements of Bradford Hospitals Charity (the Charity), charity registration number 1061753, on the grounds of materiality.

The NHS 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 Charities (Accounts and Reports) Regulations 2008 (as modified by section 5 and the Schedule to Order) and the Statement of Recommended Practice (FRS 102, effective from 01 January 2015). The NHS foundation trust Board of Directors has devolved responsibility for the on-

going management of funds to the Charitable Fund Committee, which administers the funds on behalf of the Corporate Trustee.

1.4 Income

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The DHSC GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the NHS foundation trust is contracts with commissioners for health care services. In 2021/22 and 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. The Trust receives block funding from its commissioners where funding envelopes are set at an Integrated Care System level. For the first half of the 2020/21 comparative year, these blocks were set for individual NHS providers directly, but revenue recognition principles are the same. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and in 2020/21 other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

In 2021/22, the Elective Recovery Fund enabled systems to earn income linked to the achievement of elective activity targets including funding any increased use of independent sector capacity. Income earned by the system is distributed between individual entities by local agreement. Income earned from the fund is accounted for as variable consideration.

Revenue was recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the NHS foundation trust reflected this in the transaction price and derecognised the relevant portion of income.

Revenue from research contracts

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

NHS injury cost recovery scheme

The NHS foundation trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The NHS foundation trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset. This has been measured by a Compensation Recovery Unit rate of 23.76% (2020/21: 22.43%).

Grants and donations

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

Apprenticeship service income

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

1.5 Expenditure on employee benefits

Short-term employee benefits

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

NHS Pension Scheme

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

Additional pension liabilities arising from early retirements are not funded by the schemes 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 NHS foundation trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at 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.

1.7 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 NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has a 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 £250 or more, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control; or
    - have a cost of £250 or more and form part of the initial set up cost of a new building or refurbishment of a ward or unit, where the value is consistent with that of grouped assets.

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

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 (SoCI) in the period in which it is incurred.

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided.

Assets held at depreciated replacement cost have been on a single site basis with reprovision of all services on the current Bradford Royal Infirmary site. This meets the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

For non-operational properties, including surplus land, the valuations are carried out at open market value. Any new building construction or an enhancement to an existing building or building related expenditure of greater than, or equal to, £1,000,000 will necessitate a formal impairment valuation.

Depreciation

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

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

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

Gains and losses recognised in the revaluation reserve are reported in the SoCI as an item of 'other comprehensive income'.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. In 2021/22 the impairment is £8,277,000 and in 2020/21 there was an impairment of £10,132,000.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed.

Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets, intended for disposal, are reclassified as 'Held for Sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sales proceeds (if any) and the carrying amount of the asset and is recognised in the SoCI.

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.

This includes assets donated to the NHS foundation trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the DHSC GAM, the NHS foundation trust applies the principle of donated asset accounting to assets that the NHS foundation trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	16	52
Dwellings	27	35
Plant & machinery	5	15
Transport equipment	7	7
Information technology	4	10
Furniture & fittings	7	10

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

1.8 Intangible assets

Recognition

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

Software

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

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised on a straight line basis over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives for intangible assets are between 2 and 10 years.

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of pharmacy inventories is measured using weighted average historical cost method. The cost of other inventories is measured using the First In First Out (FIFO) method. Provision is made where necessary for obsolete, slow moving inventory where it is deemed that the costs incurred may not be recoverable through usage or sale.

In 2020/21 and 2021/22, the NHS foundation trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the DHSC GAM and applying the principles of the IFRS Conceptual Framework, the NHS foundation trust accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department of Health and Social Care.

1.10 Cash and cash equivalents

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

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

1.11 Climate Change Levy

Expenditure on the climate change levy is recognised in the SoCI as incurred, based on the prevailing chargeable rates for energy consumption.

1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the NHS foundation trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the NHS foundation trust recognises an allowance for expected credit losses.

The NHS foundation trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated by applying a rolling 3 year average write off percentage against Non-NHS aged debt. The write off percentage for each financial year is based upon the total invoice written off against total invoices raised in the respective financial year. This approach is applied to a number of income streams to capture their different risk profiles.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The NHS foundation trust as a lessee

Finance leases

The NHS foundation trust does not currently hold Finance leases.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Leases of land and buildings

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

The NHS foundation trust as a lessor

Finance leases

The NHS foundation trust does not currently hold Finance leases.

Operating leases

The NHS found trust does not currently hold Operating leases.

1.14 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
- where 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.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 1.30% in real terms (2020/21: minus 0.95%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although the NHS Resolution 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 NHS Resolution on behalf of the NHS foundation trust is disclosed at note 14 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 NHS foundation trust pays an annual contribution to the NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

1.15 Contingencies

Contingent assets (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 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.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS foundation trust. PDC is recorded at the value received.

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, with certain additions and deductions as defined in the PDC dividend policy issues by the DHSC. This policy is available at https://www.gov.uk/government/publications-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

Most of the activities of the NHS foundation trust are an exempt VAT supply and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of both intangible assets and property, plant and equipment. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

The NHS 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 2021, this power has not been exercised. Accordingly, the NHS foundation trust is not within the scope of corporation tax.

1.19 Foreign exchange

The functional and presentational currencies of the NHS foundation trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the NHS foundation trust has assets or liabilities denominated in a foreign currency at the SoFP date:

- monetary items are translated at the spot exchange rate on 31 March 2021;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SoFP date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties in which the NHS foundation trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 16.1 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.21 Losses and special payments

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

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

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2021/22.

1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

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

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The NHS foundation trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the NHS foundation trust will apply the standard retrospectively without restatement and with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the NHS foundation trust's incremental borrowing rate. The NHS foundation trust's incremental borrowing rate will be a rate defined by HM Treasury. For 2022 this rate is 0.95%. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. No adjustments will be made on 1 April 2022 for existing finance leases.

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

The NHS foundation trust has estimated the impact of applying IFRS 16 in 2022/23 on the opening statement of financial position and the in-year impact on the statement of comprehensive income and capital additions as follows:

Estimated impact on 1 April 2022 statement of financial position	**£000**
Additional right of use assets recognised for existing operating leases	11,885
Additional lease obligations recognised for existing operating leases	(11,849)
Changes to other statement of financial position line items	0
Net impact on net assets on 1 April 2022	**36**

Estimated in-year impact in 2022/23	**£000**
Additional depreciation on right of use assets	(1,345)
Additional finance costs on lease liabilities	(106)
Lease rentals no longer charged to operating expenditure	1,408
Other impact on income / expenditure	0
Estimated impact on surplus / deficit in 2022/23	**(43)**

Estimated increase in capital additions for new leases commencing in 2022/23	**3,520**

IFRS 17 Insurance Contracts

Application is required for accounting periods beginning on or after 01 January 2023. The standard is yet to be adopted by the FReM and therefore early adoption is not permitted. Work has not yet started on understanding the impact that this standard will have in the NHS.

At this stage and subject to any interpretation by the FT ARM, we do not envisage a material impact on the NHS foundation trust's financial statements as a result of adopting IFRS 17.

1.25 Critical accounting judgements

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of land and buildings

The valuation of land and buildings has been identified as a critical accounting judgement. The valuation is provided by an independent valuer, Cushman & Wakefield, who have applied the modern equivalent asset valuation. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery or reduced operational use.

1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

i. Impairments are recognised where management believe that there is an indication of impairment (through for example, obsolescence). They are recognised where the carrying amount of an asset exceeds its estimated recoverable amount. Significant assets of the NHS foundation trust are reviewed for impairment as they are brought into operational use. Where possible specialists are used to value the recoverable amout however there remains a degree of uncertainty within these estimates. The value of impairments charged to the Statement of Comprehensive Income is disclosed in Note 7 Intangible Assets and Note 8 Property, plant and equipment. Total impairment losses charged to the Statement of Comprehensive Income for 2021/22 amounted to £10,600,000 (2020/21: £751,000).

ii. The valuation of the NHS foundation trust's estate is based on reports from a Chartered Surveyor on a five-year rolling basis, supplemented by indices provided by the Surveyor in the intervening period where values change by 5% or more. These property valuations and useful economic lives are based on the Royal Institute of Chartered Sureveyors valuation standards. The valuation indices include estimates for building costs including materials and adjustments for local market values. The net book value of the NHS foundation trust's land, buildings and dwellings as at 31 March 2022 was £169,616,000 (31 March 2021: £158,333,000).

iii. The NHS foundation trust hold a number of provisions where the actual outcome may vary from the amount recognised in the financial statements. Provisions are based on the most reliable evidence available at the year-end, however by their nature they are a matter of judgement and estimation. Provisions that carry a high degree of uncertainty include those relating to legal settlements yet to be finalised. These include employment tribunals, claims relating to employee contracts and third party and employee liability claims. Details surrounding provisions held at the year-end are included in Note 14 Provisions. Uncertainties and issues arising from provisions and contingent liabilities are assessed and reported in Note 14 Provisions and Note 18 Contingent liabilities / assets. As at 31 March 2022 provisions

amounted to £5,306,000 (31 March 2021: £5,605,000) and contingent liabilities amounted to £74,000 (31 March 2021: £68,000).

iv. The NHS foundation trust has a number of agreements in place to provide services over more than one year (for example, contracts relating to research and development). These agreements are reviewed at each Statement of Financial Position date to identify which contractual obligations have been completed and which remain outstanding. The revenue recognised in the year reflects the calculated value of the completed contractual obligations. Income which has been deferred to future periods relating to these contracts at 31 March 2022 amounted to £21,092,000 (31 March 2021: £17,391,000).

18 Note 2 Operating income

Note 2.1 Income from patient care (by nature)

	Note	2021/22 £000	2020/21 £000
Income from activities			
Block contract / system envelope income		348,289	366,336
High cost drugs income from commissioners		40,693	36,297
Private patient income		99	49
Elective recovery fund		1,282	0
Additional pension contribution central funding[1]		12,500	12,001
Other clinical income	2.2	66,460	7,683
Total income from activities		**469,323**	**422,366**
Other operating income from contracts with customers:			
Research and development		10,077	4,656
Education and training		21,909	19,631
Reimbursement and top up funding		6,028	22,265
Income in respect of employee benefits accounted on a gross basis	2.3	5,436	4,197
Other Income	2.4	9,581	6,557
Other non-contract operating income			
Research and development (non-contract)		7,909	4,648
Education and training		882	628
Receipt of capital grants and donations		1,004	1,347
Charitable and other contributions to expenditure		1,573	7,676
Total other operating income		**64,399**	**71,605**
Total		**533,722**	**493,971**

[1]The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

Note 2.2 Other clinical income

Other clinical income in the main comprises of Covid 19 funding £64,700,000 (2020/21: nil), cystic fibrosis and maternity pathway £500,000 (2020/21: nil), Road Traffic Accident (RTA) income £900,000 (2020/21: 903,000) and income from overseas patients £234,000 (2020/21: £367,000). Other clinical income in 2020/21 also included annual leave central funding £5,965,000, central funding for overtime payment and pay during annual leave (Flowers) £438,000. Nil funding was provided for these items in 2021/22.

Overseas visitors (relating to patients charged directly by the provider)

	2021/22 £000	2020/21 £000
Income recognised this year	234	367
Cash payments received in-year	14	52
Amounts added to provision for impairment of receivables	87	227
Amounts written off in-year	684	243

Note 2.3 Income in respect of employee benefits accounted for on a gross basis

Provider to provider income relates to services provided by the NHS foundation trust to other trusts or commissioners. Income recorded under this heading relates to areas including ear, nose and throat, ophthalmology and plastic surgeons working at Calderdale and Huddersfield NHS Foundation Trust £287,000 (2020/21: £270,000), Airedale NHS Foundation Trust £1,779,000 (2020/21: £1,436,000), individual posts and services charged to Leeds Teaching Hospitals £344,000 (2020/21: £524,000), Bradford District Care Trust £535,000 (2020/21: £368,000), other hospitals across Yorkshire £153,000 (2020/21: £203,000), paediatrics for Bradford District and Craven CCG's, Department of Health and Social Care and Health Education England £499,000 (2020/21: nil) and support to non NHS organisations £1,839,000 (2020/21: £1,396,000) including McMillian Cancer Support and Marie Curie Hospice for doctors, nurses, AHPs and administrative staff.

Note 2.4 Other income

Other income, in the main, includes income associated with services provided to other NHS organisations & local authorities £6,390,000 (2020/21: £4,470,000), pharmacy sales £1,282,000 (2020/21: £1,448,000), car parking income £465,000 (2020/21: £27,000), catering £627,000 (2020/21: £210,000), clinical excellence awards £289,000 (2020/21: £161,000) and staff accommodation £233,000 (2020/21: £215,000).

Note 2.5 Segmental analysis

The Chief Operating Decision Maker (CODM) is the Board of Directors because it is at this level where overall financial performance is measured and challenged. The Board of Directors primarily considers financial matters at a trust wide level. The Board of Directors is presented with information on clinical divisions but this is not the primary way in which financial matters are considered.

The NHS foundation trust has applied the aggregation criteria from IFRS 8 operating segments because the clinical divisions provide similar services, have homogenous customers, common production processes and a common regulatory environment. Therefore the NHS foundation trust believes that there is one segment and have reported under IFRS 8 on this basis.

To effectively manage financial performance the Board of Directors review organisation wide income and expenditure, cash, liquidity and capital programme delivery against an approved annual plan. The Board of Directors also review operational performance including waiting lists, achievement of the emergency care standard, length of stage and bed occupancy.

Note 2.6 Income from patient care (by source)

Income from activities	**2021/22 £000**	**2020/21 £000**
NHS England	86,427	85,927
Clinical commissioning groups	381,084	334,561
NHS Foundation Trusts	182	350
NHS Trusts	382	193
NHS other (including Public Health England)	0	1
Non-NHS: private patients	99	49
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	234	367
Injury cost recovery scheme	915	903
Non-NHS: Other	0	15
Total income from activities	**469,323**	**422,366**
Of which:		
Related to continuing operations	469,323	422,366
Related to discontinued operations	0	0

Note 2.7 Income from activities arising from commissioner requested services

	2021/22 £000	**2020/21 £000**
Income for services designated as commissioner requested services	467,511	420,504
Income from services not designated as commissioner requested services	1,812	1,862
Total	**469,323**	**422,366**

Under the terms of its provider license, the NHS foundation 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.

19 Note 3 Operating expenses

Note 3.1 Operating expenses

	Note	2021/22 £000	2020/21 £000
Purchase of healthcare from NHS and DHSC bodies		1,870	1,924
Purchase of healthcare from non NHS bodies and non-DHSC bodies		6,376	1,288
Staff and executive directors costs		314,077	303,061
Non-executive directors		155	98
Supplies and services – clinical (excluding drug costs)		57,477	51,725
Supplies and services – general		24,247	21,987
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		43,131	37,646
Inventories written down		0	344
Consultancy costs		1,025	984
Establishment		3,365	2,792
Premises – business rates collected by local authorities		1,536	1,950
Premises – other		7,722	7,486
Transport – (business travel only)		476	382
Transport – other (including patient travel)		4	2
Depreciation on property, plant & equipment		10,345	10,760
Amortisation on intangible assets		5,444	3,893
Impairments net of (reversals)	3.6	10,600	751
Movement in credit loss allowance: contract receivables / assets		9	51
Change in provisions discount rate		99	139
Audit services – statutory audit		92	83
Internal Audit – non-staff		203	195
Clinical negligence – amounts payable to the NHS Resolution (premium)		16,216	15,575
Legal fees		188	72
Insurance		474	360
Research and development – staff costs		10,065	8,962
Research and development – non-staff		9,098	6,097
Education and training – staff costs		8,137	6,430
Education and training – non-staff		2,165	158
Education and training – notional expenditure funded from apprenticeship fund		882	628
Operating lease expenditure	3.3	2,106	2,568
Car parking and security		8	12
Hospitality		82	1
Other losses and special payments – non-staff		138	18
Other services (e.g. external payroll)		975	951
Total		**538,787**	**489,373**

Note 3.2 Other audit remuneration

There were no non-audit fees payable to the external auditor in 2021/22 (2020/21: nil).

Note 3.3 Operating leases

	2021/22	2020/21
	£000	£000
Minimum lease payments	2,106	2,568
Total	**2,106**	**2,568**

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

Note 3.4 Future minimum lease payments

	2021/22	2020/21
	£000	£000
- not later than one year	4,730	4,815
- later than one year and not later than five years	2,402	1,950
Total	**7,132**	**6,765**

Leases comprise of buildings, medical equipment, motor vehicles and other equipment.

Buildings relates to leases held in Community Health Partnerships Limited for accommodation acquired through Transforming Community Services.

All medical equipment currently held under lease is leased under NHS Purchasing and Supply Agency agreements. These make no provision for any contingent rentals. They are silent on renewal and purchase options and do not comprise escalation clauses. The framework they provide is consistent with an operating lease arrangement.

Motor vehicles and other equipment currently held under lease are leased under agreements specific to the lessor concerned. None of the agreements currently in force make provision for any contingent rentals nor include escalation clauses.

There was no intention from the inception of any of the current leases that any of the leased equipment would be purchased outright either at the end of, or at any time during, the lease terms.

Note 3.5 Limitation on auditor's liability

In accordance with SI 2008 no.489, the Companies (Disclosure of Auditor Remuneration and Liability Limitation Agreement) Regulations 2008, the limitation on auditor’s liability for the year ended 31 March 2022 is £1,000,000 (31 March 2021 £1,000,000).

Note 3.6 Impairment of assets

	2021/22 £000	2020/21 £000
Changes in market price	10,597	273
Other	3	478
Total net impairments charged to operating surplus	**10,600**	**751**
Impairments charged to the revaluation reserve	(2,323)	9,381
Total net impairments	**8,277**	**10,132**

20 Note 4 Employee expenses

Note 4.1 Employee expenses

	2021/22 £000	2020/21 £000
Salaries and wages	255,852	243,348
Social security costs	24,369	24,523
Apprenticeship Levy	1,276	1,196
Employer's contributions to NHS Pensions	41,043	41,599
Temporary Staff - Agency / contract staff	10,079	8,268
Total	**332,619**	**318,934**
Included within :		
Costs capitalised as part of assets	340	481

All employer pension contributions in 2021/22 and 2020/21 were paid to the NHS Pensions Agency.

The operating employee expense, excluding costs capitalised as part of assets, of £332,279,000 is reported in table 3.1 Operating expenses as Staff and executive directors costs (£314,077,000), Research and Development – staff costs (£10,065,000) and Education and training – staff costs (£8,137,000).

Salaries and wages include £17,956,000 for internal temporary bank staff (2020/21: £16,649,000).

Included in the above figures are the following balances for executive directors:

	2021/22 £000	2020/21 £000
Directors' remuneration	1,253	1,315
Employer pension contributions in respect of directors	172	155

Note 4.2 Average number of employees

	2021/22	2020/21
	WTE	WTE
Medical and dental	881	843
Administration and estates	1,882	1,892
Healthcare assistants and other support staff	714	712
Nursing, midwifery and health visiting staff	2,044	2,061
Scientific, therapeutic and technical staff	777	766
Other	3	2
Total	**6,301**	**6,276**
of which		
Number of employees engaged on capital projects	9	9

Note 4.3 Exit package cost band (including any special payment element)

	2021/22	2021/22	2020/21	2020/21
	Total number of exit packages	Total cost of exit packages £000	Total number of exit packages	Total cost of exit packages £000
<£10,000	2	9	4	16
£10,000 - £25,000	2	28	1	19
£25,001 - £50,000	0	0	0	0
£50,001 - £100,000	0	0	0	0
Total	**4**	**37**	**5**	**35**

Note 4.4 Exit packages: other (non-compulsory) departure payment

	2021/22 Agreements	2021/22 Total value of agreements	2020/21 Agreements	2020/21 Total value of agreements
	Number	£000	Number	£000
Contract payments in lieu of notice	0	0	4	16
Exit payments following employment tribunals or court orders	2	19	1	19
Total	**2**	**19**	**5**	**35**

Note 4.5 Early retirements due to ill health

	2021/22 £000	2021/22 Number	2020/21 £000	2020/21 Number
Number of early retirements on the grounds of ill-health	-	4	-	6
Value of early retirements on the grounds of ill-health	185	-	130	-

Note 4.6 Analysis of termination benefits

	2021/22 £000	2021/22 Number	2020/21 £000	2020/21 Number
Number of cases	-	0	-	0
Cost of cases	0	-	0	-

Note 4.7 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 for Health and Social Care 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 is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2022, is based on valuation data as 31 March 2021, updated to 31 March 2022 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay.

The 2016 funding valuation also expected the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. There was initially a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

HMT published valuation directions dated 7 October 2021 (see Amending Directions 2021) that set out the technical detail of how the costs of remedy are included in the 2016 valuation process. Following these directions, the scheme actuary has completed the cost control element of the 2016 valuation for the NHS Pension Scheme, which concludes no changes to benefits or member contributions are required. The 2016 valuation reports can be found on the NHS Pensions website at https://www.nhsbsa.nhs.uk/nhs-pension-scheme-accounts-and-valuation-reports.

Auto-enrolment / NEST Pension Scheme

On 1 April 2013, the NHS 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 1 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 NHS foundation trust is required to make contributions to the NEST pension fund for any such employees enrolled. From April 2019 onwards the combined contribution rate (employee and employer) is 8%, with a contribution of 3% from the NHS Foundation Trust.
Employees are permitted to opt out of the auto-enrolment, from 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 NHS foundation trust.

In the financial year to 31 Mar 2022, the NHS foundation trust made contributions totalling £99,000 into the NEST fund (31 March 2021 £89,000).

21 Note 5 Finance income

	2021/22 £000	2020/21 £000
Interest on bank accounts	46	0
Total	**46**	**0**

Interest receivable relates to interest earned with the Government Banking Service and the National Loans Fund.

2020/21 interest earned is nil due to the Bank of England base rate being set at 0.1% throughout the year.

22 Note 6 Finance costs and Public Dividend Capital dividend

Note 6.1 Finance costs

Interest expense amounted to £359,000 (2020/21: £402,000). This is interest due on the following loans taken from the DHSC.

Date Total Loan Taken	Duration of Loan	Total Loan Amount (£000)	Remaining Amount to Withdraw (£000)	Amount Repaid (£000)	Balance Outstanding (£000)	Total Interest (£000)
20 June 2016	20 Years	20,000	0	6,312	13,688	283
19 September 2016	8 Years	16,000	0	10,000	6,000	76
		36,000	**0**	**16,312**	**19,688**	**359**

The unwinding of discount on provisions amounted to negative £42,000 (2020/21 negative £31,000).

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2021/22 or 2020/21.

Note 6.2 Public dividend capital dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. See accounting policy 1.17 for an explanation of how this dividend is calculated.

The amount payable this year is £3,598,000 (2020/21: £3,329,000), which is 3.50% of the year's average relevant net assets of £194,650,000 (2020/21: £182,983,000) less average daily cleared cash balance £91,841,000 (2020/21: £87,873,000) at 3.50%.

Note 6.3 Losses and special payments

NHS Foundation Trusts are required to record cash and other adjustments that arise as a result of losses and special payments. These losses to the NHS foundation trust will result from the write off of bad debts, compensation paid for lost patient property, or payments made for litigation claims in respect of personal injury. In the year the NHS foundation trust has had 392 (2020/21: 223) separate losses and special payments, totalling £1,280,000 (2020/21: £335,000). The bulk of these were in relation to bad debts and ex gratia payments in respect of overtime corrective payments to staff.

Losses and special payments are reported on an accruals basis but excluding provisions for future losses.

	2021/22 Total Number of Cases Number	2021/22 Total Value of Cases £000	2020/21 Total Number of Cases Number	2020/21 Total Value of Cases £000
Losses				
Cash losses	10	3	25	9
Bad debts and claims abandoned	309	687	174	264
Total losses	**319**	**690**	**199**	**273**
Special Payments				
Ex-gratia payments	73	590	24	62
Total special payments	**73**	**590**	**24**	**62**
Total losses and special payments	**392**	**1,280**	**223**	**335**

Included within ex-gratia payments are overtime corrective payments to staff of £454,000. These payments were made following the Flowers court ruling which entitles staff to holiday pay on overtime.

23 Note 7 Intangible assets

Note 7.1 Intangible assets 2021/22

	Total	Software licences
	£000	£000
Valuation / gross cost at 1 April	19,978	19,978
Additions – purchased / internally generated	6,430	6,430
Reclassifications	270	270
Disposals / derecognition	(4,140)	(4,140)
Gross cost at 31 March	**22,538**	**22,538**
Accumulated amortisation at 1 April	**8,911**	**8,911**
Provided during the year	5,444	5,444
Impairments	3	3
Reclassifications	270	270
Disposals / derecognition	(4,140)	(4,140)
Amortisation at 31 March	**10,488**	**10,488**
Net book value at 31 March 2022	**12,050**	**12,050**
Net book value at 31 March 2021	**11,067**	**11,067**

Note 7.2 Intangible assets 2020/21

	Total	Software licences
	£000	£000
Valuation / gross cost at 1 April	**24,365**	24,365
Additions – purchased / internally generated	**3,520**	3,520
Additions – donation of physical assets (non cash)	**5**	5
Reclassifications	**763**	763
Disposals / derecognition	**(8,675)**	(8,675)
Gross cost at 31 March	**19,978**	**19,978**
Accumulated amortisation at 1 April	**12,699**	**12,699**
Provided during the year	**3,893**	3,893
Impairments	**68**	68
Reclassifications	**926**	926
Disposals / derecognition	**(8,675)**	(8,675)
Amortisation at 31 March	**8,911**	**8,911**
Net book value at 31 March 2021	**11,067**	**11,067**
Net book value at 31 March 2020	**11,666**	**11,666**

All assets classed as intangible meet the criteria set out in IAS 38 (2) in terms of identifiability, control (power to obtain benefits from the asset), and future economic benefits (such as revenues or reduced future costs). The cost less residual value of an intangible asset with a finite useful life is amortised on a systematic basis over that life, as required by IAS 38 (97).

The electronic patient records system is a material asset within the NHS foundation trusts intangible assets balance. The closing net book value of the asset was £3,118,000 (2020/21: £4,157,000) which will be amortised over the life of the service contract which expires on 31 January 2025.

Note 8 Property, plant and equipment

Note 8.1 Property, plant and equipment 2021/22

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	**226,078**	**9,062**	**146,252**	**3,019**	**7,026**	**43,272**	**39**	**17,131**	**276**
Additions – purchased	**31,208**	0	1,440	0	22,741	4,200	3	2,822	2
Additions – donations / grants	**1,004**	0	84	0	0	920	0	0	0
Impairments charged to revaluation reserve	**(3,748)**	0	(3,748)	0	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	**6,071**	0	5,897	174	0	0	0	0	0
Reclassifications	**(270)**	0	20,562	0	(20,562)	32	14	(241)	(75)
Revaluations	**(12,764)**	1,815	(14,486)	(93)	0	0	0	0	0
Disposals	**(7,253)**	0	0	0	0	(6,533)	0	(628)	(92)
Valuation/Gross cost at 31 March	**240,326**	**10,877**	**156,001**	**3,100**	**9,205**	**41,891**	**56**	**19,084**	**111**
Accumulated depreciation at 1 April	**33,676**	**0**	**0**	**0**	**0**	**25,357**	**23**	**8,050**	**245**
Provided during the year	**10,345**	0	4,823	97	0	3,185	2	2,209	29
Impairments charged to operating expenses	**13,333**	0	13,333	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	**(2,736)**	(1,008)	(1,728)	0	0	0	0	0	0
Revaluations	**(15,155)**	1,008	(16,066)	(97)	0	0	0	0	0
Reclassifications	**(270)**	0	0	0	0	33	14	(242)	(75)
Disposals	**(7,212)**	0	0	0	0	(6,492)	0	(628)	(92)
Accumulated depreciation at 31 March	**31,981**	**0**	**362**	**0**	**0**	**22,083**	**39**	**9,389**	**107**

A desktop valuation for land, buildings and dwellings was carried out at 31st March 2022 the independent valuer Cushman & Wakefield. The modern equivalent asset valuation was applied based on a single site replacement of the NHS foundation trust's buildings based at the Bradford Royal Infirmary.

Plant and Machinery assets with a total gross value of £6,533,000 were disposed of in 2021/22 (2020/21: £2,901,000). The vast majority of these assets had a nil net book value. The large disposal includes assets which have been held for over 7 years and were no longer in use.

Note 8.2 Property, plant and equipment financing 2021/22

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	**204,006**	10,877	153,448	3,100	9,205	17,663	17	9,695	1
Donated	**4,339**	0	2,191	0	0	2,145	0	0	3
Net book value at 31 March	**208,345**	**10,877**	**155,639**	**3,100**	**9,205**	**19,808**	**17**	**9,695**	**4**

No assets were held under finance leases and hire purchase contracts at the SoFP date in either 2021/22 or 2020/21.

No depreciation was charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts in either 2021/22 or 2020/21.

There are no restrictions imposed by the donors on the use of donated assets.

Note 8.3 Property, plant and equipment 2020/21

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	**229,914**	**8,662**	**155,843**	**3,210**	**0**	**35,819**	**42**	**25,941**	**397**
Additions – purchased	**25,491**	0	4,220	42	7,026	8,169	16	6,018	0
Additions – donations / grants	**1,342**	0	126	0	0	1,216	0	0	0
Impairments charged to operating expenses	**0**	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	**(9,381)**	0	(9,249)	(132)	0	0	0	0	0
Reclassifications	**(763)**	0	0	0	0	969	0	(1,733)	1
Revaluations	**(4,389)**	400	(4,688)	(101)	0	0	0	0	0
Disposals	**(16,136)**	0	0	0	0	(2,901)	(19)	(13,095)	(121)
Valuation/Gross cost at 31 March	**226,078**	**9,062**	**146,252**	**3,019**	**7,026**	**43,272**	**39**	**17,131**	**277**
Accumulated depreciation **at 1 April**	**44,086**	**0**	**0**	**0**	**0**	**24,457**	**41**	**19,341**	**247**
Provided during the year	**10,760**	0	4,458	101	0	2,955	1	3,128	117
Impairments charged to operating expenses	**1,565**	0	1,155	0	0	326	0	82	2
Reversal of impairments charged to operating expenses	**(882)**	0	(882)	0	0	0	0	0	0
Revaluations	**(4,832)**	0	(4,731)	(101)	0	0	0	0	0
Reclassifications	**(926)**	0	0	0	0	479	0	(1,406)	1
Disposals	**(16,095)**	0	0	0	0	(2,860)	(19)	(13,095)	(121)
Accumulated depreciation at 31 March	**33,676**	**0**	**0**	**0**	**0**	**25,357**	**23**	**8,050**	**246**

Note 8.4 Property, plant and equipment financing 2020/21

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - Purchased	**188,891**	9,062	144,207	3,019	7,026	16,467	16	9,074	20
Donated	**3,511**	0	2,045	0	0	1,448	0	7	11
Net book value at 31 March	**192,402**	**9,062**	**146,252**	**3,019**	**7,026**	**17,915**	**16**	**9,081**	**31**

25 Note 9 Inventories

	31 Mar 22	31 Mar 21
	£000	£000
Consumables	3,674	4,847
Drugs	4,248	3,187
Buildings and engineering	60	61
Total	**7,982**	**8,095**

Inventories recognised in expenses for the year were £43,131,000 (2020/21: £44,597,000). Write-down of inventories recognised as expenses for the year were nil (2020/21: £344,000).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2021/22 the Trust received £1,468,000 of items purchased by DHSC (2020/21: £7,420,000).

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

26 Note 10 Receivables

Note 10.1 Trade receivables and other receivables

	31 Mar 22	31 Mar 21
	£000	£000
Current		
Contract receivables	14,559	14,166
Contract assets	0	0
Capital receivables	0	0
Allowance for impaired contract receivables / assets	(805)	(928)
Prepayments	4,264	4,608
Interest receivable	0	0
PDC dividend receivable	1,254	336
VAT receivables	1,458	1,360
Other receivables	434	813
Total	**21,164**	**20,355**
Non-current		
Contract receivables	1,117	1,071
Other receivables – revenue	822	1,112
Total	**1,939**	**2,183**
Of which receivables from NHS and DHSC group bodies		
Current	9,091	7,624
Non-current	822	1,112

Note 10.2 Allowances for credit losses 2021/22

	2021/22 Contract receivables and contract assets £000	2021/22 All other receivables £000	2020/21 Contract receivables and contract assets £000	2020/21 All other receivables £000
Allowances as at 1 April 2021 – brought forward	**928**	**0**	**934**	**0**
New allowances arising	41	0	116	0
Reversals of allowances	(32)	0	(65)	0
Utilisation of allowances (write offs)	(132)	0	(57)	0
Total	**805**	**0**	**928**	**0**

Note 10.3 Exposure to credit risk

The NHS foundation trust receives the majority of it's income from CCG's, NHS England and statutory bodies and therefore the credit risk is negligible.

27 Note 11 Trade and other payables

	31 Mar 22 £000	31 Mar 21 £000
Current		
Trade payables	17,636	15,384
Capital payables	16,360	13,321
Other taxes payable	7,418	6,529
Other payables	2,481	4,091
Accruals	40,693	28,723
Total	**84,588**	**68,048**
Of which payables from NHS and DHSC group bodies:		
Current	2,216	4,733

28 Note 12 Other liabilities

	31 Mar 22 £000	31 Mar 21 £000
Current		
Deferred income: contract liabilities	16,732	14,612
Deferred grants	0	0
Total other current liabilities	**16,732**	**14,612**
Non-current		
Deferred income: contract liabilities	4,360	2,779
Deferred grants	0	0
Total other non-current liabilities	**4,360**	**2,779**

29 Note 13 Borrowings

Note 13.1 Borrowings

	31 Mar 22 £000	31 Mar 21 £000
Current		
Loans from DHSC (capital loans)	3,107	3,117
Total	**3,107**	**3,117**
Non-current		
Loans from DHSC (capital loans)	16,636	19,688
Total	**16,636**	**19,688**

Note 13.2 Borrowings Reconciliation of liabilities arising from financing activities

	Loans from DHSC £000	Total £000
Carrying value at 1 April 2021	**22,805**	**22,805**
Cash movements:		
Financing cash flows – payments and receipts of principal	(3,052)	(3,052)
Financing cash flows – payments of interest	(369)	(369)
Non-cash movements:		
Application of effective interest rate	359	359
Carrying value at 31 March 2022	**19,743**	**19,743**

30 Note 14 Provisions

Note 14.1 Provisions for liabilities and charges

	Current 31 Mar 22 £000	Current 31 Mar 21 £000	Non-current 31 Mar 22 £000	Non-current 31 Mar 21 £000
Pensions – Injury benefits	123	122	2,312	2,357
Legal claims	0	0	552	574
Equal pay	0	0	143	106
Other	841	758	1,335	1,688
Total	**964**	**880**	**4,342**	**4,725**

Note 14.2 Provisions for liabilities and charges analysis 2021/22

	Total £000	Pensions – Injury benefits £000	Legal Claims £000	Equal Pay £000	Other £000
At 1 April 2021	**5,605**	**2,479**	**574**	**106**	**2,446**
Change in the discount rate	**99**	89	0	0	10
Arising during the year	**474**	13	156	37	268
Utilised during the year – cash	**(192)**	(113)	0	0	(79)
Reversed unused	**(638)**	0	(178)	0	(460)
Unwinding of discount rate	**(42)**	(33)	0	0	(9)
At 31 March 2022	**5,306**	**2,435**	**552**	**143**	**2,176**
Expected timings of cash flows:					
-not later than one year	**964**	123	0	0	842
-later than one year and not later than five years	**4,342**	2,312	552	143	1,334
Total	**5,306**	**2,435**	**552**	**143**	**2,176**

Legal claims relate to a provision for claims relating to employment tribunals. Equal pay claims relate to a provision for claims relating to employment contracts.

Other contains amounts due as a result of third party and employee liability claims of £729,000. The values are based on information provided by the NHS Resolution, NHS Business Services Authority and NHS Pensions.

Other also includes clinician pension tax reimbursement of £824,000 (2020/21: £1,210,000). This relates to a commitment to repay clinicians the tax charge they incur when their pension grows above the annual allowance threshold. Payment will be made on retirement and the scheme is only open to members of the NHS Pension scheme. Additionally, Other also contains reimbursement of VAT recovery relating to salary sacrifice of £624,000 (31 March 2021: £454,000).

As at 31 March 2021 the provisions of NHS Resolution include £404,377,000 (31 March 2021: £253,381,000) in respect of clinical negligence liabilities of the NHS foundation trust.

31 Note 15 Revaluation reserve movement

Note 15.1 Revaluation reserve movement – 2021/22

	Note	Total revaluation reserve £000	Revaluation reserve – intangibles £000	Revaluation reserve – property, plant and equipment £000
Revaluation reserve at 1 April		49,706	0	49,706
Net Impairments	3.6	2,323	0	2,323
Revaluations		2,391	0	2,391
Transfers to other reserves		(1,508)	0	(1,508)
Revaluation reserve at 31 March		**52,912**	**0**	**52,912**

Note 15.2 Revaluation reserve movement – 2020/21

	Note	Total revaluation reserve £000	Revaluation reserve – intangibles £000	Revaluation reserve – property, plant and equipment £000
Revaluation reserve at 1 April		60,415	0	60,415
Net Impairments	3.6	(9,381)	0	(9,381)
Revaluations		443	0	443
Transfers to other reserves		(1,771)	0	(1,771)
Revaluation reserve at 31 March		49,706	0	49,706

32 Note 16 Cash and cash equivalents

Note 16.1 Cash and cash equivalents

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.

	2021/22 £000	2020/21 £000
At 1 April	**75,015**	**29,618**
Net change in year	6,124	45,397
At 31 March	**81,139**	**75,015**
Broken down into:		
Cash at commercial banks and in hand	26	11
Cash with the Government Banking Service	81,113	75,004
Cash and cash equivalents as in SoFP and SoCF	**81,139**	**75,015**

Third party assets held by the NHS foundation trust at 31 March 2022 were £3,000 (31 March 2021: £3,000).

Note 16.2 Pooled budgets

The NHS foundation trust is not party to any pooled budget arrangements in 2021/22 or 2020/21.

33 Note 17 Contractual capital commitments and events after the reporting period

Note 17.1 Contractual capital commitments

Commitments under capital expenditure contracts at the reporting date were £1,335,000 (31 March 2021: £1,048,000). The NHS foundation trust has capital commitments for a number of capital schemes which include the purchase of a number of pieces of medical equipment (including a new MRI scanner for Bradford Royal Infirmary), a number of pieces of IT hardware and a number of estates enabling work schemes.

Note 17.2 Other financial commitments

Other financial commitments at the reporting date were £3,810,000 (31 March 2021: £5,097,000). The NHS foundation trust has financial commitments for the ongoing support and maintenance charges for the electronic patient records system.

Note 17.3 Events after the reporting period

There are no events after the reporting period to disclose.

34 Note 18 Contingent liabilities / assets

	31 Mar 22 £000	31 Mar 21 £000
Value of contingent liabilities		
NHS Resolution legal claims	74	68
Total	**74**	**68**

At 31 March 2022 the NHS foundation trust has £74,000 contingent liability (31 March 2021: £68,000). This includes £74,000 for legal expenses, which is based upon the information provided by NHS Resolution (31 March 2021: £68,000).

35 Note 19 Related party transactions

Note 19.1 Related party transactions

The NHS foundation trust is a public interest body authorised by NHSI, the Independent Regulator for NHS foundation trusts.

During the year none of the Board members nor members of the key management staff, nor parties related to them, has undertaken any material transactions with the NHS foundation trust.

The Register of Interests for the Council of Governors for 2020/21 has been compiled in accordance with the requirements of the Constitution of the NHS foundation trust.

The Department of Health and Social Care is regarded as a related party. During the year the NHS foundation trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These include NHS England, NHS Resolution, HM Revenue and Customs, NHS Pension Service, Health Education England, NHS Bradford Districts CCG, NHS Bradford City CCG and NHS Airedale, Wharfedale and Craven CCG.

The NHS foundation trust has also received capital payments from a number of funds held within the Charity, the trustee of which is the NHS foundation trust. Furthermore, the NHS foundation trust has levied a management charge on the Charity in respect of the services of its staff. The Charity accounts have not been consolidated into the NHS foundation trust's accounts (see note 1.3).

Note 19.2 Related party balances

	2021/22 Income £000	2021/22 Expenditure £000	2020/21 Income £000	2020/21 Expenditure £000
Value of transactions with other related parties				
Charitable fund	486	0	841	0
Non-consolidated joint ventures	67	11,742	141	11,302
Other bodies or persons outside of the whole of government accounting boundary	0	0	0	0
Total	**553**	**11,742**	**982**	**11,302**

	2021/22 Receivables £000	2021/22 Payables £000	2020/21 Receivables £000	2020/21 Payables £000
Value of balances with other related parties				
Charitable fund	27	0	155	0
Non-consolidated joint ventures	81	1,285	116	1,418
Other bodies or persons outside of the whole of government accounting boundary	0	0	0	0
Total as at 31 March 2022	**108**	**1,285**	**271**	**1,418**

In line with the DHSC interpretation of IAS 24 related parties the NHS foundation trust only collect details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

36 Note 20 Transactions with Joint Venture

The NHS foundation trust has a 33.33% equity share and voting rights in both Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, with losses limited to £1 each. Neither Integrated Pathology Solutions, nor Integrated Laboratory Solutions hold capital assets.

The NHS foundation trust established Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP with Airedale NHS Foundation Trust in February 2016. Both organisations held a 50% equity share. In October 2019 Harrogate and District NHS Foundation Trust became a partner in both organisation and all three partners now hold a 33.33% equity share. Control is shared equally between the three partners and both organisation are considered to be joint ventures.

2021/22 interests in Joint Ventures:

	Profit £000	Gross Assets £000	Net Assets £000
Integrated Laboratory Solutions LLP	1,459	4,401	446
Integrated Pathology Solutions LLP	460	1,208	612
Total	**1,919**	**5,609**	**1,058**

Since establishment Integrated Laboratory Solutions LLP has accumulated a cumulative profit of £1,339,000 (2020/21: cumulative loss of £120,000) and Integrated Pathology Solutions LLP has accumulated a profit of £254,000 (2020/21: cumulative loss of £206,000). The NHS foundation trust did not receive dividend payments in 2021/22 or 2020/21.

2020/21 interests in Joint Ventures:

	Profit £000	Gross Assets £000	Net Liabilities £000
Integrated Laboratory Solutions LLP	432	3,309	(38)
Integrated Pathology Solutions LLP	644	148	(252)
Total	**1,076**	**3,457**	**(290)**

37 Note 21 Private Finance transactions

The NHS foundation trust is not party to any Private Finance Initiatives. There are therefore no on-SoFP or off-SoFP transactions which require disclosure.

38 Note 22 Financial instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The NHS foundation trust actively seeks to minimise its financial risks. In line with this policy, the NHS 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 NHS foundation trust in undertaking its activities.

Liquidity risk

Liquidity risk is the NHS foundation trust's ability to meet its cash obligations in delivering services to patients.

The NHS foundation trust's net operating costs are predominantly incurred to deliver, one year, nationally mandated healthcare contracts with a range of Commissioners. Commisioners are financed from resources voted annually by Parliament. In 2021/22 and 2020/21 the NHS foundation trust received contract income in accordance with nationally set block payments in response to the coronavirus pandemic. Cash was paid on a monthly basis. In 2020/21 payment made one month in advance to ensure a robust cashflow within the NHS.

The NHS foundation trust currently finances the majority of its capital expenditure from internally generated funds and funds made available from Government, in the form of additional Public Dividend Capital, under an agreed limit. In addition, the NHS foundation trust can borrow, both from the DHSC Financing Facility and commercially, to finance capital schemes. Financing is drawn down to match the spend profile of the scheme concerned and the NHS foundation trust is not, therefore, exposed to significant liquidity risks in this area.

Interest rate risk

Interst rate risk is the NHS foundation trust's exposure to interest rates fluctuations.

With the exception of cash balances, the NHS foundation trust's financial assets and financial liabilities carry nil or fixed rates of interest. The NHS foundation trust monitors the risk but does not consider it appropriate to purchase protection against it.

Foreign currency risk

Foreign currency risk is the NHS foundation trust's exposure to changing currency exchange rates impacting income, expenditure or the value of assets and liabilities.

The NHS foundation trust has negligible foreign currency income, expenditure, assets or liabilities.

Credit risk

Credit risk is the potential for lost income should creditors be unable to pay debts owed to the NHS foundation trust.

The NHS foundation trust receives the majority of its income from NHS England, CCGs and statutory bodies and therefore the credit risk is negligible.

The NHS foundation trust's treasury management policy minimises the risk of loss of cash invested by limiting its investments to:

- the Government Banking Service and the National Loans Fund;
- UK registered banks directly regulated by the FSA ; and
- UK registered building societies directly regulated by the FSA.

The policy limits the amounts that can be invested with any one non-government owned institution and the duration of the investment to between £3,000,000 and £12,000,000 for no more than 3 months.

Price risk

Price risk is due to increases or decreasing market prices leading to high costs or reduced income for the NHS foundation trust.

The NHS foundation trust is not materially exposed to any price risks through contractual arrangements.

39 **Note 23 Financial assets and liabilities**

Note 23.1 Financial assets by category

	31 Mar 22	31 Mar 21
	£000	£000
Assets as per SoFP at 31 March		
Trade and other receivables excluding non-financial assets – with NHS and DHSC bodies	8,659	8,400
Trade and other receivables excluding non-financial assets – with other bodies	7,468	7,834
Cash and cash equivalents at bank and in hand	81,139	75,015
Total	**97,266**	**91,249**

All financial assets are held at amortised cost.

Note 23.2 Financial liabilities by category

	31 Mar 22	31 Mar 21
	£000	£000
Liabilities as per SoFP at 31 March		
Borrowings excluding finance lease and PFI liabilities	19,743	22,805
Trade and other payables excluding non-financial liabilities – with NHS and DHSC bodies	2,155	4,638
Trade and other payables excluding non-financial liabilities – with other bodies	75,015	56,568
Provisions under contract	2,142	2,344
Total	**99,055**	**86,355**

All financial liabilities fall within "other financial liabilities" and are held at amortised cost.

Note 23.3 Fair values

For all of the NHS foundation trust's financial assets and financial liabilities, fair value approximates carrying value.

Note 23.4 Maturity of financial liabilities

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

	31 Mar 22	31 Mar 21
	£000	£000
In one year or less	81,217	65,234
In more than one year but not more than five years	10,606	13,018
In more than five years	9,116	10,347
Total	**100,939**	**88,599**

40 ACRONYMS

CCG	Clinical Commissioning Group
CODM	Chief Operating Decision Maker
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
DAS	Digital Apprenticeship Service
DHSC	Department of Health and Social Care
DHSC GAM	Department of Health and Social Care Group Accounting Manual
DRC	Depreciation Replacement Cost
EU	European Union
FIFO	First In First Out
FRF	Financial Recovery Fund
FT ARM	NHS Foundation Trust Annual Reporting Manual
FReM	Financial Reporting Manual
FSA	Financial Services Authority
HMRC	Her Majesty's Revenue and Customs
IAS	International Accounting Standards
ICTA	Income and Corporate Taxes Act
IFRIC	International Financial Reporting Interpretations Committee
IFRS	International Financial Reporting Standards
MEA	Modern Equivalent Asset
NEST	National Employment Savings Trust
NHS	National Health Service
NHSI	National Health Service Improvement
ONS	Office for National Statistics
PbR	Payment by Results
PDC	Public Dividend Capital
PSF	Provider Sustainability Fund
RTA	Road Traffic Accident
SoCI	Statement of Comprehensive Income
SoCF	Statement of Cash Flows

SoFP	Statement of Financial Position
The Charity	Bradford Hospitals' Charity
VAT	Value Added Tax
WOS	Wholly Owned Subsidiary
WTE	Whole Time Equivalents