



Bradford Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts 2019/20

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**Annual Report and Accounts
2019/20**

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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 5,800 people working across 6 sites. Each year we deliver around 6,000 babies, perform over 300,000 operations and see around 500,000 patients in outpatient clinics. Approximately 140,000 people attend our Emergency department each year.

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. 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

The past year has seen us face some significant challenges but also take great strides in bringing digital innovations to life across our wards and departments. At the core of our foundations is making our infrastructure and Information Technology fit for the 21st century. March 2020 saw possibly the largest single transformation to the NHS as dedicated and courageous staff responded to the emerging COVID-19 crisis. Innovation and rigour have undoubtedly lessened the impact the Coronavirus could have had, but services deemed non-critical have faced deterioration in performance in this time as can be seen in Figure 2.

Our reputation has grown in the field of digital enablement with us becoming the first NHS organisation, and indeed the first healthcare organisation in Europe, to implement a Command Centre. The Command Centre opened on 12 November 2019 and is helping us to

transform care - reducing waiting times, making the experience of being in hospital smoother, faster and more efficient for patients.

Powered by artificial intelligence (AI), the new system will provide staff with real-time information to help them make speedy and informed decisions on managing patient flow across the Trust's hospitals.

We also broke new ground with the appointment of Dr Tom Lawton, a consultant in Critical Care and Anaesthesia, as Head of Artificial Intelligence – the first in the NHS.

While recruitment remains challenging for the whole of the NHS, we continue to attract high calibre staff to our Trust and develop innovative schemes to support retention, such as our in-house transfer process which supports clinical staff to move to a different specialty without having to leave the Trust to seek a new role.

We faced a significant challenge during the year when our plans to implement a wholly owned subsidiary for our Estates, Facilities and Clinical Engineering services led to industrial action. Our Board listened to the concerns of colleagues in those services and reviewed and ultimately reversed its decision. We are now rebuilding relationships and working with colleagues to engage in service improvement work in the coming year.

The CQC visited our Trust at the end of 2019 which gave us an opportunity to demonstrate just how much progress and improvement had been made in the year since the last inspection. They looked at four services at Bradford Royal Infirmary: medical care (including older people's care), maternity, services for children and young people, and outpatients, including outpatients at St Luke's Hospital. The inspectors recognised the improvements that had been made. Medical care (including older people's care), services for children and young people, and outpatients had all been rated 'Good', up from 'Requires Improvement'. Maternity remains as 'Requires Improvement'. Overall, the Trust was rated 'Good', with the 'well-led' and 'use of resources' domains also being rated 'Good'. CQC also identified areas of outstanding practice as well as areas for improvement and we are working hard to develop and implement action plans to address these findings.

We started to build a much closer relationship with Airedale NHS Foundation Trust through a two-year programme called the Acute Provider Collaboration (APC) to make the services delivered by both our organisations clinically, operationally and financially sustainable.

Our research activities continued to flourish with the Bradford Institute for Health Research (BIHR) becoming part of a new research fund to tackle some of the biggest healthcare challenges of our generation.

The opening of the new £3m flagship Wolfson Centre for Applied Health Research was a hugely symbolic act, bringing together our academic partners and our own Trust colleagues to work together for the good of our wider population, our patients and their families. This partnership helps consolidate and build upon the reputation we have as national leaders in the field of applied health and care research.

And we continued to win national awards: from the Health Service Journal and the King's Fund; for the ambulatory care experience provided to our patients, for our work on identifying and treating deteriorating patients, for reducing infections and for our informatics and flexible workforce teams.

We also published our comprehensive Quality Plan for the next three years. The plan shares our ambitious quality goals and targets which we aim to achieve between now and 2022, on our journey to becoming an outstanding provider of care.

Our achievements in 2019/20 will be listed in full in the Quality Report which is to be published at the end of Quarter 3 2020 due to revised NHS guidance following the COVID-19 epidemic.

2.1.3. PURPOSE AND ACTIVITIES OF THE FOUNDATION TRUST

All Foundation Trusts are required to have a constitution, containing detailed information about how that Foundation Trust will operate. The purpose of the Trust is set out in its Constitution as follows:

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

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

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

In short, the purpose of the Trust can be summarised in its mission statement which is “to provide the highest quality healthcare at all times” and to do this in a way that is consistent with our values.

We also have a number of strategic objectives at the Trust to provide a link between our mission and vision statements, and the actions that we need to deliver them. We have developed five key objectives for the Trust, reflecting our mission and our values, 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
5. work effectively with local and regional partners

These objectives frame the practical steps we will take to help deliver our mission and vision statements and implement our Clinical Service Strategy.

[“A commitment to our patients: our Clinical Service Strategy 2017-2022”](#) sets out how we will improve the services that we offer and describes the type of Trust that we intend to be by 2022.

The Clinical Service Strategy 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 will 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.

We have recognised that the way in which we operate has to be dynamic and open to change, both in terms of the treatments we offer, and the way we offer them. Quality must be at the heart of everything we do. It is imperative that we embed a culture of safety into all of our processes; that we learn through our experience, and strive for ongoing improvement in patient outcomes. This makes it vital that we get the correct care models in place for future service provision, and with this in mind we have shaped the Clinical Service Strategy around four themes, each comprising specific actions:

1. High quality care

We will

- provide high quality healthcare, 24 hours a day, 7 days a week
- take pride in being professional, compassionate and always putting safety first

2. Research-led care and learning

We will

- capitalise on our outstanding research capacity, to make the Trust a national exemplar for applying research findings to clinical practice and in improving the health of our population
- develop the Trust further as a centre of learning excellence and professional development

3. Collaborative hospital care

We will

- develop the Trust as the hub for a range of specialised services in the west of West Yorkshire
- work with other providers of acute hospital care, to best meet the needs of our shared patient populations

4. Connected local care

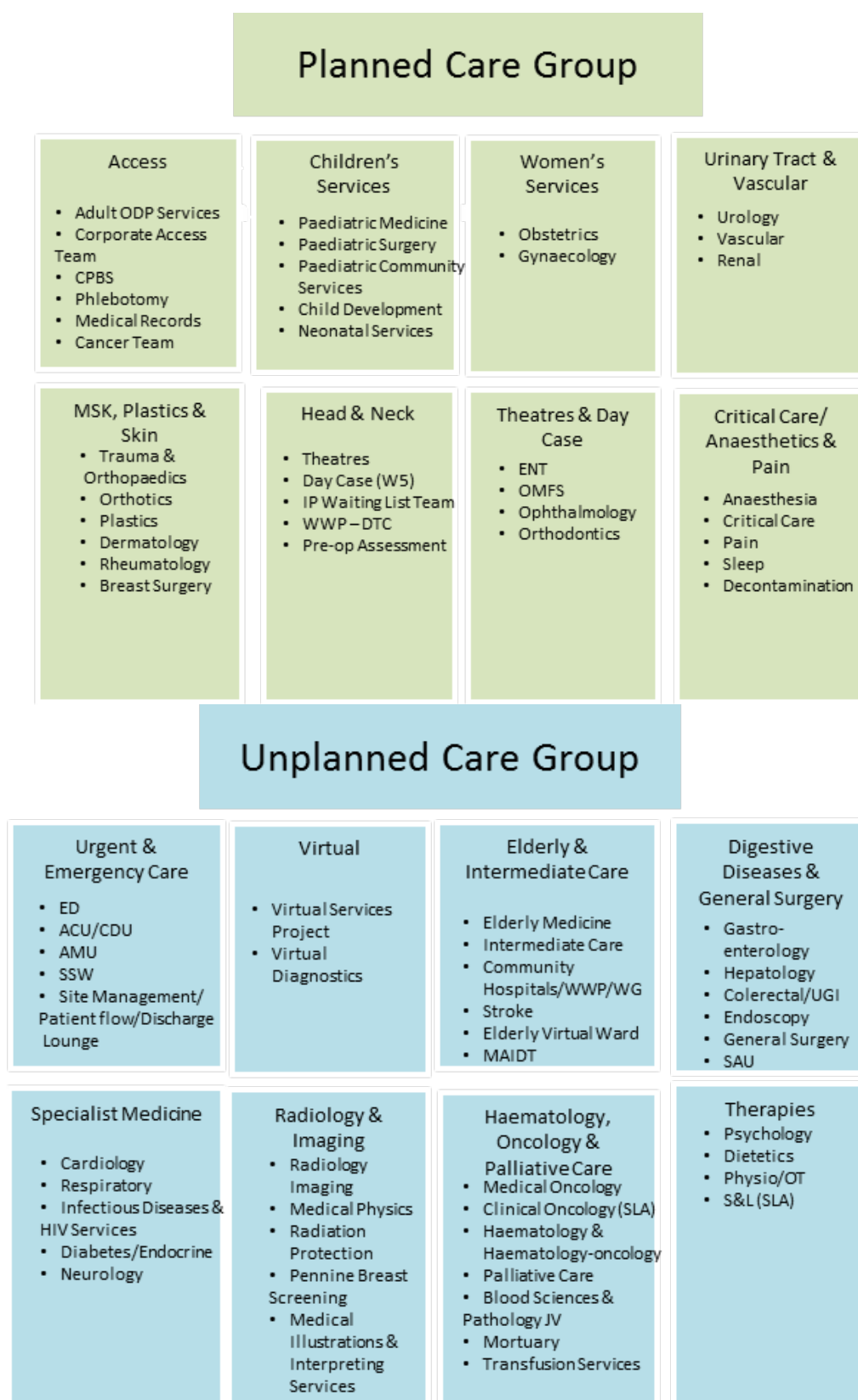
We will

- support people to stay out of hospital where appropriate or be safely discharged as soon as they are ready, so that the defining feature of our approach is that we are “short stay by design”
- work with local partners and contribute to the formal establishment of a responsive integrated care system
- ensure the Trust remains closely connected to the community that it serves and becomes a “health-promoting hospital”

In 2019 the Trust implemented a significant change to operational leadership and divisional management structure to improve clinical engagement, decision making and clarity of lines of accountability. The previous divisional management structure was replaced by a clinical business unit model (CBU) which enabled a more devolved and empowered way of working within a system of earned autonomy.

Within the CBU model, operational managers and clinical leaders will work in partnership to harness the expertise, innovation and creativity of all staff to deliver improved outcomes for patients and improved operational and financial performance.

Figure 1 – Implementation of Clinical Business Units 2018/19



2.1.4. HISTORY OF THE TRUST AND STATUTORY BACKGROUND

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.

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.

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 (which is currently not in use) and serves a population of around 530,000 people from Bradford and the surrounding area. We have approximately 900 acute beds, employ around 5,800 members of staff, and have more than 500 volunteers supporting our services. In year, our services deliver around 6,000 babies, perform over 300,000 operations and handle in the region of 500,000 outpatient appointments. Approximately 140,000 people attend our Emergency Department each year.

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, or describe the confidence that it has about the successful delivery of its strategic objectives. The strategic risks described in the BAF are based on a collective assessment by the Executive Directors, the mitigation of which are scrutinised by the Non-Executive Directors through the work of the Board Committees and the Board itself, of the collective environment in which the Trust is operating (the 'Principal risks'). The strategic risk profile underpinning the BAF is directly influenced by high scoring risks identified at ward, specialty, care group or corporate department which may impact the effective delivery of the Strategic Objectives.

The key risks that the Trust was exposed to during 2018/19 were in relation to the following areas:

- Internally agreed performance measures
- Maternity service
- Planned income levels and expenditure controls
- Developing and delivering effective productivity improvement and cost reduction
- The impact of industrial action on the operational delivery of services
- Compliance with access standards
- The impact of a 'no deal' EU Exit
- The impact of the COVID19 pandemic

The BAF was maintained by the Executive Directors throughout the year. 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 presented in the BAF; any identified gaps in controls or assurance are subject to action planning and are recorded on the BAF. The Board therefore has had clear sight of significant risks and ensured actions are prioritised appropriately.

2.1.6. GOING CONCERN DISCLOSURE

After consideration of the contract position with commissioners including the interim financial regime put in effect during the COVID 19 pandemic, the control total offered by NHSI and forecast cash balances for 2020/21, the Directors have a reasonable expectation that the

NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

2.1.7. SUMMARY OF PERFORMANCE

During the 2019/20 Financial Year, the Trust has been working to improve its performance against the core contractual targets, including those indicated within the NHS Oversight Framework 2019/20.

The table below describes the results achieved against these targets. While further analysis of each indicator is given below, it is positive that the Trust has been able to recover or improve performance against a number of metrics, particularly within emergency care and cancer waiting times.

Figure 2 - Monthly results achieved against KPIs 2019/20

| KPI | 4 Hour Emergency Care Standard | Cancer 2 week wait | Cancer 62 day first treatment | Diagnostic 6 week wait | 18 weeks RTT Incomplete |
|----------------|---|-----------------------|-------------------------------------|---------------------------|-------------------------------|
| Apr-19 | 77.85% | 88.77% | 87.98% | 97.50% | 85.65% |
| May-19 | 85.11% | 91.68% | 82.45% | 95.35% | 86.37% |
| Jun-19 | 81.30% | 93.23% | 82.24% | 93.82% | 86.36% |
| Jul-19 | 83.58% | 94.11% | 86.98% | 96.48% | 85.10% |
| Aug-19 | 81.26% | 92.15% | 83.42% | 95.92% | 83.49% |
| Sep-19 | 78.41% | 94.13% | 78.70% | 98.18% | 84.80% |
| Oct-19 | 77.45% | 96.03% | 80.21% | 96.55% | 84.76% |
| Nov-19 | 77.08% | 96.39% | 76.34% | 97.36% | 85.27% |
| Dec-19 | 71.32% | 96.40% | 84.42% | 96.49% | 85.14% |
| Jan-20 | 77.44% | 93.97% | 77.50% | 97.94% | 85.28% |
| Feb-20 | 84.05% | 94.17% | 78.49% | 98.29% | 84.32% |
| Mar-20 | 85.86% | 96.21% | 88.83% | 93.21% | 80.73% |
| 2019/20 | 76.61% | 93.61% | 81.75% | 96.43% | 84.78% |
| 2018/19 | 80.08% | 73.35% | 67.21% | 95.78% | 77.55% |

During January to March 2020, the COVID-19 pandemic had a significant impact on the Trust operational performance. Cessation of routine elective procedures, outpatient appointments and diagnostic tests has caused deterioration in Referral to Treatment and Diagnostic Standards.

However, the care we provided for cancer patients has shown significant improvement in 2019-20. The Trust has successfully recovered and stabilised performance against the Cancer 2 Week Waiting time standard (2WW), and following improvement in Upper and Lower Gastrointestinal and Urological Cancer pathways was able to recover performance against the 62 day First Treatment Standard to meet the standard in the final month.

Cancer is measured across a range of indicators and we are safe to say collectively these improved this year. The 62 day target was only achieved by reducing the backlog and this was achieved over several months which resulted in the final month being a pass.

2.2. PERFORMANCE ANALYSIS

2.2.1. MEASUREMENT OF PERFORMANCE

Performance Monitoring

Performance Monitoring within the Trust 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 NHS England / Improvement (NHSEI) 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 the 2019/20.

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

- NHSI Single Oversight Framework KPIs
- NHSI 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 NHSI 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:

- NHSI Single 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, which are delivered by its assurance committees.

The Board Assurance Framework provides that, wherever possible, assurance regarding the performance of the organisation is:

- Systematic
- Consistent
- Independently verified
- 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

The Trust's Performance Framework

The Trust also has a Performance and Accountability 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 Performance Management and Accountability Framework defines how the Trust manages performance, how we identify areas for improvement and track progress against plans. It allows our services to focus on the quality of care and ongoing stability by using resources effectively.

As such, the framework is based on the following guiding principles:

- **Shared ownership:** decisions are taken in the best interests of patients, stakeholders and the organisation
- **Decision and action-focused:** staff act with the end in mind
- **Transparent:** everyone is on the same page, and clear on expectations, goals and tasks
- **Flexible:** teams respond to an ever-changing environment and context
- It is focused on **continuous improvement**

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

- Daily and Weekly performance monitoring of KPIs
- Weekly multi-departmental reviews of how long patients are waiting to access our services, either in our Emergency Department or on waiting lists
- Monthly or quarterly performance reviews
- Monthly reporting to the Trust's Board and Committee structures

2.2.2. ANALYSIS OF PERFORMANCE

2.2.2.1. Cancer waiting time standards

2 Week Wait

Patients referred to us on Fast Track pathways have received an excellent service from the Trust during 2019/20, with performance improving by 5.19% across a 12 month linear trend for those first seen within two weeks.

Cancer Summary

2 Week Wait

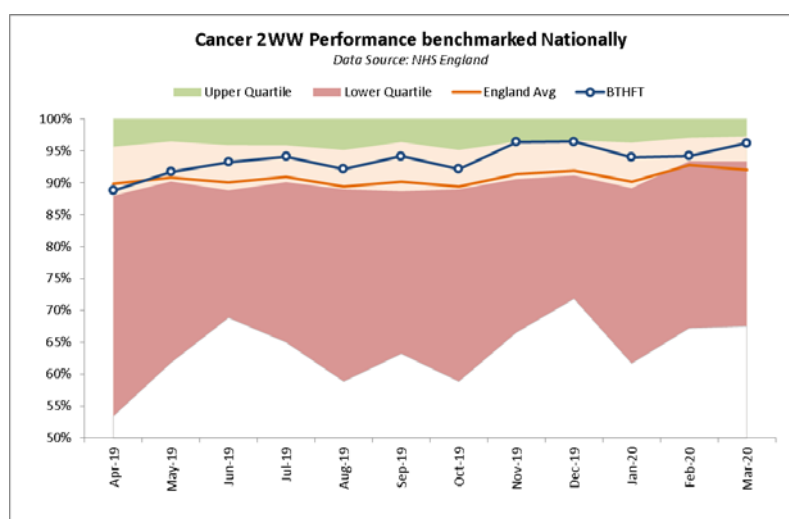
19,710 Referrals received

93.91% Seen within 2 weeks

62 Day First Treatment

1,151 Patients Treated

81.75% Treated in 62 days



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 time pathways resulting in reduced time to first seen.

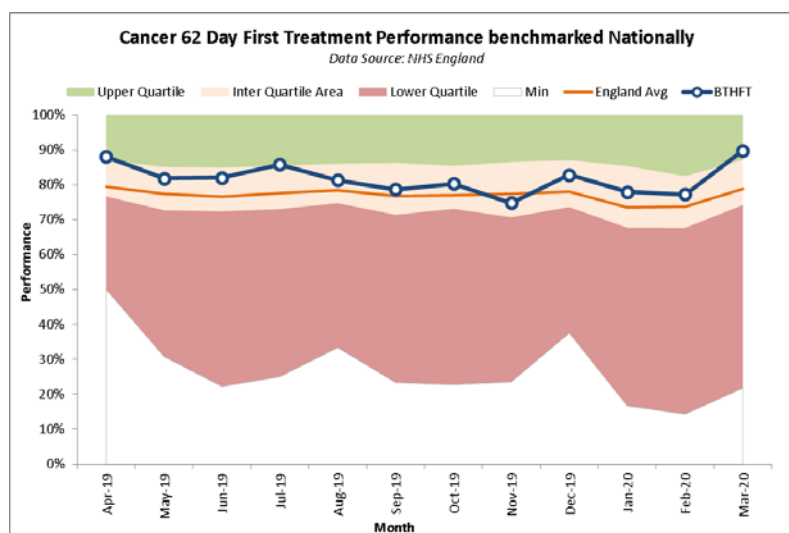
These improvements have been delivered against an increase of 446 (2.3%) 2 Week Wait (2WW) referrals compared to 2018/19. In addition, we have seen 4,572 (24.71%) more patients within 2 weeks in 2019/20 compared to 2018/19.

62 Day First Treatment

Performance against the 62 Day First Treatment standard deteriorated during the year; however the Trust achieved the standard in March 2020 with performance at 88.83%. Our performance overall this year was also a significant improvement on 2018/19.

This improvement was the result of recovery within Urology which included a specific focus on early diagnosis and undertaking additional surgical activity.

A significant reduction in the number of patients waiting more than 62 days across all tumour groups also contributed to improved performance.



Emergency Care Standard

2019/20 has been a challenging year for our Urgent and Emergency Care departments but we have made a number of improvements along the patient pathway.

ECS Summary

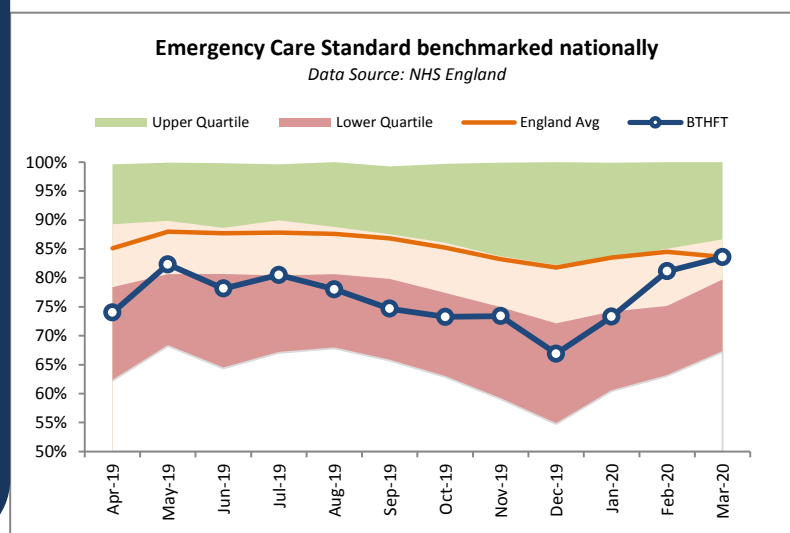
160,592 Emergency attendances

79.92% Seen within 4 hours

22.78% Admission Rate

0 12hr Trolley Waits

13:28 Ambulance Handover Time



During 2019/20 our Emergency Department recorded an average of 381 attendances per day prior to the COVID-19 pandemic. There were a further 66 emergency attendances per day direct to speciality assessment areas. Attendances during March 2020 reduced significantly due to the COVID-19 pandemic

A comprehensive improvement programme was implemented, with a number of initiatives focusing on making sure that patients are seen in the most appropriate service for their urgent or emergency care needs. This has included the following:

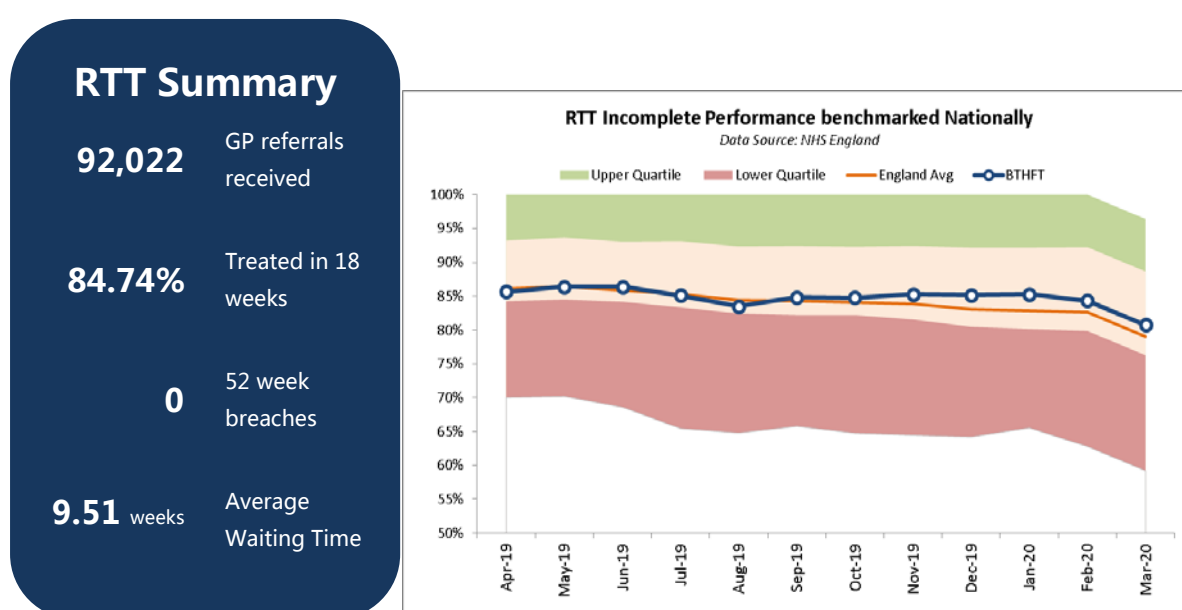
- Approval of a business case for workforce expansion and implementation of a new workforce model.
- Launch of a GP-led urgent care service, co-located with our emergency department minor injuries team.
- Launch of a Same-Day Emergency Care model, streaming patients directly from the ED to Ambulatory Care Unit or Surgical Assessment Unit.
- A number of pathway and role changes to ensure patients are assessed in a timely manner and directed to the most appropriate service.
- Implementation of our Command Centre supporting exception based alerts to patient-level delays in Emergency Department and essential situational awareness.
- Implementation of the voluntary sector Multi-Agency Support Team (MAST) which provides peer support and signposting to community support services for patients requiring advice and support to avoid the need for hospital admission.

These initiatives have enabled the Trust to improve its performance against the Emergency Care Standard when compared to the national average for Acute Trusts. Our teams have also maintained a consistent waiting time of 60 minutes from arrival to treatment for the sickest patients.

Referral to Treatment

Referral-to-Treatment (RTT) Performance has remained relatively stable during 2019/20, and has been above the England average since November 2019 (see chart below).

The Trust has not had an RTT incomplete pathway exceed 52 weeks since October 2018 and the total waiting list over 40 weeks has reduced during the last 12 months.

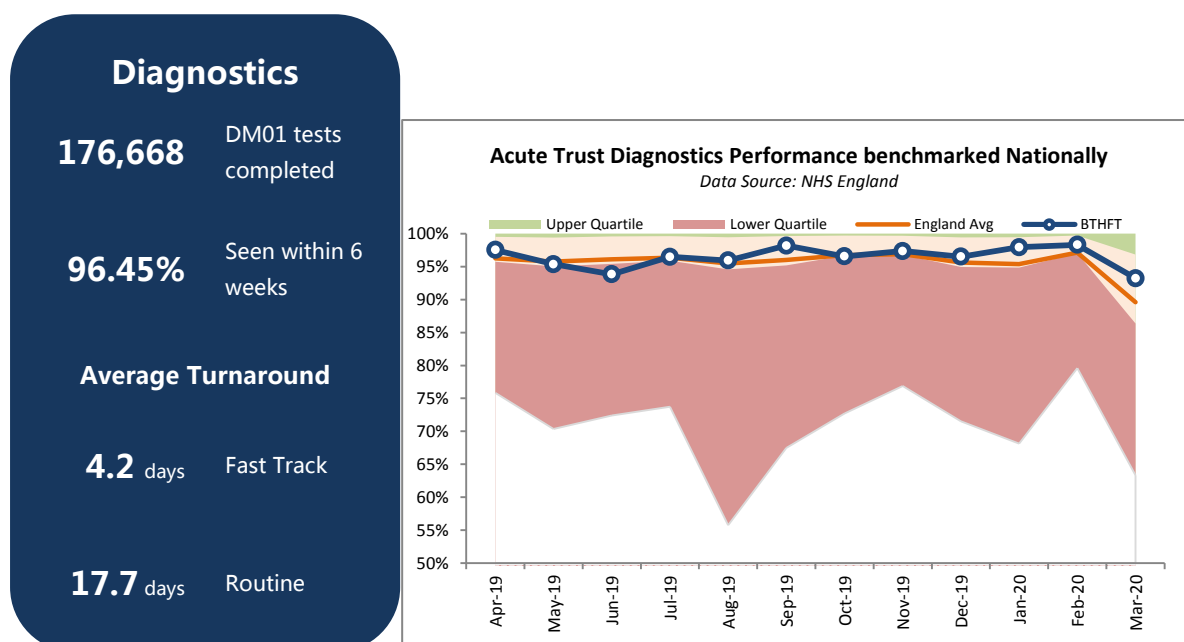


As a result of improvement activity with key specialties the Trust reduced the average waiting time to 9.51 weeks, down from 11.16 weeks in 2018/19.

Performance has inevitably been impacted by the COVID-19 pandemic, which led to a reduction of elective activity and cessation of routine GP referrals as well as an overall increase in waiting times.

Routine Diagnostic Standards

The Trust made excellent improvement during 2019/20 for those patients referred to us for routine diagnostic services.



Improvements in Radiology have been sustained throughout the year with these modalities meeting the standard whilst challenges in Endoscopy and Cystoscopy following increased demand have been addressed, with both areas significantly reducing their waiting lists during the financial year and Cystoscopy meeting the standard from October 2019 onwards.

Performance in Q4 has shown signs of deterioration, as all routine procedures have been cancelled following the COVID-19 outbreak.

Patient Care Standards

This year the Trust was particularly proud of the quality of care that we delivered to our patients. This was ultimately reflected by the CQC who inspected us in 2019. They uplifted our rating for the Safety of our services from “Requires Improvement” to “Good”. Our Caring rating also retained its “Good” from previous inspections. Our Effective rating is “Requires Improvement”.

This is recognition of the work of our wonderful nursing and medical staff. Our teams were supported with increased training, increased staffing (e.g. in Children’s and Maternity teams) and better processes to avoid harm coming to patients.

Quality Summary

Harm Free Care

137,970 Total Hospital Admissions

3.21 days Avg. Length of Stay

46 c. Difficile and MRSA infections

0 Never Events

0 Duty of Candour Breaches

Patient Experience

0 Patients treated in corridors

96.05% Patients screened for VTE

92.98% Patient Satisfaction

We have implemented a number of schemes aimed at both avoiding unnecessary admissions (for example our Frail Elderly Pathways and Virtual Diagnostics services) and enabling safe early discharge (our Virtual Wards). These efforts have enabled us to maintain an effective working bed-base, meaning that no patient has needed to be treated in a corridor. This is an achievement we are particularly proud of.

Although we have only recorded 2 cases of MRSA within our wards this year, we have reported a total of 44 Clostridium Difficile Infections, which is above our target of 30 cases. Each case has been fully investigated, and learning has been shared with relevant staff and managers, to help further improve the care our patients receive.

When completing the Friends and Family Test, 92.98% of patients reported that they would be happy for their Friends and Family to be treated at one of our Hospitals.

In direct response to patient feedback, we have also implemented a number of schemes to improve the experience patients have on our Wards. These have included a "Good Night, Sleep Tight" campaign to aid better sleep, and "Tea with Matron" to ensure patients get to ask questions about their care with senior decision makers.

2.2.2.2. Overview of Financial Performance for 2019/20

All NHS providers were given a financial control total by NHS England / NHS Improvement (NHSE/I) for 2019/20's Income & Expenditure performance. The Trust has again successfully delivered its control total. It has a strong track record of having achieved its control total in every year since the control total regime was introduced.

Due to the way in which the regulators assess performance against the control total, it is helpful to explain the income and expenditure performance in two distinct ways:

- The Income and Expenditure (I&E) performance assessed against NHSE/I's criteria for control total delivery.
- The I&E performance formally recorded in the statutory accounts according to all relevant accounting standards.

Figure 3 - Income and Expenditure Position 2019/20

| | 18/19 Actual | 19/20 Plan | 19/20 Actual | 19/20 Variance | Change vs 18/19 |
|---|-----------------|---------------|-----------------|-------------------|--------------------|
| Control Total Excluding PSF/ FRF | (7.5) | (12.5) | (18.8) | (6.3) | (11.3) |
| PSF / FRF income | 13.9 | 12.5 | 18.9 | 6.4 | 5.0 |
| Control Total Including PSF/ FRF | 6.4 | 0.0 | 0.1 | 0.1 | (6.3) |
| <u>Reinstate Items excluded from control total</u> | | | | | |
| Prior year PSF post accounts allocation | 0.0 | 0.0 | 0.5 | 0.5 | 0.5 |
| Net Impairment / (Revaluation) | (19.0) | 0.0 | 5.1 | 5.1 | 24.1 |
| Capital donations/grants I&E impact | (0.1) | (0.3) | (0.2) | 0.1 | (0.1) |
| Surplus/(Deficit) per Statutory Accounts | (12.7) | (0.3) | 5.5 | 5.8 | 18.3 |

Excluding depreciation on donated assets, the Trust's financial plan for 2019/20 included a control total Income & Expenditure (I&E) deficit target excluding Provider Sustainability Funding (PSF) and Financial Recovery Funding (FRF) of £12.5m. For brevity, PSF and FRF are collectively referred to as PSF in the remainder of this financial narrative.

If this control total excluding PSF were delivered, the Trust would receive £12.5m of PSF cash. The planned (control total) I&E performance including PSF was therefore a breakeven position.

For items included in NHSE/I's assessment of control total delivery, the Trust posted a deficit excluding PSF of £18.8m. This was £6.3m below the control total.

There are two exceptional reasons for this adverse variance to the control total excluding PSF:

- Cancellation of wholly owned subsidiary plan £6.1m
- Change in discount rate for certain provisions in the NHS £0.2m

Due to the exceptional nature of these two items, NHSE/I excluded them from its assessment of the Trust's delivery against its 2019/20 control total. The Trust was therefore reimbursed with additional PSF to improve the post-PSF margin by £6.4m to result in a £0.1m surplus on a control total basis and a minor over-delivery against the post-PSF control total.

The statutory accounts include some items which NHSE/I excludes from its control total assessment. The most material of these for the Trust in 2019/20 is the impact of new or reversed impairments of property, plant and equipment assets. Reinstating these specific items as recorded in the statutory accounts to reflect the unadjusted Income & Expenditure position results in a formally reported surplus margin of £5.5m. This surplus is £5.8m higher than the control total target and will be reinvested in patient care in future years.

Provider Sustainability Funding (PSF) in 2019/20

The total PSF allocated to the Trust was £19.4m. This is made up of:

- Planned PSF 2019/20: £12.5m
- PSF to offset exceptional items 2019/20: £6.3m
- National distribution of 2018/19 surplus PSF in 2019/20: £0.5m

Efficiency Requirements

The annual plan determined that Cost Improvement Programme (CIP) savings of £16.2m would be required to deliver the control total. The actual CIP savings recorded for the year were £12.7m; however, this delivery was supported by a degree of non-recurrent financial efficiencies to ensure the control total was met.

The efficiency plans have been delivered through a cost improvement programme carried out by the Care Groups and support service departments. In addition, a number of trust-wide schemes were commissioned to support the delivery of CIPs as well as technical efficiencies.

This combination of efficiency plans and ad hoc measures was sufficient to deliver the control total, however much of this improvement is recognised as non-recurrent, and it is therefore likely that these savings must be found again in future financial years when the new NHS financial regime becomes clearer.

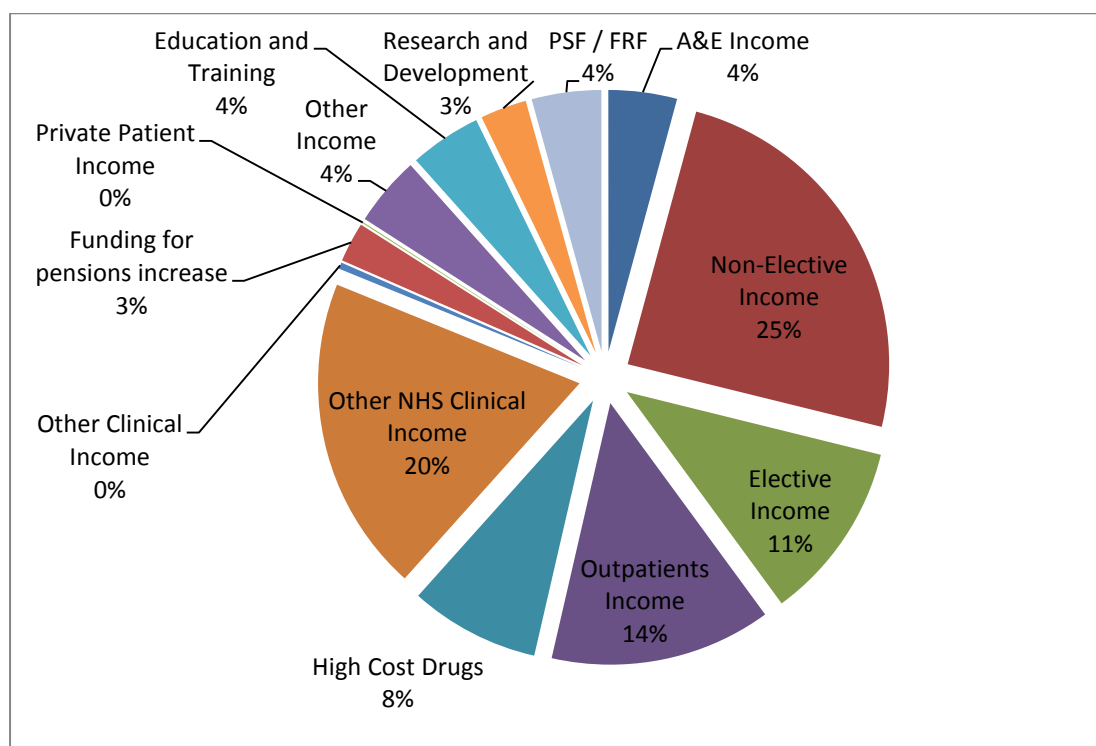
Income Summary

The total income, including PSF, reported for the 2019/20 financial year was £450.4m, which is split as follows:

- Clinical Income - £378.7m
- Other Operating Income - £52.3m
- PSF / FRF - £19.4m

A more detailed breakdown of income in 2019/20 is provided in Figure 4.

Figure 4 - Breakdown of Income in 2019/20



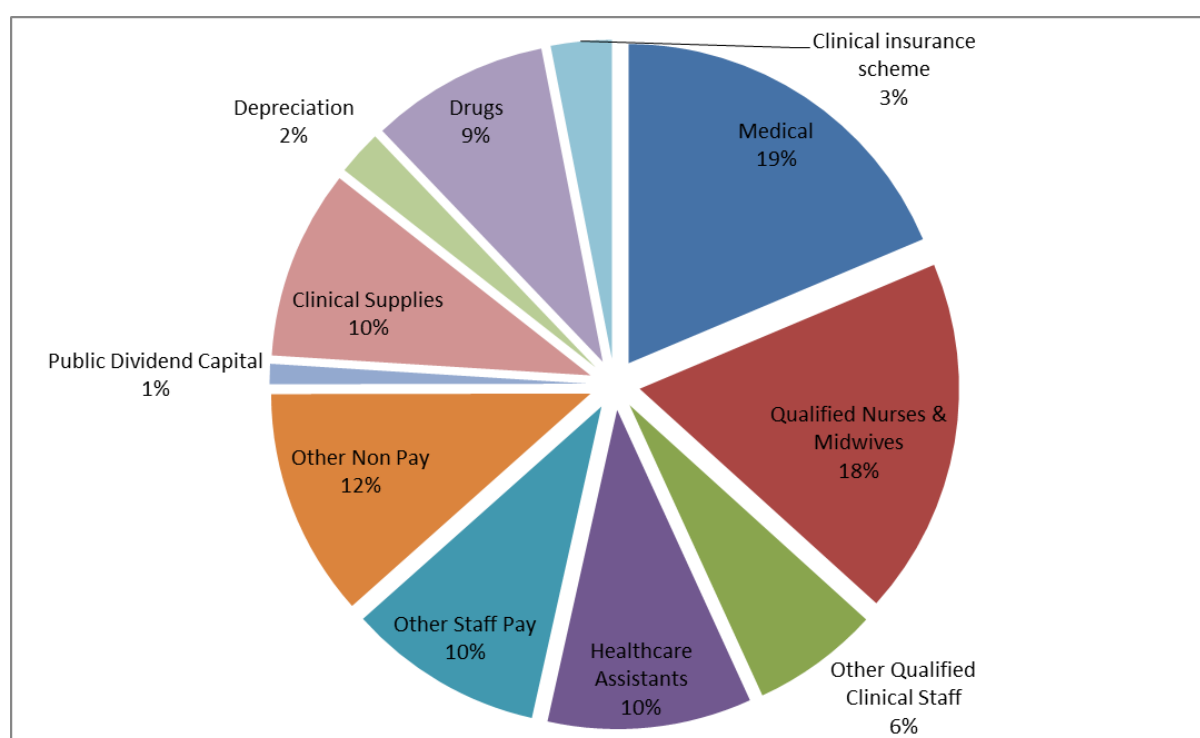
Expenditure Summary

Including the reversed impairment (the reversal of a non-cash accounting adjustment from 2018/19), the total expenditure reported for 2018/19 was £444.8m, which is split as follows:

- Payroll bill for employed and agency staff: £285.5m
- Non-Pay costs including drug costs: £149.5m
- Depreciation and amortisation: £10.3m
- Financing costs including Public Dividend Capital: £4.6m
- Net impairment (nil cash impact): (£5.1m)

A more detailed breakdown of expenditure in 2018/19 is provided in Figure 5. This chart excludes the negative expenditure recorded in the accounts resulting from the reversed impairment, which is also a non-cash item.

Figure 5 - Breakdown of Expenditure 2019/20



Cash and Statement of Financial Position

The year-end cash position has increased to £29.6m (2018/29 £21.2m) which is largely due to generating an in year operating surplus, improvements in working capital and slippage within the capital programme.

Long Term Borrowing

Loans from the DHSC have been taken to finance the capital investment strategy:

- A loan of £20m was secured over 20 years to fund the New Hospital Wing. A total of £20m has been drawn down and repayments totalling £4.208m have been made, with the final principal repayment due in February 2035.
- A loan of £16m was secured over 8 years to finance the investment in the Electronic Patient Record. A total of £16m has been drawn down and repayments totalling £6m have been made, with the final principal repayment due in November 2024.

The dates each loan was secured and first repayment dates are in Figure 6. The balances outstanding on each of these loans is shown in Figure 6 - Loan Dates.

Figure 6 - Loan Dates

| Loan | Date Secured | First Repayment Date |
|---|---------------|----------------------|
| Loans from DHSC – New Hospital Wing | 12 March 2015 | 18 August 2015 |
| Loans from DHSC – Electronic Patient Record | 13 April 2015 | 18 May 2017 |

| | 31 Mar 20 £000 | 31 Mar 19 £000 |
|---|-------------------|-------------------|
| Current | | |
| Loans from DHSC – New Hospital Wing | 1,052 | 1,052 |
| Loans from DHSC – Electronic Patient Record | 2,000 | 2,000 |
| Total | 3,052 | 3,052 |
| Non-Current | | |
| Loans from DHSC – New Hospital Wing | 14,740 | 15,792 |
| Loans from DHSC – Electronic Patient Record | 8,000 | 10,000 |
| Total | 22,740 | 25,792 |

Investments

The Trust does not have any investments in subsidiaries. However, during 2016/17 the Trust entered into two joint venture limited liability partnerships (LLPs). The Trust holds a 33% equity investment, with Airedale NHS Foundation Trust and Harrogate District NHS Foundation Trust, with losses limited to £1 each. The joint ventures, Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, have been established to deliver and develop laboratory based pathology services.

The Trust invests any short term cash surpluses in the Government Banking Service and the National Loans Fund Temporary Deposit facility in line with the approved policy.

Capital Programme

Capital investment totalling £11.8m was made during the year. The main elements of the capital programme are in Figure 7.

Figure 7 - Capital Investment

| Scheme | £million |
|--|-------------|
| Information Technology Schemes | 3.9 |
| Medical Equipment | 3.7 |
| Buildings and Engineering Maintenance and Upgrade | 1.7 |
| New Building Schemes & Other Strategic Investments | 2.5 |
| Total | 11.8 |

2.2.3. ENVIRONMENT AND SUSTAINABILITY

The Trust is committed to the UK's Climate Change Act 2008, which has legally binding targets of reducing carbon emissions by 28% by 2020 and 80% by 2050, measured against a 2013 baseline. The Trust has already exceeded this target on its gas and electricity consumption by achieving a 31.3% reduction. As a healthcare provider, employer and purchaser of goods and services, the Trust recognises that it has a significant impact on the environment. It acknowledges its role in promoting sustainability and improving

environmental performance by reducing its carbon emissions associated with procuring goods and services.

The Trust aims to be in the top 20% of NHS employers and to provide the best possible work environment for its staff. The organisation also recognises the impact that the environment in which people live has on their health. Therefore, by becoming more sustainable through the delivery of the recently Board approved Sustainable Development Management Plan (SDMP), and through caring for the environment, the Trust can help improve the lives of the people in its care.

The Trust has to demonstrate its current environmental performance by presenting, in the publicly accessed areas, a Display Energy Certificate (DEC). A DEC shows the 'operational rating' of the building, based on its actual carbon emissions compared to what would be considered typical for the type of building, where zero is the best rating and a rating over 150 is the worst. This is then benchmarked on an A-G scale, where A is the best. It should be noted that a rating of 100 is a typical hospital building. The ratings equate to Bradford Royal Infirmary being categorised as D on the A-G scale, and the Horton Wing at St Luke's Hospital being categorised as B. The progress made since 2013, (Figure 8 & Figure 9) demonstrates that the Trust has improved its energy and environmental performance and thereby reducing its carbon emissions.

The Trust has optimised its Combined Heat and Power (CHP) units at Bradford Royal Infirmary and St Luke's Hospital, as well as installing NHS England funded LED lighting. These initiatives have reduced the demand for electricity resulting in both sites improving their operational ratings against last year.

Figure 8 - Energy Certificate Performance for the main building at Bradford Royal Infirmary

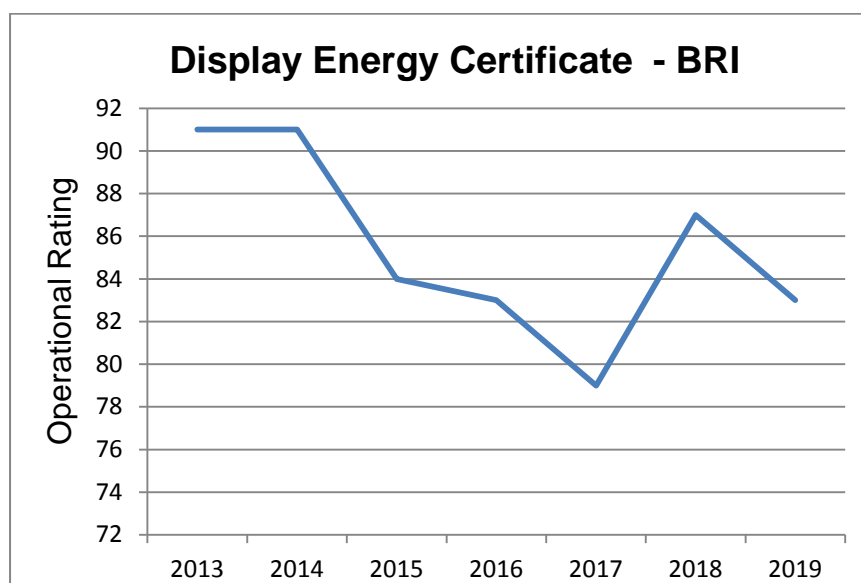


Figure 9 - Energy Certificate Performance for Horton Wing Building at St Luke's Hospital

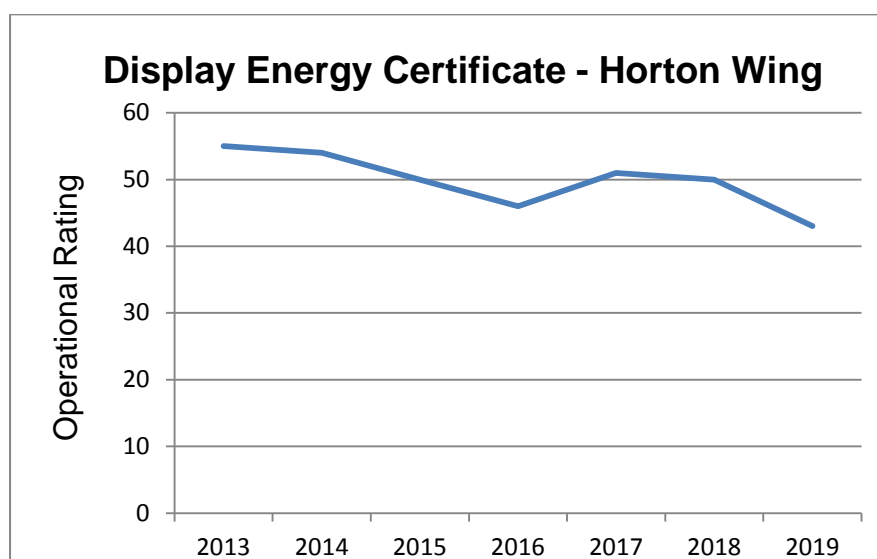
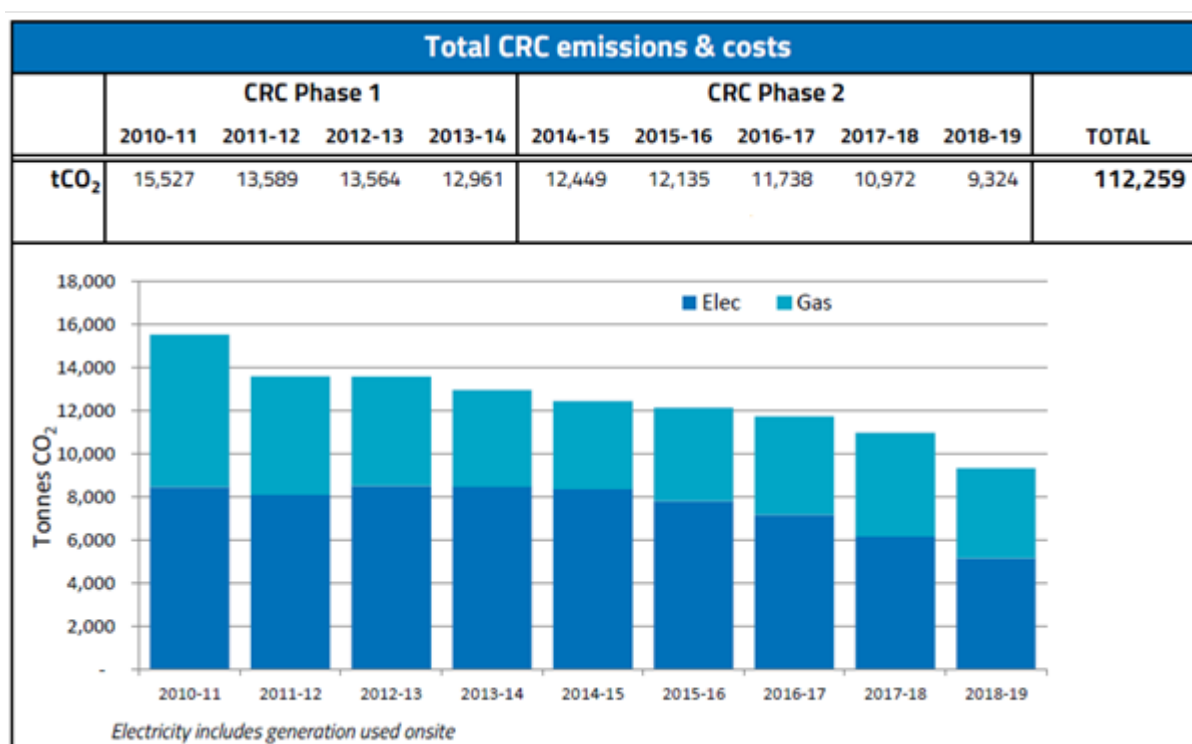


Figure 10 below shows that the Trust has reduced its building operational carbon emissions by 40% in the past nine financial years. In terms of the Climate Change Act 2008 target of 28% reduction by 2020 against a 2012/13 baseline, we are currently achieving a 31.3% reduction on our externally verified gas and electricity consumption.

Figure 10: The Trust's Carbon Reduction Commitment energy efficiency scheme performance 2010 - 2019

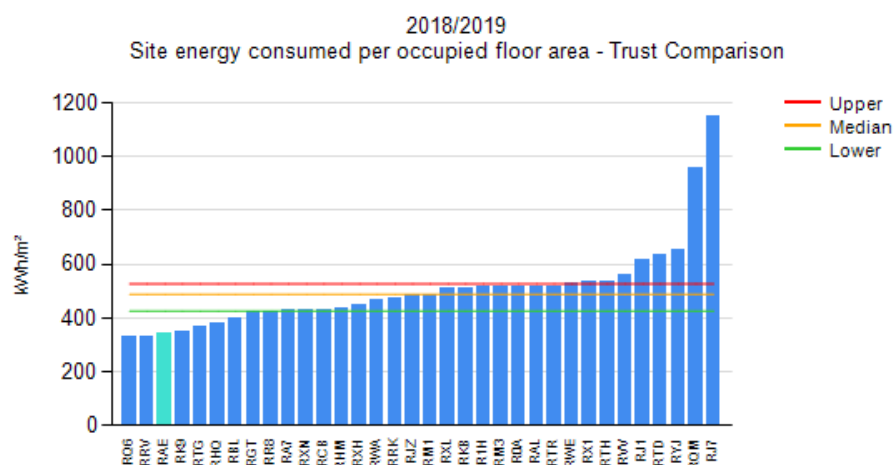


The Trust Utilities Consumption Group is continually investigating ways to operate the hospital more sustainably, for example, by assessing further investment opportunities in energy efficient technologies and introducing energy saving initiatives. Therefore, the Trust continues to strive to reduce its impact on the environment.

The Trust has been accepted on a government funded NHS England Artificial Intelligence (AI) energy monitoring innovation project. This project will use AI to identify trends and any inefficiency within Trust plant and infrastructure. The Trust has also attracted over £18,000 of external local authority funding to improve public transport accessibility on Smith Lane and complete a project to ensure there is a bus shelter in both directions at both Bradford Royal Infirmary and St Luke's Hospital.

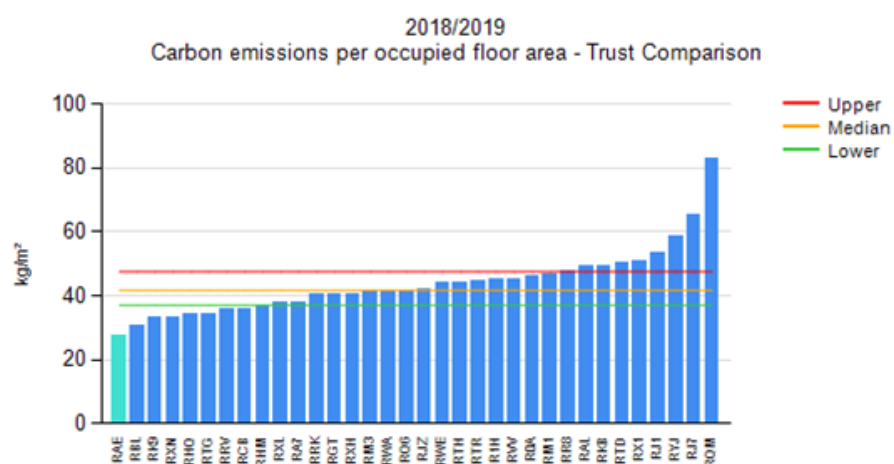
The Trust submits data for the [Estates Returns Information Collection](#)¹ (ERIC), which is a mandatory collection for all NHS trusts. This includes information relating to the costs of providing, maintaining and servicing the NHS estate, including energy use; we expect data for 2019/20 to be published on the gov.uk website. Please see below the 2018/19 ERIC return for Carbon Emissions and Energy consumed per square metre. As can be seen in Figure 11 and Figure 12 the Trust performed strongly in comparison to its ERIC NHS peer group.

Figure 11: The Trust's ERIC return 2018/19 comparing NHS Acute Teaching Hospitals energy consumed per patient occupied floor area



The Trust is highlighted in green (RAE on the x axis) and had the third lowest energy consumed per occupied floor area at 346.20 KWh/m².

Figure 12: The Trust's ERIC return 2018/19 comparing NHS Acute Teaching Hospitals Carbon emissions per occupied floor area



The Trust is highlighted in green (RAE on the x axis) and has the lowest emissions per occupied floor area at 27.77 kg/ m².

¹ <https://digital.nhs.uk/data-and-information/publications/statistical/estates-returns-information-collection/england-2018-19>

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 this 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

As required by NHSI/E, and in response to the COVID19 pandemic, the Trust has fundamentally changed its operating and governance models. These are under regular Executive Director review and subject to regular Board and Board Committee assurance processes. These changes in operating and governance models are reflected in the Trust's strategic risk register and the Board Assurance Framework.

The Trust's CQC report was published on 9th April 2020, the outcome of which is included in this report (See 2.1.2).

2.2.6. OVERSEAS OPERATIONS

The Trust has no overseas operations.

Signed

A handwritten signature in black ink, appearing to read 'Mel Pickup', written in a cursive style.

Mel Pickup
Chief Executive
18 June 2020

3. ACCOUNTABILITY REPORT

3.1. DIRECTORS' REPORT

3.1.1. THE BOARD OF DIRECTORS

The Board of Directors consists of individuals 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 (Nov 2019), they each share the same responsibility and liability and 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 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 and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The Scheme of Delegation sets out the matters reserved for the Board of Directors in full.

In 2019/20, the Board of Directors included the following positions: Dr Maxwell Mclean, Chairman; Ms Selina Ullah, Deputy Chair; Mr John Holden, Acting Chief Executive (Apr 2019 to Oct 2019); and Ms Mel Pickup, Chief Executive (Nov 2019 to present). A full list of Directors for this period is presented in 3.5.5.

All Directors are required to meet the standards of 'Fit and Proper Persons Requirement' and to make annual declarations. The register of 'Declarations of Interests' 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.

Further information and key documents, such as our constitution and scheme of delegation, are available on the Trust website here:

- www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/
- www.bradfordhospitals.nhs.uk/our-trust/lists-and-registers/
- <https://www.bradfordhospitals.nhs.uk/our-trust/who-we-are-and-what-we-do/>

Further information, or a request to contact governors and/or directors may be requested from The Trust Secretary by contacting the Trust Secretary, Trust Headquarters, Bradford Royal Infirmary, Bradford, BD9 6RJ; 01274 36 4790.

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

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, the Trust is not bound by this code, but seeks to abide by it as it represents best practice.

The Trust aims 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 improved for payments to both NHS and non NHS organisations with performance improving by number and value.

Figure 13 - Better Payment Practice Code

| | 2019/20 | | 2018/19 | |
|--|---------|---------|---------|---------|
| | Number | £000 | Number | £000 |
| Total Non-NHS trade invoices paid in year | 51,767 | 203,663 | 55,793 | 200,734 |
| Total Non-NHS trade invoices paid within target | 47,373 | 189,457 | 45,743 | 172,610 |
| % of Non-NHS trade invoices paid within target | 92% | 93% | 83% | 86% |
| Total NHS trade invoices paid in year | 2,728 | 15,359 | 3,268 | 14,699 |
| Total NHS trade invoices paid within target | 2,066 | 12,028 | 2,367 | 10,948 |
| % of NHS trade invoices paid within target | 76% | 78% | 73% | 75% |

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2019/20 or 2018/19.

3.1.3. NHS IMPROVEMENT'S WELL-LED FRAMEWORK

The Trust's approach to Quality and Quality Governance is presented in detail in section 3.8 (Annual Governance Statement) of the Annual Report.

The Trust was inspected by the CQC in December 2019 (the report being published on the 9th April 2020). The Trust's rating for the well-led domain is 'Good'. The reasons it was rated as good can be read on the CQC report available on their [website](#)².

3.1.3.1. Collaborative Hospital Care

During 2019/20, the Trust has worked closely with its acute hospital partners across West Yorkshire including:

Acute Provider Collaboration (APC) with Airedale NHS Foundation Trust

We are active participants in the APC, a programme of collaboration with our neighbouring acute trust, to ensure the sustainability of secondary care services for our shared population. The programme formally began in April 2019, and we have seen a real collaborative culture emerging. In January 2020, phase one of the programme was streamlined to six specialties in order to go further & faster. The APC is only one element of how we work closely with partners to create better ways of working, more sustainable workload and improved patient care.

² https://www.cqc.org.uk/sites/default/files/new_reports/AAAJ7731.pdf

WYAAT

Working closely with our partners in the West Yorkshire Association of Acute Trusts (WYAAT) we aim to improve care for patients and deliver efficiencies through a number of joint projects spanning areas such as workforce, radiology and orthopaedics. Examples of joint work undertaken by WYAAT include finalising the plans for implementing the Bradford Royal Infirmary vascular arterial centre, working together to use our collective purchasing power to reduce the cost of procurement, as well as creating technology solutions that allow Trusts to more easily share results of diagnostic imaging. The intention is to provide a seamless and efficient service for patients across the whole West Yorkshire & Harrogate Health & Care Partnership (an Integrated Care System).

Pathology Joint Venture

We are consolidating the progress made in the established Joint Venture (Integrated Pathology Solutions LLP) between Airedale NHS Foundation Trust and the Trust to deliver pathology services. Agreement has been reached to extend the number of partners to include Harrogate and District NHS Foundation Trust which is set to join in 2020. This Joint Venture continues to deliver benefits including economies of scale, shared expertise and delivering high quality diagnostic services to other primary and secondary care providers.

3.1.3.2. Connected Local Care

During 2019/20, the Trust has worked closely with its partners across West Yorkshire including:

Integrated Care System (ICS)

We have strengthened our partnership working across the West Yorkshire & Harrogate Health & Care Partnership (the “ICS”), through our participation in shared programmes of work and our contribution to the development of a five year plan for the ICS, intended to explain how we will collectively respond to the challenge set out by the NHS Long Term Plan. We have signed up to a refreshed Memorandum of Understanding between all the partners, and our senior leaders are actively involved in helping to take the work forward: for example Cindy Fedell, the Trust’s Chief Digital and Information Officer, is the Senior Responsible Officer for the Partnership’s Digital and Interoperability programme. Our Board has created a Partnerships Committee, chaired by the Board Chairman, which brings added focus to our work in this area, and which has encouraged a collaborative approach to “seize the opportunity” rather than fear the consequences of closer working with system partners.

The Bradford districts & Craven “place”

Our ICS comprises six places, and the Trust has been an influential participant in the Integration & Change Board and the Bradford Health & Care Partnership Board, both of which facilitate partnership working across our local Bradford District & Craven place. The Trust also supports the Bradford Provider Alliance, and our Director of Strategy chaired its Integrated Management Board for a six-month period during 2019/20.

In March 2019, the Trust joined with 12 other partners across Bradford District and Craven in signing up to a Strategic Partnering Agreement covering all of Bradford District and Craven. System-wide Quality and Finance/Performance Committees have been established and a review of system-wide programmes has been carried out to better focus efforts on delivering the goal of the Bradford partners to support our citizens to be “Happy, Healthy at Home”. The Trust also continues to build partnerships within Bradford:

- We are starting to work with the ten new Primary Care Networks in Bradford and looking for opportunities to support their crucial role in integrating primary and community care. Diabetes care is one example where the Trust is working with partners to move the community diabetes service onto a PCN footprint.

- The Trust continues to be an active partner in the Community Partnerships that bring PCNs together with their wider system partners to focus on the specific needs of their 30,000 – 60,000 populations.

Well Bradford

The Trust continues to host the “Well Bradford” programme, which began as one of the 10 “Well North” pathfinder sites but now exists in its own right as a partnership with the Local Authority and CCG.

Well Bradford works with local partners to deliver projects in the community with the aim of improving the overall health outcomes and wellbeing of three areas – Keighley, Holme Wood and Girdlington. All areas share three objectives which are to facilitate the implementation of green spaces, healthy places and to help create social mobility for individuals and families and strengthen the existing communities. Highlights of the past 12 months include Well Bradford’s promotion of Clean Air Day working collaboratively with local schools, organisations and research partners across the UK. Well Bradford have also launched the Green Mile in Girdlington which provides residents a walking route to support a more active and healthy lifestyle. Productive partnerships have blossomed with organisations including Morrisons, the National Farmers Union, local care homes and community based groups. A key workstream in progress is the collaborative work that is ongoing with local stakeholders to ensure the Squire Lane development (a site potentially hosting health focused services such as a swimming pool) is aligned to the community’s needs. The Well Bradford programme has been extended for a further year to March 2021.

3.1.4. FEES AND CHARGES (INCOME GENERATION)

The Trust undertakes income generation activities with an aim of achieving 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 schemes are included in the annual accounts.

3.1.5. 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 provision of goods and services for the purposes of the health service in England is greater than the income it received from the provision of goods and services for any other purpose. Furthermore, the generation of “non-NHS related income” does not impact adversely on the quality of healthcare services delivered by the Trust.

Signed



Mel Pickup

Chief Executive

On behalf of the Board of Directors

18 June 2020

3.2. REMUNERATION REPORT

3.2.1. ANNUAL STATEMENT

Annual statement from the Chair of the Trust's Nominations and Remuneration Committee.

I am pleased to present the Directors' Remuneration report for the financial year 2019/2020. 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.

In accordance with the requirements of the HM Treasury Financial Reporting Manual (FReM) and NHS Improvement, the report is divided into the following parts:

- Senior Managers' Remuneration Policy
- Annual Report on Remuneration. This 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 considered and agreed the annual pay increase for Executive Directors following recommendations received from NHS England and NHS Improvement in January 2020. The Committee managed the appointment process for the Chief Executive Officer position following Professor Clive Kay leaving the Trust in March 2019 and agreed the level of remuneration for the post. Ms Mel Pickup commenced in post 1 November 2019.

Signed



Dr Maxwell Mclean

Trust Chair and Chair of the Nominations and Remuneration Committee for Directors
18 June 2020

3.2.2. SENIOR MANAGERS REMUNERATION POLICY

Figure 14 - 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 Trust to attract, retain and motivate suitably skilled and experienced Executive Directors. | <p>As determined by salary band. Normally appointed on a 3 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 assessed. In determining the appropriate salary band the committee considers :</p> <ul style="list-style-type: none"> • 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. | <p>Increments if awarded are set at £5,000.</p> <p>The committee on occasion will also recognise changes in the role, and/or duties of a Director and salary progression for newly appointed Directors.</p> | <p>Earn-back arrangements within contracts for new appointments whose salary is over £150,000 would require 10% of the salary to be repaid if objectives have not been met. Any decision would be made by the Nominations and Remuneration Committee on the recommendation of the Chairman at the end of each 12 month period.</p> <p>Awaiting publication of VSM Framework on pay before revising policy.</p> |

| Element of Policy | Purpose and link to Strategy | How operated in practice | Maximum opportunity | Changes to Remuneration Policy from previous year |
|---------------------------------|---|--|--|---|
| | | <ul style="list-style-type: none"> Any opinion received by NHSI. <p>These factors are taken into account when setting and reviewing the salaries of staff who earn over £150,000.</p> | | |
| Benefits (taxable) | To enable the Trust to attract, retain and motivate suitably skilled and experienced Executive Directors. | Pension related benefits only. | As per NHS Pension Scheme regulations. | No change. |
| Pension | To enable the 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. |
| Recovery of overpayments | To enable the Trust to recover overpayments. | The contract of employment authorises deduction from salary in respect of any overpayment and reimbursement of the cost of DBS checks | As per contract of employment | No change |

Figure 15 - Non-Executive Directors Remuneration Policy

| Position | Remuneration | Policy |
|-------------------------------------|--------------|---|
| Chairperson Remuneration | £51,835 | The remuneration for all Non-Executive Directors and the Chairperson is reviewed annually by the Governors' Nominations and Remuneration Committee. At the Governors Nominations and Remuneration Committee meeting held on 15 June 2018 remuneration was discussed in detail with reference to the current benchmarking information available from NHS Providers for the period 2018/19. |
| From 1 November 2017 | | The Council of Governors, following the receipt of a recommendation from the Governors' Nominations and Remuneration Committee, confirmed at their meeting on 20 July 2019 that at the present time, there would be no change to the remuneration of the Chair and Non-Executive Directors for 2019/20 and the rate would remain the same as that agreed for the previous year 2018/19. |
| Non-Executive Director | £13,785 | In July 2019 the Council of Governors considered a recommendation from the Governors' Nominations and Remuneration Committee to appoint an Associate Non-Executive Director for a period of one year. The Council of Governors approved the remuneration for the role at £5,000 per annum. The appointment commenced in September 2018 and concluded at the end of May 2019. |
| Associate Non-Executive Director | £5,000 | There are no additional fees payable for other duties and no other items that are considered to be remuneration in nature. |
| From 24 September 2018 | | Non-Executive Directors do not receive pensionable remuneration. |

Policy on payment for loss of office

In relation to loss of office, if this is on the grounds of redundancy then this would be 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. There were no payments made in 2019/20 for loss of office.

Statement of consideration of employment conditions elsewhere in the Trust

The Trust has not consulted with employees when determining its Remuneration Policy for Executive Directors. Given the number of new Executive Director appointments in the last few years we take into account available benchmarking data and the guidance on pay for very senior managers published by NHSI to enable us to recruit and retain the best people.

Senior managers' remuneration policy

In accordance with the updated UK Corporate Governance Code, the Trust is reviewing its diversity and inclusion policy with regard to Senior Managers' remuneration which will be reported on for 2020/21.

3.2.3. ANNUAL REPORT ON REMUNERATION

3.2.3.1. Service Contracts

As described in the senior managers' remuneration policy section at Figure 14, senior manager contracts contain a notice period of 3 months and permanent contracts are issued. In the case of the Chief Executive Officer the contract contains a notice clause of 6 months. Service 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 3.5.5.

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 with regard to any local pay arrangements not covered by national terms and would be responsible for approving the running of any mutually agreed resignation scheme (MARS) or Voluntary Redundancy Scheme.

The Committee comprises the Chair 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 their own performance or remuneration. The Director of Human Resources (HR) is in attendance and will provide employment advice and guidance as necessary. The Director of Human Resources withdraws from the meeting when any discussions are held with regard to their performance or remuneration. The Director of HR also acts as Committee Secretary.

The Committee met five times during the year and has made a number of decisions during this time.

The key work of the Committee this year was to agree the recruitment and selection process for the Chief Executive Officer post. The Committee agreed to the procurement of an Executive Search Agency and Gatenby Sanderson were appointed to manage the search process in line with the parameters dictated by the Committee to ensure objectivity and independence; GatenbySanderson was appointed by the Trust following a tender process undertaken in line with the Trust's Standing Financial Instructions and rules regarding procurement. An established framework was used. The fee paid for the services provided was £26,363.82. The service included the provision of a search for suitable candidates, and the facilitation of the interview process as determined by the committee. The committee also agreed for the remit of the post to include Partnership Lead for the Bradford Health and Care Partnership. The selection process was comprehensive and included a presentation/question and answer session to an invited audience, an internal and external

stakeholder panel, a psychometric assessment, and a final panel interview. The Council of Governors subsequently approved the appointment of Ms Mel Pickup on 2 July 2019 and following due diligence in ensuring that Board level appointments must be 'fit and proper persons', she commenced in post 1 November 2019.

In respect of remuneration decisions the Committee authorised the remuneration for the Chief Executive Officer position which was submitted to NHSI for their opinion. The Committee also agreed to the Chief Operating Officer and the Chief Nurse receiving performance related pay increases in line with their contracts. The Committee considered the guidance received by NHSE/I and the 2019/20 annual pay increase recommendations for very senior managers and agreed to award a consolidated increase of 1.32% from 1 April 2019, plus a one-off non-consolidated lump sum of 0.77%. This was the same as the percentage increase paid to those on the top of agenda for change band 9 in 2019/20. In line with the recommendations the total pay award was unconsolidated for those Directors whose salaries were equal to or exceeded the upper quartile value of their pay range. All Executive Directors were given the choice of the pay award being made in 2019/20 or in 2020/21.

In terms of other business the Committee reviewed the Trust's Fit and Proper Persons Assurance Process and agreed some minor changes, and also considered the Board composition proposal and appointment process for Bradford Health Facilities Management Ltd (BHFML) which was subsequently discontinued.

Figure 16 - Attendance and membership during 2019/20

| Member | Meetings Attended |
|---|-------------------|
| Dr Maxwell Mclean, Chairman | 5 of 5 |
| Mr Trevor Higgins, Non-Executive Director | 0 of 1 |
| Mr Amjad Pervez, Non-Executive Director | 3 of 4 |
| Ms Selina Ullah, Non-Executive Director | 4 of 5 |
| Ms Laura Stroud, Non-Executive Director | 5 of 5 |
| Mr Barrie Senior, Non-Executive Director | 5 of 5 |
| Mr Jon Prashar, Non-Executive Director | 2 of 5 |
| Ms Trudy Feaster-Gee, Non-Executive Director | 4 of 5 |
| Ms Julie Lawreniuk, Non-Executive Director | 3 of 3 |
| Mr Mohammed Hussain, Non-Executive Director | 2 of 3 |
| Ms Pat Campbell, Director of HR (in attendance) | 5 of 5 |

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 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 2019/20 the committee met a total of 6 times (four routinely scheduled meetings and two extraordinary meetings). The meetings are chaired by Dr Maxwell Mclean, Chair. Where a conflict arises with regard to the Chairman, there is a process in place for the committee to appoint a replacement Chair from amongst the Governors.

Figure 17 - Membership and meeting attendance for 2019/20

| NRC membership | Meetings Attended |
|--------------------------------------|-------------------|
| Dr Maxwell Mclean, Chairman | 6 of 6 |
| Ms Hardev Sohal, Patient Governor | 3 of 6 |
| Ms Wendy McQuillan, Public Governor | 6 of 6 |
| Mr David Wilmshurst, Public Governor | 6 of 6 |
| Mr Alan English, Public Governor | 5 of 6 |
| Mr Alan Edmonds, Public Governor | 6 of 6 |
| Mr Kursh Siddique, Public Governor | 2 of 2 |
| Ms Ruth Wood, Staff Governor | 0 of 2 |

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](#)³.

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.

- Review of the NED/Chair Appraisal process
- Report on the outcomes of the NED Appraisals
- Report on the outcome of the Chair Appraisal
- Board skills, knowledge and experience evaluation
- Review of the NED/Chair Appointments Process
- Development of recommendations to the Council of Governors regarding the remuneration of the Chair and NEDs
- Review of the NRC terms of reference
- Review of NED and Chair terms and conditions
- Oversight of the appointment of two NEDs to replace Dr Trevor Higgins and Ms Pauline Vickers.
- Oversight of a recruitment process to appoint a NED to replace Mr Amjad Pervez following his resignation effective 31 January 2020.

In year, the Council of Governors appointed Ms Julie Lawreniuk and Mr Mohammed Hussain as Non-Executive Directors. Ms Julie Lawreniuk was also appointed Chair of the Finance and Performance Committee. Both appointees took up their posts from 1 September 2019. With regard to the process undertaken for the appointments of Ms Lawreniuk and Mr Hussain, the NRC with the support of the Chair and the Trust;

- Confirmed the appointment of Harvey Nash, Executive Search Agency, to assist with the appointments
- Agreed the job descriptions and person specifications along with a schedule for the appointment process
- Confirmed the membership of the interview panels.
- Presented the recommendations for appointment to the Council of Governors in May 2020.

Mr Amjad Pervez resigned from his post effective 31 January 2020. Following a review of the skills, knowledge and experience of the Board, the NRC recommended to the Council of Governors that a search be undertaken to for the appointment of a new NED to the Board of

³ <https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2019/08/NRC-ToR-approved-JAN-2018.doc.pdf>

Directors. The NRC is overseeing the search for the new NED which will conclude in early 2020/21.

3.2.3.4. Disclosures required by Health and Social Care Act

Expenses claimed by Directors

The total number of Directors holding office during 2019/20 was 18 (the number in 2018/19 was 20). The number of Directors receiving expenses during 2019/20 was 9 (the number in 2018/19 was 12). The aggregate sum of expenses paid to Directors in 2019/20 was £7,483 (in 2018/19 this was £5,051).

Expenses claimed by Governors

The total number of Governors holding office during 2019/20 was 23 (the number in 2018/19 was 19). The number of Governors receiving expenses during 2019/20 was 4 (the number in 2018/19 was 7). The aggregate sum of expenses paid to Governors in 2019/20 was £1,064 (in 2018/19 it was £780.20).

Figure 18 - Remuneration of Senior Managers 2019/20 (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 2019/20 | 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 |
|--|---|---|--|---|--|-------------------------------------|
| Trevor Higgins (Non-Executive Director / Acting Chairman) ⁴ | 5 - 10 | | | | | 5 - 10 |
| Maxwell Mclean (Chairman) ⁵ | 50 - 55 | | | | | 50 - 55 |
| John Holden (Acting Chief Executive and Director of Strategy and Integration) ⁶ | 170 - 175 | | | | | 170 - 175 |
| Mel Pickup (Chief Executive) ⁷ | 90 - 95 | | | | 125.0 - 127.5 | 215 - 220 |
| Sandra Shannon (Chief Operating Officer / Deputy Chief Executive) | 140 - 145 | | | | 85.0 - 87.5 | 225 - 230 |
| Karen Dawber (Chief Nurse) | 135 - 140 | | | | 35.0 - 37.5 | 170 - 175 |
| Bryan Gill (Medical Director) | 235 - 240 | | | | 0 | 235 - 240 |
| Matthew Horner (Director of Finance) | 150 - 160 | | | | 17.5 - 20.0 | 165 - 170 |
| Patricia Campbell (Director of Human Resources) | 115 - 120 | | | | 40.0 - 42.5 | 155 - 160 |
| Cindy Fedell (Chief Digital and Information Officer) | 120 - 125 | | | | 30.0 - 32.5 | 150 - 155 |
| Amjad Pervez (Non-Executive) | 10 - 15 | | | | | 10 - 15 |

⁴ Trevor Higgins (Non Executive Director), Acting Chairman from 01 February 2019 to 20 May 2019

⁵ Maxwell Mclean, Chairman from 01 May 2019

⁶ John Holden, Acting Chief Executive from 01 April to 31 October 2019

⁷ Mel Pickup, Chief Executive from 01 November 2019

| Name and Title | Salary and fees | All taxable benefits | Annual performance related bonuses | Long term performance related bonuses | All pension related benefits | Total |
|--|-------------------|-----------------------|------------------------------------|---------------------------------------|------------------------------|-------------------|
| 2019/20 | (Bands of £5,000) | (to the nearest £100) | (Bands of £5,000) | (Bands of £5,000) | (Bands of £2,500) | (Bands of £5,000) |
| | £000s | £00s | £000s | £000s | £000s | £000s |
| Director)⁸ | | | | | | |
| Selina Ullah (Non-Executive Director) | 10 - 15 | | | | | 10 - 15 |
| Laura Stroud (Non-Executive Director) | 0 | | | | | 0 |
| Barrie Senior (Non-Executive Director) | 10 - 15 | | | | | 10 - 15 |
| Trudy Feaster-Gee (Non-Executive Director) | 0 | | | | | 0 |
| Jon Prashar (Non-Executive Director) | 10 - 15 | | | | | 10 - 15 |
| Andrew McConnell (Associate Non-Executive Director)⁹ | 0 - 5 | | | | | 0 - 5 |
| Julie Lawreniuk (Non-Executive Director)¹⁰ | 5 - 10 | | | | | 5 - 10 |
| Mohammed Hussain (Non-Executive Director)¹¹ | 5 - 10 | | | | | 5 - 10 |

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 the individual. 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 the benefit 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 receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive members.

⁸ Amjad Pervez, Non-Executive Director until 31 January 2020

⁹ Andrew McConnell (Associate Non-Executive Director) until 20 May 2019

¹⁰ Julie Lawreniuk, Non-Executive Director from 01 September 2019

¹¹ Mohammed Hussain, Non-Executive Director from 01 September 2019

Figure 19 -Remuneration of Senior Managers 2018/19 (subject to audit)

| Name and Title 2018/19 | Salary and fees | All taxable benefits | Annual performance related bonuses | Long term performance related bonuses | All pension related benefits | Total |
|--|----------------------|--------------------------|---|--|------------------------------------|----------------------|
| | (Bands of £5,000) | (to the nearest £100) | (Bands of £5,000) | (Bands of £5,000) | (Bands of £2,500) | (Bands of £5,000) |
| | £000s | £00s | £000s | £000s | £000s | £000s |
| Bill McCarthy (Chairman) ¹² | 45 - 50 | - | - | - | - | 45 - 50 |
| Trevor Higgins (Non-Executive Director / Acting Chairman) ¹³ | 20 - 25 | - | - | - | - | 20 – 25 |
| Clive Kay (Chief Executive) ¹⁴ | 250 - 255 | - | - | - | - | 250 – 255 |
| John Holden (Director of Strategy and Integration / Deputy Chief Executive) | 140 -145 | - | - | - | 5.0 – 7.5 | 145 – 150 |
| Sandra Shannon (Chief Operating Officer / Deputy Chief Executive) | 125 – 130 | - | - | - | 52.5 – 55.0 | 180 – 185 |
| Karen Dawber (Chief Nurse) | 125 – 130 | - | - | - | 40.0 – 42.5 | 170 – 175 |
| Bryan Gill (Medical Director) | 230 -235 | - | - | - | - | 230 – 235 |
| Matthew Horner (Director of Finance) | 140 – 145 | - | - | - | 12.5 – 15.0 | 155 – 160 |
| Patricia Campbell (Director of Human Resources) | 110 – 115 | - | - | - | - | 110 – 115 |
| Cindy Fedell (Director of Informatics) | 115 -120 | - | - | - | 30.0 – 32.5 | 145 – 150 |
| Tanya Claridge (Director of Governance and Corporate Affairs) ¹⁵ | 95 – 100 | - | - | - | 180.0 – 182.5 | 275 – 280 |
| Pauline Vickers (Non-Executive Director) ¹⁶ | 10 – 15 | - | - | - | - | 10 – 15 |

¹² Bill McCarthy (Chairman) left 31 January 2019,

¹³ Trevor Higgins (Non-Executive Director) Acting Chairman from 01 February 2019

¹⁴ Clive Kay (Chief Executive) left 31 March 2019

¹⁵ Tanya Claridge (Director of Governance and Corporate Affairs) Executive Director until 30 September 2018

¹⁶ Pauline Vickers (Non-Executive Director) left 03 November 2018

| Name and Title 2018/19 | Salary and fees | All taxable benefits | Annual performance related bonuses | Long term performance related bonuses | All pension related benefits | Total |
|---|----------------------|--------------------------|---|--|------------------------------------|----------------------|
| | (Bands of £5,000) | (to the nearest £100) | (Bands of £5,000) | (Bands of £5,000) | (Bands of £2,500) | (Bands of £5,000) |
| | £000s | £00s | £000s | £000s | £000s | £000s |
| Amjad Pervez (Non-Executive Director) | 10 - 15 | - | - | - | - | 10 - 15 |
| Selina Ullah (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Laura Stroud (Non-Executive Director) | - | - | - | - | - | - |
| Barrie Senior (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Trudy Feaster-Gee (Non-Executive Director) | - | - | - | - | - | - |
| Jon Prashar (Non-Executive Director) | 10 – 15 | - | - | - | - | 10 – 15 |
| Andrew McConnell (Associate Non-Executive Director)¹⁷ | 0 - 5 | - | - | - | - | 0 - 5 |

¹⁷ Andrew McConnell (Associate Non-Executive Director) started 24 September 2018.

Figure 20 - Pension entitlements of senior managers 2019/20 (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 2020 | Lump sum at pension age related to accrued pension at 31st March 2020 | CETV at 1st April 2019 | Real increase / (decrease) in CETV | CETV at 31st March 2020 |
|---|---|--|---|---|----------------------------|------------------------------------|----------------------------|
| | (Bands of £2,500) £ 000s | (Bands of £2,500) £ 000s | (Bands of £5,000) £ 000s | (Bands of £5,000) £ 000s | (Nearest £1,000) £ 000s | (Nearest £1,000) £ 000s | (Nearest £1,000) £ 000s |
| John Holden (Acting Chief Executive and Director of Strategy and Integration)¹⁸ | (0 - 2.5) | 25 - 27.5 | 55 - 60 | 165 - 170 | 1,119 | 80 | 1,226 |
| Mel Pickup (Chief Executive)¹⁹ | 5 - 7.5 | 12.5 - 15 | 85 - 90 | 215 - 220 | 1,374 | 127 | 1,726 |
| Sandra Shannon (Chief Operating Officer / Deputy Chief Executive) | 2.5 - 5 | 12.5 - 15 | 55 - 60 | 175 - 180 | 1,262 | 128 | 1,441 |
| Karen Dawber (Chief Nurse) | 2.5 - 5 | 0 - 2.5 | 40 - 45 | 95 - 100 | 681 | 32 | 748 |
| Matthew Horner (Director of Finance) | 0 - 2.5 | 0 - 2.5 | 50 - 55 | 125 - 130 | 910 | 27 | 972 |
| Patricia Campbell (Director of Human Resources) | 2.5 - 5 | 0 - 2.5 | 45 - 50 | 135 - 140 | 986 | 51 | 1,077 |
| Cindy Fedell (Chief Digital and Information Officer) | 2.5 - 5 | 0 | 10 - 15 | 0 | 145 | 17 | 181 |

Notes to Figure 20

- NHS Pensions are still assessing the impact of the McCloud judgement in relation to changes to benefits in 2015. The benefits and related CETVs disclosed do not allow for any potential future adjustments that may arise from this judgement
- Following the government's announcement that all public sector pension schemes will be required to provide the same indexation on the Guaranteed Minimum Pension (GMP) as on the remainder of the pension, the NHSPS has revised its method to calculate the CETV values. The real increase in CETV will therefore be impacted as it will include any increase in CETV due to the change in GMP methodology

¹⁸ John Holden, Acting Chief Executive from 01 April to 31 October 2019

¹⁹ Mel Pickup, Chief Executive from 01 November 2019

3.2.3.5. Fair pay multiple (subject to audit)

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid Director in their organisation and the median remuneration of the organisation's workforce. The banded remuneration of the highest paid Director in the Trust in the financial year 2019/20, £235,000 - £240,000 (2018/19, £250,000 - £255,000). This was 8.7 times (2018/19, 9.4 times) the median remuneration of the workforce, which was £27,260 (2018/19, £26,963). The median salary calculation is based on the spine point of individuals employed by the Trust on the last day of the financial year. Each staff member's spine point was taken and the median calculated from this population. Agency costs were not included as it was considered impracticable to evaluate the individual cost of vacant posts covered by temporary workers and deemed that such calculation would not materially alter the calculation of the median. In 2019/20, and 2018/19, no employees received remuneration in excess of the highest-paid director. Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Signed

A handwritten signature in black ink, appearing to read 'Mel Pickup', written in a cursive style.

Mel Pickup
Chief Executive
18 June 2020

3.3. STAFF REPORT

3.3.1. ANALYSIS OF STAFF COSTS AND NUMBERS

Figure 21 - Staff Costs 2019/20 (£'000)

| Staff Costs | Permanently employed | Other | 2019/20 Total | 2018/19 Total |
|--|----------------------|---------------|----------------|----------------|
| Salaries and wages | 217,541 | 2,558 | 220,099 | 209,222 |
| Social security costs | 20,194 | 0 | 20,194 | 19,205 |
| Apprenticeship Levy (pay element) | 1,067 | 0 | 1,067 | 1,020 |
| Pension cost - defined contribution plans employer's contributions to NHS pensions | 24,817 | 0 | 24,817 | 23,592 |
| Pension cost - employer contributions paid by NHSE on provider's behalf | 11,068 | 0 | 11,068 | 0 |
| Temporary staff - agency/contract staff | 0 | 8,596 | 8,597 | 10,360 |
| Total gross staff costs | 274,687 | 11,154 | 285,841 | 263,400 |

Figure 22 - Average number of employees Whole Time Equivalent for 2019/20

| | Total Number | Permanent Number | Other Number |
|--|--------------|------------------|--------------|
| Medical and dental | 779 | 768 | 11 |
| Administration and estates | 1,848 | 1,791 | 57 |
| Healthcare assistants and other support staff | 671 | 671 | |
| Nursing, midwifery and health visiting staff | 1,988 | 1,580 | 408 |
| Scientific, therapeutic and technical staff | 736 | 722 | 14 |
| Other | 3 | 3 | 0 |
| Total average numbers | 6,025 | 5,535 | 490 |
| Of which, number of employees (WTE) engaged on capital projects | 8 | 8 | 0 |

Figure 23 - Average number of employees Whole Time Equivalent for 2018/19

| | Total Number | Permanent Number | Other Number |
|---|--------------|------------------|--------------|
| Medical and dental | 717 | 702 | 15 |
| Ambulance staff | 0 | | |
| Administration and estates | 1,837 | 1,752 | 85 |
| Healthcare assistants and other support staff | 704 | 671 | 33 |
| Nursing, midwifery and health visiting staff | 1,947 | 1,548 | 399 |
| Nursing, midwifery and health visiting learners | 0 | | |
| Scientific, therapeutic and technical staff | 669 | 650 | 19 |
| Healthcare science staff | 0 | | |
| Social care staff | 0 | | |
| Agency and contract staff | 0 | | 0 |
| Bank staff | 0 | | |
| Other | 3 | 3 | |

| | Total Number | Permanent Number | Other Number |
|--|--------------|------------------|--------------|
| Total average numbers | 5,877 | 5,326 | 551 |
| Of which, number of employees (WTE) engaged on capital projects | 8 | 8 | 0 |

Figure 24 – 31 March 2020 distribution of staff, male and female

| Group | Female | Male | Total |
|------------------------|--------------|--------------|--------------|
| Directors | 9 | 7 | 16 |
| Senior Managers | 248 | 148 | 396 |
| Other Employees | 4,637 | 1,253 | 5,890 |
| Total | 4,894 | 1,408 | 6,302 |

Figure 25 - 31 March 2019 distribution of staff, male and female

| Group | Female | Male | Total |
|------------------------|--------------|--------------|--------------|
| Directors | 8 | 10 | 18 |
| Senior Managers | 244 | 146 | 390 |
| Other Employees | 4,526 | 1,243 | 5,769 |
| Total | 4,778 | 1,399 | 6,177 |

Sickness absence data for 2019/20 is available from NHS Digital's website [here](#)²⁰.

3.3.2. STAFF POLICIES AND ACTIONS

3.3.2.1. Policies Relating to Disabled Employees

The Trust launched its Disability Equality & Disability Leave Policy in January 2020. The policy focusses on preventing discrimination in the workplace and improving the working lives of disabled staff and those with long term health conditions. Using the social model of disability as its linchpin; it aims to provide a culture shift by taking the emphasis away from attendance management and removing the barriers that prevent disabled staff from engaging on an equal footing with others in the workplace. It provides guidance, mechanisms for support and a clear process for both staff and managers around implementing Reasonable Adjustments. It also introduces a new Disability Leave facility, which allows staff who fall under the Equality Act 2010 paid time off to attend appointments, therapy or treatment (for example) relating to their disability, with the clear aim of supporting disabled staff and improving their attendance and engagement in the longer term. It makes clear the requirement to ensure Disabled staff maintain access to training whilst on Disability leave.

The policy was introduced as part of the Workforce Disability Equality Scheme Action Plan following consultation with disabled staff in the workforce around what would improve working lives for them. A task and finish group, which included "Enable" (the Disabled Staff Network) worked with us on the new policy and will support the introduction of a new training programme to complement this.

In addition; the Policy on Managing Attendance details the arrangements for continuing the employment of, and for arranging appropriate training for, employees who have become disabled or developed a long term health condition during their employment.

²⁰ <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates>

The Trust's Recruitment and Selection Policy ensures full and fair consideration is given to applications for employment made by disabled people by guaranteeing interviews for those who meet the essential criteria on a person specification. As a reasonable adjustment; graduates from the Trust's Project Search scheme (which offers work experience to students with learning disabilities), may be offered a priority work trial for advertised posts in the Trust that are agreed as suitable. This work trial is offered as an alternative to following the usual selection process and removes the element of competition that may see them at a disadvantage. They are then offered the support of a follow-on coach in their new job.

The Study Leave Policy (non-medical staff) covers the arrangements for the training and development of all employees.

3.3.2.2. Interpreting and Translation Policy

The Trust has an Interpreting and Translation Policy. The policy ensures staff and service users are fully aware of the interpreting and translation services available to them and how to access them appropriately.

3.3.2.3. Information on health and safety performance and occupational health

The Trust has continued to make progress in relation to Health and Safety during 2019/20. Performance is generally good, but there remain opportunities for change and improvement in relation to Health and Safety, particularly in relation to Control of Substances Hazardous to Health and medical device training. The Trust continues to monitor and mitigate any risks associated with the gap analysis undertaken in relation to key areas of national policy and Trust performance. This approach of identifying gaps and risks associated with any health and safety regulations provides a clear picture of our health and safety compliance and facilitates the identification of organisational priorities for action.

3.3.2.4. Information on policies and procedures with respect to countering fraud and corruption

Detail can be found in section 3.5.5.8.

3.3.3. STAFF SURVEY

3.3.3.1. Staff engagement

Our vision is for our staff to feel valued, motivated and well led. We know that improving staff experience has a direct impact on patient experience, so improving staff engagement and experience is a top priority.

'We are Bradford', is an on-going conversation with our staff about why we're here and what makes us special. It is about bringing our values to life through recruitment, induction, appraisals and staff awards. Our 'Work as One' events held throughout the year got everyone working together and making improvements for patients, as well as focusing on the importance of wellbeing and looking after each other. These have brought our values to life across teams and across the wider Health and Social Care system.

'Let's Talk' has become the brand for our engagement activities, from 'Let's Talk Live' events with the Chief Executive, 'Let's Talk Together' Senior Leader sessions to our Let's Talk newsletter providing regular updates and staff stories.

We are proud that our on-going work to make our Trust a great place to work was recognised this year as a finalist in the HSJ 2019 award for Staff Engagement.

3.3.3.2. NHS Staff survey

The NHS Staff Survey is conducted annually. From 2018 onwards, the results from questions are grouped to give scores in eleven themes relating to staff experience. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. The response rate between September and December for the 2019 Staff Survey was 38 % (2018: 35%). Scores for each theme together with that of the survey benchmarking group average of other Acute Trusts are presented below:

Figure 26: NHS Staff Survey - Comparison of other Acute Trusts Benchmarking Group

| | 2019/20 | | 2018/19 | | 2017/18 | |
|---|---------|--------------------|---------|--------------------|---|--------------------|
| | Trust | Benchmarking Group | Trust | Benchmarking Group | Trust | Benchmarking Group |
| Equality, diversity and inclusion | 9.0 | 9.0 | 9.0 | 9.1 | 9.0 | 9.1 |
| Health and wellbeing | 6.1 | 5.9 | 6.0 | 5.9 | 6.1 | 6.0 |
| Immediate managers | 7.0 | 6.8 | 6.9 | 6.7 | 6.7 | 6.7 |
| Morale | 6.4 | 6.1 | 6.3 | 6.1 | New indicator – no comparative result available | |
| Quality of appraisals | 5.7 | 5.6 | 5.6 | 5.4 | 5.3 | 5.3 |
| Quality of care | 7.6 | 7.5 | 7.5 | 7.4 | 7.5 | 7.5 |
| Safe environment – bullying and harassment | 8.1 | 7.9 | 8.1 | 7.9 | 8.0 | 8.0 |
| Safe environment – violence | 9.5 | 9.4 | 9.6 | 9.4 | 9.4 | 9.4 |
| Safety culture | 6.9 | 6.7 | 6.7 | 6.6 | 6.6 | 6.6 |
| Staff engagement | 7.2 | 7.0 | 7.2 | 7.0 | 7.0 | 7.0 |
| Team working | 6.8 | 6.6 | 6.7 | 6.5 | 6.6 | 6.5 |

The results of the 2019 Staff Survey show our staff feel they are making a difference and are trusted to do their job. An increasing number feel satisfied with the care they give and are delivering the care they aspire to. Morale is up with staff feeling able to show their initiative and make suggestions for improvements. Staff are confident action will be taken to make sure errors, near misses or incidents do not happen again and say that feedback is given about changes made. Staff feel safe to raise concerns about unsafe clinical practice and feel confident that concerns raised by staff and patients would be addressed. An increasing number of staff would recommend us as a place to work or receive care or treatment. The results show we work well as a team - this is the essence of 'We are Bradford' and shows how important it is to continue our work on culture and staff engagement.

Compared to 2018 we have improved scores in eight of the eleven themed areas: Health and wellbeing; Immediate managers; Morale; Quality of appraisals; Quality of care; Safe environment – bullying and harassment; Safety culture and Team working.

Our scores remained the same in two areas: Staff engagement and Equality, diversity and inclusion. Increasing staff engagement was our top priority in 2019 and although we have not made an improvement in our overall score compared to last year (7.2) we have seen significant improvements in scores in seven of the nine indicators. More staff are enthusiastic about their job and feel they have opportunities to show initiative; more feel able to make suggestions and make improvements happen. More staff would recommend us as a place to receive care or treatment – up from 68% to 71% and more staff would recommend us as a place to work up from 64.7% to 68.5%. We are above average in all areas. However there has been a decrease in scores in two areas with fewer staff saying that time passes quickly when they are working and that they look forward to going to work, which will be a focus going forward.

In the questions about Equality, diversity and inclusion, although the overall score has not changed, we have seen an improvement in the perception around career progression and promotion this year with more staff saying that the Trust acts fairly with regard to career progression/promotion. More feel adequate adjustments have been made to enable staff to carry out their work and fewer staff have experienced discrimination at work from a manager or colleague. However there has been an increase in the number of staff experiencing discrimination at work from patients/service users, their relatives or members of the public; this has increased from 7.7% to 8.2% (compared to an average of 6.8%).

Our score decreased for Safe environment – violence. Although there is a drop in number of staff saying they have experienced physical violence from colleagues (from 1.5% to 1.2%) there has been an increase in the number of staff saying they experienced physical violence from patients/service users, their relatives or public, (from 11.2% to 12.5%) and the number of staff saying they experienced an incident of physical violence from managers (from 0.3% to 0.4%). This is a priority area to address. Despite the drop in score for this area, it remains our top score, just short of the best score for acute trusts.

Our priorities in the 2019 Staff Survey action plan were:

- Improve staff engagement and morale
- Equality, Diversity and Inclusion - improving perception and experience of career progression and promotion; provision of adequate reasonable adjustments
- Health and Wellbeing - taking positive action on health and wellbeing and reducing work related stress; experience of Musculoskeletal pain as a result of work activities
- Safe environment – bullying and harassment - reducing experience of harassment, bullying or abuse at work
- Quality of care - improving our quality of care and improving use of patient and service user feedback

We made improvements in seven of our priorities: Morale; Equality, Diversity and Inclusion; Health and wellbeing around taking positive action and reducing experience of MSK and in improving Quality of Care. This shows our focused work in these areas has made a difference. Our scores stayed the same for Staff engagement and Safe environment – bullying and harassment. We did not make an improvement in reducing the experience of work related stress despite a focus on health and wellbeing with a range of awareness and development events for managers and staff. These areas remain a priority for 2020/21.

3.3.3.3. Future priorities and targets 2020/21

Building on the success of 'We are Bradford' and to keep up the momentum that will drive the behavioural change we need to make our Trust 'outstanding', this year the focus is making sure our staff feel motivated, valued and engaged; feel safe at work and take care of ourselves and each other. The priorities are:

- Increasing staff engagement with a focus on motivation
- Improving morale
- Health and wellbeing – in particular reducing work related stress
- Safe environment – reducing experience of harassment, bullying or abuse at work
- Safe environment – reducing experience of physical violence at work

Equality, diversity and inclusion will continue to be a priority and will be addressed through the ongoing Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans and equality, diversity and inclusion work.

Performance around staff engagement and morale will be measured through the Staff Friend and Family Test. Overall performance against our priorities will be monitored throughout the year by the Education and Workforce Committee reporting to the Workforce Committee.

3.3.4. TRADE UNION FACILITY TIME

The tables below set out the information the Trust is to disclose regarding Trade Union activity amongst staff, this is required by Schedule 2 of the Trade Union (Facility Time Publication Requirements) Regulations 2017²¹.

Figure 27 - Relevant Union Officials

| Number of employees who were relevant union officials during the relevant period | Full-time equivalent employee number |
|--|--------------------------------------|
| 60 | 53.65 |

Figure 28 - Percentage of time spent on facility time

| Percentage of time | Number of employees |
|--------------------|---------------------|
| 0% | 52 |
| 1-50% | 8 |
| 51%-99% | 0 |
| 100% | 0 |

Figure 29 - Percentage of pay bill spent on facility time

| | |
|---|--------------|
| Total cost of facility time | £12,941.28 |
| Total pay bill | £274,436,933 |
| Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100 | 0.004% |

Figure 30 - Paid trade union activities

| | |
|--|----|
| Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant union officials during the relevant period ÷ total paid facility time hours) x 100 | 0% |
|--|----|

²¹ <http://www.legislation.gov.uk/uksi/2017/328/made>

3.3.5. CONSULTANCY AND OFF-PAYROLL ARRANGEMENTS

When considering the employment of workers off payroll, the Trust completes an Employer Status Indicator test that can be found on HMRC's [website](#)²². 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.

In 2019/20 the Trust spent £846,137 on consultancy (£1,128,605 in 2018/19).

Figure 31 - For all off-payroll engagements as of 31 March 2020, for more than £245 per day and that last longer than six months:

| | |
|---|----|
| Number of existing engagements as of 31 March 2020 | 0* |
| Of which: | |
| Number that have existed for less than one year at time of reporting | 0 |
| Number that have existed for between one and two years at time of reporting | 0 |
| Number that have existed for between two and three years at time of reporting | 0 |
| Number that have existed for four or more years at time of reporting | 0 |

* Existing engagements as of 31 March 2020 that are not included here (due to being on-payroll) equals 11.

Figure 32 - For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and March 2020, for more than £245 per day and that last for longer than six months

| | |
|---|----|
| Number of new engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020 | 11 |
| Of which: | |
| Number assessed as within the scope of IR35 | 11 |
| Number assessed as not within the scope of IR35 | 0 |
| Number engaged directly (via PSC contracted to Trust) and are on the Trust's payroll | 11 |
| Number of engagements reassessed for consistency / assurance purposes during the year. | 0 |
| Number of engagements that saw a change to IR35 status following the consistency review | 0 |

Figure 33 - For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2019 and 31 March 2020

| | |
|---|----|
| Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year. | 0 |
| Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements | 18 |

²² <https://www.gov.uk/guidance/check-employment-status-for-tax>

3.3.6. EXIT PACKAGES (SUBJECT TO AUDIT)

Figure 34 - All exit packages 2019/20

| Exit package cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
|---------------------------------------|-----------------------------------|-----------------------------------|--|
| Total number of exit packages by type | 0 | 0 | 0 |
| Total resource cost | £0 | £0 | 0 |

Figure 35 - All exit packages 2018/19

| Exit package cost band | Number of compulsory redundancies | Number of other departures agreed | Total number of exit packages by cost band |
|---------------------------------------|-----------------------------------|-----------------------------------|--|
| <£10,000 | 0 | 1 | 1 |
| £10,000 – £25,000 | 2 | 0 | 2 |
| Total number of exit packages by type | 2 | 1 | 3 |
| Total resource cost | £44,000 | £2,000 | |

Figure 36 - Exit packages, non-compulsory departure

| | 2019/20 Agreement Number | 2019/20 Total Value of Agreements £000 | 2018/19 Agreement Number | 2018/19 Total Value 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 |
| Exit payments following Employment Tribunals or court orders | 0 | 0 | 0 | 0 |
| Non-contractual payments requiring HMT approval | 0 | 0 | 1 | 15 |
| Total | 0 | 0 | 1 | 15 |
| Of which: non-contractual payments requiring HMT approval made to | 0 | 0 | 1 | 2 |

| | 2019/20 Agreement Number | 2019/20 Total Value of Agreements £000 | 2018/19 Agreement Number | 2018/19 Total Value of Agreements £000 |
|---|--------------------------------|---|--------------------------------|---|
| individuals where the payment value was more than 12 months of their annual salary | | | | |

3.3.7. GENDER PAY GAP

The Trust has registered with the government gender pay gap reporting service. Using the [Cabinet Office's](https://gender-pay-gap.service.gov.uk/)²³ guidance and the guidance from NHS Employers ["Addressing your Gender Pay Gap"](https://www.nhsemployers.org/-/media/Employers/Publications/women-leaders/Addressing-your-gender-pay-gap-guide.pdf)²⁴ a focus group reviewed the data and drafted an action plan which was agreed by the Trust Diversity Workstream. Due to the Covid-19 Pandemic; publication of this action plan and submission of the data has been suspended until further notice by the government office. We will therefore await further guidance from the government in terms of our approach to future Gender Pay Gap reporting.

See section 3.4.4 in the Equality Report for further information.

²³ <https://gender-pay-gap.service.gov.uk/>

²⁴ <https://www.nhsemployers.org/-/media/Employers/Publications/women-leaders/Addressing-your-gender-pay-gap-guide.pdf>

3.4. EQUALITY REPORT

Once again, our year included many and wide-ranging highlights:

- We launched our comprehensive Equality Plan. This shares with our staff and our patients everything we are doing to eliminate unlawful discrimination, harassment and victimisation; and to advance equality of opportunity. You can read it [here](#)²⁵.
- Project SEARCH, our award-winning work placement scheme which helps young people with a learning disability to develop new skills and secure meaningful employment, has entered its seventh year. We are proud to host it, and work in partnership with Bradford's Co-op Academy Southfield, HFT – a national charity which supports adults with learning disabilities, the University of Bradford and Bradford Council, to ensure it goes from strength-to-strength. Since its launch, 52 interns have graduated and 39 have found employment - 15 within our own teams.
- Our Interpreting Services team supported people on no fewer than 43,725 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 24/7 access. Requests for support in other formats, such as Braille, are also met through our team.

Figure 37 - Top 10 languages requested 2019/20

| Language | Sessions |
|--------------|----------|
| Urdu/Punjabi | 20,559 |
| Czech/Slovak | 6,617 |
| Polish | 3,579 |
| Arabic | 2,659 |
| Bengali | 2,133 |
| Hungarian | 1,452 |
| Romanian | 841 |
| BSL | 766 |
| Pushto | 669 |
| Kurdish | 558 |

3.4.1. STAFF EQUALITY

Black Asian and Minority Ethnic (BAME) Employment Targets

- We continue to make good progress towards ensuring our workforce mirrors the local Black Asian and Minority Ethnic (BAME) community – having set a challenging, but achievable, target of 35% by September 2025. Latest figures show that the overall percentage of BAME staff now stands at 31.6%, up from 24.7% when we first launched our goal in 2015. Building on this platform at this current pace, we would not only meet our target – but beat it by 4%.
- BAME representation among Band 8+ colleagues (our most senior managers) has risen to 15.6% from a 2015 starting point of 7.59%. However, this trajectory tells us that by 2025, only 26% will be from BAME backgrounds. A range of initiatives are in now place to accelerate this year's progress.
- In a new development, a senior BAME colleague is now fully involved in the recruitment process for all appointments at Band 8a and above. At Bands 8/9, promotions for BAME staff have increased by 2%, which is positive step forward.
- Our overall performance has ensured that we continue to forge ahead of the aspirational target figures for the recruitment and promotion of BAME staff.

²⁵ <https://www.bradfordhospitals.nhs.uk/equality-and-diversity/>

3.4.2. WORKFORCE RACE EQUALITY STANDARD (WRES)

We were rated as one of ten top-performing Trusts this year for two indicators in the WRES. This measures workplace experience and opportunity, and also helps us track progress in pursuit of our corporate objective to be in the top 20% of NHS employers. These ratings were achieved in regard to:

- The number of staff who have experienced harassment, bullying or abuse from colleagues
- The number of staff that personally experienced discrimination at work from a manager, team leader or other colleague

Building on this platform, we are now focusing on delivering a series of priorities including:

- Reviewing and refreshing existing approaches to equality, diversity and inclusion
- Expanding training opportunities for Band 8/9 BAME staff to become independent panel members on all recruitment processes for Band 8/9 posts
- Promoting the NHS Leadership Academy Stepping Up and Ready Now programmes to our BAME staff
- Launching a Reciprocal Mentoring Scheme, where members of the senior leadership team and Trust Board are paired with BAME staff and those with a disability or long-term health condition

3.4.3. WORKFORCE DISABILITY EQUALITY STANDARD (WDES)

As a result of the work we have completed, we received recognition from NHS Improvement and NHS England and are to be included in the WDES Annual Report 2019 as an example of good practice for the region.

The WDES is a new standard that uses a series of measures to improve the experience of disabled staff in the NHS. Our first data submission was made in July 2019 and our WDES action plan was approved by our Board in August and shared on our website the following month. You can find out more here. (DN: [link to WDES plan](#)).

Successes include:

- Surveying the experiences of all our disabled staff ahead of launching a focus group to inform our WDES action plan
- Introducing a Disability Equality and Disability Leave Policy and launching a new training course to accompany this.
- Providing training to Staff Advocates around disability/ reasonable adjustments, and hate crime
- Achieving Level Two of the Disability Confident Employer standard – with a goal to reach Level Three (Disability Confident Lead)
- Launching a 'hate crime' reporting functionality on Datix
- Reviewing and promoting staff access to facilities (e.g. disabled parking, toilet facilities)

3.4.4. GENDER PAY GAP

We were due to publish our third annual Gender Pay Gap (GPG) report in March 2020. However, due to the Covid-19 Pandemic, publication of this action plan and submission of the data has been suspended until further notice by the government office. We will therefore await further guidance from the government in terms of our approach to future Gender Pay Gap reporting. Our analysis of the data from March 2019 on gender equality shows that:

- 78% of our workforce is female.

- At 68%; Women are proportionately under-represented in quartile 4 (higher paid staff) by 9%. They are over-represented in quartiles 2 and 3 and proportionately represented in quartile 1 (lowest paid staff).
- Women earn 9% less than men (median average pay), but this gap has narrowed by 1% from last year.
- Men continue to earn 33% more in bonuses (attributable only to Medical & Dental Consultants)

We are taking action to reduce the gap in our overall GPG and bonus pay.

3.4.5. EQUALITY AND DIVERSITY TRAINING

Our achievements include:

- 92.9% of staff in senior management positions have received Equality and Diversity training
- 99.6% of all staff have undertaken a mandatory e-learning package. It includes an introduction to bias, equality legislation and highlights the rights and responsibilities that all staff have in relation to equality and diversity both as employees and as service providers

3.4.6. STAFF ADVOCATES

We have acted on feedback from Staff Survey results which told us, for some staff, there is a real disparity in their perception of fairness in, for example, equal opportunities for career progression, promotion, and harassment and bullying.

In partnership with the Royal College of Nursing, we have provided training and support to 13 staff who are now able to provide confidential help and to identify solutions to the issues staff may have – with more than 100 colleagues already benefitting from confidential discussions with this team of Staff Advocates.

In tandem with other data, the initiative also helps us to identify “hot spots and patterns” that may require additional action or focus to improve the working lives of staff.

3.4.7. STAFF NETWORKS

All three of our staff equality networks (disability, BAME and LGBT+) are confidential, self-governing groups which provide support in raising awareness of issues affecting colleagues with these protected characteristics.

We ensure they have a voice through bi-monthly meetings of the Diversity Work Stream, which is attended by representatives from all three networks. Their insight has been invaluable in shaping both our WRES and WDES action plans, as well as our new Disability Equality and Disability Leave Policy.

In October, our BAME staff network held its first BAME Conference which was well attended. Recommendations from it are feeding into our plans to advance diversity and inclusion across our hospitals.

NHS Rainbow Badge Scheme

We were proud to introduce this scheme, which supports LGBT+ patients and their families, across all our hospitals in October. In return for attending a training session and making a pledge, our staff receive an enamel NHS Rainbow Badge and information about how to support our LGBT+ patients. By wearing the badge our staff show that this is an open, non-

judgemental place for people who identify as LGBT+ and sends a clear message that people can talk to them about LGBT+ issues. The Trust has already provided training to 800 staff.

3.4.8. EQUALITY ANALYSIS

Our Head of Equality, Diversity and Inclusion meets with authors of all policy documentation to complete an equality analysis of our new and revised policies. The Equality Impact Assessment includes analysis of all nine protected groups, and also considers the human rights FREDA principles (Fairness, Respect, Equality, Dignity, and Autonomy).

Action is taken to mitigate against disadvantage where there is evidence that protected groups might be affected by the policy or service development.

3.4.9. EQUALITY OBJECTIVES

These identify the challenges that we face in providing services and employment opportunities for people from the protected groups. Making progress against these is challenging but we have put in place realistic targets for achieving all patient, staff and workforce-focused objectives.

Our Workforce Committee receives a six-monthly equality update report for discussion, which enables it to track progress against the equality objectives, which include:

Patient-focused

- Implementing the Accessible Information Standard (AIS)
- Improving BAME service users access and experience of services
- Increasing awareness of mental health issues and to improve access and experience of mental health service users across the health economy

Staff-focused

- Implementing the recommendations in Stonewall's Unhealthy Attitudes study and Bradford Equity Partnership's lesbian, gay, bisexual, and transgender local health needs assessment

Workforce-focused

- Implementing the WDES and WRES
- Carrying out a Gender Pay Gap audit using a recognised audit framework
- Employing at least a third of Project SEARCH interns

We work in partnership with other local health economy partners and consult with the local community on our progress.

A final review of our patient-focused objectives, using the Equality Delivery System 2, assigned an amber rating. This means that "We have taken action to improve each aspect of equality embedded in our day-to-day activities and we've got evidence that it's having a positive effect". However, we recognise there is still work to do in our quest to achieve either a green (achieving) or purple (excelling) rating.

3.4.10. STAFF SURVEY

As a result of the 2019/20 Staff Survey it has highlighted the need to address issues of Bullying and Harassment. In 2020/2021 there will be an increased focus on raising awareness of dignity and respect in the workplace. A range of sessions exploring the impact

of dignity and respect within the workplace will be delivered to a range of staff across the Trust. A detailed analysis of our latest staff survey results can be found in 3.3.3.2

3.5. NHS FOUNDATION TRUST CODE OF GOVERNANCE

3.5.1. STATEMENT OF COMPLIANCE

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

A review of the Trust's compliance with the [NHS Foundation Trust Code of Governance](#)²⁶, and to identify any areas for further development, was carried out by the Board of Directors in May 2020.

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 NHS Improvement (NHSE/I) as described within their Annual Reporting Manual 2019/20.

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](#)²⁷.

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 are able to give their views on relevant issues to 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.

Local people and those accessing our services as a patient or carer are invited to become a member of the Trust, either by completing a form at an event, or via the [online membership form](#)²⁸.

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, if you live in one of the above areas (as determined by your postcode) then you can join as a public member.

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,

²⁶ <https://www.gov.uk/government/publications/nhs-foundation-trusts-code-of-governance>

²⁷ <http://www.england.nhs.uk/publication/nhs-provider-directory-and-registers-of-licensed-healthcare-providers/>

²⁸ <https://secure.membra.co.uk/bradfordteachingapplicationform/>

and All our other Staff Groups (comprising administration and clerical staff, estates and facilities staff and some members of staff who provide additional clinical services).

3.5.3.1. Number of Members

Figure 38 highlights our total membership as at 31 March 2020. A breakdown is provided for each of the main membership constituencies and where applicable the sub-membership constituency or group.

Figure 38: Total membership as at 31 March 2020 with a breakdown by constituency

| Public Membership Constituency Breakdown | FT members | % membershi | BMDC total population | % of BMDC population |
|--|---------------|-------------|-----------------------|----------------------|
| Bradford East | 8,649 | 24.39 | 118,064 | 21.96 |
| Bradford South | 8,322 | 23.47 | 105,803 | 19.68 |
| Bradford West | 8,755 | 24.69 | 118,589 | 22.06 |
| Keighley | 2,943 | 8.30 | 98,174 | 18.26 |
| Shipley | 6,546 | 18.46 | 96,901 | 18.03 |
| Rest of England | 251 | 0.71 | 0 | 0 |
| Total Public Membership | 35,466 | | 537,531 | |

| | |
|------------------------------|--------------|
| Total Patient Members | 6,234 |
|------------------------------|--------------|

| Staff Membership Constituency breakdown | FT members | Total eligible staff population | Membership as % of total eligible staff population |
|--|-------------|---------------------------------|--|
| Allied Health Professionals and Scientists | 768 | 768 | 100% |
| Nursing and Midwifery | 1580 | 1580 | 100% |
| Medical and Dental | 768 | 768 | 100% |
| All Other Staff Groups | 2462 | 2462 | 100% |
| Total Staff Membership | 5532 | 5532 | 100% |

3.5.3.2. Membership representation, engagement and communications 2019/20

Representation

At the beginning of April 2019, total overall public and patient membership stood at 42,142. During the year, membership has declined overall by 442 members (1%). Membership trends across the sector have been reviewed and the general trend is that membership levels are falling (for those Foundation Trusts with sizeable memberships).

The profile of the membership is monitored to determine whether it reflects our population. From a socio-economic perspective the membership remains, on the whole, fairly representative of the communities served. The number of members within the 16-22 age group is under-represented, and the number of members within the 60-75 age group is over-represented. With regard to ethnicity the Trust is fairly well represented with regard to the majority of the communities served however has identified that the proportion of members from our Eastern European communities is low compared to our local population.

Since July 2019 a 'task and finish group' comprising Governors, Non-Executives and Executive members of the Board has been working to develop a Membership Plan for 2020 to 2022.

Engagement

Members and the public were invited to join Governors and our Board members at a number of key events delivered in year.

- **'Green Spaces, Healthy Places' festival** In July the Trust delivered its first annual joint community fun day event with the [Well Bradford Initiative](#)²⁹. The event took place in the grounds of BRI. Visitors were able to find out about a number of the Trust's services, meet members of staff who could explain their work, and also meet a variety of community groups, while taking part in educational and fun activities. Governors were represented and able to discuss membership with interested members of the public.
- **Annual Members Meeting / Annual General Meeting.** The Annual Members' Meeting (AMM) was combined with the Annual General Meeting (AGM) in October. As well as receiving the formal presentation of the Annual Report and Accounts 2018/19 the key note presentation was delivered by the Chief Nurse, Karen Dawber, and detailed the Trust's Patient Experience Strategy, the Patient Stories discussed through the year with the Board of Directors and how the learning was being used to support improvements.
- **Celebration!** An event to accompany the Trust's Annual General Meeting/Annual Members' Meeting was delivered in October which involved displays and posters showcasing the work of the hospital's various clinical departments and their successes of the past 12 months, presenting opportunities for visitors to engage with the Trust's staff, Governors and Directors.
- **World Café: Learning Matters** In December an open invitation was extended to members and our local population to attend a very popular "world café" event where attendees were able to learn about the Trust's services and specialties, and engage in conversations to share knowledge and discuss key topics with staff from a wide range of clinical and non-clinical areas, with a focus on the way we try to learn systematically from events to improve patient care
- **General opportunities for involvement and engagement:** Members and the public continue to be:
 - involved in 'patient and public engagement' activities across the Trust including Patient-Led Assessments of the Care Environment (PLACE)
 - signposted to other health related activities and events both at our Trust and across the district
 - encouraged to register as [Volunteers](#)³⁰

Communications

General and targeted emails along with press releases have continued to be used as the main means of communications with members and the public. As part of the developments related to the new Membership Plan, routine e-bulletins and newsletters will be scheduled for implementation in 2020.

²⁹ <https://www.bradfordhospitals.nhs.uk/well-bradford/>

³⁰ <https://www.bradfordhospitals.nhs.uk/our-people/volunteering/>

Contact procedures for members who wish to communicate with Governors and the Membership office.

If members have specific issues they wish to raise they are able to contact the Council of Governors or the Membership office via any of the following methods:

- 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

Papers and agendas for Council of Governor meetings are published on the Trust's [website](#)³¹ in advance of the meetings taking place.

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 the majority 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 Trust's Council of Governors

There are 20 seats on the Trust's 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 39 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 five formal meetings held in year.

Figure 39: Members of the Council of Governors during 2019/20

| Public Governors (elected) | | Term start date | Term end date | Meetings attended 2019/20 |
|----------------------------|----------------|-----------------|---------------|---------------------------|
| Ms Stella Hall | Bradford East | 04/2019 | 03/2022 | 4 of 5 |
| Mr Michael Parry | Bradford East | 02/2016 | 05/2019 | 0 of 1 |
| Mr Kursh Siddique | Bradford East | 05/2019 | 04/2022 | 4 of 4 |
| Ms Hilary Meeghan | Bradford South | 12/2018 | 11/2021 | 4 of 5 |
| Mr Alan English | Bradford South | 05/2016 | 04/2019 | 1 of 1 |
| Mr Alan English | Bradford South | 05/2019 | 04/2022 | 4 of 4 |
| Ms Jenny Scott | Bradford West | 12/2016 | 11/2019 | 4 of 4 |
| Mr Dermot Bolton | Bradford West | 12/2019 | 11/2022 | 1 of 1 |
| Mr Al Edmonds | Bradford West | 12/2018 | 11/2022 | 5 of 5 |
| Mr David Wilmshurst | Shipley | 12/2016 | 11/2019 | 4 of 5 |
| Mr David Wilmshurst | Shipley | 12/2019 | 11/2022 | 1 of 1 |

³¹ <http://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/>

| Public Governors (elected) | | Term start date | Term end date | Meetings attended 2019/20 |
|--|---------------------------|-----------------|---------------|---------------------------|
| Ms Wendy McQuillan | Keighley | 04/2019 | 03/2022 | 4 of 5 |
| Ms Marian Olonade-Taiwo | Keighley | 12/2016 | 11/2019 | 4 of 4 |
| Ms Marian Olonade-Taiwo | Keighley | 12/2019 | 12/2022 | 0 of 1 |
| Mr Amit Bhagwat | Rest of England and Wales | 12/2019 | 12/2022 | 1 of 1 |
| Ms Hardev Sohal | | 04/2019 | 03/2022 | 4 of 5 |
| Mr Mark Chambers | | 12/2019 | 12/2022 | 1 of 1 |
| Staff Governors (elected) | | | | |
| Ms Ruth Wood | All Other Staff Groups | 12/2016 | 11/2019 | 3 of 4 |
| Ms Ruth Wood | All Other Staff Groups | 03/2020 | 02/2023 | N/A* |
| Ms Katherine Wright | AHPS | 05/2016 | 04/2019 | 1 of 1 |
| Ms Helen Wilson | AHPS | 12/2019 | 11/2022 | 1 of 1 |
| Ms Pauline Garnett | Nursing and Midwifery | 04/2019 | 03/2022 | 5 of 5 |
| Dr Sulleman Moreea | Medical and Dental | 12/2016 | 11/2019 | 4 of 5 |
| Dr Kavitha Nadesalingam | Medical and Dental | 03/2020 | 02/2023 | N/A* |
| Cllr Tariq Hussain | BMDC | 06/2019 | 05/2022 | 4 of 5 |
| Dr Andrew Clegg | University of Leeds | 04/2017 | 03/2020 | 2 of 5 |
| Professor Alastair Goldman | University of Bradford | 06/2019 | 05/2022 | 2 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 are able to serve a maximum of nine consecutive years in total (generally equivalent to three full term lengths). Profile information regarding all our Governors is available on the Trust's [website](#)³².

3.5.4.2. Election processes held in year

Three election processes have been held in year. Candidates are able to self-nominate for the roles and are required to be a registered member of the Trust. The first election process was launched in 2018/19 and concluded in May 2019. The second election process was launched in October 2019 and concluded in December 2019. The third election process was launched in January 2019 and concluded in March 2020.

In year the Council has welcomed back for additional terms Mr Alan English, Ms Marian Olonade-Taiwo, and Mr David Wilmshurst who were elected uncontested.

The Council has welcomed seven new Governors in year namely;

- Mr Kursh Siddique, Ms Helen Wilson, Mr Amit Bhagwat, Mr Mark Chambers, Ms Ruth Wood and Dr Kavitha Nadesalingam who were elected uncontested.
- Mr Dermot Bolton who was successful following an election held in the Bradford West public membership constituency.

The election processes undertaken in year were held in accordance with the rules outlined in appendix 1 of the Trust's Constitution. All election processes were managed by Ms Ciara Norris, Returning Officer, Civica Election Services, The Election Centre 33 Clarendon Road London, N8 0NW.

³² <https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/>

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 Governors' Register of Interests is publicly available on the Trust's [website](#)³³. In addition, the register can be obtained via the Director of Governance and Corporate Affairs using 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 Chair and Non-Executive Directors
- set the terms and conditions and remuneration of the Chair 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
- 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
- approve amendments to the Trust's Constitution

3.5.4.5. Council of Governors Nominations and Remuneration Committee

The Council of Governors have established a Nominations and Remuneration Committee that meets at least quarterly to discuss the formal aspects of the Non-Executive Directors' role. This includes remuneration, terms of office and their annual performance evaluation. The Remuneration Report on page 26 includes a report on the work of the Committee in year (See Section 3.2.3.2).

³³ <https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2019/07/Declaration-of-Interests-for-Council-of-Gov-July-2019-current-version.pdf>

3.5.4.6. Council of Governors Meetings

During 2019/20 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;

- Trust's Operational Plan 2019/20
- Foundation Trust Membership Plan 2019/20 and 2020/22
- NHS Provider Licence Self Certification 2018/19
- Our Strategic objectives - the work of the Board Committees
- Outcomes from the Inpatient Survey published in 2019
- Highlight reports presented by the Committee Chairs

The agendas and papers for the Council of Governors meetings are available on the Trusts [website](#)³⁴.

With regard to their statutory duties and responsibilities the Governors have, during 2019/20:

- received the Annual Accounts, Auditor's Report and the Annual Report 2018/19
- received the Audit Report from the Auditor on the Quality Report and the Annual Report 2018/19
- approved the remuneration of the Chair and Non-Executive Directors for the period 2019/20
- appointed Ms Julie Lawreniuk as Non-Executive Director with a specific responsibility to chair the Board Finance and Performance Committee.
- appointed Mr Mohammed Hussain as a Non-Executive Director
- approved the appointment of Ms Melanie Pickup as Chief Executive Officer
- approved the appraisal processes for the Chair and the Non-Executive Directors for 2019
- received the report from the Chair on the outcome of the appraisal process of the Non-Executive Directors 2019
- received the report from the Senior Independent Director on the outcome of the appraisal process of the Chairperson 2019
- received regular reports from the governors Nominations and Remuneration Committee on the business conducted by the Committee
- following consultation with the Board of Directors, confirmed the Council's support for the appointment of Ms Selina Ullah as Deputy Chairperson of the Board of Directors.
- initiated a search, in line with the process approved by the Council, for the appointment of a Non-Executive Director following the resignation of Mr Amjad Perez
- reappointed Deloitte LLP as the External Auditor
- together, with the Board of Directors, held discussions with regard to annual planning, strategic development, performance and regulatory compliance

The Council of Governors has also reviewed and 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 of Mr Al Edmonds and Mr Kursh Siddique and the reappointments of Ms Wendy McQuillan and Mr Alan English as members of the Governors Nominations and Remuneration Committee
- appointment of Ms Wendy McQuillan as the Lead Governor
- appointment process for the Non-Executive Directors (including the Chair appointment process)

³⁴ <https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/>

- terms and conditions for Non-Executive Director appointments made in year
- locally selected indicator for external audit in 2019/20, in line with NHSI reporting requirements. The indicator selected, and based on local priorities, is the 'percentage of patients seen within two weeks of an urgent GP referral for suspected cancer'.

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 2019/20 the Governors have not exercised their 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.

3.5.4.8. Governors' effectiveness

In June 2019 the Chairman undertook a review of the Council's effectiveness with Governors. The key areas of focus for 2019/20 were identified as;

- increased input into operational planning and strategy development
- supporting governors in development of opportunities to engage with members
- development of stronger relationships between the Non-Executive Directors and the Governors.

As part of the review of effectiveness the Council considered the size of the Council of Governors and determined that at 21 members, it was adequate.

3.5.4.9. Governor engagement with the Board of Directors

The members of the Board of Directors, in particular the Non-Executive Directors, regularly engage with the Council of Governors to develop an understanding of the views presented by Governors with regard to the Trust. The Board and Governors continue to cement and develop a range of engagement models during 2019/20. These activities have also supported the delivery of responsive learning and development opportunities for Governors (both individually and collectively). The following provides a summary of the activities that have taken place in year:

- **Governor focused development sessions:** In year sessions have taken place at the request of Governors and, at the suggestion of the Board, to respond to questions and queries raised in relation to key matters of material interest. The following subjects have been covered and Governor attendance has been voluntary.
 - Command Centre Programme
 - Wholly Owned Subsidiary
 - NHS Long Term Plan
 - The Trust's Capital Programme
 - Acute Provider Collaboration (between the Trust and Airedale NHS FT)
 - End of Life Care
 - Trust's Clinical Strategy development: 2020 Vision
 - Operational Planning 2020/21
- **Individual and collective meetings with the Chair:** Dr Maxwell Mclean has held individual sessions with all Governors and has routinely met with Governors on a quarterly informal basis 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. The

attendance now includes the Senior Independent Director/Deputy Chair of the Board of Directors, Ms Selina Ullah.

- **Joint meetings between the Non-Executive Directors and Governors:** Quarterly informal sessions between Governors and Non-Executive Directors continue to support the focus on matters discussed at meetings of the Board of Directors 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 developing their relationships.
- **Governors observing at Board Committees and Board meetings:** To support Governors in their duty to hold the Non-Executives individually and collectively to account for the performance of the Board, a new development in year has been Governors observing at Board committee meetings. The principles regarding Governors attending committees were developed in conjunction with the Council of Governors.

Governors have organised a schedule of Governor attendance at Board meetings and seek to ensure that at least one Governor attends the meeting of the Board and provides feedback on that attendance to their fellow Governors.

- 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 is available via the Trust's [website](#)³⁵.
- **Communications with Governors:** There has been a focus on improvements to 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 initiated include:
 - a quarterly Chair's Bulletin from Dr Maxwell Mclean to ensure that Governors are kept abreast of key developments, activities and governor engagement opportunities 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, NHSI, NHS Providers and the King's Fund.
 - Provision of a Trust secure email address to all Governors
 - 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 to the press

3.5.4.10. Governor engagement with Patients, Visitors and Staff

Governors have attended the events and activities listed under the report on Foundation Trust Membership in paragraph 3.5.3.2. At these events Governors have engaged with our diverse communities, staff, patients and members to understand their views on the impact of the Trust's strategic developments. During 2019/20 Governors have had opportunity to visit a range of clinical and non-clinical operational areas through participation in a number of programmes and initiatives taking place at the Trust. In year involvement has included:

- support of the 'Work as One Week'

³⁵ <https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/>

- participation in the mock CQC inspection programme
- routine involvement in team of the month and team of the year judging panels
- BRI/SLH site visits to clinical areas
- two Governors continue to attend the panel of the Bradford Innovation Group (BIG) which supports the development of ideas and innovations amongst staff teams to support improvements in patients' experience and contribute to the safety and quality of care provided in our Trust.
- Governors have routinely taken part in the Patient-Led Assessment of the Care Environment (PLACE) visits programme.

3.5.4.11. 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 engagement activities specific to their role as Governors. In year this has included Governors attendance or involvement in:

- National Governors' Conference, FOCUS, delivered by NHS Providers
- NHS Providers Governor Advisory Panel where one of the Trust's Governors is an elected member of the national body
- BMDC Health and Social Care Overview and Scrutiny Committee

3.5.4.12. Governors learning and development

Formal and informal learning and development opportunities have continued to be made available to the Council of Governors. In year these have included participation in:

- General sessions delivered by GovernWell (NHS Providers) which delivers the national training programme for Governors.
- An in-house bespoke session commissioned by the Trust on Challenge and the role of the Council and the Board.
- Internally delivered sessions related to 'recruitment' and 'equality and diversity' to support Governors in relation to the Non-Executive Director recruitment.

3.5.4.13. Communicating with Governors

There are a number of easy ways for members and the public to communicate with the Council of Governors. They can do so via the following methods.

- Email: governors@bthft.nhs.uk
- 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. BOARD OF DIRECTORS

The Board of Directors is responsible for the day-to-day management of the Trust and the operational delivery of its services, targets and performance. Full details regarding the Board's responsibilities, as required to be disclosed under the code of governance, are available in the Directors' Report on page 22.

The Trust's Constitution sets out the circumstances that would disqualify an individual from holding a directorship and should any of those circumstances become applicable to a Non-Executive Director, their appointment would be terminated. Other circumstances that would result in termination of a Non-Executive Director's appointment are laid out in the Terms and Conditions agreed with the Non-Executive Director at appointment.

If the Council of Governors is of the opinion that it is no longer in the interests of the National Health Service that the individual continues to hold office, then, subject to the provisions of the Constitution, an appointment may be terminated with immediate effect. The Council of Governors will consider each case on its merits, taking account of all relevant factors. These include;

- If a Non-Executive Director fails to meet the requirements of the Fit and Proper Persons Test as set out in Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (as amended or supplemented from time to time)
- If an annual appraisal or sequence of appraisals is unsatisfactory
- If the Non-Executive Director fails to deliver work against pre-agreed targets incorporated within their annual objectives
- If there is a terminal breakdown in essential relationships, for example, between a Non-Executive Director and the Board of Directors
- Non-compliance with the requirements of the Standing Orders of the Trust with regard to pecuniary interests in matters under discussion at meetings of the Trust (e.g. a failure to disclose such an interest)
- Non-attendance at a meeting of the Trust for a period of three months unless the Council of Governors is satisfied that the absence was due to a reasonable cause and the Non-Executive is able to attend within such time as is considered reasonable.
- The Non-Executive ceases to be independent within the meaning of the NHS Foundation Trust Code of Governance

Figure 40 - Non-Executive Directors 2019/20

| Name | Role | Appointment From | Appointment To |
|---|------------------------------|---------------------------------|------------------------------|
| Dr Maxwell Mclean | Chairperson | 01 May 2019 | 30 April 2022 |
| Jon Prashar | Non-Executive Director | 1 February 2018 | 31 January 2021 |
| Selina Ullah | Non-Executive Director | 1 September 2015 | 31 August 2021 |
| Barrie Senior | Non-Executive Director | 1 December 2017 | 30 November 2020 |
| Laura Stroud | Non-Executive Director | 23 October 2017 | 22 October 2020 |
| Trudy Feaster-Gee | Non-Executive Director | 1 January 2018 | 31 December 2020 |
| Julie Lawreniuk | Non-Executive Director | 01 September 2019 | 31 August 2022 |
| Mohammed Hussain | Non-Executive Director | 01 September 2019 | 01 August 2022 |
| (Former Non-Executive Directors) | | | |
| Amjad Pervez | Non-Executive Director | 1 February 2015 | 31 January 2020 |
| Trevor Higgins | Deputy Chair Acting Chair | 21 May 2012 01 February 2019 | 20 May 2019 30 April 2019 |
| (Associate Non-Executive Director) | | | |
| Mr Andrew McConnell | Non-Executive Director | 24 September 2018 | 23 September 2019 |

The Board of Directors has considered the independence of the Board and confirms that it considers all the Non-Executive directors (including the Chair) to be independent in character and judgement and that the Board has assured itself that there are no relationships or circumstances which could affect or appear to affect, the director's judgment.

Figure 41 - Executive Directors 2019/20

| Name | Role | Appointment From | Appointment To |
|--------------------------------|---|-------------------|-----------------|
| Ms Mel Pickup | Chief Executive | 1 November 2019 | Present |
| Ms Pat Campbell* | Director of Human Resources | 1 December 2008 | Present |
| Ms Karen Dawber | Chief Nurse | 29 August 2016 | Present |
| Ms Cindy Fedell | Chief Digital and Information Officer | 13 September 2013 | Present |
| Dr Bryan Gill | Chief Medical Officer | 5 May 2015 | Present |
| Mr John Holden* | Director of Strategy and Integration | 22 August 2016 | 1 May 2018 |
| | Director of Strategy and Integration / Deputy Chief Executive | 1 May 2018 | Present |
| | Interim Chief Executive | 1 April 2019 | 1 November 2019 |
| Mr Matthew Horner | Acting Director of Finance | 1 November 2011 | 1 August 2012 |
| | Director of Finance | 1 August 2012 | Present |
| Sandra Shannon* | Acting Chief Operating Officer | 8 January 2018 | 1 April 2018 |
| | Chief Operating Officer | 1 April 2018 | 1 May 2018 |
| | Chief Operating Officer / Deputy Chief Executive | 1 May 2018 | Present |
| *Non-voting Executive Director | | | |

3.5.5.1. Composition of the Board of Directors 2019/20

Dr Maxwell Mclean, Chairperson

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.

Ms Selina Ullah, Non-Executive Director, Deputy Chair and Senior Independent Director

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 Trudy Feaster-Gee, Non-Executive Director

Trudy Feaster-Gee is a barrister and partner at Walker Morris LLP (Leeds) with some 25 years' experience advising businesses and public sector organisations across a broad range of industries, with a particular emphasis on regulated sectors. Trudy also has experience of advising in-house as well as within enforcement agencies, having worked on secondment at the European Commission, Volkswagen Group UK (as head of legal), the UK's Competition Commission (now part of the Competition and Markets Authority) and at Lloyds Banking Group (as head of external competition engagement). Trudy lives in Yorkshire and enjoys walking, mountain biking and horse riding.

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.

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 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 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.

Professor Laura Stroud, Non-Executive Director

Laura is a Professor of Public Health and Education Innovation and the director of the Institute of Health Sciences at the University of Leeds. Laura's expertise is in professional education and supervision, and she has significant experience of mentoring and supporting the development of individuals and teams, and has held a number of roles as an independent chair or expert invitee in the health and not-for-profit sector. She has recently been working on quality improvement initiatives in association with the local NHS through her work with the Centre for Innovation in Health Management.

Ms Mel Pickup, Chief Executive Officer

Mel joined the Trust as Chief Executive Officer in November 2019. She qualified as a registered general nurse in 1990 and after a number of clinical roles, worked in management before moving back into a professional nursing leadership role. In 1998 Mel became the Deputy Director of Nursing at Doncaster and Bassetlaw Hospitals NHS Trust and was appointed Director of Nursing and Quality at Rotherham General Hospitals NHS Trust in 2001. Mel then moved to Wrightington, Wigan and Leigh NHS Trust in 2003 to take up the post of Director of Nursing and Governance, a role in which she later became Director of Operations and Deputy Chief Executive. Mel was Chief Executive of The Walton Centre NHS Foundation Trust from January 2007 prior to her appointment with Warrington and Halton Hospitals NHS Foundation Trust in 2011.

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.

Ms Sandra Shannon, Deputy Chief Executive and Chief Operating Officer

Sandra was appointed to the role of Acting Chief Operating Officer in January 2018, and became the substantive post holder in April 2018. She has more than 12 years' experience in senior operational management roles including deputy chief operating officer, hospital director and PMO director as well as leading turnaround and performance improvement in a number of NHS organisations. She also worked as part of the National Intensive Support Team at the DH Business Services Authority supporting NHS trusts to reduce healthcare-associated infections and improve hospital cleanliness. Sandra started her career as a nurse and midwife and held a number of professional roles including head of midwifery and deputy director of nursing before moving into general management.

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 25 years and covers a variety of finance roles. For the last 18 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.

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.

Dr Bryan Gill, Chief Medical Officer

Bryan was appointed to the position of Chief Medical Officer at the Trust in May 2015, and became the Responsible Officer for the Trust in July 2015. Bryan was a consultant in neonatology for 19 years before going into a full-time medical management role in 2013. He has 15 years' experience at senior medical management level in the acute trust sector, and possesses particular interest and expertise in quality improvement, patient safety and medical workforce issues. He presently holds the chairs position on the Medical Directors and Vascular Network WYAAT group and is deputy chair of the West Yorkshire & Harrogate ICS Clinical Forum. He is a past President of the British Association of Perinatal Medicine (2011-2014), and has previously held the national roles of Honorary Secretary of the British Association of Perinatal Medicine, and Chairman and Training Advisor for the Royal College

of Paediatrics and Child Health (2001-2011). Bryan is a Fellow of the Royal College of Paediatrics and Child Health.

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 Cindy Fedell, Chief Digital and Information Officer

Cindy joined the Trust in September 2013, and is our Chief Digital and Information Officer. She is a keen collaborator, and chairs the Yorkshire Imaging Collaborative which crosses two integrated care systems, and is the Digital SRO for the West Yorkshire and Harrogate Health and Care Partnership. Cindy has spent the last several years successfully digitising the Trust and progressing digital-enablement of the Bradford District and Craven Place. She holds chief information officer and advanced leadership certificates from the USA College of Healthcare Information Management Executives and the University of Toronto respectively, as well as degrees from Ryerson University and Lakehead University in Canada. Cindy previously worked at Toronto's Mount Sinai Hospital and has also worked in the private sector as an informatics management consultant, advising hospitals on systems design and implementation.

3.5.5.2. Former Directors (who resigned or whose term of office ended in year):

Mr Andrew McConnell OBE, Associate Non-Executive Director

Andrew was appointed as an Associate Non-Executive Director in September 2018. He obtained a degree in Mathematics at the University of Manchester and went on to qualify as a chartered accountant with a major firm. During 20 years of audit and general practice advisory work he was a partner in a West Yorkshire based regional firm of chartered accountants and in a major global firm when this practice merged. Andrew has been Director of Finance at the University of Huddersfield since 2001, a role which encompasses strategic and business planning, delivering financial sustainability and value for money, financial management and reporting, risk management and liaising with internal and external audit teams. Throughout his career Andrew has had a commitment to education, taking governance roles at junior, secondary and FE colleges in the local area. He was formerly chair of the University's Audit Committee and vice-chair of the University Council. He holds several related posts outside the university and is a past chair of the British Universities Finance Directors' Group. He is also currently a board member of the Higher Education Statistics Agency Ltd (and chairs its Audit Committee), Wakefield College (vice-chair) and several other companies. Andrew was invited to become a Companion of the Chartered Management Institute in 2017. He was awarded an OBE for services to accounting and the community in the 2015 Queen's Birthday Honours list. Andrew resigned his appointment in July 2019.

Dr Trevor Higgins, Non-Executive Director, Deputy Chair and Acting Chair

Trevor was appointed as a Non-Executive Director in May 2012, and became Deputy Chair on 1 November 2013, a role he has retained apart from a 5 month period as acting Chair, from June to October 2016. Trevor was born and educated in the city. He was the Regional Partnership Director for BT and enjoyed a diverse career in over forty years with the company – his roles ranged from call centre management to senior operations management. He has now retired, but in his last role represented all BT's operational divisions. In his previous role, as BT's Regional Business Manager, he managed 1,200 people with responsibility for a budget in excess of £30 million. Trevor is also Chief Executive of Bradford Breakthrough, Chair of the Digital Health Enterprise Zone, Board Member of Bradford Chamber Council and a Lay Member of the University of Bradford Council.

Educated to postgraduate level, in July 2011 he was awarded an Honorary Doctorate as Doctor of Bradford University for services to businesses and communities across the region. Trevor's term ended in May 2019.

Mr Amjad Pervez, Non-Executive Director

Amjad was appointed as a Non-Executive Director in February 2015. He founded Seafresh/Adams in Bradford over 30 years ago and it is now one of the largest groups of independent specialist catering food service and cash and carry groups in the UK. Amjad has committed a lot of time to education and enterprise in Bradford and the wider West Yorkshire region including establishing Asian Trade Link Yorkshire Limited in 1999, which he chaired until last year. Until recently he was also a Board member of the Leeds City Region Enterprise Partnership. Amjad is currently a Board member with Bradford Matters, Bradford Breakthrough and The National Asian Business Association. He is Chair of the Rainbow Trust through which Rainbow Primary Free School is operated, which opened in 2012. Amjad resigned his appointment in January 2020.

3.5.5.3. Attendance at meetings of the Board of Directors during 2019/20

Board meetings are held bi-monthly. During 2019/20 they took place in May 2019, July 2019, September 2019, November 2019, January 2020 and March 2020. The following table reports on the number of meetings attended by Board members in year.

Figure 42: 2019/20 Board of Directors attendance

| BOARD MEMBERS | | Meetings attended |
|------------------------|---|--------------------------|
| Ms Pat Campbell | Director of Human Resources | 6 of 6 |
| Ms Karen Dawber | Chief Nurse | 6 of 6 |
| Ms Trudy Feaster-Gee | Non-Executive Director | 5 of 6 |
| Ms Cindy Fedell | Chief Digital and Informatics Officer | 6 of 6 |
| Dr Bryan Gill | Chief Medical Officer | 6 of 6 |
| Mr John Holden | Deputy Chief Executive and Director of Strategy and Integration | 6 of 6 |
| Mr Matthew Horner | Director of Finance | 6 of 6 |
| Mr Andrew McConnell | Associate Non-Executive Director | 1 of 1 |
| Dr Maxwell Mclean | Chairperson | 6 of 6 |
| Ms Sandra Shannon | Deputy Chief Executive and Chief Operating Officer | 5 of 6 |
| Dr Trevor Higgins | Non-Executive Director | 1 of 1 |
| Mr Amjad Pervez | Non-Executive Director | 3 of 5 |
| Ms Mel Pickup | Chief Executive Officer | 3 of 3 |
| Mr Jon Prashar | Non-Executive Director | 3 of 6 |
| Mr Barrie Senior | Non-Executive Director | 6 of 6 |
| Professor Laura Stroud | Non-Executive Director | 5 of 6 |
| Ms Selina Ullah | Non-Executive Director | 6 of 6 |
| Ms Julie Lawreniuk | Non-Executive Director | 4 of 4 |
| Mr Mohammed Hussain | Non-Executive Director | 4 of 4 |

The meetings are also attended by the Director of Governance and Corporate Affairs in their capacity as the Trust Secretary.

3.5.5.4. Committees of the Board of Directors

In line with statutory requirements the Board of Directors has an established (Board) Nominations and Remuneration Committee and Audit and Assurance Committee. In addition, the Board has established the following committees.

- **Charitable Funds Committee.** The Committee provides the Board of Directors with an objective and independent review of the management of charitable activity within the Trust as set out within its governing document, registered with the Charity Commission.
- **Integrated Governance and Risk Committee.** The Committee provides assurance to the Board that the arrangements for integrated governance and risk management are consistent and comprehensive and effective.
- **Finance and Performance Committee.** The committee provides the Board with an objective and independent review (including relevant strategic risks and associated assurance) of the management of assets and resources in relation to the achievement of financial targets, business objectives and the financial stability of the Trust, and the effective management of all performance related matters.
- **Quality Committee.** The committee provides the Board with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, and on also on the effectiveness of quality governance and risk management (including health and safety) systems.
- **Workforce Committee.** The Committee provides the Board with an objective and independent review (including relevant strategic risks and associated assurance) of the effectiveness of the workforce management arrangements for the Trust.
- **Major Projects Committee.** The Committee provides the Board with an objective and independent review (including relevant strategic risks and associated assurance) of the management of Major Projects being planned or implemented within the Trust.
- **Partnerships Committee.** The committee provides the Board with an objective and independent review (including relevant strategic risks and associated assurance) of the management of partnerships and collaborative working for the Trust.

The full terms of reference for all Board Committees are contained within the Board Standing Orders which is available on the Trust [website](#)³⁶.

3.5.5.5. The Board Nominations and Remuneration Committee

The Nominations and Remuneration Committee is established under the Trust's Standing Order – Arrangements for the Exercise of Functions by delegation and is constituted as a standing committee of the Board of Directors. The committee is authorised by the Board of Directors to act within its terms of reference. The activities of the Board Nominations and Remuneration Committee, including attendance at the committee and the work of the committee, is reported on within the Remuneration Report on page 26.

3.5.5.6. Audit and Assurance Committee

The purpose of the Audit and Assurance Committee 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 Audit and Assurance Committee are included within the Audit and Assurance Committee Terms of Reference which are reviewed annually and approved by the Board of Directors. The Terms of Reference for the Audit and Assurance Committee are contained within the Board Standing Orders and also published separately on the Trust website.

³⁶ <https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/>

With regard to the work of the Audit and Assurance Committee during 2019/20; the committee considered and reviewed the following reporting from Internal Audit.

- Internal Audit Annual Report & Head of Internal Audit Opinion
- the Counter Fraud Annual Report
- Local Counter Fraud Specialist Risk Assessment 2019/20
- the Internal Audit Plan for 2019/20
- regular Internal Audit Progress reports
- regular reports concerning follow up of Internal Audit recommendations
- Counter Fraud Progress Reports
- Internal Audit Charter

The Committee considered and reviewed the following reporting from the Trust.

- Accounting Standards 2019/20
- Annual Governance Statement 2018/19
- Annual Report/Quality Report 2019/20 timetable for production
- Annual Review of Internal Audit and External Audit Performance
- Annual Security Report
- Audit and Assurance Committee Work plan 2019/20
- Audit Committee Annual Self- Assessment
- Board Assurance Framework
- Bradford Hospitals Charity Annual Report and Accounts 2018/19
- Business Continuity Planning (BCP)
- Charitable Funds Accounts
- Clinical Audit Annual Report
- Clinical Audit High Priority Work plan
- CQC Compliance
- CQC Inspection Report and Compliance Actions
- Cyber Security Update
- Data Quality
- Draft Annual Accounts 2018/19
- Draft Annual Report/Quality Report 2018/19
- Effectiveness Reporting and Governance
- Exception Reports
- Final Annual Accounts 2018/19
- High Priority Clinical Audit Plan 2019/20
- Internal Audit Charter
- Internal Audit Report Process
- Losses and Special Payments and Tender Waivers Updates
- Proposed Appointment of External Audit to perform non-audit work
- Regulatory Framework Assurance
- Regulatory Requirements
- Review of Audit Committee Terms of Reference
- Review of Board Committees' Terms of Reference
- Progress with remedial actions resulting from the External Audit of the Quality Report 2018/19
- Security Management Standards for Providers
- Self-Certification of the NHS Provider Licence
- Third Party Provider Functions
- Business Conduct Policy and Conflicts of Interest Policy
- Board Standing Orders and Reservation of the Scheme of Delegation
- Routine Assurance Reports from Committee Chairs

- Annual Assurance Reports from Committee Chairs
- Recommendation to the Council of Governors regarding the appointment of the External Auditor

The committee considered and reviewed the following reporting from the External Auditors

- External Audit Report 2018/19
- Charitable Accounts ISA 260
- Draft letter of Representation 2018/19 (Charitable Accounts)
- Annual Report and Accounts ISA 260
- Draft letter of Representation 2018/19 (Annual Report and Accounts)
- Quality Report Audit Guidance 2019/20

In-year, the Audit and Assurance Committee considered and approved the following items

- Internal Audit Plan
- Internal Audit Charter
- External Audit Plan
- Trust Annual Accounts 2018/19.
- Review of arrangements for use of External Auditors for Non-Audit Purposes
- Additional External Audit Fee for 2018/19 Audit
- Audit and Assurance Committee Work plan 2019/20
- Proposed Appointment of External Audit to perform non-audit work
- Audit Committee Annual Report to Board

Throughout 2019/20 the Audit and Assurance Committee considered the following significant risks highlighted by Deloitte:

- Management of overrides of controls
- Accounting for the discontinuation of the development of a subsidiary company
- Property revaluation of fixed assets (added following the material valuation uncertainty due to COVID-19)

The minutes from the meetings of the Audit and Assurance Committee, along with reports from the Chair of the Audit and Assurance Committee, 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.

The committee's membership has been as follows:

- Mr Barrie Senior, Non-Executive Director, Committee Chair
- Dr Trevor Higgins, Non-Executive Director
- Ms Selina Ullah, Non-Executive Director
- Mr Jon Prashar, Non-Executive Director

The Committee met six times during the year. Attendance at these meetings is detailed in the following table.

Figure 43: 2019/20 Audit and Assurance Committee attendance

| MEMBERS | TOTAL |
|-------------------|--------|
| Mr Barrie Senior | 6 of 6 |
| Dr Trevor Higgins | 2 of 2 |
| Ms Selina Ullah | 3 of 6 |
| Mr Jon Prashar | 4 of 6 |

Audit and Assurance Committee meetings are also attended by the Director of Finance, a Deputy Director of Finance and the Director of Governance and Corporate Affairs in their

capacity as Trust Secretary. The Chief Executive Officer attends at least one meeting per year. Representatives of both Internal and External Audit also attend meetings.

3.5.5.7. External Audit

The external auditor for the Trust is:

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

The external auditor was initially appointed in June 2017 and reappointed in April 2020 following a procurement exercise led by a working group of the Council of Governors. The appointment was in accordance with the Code of Audit Practice for NHS Foundation Trusts, issued by the National Audit Office on behalf of the Comptroller and Auditor General.

Figure 44: Remuneration of External Auditors 2019/20

| Fee (Excluding VAT) | 2019/20 £000 | 2018/19 £000 |
|---|-------------------------|-------------------------|
| Audit Services – Statutory Audit | 54 | 48 |
| Non Audit Services – Audit-related assurance services | 1 | 6 |
| Non Audit Services – Other Assurance Services | 0 | 33 |
| Total | 55 | 87 |

Any proposal for the use of the external auditors to provide non-audit services is reported to the Audit and Assurance Committee. There were no such engagements during 2019/20.

3.5.5.8. 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 updated, reviewed and approved by the Audit and Assurance Committee in December 2019. The Audit and Assurance Committee approved the planning methodology to be used by Internal Audit to create the Internal Audit Plan for 2019/20, and gave formal approval of the Internal Audit Operational Plan in May 2019.

The conclusions as well as all findings and recommendations of finalised Internal Audit reports are shared with the Audit and Assurance Committee. The Committee can, and does, challenge Internal Audit on assurances provided, and requests additional information, clarification or follow-up work if considered necessary.

A system is in place whereby all internal audit recommendations are followed-up on a quarterly basis. Progress towards the implementation of agreed recommendations is reported (including full details of all outstanding recommendations) to the Executive Management Team and the Audit and Assurance Committee on a quarterly basis. This has been an area of focus by the Committee during the year and Trust management have worked hard to ensure that the process for responding to Internal Audit recommendations has been improved.

The Counter Fraud Plan was reviewed and approved by the Audit and Assurance Committee and the Local Counter-Fraud Specialist (LCFS) presented regular reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

3.6. NHS OVERSIGHT FRAMEWORK

3.6.1. INTRODUCTION

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

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

3.6.2. SEGMENTATION

NHS Improvement has placed the Trust in segment 2 which maintains the rating achieved in 2018/19. This category is for providers who 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 as at 31 March 2020. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

3.6.3. FINANCE AND USE OF RESOURCES

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the NHS Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here.

Figure 45 - Finance and Use of Resources Scores

| Area | Metric | 2019/20 scores | | | | 2018/19 scores | | | |
|---------------------------------|------------------------------|----------------|----------|----------|----------|----------------|----------|----------|----------|
| | | Q4 | Q3 | Q2 | Q1 | Q4 | Q3 | Q2 | Q1 |
| Financial sustainability | Capital service capacity | 2 | 3 | 4 | 4 | 2 | 3 | 4 | 4 |
| | Liquidity | 1 | 1 | 1 | 1 | 1 | 2 | 1 | 1 |
| Financial efficiency | I&E margin | 2 | 3 | 4 | 4 | 1 | 4 | 4 | 4 |
| Financial controls | Distance from financial plan | 1 | 1 | 1 | 1 | 1 | 2 | 2 | 2 |
| | Agency spend | 1 | 1 | 1 | 1 | 1 | 1 | 2 | 2 |
| Overall scoring | | 1 | 1 | 2 | 3 | 3 | 1 | 3 | 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 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

A handwritten signature in black ink, appearing to read 'Mel Pickup', written in a cursive style.

Mel Pickup
Chief Executive
Date: 18 June 2020

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 control and report on any significant issues that have arisen during the financial year, including information and quality governance. The Chief Executive owns and 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 NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

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 Bradford Teaching Hospitals NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2020 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 Foundation Trust. I have overall responsibility for ensuring effective risk management arrangements are in place. I am supported by the Director of Strategy and Integration, who is the lead director for risk management and the Director of Governance and Corporate Affairs who fulfils the role of Board Secretary. The Director of Governance and Corporate Affairs develops and manages the corporate approach to the management of risk, including the Risk Management Strategy and the use of the Board Assurance Framework (BAF). I routinely use the BAF, the Foundation Trust's strategic 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 Foundation Trust is able to 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 46. In addition, for selected roles there is an identified Non-Executive Director sponsor.

Figure 46 - Executive Director's key responsibilities

| Role | Executive Director Lead | Non-Executive Director sponsor |
|---|---------------------------------------|--------------------------------|
| Accountable Officer | Chief Executive | |
| Caldicott Guardian | Chief Medical Officer | |
| Senior Information Risk Owner | Chief Digital and Informatics Officer | |
| Fundamental Standards of Quality and Safety (CQC) | Chief Executive | |
| Controlled Drugs | Chief Medical Officer | |
| Allegations against professionals | Director of Human Resources | |
| Doctors in Difficulty | Chief Medical Officer | |
| Responsible Officer | Chief Medical Officer | |
| Equality and Diversity | Director of Human Resources | • |
| Learning from deaths | Chief Medical Officer | |
| End of Life | Chief Nurse | • |
| Fire Safety | Chief Operating Officer | • |
| Health and Safety | Chief Executive | • |
| Emergency Planning | Chief Operating Officer | |
| Infection Prevention and Control | Chief Nurse | • |
| Patient Safety | Chief Medical Officer Chief Nurse | • |
| Freedom to Speak Up | Chief Nurse | • |
| Digitisation | Chief Digital and Informatics 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, which includes governance and risk management awareness and training. Training is delivered centrally and within individual Clinical Business Units/Specialties. Training can be classroom-based with internal or external trainers, web-based or 'in situ'; this sort of training often being developed following identification of potential risk in the way that care is being delivered through learning from incidents or proactive risk assessments. The Trust also has a clear commitment to individual personal development, and through all these mechanisms staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The governance and risk management training programme is reviewed annually by the Office of Governance and Corporate Affairs to ensure that it remains responsive to the needs of staff. There is regular reinforcement of the requirements of the Mandatory Training Policy, and the duty of staff to complete training deemed mandatory for their role is a key element of the annual appraisal process. Monitoring and escalation arrangements are in place to ensure that the Trust can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

We have continued with our focus on developing awareness and skills in relation to high quality and focused risk assessments and business continuity planning, amongst both clinical and non-clinical staff. A Risk Management and Compliance Development Group is supporting this work and a central repository for all risk assessment documentation has been implemented.

The NHS has a key role in responding to large scale emergencies and major incidents and throughout 2019/20 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. The Trust will be able to demonstrate full compliance during Quarter 1 2020/21, demonstrating the continued progress we have made with emergency preparedness, including business continuity arrangements.

The Trust's 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 current Trust 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. The Trust has a Health and Safety Committee, which reports to the Quality Committee and ensures that it has all other Health and Safety related statutory Committees in place.

The Trust was inspected by the CQC in December 2019 in relation to the 'well led' domain, and received an overall rating of 'Good'. In addition the Trust continues to monitor and assure the effectiveness of actions being taken to address the findings of the CQC inspection in 2018 and external well led reviews undertaken in 2016 and 2017.

The effectiveness of our implementation of our Risk Management Strategy was audited by Audit Yorkshire during 2019/20, who found there was significant assurance relating to the processes we have in place.

3.8.5. THE RISK AND CONTROL FRAMEWORK

3.8.5.1. Our strategic approach to risk management

We are committed to establishing 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 will identify risk as either an opportunity or a threat, or a combination of both, and will assess the significance of a risk as a combination of probability and consequences of the occurrence.

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

The Trust's 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 the Trust's strategic or operational objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust.

In order to effectively deliver the objectives of the Risk Management Strategy we have ensured that the following are in place:

- An articulated and demonstrated Board and Senior Management commitment to risk management.
- A clearly articulated organisational risk appetite, described and ratified on at least an annual basis by the Board of Directors. (see Figure 47)
- An effective Trust Governance and Quality framework to ensure the strategy remains effective in the application of risk management.
- Employee participation, consultation and accountability in risk management processes.
- Effective systems of control to ensure compliance with regulatory standards are routinely assured.
- Effective systems to ensure that risks identified from major projects are incorporated into operational risk assessment and mitigation strategies.
- Application of this strategy across the organisation, including Clinical Business Units and corporate departments.

- Effective application of Equality, Quality, Cost and Privacy Impact Assessments across the governance and business of the Trust
- Effective mechanisms for incidents to be immediately reported, categorised by their potential impact and consequences and investigated to determine system failures in an open and fair manner.
- System design with a focus on the reduction of the likelihood of human error occurring.
- Formal and effective mechanisms to measure the effectiveness of risk management strategies and infection control strategies, plans and processes against NHS standards.
- Preventative risk management processes applied to the management of facilities, amenities and equipment.
- Risk Management principles and processes applied to contract management especially when acquiring, expanding or outsourcing services.
- Safe systems of work and practice in place for the protection and safety of patients, visitors and staff.
- Plans for emergency preparedness, emergency response, business continuity and contingency.

Our risk management strategy directly influences and supports the following:

- Development and maintenance of risk registers for all major projects, service improvement activities, and departments within the Trust.
- Implementation of a risk escalation framework.
- Development and implementation of our Board Assurance Framework.
- Training for managers to enable them to identify, assess and manage risk as part of normal everyday management responsibilities.
- Effective use of the Trust's governance system and structures.
- Implementation of systems and processes to ensure that risk assessments are undertaken systematically in all Clinical Business Units and departments, and the effectiveness of controls is monitored.
- Development of action plans at corporate and service level.
- Development and implementation of Trust policies to strengthen the systems of control.
- Use of information from risk assessments, incidents, complaints, audit, claims, implementation of external recommendations and other relevant external sources to improve safety and support organisational learning.
- Use of internal and external audit findings and assessments to provide assurance on the effectiveness of controls to minimise risk

All the above enable the Trust to assure itself of the validity of its Corporate Governance Statement, which is required under NHS foundation trust condition 4(8)(b).

Figure 47 - Our risk appetite

The Board of Directors has a defined risk appetite statement, 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).

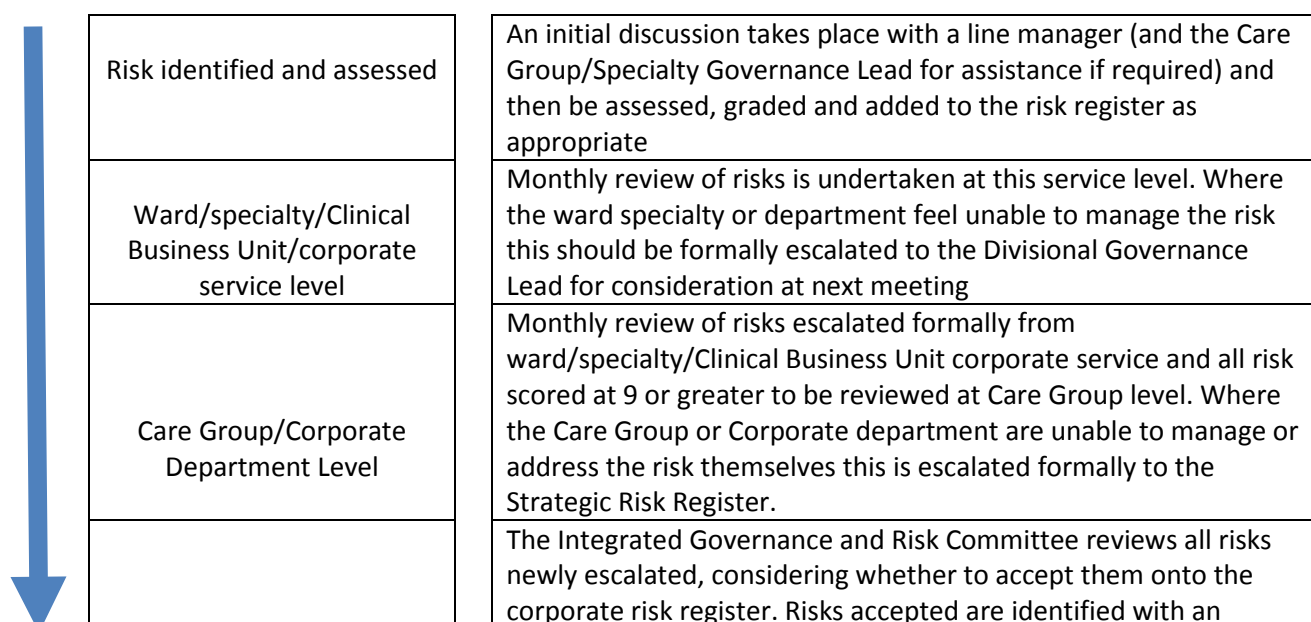
'At a meeting of the Trust's Board of Directors on the 9th January 2020 the Trust's strategic objectives were used, alongside the principal risks managed by the organisation, as a framework to support the outcome of the review of the Trust's risk appetite by its Board Committees. The Board of Directors 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.'


3.8.5.2. Risk identification, assessment, management and escalation

We routinely identify risks from a range of reactive and pro-active, and internal and external sources, including workplace risk assessments, analysis of incidents, complaints, claims, external safety alerts, the 'Freedom to Speak' initiative, through ProGRESS (Our Programmed reviews of Effectiveness, Safety and Sensitivity-assuring our compliance with the Fundamental Standards of Quality and Safety) 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 the Trust's risk registers. Risks are evaluated using the Trust risk matrix which contributes to decision making in the context of the Trust's Risk Appetite and risk tolerance. The Trust rates these risks on a scale from 1-25, where 25 is the highest risk. Risks are appropriately graded and included on the Trust's Risk Register.

Figure 48 - Risk escalation framework





| | |
|-----------------|---|
| Strategic level | Executive Lead. All risks on the Strategic Risk Register scoring greater than 12 are reviewed monthly at the Integrated Governance and Risk Committee., and managed within the principal risk structure of the register to enable alignment to the Board Assurance Framework |
| Committee Level | Board committees will review the principal risks and their component risks assigned to them and consider their impact on the Board Assurance Framework and how they should be reflected |
| Board Level | The Board reviews a high level register of Trust wide risks graded at 12 or greater at each meeting as required by the Integrated Governance and Risk Committee. The Board reviews its strategic risks (12 or above) via the BAF, receiving assurances from the Board Committees and undertaking a review of all these risks at each meeting. |

The Trust uses a single electronic Risk Management System - 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 Trust's Risk Register, which is also held on Datix.

The Trust identifies and manages risk at service, organisational and strategic levels. Service level (Care Group/Clinical Business Unit/Specialty/Ward) risks are risks that have been assessed in relation to their likelihood and consequence and it is considered that they can be effectively managed and mitigated at Care Group/Clinical Business Unit/Specialty or ward level. Organisational risks are risks that apply to the organisation as a whole, and cannot be managed at Care Group level, these are reflected on the Strategic Risk Register along with risks which relate to the achievement of our Strategic Objectives. The Risk Escalation Framework is described in Figure 48.

3.8.5.3. Risk Profile

A suite of principal risks are used to structure the Strategic Risk Register. These are presented in a matrix, shown in Figure 49, together with their overall proposed risk rating. Principal risks have a number of component risks and an assessment of their impact on the overall principal risk score is made on a monthly basis by the lead Executive Director.

Figure 49 - Principal risk matrix for quarter 4 2019/20

| | | Proposed Overall Risk Rating | | | | Risk Appetite |
|----------------|--|------------------------------|----------|--------|---------|---------------|
| Principal Risk | | Initial | Residual | Target | Current | |
| 1 | Failure to maintain the quality of patient services | 16 | 8 | 4 | 12 | Open |
| 2 | Failure to recruit and retain an effective and engaged workforce | 15 | 6 | 4 | 12 | Open |
| 3 | Failure to maintain operational performance | 20 | 6 | 6 | 16 | Cautious |
| 4 | Failure to maintain financial sustainability | 16 | 10 | 10 | 16 | Open |
| 5 | Failure to deliver the required transformation of services | 12 | 8 | 8 | 8 | Open |
| 6 | Failure to achieve sustainable contracts with commissioners | 12 | 6 | 6 | 12 | Cautious |
| 7 | Failure to deliver the benefits of | 12 | 9 | 9 | 12 | Seek |

| | | Proposed Overall Risk Rating | | | | Risk Appetite |
|----|--|------------------------------|----------|--------|---------|---------------|
| | Principal Risk | Initial | Residual | Target | Current | |
| | strategic partnerships | | | | | |
| 8 | Failure to maintain a safe environment for staff patients and visitors | 12 | 8 | 6 | 8 | Cautious |
| 9 | Failure to meet regulatory expectations and comply with laws, regulations and standards | 12 | 6 | 4 | 12 | minimal |
| 10 | Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients | 12 | 8 | 6 | 8 | Open |

*Note: 0 = lowest risk score, 25 = highest risk score

The Strategic Risk Register currently (Month 3 Quarter 4 2019/20) has one risk that is rated 20 or above; this is a current, in-year risk but will require ongoing management into the future, especially in light of the likely impact of the Trust's response to the COVID-19 Pandemic. The risk is described below; mitigating actions have been developed and are recorded on the Strategic Risk Register, along with the details of the action plan lead and the date for completion of these actions. The Strategic Risk Register is monitored each month at the Integrated Governance and Risk Committee meeting, and progress is also evaluated in line with the processes detailed elsewhere in this Annual Governance Statement.

- *'There is a risk that patients may come to harm due to delays in the diagnostic pathway due to insufficient endoscopy capacity'*

3.8.5.4. Control and Assurance

The Trust has an established assurance framework which provides a number of benefits. It;

- provides confidence in the operational working of the Trust,
- maximises the use of resources available in terms of audit planning, avoiding duplication of effort
- educates members of staff across all disciplines,
- ensures assurances are appropriately gathered, reported and that the governance structure is working as intended,
- identifies any potential gaps in assurances relating to key risks and key controls, and ensures that these are understood and accepted, addressed as necessary
- supports the preparation of this Annual Governance Statement and regular governance reports.

The assurance associated with the effective management of risk has continued to improve during 2019/20. This can be evidenced through the widespread use of the Trust's Board Assurance Framework which describes the Trust's key strategic objectives, the associated assurance and risks and controls in place, in addition the Board of Directors and Board Committees receive regular reports, including an Integrated Dashboard, containing assurance related to key controls for the risks associated with the achievement of the Trust's Strategic Objectives

3.8.5.5. Learning

We have an established knowledge management framework to support our learning, embedded within a quality oversight system. This system enables the identification of precursor incidents from complaints, claims, incident reporting, inquests, mortality reviews, patient experience information, ProgRESS reviews (our reviews of our compliance with fundamental standards, effectiveness data information from regulators and external partners, staff and patient conversations, risks and a quarterly focus group of the learning and surveillance hub. The system allows the creation, acquisition, dissemination, and implementation of this knowledge across the organisation.

Key outputs from the system are

- 'bounce back communication' to staff or patients that identify an incident or a risk, in order to keep them informed;
- the publication of 'rapid response alerts' to support immediate notification of actual or potential risks to patient safety. These alerts are issued at the discretion of the Quality of Care Panel, which is chaired by an Executive Director, meets weekly and considers current actual and potential risks to quality and patient safety;
- the monthly publication of 'Learning Matters' through the Learning and Surveillance Hub, which is a prioritised programme of dissemination of targeted learning from incidents, claims, complaints and inquests;
- the quarterly publication of 'Responding and Improving', which is a document that describes serious incidents or complaints, their impact on the patient or staff involved, their root cause, what was done to prevent a re-occurrence and details of how we know that the actions taken have been effective.

The Trust-Wide Learning and Surveillance Hub, which was established during 2016/17, is a developing multi-disciplinary group that explores transferable learning and works to identify new and novel ways of dissemination across the organisation.

3.8.5.6. 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 the Trust's public stakeholders are involved in the understanding and contextualisation of risk. The Council meets five times per year and receives reports on performance, quality and safety. The Trust Board of Directors meets in public and all papers are available on the Trust's website. The Trust has recently approved a revised Membership Plan and will be seeking different and novel ways of engaging with our membership about a number of matters, but including risk and governance.

During 2019/20 the Trust has worked closely with NHS Improvement, which is responsible for overseeing the performance management, clinical quality, and governance of NHS Trusts. Performance against the national priorities set out in the 'Single Oversight Framework for NHS Providers' is discussed at the regular Provider Oversight Meetings held between the Trust and NHSI covering the themes of quality of care; finance and use of resources; operational performance; strategic change; and leadership and improvement

I lead the Trust's Executive Team in developing positive relationships with stakeholder partners including Clinical Commissioning Groups, Local Authority, other partner organisations across Bradford and across the region through the West Yorkshire Association of Acute Trusts (WYAAT) in order 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

The Trust directly participates in the Bradford Health and Well Being Board, Health Scrutiny Committee and Safeguarding Boards and 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 and Harrogate Healthcare Partnership 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.

3.8.5.7. Governance

Every Care Group, and in turn each component specialty, has a Quality and Safety Meeting where key individuals come together to discuss quality and safety issues as part of a standard agenda, ensuring the sharing of transferable lessons from incidents, complaints and claims and reviewing the risks being managed at both Clinical Business Unit and Specialty level, identifying the effectiveness of controls in place and ensuring appropriate application of the risk escalation framework.

During 2019/20 the Trust continued to strengthen the governance of the Committees of its Board of Directors. Following a formal self-assessment process in 2018/19 which resulted in a revision to the terms of reference of the Committees, the Board of Directors gave formal delegated accountability for assurance in relation to the effective management of risk associated with the delivery of the Trust's strategic objectives to its Committees (See Figure 2).

The Committees with an assuring role in relation to a strategic objective (*) are all chaired by a Non-Executive Director. The Committees each have one or more lead Executive Directors, reflecting their accountability (delegated from the Chief Executive) for specific areas of risk, and take responsibility for the Committee's operational management.

The principal duties of the all the Committees are:

- To receive and review the strategic objectives allocated to it by the Board of Directors, agreeing the key controls and identifying any areas where routine and additional assurance is required within its work-plan and what type of assurance is required.
- To receive and review the Board of Director's Risk Appetite statement at each meeting and apply it to their review of the risks and assurance associated with the Trust's Strategic Objectives.
- To receive and scrutinise the Strategic Risks (with a risk score of 12 or more) or any other risks identified or being managed by the Trust allocated to it by the Board of Directors in the context of the Board Assurance Framework, monitoring progress made in mitigating those risks through the work of the Integrated Governance and Risk Committee and, identifying any areas where additional assurance is required.
- To report to the Audit and Assurance Committee, as per the memorandum of understanding and provide assurance to the Trust Board on the adequacy of the controls and mitigations against such risks.
- Following consideration of the assurances received through the discharge of its operational responsibilities, agree the level of confidence the Committee has in relation to the achievement of the strategic objectives allocated to it and provide the associated rationale for inclusion within the Board Assurance Framework.

The Integrated Governance and Risk Committee receives monthly reports in relation to significant new and changed risks and those that have not been reviewed; this is because

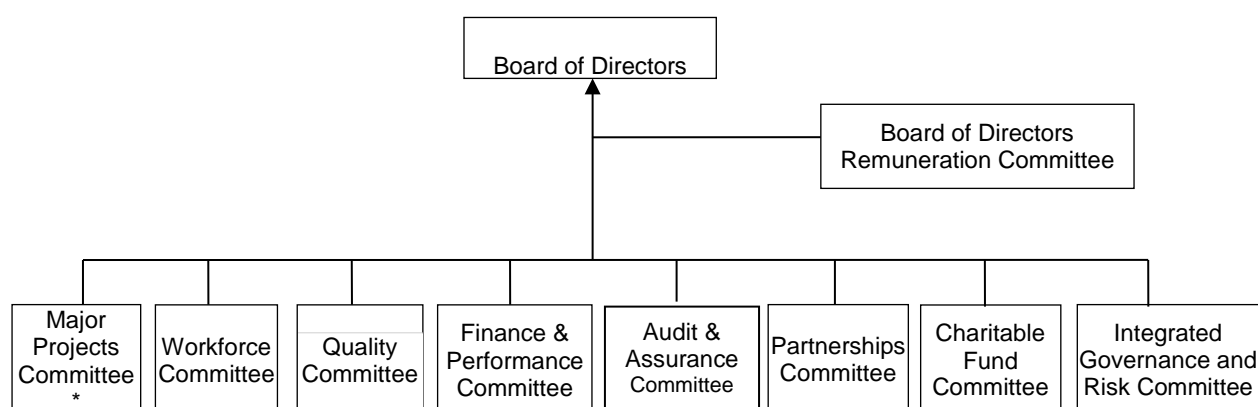
the Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the strategic risk register is an ongoing, dynamic process.

The Strategic Risk Register, together with the Board Assurance Framework, is a monthly agenda item at the Integrated Governance and Risk Committee, and the Chief Executive holds to account the Executive Director Lead for each strategic risk. Each month, the Board Committees receive the section of the Board Assurance Framework related to the Strategic Objective they have an assuring role for. The Board Assurance Framework is also an agenda item at each meeting of the Board of Directors, and the Audit and Assurance Committee reviews the Board Assurance Framework process annually.

Oversight and assurance related to the Trust's risk management arrangements (both clinical and non-clinical) are provided by the Audit and Assurance Committee to the Board of Directors.

The approved minutes of these Committees along with Chairs' summaries are included in Board of Directors papers which are published on the Trust's website, apart from reports and minutes containing confidential information. All Committees have a programme of work for the year in the form of a work plan, which is aligned to the key controls identified in relation to the risks to achieving the Trust's Strategic Objectives and each Committee maintains an action log that ensures the flow of work from one meeting to the next.

Figure 50 - Board and Board Committees



*The Major Projects Committee was dis-established during Quarter 4 2019/20 following a review by Executive Directors, the outcome of which was approved by the Board of Directors. The governance associated with existing workplan of that Committee was transferred to other relevant Committees of the Board.

3.8.5.8. Quality Governance

The Quality Committee provides the Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the quality of the care the Trust provides. This remit includes a focus on the Care Quality Commission (CQC) domains of safe, effective, caring, responsive and well led, the NHSI Well-led framework and on also on the effectiveness of quality governance and risk management (including health and safety) systems.

The objective of the Committee is to enable the Trust Board to obtain assurance that high standards of care are provided and that adequate and appropriate governance structures, processes and controls are in place throughout the Trust to:

- Promote safety, high quality patient care across the Trust
- Identify, prioritise and manage risk arising from clinical care
- Ensure the effective and efficient use of resources through evidence based clinical practice
- Ensure that the Trust is aligned to the statutory and regulatory requirements relating to quality and safety
- Protect the health, safety and wellbeing of Trust employees
- Ensure effective information governance across the Trust's functions.

3.8.5.9. Finance and Performance Governance

The Finance and Performance Committee provides the Trust's Board with an objective and independent review (including relevant strategic risks and associated assurance) of 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.

The objective of the Committee is to enable the Trust Board to obtain assurance that the arrangements for the management and development of finance and performance matters are effective and that appropriate governance structures, processes and controls are in place for the Trust to:

- Promote the effective use of resources (including the effective use of data from the Model Hospital)
- Identify, prioritise and manage risk associated with financial or clinical performance
- Ensure that the Trust is aligned to the statutory and regulatory requirements relating to finance and performance
- Ensure that the digital strategy and the informatics infrastructure of the Trust is aligned to the Trust's objectives both in relation to the Business Intelligence function and clinical digital innovations

3.8.5.10. Workforce Governance

The Workforce Committee provides the Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the effectiveness of the workforce management arrangements for the Trust.

The objective of the Committee is to enable the Trust Board to obtain assurance that high standards of workforce management are in place across the organisation and that adequate and appropriate governance structures, processes and controls are in place to

- Protect the health, safety and well-being of Trust employees
- Protect the safety and the effectiveness of care provided through the oversight of short, medium and long term workforce planning (aligned to the NHS I Developing Workforce Safeguards Recommendations), staffing levels, appraisal and training and development.

3.8.5.11. Care Quality Commission Regulatory Framework

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

During early November 2019 the CQC carried out an unannounced inspection of the Trust. The CQC inspected the following core services:

- Maternity
- Medicine and care of older people
- Services for Children and Young People

In addition, during the planned 'Well led' inspection during December 2019, the CQC also undertook an unannounced inspection of Outpatient Services

The Trust was rated as 'Good' overall. Maternity were rated as 'Requires Improvement', Medicine and care of older people were rated as 'Good', Services for Children and Young People were rated as 'Good' and outpatient services were rated as 'Good'.

We were told we were required to take action to bring services into line with legal requirements. This action related to the Trust and four services.

Trust wide:

- We must improve governance and oversight of risk in maternity services. (Regulation 17: Good governance)
- We must ensure we investigate, respond to and close complaints in all services in line with Trust policy. (Regulation 16: Receiving and acting on complaints)

In medical care services:

- The service must continue to take action to improve performance in national audits to demonstrate effective patient outcomes. (Regulation 12: Safe care and treatment).

In maternity services:

- The service must monitor and control infection risks in theatres consistently well and ensure that mitigating actions (including incident reporting of theatre use) are implemented and closely monitored. (Regulation 12: Safe care and treatment).
- The service must ensure that stillbirths rates are closely and appropriately monitored, escalated where required, and actions are put in place to improve stillbirth rates. (Regulation 12: Safe care and treatment).
- The service must ensure all staff are engaged with and participate in all steps of the World Health Organisation surgical safety checklist, the checklist is fully completed, and observational and record audits are undertaken to monitor compliance. (Regulation 12: Safe care and treatment). The service must ensure systems and processes are used to safely record the use of controlled drugs in the maternity service, and compliance is monitored. (Regulation 12: Safe care and treatment). The Trust must ensure the outcomes/recommendations of any serious case reviews are acted on, and midwives have the opportunity to regularly attend child protection conferences and submit reports to facilitate decision making and safety planning. (Regulation 12: Safe care and treatment)
- The service must ensure all staff are up to date with mandatory training, including safeguarding children level three training. (Regulation 18: Staffing).

We initiated a Trust-wide compliance action plan to address the concerns in April 2020.

In August 2019 the Trust received a short notice inspection by the CQC in relation to IRMER regulations. The Trust was issued with an improvement notice in relation to our management of procedures and guidance. At a subsequent re-inspection in December 2019, the CQC was satisfied that the actions taken to address the improvement notice schedule and recommendations made following the inspection had been effective and closed the file on both the improvement notice and inspection. The enforcement registry was updated to confirm the compliance of the Trust.

3.8.5.12. Management of risks to compliance with the NHS Foundation Trust licence condition 4

Compliance with the Code of Governance 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 2020. The review concluded that the Trust was compliant with all requirements.

A CQC Well Led Review was undertaken in December 2019. The Trust was rated 'good' overall for the 'well-led' domain. The Trust also underwent a 'Use of Resources' inspection, and again was rated 'Good' overall.

3.8.5.13. 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 SIRO Chairs the Information Governance Sub-Committee which reports quarterly to the Quality Committee and in turn to the Board of Directors. The Caldicott Guardian is the Deputy Chair of the Information Governance Sub-Committee.

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).

3.8.5.14. Register of Interests

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the [NHS guidance](https://www.england.nhs.uk/publications/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/)³⁷.

3.8.5.15. NHS Pension Scheme

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

³⁷ <https://www.england.nhs.uk/publications/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/>

3.8.5.16. Equality and Diversity

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

3.8.5.17. Carbon Reduction

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

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 provided to the Finance and Performance Committee 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 Board Assurance Framework to assure and ensure that the Trust is using resources effectively. The Trust also provides financial information to NHS Improvement, the Integrated Care System and local place Health Care Partnership on a monthly basis.

The resources of the Trust 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.

We have a risk based three year audit plan with our internal auditors. We regularly use the audits to evaluate our effective use of resources.

Our external auditors are required, as part of their annual audit, to satisfy themselves that we have made proper arrangements for securing economy, efficiency and effectiveness in our use of resources and report to the Audit and Assurance Committee by exception, if, in their opinion the Trust has not.

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

To ensure that any cost improvement schemes, developed through the Bradford Improvement Programme, 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 to 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.

3.8.7. INFORMATION GOVERNANCE

During the last financial year, the organisation has had 4 externally reportable incidents where personal data has been compromised. These incidents were classified as 'high risk' and were reported to the Information Commissioner's Office (ICO). No action has been taken against the Trust.

A strong emphasis continues to be put on staff awareness around information governance and training to reduce information risk and avoid breaches.

Details of Data Security and Protection Incidents (personal data breaches) are set out in the tables below. Figure 51 confirms externally reportable incidents. Figure 52 details all information governance incidents classified at lower level security to January 2020.

Figure 51 - Personal data breaches reported to ICO 2019/20

| Date of incident (month) | Nature of Incident | Nature of data involved | Number of data subjects potentially affected | Notification steps |
|------------------------------|--|--------------------------|--|----------------------------------|
| May 2019WR84643 | Unauthorised Disclosure | Clinical | 1 | Reported to ICO, no action taken |
| August 2019WR87538 | Unauthorised Disclosure | Clinical | 2 | Reported to ICO, no action taken |
| September 2019WR89212 | Unauthorised access to one patient's health record | Clinical and Demographic | 1 | Reported to ICO, no action taken |
| December 2019WR92518 | Unauthorised access to one patient's health record | Clinical and Demographic | 1 | Reported to ICO, no action taken |

Figure 52 - Other personal data incidents 2019/20

| Category | Breach Type (ICO categorisation) | Total Number of Incidents in this category |
|------------------------|--|--|
| Confidentiality | Unauthorised or accidental disclosure | 10 Data emailed to incorrect recipient 19 Data posted or faxed to incorrect recipient 1 Failure to redact data 7 Verbal disclosures |
| Availability | Unauthorised or accidental loss | 27 Loss or theft of paperwork 7 Data left in insecure location |
| Availability | Unauthorised or accidental destruction | 1 Insecure disposal of paperwork |

3.8.8. DATA QUALITY AND GOVERNANCE

3.8.8.1. Governance and Leadership

The Chief Medical Officer and the Chief Nurse are the Executive Directors accountable for the delivery of our strategic objective to 'provide outstanding care to patients' and the delivery of our Quality Plan 2019-2022. The Quality Committee, which is chaired by a Non-Executive Director, ensures an integrated and co-ordinated approach to the management and development of quality and safety at a corporate level in the Trust.

The Director of Governance and Corporate Affairs leads on matters relating to the preparation of the Trust's Annual Quality Report. The Quality and the Audit and Assurance Committees, which are chaired by Non-Executive Directors, and the Board of Directors maintain oversight of the Report throughout production, using their wider knowledge of the Trust activities to ensure the Report presents a balanced view.

3.8.8.2. Our Quality Plan

The underpinning principle of our Quality Plan is that learning from the past drives our commitment to continuous and sustainable quality improvement thereby achieving our strategic objectives to provide outstanding care for our patients and to be a continually learning organisation.

In 2017 we launched our Clinical Services Strategy and we subsequently implemented a successful one year quality plan during 2018/19. This allowed us time to engage with our staff and patients and await the publication of new national guidance on the quality of care across the NHS in 2019. We published our comprehensive quality plan for the next 3 years in December 2019.

The overarching framework for our Quality Plan is the Care Quality Commission (CQC) five Domains of Quality. In our plan we make it clear that we want to demonstrate that we provide safe, effective, caring and responsive care to our patients and show that we are well led.

We continue to see significant improvements in the care we provide for our patients and their families. We can demonstrate a proven track record in using innovation and collaboration to improve the quality of our services. Our approach to all our quality improvement has been by using a consistent method, namely the IHI 'Model for Improvement' which applies the principles of plan, do, study, act (PDSA) and measuring all improvement, learning as much from failure as success.

The Plan sets out our ambitious quality goals and targets which we aim to achieve over the next three years and describes some of the organisational improvements we plan to make in light of the national guidance published in 2019.

Figure 53 - Our Quality Goals

| |
|--|
| GOAL: To eliminate avoidable harm to patients in our care evidenced through a reduction in the number of avoidable incidents which cause serious harm and for there to be no serious incidents where the root cause is repeated |
| GOAL: To perform the same as or better than the national average in all standards of all National Clinical Audits that we are eligible to participate in |
| GOAL: We will organise our services so that we meet the needs of the population we serve |
| GOAL: To demonstrate that our patients feel that they are treated with compassion, kindness, dignity and respect through them recommending our Trust to their friends and family. None of our services will perform in the bottom 20% of Trusts in a national survey |

GOAL: To meet our access targets

GOAL: To increase the percentage of our people who would recommend our Trust to friends and family as a place to work or a place for treatment and to be in the top 20% of places to work as measured by the NHS staff survey though a year on year

3.8.8.3. Systems and Processes

The effectiveness of the systems of internal control in relation to data are subject to review by Internal Audit. This will be reported on in our Quality Account 2019/20 which will be published in December 2020.

Views will be sought from Governors and members of the Trust to with regard to the priorities in the Quality Account. Information about the progress against these priorities will be routinely fed back to Governors and members. A draft of our Quality Account 2019/20 will be provided to our stakeholders (for 'document assurance' as required by the quality accounts regulations) prior to publication to allow for scrutiny and comment.

3.8.8.4. Data use and reporting

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

We recognise that high quality data is a fundamental requirement for the Trust to conduct its business efficiently and effectively. This applies in all areas of activity including the delivery of care to service users, service management, performance management, corporate governance, internal and external accountability, and communication. High quality data is crucial to enable the right clinical and non-clinical decisions to be made, and it is particularly important for the Trust to assure the quality and accuracy of elective waiting time data.

The Trust has a range of mechanisms to ensure that data generated, collected and used either internally or externally is subject to the appropriate level of scrutiny and assurance. This includes the data quality 'kite marking' of all data used in the Trust Integrated Dashboard.

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 Directors and clinical leads within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on 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 and Assurance Committee on 10 June 2020. The opinion was that 'Significant assurance is given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and

that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk’.

- Internal audits carried out have provided a range of assurance levels, from limited to high assurance: any internal audit reports with Limited Assurance opinions are reviewed by the Integrated Governance and Risk Committee and where appropriate added to the strategic risk register. For each Internal Audit report where a limited assurance opinion is given, the Executive Director responsible is asked to attend the Audit and Assurance 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 are followed up by Internal Audit and reported to the Audit and Assurance Committee.
- Executive Directors and Non-Executive Directors and managers within the organisation who have responsibility for the development and maintenance of the system of internal control have provided me with written assurance statements. Such statements confirm that each director knows of no information which would have been relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and each of them has taken the steps that they ought to have taken to make themselves aware of any information and to establish that the auditors were aware of it.
- The Trust Board Assurance Framework 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 Board Assurance Framework carries an opinion of significant assurance.
- Through the use of an integrated dashboard the Trust Board and its Committees routinely review contemporaneous and quality assured data in relation to quality, finance, performance, workforce and strategic partnerships.
- The Audit and Assurance 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 the Trust’s general risk management structures and ensures appropriate information flows to the Audit and Assurance 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 of the Trust in December 2019; 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 impact of the industrial action which occurred at the Trust during Quarter 2 2019//20. The Trust effectively managed the risk to the Trust’s delivery of its strategic objectives during 2019/20 and does not consider this an internal control issue that has had an impact on the completion of this statement.
- the anticipated impact of the COVID-19 pandemic and considered that this does not have an impact on the completion of this statement for 2019/20.

- As a result of the Covid-19 Pandemic NHS Shared Business Services auditors (PWC) were not able to obtain evidence for a small number of controls operating for February and March 2020. As a result PWC have issued a qualified opinion, which is in line with the requirements of the ISAE 3402 Standard. During 2019/20 testing no exceptions were identified by PWC for any of the listed controls, and although the testing could not be completed for February and March 2020 NHS Shared Business Services have assured the Trust that all controls remained in place and fully operational.

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

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

A handwritten signature in black ink, appearing to read 'Mel Pickup', written in a cursive style.

Mel Pickup
Chief Executive
18 June 2020

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 page number identifying where they are located within this Annual Report.

| Relating to | FT Code of Governance reference | Summary of requirement | Page 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. <i>* This requirement is also contained in paragraph 2.41 of the ARM as part of the remuneration report requirements. The disclosure relating to the remuneration committee should only be made once.</i> | 3.1.1 3.2.1 3.2.3.2 3.5.5 |
| 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. | Figure 39 |
| 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. | Figure 39 |
| 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. | Figure 41 |
| 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. | 3.5.5.1 |
| Board | n/a | The annual report should include a brief description of the length of appointments of the non-executive directors, and how they may be terminated | 3.5.5 |
| Nominations | B.2.10 | A separate section of the annual report should describe the | 3.2.3.2 |

| Relating to | FT Code of Governance reference | Summary of requirement | Page reference within the annual report |
|----------------------------|---------------------------------|--|---|
| Committee(s) | | work of the nominations committee(s), including the process it has used in relation to board appointments. | |
| 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. | 3.2.3.2 |
| 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. | 3.5.4.10 |
| 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. | 3.8.5.7 3.5.4.6 |
| 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 has conducted a review of the effectiveness of its system of internal controls. | 3.8.3 |
| Audit | C.2.2 | A trust should disclose in the annual report: | 3.5.5.8 |

| Relating to | FT Code of Governance reference | Summary of requirement | Page reference within the annual report |
|--|---------------------------------|---|---|
| Committee/control environment | | (a) if it has an internal audit function, how the function is structured and what role it performs; or (b) 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. | |
| 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. | 3.5.4.6 |
| 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: <ul style="list-style-type: none"> 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. | 3.5.5.6 3.5.5.7 |
| 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. | 3.5.4.9 |
| 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. | 3.1.1 |
| Membership | n/a | The annual report should include: | 3.5.3 |

| Relating to | FT Code of Governance reference | Summary of requirement | Page reference within the annual report |
|----------------------------|---------------------------------|--|---|
| | | <ul style="list-style-type: none"> • 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 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 | <p>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.</p> | 3.1.1 |

5. ANNUAL ACCOUNTS

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2020

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 gains and losses, 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

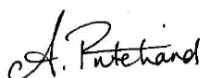
(1) The statement of accounting officer's responsibilities in respect of the accounts shall be signed and dated by the chief executive of the NHS foundation trust.

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: Amanda Pritchard (Chief Executive)

Dated: January 2020

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

Report on the audit of the financial statements

1. Opinion

In our opinion the financial statements of Bradford Teaching Hospitals 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 2020 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.





2. Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) 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.

3. Summary of our audit approach

| | |
|--|---|
| Key audit matters | <p>The key audit matters that we identified in the current year were:</p> <ul style="list-style-type: none">• Accounting for the discontinuation of the development of a subsidiary property and facilities management company; and• Property valuations. <p>Within this report, key audit matters are identified as follows:</p> <div><div> Newly identified</div><div> Similar level of risk</div><div> Increased level of risk</div><div> Decreased level of risk</div></div> |
| Materiality | <p>The materiality that we used for the financial statements was £9m which was determined on the basis of 2% of total operating income.</p> |
| Scoping | <p>The scope of the audit is in line with the Code of Audit Practice issued by the National Audit Office.</p> <p>Audit work to respond to the risk of material misstatement was performed directly by the audit engagement team.</p> |
| Significant changes in our approach | <p>In the current year, revenue recognition in respect of Commissioning for Quality and Innovation (CQUIN) income and Provider Sustainability Fund (PSF) income is no longer considered to be a key audit matter. We have introduced a new Key Audit Matter concerning the accounting for the discontinuation of the development a subsidiary property and facilities management company.</p> <p>We have further identified property valuations as a key audit matter in the current year due to material uncertainty arising in connection with the impact of COVID-19.</p> |

4. Conclusions relating to going concern

| | |
|--|---|
| <p>We are required by ISAs (UK) to report in respect of the following matters where:</p> <ul style="list-style-type: none">• the directors' use of the going concern basis of accounting in preparation of the financial statements is not appropriate; or• the directors have not disclosed in the financial statements any identified material uncertainties that may cast significant doubt about the foundation trust's ability to continue to adopt the going concern basis of accounting for a period of at least twelve months from the date when the financial statements are authorised for issue. | <p>We have nothing to report in respect of these matters.</p> |
|--|---|

5. Key audit matters

Key audit matters are those matters that, in our professional judgement, were of most significance in our audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) that we identified. These matters included those which had the greatest effect on: the overall audit strategy, the allocation of resources in the audit; and directing the efforts of the engagement team.

These matters were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters.

5.1. Accounting for the discontinuation of efforts to develop a subsidiary property and facilities management company

| | |
|---|--|
| Key audit matter description | <p>Owing to the revenue recognition key audit matter not being applicable in the current year and due to the accounting complexities involved in reversing the transaction relating to the subsidiary following the Board's decision not to proceed with the setup of the subsidiary company, we have focused this key audit matter upon the Trust's accounting for the discontinuation of the development of its subsidiary company. This change impacts on a number of balances within the Trust's financial statements including the Property, Plant and Equipment valuation and the reversal of the Capital Goods Scheme debtor recognised in the prior year and how these matters are reflected within the Comprehensive Statement of Income and Expenditure for the year, note 3.1 and note 8.1.</p> |
| How the scope of our audit responded to the key audit matter | <p>We have obtained an understanding of relevant controls within the process for the calculation, review and approval of the transactions.</p> <p>We obtained a management paper setting out the proposed accounting treatment and the underlying calculations for the required adjustments.</p> <p>We have traced the required adjustments through to the accounts, to confirm they have been correctly classified.</p> <p>We assessed the proposed accounting treatment against the requirements of the Department of Health and Social Care Group Accounting Manual.</p> |
| Key observations | <p>We consider the transactions connected to the discontinuation of the development of the subsidiary company to be appropriately recognised in the year.</p> |

5.2. Property valuations

| | |
|---|---|
| Key audit matter description | <p>The foundation trust holds property assets within Property, Plant and Equipment at current valuation using the modern equivalent asset valuation methodology. As at 31 March 2020 Property Plant and Equipment was valued at £168m (2018/19: £147m). The valuations are by nature significant estimates which are based on specialist and management assumptions and are influenced by market conditions.</p> <p>As detailed in notes 1.27 and 8.1, in applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the Trust's valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19, and therefore being able to attach less weight to previous market evidence and published build cost information for comparison purposes, to inform opinions on value.</p> |
| How the scope of our audit responded to the key audit matter | <p>We have obtained an understanding of the relevant controls within the property valuation process.</p> <p>We worked with our internal valuation specialists to review and challenge the appropriateness of the assumptions applied by management in the valuations following the impact of COVID-19.</p> <p>In evaluating the property valuation we considered the impact of uncertainties relating to the COVID-19 pandemic upon the valuations and related disclosures, including the adequacy of the disclosure in notes 1.27 and 8.1 of the material valuation uncertainty.</p> |
| Key observations | <p>While we note the increased estimation uncertainty in relation to the property valuation as a result of COVID-19, and as disclosed in notes 1.27 and 8.1, we consider that the property valuations are appropriately stated.</p> |

6. Our application of materiality

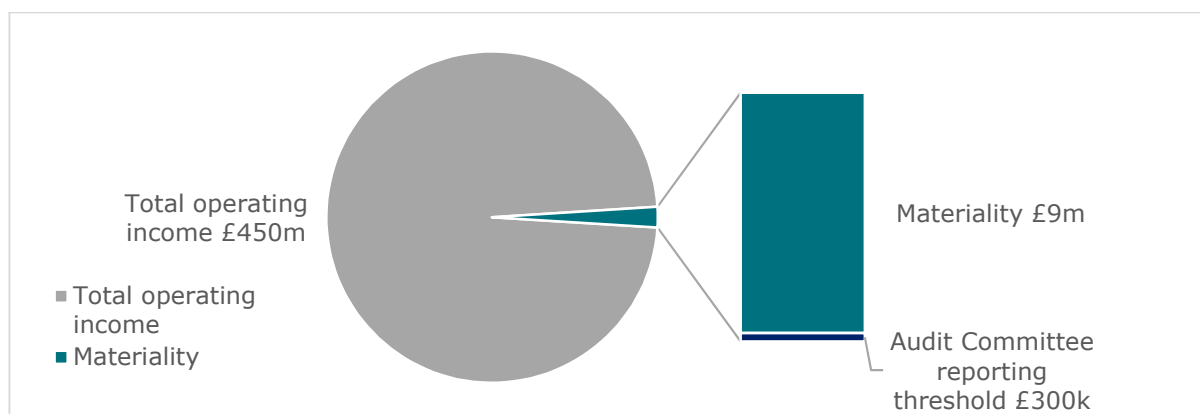
6.1. Materiality

We define materiality as the magnitude of misstatement in the financial statements that makes it probable that the economic decisions of a reasonably knowledgeable person would be changed or influenced. We use materiality both in planning the scope of our audit work and in evaluating the results of our work.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Foundation trust financial statements

| | |
|--|--|
| Materiality | £9m (2018/19: £8m) |
| Basis for determining materiality | 2% of total operating income (2018/19: 2% of total operating income) |
| Rationale for the benchmark applied | Total Operating income was chosen as a benchmark as the foundation trust is a non-profit organisation, and operating income is a key measure of financial performance for users of the financial statements. |



6.2. Performance materiality

We set performance materiality at a level lower than materiality to reduce the probability that, in aggregate, uncorrected and undetected misstatements exceed the materiality for the financial statements as a whole. Performance materiality was set at 75% of materiality for the 2019/20 audit (2018/19: 75%). In determining performance materiality, we considered the following factors:

- Our risk assessment, including our assessment of the foundation trust's overall control environment; and
- Our past experience of the audit, which has indicated a low number of corrected and uncorrected misstatements identified in prior periods.

6.3. Error reporting threshold

We agreed with the Audit Committee that we would report to the Committee all audit differences in excess of £300k (2018/19: £300k), as well as differences below that threshold that, in our view, warranted reporting on qualitative grounds. We also report to the Audit Committee on disclosure matters that we identified when assessing the overall presentation of the financial statements.

7. An overview of the scope of our audit

7.1. Identification and scoping of components

Our audit was scoped by obtaining an understanding of the foundation trust and its environment, including internal controls, and assessing the risks of material misstatement. The foundation trust is located in Bradford, and audited directly by the audit engagement team.

8. Other information

The accounting officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon.

Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in respect of these matters.

9. Responsibilities of accounting officer

As explained more fully in the accounting officer's responsibilities statement, 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 the accounting officer either intends to liquidate the foundation trust or to cease operations, or has no realistic alternative but to do so.

10. 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.

Report on other legal and regulatory requirements

11. Opinion on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared 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.

12. Matters on which we are required to report by exception

12.1. Annual Governance Statement, use of resources, 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;
- the foundation trust has not made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; 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.

12.2. 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.

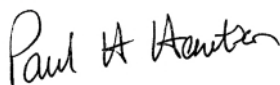
We have nothing to report in respect of these matters.

13. Certificate

We certify that we have completed the audit of the accounts in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

14. Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Bradford Teaching Hospitals 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 foundation trust and the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Paul Hewitson FCA (Senior statutory auditor)

For and on behalf of Deloitte LLP

Statutory Auditor

Newcastle Upon Tyne, United Kingdom

19 June 2020

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2020 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the NHS foundation trust) in accordance with paragraph 24 and 25 of Schedule 7 within 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.

Signed:

A handwritten signature in black ink, appearing to read 'Mel Pickup', with a large, stylized initial 'M'.

Name: Mel Pickup (Chief Executive)
Dated: 18 June 2020

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2020

| | Note | 2019/20 £000 | 2018/19 £000 |
|--|------|-----------------|-----------------|
| Operating income from patient care activities | 2.1 | 378,652 | 346,674 |
| Other operating income | 2.1 | 71,664 | 64,429 |
| Operating expenses | 3.1 | (440,163) | (418,609) |
| OPERATING SURPLUS / (DEFICIT) | | 10,153 | (7,506) |
| FINANCE COSTS | | | |
| Finance income | 5 | 258 | 192 |
| Finance expense | 6.1 | (429) | (516) |
| Public dividend capital dividends payable | 6.2 | (4,433) | (4,840) |
| NET FINANCE COSTS | | (4,604) | (5,164) |
| Losses on disposals of assets | | (13) | (6) |
| SURPLUS/(DEFICIT) FOR THE YEAR | | 5,536 | (12,676) |
| Other comprehensive income | | | |
| Will not be reclassified to income and expenditure: | | | |
| Impairment losses | 15.1 | (1,080) | (35,132) |
| Revaluation gains | 15.1 | 15,799 | 13,371 |
| TOTAL COMPREHENSIVE INCOME / (EXPENDITURE) FOR THE YEAR | | 20,255 | (34,437) |

All income and expenses shown relate to continuing operations.

The notes on pages 14 to 56 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2020

| | Note | 31 Mar 2020 £000 | 31 Mar 2019 £000 |
|--|------|---------------------|---------------------|
| Non-current assets | | | |
| Intangible assets | 7.1 | 11,666 | 11,776 |
| Property, plant and equipment | 8.2 | 185,828 | 164,315 |
| Trade and other receivables | 10.1 | 2,718 | 5,978 |
| Total non-current assets | | 200,212 | 182,069 |
| Current assets | | | |
| Inventories | 9 | 7,970 | 7,413 |
| Trade and other receivables | 10.1 | 28,306 | 27,017 |
| Cash and cash equivalents | 16.1 | 29,618 | 21,203 |
| Total current assets | | 65,894 | 55,633 |
| Current liabilities | | | |
| Trade and other payables | 11 | (37,312) | (33,367) |
| Borrowings | 13 | (3,129) | (3,138) |
| Provisions | 14.1 | (339) | (355) |
| Other liabilities | 12 | (7,672) | (4,952) |
| Total current liabilities | | (48,452) | (41,812) |
| Total assets less current liabilities | | 217,654 | 195,890 |
| Non-current liabilities | | | |
| Borrowings | 13 | (22,740) | (25,792) |
| Provisions | 14.1 | (4,116) | (2,953) |
| Other liabilities | 12 | (1,969) | (1,819) |
| Total non-current liabilities | | (28,825) | (30,564) |
| Total assets employed | | 188,829 | 165,326 |
| Financed by taxpayers' equity | | | |
| Public Dividend Capital | | 125,829 | 122,581 |
| Revaluation reserve | 15.1 | 60,415 | 48,310 |
| Income and expenditure reserve | | 2,585 | (5,565) |
| Total taxpayers' equity | | 188,829 | 165,326 |

These accounts together with notes on pages 14 to 56 were approved by the Board of Directors on [insert date].

Signed:



Name: Mel Pickup (Chief Executive)
Dated: 18 June 2020

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

| | Total | Public Dividend | Revaluation reserve | Income and |
|--|----------------|------------------------|----------------------------|----------------------------|
| | £000 | Capital | (see note 15.1) | expenditure reserve |
| | | £000 | £000 | £000 |
| Taxpayers' equity at 1 April 2019 | 165,326 | 122,581 | 48,310 | (5,565) |
| Surplus for the year | 5,536 | 0 | 0 | 5,536 |
| Other transfers between reserves | 0 | 0 | (2,614) | 2,614 |
| Net impairments | (1,080) | 0 | (1,080) | 0 |
| Revaluations – property, plant and equipment | 15,799 | 0 | 15,799 | 0 |
| Public dividend capital received | 3,248 | 3,248 | 0 | 0 |
| Taxpayers' equity at 31 March 2020 | 188,829 | 125,829 | 60,415 | 2,585 |
| Taxpayers' equity at 1 April 2018 | 198,426 | 121,244 | 75,332 | 1,850 |
| Deficit for the year | (12,676) | 0 | 0 | (12,676) |
| Other transfers between reserves | 0 | 0 | (5,261) | 5,261 |
| Net impairments | (35,132) | 0 | (35,132) | 0 |
| Revaluations – property, plant and equipment | 13,371 | 0 | 13,371 | 0 |
| Public Dividend Capital received | 1,337 | 1,337 | 0 | 0 |
| Taxpayers' equity at 31 March 2019 | 165,326 | 122,581 | 48,310 | (5,565) |

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

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS foundation trust.

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2020

| | 2019/20 £000 | 2018/19 £000 |
|---|-------------------------|-------------------------|
| Cash flows from operating activities | | |
| Operating surplus/(deficit) from continuing operations | 10,153 | (7,506) |
| Non-cash income and expense | | |
| Depreciation and amortisation | 10,260 | 9,068 |
| Impairments and reversals | (5,147) | 18,964 |
| Income recognised in respect of capital donations (cash and non-cash) | (70) | (133) |
| (Increase)/decrease in trade and other receivables | 1,798 | (779) |
| (Increase) in inventories | (557) | (825) |
| Increase/(decrease) in trade and other payables | 2,873 | (4,683) |
| Increase in other liabilities | 2,870 | 1,030 |
| Increase/(decrease) in provisions | 1,164 | (1,083) |
| Net cash generated from operations | 23,344 | 14,053 |
| Cash flows from investing activities | | |
| Interest received | 244 | 191 |
| Purchase of intangible assets | (2,234) | (1,896) |
| Purchase of property, plant and equipment and investment property | (8,504) | (8,174) |
| Sale of property, plant and equipment and investment property | 0 | 6 |
| Receipt of cash donations to purchase capital assets | 0 | 133 |
| Net cash used in investing activities | (10,494) | (9,740) |
| Cash flows from financing activities | | |
| Public dividend capital received | 3,248 | 1,337 |
| Movement in loans from the Department of Health and Social Care | (3,052) | (4,052) |
| Interest paid on DHSC loans | (455) | (520) |
| Public dividend capital dividend paid | (4,176) | (5,521) |
| Net cash used in financing activities | (4,435) | (8,756) |
| Increase/(decrease) in cash and cash equivalents | 8,415 | (4,443) |
| Cash and cash equivalents at 1 April | 21,203 | 25,646 |
| Cash and cash equivalents at 31 March | 29,618 | 21,203 |

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2019/20 issued by the Department of Health and Social Care. The accounting policies contained in the 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 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.

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified, where applicable, to account for the revaluation of property, plant and equipment and intangible assets.

1.2 Going Concern

After consideration of the contract position with commissioners, including the interim financial regime put in effect during the Novel Coronavirus (COVID-19) pandemic, the control total offered by NHSI and forecast cash balances for 2020/21, the Directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

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 2016/17 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% equity investment in both organisations, with losses limited to £1 each, with Airedale NHS Foundation Trust and Harrogate and District NHS Foundation Trust. 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. At present the Joint Ventures Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP are not consolidated on the grounds of materiality.

NHS Charitable Funds

The NHS foundation trust has not consolidated the financial statements with 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 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 NHS foundation trust accrues income relating to performance obligations satisfied in that year. Where the NHS foundation 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.

Income derived from NHS commissioners is received in the month performance obligations fall due. Reconciliation is carried out with commissioners annually to adjust for any over or under trades against the agreed performance. The contracts held with Bradford City CCG, Bradford Districts CCG, and Airedale, Wharfedale and Craven CCG are no longer activity based removing the need for reconciliation. All other activity is invoiced monthly or quarterly in arrears with credit terms of 30 days.

Revenue from NHS contracts

The main source of income for the NHS foundation trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the NHS foundation trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the NHS foundation trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete. This accrual is disclosed as a contract receivable as entitlement to payment for work completed is usually only dependent on the passage of time.

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the NHS foundation trust reflects this in the transaction price and derecognises the relevant portion of income.

The Trust receives income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agrees schemes with its commissioner but they affect how care is provided to patients. That is, the CQUIN payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the contract.

Where the NHS foundation trust is aware of a penalty based on contractual performance, the NHS foundation trust reflects this in the transaction price for its recognition of revenue. Revenue is reduced by the value of the penalty.

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 21.79% (2018/19: 21.89%).

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

The PSF and FRF enable providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

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 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 Discontinued operations

Discontinued operations occur where activities either cease without transfer to another entity, or transfer to an entity outside of the boundary of Whole of Government Accounts, such as private or voluntary sectors. Such activities are accounted for in accordance with IFRS 5. Activities that are transferred to other bodies within the boundary of Whole of Government Accounts are 'machinery of government changes' and treated as continuing operations.

1.8 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; and
- 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 simultaneous disposal dates and are under single managerial control;
 - 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 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 to their residual values over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which 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 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 2019/20 the reversal of impairment is £4,067,000 and in 2018/19 there was an impairment of £54,096,000.

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 income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

De-recognition

Assets, intended for disposal, are reclassified as 'Held for Sale' once all of the following criteria are met. The 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. 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.

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 | 18 | 54 |
| Dwellings | 29 | 37 |
| 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.

1.9 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.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38.

There was no such expenditure requiring capitalisation at the SoFP date. Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred. NHS foundation trusts disclose the total amount of research and development expenditure charged in the SoCI separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of 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.

The range of useful lives for intangible assets are between 4 and 10 years.

1.10 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.

1.11 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.

1.12 Climate Change Levy

Expenditure is recognised in line with the levy charged, based on the chargeable rates for energy consumption as detailed in the Climate Change Levy documentation.

1.13 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 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 and 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 or assets measured at fair value through other comprehensive income, 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.

1.14 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.

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.

1.15 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 0.50% in real terms (2018/19: positive 0.29%).

Clinical negligence costs

NHS Resolution (formerly NHS Litigation Authority) 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 14.1 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.

1.16 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.

1.17 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, except for

- (i) donated and grant funded assets,
- (ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility,
- (iii) any PDC dividend balance receivable or payable, and
- (iv) Assets purchased in response to the Novel Coronavirus (COVID-19) pandemic.

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.

1.18 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.

1.19 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 2020, this power has not been exercised. Accordingly, the NHS foundation trust is not within the scope of corporation tax.

1.20 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 2020;
- 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.

1.21 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.

1.22 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.

1.23 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.

1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2019/20.

1.25 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 2021. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The 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 2021, the NHS foundation trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the NHS foundation trust's incremental borrowing rate. The NHS foundation trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 1.27% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2021 for existing finance leases.

For leases commencing in 2021/22, 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.

HM Treasury revised the implementation date for IFRS 16 in the UK public sector to 1 April 2021 on 19 March 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2021 and beyond, a quantification of the expected impact of applying the standard in 2021/22 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets and liabilities.

The Department of Health & Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2019/20.

IFRS 17 Insurance Contracts

Application required for accounting periods beginning on or after 01 January 2023, but not yet adopted by the FReM: early adoption is not therefore permitted.

IFRS 14 Regulatory Deferral Accounts

Not EU-endorsed. Applies to first time adopters of IFRS after 01 January 2016. Therefore not applicable to the DHSC group of bodies.

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 or IFRS 14..

1.26 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:

Impairment of fixed assets

In accordance with the stated policy on asset valuation a desktop valuation of assets was carried out at the valuation date of 31 March 2020.

Specialised property has been valued at depreciated replacement cost on a modern equivalent asset basis in line with Royal Institute of Chartered Surveyors standards. Land has been valued having regard to the cost of purchasing notional replacement sites in the same locality as the existing sites.

Recoverability of receivables

In accordance with the stated policy on impairment of financial assets, management assess the impairment of receivables and make appropriate adjustments to the existing allowance account for credit losses.

In accordance with the stated policy on provisions, management have used best estimates of the expenditure required to settle the obligations concerned, applying HM Treasury's discount rates as stated, as appropriate. Management have also taken into account all available information for disputes and possible outcomes.

1.27 Critical judgements in applying accounting policies

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 recoverable amount. Significant assets of the NHS foundation trust are reviewed for impairment as they are brought into operational use. 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.
- 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. The net book value of the NHS foundation trust's land, buildings and dwellings as at 31 March 2020 was £167,716,000 (31 March 2019: £147,292,000).
- 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. 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.
- 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 are reviewed for profitability at each Statement of Financial Position date, but the assessment of future costs to complete are subject to uncertainty. The revenue recognised in the year reflected management's judgement regarding the outstanding obligations and the associated

income values. Income which has been deferred to future periods relating to these contracts at 31 March 2020 amounted to £6,941,000 (31 March 2019: £6,771,000).

- v. The Novel Coronavirus (COVID-19) pandemic has led to an element of degree of uncertainty across the economy as at 31 March 2020 which could continue throughout 2020/21. The NHS foundation trust's valuers have declared a material valuation uncertainty in their report as the indices which the valuations are based on could be subject to change. More details of this declaration is provided in Note 8. While the values declared in the accounts represent the best information available at this time there is less certainty than in previous years with regard to the valuation of land and buildings. A 3% movement in asset valuation would have an impact of £5,031,000 on the Statement of Financial Position. This would have a subsequent impact of £88,000 on PDC charges to be paid next year and accrued in these financial statements.

Note 2 Operating income

Note 2.1 Income from patient care (by nature)

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|------|-----------------|-----------------|
| Income from activities | | | |
| Elective income | | 49,922 | 50,723 |
| Non elective income ¹ | | 110,982 | 96,621 |
| First outpatient income | | 30,954 | 33,131 |
| Follow Up outpatient income | | 30,598 | 28,002 |
| Accident and emergency income | | 18,958 | 16,217 |
| High cost drugs income from commissioners | | 36,095 | 29,901 |
| Other NHS clinical income | 2.2 | 75,331 | 74,170 |
| Income from CCG's and NHS England | | 12,623 | 12,124 |
| Private patient income | | 323 | 604 |
| Agenda for Change pay award central funding ² | | 0 | 3,800 |
| Additional pension contribution central funding ³ | | 11,068 | 0 |
| Other clinical income | 2.3 | 1,798 | 1,381 |
| Total income from activities | | 378,652 | 346,674 |
| Other operating income from contracts with customers: | | | |
| Research and development | | 8,020 | 7,439 |
| Education and training | | 19,881 | 17,656 |
| Provider sustainability fund income (PSF) | 2.4 | 5,120 | 13,908 |
| Financial recovery fund (FRF) | 2.4 | 14,271 | 0 |
| Income in respect of employee benefits accounted on a gross basis | 2.5 | 4,458 | 4,097 |
| Other Contract Income | 2.6 | 14,753 | 16,218 |
| Other non-contract operating income | | | |
| Research and development (non-contract) | | 4,940 | 4,851 |
| Cash donations for the purchase of capital assets received from other bodies | | 70 | 133 |
| Charitable and other contributions to expenditure – received from NHS charities | | 151 | 127 |
| Total other operating income | | 71,664 | 64,429 |
| Total | | 450,316 | 411,103 |

¹ 18/19 Non-elective point of delivery included a Commissioner challenge relating to the coding of non-elective activity of (£14,469k), this challenge has now been removed as part of counting and coding notice and the agreement to have a Fixed Income contract with the Bradford CCGs. The emergency re-admission penalty has also been removed in 19/20, in line with national guidance. Additionally, the volume of non-elective activity has reduced but a higher average price is being received due to more complex patients now been coding accurately through the use of the Electronic Patient Records system and the transfer of the Provider Sustainability Fund (PSF) which was centrally funded in 18/19 but transferred into tariff prices from 19/20.

² 2018/19 Agenda for Change pay award received central funding. From 2019/20 this funding is incorporated into tariff for individual services.

³ 2019/20 Additional pension contribution central funding relates to an increase in employer pension contributions for NHS pensions. The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. For 2019/20, NHS providers 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 NHS clinical income

Other NHS clinical income comprises of income for maternity pathway £25,000,000 (2018/19: £10,900,000), Block funding £12,200,000 (2018/19: £12,200,000), Adult critical care £8,400,000 (2018/19: £8,500,000), Neo-natal critical care £7,900,000 (2018/19: £7,200,000), Renal dialysis £6,800,000 (2018/19: £6,100,000), Diagnostic imaging £5,700,000 (2018/19: £4,700,000), Maintenance £4,700,000 (2018/19: £4,300,000) and CQUIN £4,000,000 (2018/19: £6,200,000). This is in line with the national contract.

Note 2.3 Other clinical income

Other clinical income comprises of, in the main, Road Traffic Accident (RTA) income £1,500,000 (2018/19: £1,300,000).

Overseas visitors (relating to patients charged directly by the provider)

| | 2019/20 £000 | 2018/19 £000 |
|--|-----------------|-----------------|
| Income recognised this year | 266 | 185 |
| Cash payments received in-year | 110 | 57 |
| Amounts added to provision for impairment of receivables | 169 | 130 |
| Amounts written off in-year | 160 | 113 |

Note 2.4 Provider Sustainability Fund (PSF) & Financial Recovery Fund (FRF) Income

| | 2019/20 £000 | 2018/19 £000 |
|--|-----------------|-----------------|
| Provider Sustainability Fund (PSF) | 4,609 | 13,908 |
| PSF – 2018/19 post accounts reallocation | 511 | 0 |
| Financial Recovery Fund (FRF) | 14,271 | 0 |
| Total | 19,391 | 13,908 |

The provider sustainability fund (formally sustainability and transformation fund) was introduced in July 2016 as part of the NHS financial reset. The changes introduced included the introduction of agreed financial control totals for individual trusts. Provider sustainability funding is paid to trusts should they meet financial and operational targets. The financial recovery fund was introduced as part of the NHS Long Term plan in January 2019. This funding seeks to reduce the number of NHS organisation reporting in year deficits. Of the total £14,271,000 FRF income received £4,374,000 was contingent on the Integrated Care System (ICS) collectively achieving its control total.

Note 2.5 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 £200,000 (2018/19: £500,000), Airedale NHS Foundation Trust £1,300,000 (2018/19: £800,000), individual posts and services charged to Leeds Teaching Hospitals £400,000 (2018/19: £300,000), Bradford CCGs £800,000 (2018/19: £700,000), Bradford District Care Trust £200,000 (2018/19: £300,000), other hospitals across Yorkshire £100,000 (2018/19: £300,000) and support to non NHS organisations £1,400,000 (2018/19: £1,200,000) including Macmillian Cancer Support and Marie Curie Hospice for doctors, nurses, AHPs and administrative staff.

Note 2.6 Other contract income

Other income, in the main, includes income associated with services provided to other NHS organisations £9,400,000 (2018/19: £10,400,000), Pharmacy Sales £2,800,000 (2018/19: £2,800,000), car parking income £1,300,000 (2018/19: £1,700,000), Catering £500,000 (2018/19: £500,000) and clinical excellence awards £500,000 (2018/19: £500,000).

Note 2.7 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.

Note 2.8 Income from patient care (by source)

| Income from activities | Note | 2019/20 £000 | 2018/19 £000 |
|--|-------------|-------------------------|-------------------------|
| NHS England | | 77,282 | 63,514 |
| Clinical commissioning groups | | 298,908 | 276,780 |
| Department of Health & Social Care | | 0 | 3,800 |
| NHS Foundation Trusts | | 104 | 211 |
| NHS Trusts | | 226 | 236 |
| NHS other (including Public Health England) | | 10 | 0 |
| Non-NHS: private patients | | 323 | 604 |
| Non-NHS: overseas patients (non-reciprocal, chargeable to patient) | | 266 | 185 |
| Injury cost recovery scheme | | 1,533 | 1,344 |
| Non-NHS: Other | | 0 | 0 |
| Total income from activities | | 378,652 | 346,674 |
| Of which: | | | |
| Related to continuing operations | | 378,652 | 346,674 |
| Related to discontinued operations | | 0 | 0 |

Note 2.9 Income from activities arising from commissioner requested services

| | 2019/20 £000 | 2018/19 £000 |
|--|-------------------------|-------------------------|
| Income for services designated as commissioner requested services | 376,531 | 340,889 |
| Income from services not designated as commissioner requested services | 2,121 | 5,785 |
| Total | 378,652 | 346,674 |

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.

Note 2.10 Additional information on contract revenue (IFRS 15) recognised in the period

| | 2019/20 £000 | 2018/19 £000 |
|---|-------------------------|-------------------------|
| Revenue recognised in the reporting period that was included within contract liabilities at the previous period end | 2,441 | 698 |
| Revenue recognised from performance obligations satisfied (or partly satisfied) in previous periods | 0 | 0 |

Note 3 Operating expenses

Note 3.1 Operating expenses

| | Note | 2019/20 £000 | 2018/19 £000 |
|---|------|-----------------|-----------------|
| Purchase of healthcare from NHS and DHSC bodies | | 1,743 | 0 |
| Purchase of healthcare from non NHS bodies and non-DHSC bodies | | 284 | 448 |
| Staff and executive directors costs | | 271,743 | 251,115 |
| Non-executive directors | | 137 | 120 |
| Supplies and services – clinical (excluding drug costs) | | 43,229 | 42,203 |
| Supplies and services – general | | 21,726 | 15,309 |
| Drug costs (drugs inventory consumed and purchase of non-inventory drugs) | | 40,703 | 39,549 |
| Consultancy costs | | 846 | 1,299 |
| Establishment | | 2,804 | 3,048 |
| Premises – business rates collected by local authorities | | 1,974 | 1,928 |
| Premises – other | | 6,981 | 6,086 |
| Transport – (business travel only) | | 444 | 437 |
| Transport – other (including patient travel) | | 23 | 20 |
| Depreciation on property, plant & equipment | | 8,111 | 6,845 |
| Amortisation on intangible assets | | 2,149 | 2,223 |
| Impairments net of (reversals) | | (5,147) | 18,964 |
| Movement in credit loss allowance: contract receivables / assets | | 86 | 123 |
| Movement in credit loss allowance: all other receivables & investments | | 0 | 0 |
| Change in provisions discount rate | | 239 | (58) |
| Audit services – statutory audit | | 64 | 57 |
| Other auditor remuneration | 3.2 | 1 | 40 |
| Internal Audit – non-staff | | 176 | 175 |
| Clinical negligence – amounts payable to the NHS Resolution (premium) | | 13,869 | 12,294 |
| Legal fees | | 276 | 224 |
| Insurance | | 107 | 337 |
| Research and Development – staff costs | | 8,263 | 7,592 |
| Research and development – non-staff | | 5,528 | 4,697 |
| Education and training – staff costs | | 5,498 | 4,345 |
| Education and training – non-staff | | 519 | 571 |
| Operating lease expenditure (net) | | 2,252 | 2,159 |
| Redundancy costs – non-staff | | 0 | 0 |
| Car parking and security | | 11 | 10 |
| Hospitality | | 20 | 17 |
| Other losses and special payments – non-staff | | 121 | 27 |
| Other services (e.g. external payroll) | | 810 | 978 |
| Other ¹ | | 4,573 | (4,573) |
| Total | | 440,163 | 418,609 |

¹2018/19 Other expenditure includes a credit of £4,573,000 as a result of an historic VAT reclaim which the NHS foundation trust qualifies for following the establishment of a wholly owned subsidiary (WOS) for Estates and Facilities services. This transaction was reversed in 2019/20 as a result of the NHS foundation trust's decision not to proceed with the WOS.

Note 3.2 Other audit remuneration

| | 2019/20 | 2018/19 |
|----------------------------------|----------|-----------|
| | £000 | £000 |
| Audit related assurance services | 1 | 7 |
| Other assurance Services | 0 | 33 |
| Total | 1 | 40 |

Note 3.3 Operating leases

| | 2019/20 | 2018/19 |
|------------------------|--------------|--------------|
| | £000 | £000 |
| Minimum lease payments | 2,252 | 2,159 |
| Total | 2,252 | 2,159 |

Note 3.4 Future minimum lease payments

| | 2019/20 | 2018/19 |
|---|--------------|--------------|
| | £000 | £000 |
| - not later than one year | 3,898 | 3,504 |
| - later than one year and not later than five years | 1,183 | 1,528 |
| Total | 5,081 | 5,032 |

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 2020 is £1,000,000 (31 March 2019 £1,000,000).

Note 3.6 Impairment of assets

| | 2019/20 | 2018/19 |
|---|----------------|---------------|
| | £000 | £000 |
| Unforeseen obsolescence | 86 | 0 |
| Changes in market price | (5,233) | 1,197 |
| Other | 0 | 17,767 |
| Total net impairments charged to operating surplus / deficit | (5,147) | 18,964 |
| Impairments charged to the revaluation reserve | 1,080 | 35,132 |
| Total net impairments | (4,067) | 54,096 |

Note 4 Employee expenses

Note 4.1 Employee expenses

| | 2019/20 | 2018/19 |
|---|----------------|----------------|
| | £000 | £000 |
| Salaries and wages | 220,099 | 209,222 |
| Social security costs | 20,194 | 19,205 |
| Apprenticeship Levy | 1,067 | 1,020 |
| Pension cost – defined contribution plans, employer's contributions to NHS Pensions | 35,885 | 23,592 |
| Temporary Staff - Agency / contract staff | 8,596 | 10,360 |
| Total | 285,841 | 263,399 |
| Included within : | | |
| Costs capitalised as part of assets | 337 | 347 |

All employer pension contributions in 2019/20 and 2018/19 were paid to the NHS Pensions Agency.

2019/20 Pension cost includes £11,068,000 due to employer contribution rates increase from 14.3% to 20.6% on 1 April 2019.

The operating employee expense, excluding costs capitalised as part of assets, of £285,504,000 is reported in table 3.1 Operating expenses as Staff and executive directors costs (£271,743,000), Research and Development – staff costs (£8,263,000) and Education and training – staff costs (£5,498,000).

Salaries and wages include for internal temporary bank staff £15,171,000 (2018/19 £15,824,000).

Included in the above figures are the following balances for executive directors:

| | 2019/20 | 2018/19 |
|--|---------|---------|
| | £000 | £000 |
| Directors' remuneration | 1,169 | 1,355 |
| Employer pension contributions in respect of directors | 122 | 122 |

Note 4.2 Average number of employees

| | 2019/20 | 2018/19 |
|---|--------------|--------------|
| | WTE | WTE |
| Medical and dental | 779 | 717 |
| Administration and estates | 1,848 | 1,837 |
| Healthcare assistants and other support staff | 671 | 704 |
| Nursing, midwifery and health visiting staff | 1,988 | 1,947 |
| Scientific, therapeutic and technical staff | 736 | 669 |
| Other | 3 | 3 |
| Total | 6,025 | 5,877 |
| of which | | |
| Number of employees engaged on capital projects | 8 | 8 |

Note 4.3 Exit package cost band (including any special payment element)

| | 2019/20 | 2018/19 |
|--------------------|--|--|
| | Total number of exit packages by cost band | Total number of exit packages by cost band |
| <£10,000 | 0 | 0 |
| £10,000 - £25,000 | 0 | 1 |
| £25,001 - £50,000 | 0 | 0 |
| £50,001 - £100,000 | 0 | 1 |
| Total | 0 | 2 |

Note 4.4 Exit packages: other (non-compulsory) departure payment

| | 2019/20 | 2019/20 |
|--|------------|---------------------------|
| | Agreements | Total value of agreements |
| | Number | £000 |
| Exit payments following employment tribunals or court orders | 0 | 0 |
| Total | 0 | 0 |

| | 2018/19 Agreements Number | 2018/19 Total value of agreements £000 |
|--|---------------------------------|--|
| Exit payments following employment tribunals or court orders | 1 | 15 |
| Total | 1 | 15 |

Note 4.5 Early retirements due to ill health

| | 2019/20 £000 | 2019/20 Number | 2018/19 £000 | 2018/19 Number |
|--|-----------------|-------------------|-----------------|-------------------|
| Number of early retirements on the grounds of ill-health | - | 3 | - | 4 |
| Value of early retirements on the grounds of ill-health | 255 | - | 199 | - |

Note 4.6 Analysis of termination benefits

| | 2019/20 £000 | 2019/20 Number | 2018/19 £000 | 2018/19 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 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 2020, is based on valuation data as 31 March 2019, updated to 31 March 2020 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%, and the Scheme Regulations were amended accordingly.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

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, 1% from 1 April 2014, rising to 2% in April 2018 and 3% in April 2019.

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 March 2020, the NHS foundation trust made contributions totalling £79,000 into the NEST fund (31 March 2019 £42,000).

Note 5 Finance income

| | 2019/20 £000 | 2018/19 £000 |
|--|-----------------|-----------------|
| Interest on bank accounts | 141 | 111 |
| Interest on other investments / financial assets | 117 | 81 |
| Total | 258 | 192 |

Interest receivable relates to interest earned with the Government Banking Service and the National Loans Fund.

Note 6 Finance costs and Public Dividend Capital dividend

Note 6.1 Finance costs

Interest expense amounted to £446,000 (2018/19: £506,000). This is interest due on the following loans taken from the DHSC.

| Date Total Loan Taken | Duration of Loan | Total Loan Amount | Remaining Amount to Withdraw | Amount Repaid | Balance Outstanding | Total Interest |
|-----------------------|------------------|-------------------|------------------------------|---------------|---------------------|----------------|
| | | (£000) | (£000) | (£000) | (£000) | (£000) |
| 20 June 2016 | 20 Years | 20,000 | 0 | 4,208 | 15,792 | 325 |
| 19 September 2016 | 8 Years | 16,000 | 0 | 6,000 | 10,000 | 121 |
| | | 36,000 | 0 | 10,208 | 25,792 | 446 |

The unwinding of discount on provisions amounted to negative £17,000 (2018/19 positive £10,000).

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2019/20 or 2018/19.

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 £4,433,000 (2018/19: £4,840,000), which is 3.50% of the year's average relevant net assets of £165,603,000 (2018/19: £172,051,000) less average daily cleared cash balance £38,957,000 (2018/19: £33,787,000) 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 190 (2018/19: 195) separate losses and special payments, totalling £294,000 (2018/19: £233,000). The bulk of these were in relation to bad debts and ex gratia payments in respect of personal injury.

Losses and special payments are reported on an accruals basis but excluding provisions for future losses. There were no individual cases exceeding £100,000.

| | 2019/20 | 2019/20 | 2018/19 | 2018/19 |
|--|---------------------------------------|------------------------------------|---------------------------------------|------------------------------------|
| | Total Number of Cases Number | Total Value of Cases £000 | Total Number of Cases Number | Total Value of Cases £000 |
| Losses | | | | |
| Cash losses | 31 | 21 | 24 | 8 |
| Bad debts and claims abandoned | 126 | 185 | 130 | 119 |
| Total losses | 157 | 206 | 154 | 127 |
| Special Payments | | | | |
| Ex-gratia payments | 33 | 88 | 40 | 91 |
| Special severance payments | 0 | 0 | 1 | 15 |
| Total special payments | 33 | 88 | 41 | 106 |
| Total losses and special payments | 190 | 294 | 195 | 233 |

Note 7 Intangible assets

Note 7.1 Intangible assets 2019/20

| | Total | Software licences | Assets under construction |
|---|---------------|----------------------|---------------------------------|
| | £000 | £000 | £000 |
| Valuation / gross cost at 1 April | 22,326 | 19,963 | 2,363 |
| Additions – purchased / internally generated | 2,039 | 977 | 1,062 |
| Additions – donation of physical assets (non cash) | 0 | 0 | 0 |
| Reclassifications | 0 | 3,425 | (3,425) |
| Disposals / derecognition | 0 | 0 | 0 |
| Gross cost at 31 March | 24,365 | 24,365 | 0 |
| Accumulated amortisation at 1 April | 10,550 | 10,550 | 0 |
| Provided during the year | 2,149 | 2,149 | 0 |
| Reclassifications | 0 | 0 | 0 |
| Disposals / derecognition | 0 | 0 | 0 |
| Amortisation at 31 March | 12,699 | 12,699 | 0 |
| Net book value at 31 March 2020 | 11,666 | 11,666 | 0 |
| Net book value at 1 April 2019 | 11,776 | 9,413 | 2,363 |

Note 7.2 Intangible assets 2018/19

| | Total | Software licences | Assets under construction |
|--|---------------|------------------------------|--|
| | £000 | £000 | £000 |
| Valuation / gross cost at 1 April | 19,600 | 19,380 | 220 |
| Additions – purchased / internally generated | 2,744 | 267 | 2,477 |
| Additions – donation of physical assets (non cash) | 0 | 0 | 0 |
| Reclassifications | (14) | 320 | (334) |
| Disposals / derecognition | (4) | (4) | 0 |
| Gross cost at 31 March | 22,326 | 19,963 | 2,363 |
| Accumulated amortisation at 1 April | 8,343 | 8,343 | 0 |
| Provided during the year | 2,223 | 2,223 | 0 |
| Reclassifications | (12) | (12) | 0 |
| Disposals / derecognition | (4) | (4) | 0 |
| Amortisation at 31 March | 10,550 | 10,550 | 0 |
| Net book value at 31 March 2019 | 11,776 | 9,413 | 2,363 |
| Net book value at 1 April 2018 | 11,257 | 11,037 | 220 |

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 £5,196,000 (2018/19: £6,116,000) 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 2019/20

| | 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 | 221,360 | 8,662 | 135,825 | 2,805 | 39 | 49,311 | 42 | 24,279 | 397 |
| Additions – purchased | 9,701 | 0 | 4,253 | 0 | 527 | 3,510 | 0 | 1,411 | 0 |
| Additions – donations / grants | 70 | 0 | 70 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged to operating expenses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged to revaluation reserve | (1,080) | 0 | (1,080) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | (566) | 0 | 0 | 566 | 0 |
| Revaluations | 16,865 | 0 | 16,775 | 405 | 0 | 0 | 0 | (315) | 0 |
| Disposals | (17,002) | 0 | 0 | 0 | 0 | (17,002) | 0 | 0 | 0 |
| Valuation/Gross cost at 31 March | 229,914 | 8,662 | 155,843 | 3,210 | 0 | 35,819 | 42 | 25,941 | 397 |
| Accumulated depreciation at 1 April | 57,045 | 0 | 0 | 0 | 0 | 38,961 | 40 | 17,807 | 237 |
| Provided during the year | 8,111 | 0 | 3,768 | 85 | 0 | 2,485 | 1 | 1,762 | 10 |
| Impairments charged to operating expenses | 204 | 0 | 117 | 0 | 0 | 0 | 0 | 87 | 0 |
| Reversal of impairments charged to operating expenses | (5,351) | 0 | (5,351) | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | 1,066 | 0 | 1,466 | (85) | 0 | 0 | 0 | (315) | 0 |
| Reclassifications | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (16,989) | 0 | 0 | 0 | 0 | (16,989) | 0 | 0 | 0 |
| Accumulated depreciation at 31 March | 44,086 | 0 | 0 | 0 | 0 | 24,457 | 41 | 19,341 | 247 |

A desktop valuation for land, buildings and dwellings was carried out at 31st March 2020 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. The valuation included VAT following a Board decision not to proceed with establishment of a wholly owned subsidiary for Estates and Facilities services.

In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19.

Cushman & Wakefield, the NHS foundation trust's valuers have commented on this issue as follows;

The outbreak of the Novel Coronavirus (COVID-19), declared by the World Health Organisation as a "Global Pandemic" on the 11th March 2020, has impacted global financial markets. Travel restrictions have been implemented by many countries.

Market activity is being impacted in many sectors. As at the valuation date, we consider that we can attach less weight to previous market evidence and published build cost information for comparison purposes, to inform opinions of value. Indeed, the current response to COVID 19 means that we are faced with an unprecedented set of circumstances on which to base a judgement.

Our valuation(s) is / are therefore reported on the basis of 'material valuation uncertainty' as per VPS 3 and VPGA 10 of the RICS Red Book Global. Consequently, less certainty – and a higher degree of caution – should be attached to our valuation[s] than would normally be the case. Given the unknown future impact that COVID-19 might have on the real estate market, we recommend that you keep the valuation of these properties under frequent review.

For the avoidance of doubt, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. It is used in order to be clear and transparent with all parties, in a professional manner that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case.

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the NHS foundation trust.

Of the £167,715,000 net book value of land and buildings subject to valuation, £157,554,000 relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the NHS foundation trust of replacing the service potential of the assets. The uncertainty explained above relates to the estimated cost of replacing the service potential, rather than the extent of the service potential to be replaced.

Plant and machinery assets with a total gross value of £17,002,000 were disposed of in 2019/20. These assets had a net book value at disposal of £13,000. The large disposal includes assets which have been held for over 15 years in age and were no longer in use.

Note 8.2 Property, plant and equipment financing 2019/20

| | 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 | 183,022 | 8,662 | 153,803 | 3,210 | 0 | 10,619 | 1 | 6,600 | 127 |
| Donated | 2,806 | 0 | 2,040 | 0 | 0 | 743 | 0 | 0 | 23 |
| Net book value at 31 March | 185,828 | 8,662 | 155,843 | 3,210 | 0 | 11,362 | 1 | 6,600 | 150 |

No assets were held under finance leases and hire purchase contracts at the SoFP date in either 2019/20 or 2018/19.

No depreciation was charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts in either 2019/20 or 2018/19.

There are no restrictions imposed by the donors on the use of donated assets.

Note 8.3 Property, plant and equipment 2018/19

| | 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 | 259,447 | 14,003 | 170,519 | 1,540 | 1,079 | 48,990 | 43 | 22,870 | 402 |
| Additions – purchased | 5,581 | - | 3,807 | - | 332 | 821 | - | 621 | 0 |
| Additions – donations / grants | 133 | 0 | 0 | 0 | 0 | 133 | 0 | 0 | 0 |
| Impairments charged to operating expenses | (21,390) | (987) | (20,403) | 0 | 0 | 0 | 0 | 0 | 0 |
| Impairments charged to revaluation reserve | (35,132) | (4,648) | (30,484) | 0 | 0 | 0 | 0 | 0 | 0 |
| Reversal of impairments credited to operating expenses | 2,426 | 159 | 2,122 | 145 | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | (139) | 135 | 408 | (16) | (1,372) | (109) | (1) | 822 | (6) |
| Revaluations | 10,992 | 0 | 9,856 | 1,136 | 0 | 0 | 0 | 0 | 0 |
| Disposals | (558) | 0 | 0 | 0 | 0 | (524) | 0 | (34) | 0 |
| Valuation/Gross cost at 31 March | 221,360 | 8,662 | 135,825 | 2,805 | 39 | 49,311 | 42 | 24,279 | 396 |
| Accumulated depreciation at 1 April | 53,266 | 0 | 131 | 11 | 0 | 37,031 | 38 | 15,830 | 224 |
| Provided during the year | 6,845 | 0 | 2,327 | 52 | 0 | 2,442 | 1 | 2,011 | 12 |
| Impairments charged to operating expenses | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Revaluations | (2,379) | 0 | (2,327) | (52) | 0 | 0 | 0 | 0 | 0 |
| Reclassifications | (141) | 0 | (131) | (11) | 0 | 0 | 1 | 0 | 0 |
| Disposals | (546) | 0 | 0 | 0 | 0 | (512) | 0 | (34) | 0 |
| Accumulated depreciation at 31 March | 57,045 | 0 | 0 | 0 | 0 | 38,961 | 40 | 17,807 | 236 |

Revised valuations for land, buildings and dwellings were applied twice in 2018/19 by the independent valuer's Cushman and Wakefield.

The first valuation dated 1st April 2018 incorporated the following changes to the basis of valuation:

- A revised 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.
- Exclusion of VAT from the valuation due to the in year establishment of an Estates and Facilities subsidiary.

The second valuation dated 31st March 2019 was a desktop valuation based on the assumptions above.

Note 8.4 Property, plant and equipment financing 2018/19

| | 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 | 161,628 | 8,662 | 134,124 | 2,805 | 39 | 9,394 | 2 | 6,472 | 130 |
| Donated | 2,687 | 0 | 1,701 | 0 | 0 | 956 | 0 | 0 | 30 |
| Net book value at 31 March | 164,315 | 8,662 | 135,825 | 2,805 | 39 | 10,350 | 2 | 6,472 | 160 |

Note 9 Inventories

| | 31 Mar 20 | 31 Mar 19 |
|---------------------------|--------------|--------------|
| | £000 | £000 |
| Consumables | 4,392 | 4,035 |
| Drugs | 3,512 | 3,300 |
| Buildings and engineering | 66 | 78 |
| Total | 7,970 | 7,413 |

Note 10 Receivables

Note 10.1 Trade receivables and other receivables

| | 31 Mar 20 | 31 Mar 19 |
|--|---------------|---------------|
| | £000 | £000 |
| Current | | |
| Contract receivables | 23,731 | 20,631 |
| Contract assets | 724 | 724 |
| Capital receivables | 70 | 0 |
| Allowance for impaired contract receivables / assets | (934) | (880) |
| Prepayments | 3,147 | 2,824 |
| Interest receivable | 24 | 10 |
| PDC dividend receivable | 251 | 508 |
| VAT receivables | 652 | 1,058 |
| Other receivables | 641 | 2,142 |
| Total | 28,306 | 27,017 |
| Non-current | | |
| Contract receivables | 1,688 | 1,405 |
| VAT receivables | 0 | 4,573 |
| Other receivables – revenue | 1,030 | 0 |
| Total | 2,718 | 5,978 |

Of which receivables from NHS and DHSC group bodies

| | | |
|-------------|--------|--------|
| Current | 19,651 | 16,456 |
| Non-current | 1,030 | 0 |

Note 10.2 Allowances for credit losses 2019/20

| | Contract receivables and contract assets £000 | All other £000 |
|--|--|---------------------------|
| Allowances as at 1 April 2019 – brought forward | 880 | 0 |
| New allowances arising | 240 | 0 |
| Reversals of allowances | (154) | 0 |
| Utilisation of allowances (write offs) | (32) | 0 |
| Total | 934 | 0 |

Note 10.3 Allowances for credit losses 2018/19

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

| | Contract receivables and contract assets £000 | All other £000 |
|---|--|---------------------------|
| Allowances as at 1 April 2018 – brought forward | 0 | 885 |
| Impact of implementing IFRS 9 & IFRS 15 on 1 April 2018 | 885 | (885) |
| New allowances arising | 164 | 0 |
| Reversals of allowances | (41) | 0 |
| Utilisation of allowances (write offs) | (128) | 0 |
| Total | 880 | 0 |

Note 11 Trade and other payables

| | 31 Mar 20 £000 | 31 Mar 19 £000 |
|--|---------------------------|---------------------------|
| Current | | |
| Trade payables | 14,453 | 11,123 |
| Capital payables | 2,901 | 1,829 |
| Other taxes payable | 5,986 | 5,606 |
| Other payables | 3,675 | 2,259 |
| Accruals | 10,297 | 12,550 |
| Total | 37,312 | 33,367 |
| Of which payables from NHS and DHSC group bodies: | | |
| Current | 5,533 | 5,419 |

Note 12 Other liabilities

| | 31 Mar 20 £000 | 31 Mar 19 £000 |
|--|-------------------|-------------------|
| Current | | |
| Deferred income: contract liabilities | 7,145 | 2,441 |
| Deferred grants | 527 | 2,511 |
| Total other current liabilities | 7,672 | 4,952 |
| Non-current | | |
| Deferred income: contract liabilities | 1,010 | 0 |
| Deferred grants | 959 | 1,819 |
| Total other non-current liabilities | 1,969 | 1,819 |

Note 13 Borrowings

Note 13.1 Borrowings

| | 31 Mar 20 £000 | 31 Mar 19 £000 |
|---------------------------------|-------------------|-------------------|
| Current | | |
| Loans from DHSC (capital loans) | 3,129 | 3,138 |
| Total | 3,129 | 3,138 |
| Non-current | | |
| Loans from DHSC (capital loans) | 22,740 | 25,792 |
| Total | 22,740 | 25,792 |

Note 13.2 Borrowings Reconciliation of liabilities arising from financing activities

| | Loans from DHSC | Total |
|---|--------------------|---------------|
| | £000 | £000 |
| Carrying value at 1 April 2019 | 28,930 | 28,930 |
| Cash movements: | | |
| Financing cash flows – payments and receipts of principal | (3,052) | (3,052) |
| Financing cash flows – payments of interest | (455) | (455) |
| Non-cash movements: | | |
| Application of effective interest rate | 446 | 446 |
| Carrying value at 31 March 2020 | 25,869 | 25,869 |

Note 14 Provisions

Note 14.1 Provisions for liabilities and charges

| | Current 31 Mar 20 £000 | Current 31 Mar 19 £000 | Non-current 31 Mar 20 £000 | Non-current 31 Mar 19 £000 |
|-------------------------------------|------------------------------|------------------------------|----------------------------------|----------------------------------|
| Pensions – Injury benefits | 127 | 125 | 2,477 | 2,310 |
| Clinician pension tax reimbursement | 0 | 0 | 1,030 | 0 |
| Other | 212 | 230 | 609 | 643 |
| Total | 339 | 355 | 4,116 | 2,953 |

Other contains amounts due as a result of third party and employee liability claims. The values are based on information provided by the NHS Resolution, NHS Business Services Authority and NHS Pensions and have previously been reported in legal claims.

As at 31 March 2020 is included in the provisions of NHS Resolution in respect of clinical negligence liabilities of the NHS foundation trust £267,885,000 (31 March 2019: £287,790,000).

Clinician pension tax reimbursement 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.

Note 14.2 Provisions for liabilities and charges analysis 2019/20

| | Total £000 | Pensions – Injury benefits £000 | Other £000 |
|--|---------------|---------------------------------------|---------------|
| At 1 April 2019 | 3,308 | 2,435 | 873 |
| Change in the discount rate | 239 | 211 | 28 |
| Arising during the year | 1,229 | 64 | 1,165 |
| Utilised during the year – cash | (184) | (89) | (95) |
| Reversed unused | (120) | 0 | (120) |
| Unwinding of discount rate | (17) | (17) | 0 |
| At 31 March 2020 | 4,455 | 2,604 | 1,851 |
| Expected timings of cash flows: | | | |
| -not later than one year | 339 | 127 | 212 |
| -later than one year and not later than five years | 4,116 | 2,477 | 1,639 |
| Total | 4,455 | 2,604 | 1,851 |

Note 15 Revaluation reserve movement

Note 15.1 Revaluation reserve movement – 2019/20

| | Total revaluation reserve £000 | Revaluation reserve – intangibles £000 | Revaluation reserve – property, plant and equipment £000 |
|---------------------------------|--------------------------------------|---|--|
| Revaluation reserve at 1 April | 48,310 | 122 | 48,188 |
| Net Impairments | (1,080) | 0 | (1,080) |
| Revaluations | 15,799 | 0 | 15,799 |
| Transfers to other reserves | (2,614) | (122) | (2,492) |
| Revaluation reserve at 31 March | 60,415 | 0 | 60,415 |

Note 15.2 Revaluation reserve movement – 2018/19

| | Total revaluation reserve £000 | Revaluation reserve – intangibles £000 | Revaluation reserve – property, plant and equipment £000 |
|---------------------------------|--------------------------------------|---|--|
| Revaluation reserve at 1 April | 75,332 | 74 | 75,258 |
| Net Impairments | (35,132) | 0 | (35,132) |
| Revaluations | 13,371 | 0 | 13,371 |
| Transfers to other reserves | (5,261) | 0 | (5,261) |
| Other Reserve Movements | 0 | 48 | (48) |
| Revaluation reserve at 31 March | 48,310 | 122 | 48,188 |

Note 16 Cash and cash equivalents

Note 16.1 Cash and cash equivalents

| | 2019/20 £000 | 2018/19 £000 |
|--|-----------------|-----------------|
| At 1 April | 21,203 | 25,646 |
| Net change in year | 8,415 | (4,443) |
| At 31 March | 29,618 | 21,203 |
| Broken down into: | | |
| Cash at commercial banks and in hand | 139 | 24 |
| Cash with the Government Banking Service | 29,479 | 21,179 |
| Cash and cash equivalents as in SoFP and SoCF | 29,618 | 21,203 |

Third party assets held by the NHS foundation trust at 31 March 2020 were £3,000 (31 March 2019: £3,000).

Note 16.2 Pooled budgets

The NHS foundation trust is not party to any pooled budget arrangements in 2019/20 or 2018/19.

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 £7,166,000 (31 March 2019: £6,689,000). The NHS foundation trust has capital commitments for a number of capital schemes which include the creation of a Command Centre to manage patient flow, the purchase of several pieces of Radiology equipment and the purchase of a number of items relating to the Novel Coronavirus (COVID-19) pandemic.

Note 17.2 Other financial commitments

Other financial commitments at the reporting date were £6,384,000 (31 March 2019: £7,751,000). 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.

Note 18 Contingent liabilities / assets

| | 31 Mar 20 | 31 Mar 19 |
|---|------------------|------------------|
| | £000 | £000 |
| Value of contingent liabilities | | |
| NHS Resolution legal claims | 77 | 87 |
| Employment Tribunal and other employment related litigation | 780 | 0 |
| Total | 857 | 87 |

At 31 March 2020 the NHS foundation trust has £857,000 contingent liability. This includes £77,000 for legal expenses, which is based upon the information provided by NHS Resolution (31 March 2019: £87,000) and £780,000 for the Flowers legal case which seek to reimburse staff for holiday pay while working overtime (31 March 2019: nil).

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 2019/20 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 1.4).

Note 19.2 Related party balances

| | Income £000 | Expenditure £000 |
|--|----------------|---------------------|
| Value of transactions with other related parties 2019/20 | | |
| Charitable fund | 314 | 0 |
| Non-consolidated joint ventures | 38 | 7,915 |
| Other bodies or persons outside of the whole of government accounting boundary | 0 | 0 |
| Total as at 31 March 2020 | 352 | 7,915 |

Value of transactions with other related parties 2018/19

| | | |
|--|------------|--------------|
| Charitable fund | 219 | 0 |
| Non-consolidated joint ventures | 628 | 7,840 |
| Other bodies or persons outside of the whole of government accounting boundary | 93 | 595 |
| Total as at 31 March 2019 | 940 | 8,435 |

| | Receivables £000 | Payables £000 |
|--|---------------------|------------------|
| Value of balances with other related parties 2019/20 | | |
| Charitable fund | 262 | 0 |
| Non-consolidated joint ventures | 825 | 0 |
| Other bodies or persons outside of the whole of government accounting boundary | 0 | 0 |
| Total as at 31 March 2020 | 1,087 | 0 |

Value of balances with other related parties 2018/19

| | | |
|--|------------|------------|
| Charitable fund | 189 | 0 |
| Non-consolidated joint ventures | 282 | 33 |
| Other bodies or persons outside of the whole of government accounting boundary | 0 | 433 |
| Total as at 31 March 2019 | 471 | 466 |

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.

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. Under the terms of the joint venture agreement, the NHS foundation trust is not liable for any losses in the first two years of trading. In year three (2019/2020) of trading the NHS foundation trust is able to receive a 33% share of any profits made, once they exceed the losses in the first two years.

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. Harrogate and District NHS Foundation Trust became a partner in both organisations in October 2019. All three partners now hold a 33.33% equity share.

2019/20 interests in Joint Ventures accounted for using the equity method:

| | Profit £000 | Gross Assets £000 | Net Liabilities £000 |
|-------------------------------------|------------------------|------------------------------|---------------------------------|
| Integrated Laboratory Solutions LLP | 57 | 1,516 | (468) |
| Integrated Pathology Solutions LLP | 262 | 2,482 | (895) |
| Total | 319 | 3,998 | (1,363) |

The combined profit of £319,000 (2018/19: loss of £1,928,000) therefore means the NHS foundation trust has not reflected any entries in the statement of comprehensive income for 2019/20 as there has been a cumulative loss since establishment of £1,609,000.

2018/19 interests in Joint Ventures accounted for using the equity method :

| | Profit £000 | Gross Assets £000 | Net Liabilities £000 |
|-------------------------------------|------------------------|------------------------------|---------------------------------|
| Integrated Laboratory Solutions LLP | 138 | 1,267 | (524) |
| Integrated Pathology Solutions LLP | 1 | 725 | (1,152) |
| Total | 139 | 1,992 | (1,676) |

The NHS foundation trust held a 50% equity share and voting rights in both Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP in 2018/19.

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.

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

The NHS foundation trust's net operating costs are incurred under three year agency purchase contracts with local CCGs, which are financed from resources voted annually by Parliament. The NHS foundation trust receives such contract income in accordance with either the agreed block contract or PbR., which is intended to match the income received in year to the activity delivered in that year by reference to the National Tariff procedure cost. The NHS foundation trust receives cash each month based on an annually agreed level of contract activity, and there are quarterly corrections made to adjust for the actual income due under PbR.

The 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

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

The NHS foundation trust has negligible foreign currency income, expenditure, assets or liabilities.

Credit risk

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

The NHS foundation trust is not materially exposed to any price risks through contractual arrangements.

Note 23 Financial assets and liabilities

Note 23.1 Financial assets by category

| | 31 Mar 20 | 31 Mar 19 |
|---|---------------|---------------|
| | £000 | £000 |
| Assets as per SoFP at 31 March | | |
| Trade and other receivables excluding non-financial assets – with NHS and DHSC bodies | 20,430 | 15,948 |
| Trade and other receivables excluding non-financial assets – with other bodies | 6,544 | 8,084 |
| Cash and cash equivalents at bank and in hand | 29,618 | 21,203 |
| Total | 56,592 | 45,235 |

Note 23.2 Financial liabilities by category

| | 31 Mar 20 | 31 Mar 19 |
|---|---------------|---------------|
| | £000 | £000 |
| Liabilities as per SoFP at 31 March | | |
| Borrowings excluding finance lease and PFI liabilities | 25,869 | 28,930 |
| Trade and other payables excluding non-financial liabilities – with NHS and DHSC bodies | 5,490 | 5,363 |
| Trade and other payables excluding non-financial liabilities – with other bodies | 25,836 | 22,398 |
| Provisions under contract | 1,030 | 0 |
| Total | 58,225 | 56,691 |

All financial liabilities fall within "other financial liabilities".

Note 23.3 Fair values

For all of the NHS foundation trust's financial assets and financial liabilities, fair value matches carrying value.

Note 23.4 Maturity of financial liabilities

| | 31 Mar 20 | 31 Mar 19 |
|---|---------------|---------------|
| | £000 | £000 |
| In one year or less | 34,455 | 30,899 |
| In more than one year but not more than two years | 4,082 | 3,052 |
| In more than two years but not more than five years | 9,156 | 9,156 |
| In more than five years | 10,532 | 13,584 |
| Total | 58,225 | 56,691 |

ACRONYMS

| | |
|--------|---|
| CCG | Clinical Commissioning Group |
| CQUINS | Commissioning for Quality and Innovation |
| CSU | Commissioning Support Unit |
| DHSC | Department of Health and Social Care |
| EU | European Union |
| 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 |
| 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 |
| SoCI | Statement of Comprehensive Income |
| SoCF | Statement of Cash Flows |
| SoFP | Statement of Financial Position |
| VAT | Value Added Tax |
| WTE | Whole Time Equivalents |

