Bradford Teaching Hospitals
NHS Foundation Trust

Annual Report and Accounts 2020/21

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

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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 around 5,700 people working across six sites.

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

We are one of the few hospitals around the country that 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, our vision for the Trust describes our ambition and where we want to be as an organisation:

"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

Without doubt, 2020 has been the toughest year in the history of the Trust and, indeed, the wider NHS. Our staff have experienced the relentless challenges of the COVID-19 pandemic first-hand.

But, in the face of adversity and at times sadness, we have also witnessed incredible compassion, strength and unity from our colleagues, our partners, and our communities.

Many people lost their lives to COVID-19, but well over 2,800 patients who were admitted to our hospital with it recovered and were discharged home after surviving this terrible virus.

Winter is always a pressurised time for our region's health and care services, but with COVID-19 continuing to spread throughout the year, our services were stretched as never before.

We are proud to have played a part in medical and scientific breakthroughs in the race to find a vaccine, and treatments which could help protect patients with COVID-19 from developing serious illness requiring intensive care.

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

The pandemic forced rapid change to new ways of working that we all had to adapt to. From the national lockdown on 23 March last year, so much of what we do had to transform virtually overnight – and this was only possible thanks to the commitment and sheer hard work of our people. We have produced a separate report to document our learning from COVID, which will be published on our website[1] in the Summer of 2021.

Bradford had a consistently high number of COVID patients in hospital throughout the year: there was no down-time for our staff. But we consistently kept at the job of caring for our patients while still looking forward and transforming services.

And our staff continued to get national recognition for their efforts during the pandemic. Intensive Care Consultant, Dr Tom Lawton, was awarded an MBE for his services to the NHS during the pandemic, and Physiotherapist, Cordy Gaubert, won a top Health Heroes award for her 'outstanding' work in the fight against COVID-19.

In May our Trust was chosen as one of five national Patient Recruitment Centres for cutting edge treatment trials – including for COVID-19. The new research centre, part of a £7m Government investment, has helped people across the region to take part in important late-phase commercial clinical research.

In December an 85-year-old man became one of the first people in Bradford to receive a COVID vaccine as our Trust became a vaccine hospital hub – marking the start of the district's vaccine programme to protect patients, care home staff and frontline NHS staff.

During the pandemic, the support we have had from local people and communities – in both donations of money and in kind - has been overwhelmingly generous and much appreciated. Bradford Hospitals' Charity received £881,000 in income - £391,000 of which was related to COVID-19, and there were a further £150,000 of donations in kind to our staff, including food, drink and self-care items. Alongside this, we have put donations from our radiology and neonatal appeals to excellent use, giving support to patients, their families and our staff. 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**.**

We joined forces with local health and social care services to launch a new digital roadmap for Bradford district and Craven to help people to be happy, healthy and at home. *People First: Digital First* shows how patient care has been, and will continue to be, better and safer through innovative digital technology.

And we appointed our first Living Donor Co-ordinator to help raise awareness of living kidney donation across Bradford and Airedale. We also unveiled a new memorial which honours people whose gifts of organ and tissue donation in death have given life to so many others.

The New Year saw the start of a multi-million-pound building project to improve the obstetric theatres and labour ward facilities at Bradford Royal Infirmary (BRI). This is part of more than £9m worth of improvements to our main hospital for the benefit of patients and staff.

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

And we took our next steps to becoming an outstanding maternity service provider with the launch of a two-year programme of work which is set to transform care for the women and families in the district.

We are investing £4.9m in capital funds (including research and development) across two building projects at BRI and NHS Improvement (NHSI) are providing £4.25m for three ward refurbishment programmes.

2.1.3. Purpose and activities of the Foundation Trust

All foundation trusts are required to have a constitution, containing detailed information about how they will operate. The purpose of the Trust is set out in its constitution[2] 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 have five strategic objectives that link between our mission and vision statements, and the actions to deliver them. They are to:

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

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

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

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

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

[2] https://www.england.nhs.uk/wp-content/uploads/2019/09/Bradford_Teaching_Hospitals_NHS_FT_-_constitution_January_2018.pdf

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

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

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

A new, longer term corporate strategy will be developed during 2021/22. This will include our work to 'reset and restart' following COVID-19, and to progress digital transformation, strengthen sustainability and consider our strategic estate.

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.

This CBU model has been consolidated in 2020/21, with operational managers and clinical leaders working in partnership to harness the expertise, innovation and creativity of all staff to deliver improved outcomes for patients and improved operational and financial performance.

Figure 1: Clinical business units

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

[3] https://www.bradfordhospitals.nhs.uk/ppp/
[4] https://www.bradfordhospitals.nhs.uk/working-with-our-partners/

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

2.1.4. History of the Trust and statutory background

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[5].

In addition to Bradford Royal Infirmary, the Trust has five further sites at St Luke's Hospital, Westbourne Green, Westwood Park, Shipley, and Eccleshill Community Hospital and serves a population of around 530,000 people from Bradford and the surrounding area. We have approximately 800 acute beds, employ over 5,700 permanent members of staff, and have more than 500 volunteers supporting our services, although their contribution has been sadly missed this year due to COVID-19 restrictions limiting access to our hospitals. Ordinarily, in a non-pandemic 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. In 2020/21 our Trust services delivered 4,919 babies, performed 51,607 operations and handled 359,543 outpatient appointments. We had 108,513 attendances at our Emergency Department.

2.1.5. Key issues, opportunities and risks affecting the Trust

The Trust uses a Board Assurance Framework (BAF) as a tool for the Board of Directors to assure itself of, or describe the confidence that it has about, the successful delivery of its strategic objectives. The strategic risks described in the BAF are based on a collective assessment by the executive directors. The mitigation of these risks is scrutinised by the non-executive directors through the Board Academies and Regulation and Assurance Committee. 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.

[5] https://www.legislation.gov.uk/ukpga/2003/43/contents

The key risk that the Trust was exposed to during 2020/21 was the impact of the pandemic on our ability to maintain operational performance, impact on quality of patient care and staff wellbeing.

Other key risks were as follows:

- There is a risk that, due to our above average stillbirth rate, reduced one-to-one care in labour rate, and a CQC rating of 'requires improvement', members of the public and external stakeholders may lose confidence in the service. This risk was mitigated through the implementation of the outstanding maternity services programme, progress against which is reported to the Board on a regular basis.
- There is a risk that patients may come to harm due to delays in the diagnostic pathway due to insufficient endoscopy capacity. A recovery plan is in place and is monitored on a weekly basis. Capacity has been increased wherever possible. The independent sector has been used to provide additional capacity.
- There is a risk that patients with a mental health diagnosis may not be treated appropriately due to a lack in staff knowledge/awareness and provision of expert clinical advice (mental health). The Board approved a mental health strategy for the Trust in March 2021. A mental health practitioner has been appointed and training in restraint and de-escalation is being implemented for relevant staff.
- If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, significant business continuity impact due to failure of estates infrastructure/engineering systems/building fabric will be experienced. An identified backlog maintenance programme of work has been identified, risk assessments and weighted assessments for backlog risk prioritisation has been undertaken, and a current facet survey inspection has been done to identify and allocate funding resources. Planned preventative maintenance is done as per statutory and good practice guidance to maintain buildings and building services plant and equipment. A strategic outline case has also been submitted to NHS England/Improvement to seek capital funding for a new development.

The Trust's highest scoring risks as at March 2021 are described in the Annual Governance Statement (section 3.8.5.2).

Through responding to the pandemic, the Trust has identified opportunities for learning and improvement such as enhancing the use of technology for remote consultations and innovations such as the use of early CPAP in moderate or severe respiratory failure due to COVID-19. These are outlined in more detail in our report 'Learning from the COVID-19 pandemic – a Bradford Teaching Hospitals perspective', which will be available on our website from Summer 2021.

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. The Board therefore has had clear sight of significant risks and ensured actions are prioritised appropriately.

2.1.6. GOING CONCERN DISCLOSURE

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

2.1.7. SUMMARY OF PERFORMANCE

2.1.7.1. Performance summary

During the 2020/21 financial year, the Trust faced unprecedented challenges due to the global pandemic. Throughout this period we have worked hard to maintain delivery of safe, high quality services whilst maintaining close oversight on performance against the core contractual targets. This includes those indicated within the NHS Oversight Framework 2019/20[6] (NHSOF) and the recovery targets set by NHS England and NHS Improvement in September 2020.

The pandemic has had a significant impact on the Trust's operational performance. Cessation of routine elective procedures, outpatient appointments and diagnostic tests caused deterioration in cancer, referral to treatment and diagnostic standards as well as placing pressure on bed occupancy and the emergency care standard. Throughout this challenging period the Trust has ensured that it has maintained access to urgent services and delivered care in such a way as to minimise the risk to patients of infections acquired in hospital (known as nosocomial spread).

The table below (figure 2) describes the results achieved against the core operational key performance indicators (KPIs) within the NHSOF. There are usually targets for each of the indicators but due to Covid they were not applied in 2020/21 however the Trust still did its best to deliver against the indicators.

Figure 2: Monthly results achieved against KPIs 2020/21

KPI	4 Hour Emergency Care Standard	Cancer two week wait	Cancer 62 day first treatment	Diagnostic six week wait	18 weeks RTT Incomplete
Apr-20	90.28%	88.09%	80.74%	33.70%	70.61%
May-20	92.10%	97.65%	80.90%	28.90%	59.48%
Jun-20	93.40%	97.44%	73.47%	32.48%	47.22%
Jul-20	95.24%	98.38%	80.58%	45.80%	45.19%
Aug-20	91.72%	97.41%	82.76%	56.26%	52.98%
Sep-20	88.37%	93.83%	73.78%	53.76%	62.52%
Oct-20	85.76%	93.77%	66.84%	61.76%	70.48%
Nov-20	86.43%	94.05%	73.99%	65.26%	70.52%
Dec-20	86.82%	96.18%	75.00%	66.33%	69.24%
Jan-21	84.33%	94.06%	68.94%	63.64%	67.95%
Feb-21	82.84%	96.82%	71.28%	69.64%	65.85%
Mar-21	85.41%	95.54%	78.72%	77.70%	67.81%
2020/21	**88.46%**	**95.54%**	**78.72%**	**54.90%**	**63.23%**
2019/20	76.61%	93.61%	81.75%	96.43%	84.78%

Throughout this period, emergency care standard and cancer waiting times performance have benchmarked positively against peer and national averages. Overall cancer treatment numbers have remained high and the extended waiting times created during the first wave have reduced significantly. There has been particular impact on diagnostic capacity (endoscopy) however the recovery actions are progressing well, with independent sector support secured during quarter four for the modalities in greatest need. Elective activity has been restricted during the whole of 2020/21 which has negatively impacted on treatment waiting times however clinical prioritisation processes have been in place since April 2020 which has ensured the most urgent operations have continued to be listed for surgery. Independent sector support remains in place to ensure delays are minimised.

[6] https://www.england.nhs.uk/publication/nhs-oversight-framework-for-2019-20/

The Trust has detailed plans in place to support recovery against these standards whilst maintaining the highest standards of quality of care during 2021/22.

2.1.7.2. Finance summary

To facilitate the NHS's response to the pandemic, NHS England/NHS Improvement (NHSE/I) introduced an interim financial framework for providers and commissioners in 2020/21. The established financial regime was suspended and replaced with a simplified framework designed to ensure providers received sufficient cash to facilitate the required response to the pandemic. Normal contractual arrangements with commissioners were suspended and replaced with a centrally defined block funding mechanism not linked to activity levels. The simplified framework reimbursed providers for any legitimate exceptional revenue costs of their response to the pandemic. The Trust incurred £23.6m of exceptional revenue costs related to the pandemic of which, £0.8m related to supporting the vaccination programme.

The interim national NHS financial regime meant there was no traditional efficiency target to be delivered in 2020/21. Instead, the Trust was required to deliver a £1.8m deficit to contribute to the West Yorkshire Integrated Care System's (ICS) overall break even target set by NHSE/I. The Trust has reported a breakeven position for 2020/21, which is £1.8m better than the planned deficit. This improvement in the cost position is largely attributed to reduced variable expenditure on elective work due to the suppression of this activity by the ongoing pandemic response in Quarter 4.

The final income and expenditure position for 2020/21 is summarised in the table below.

Details	20/21 plan £m	20/21 actual £m	Variance £m
Income			
NHS block	407.9	419.7	11.8
Other income	29.4	47.4	18
Exceptional pandemic funding	26.9	26.9	0
Total income	**464.2**	**494**	**29.8**
Expenditure			
Pay	-298.7	-318.5	-19.7
Non-pay	-163.5	-171.7	-8.2
Cost improvement programme /efficiency	-3.8	-3.8	0
Total expenditure	**-466**	**-494**	**-28**
Margin	**-1.8**	**0**	**1.8**

2.1.8. DISCLOSURE ON EQUALITY OF SERVICE DELIVERY

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

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

organisation. We will continue to publish equality impact assessments in line with our contractual and legal requirements.

2.1.8.2. Equality of service delivery: data

We collect data about age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation as part of a number of patient feedback measures. Examples of where this data is collected include the NHS Friends and Family Test[7], feedback from our patient experience service[8] which includes almost 1500 patient contacts in the last year, and national Care Quality Commission (CQC) surveys[9] in which the Trust participates.

The Friends and Family Test was on hold for a time due to the pandemic but was reintroduced in November 2020. We use the data to help inform service delivery and improvements in care to the diverse communities that we service.

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

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

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

In addition to the work being undertaken at place level there are a number of initiatives undertaken with our own Patient Experience and Chief Nurse team to promote the equality of service in relation to protected characteristics. We are learning continually from patient feedback and complaints, and our leads for equality, diversity and inclusion are involved in the review of any complaints pertaining to equality and diversity issues.

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

- The chaplaincy team have employed a specialist academic to develop the "Bradford Model" to chaplaincy. This model aims to implement an inclusive service to ensure that we reach all members of the community who require any kind of pastoral support and ensure that we don't discriminate against race, age, gender or religious belief.

- We are working with recognised partners to provide comprehensive guidance about access to our sites. This includes bespoke mapping of our premises in terms of accessibility as well as locations of patient and visitor toilets and changing facilities.

- We adhere to the Accessible Information Standard[10] and provide information in different formats which include easy read, large print braille, and text-phone for hearing and speech difficulties. Our interpreting services provides written and verbal translations where required and supports clinic appointments.

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

- During the pandemic we have adapted and established a relatives' telephone line manned by clinical colleagues who have liaised with wards and relatives to keep them apprised of the care and treatment their loved ones are receiving whilst in hospital. This has been a vital service that has received positive feedback whilst restrictions to visiting have been in place.

Signed

Mel Pickup
Chief Executive
10 June 2021

3. ACCOUNTABILITY REPORT

3.1. DIRECTORS' REPORT

The Board of Directors consists of people with the range of experience and expertise necessary to steward the Trust. They provide the vision, oversight and encouragement required for the Trust to thrive. They make decisions collectively according to the Reservation of powers to the Board and scheme of delegation[11] (February 2020), they each share the same responsibility and liability. The chairman and the non-executive directors are accountable to the Council of Governors.

The Board of Directors is responsible for all aspects of the operation and performance of the Trust, and for its effective governance. This includes setting the corporate strategy and organisational culture, taking those decisions reserved for the Board, and being accountable to our stakeholders for those decisions. The Board is responsible for the preparation of the annual report and accounts. The Board considers whether the annual report and accounts, taken as a whole, are fair, balanced, and understandable. It provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy. The scheme of delegation[12] sets out the matters reserved for the Board of Directors in full.

In 2020/21, the Board of Directors included the following positions: Dr Maxwell Mclean - Chairman, Ms Selina Ullah - Deputy Chair and Senior Independent Director, and Professor Mel Pickup, Chief Executive.

All directors are required to meet the standards of the 'fit and proper persons requirement[13]' and to make annual declarations. The register of declarations of interests[14] provides details of external directorships and other positions of authority held by the directors of the Trust and is made publicly available on the Trust's website.

Our constitution was last approved by the Board and the Council in January 2018.

[11] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2020/06/CG04-2020-Reservation-of-Powers-to-the-Board-and-Scheme-of-Delegation.pdf
[12] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2020/06/CG04-2020-Reservation-of-Powers-to-the-Board-and-Scheme-of-Delegation.pdf
[13] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-19-fit-proper-persons-employed
[14] https://bthft.mydeclarations.co.uk/declarations

Further information about the Board of Directors[15] is available on our website or, from the Associate Director of Corporate Governance/Board Secretary at:

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

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

3.1.1. The Board of Directors

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

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

Full details regarding the Board's responsibilities, as required to be disclosed under the NHS Foundation Trust Code of Governance[16], are available on page 62.

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

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

The Board has set out the Trust's vision and values[17] alongside the mission of providing the highest quality healthcare at all times. Our clinical strategy[18] was set in 2017. In 2020 the Board

[15] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/
[16] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/327068/CodeofGovernanceJuly2014.pdf
[17] https://www.bradfordhospitals.nhs.uk/our-trust/our-vision-and-values/
[18] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2018/02/bthft_clinical_service_strategy_2017-2022-20170920084540.pdf

approved People, Partners and Place[19], our plan for the year ahead. This plan sets out the first steps in our journey towards jointly developing a new five-year strategy with partners across Bradford district and Craven (our 'Place') so that we 'Act as One' to deliver care in an integrated way, bringing our services closer to those who need them and making a real difference to the lives of our residents.

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

For 2020/21 the Board of Directors included the following members:

Figure 3 - Non-executive directors 2020/21

Name	Role	Term start	Term end
Dr Maxwell Mclean	Chairman	01/05/2019	30/04/2022
Ms Trudy Feaster-Gee	Non-Executive Director	01/01/2018	31/12/2020
Mr Mohammed Hussain	Non-Executive Director	01/09/2019	01/08/2022
Ms Julie Lawreniuk	Non-Executive Director	01/09/2019	31/08/2022
Mr Jon Prashar	Non-Executive Director	01/02/2018	31/01/2024
Mr Altaf Sadique	Non-Executive Director	01/12/2020	31/11/2023
Mr Barrie Senior	Non-Executive Director	01/12/2017	30/11/2023
Professor Laura Stroud	Non-Executive Director	23/10/2017	22/10/2020
Ms Selina Ullah	Non-Executive Director	01/09/2015	31/08/2021
Ms Karen Walker	Non-Executive Director	01/01/2021	31/12/2023

During 2020/21 two non-executive directors tendered their resignations due to competing pressures. These were Professor Laura Stroud and Ms Trudy Feaster-Gee. Both were commended by the Board for their contributions to the Trust during their terms. Mr Altaf Sadique was welcomed as a new non-executive member of the Board in December 2020 following his appointment by the Council of Governors to fill the vacancy left as a result of Mr Amjad Pervez's resignation in the previous year (2019/20). Ms Karen Walker joined the Board in January 2021 following her appointment by the Council to fill the vacancy left by Ms Trudy Feaster-Gee. The nomination for a non-executive director to fill the vacancy left by Professor Stroud is currently being considered with the School of Medicine, University of Leeds.

Figure 4: Executive directors 2020/21

Name	Role	Appointed	To
Professor Mel Pickup	Chief Executive	01/11/2019	Present
Mr Sajid Azeb	Chief Operating Officer	12/10/2020	Present
Ms Pat Campbell*	Director of Human Resources	01/12/2008	Present
Ms Karen Dawber	Chief Nurse	29/08/2016	Present
Ms Cindy Fedell*	Chief Digital and Information Officer	13/09/2013	30/09/2020
Dr Bryan Gill	Chief Medical Officer	05/05/2015	31/12/2020
Mr John Holden	• Director of Strategy and Integration • Interim Chief Executive • Director of Strategy and Integration/Deputy Chief Executive	22/08/2016 01/04/2019 01/05/2018	01/05/2018 31/10/2019 Present
Mark Holloway*	Director of Estates and Facilities	12/11/2020	Present
Mr Matthew Horner	• Acting Director of Finance • Director of Finance	01/11/2011 01/08/2012	01/08/2012 Present

[19] https://www.bradfordhospitals.nhs.uk/ppp/

Name	Role	Appointed	To
Dr Paul Rice*	Chief Digital and Information Officer (BTHFT and Airedale NHS FT)	01/01/2021	Present
Ms Sandra Shannon	• Acting Chief Operating Officer • Chief Operating Officer • Chief Operating Officer/Deputy Chief Executive	08/01/2018 01/04/2018 01/05/2018	31/03/2018 01/05/2018 31/10/2020
Dr Ray Smith	Chief Medical Officer	01/01/2021	Present
**Non-voting executive director*			

Board profiles

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

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

The Board of Directors considers annually the independence of the Board and for 2020/21 it confirms that it considers all the non-executive directors (including the Chairman) 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 judgement.

Non-executive directors

Dr Maxwell Mclean, Chairman

Maxwell joined the Trust on 1 May 2019 from Bradford City Clinical Commissioning Group (CCG), where he had been lay member for patient and public involvement and vice-Chairman 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 reference 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 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 multi-disciplinary clinical team which is tasked with ensuring that NHS Digital's services have the appropriate clinical assurance and governance. Mohammed has been working in national clinical informatics roles since 2009, delivering services such as the Electronic Prescription Service, NHS Mail, Summary Care Records and more across England. He is also a Founding Fellow of the Faculty of Clinical Informatics. Mohammed was a Council Member on the General Pharmaceutical Council, the pharmacy regulator, and is a Fellow of both the Royal Pharmaceutical Society and the Association of Pharmacy Technicians UK, both awards recognising distinction for services to the profession of Pharmacy. He has previously held roles as a lecturer practitioner at the University of Leeds, and a pharmaceutical advisor for the NHS in Leeds. He is currently a member of the Expert Advisory Board for the School of Pharmacy at Bradford University. Mohammed continues to practice as a pharmacist alongside his other duties at NHS Digital, the Trust and NHS England. He is passionate about health technology, championing diversity and delivering excellent clinical care.

Ms Julie Lawreniuk, Non-Executive Director

Qualified accountant Julie 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 CCGs. She brings a wealth of NHS experience, with a career that has spanned over 27 years working across several 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.

Mr Jon Prashar, Non-Executive Director

Jon has over 30 years' experience of working in the public, private and voluntary sectors and a background in construction, organisational development and training. He has 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 various Equality and Diversity Boards and a board member of Leeds and Yorkshire Housing Association. Jon also operates as a consultant for various organisations including the charity Enhance The UK. Jon has a visual impairment and considers himself to be the very lucky owner of a guide dog.

Mr Altaf Sadique, Non-Executive Director

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

Mr Barrie Senior, Non-Executive Director

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

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. She 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 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.

Karen Walker, Non-Executive Director

Karen has spent 30 years in the Customer Services industry, gaining a wealth of experience spanning financial services, utilities and telecoms at brands such as telephone and online bank First Direct, Centrica and Virgin Media. She is currently Director of Strategy and Change at the Independent Parliamentary Standards Authority, the independent regulator of MPs' pay and business costs, and is responsible for developing and delivering a three-year strategy that creates a customer-focused culture and a sustainable, efficient and seamless service for the UK's 650 MPs and their staff. She has a background in operational and change leadership, culture change, regulation, credit management

and customer service excellence and is renowned for developing purposeful customer-centric cultures to drive advocacy and great customer outcomes, breaking down barriers to service excellence. Karen has a keen interest in people and customers and firmly believes valued people value customers. She is looking forward to translating her experience into helping Bradford achieve great patient outcomes and service excellence. Yorkshire born and bred, Karen enjoys being outdoors and spends most of her spare time at the side of a rugby pitch, supporting her son and keeping the players safe in her role as Club Welfare Officer at Siddal ARLFC.

Executive Directors

Professor Mel Pickup, Chief Executive Officer

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 Sajid Azeb

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

Ms Pat Campbell, Director of Human Resources

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

Ms Karen Dawber, Chief Nurse

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

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. She is the Digital senior responsible owner 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.

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 is chair of the Medical Directors and Vascular Network WYAAT group and deputy chair of the West Yorkshire and 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.

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 Interim 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.

Mark Holloway, Director of Estates and Facilities

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

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

He has developed a range of estate strategies and large multi-million-pound capital development programmes

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

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 almost 30 years and covers a variety of finance roles. For the last 20 years, he has worked for the Trust in Bradford, progressing from Finance Manager to Deputy Director of Finance. Matthew subsequently joined the Board as Acting Director of Finance in November 2011 and was appointed substantive Director of Finance in August 2012.

Dr Paul Rice, Chief Digital and Information Officer

Paul Rice has joined Bradford and Airedale NHS foundation trusts from his role as Regional Director of Digital Transformation for NHS England and NHS Improvement in the North-East and Yorkshire. He has been responsible for supporting and enabling the rapid and effective uptake of digital technology in care pathways and new service models across health and care including most recently the COVID-19 vaccination programme and work to digitise care homes. He has been the senior responsible owner for substantial national digital transformation programmes relevant to hospital electronic patient records, mental health, transforming primary care, maternal and child health. Paul was formerly the Director of the long-term conditions programme in Yorkshire and Humber with a focus on Telehealth. He has been a Primary Care Trust director, a transformation director in the NHS Modernisation Agency and a policy lead in the Department of Health. He has published and spoken widely on the challenges and opportunities to deliver new service models using assistive technology/telehealth/information technology. He is passionate about inclusive digital transformation, ensuring diversity of interest and experience hugely influences care. Paul holds a BA degree in Law and Accounting (Manchester), a master's in informatics leadership (Imperial) and a Doctorate in medical law and bioethics (Manchester). He is also a graduate of the Saïd Business School (Oxford), where he completed the Major Projects Leadership Academy, and a Fellow of the British Computing Society. Paul is a trustee of Yorkshire Cancer Research and a volunteer fundraiser with Macmillan Cancer Support. He is married to Heather, is the father of three children and, while a native of Belfast, has lived in Yorkshire for over 20 years. He is a keen Leeds United football fan, an avid racegoer and

enjoys live music and Yorkshire's finest grub and tipples.

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.

Dr Ray Smith, Chief Medical Officer

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

Attendance at meetings of the Board of Directors during 2020/21

During 2020/21 our governance framework was affected as we responded to the pandemic. A new governance model signalling revised governance arrangements and responsibilities, first agreed in autumn 2020, has been further developed and implemented. Further details are in the Annual Governance Statement in section 3.8.5.7.

Board meetings have continued to take place bi-monthly. However, in light of government restrictions on groups of people meeting, our meetings of the Board of Directors took place virtually, and were not accessible to the public. To address this, since November 2020 the recordings from the meetings have been published online[20] along with annotated agendas. The following table reports on the number of meetings attended by Board members in-year.

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

Figure 5: 2020/21 Board of Directors attendance

BOARD MEMBERS		Meetings attended
Professor Mel Pickup	Chief Executive Officer	6 of 6
Mr Sajid Azeb	Chief Operating Officer	3 of 3
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	4 of 4
Ms Cindy Fedell	Chief Digital and Informatics Officer	3 of 3
Dr Bryan Gill	Chief Medical Officer	4 of 4
Mr John Holden	Deputy Chief Executive/Director of Strategy and Integration	6 of 6
Mr Matthew Horner	Director of Finance	4 of 6
Mr Mohammed Hussain	Non-Executive Director	5 of 6
Ms Julie Lawreniuk	Non-Executive Director	6 of 6
Dr Maxwell Mclean	Chairman	6 of 6
Mr Jon Prashar	Non-Executive Director	5 of 6
Dr Paul Rice	Chief Digital and Informatics Officer	2 of 2
Mr Barrie Senior	Non-Executive Director	6 of 6
Dr Ray Smith	Chief Medical Officer	2 of 2
Professor Laura Stroud	Non-Executive Director	3 of 3
Ms Sandra Shannon	Deputy Chief Executive/Chief Operating Officer	2 of 3
Ms Selina Ullah	Non-Executive Director	6 of 6

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

Committees of the Board of Directors

In line with statutory requirements the Board of Directors has a (Board) Nominations and Remuneration Committee (further details on the activities of this committee are available on in section 3.2.3.2.) and an Audit and Assurance Committee (AAC). The work of the AAC is detailed further in this chapter. In addition, the Board has established a Charitable Funds Committee**.** The terms of reference for all Board committees are available as part of the Board of Director Standing Orders[21].

In March 2020 the Board of Directors established an Executive/Non-Executive Regulation Committee (now referred to as the Regulation and Assurance Committee) as an emergency response to ensure appropriate governance during the pandemic. The remit of the committee which remains in place as at April 2021 is to provide the Foundation Trust Board with an objective and independent review (including relevant strategic risks and associated assurance) of the controls associated with the delivery of the Trust's strategic objectives. This committee has met on 10 occasions during 2020/21. Reports from the AAC and Regulation and Assurance Committee Chairs are presented at the open Board of Directors and as part of the Council of Governor meetings.

Audit and Assurance Committee

The purpose of the AAC 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 AAC are included within the Terms of Reference (contained within the Board Standing Orders) which are reviewed annually and approved by the Board of

[21] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2020/02/CG02-2019-Standing-Orders-Board-of-Directors.pdf

Directors. In 2020 the AAC undertook the appointment of the external auditor as part of the Council of Governors Working Group. The recommendation from the Chairman of the AAC was accepted by the Council at its closed meeting held in April 2020. Further details regarding the process undertaken to appoint the external auditor are included under section 3.5.5.1.

With regard to the additional work of the AAC during 2020/21, the committee considered and reviewed the following reporting from internal audit:

- Internal Audit Annual Report and Head of Internal Audit Opinion
- Internal Audit Plan for 2020/21
- Regular internal audit progress reports
- Regular reports concerning follow up of internal audit recommendations
- Counter fraud progress reports
- Annual internal audit performance review
- A number of bespoke and benchmarking reports
- Monthly insight reports from The Internal Audit Network (TIAN)

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

- Annual Accounts 2020/21 update
- Annual Governance Statement
- Annual Report 2019/20
- Annual Report and Quality Report 2020/21 production schedule
- Annual review of terms of reference and submission to board
- Appropriateness of single source tenders
- April 2020 CQC 'good' rating
- Assessment of bank controls
- Assurance Framework
- BHTFT Annual Accounts 2019/20
- BAF and strategic risk register
- Board Committee Assurance
- Board Committee Oversight: Governance and Process
- BTHFT draft Annual Report 2019/20
- Clinical audit
- Clinical audit annual report
- CQC compliance
- Cyber security update
- Data quality (DQ) assurance
- Effectiveness of whistleblowing/Freedom to Speak Up arrangements
- Exception reports: schedules of losses and special payments
- New governance structure update
- Quality Account 2019/20 assurance
- Quality oversight during COVID-19
- Review of the Audit Committee terms of reference
- Business continuity update
- Security management standards for providers
- Self-certification with regard to the provider licence
- The High Priority Audit Programme Plan - 2020/21: Responding to National Mandated HQIP Audit Programme

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

- External audit report 2019/20
- Annual Report and Accounts ISA 260

- Draft letter of Representation 2019/20 (Annual Report and Accounts)

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

- Internal audit plan
- External audit plan
- Trust Annual Accounts 2019/20.
- Audit Committee annual report to Board
- Audit Committee annual self-assessment, terms of reference and work plan 2020/21

Throughout 2020/21 the committee considered the following significant risks highlighted by the external auditor, Deloitte LLP.

- Capital expenditure
- Management override of controls

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

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

The committee's membership has been as follows:

- Mr Barrie Senior, Non-Executive Director, Committee Chair
- Ms Selina Ullah, Non-Executive Director
- Mr Jon Prashar, Non-Executive Director
- Ms Julie Lawreniuk, Non-Executive Director (from February 2021)

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

Figure 6: 2020/21 Audit and Assurance Committee attendance

Audit and Assurance Committee membership	Meetings attended
Mr Barrie Senior, Audit and Assurance Committee Chair	6 of 6
Ms Julie Lawreniuk, Non-Executive Director	2 of 2
Mr Jon Prashar, Non-Executive Director	4 of 6
Ms Selina Ullah, Non-Executive Director	3 of 6

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

3.1.2. Better Payment Practice Code

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

Figure7: Better Payment Practice Code

	2020/21		2019/20	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in-year	47,126	211,628	51,767	203,663
Total non-NHS trade invoices paid within target	44,171	195,963	47,373	189,457
Percentage of non-NHS trade invoices paid within target	94%	93%	92%	93%
Total NHS trade invoices paid in-year	1,849	16,293	2,728	15,359
Total NHS trade invoices paid within target	1,666	14,320	2,066	12,028
Percentage of NHS trade invoices paid within target	90%	88%	76%	78%

We aim to improve transactional processing to pay creditors within this target whilst maintaining a balance on appropriate authorisation and validation of invoices. Adherence to the code has improved for payments to both NHS and non-NHS organisations with performance improving by number and value.

3.1.3. NHS IMPROVEMENT'S WELL-LED FRAMEWORK

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

Patient care

The Trust was last inspected by the CQC in December 2019 (the report being published on 9 April 2020). The Trust's rating for the well-led domain[22] is 'good'. The reasons for this can be read in their report on the CQC website[23].

In recognition of the unprecedented pressures on the NHS during the pandemic, the CQC suspended its routine inspection regime. However, regular virtual engagement meetings continued during the year.

We responded to NHS England's Board Assurance Framework for Infection Prevention and Control[24] (IPC BAF), submitting to the CQC our evidence and assurance that all risks had been identified and mitigated appropriately. The Board of Directors continues to receive regular reports and updates of the IPC BAF to ensure that on-going and evolving risks are being managed appropriately.

The CQC also developed an 'Emergency Support Framework[25]' to establish how NHS providers were managing services during the pandemic. We took part in a series of virtual meetings with the CQC providing assurance and evidence of how the Board of Directors continued to have oversight of risk, patient safety and quality during the pandemic.

A further engagement call focussing on urgent and emergency services and potential winter pressures also took place with the CQC in November 2020. We provided further evidence and assurance highlighting our approach to managing patients presenting with COVID-19 whilst maintaining a routine service.

[22] https://www.cqc.org.uk/guidance-providers/nhs-trusts/what-we-will-inspect-nhs-trusts
[23] https://api.cqc.org.uk/public/v1/reports/edcfb304-14c0-4e3e-8557-de663e8533f0?20210113203413
[24] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/ipc-board-assurance-framework-v1.5-feb-2021.pdf
[25] https://www.cqc.org.uk/guidance-providers/how-we-inspect-regulate/emergency-support-framework-what-expect

In addition, regular virtual monitoring and engagement meetings with the CQC have continued throughout the year to provide assurance of the effectiveness of actions being taken to address the findings of the CQC inspections in 2020 and 2018 and external well-led reviews undertaken in 2016 and 2017.

Stakeholder relations

During 2020/21, we have worked closely with our partners across West Yorkshire including:

- **Acute Provider Collaboration (APC) with Airedale NHS Foundation Trust**

We were 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 March 2020, we put the programme to refocus all work at both trusts on COVID-19. The programme was reviewed in the summer of 2020, and it was revised to bring in the wider partners across Bradford district and Craven to become part of a system wide transformation programme, Act As One.

- **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. The reorganisation of vascular services in West Yorkshire saw the creation of arterial centres at Leeds and Bradford, with centre at the Bradford Royal Infirmary opening in November 2020. We have also been 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 via the Yorkshire Imaging Collaborative, and the joint solutions for pathology. The intention is to provide a seamless and efficient service for patients across the whole West Yorkshire and Harrogate Health and Care Partnership (the Integrated Care System).

- **Pathology Joint Venture (JV)**

We are consolidating the progress made in the established Joint Venture (Integrated Pathology Solutions LLP) with Airedale NHS Foundation Trust and Harrogate and District NHS Foundation Trust to deliver pathology services. 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.

Connected Local Care

- **Integrated Care System (ICS)**

We have strengthened our partnership working across the West Yorkshire and Harrogate Health and Care Partnership (the integrated care system - ICS), through our participation in shared programmes of work and our contribution to the development of a five-year plan for the ICS, to explain how we will collectively respond to the challenge set out by the NHS Long Term Plan[26]. In February 2021, the government published *Integration and Innovation: working together to improve health and social care for all*[27] which sets out its plans for the future of integrated care. The plans will put the ICS on a statutory footing, and mean changes for the way in which it works and the way

[26] https://www.longtermplan.nhs.uk/
[27] https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

in which we work with our partner organisations. Work began to prepare partners across the ICS for the forthcoming changes, which are expected to be formally implemented in 2022/23.

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

Our ICS comprises six places, and the Trust remains an influential participant in the Executive Board and the Bradford Health and Care Partnership Board, both of which facilitate partnership working across our local Bradford district and Craven place.

In March 2019, the Trust joined with 12 other partners across Bradford district and Craven in signing up to a Strategic Partnering Agreement[28] 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". In April 2020, the three CCGs - Bradford City, Bradford Districts, and Airedale, Wharfedale and Craven - merged to become NHS Bradford District and Craven CCG[29]. This change meant that we can consider working with our partners on a wider geographical basis, and we have supported the development of the Act as One programme as both an ethos for how we work together and as a programme for delivery of our shared ambitions.

- **Act as One system transformation programmes**

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

Despite the need for services to respond to the pandemic, our Act as One programme continued to make progress during 2020-2021; we have highlighted one achievement per programme below. Our focus for 2021-2022 will be supporting the recovery of services with a clear mandate to tackle health inequalities that have been further exacerbated by the pandemic.

- **Access to care:** We have recruited accident and emergency (A&E) navigators to help support victims and perpetrators of violent crime. This is designed to reduce the risk of future crime as well as offering access to services that can help victims or perpetrators. Another notable success has been our collaborative work with providers in the independent sector to secure additional theatre capacity. As a result we have been able to treat as many patients as possible who have been waiting for their procedures during the COVID pandemic.

- **Ageing well:** We received funding from West Yorkshire and Harrogate Health and Care Partnership for a deconditioning project. We used part of the finding to set up an asset based community development (ABCD) grants programme with the remaining funding being used to develop training and education resources to raise awareness of deconditioning. Allied health professionals are leading on this and working closely with the Race Equality Network to engage with wider ethnic groups through the provision of videos translated into languages such as Urdu and Bengali.

- **Better births:** The health inequalities group have been reviewing opportunities to work together with local communities to co-produce services that better meet the needs of diverse communities. Work to date includes: expanding the Maternity Voices Partnership across Bradford district and Craven; learning from videos from diverse local community members sharing their experience on accessing care during the pandemic and designing a culturally competent education package in conjunction with faith leaders.

[28] https://bradfordprovideralliance.org.uk/wp-content/uploads/2019/09/Bradford-SPA-v2-2-HD-280319-2.pdf
[29] https://www.bradfordcravenccg.nhs.uk/

- **Children and young people's mental health:** Healthy Minds has six apprentices as part of its Youth in Mind service. The apprentices aged 16 - 23 and living throughout the Bradford district, support the work of Healthy Minds. Their campaign, 'Kindness, Compassion and Understanding' aims to inspire people to make a conscious effort to do more of this. The campaign was launched in November 2020 as part of World Kindness Day and coincided with Anti-Bullying Week and Islamophobia Awareness Month.

- **Diabetes:** A clinical forum has been established to lead change for diabetes services across our place. One area of focus has been the need to change the way services communicate and involve people from diverse backgrounds. During the year a targeted engagement programme has been pulled together to find out more about the experiences of people of Bangladeshi heritage on preventing or managing diabetes.

- **Healthy hearts:** During the last year we have developed a number of work streams, including a multi-agency model to support those with a heart failure and those who are yet to be diagnosed. Another notable success of the programme is the focus on greater self-management of hypertension through 170 blood pressure machines being distributed across our place living in the most economically challenged neighbourhoods.

- **Respiratory:** A multi-disciplinary approach has been developed to support people post-COVID. Our long-COVID pathway involves partners across our health and care system including voluntary and community sector organisations and was featured nationally on Channel 4's Dispatches programme. We have established a trial offering digital support to help people self-manage chronic obstructive pulmonary disease (COPD). Early results show a 40% improvement in confidence in people managing their condition.

- You can keep up to date with the latest news from Act as One by following us on Twitter @ActAsOneBDC

- **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 Girlington. 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 role in the creation of a green space within Girlington. This has allowed work to start on the development of a pocket park for the residents of Girlington by working with partners such as the local authority who supported with landscape design and a local nursing home who agreed for the land to be utilised free of charge. During the COVID-19 pandemic, Well Bradford also worked with local partners and businesses to setup a Together Girlington work group which focuses on improving the health, business and environment aspects within the area. The Well Bradford programme has been extended for a further year to March 2022.

3.1.4. FEES AND CHARGES (INCOME GENERATION)

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

3.1.5. CHARITABLE DONATIONS

During 2020/21, Bradford Hospitals' Charity[30] received £881,000 in income - £391,000 of which was related to COVID-19. The total income has been invested across our charity's four funds, which are: children and young people (which includes neonatal), elderly and dementia, cancer, and our sunshine fund (which is everything else).

The total income has been invested across our charity's four funds, which are: children and young people (which includes neonatal), elderly and dementia, cancer, and our sunshine fund (which is everything else).

Our pandemic NHS Hospital Heroes[31] appeal has resulted in money invested in staff support and wellbeing to assist staff through the crisis, equipment to speed up and enhance diagnoses and treatment, as well as items and equipment to support patients affected by COVID-19. We have received £150,000 in donations in kind for our staff during the pandemic so far. The gifts have included food, drink and self-care items.

Our Rays a Smile for Radiology[32] appeal has seen money used to refurbish our radiology department, to create a more child-friendly environment, which is improving diagnostic processes. Our BIG Neonatal Appeal[33] has seen money invested in improving facilities for families visiting their babies in our neonatal unit. Funds have been invested across the board to support patient, their families and our staff through the purchase of equipment, training, research and projects which go over and above what the NHS provides.

3.1.6. INCOME DISCLOSURES

As required under Section 43(2A) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012), the Trust confirms that the income it received from the provision of goods and services for the purposes of the health service in England is greater than the income it received from the provision of goods and services for any other purpose. Furthermore, the generation of "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
10 June 2021

[30] https://bradfordhospitalscharity.org/
[31] https://bradfordhospitalscharity.org/nhshospitalheroes/
[32] https://bradfordhospitalscharity.org/rays-a-smile/
[33] https://bradfordhospitalscharity.org/big-neonatal-appeal/

3.2. REMUNERATION REPORT

3.2.1. ANNUAL STATEMENT

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

I am pleased to present the Directors' Remuneration report for the financial year 2020/2021. The Nominations and Remuneration Committee is established by the Board of Directors, with primary regard to executive directors' remuneration and terms and conditions of service.

The report is divided into two parts:

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

Major decisions on remuneration

The committee had a particularly busy year in managing new executive director appointments due to the retirements of Bryan Gill, our Chief Medical Officer and Sandra Shannon our Chief Operating Officer/Deputy Chief Executive. The committee also agreed our first Joint Board appointment with Airedale Hospitals NHS FT with Cindy Fedell initially taking up the joint post of Chief Digital and Information Officer before the recruitment of Paul Rice to this role when she returned to live in Canada.

In respect of remuneration the committee considered and agreed the annual pay increase for executive directors following recommendations received from NHS England and NHS Improvement in January 2021 and made decisions on pay due to changed roles, pay progression, and earn back clauses, in line with contracts of employment during the course of the year.

Signed

Dr Maxwell Mclean
Trust Chairman and Chair of the Nominations and Remuneration Committee for Directors
10 June 2021

3.2.2. SENIOR MANAGERS' REMUNERATION POLICY

Figure 8: Executive directors' remuneration policy

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

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

The Trust is mindful of equal pay considerations and its gender pay gap when setting and reviewing executive director salaries. A full review was delayed in 2020/21 due to the pandemic and will be undertaken in 2021/22.

Figure 9: Non-executive directors' remuneration policy

Position	Remuneration	Policy
Chairperson remuneration	£51,835	The remuneration for all non-executive directors and the chairperson is reviewed by the Governors' Nominations and Remuneration Committee (NRC). At the Governors NRC on 2 July 2020 remuneration was discussed in reference to the current benchmarking information available from NHS Providers and guidance published in November 2019 proposing a 'remuneration structure for NHS provider chairs and non-executive directors'. The Chair's remuneration was not considered by the NRC in 2020 and as such the remuneration level agreed in 2019 stands. The Council of Governors received and approved the recommendation from the NRC that there would be no change to the remuneration of the non-executive directors for 2020/21 and the rate would remain the same as that agreed for the previous year. There are no additional fees payable for other duties and no other items that are considered to be remuneration in nature. Non-executive directors do not receive pensionable remuneration.
Non-executive director	£13,785	

Policy on payment for loss of office

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

The figures included in the accounts show there were no compulsory redundancy payments made in 2020/21 for loss of office.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust has not consulted with employees when determining its remuneration policy for executive directors. Given the number of new executive director appointments in the last few years we have taken into account available benchmarking data and the guidance on pay for very senior managers published by NHSI/E to enable us to recruit and retain the best people.

3.2.3. ANNUAL REPORT ON REMUNERATION

3.2.3.1. Service contracts

Senior manager contracts contain a notice period of three- or six-months dependent on role and when the appointment was made. Permanent contracts are issued unless there is a requirement for a specific fixed term role. Contracts are dated with the first day of appointment, the dates of which are as set out in the Board of Directors section of the Directors' report, at 3.1.1.

3.2.3.2. Nominations and Remuneration Committee (for directors)

The Board of Directors has established a Nominations and Remuneration Committee. Its responsibilities include consideration of matters relevant to the appointment, remuneration and associated terms of service for executive directors. The committee is also responsible for making any recommendations about any local pay arrangements not covered by 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 Chairman and all non-executive directors. The Chief Executive is in attendance and will discuss Board composition, succession planning, remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to her own performance or remuneration. The Director of Human Resources (HR) is in attendance and will provide employment advice and guidance as necessary. She withdraws from the meeting when any discussions are held with regard to her performance or remuneration. The Director of HR also acts as committee secretary.

The committee met five times during the year and has made a number of decisions during this time primarily around new appointments. These were:

- Chief Operating Officer
- Joint Chief Digital and Information Officer
- Chief Medical Officer

In all of the posts agreed by the committee this year, the recruitment process was managed 'in house' rather than using an executive search agency. Each post was advertised via NHS

Jobs, use of additional external media, networks, and social media coverage. The selection process was comprehensive for each post with the use of stakeholder panels and/or engagement events, and a final panel interview with presentation where there was a technical assessor as part of the panel. Every effort was made to ensure panel membership was representative.

Following due diligence in ensuring that Board level appointments must be 'fit and proper persons' the following people commenced in post:

- Mr Sajid Azeb commenced in post as Chief Operating Officer on 12 October 2020 with the agreement of the committee that following six months in post he would take on the Deputy Chief Executive portfolio jointly with Mr John Holden, Director of Strategy and Integration.
- Dr Paul Rice commenced in post as Joint Chief Digital and Information Officer with Airedale NHSFT on 1 January 2021. The Trust holds the contract of employment with a 60% time commitment to the Trust and 40% time commitment to Airedale.
- Mr Raymond Smith commenced in post as Chief Medical Officer on 1 January 2021.

The committee had previously agreed to Ms Cindy Fedell taking up a joint appointment with Airedale NHSFT as Chief Digital and Information Officer which took effect on 1 June 2020. Given the enhanced responsibilities as part of this portfolio change and on consideration of benchmarking information the salary for this post was reviewed at the same time.

The committee agreed a proposal by the Chief Executive which would enable Ms Sandra Shannon to retire and return to a part-time position of Deputy Chief Executive [special projects] for a fixed-term period of six months. This was to give additional executive capacity in what was a very difficult operating environment at the time. Remuneration and contract terms were agreed.

In respect of other remuneration decisions, the committee authorised the final performance-based pay progression for the Chief Operating Officer and agreed on the recommendation of the Chairman that there was no requirement to trigger the 'earn back' arrangements in respect of the Chief Executive's remuneration.

The committee considered the annual pay increase recommendations from NHSE/I for 2020/21 and agreed to award the recommended 1.03% consolidated increase backdated to 1 April 2020 or to start date where applicable.

Figure 10: Attendance and membership during 2020/21

Board NRC membership	Meetings attended
Dr Maxwell Mclean, Chairman	5 of 5
Ms Selina Ullah, Non-Executive Director	5 of 5
Ms Laura Stroud, Non-Executive Director	3 of 4
Mr Barrie Senior, Non-Executive Director	5 of 5
Mr Jon Prashar, Non-Executive Director	5 of 5
Ms Trudy Feaster-Gee, Non-Executive Director	4 of 4
Ms Julie Lawreniuk, Non-Executive Director	5 of 5
Mr Mohammed Hussain, Non-Executive Director	5 of 5
Mr Altaf Sadique, Non-Executive Director	1 of 1
Ms Karen Walker, Non-Executive Director	0 of 1
Professor Mel Pickup (in attendance), Chief Executive	4 of 5
Ms Pat Campbell (in attendance), Director of HR	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 non-executive director (NED) appointments, reappointments and their remuneration in line with the governors' statutory duties.

In accordance with the terms of reference the committee is expected to meet at least quarterly in-year. During 2020/21 the NRC met a total of seven times (four routinely scheduled meetings and three extraordinary meetings). The meetings are chaired by Dr Maxwell Mclean. Where a conflict arises with regard to the meeting Chair, there is a process in place for the committee to appoint a replacement chair from amongst the Governor members of the NRC.

Figure 11: Membership and meeting attendance for 2020/21

Governors NRC membership	Meetings Attended
Dr Maxwell Mclean, Chairman	7 of 7
Ms Hardev Sohal, Patient Governor	5 of 7
Ms Wendy McQuillan, Public Governor	7 of 7
Mr David Wilmshurst, Public Governor	7 of 7
Mr Alan English, Public Governor	3 of 6
Mr Kursh Siddique, Public Governor	1 of 2
Mr Amit Bhagwat, Public Governor	4 of 4
Professor Alastair Goldman, Partner Governor	4 of 4

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[34].

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:

- Board evaluation
- Chairman, NED and Associate NED appointment process annual review
- NED remuneration annual review
- NED terms and conditions annual review
- NED reappointment update: Professor Laura Stroud (term end 22/10/20)
- NED appointment/reappointment: Mr Barrie Senior (term end 30/11/20), Ms Trudy Feaster-Gee (term end 30/11/20), Mr Jon Prashar (term end 31/01/21)
- NRC self-assessment results
- NRC terms of reference annual review
- NED Appointment: Longlisting briefing, Interview process and, Interview panel
- NED Appointment: Shortlisting (preliminary interview report); Interview process - governor panel and, confirmation of interview panel
- Approval of the recommendation regarding the non-executive director appointment
- Report on the non-executive director (NED) appraisals 2020
- NED resignation and proposal for NED appointment
- Reflections on the NED interview process
- Report on the Chairman's appraisal 2020

[34] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2020/06/NRC-ToR-approved-january-2020.pdf

- Review of NRC Membership
- Appointment of a new NED to fill a vacancy following the term-end of Ms Selina Ullah
- Amendment to NED Appointment Process
- NRC Annual Self-Assessment
- Appraisal Process of the Chairman/NEDs 2021

In-year, the Council of Governors has appointed Mr Altaf Sadique and Ms Karen Walker as non-executive directors.

With the support of the Trust the NRC has:

- developed the brief for the NED appointments;
- confirmed the appointment of GatenbySanderson, Executive Search Agency, to assist with the appointments;
- agreed the job description and person specification along with a schedule for the appointment process;
- confirmed the interview process which involved a governor led stakeholder panel;
- confirmed the members of the interview panel;
- presented the recommendations for the appointment of Mr Sadique to the Council of Governors in September 2020 and of Ms Karen Walker in October 2020.

3.2.3.4. Disclosures required by Health and Social Care Act

Expenses claimed by directors

The total number of directors holding office during 2020/21 was 22 (the number in 2019/20 was 18). The number of directors receiving expenses during 2020/21 was five (the number in 2019/20 was nine). The aggregate sum of expenses paid to directors in 2020/21 was £3,805 (in 2019/20 was £7,483).

Expenses claimed by governors

The total number of governors holding office during 2020/21 is 20 (the number in 2019/20 was 23). The number of governors receiving expenses during 2020/21 is one (the number in 2019/20 was four). The aggregate sum of expenses paid to governors in 2020/21 is £108 (in 2019/20 it was £1,064).

Figure 12: Remuneration of senior managers 2020/21 (subject to audit)

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

Name and title 2020/21	Salary and fees (bands of £5,000) £000s	All taxable benefits (to the nearest £100) £00s	Annual performance related bonuses (bands of £5,000) £000s	Long-term performance related bonuses (bands of £5,000) £000s	All pension related benefits (bands of £2,500) £000s	Total (bands of £5,000) £000s
Maxwell Mclean (Chairman)	55 - 60	0	0	0	0	55 - 60
Mel Pickup (Chief Executive)	220 - 225	0	0	0	160.0 - 162.5	380 - 385
John Holden (Director of Strategy and Integration/Deputy Chief Executive)	145 - 150	0	0	0	82.5 - 85.0	230 - 235
Sandra Shannon (Chief Operating Officer/Deputy Chief Executive)[1]	100 - 105	0	0	0	22.5 - 25.0	125 - 130
Sajid Azeb (Chief Operating Officer)[2]	60 - 65	0	0	0	30.5 - 32.5	95 - 100
Karen Dawber (Chief Nurse)	145 - 150	0	0	0	32.5 - 35.0	180 - 185
Bryan Gill (Chief Medical Director)[3]	175 - 180	0	0	0	0	175 - 180
Ray Smith (Chief Medical Officer)[4]	50 - 55	0	0	0	65.0 - 67.5	115 - 120
Matthew Horner (Director of Finance)	145 - 150	0	0	0	25.0 - 27.5	170 - 175
Patricia Campbell (Director of Human Resources)	115 - 120	0	0	0	2.5 - 5.0	120 - 125
Cindy Fedell (Chief Digital and Information Officer)[5]	70 - 75	0	0	0	45.0 - 47.5	115 - 120
Paul Rice (Chief Digital & Information Officer)[6]	30 - 35	0	0	0	12.5 - 15.0	45 - 50
Mark Holloway (Director of Estates and Facilities)[7]	30 - 35	0	0	0	12.5 - 15.0	45 - 50
Altaf Sadique (Non-Executive Director)[8]	0 - 5	0	0	0	0	0 - 5
Karen Walker (Non-Executive Director)[9]	0 - 5	0	0	0	0	0 - 5
Selina Ullah (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Barrie Senior (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Jon Prashar (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Julie Lawreniuk (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Mohammed Hussain (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Laura Stroud (Non-Executive Director)	0	0	0	0	0	0
Trudy Feaster-Gee (Non-Executive Director)	0	0	0	0	0	0

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long-term performance related bonuses	All pension related benefits	Total
2020/21	(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

[1]Sandra Shannon (Chief Operating Officer/Deputy Chief Executive) - Chief Operating Officer until 31 October 2020, Deputy Chief Executive from 16 November 2020 to 31 January 2021
[2]Sajid Azeb (Chief Operating Officer) - from 12 October 2020
[3]Bryan Gill (Chief Medical Director) - retired 31 December 2020
[4]Ray Smith (Chief Medical Officer) - from 1 January 2021
[5]Cindy Fedell (Chief Digital and Information Officer) - until 30 September 2020. In addition to this role, Cindy Fedell was appointed as the Chief Digital & Information Officer at Airedale NHS Foundation Trust from June to September 2020. Bradford Teaching Hospitals NHS Foundation Trust re-charge 40% of costs to Airedale NHS Foundation Trust for this role.
[6]Paul Rice (Chief Digital and Information Officer) - from 1 January 2021. In addition to this role, Paul Rice was appointed as the Chief Digital & Information Officer at Airedale NHS Foundation Trust from January to March 2021. A recharge at 40% was made by Airedale NHS foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust.
[7]Mark Holloway (Director of Estates and Facilities) - from 12 November 2020
[8]Altaf Sadique (Non-Executive Director) - from 1 December 2020
[9]Karen Walker (Non-Executive Director) - from 1 January 2021

Figure 13: 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)[35]	5 - 10	0	0	0	0	5 - 10
Maxwell Mclean (Chairman)[36]	50 - 55	0	0	0	0	50 - 55
John Holden (Acting Chief Executive and Director of Strategy and Integration)[37]	170 - 175	0	0	0	0	170 - 175
Mel Pickup (Chief Executive)[38]	90 - 95	0	0	0	125.0 - 127.5	215 - 220
Sandra Shannon (Chief Operating Officer/Deputy Chief Executive)	140 - 145	0	0	0	85.0 - 87.5	225 - 230
Karen Dawber (Chief Nurse)	135 - 140	0	0	0	35.0 - 37.5	170 - 175
Bryan Gill (Medical Director)	235 - 240	0	0	0	0	235 - 240
Matthew Horner (Director of Finance)	150 - 160	0	0	0	17.5 - 20.0	165 - 170
Patricia Campbell (Director of Human Resources)	115 - 120	0	0	0	40.0 - 42.5	155 - 160
Cindy Fedell (Chief Digital and Information Officer)	120 - 125	0	0	0	30.0 - 32.5	150 - 155
Amjad Pervez (Non-Executive Director)[39]	10 - 15	0	0	0	0	10 - 15
Selina Ullah (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Laura Stroud (Non-Executive Director)	0	0	0	0	0	0
Barrie Senior (Non-Executive Director)	10 - 15	0	0	0	0	10 - 15
Trudy Feaster-Gee (Non-Executive Director)	0	0	0	0	0	0
Jon Prashar (Non-Executive Director)	10 - 15	00	0	0	0	10 - 15

[35] Trevor Higgins (Non-Executive Director), Acting Chairman from 01 February 2019 to 20 May 2019
[36] Maxwell Mclean, Chairman from 1 May 2019
[37] John Holden, Acting Chief Executive from 1 April to 31 October 2019
[38] Mel Pickup, Chief Executive from 1 November 2019
[39] Amjad Pervez, Non-Executive Director until 31 January 2020

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
Andrew McConnell (Associate Non-Executive Director)[40]	0 - 5	0	0	0	0	0 - 5
Julie Lawreniuk (Non-Executive Director)[41]	5 - 10	0	0	0	0	5 - 10
Mohammed Hussain (Non-Executive Director)[42]	5 - 10	0	0	0	0	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.

[40] Andrew McConnell (Associate Non-Executive Director) until 20 May 2019
[41] Julie Lawreniuk, Non-Executive Director from 1 September 2019
[42] Mohammed Hussain, Non-Executive Director from 1 September 2019

Figure 14: Pension entitlements of senior managers 2020/21 (subject to Audit)

Name and Title 2020/21	Real increase in pension at pension age (Bands of £2,500) £ 000s	Real increase in pension lump sum at pension age (Bands of £2,500) £ 000s	Total accrued pension at pension age at 31 March 2021 (Bands of £5,000) £ 000s	Lump sum at pension age related to accrued pension at 31 March 2021 (Bands of £5,000) £ 000s	CETV at 1 April 2020 (Bands of £1,000) £ 000s	Real increase in CETV (Bands of £1,000) £ 000s	CETV at 31 March 2021 (Bands of £1,000) £ 000s
Mel Pickup (Chief Executive)	7.5 - 10	12.5 - 15.0	95 - 100	230 - 235	1,725 - 1,726	163 - 164	1,950 - 1,951
John Holden (Director of Strategy and Integration/Deputy Chief Executive)	5.0 - 7.5	(30.0 - 32.5)	60 - 65	135 - 140	1,225 - 1,226	9 - 10	1,277 - 1,278
Sandra Shannon (Chief Operating Officer/ Deputy Chief Executive)[1]	0 - 2.5	2.5 - 5.0	60 - 65	180 - 185	1,441 - 1,442	0	0
Sajid Azeb (Chief Operating Officer)[2]	0 - 2.5	0 - 2.5	35 - 40	65 - 70	425 - 426	18 - 19	493 - 494
Ray Smith (Chief Medical Officer)[3]	2.5 - 5.0	5.0 - 7.5	70 - 75	175 - 180	1,205 - 1,206	65 - 66	1,517 - 1,518
Karen Dawber (Chief Nurse)	2.5 - 5.0	0 - 2.5	45 - 50	95 - 100	747 - 748	31 - 32	810 - 811
Matthew Horner (Director of Finance)	0 - 2.5	(0 - 2.5)	55 - 60	125 - 130	971 - 972	27 - 28	1,036 - 1,037
Patricia Campbell (Director of Human Resources)	0 - 2.5	(2.5 - 5.0)	50 - 55	130 - 135	1,076 - 1,077	16 - 17	1,128 - 1,129
Cindy Fedell (Chief Digital and Information Officer)[4]	2.5 - 5.0	0.0	15 - 20	0	181 - 182	30 - 31	224 -225
Paul Rice (Chief Digital & Information Officer)[5]	0 - 2.5	0 - 2.5	40 - 45	80 - 85	668 - 669	12 - 13	749 - 750
Mark Holloway (Director of Estates and Facilities)[6]	0 - 2.5	0 - 2.5	20 - 25	35 - 40	283 - 284	7 - 8	320 - 321

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

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

[2]Sajid Azeb (Chief Operating Officer) - from 12 October 2020

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

[4]Cindy Fedell (Chief Digital and Information Officer) - until 30 September 2020

[5]Paul Rice (Chief Digital and Information Officer)- from 1 January 2021

[6]Mark Holloway (Director of Estates and Facilities) - from 12 November 2020

3.2.3.5. Fair pay multiples (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 2020/21, £220,000 - £225,000 (2019/20, £235,000 - £240,000). This was 7.3 times (2019/20, 8.7 times) the median remuneration of the workforce, which was £30,615 (2019/20, £27,260). 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 2020/21, and 2019/20, 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

Mel Pickup
Chief Executive
10 June 2021

3.3. STAFF REPORT

3.3.1. ANALYSIS OF STAFF COSTS AND NUMBERS

Figure 15: Staff Costs 2020/21 (£'000)

Staff costs	Permanently employed	Other	2020/21 total	2019/20 total
Salaries and wages	242,576	772	243,348	220,099
Social security costs	24,523	0	24,523	20,194
Apprenticeship levy (pay element)	1,196	0	1,196	1,067
Pension cost - defined contribution plans employer's contributions to NHS pensions	29,598	0	29,598	24,817
Pension cost - employer contributions paid by NHSE on provider's behalf	12,001	0	12,001	11,068
Temporary staff - agency/contract staff	0	8,267	8,267	8,597
Total gross staff costs	**309,894**	**9,039**		**285,841**

Figure 16: Average number of employees Whole Time Equivalent for 2020/21

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

Figure 17: 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 18: 31 March 2021 distribution of staff, male and female

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

Figure 19: 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**

Sickness absence data for 2020/21 is available from NHS Digital's website here[43].

Information about staff turnover for 2020/21 is also available on the website of NHS Digital[44]

3.3.2. STAFF POLICIES AND ACTIONS

Disability equality and disability leave policy

In line with our contractual obligations and as part of our wider activity on the Workforce Disability Equality Standard (WDES) we launched our new disability equality and disability leave policy[45], which is now available to all staff on our intranet. As part of the policy implementation training to accompany the policy was developed and delivered to a range of managers across the Trust, including colleagues from human resources and organisational development.

The policy provides assurances that staff with responsibility for recruitment and line management receive appropriate training about disability and employment, to ensure we meet our responsibilities as a Disability Confident Employer and the requirements of the Equality Act 2010.

Feedback received so far has been very positive and further training will be rolled out once COVID-19 pressures have been reduced. Further work is being developed and rolled out with the aim of raising the profile of disability equality across the Trust. For example, the diversity census exercise was rolled out in March 2021 with some detailed communications about the benefits of equality monitoring and why it's important to have such information. There is particular focus in increasing our disability declaration rates across the Trust.

Trans equality policy

The trans equality policy was reviewed by a small focus group at the end of 2019 taking into account issues that were raised via the LGBTQ+ Staff Network. The final revised draft went to the Joint Negotiating and Consultative Committee and, the Local Negotiating Committee on 17 June 2020 and was approved on 3 August 2020.

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

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

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

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

As examples, the Executive Management Team held open invitation meetings with staff via Microsoft Teams where updates were given, and staff were free (openly or on an anonymous basis) to ask any questions or raise any concerns. The human resources (HR) team ran question and answer sessions for managers and all COVID-related information

[43] https://bradfordhospitalscharity.org/big-neonatal-appeal/
[44] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
[45] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2021/05/PP56-2019-Disability-Equality-and-Disability-Related-Leave-Policy.pdf

was made available on our intranet. A Wellbeing Wednesday bulletin was published every week which proved very popular and had a wide range of resources signposted to staff both in terms of local and national resources and events.

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

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

Health, safety and resilience performance

Because of the pandemic, we have had a challenging year for health and safety, which refocused the priorities of the health and safety department. The versatility and expertise of the health and safety team has enabled them to play a significant role in supporting the Trust during the pandemic with numerous risk assessments, safe systems of work, COVID-19 security audits as well as stepping into alternative roles required for the unique situation. During 2020/21 we continued to mitigate any risks identified and focus on staff and patient health and safety.

In 2021/22 the health and safety department will embark on a gap analysis to evaluate and refocus health and safety in relation to legislation and identified gaps to facilitate continued improvement. The identification of gaps and risks associated with health and safety regulations provides an overview of our health and safety compliance and facilitates the development of an organisational action plan.

Occupational health

Over the last 12 months occupational health has played an important role in supporting managers and staff to deal with the multiple complex issues arising from the pandemic. This has included assisting managers and staff in identifying those who might be at greatest risk of infection or adverse outcomes by developing and refining risk assessment templates and processes as knowledge of the virus increased. Staff have been enabled to return to work safely from periods of shielding with appropriate work adjustment advice, and frequently asked questions have been compiled in response to the high level of pandemic related queries being received.

When community infection levels were high a seven-day service was established to ensure symptomatic staff tested on-site were provided with their COVID PCR test results, advice on isolation and returning to work, and prompt contact-tracing of colleagues was done. Swift health assessment of volunteers and redeployed staff helped us protect staff and maximise the workforce to deal with pandemic pressures.

When the national vaccination programme became a reality, occupational health worked with other colleagues across the Trust in creating the COVID vaccination service within the hospital hub and administering the vaccination to health and social care staff.

Counter fraud and corruption

See section 3.5.5.2.

3.3.3. STAFF SURVEY

Staff engagement

Our vision is to be an outstanding provider of healthcare, research and education, as well as a great place to work. We know that if staff are happy in their place of work that this has a direct impact on patient experience. Improving staff engagement has been our top priority but has been challenging in 2020 because of the nature of the pandemic and the major changes in the way staff have had to work across the Trust in terms of being redeployed, having to move teams, and working remotely.

During the pandemic, 26.6% of Trust staff said they had been redeployed at some point compared to 18.5% redeployed nationally, with 40.6% having worked on a COVID ward or department compared to 34.2% nationally. This is a significant number of staff who have had to work differently.

Many redeployed staff have worked in unfamiliar clinical areas and, even for those staff who have remained working on the same ward, treating people with COVID-19 has created new and intense pressures. Working remotely has also had its own pressures.

These factors will have impacted on engagement generally and also on responses to specific themes within the staff survey such as morale, teamwork and immediate managers.

While we have been able to do the usual range of face-to-face activities with staff, to respond to the different needs created by new work demands, our approach to engagement has been flexible to keep them informed and connected. We changed the delivery of induction and appraisals to maintain engagement and ensure wellbeing of staff was paramount. A weekly wellbeing bulletin and fortnightly newsletter encouraged access to national and organisational wellbeing resources.

Within the Trust we worked to improve rest and relaxation facilities including the provision of what became known as 'wobble rooms'. These were to allow staff to remove themselves from the immediate work environment into a quiet restful space. Food was also made available in the form of grab bags and other treats and we saw great support from local businesses.

A wellbeing resource survey and the People Pulse survey were mechanisms introduced to monitor and learn from staff feedback. In this way our organisational values - *we care, we value people, we are one team* - have been tested and demonstrated throughout the pandemic.

NHS staff survey

The NHS staff survey is conducted annually. This year there was a significant improvement in the Trust's staff engaging with the survey compared to previous years. The staff response rate to the 2020/21 survey was 44.1% compared to 38% for the 2019/20 survey despite the challenges with staff engagement presented by the pandemic.

A draft action plan has been written based on the responses of the survey. We ran focus groups so that staff could contribute to identifying the priorities and formulating the actions. Comments from the focus groups, along with the five identified themes that the survey indicated that we need to prioritise, form the basis of the action plan. The five priorities for 2021 included in the action plan are: immediate managers, improving morale, safe environment - addressing bullying and harassment, staff engagement and teamwork. The action plan covers what we will do as an organisation around each of the identified priorities

and by when, thus creating measurable targets. The roles of those leading the actions are part of the plan so that accountability can be upheld. Progress will be monitored directly with the clinical business units and through the People Academy going forwards so that accountability can be upheld. The results of the staff survey and the action plan will be available to staff on the Trust's intranet site.

Since 2018 onwards, the results from questions have been grouped to give scores in ten indicators. The indicator scores are based on a score out of ten for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group which is comprised of acute and community NHS trusts is presented in figure 20 below.

Figure 20: NHS staff survey indicator scores

	2020/21		2019/2020		2018/19	
	Trust	Bench-marking group	Trust	Bench-marking group	Trust	Bench-marking group
Equality, diversity and inclusion	8.9	9.1	9.0	9.0	9.0	9.1
Health and wellbeing	6.0	6.1	6.1	5.9	6.0	5.9
Immediate managers	6.7	6.8	7.0	6.8	6.9	6.7
Morale	6.3	6.2	6.4	6.1	6.3	6.1
Quality of care	7.6	7.5	7.6	7.5	7.5	7.4
Safe environment – bullying and harassment	7.9	8.1	8.1	7.9	8.1	7.9
Safe environment – violence	9.5	9.5	9.5	9.4	9.6	9.4
Safety culture	6.8	6.8	6.9	6.7	6.7	6.6
Staff engagement	7.1	7.0	7.2	7.0	7.2	7.0
Team working	6.5	6.5	6.8	6.6	6.7	6.5

3.3.4. TRADE UNION FACILITY TIME

Figure 21: The total number of employees who were relevant union officials during 2020/21

Number of employees who were relevant union officials during the relevant period	75
Full-time equivalent employee number	66.44

Figure 22: Percentage of time spent on facility time

Percentage of time	Number of employees
0%	66
1-50%	8
51%-99%	0
100%	1

Figure23: Percentage of pay bill spent on facility time

Total cost of facility time	£32,629.10
Total pay bill	£317,970,224
Percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	0.01%

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. Any engagements deemed by the test to constitute employment must be paid through payroll. The Trust also requires all roles required in statute, such as the Chief Executive, Chief Nurse, Medical Director and Director of Finance, to be on payroll.

The Trust did not engage in any off-payroll worker engagements at any point during the year ended 31 March 2021 earning £245 per day or greater.

The Trust did not engage off-payroll board member, and/or, senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021.

In 2020/21 the Trust spent £984,560 on consultancy (£846,137 in 2019/20).

3.3.6. EXIT PACKAGES (SUBJECT TO AUDIT)

Figure 24: All exit packages 2020/21

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	5	5
Total resource cost	£0	£35,000	£35,000

Figure 25: All exit packages 2020/21

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
<£10,000	0	4	4
£10,000 – £25,000	0	1	1
Total number of exit packages by type	0	5	5
Total resource cost	£0	£35,000	£35,000

Figure 26: Exit packages, non-compulsory departure

	2020/21 agreement number	2020/21 total value of agreements £000	2019/20 agreement number	2019/20 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	0	0	0	0

	2020/21 agreement number	2020/21 total value of agreements £000	2019/20 agreement number	2019/20 total value of agreements £000
efficiency of the service contractual costs				
Contractual payments in lieu of notice	4	£16,000		
Exit payments following employment tribunals or court orders	1	£19,000	0	0
Non-contractual payments requiring HM Treasury (HMT) approval	0	0	0	0
Total	5	£35,000	0	0
Of which: non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

3.3.7. GENDER PAY GAP

See section 3.4.3. of the equality report.

3.4. EQUALITY REPORT

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

COVID-19, BAME staff and communities

Emerging evidence in the UK and abroad suggests that BAME communities are being disproportionately affected by COVID-19, with particular links to other health inequalities including racism, along with concerns mounting over the over-representation of BAME health care professionals among coronavirus fatalities. The government agreed to an inquiry to understand why such a high number of people from BAME backgrounds are dying from the virus. The review was led by NHS England, and NHS Improvement and Public Health England and has guided much of our engagement work over the last twelve months.

Staff engagement

Considerable efforts have been made over the last twelve months to engage with BAME staff across the Trust, and other groups of staff who may have been disproportionately affected by COVID-19, with the aim of providing a safe space, responding to risks, concerns and issues. A number of themed webinars have taken place. By holding virtual webinars we were able to engage with much larger numbers of staff. We had over 250 BAME staff across the Trust engaging in one of these discussions. The sessions have been facilitated by the Head of Equality, Diversity and Inclusion along with members of the Executive Management Team and respected clinical practitioners as ‘panel experts’ who have listened and provided reassurance and support on the challenges and concerns raised in relation to COVID-19 and vaccine hesitancy. We have also ensured to engage with and deliver

dedicated, targeted sessions to other equality groups such as the disability staff network and LGBT+ staff network and also delivered a session for men and women around their concerns associated to fertility and the vaccine.

Risk assessments for BAME staff

Due to the disproportionate impact of COVID-19 on BAME communities there has been considerable emphasis on NHS Trusts to ensure all BAME staff undergo a risk assessment. We completed 97% of these assessments across the Trust. The assessments outstanding were due to staff on long-term sick or shielding who will be risk assessed on their return. A small number of staff have not engaged; where this is the case targeted efforts were made to ensure all BAME staff assessments are and continue to be completed.

Development of strapline and equality and diversity intranet site

A new Trust-wide diversity and inclusion strapline was developed in 2020 in consultation with our staff equality networks and wider staff. This signals a positive commitment to embedding and mainstreaming diversity and inclusion in everything we do. We also launched a new intranet site for staff which provides a central hub for all information, guidance and latest news relating to EDI.

Equality and Diversity Council

As part of our commitment in advancing workforce equality and to tackling the wider population health inequalities within the district that have become more evident in the light of COVID-19, in January 2021 we launched our strategic Equality and Diversity Council (EDC). This exciting development reflects our commitment to building a workforce in which each colleague can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued and embedded in everything we do.

The group comprises of key members from across our core functions, along with individuals who have a pivotal role to play in influencing change both across our organisation and within the wider community. As Executive sponsor for diversity and inclusion across the Trust and the Trust Lead for population health inequalities within the district, our Chief Executive Mel Pickup is demonstrating the Trust's commitment to this agenda by chairing and leading this important meeting.

Our aim will be to provide a positive working environment for staff and to enable the provision of high-quality care and good clinical outcomes for patients. To achieve this, our main purpose will be to maintain a strategic overview of our diversity and inclusion agenda/objectives, ensuring these are fit for purpose and aligned with national and regional priorities. Our engagement with both staff and community partners will help to influence this agenda that will have particular focus on:

- the commitments set up in the NHS People Plan 2020/21[46];
- the West Yorkshire and Harrogate Health and Care Partnership response to the NHS People Plan with particular emphasis on 'Belonging in the NHS';
- the West Yorkshire and Harrogate Health and Care Partnership Tackling health inequalities for BAME communities and colleagues[47] report which has a range of

[46] https://www.england.nhs.uk/ournhspeople/
[47] https://www.wyhpartnership.co.uk/publications/tackling-health-inequalities-for-bame-communities-and-colleagues

recommendations focussing on race equality in the workforce and wider population health inequalities;
- implementing phase three of the NHS response to the COVID-19 pandemic[48]; and
- tackling wider health inequalities that exist within our district.

This work will put equality high on the agenda for the whole organisation and will ensure the principles of EDI are at the core of all our functions for our workforce and for the patients and communities we serve.

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

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

- Bradford district and Craven (BD&C) Health and Social Care Integrated People Board (IPB):
- Public Sector Equalities Working Group
- West Yorkshire and Harrogate Regional BAME Network of Networks
- BD&C equality impact assessment, vaccination roll out programme

Project SEARCH

Our award-winning work placement scheme, Project SEARCH, which helps young people with a learning disability to develop new skills and secure meaningful employment, has entered its eighth year. We are proud to host it, and work in partnership with Bradford College, 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 40 have found employment - 16 within our own teams.

Interpreting services

Our interpreting services team supported people on no fewer than 40,070 occasions, and in over 50 different languages. It meets the needs of non-English speakers and British Sign Language users, primarily through face-to-face interpreting. We also provide support using telephone and video, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through our team. During the pandemic, we have been providing more support through telephone and video interpreting services to non-English speakers. The top 10 languages requested are showing below

Figure 27: top 10 languages requested through interpreter services

	Urdu/ Punjabi	Czech/ Slovak	Polish	Bengali	Arabic	Hungarian	Romanian	Pushto	Kurdish	Gujerati
Sessions	18,994	5,229	2,958	2,242	2,162	1,327	817	761	655	533

3.4.1. STAFF EQUALITY

We continue to make good progress towards ensuring our workforce mirrors the local BAME community – having set a challenging, but achievable, target of 35% by September 2025. Latest figures show that the overall percentage of BAME staff stands at 33% which is a slight

[48] https://www.england.nhs.uk/publication/implementing-phase-3-of-the-nhs-response-to-the-covid-19-pandemic/

increase from 32% as at March 2020. Based on our current trajectory we will not only meet our target but exceed it by just over 4%.

BAME representation among Band 8+ colleagues continues to be more of a challenge. However, in October last year we appointed a new Chief Operating Officer from a BAME background. This means we now have BAME representation on our Executive Management Team and increases representation on our Trust Board. This Executive representation will help to accelerate our progress of having a senior workforce reflective of the local population (35% by 2025), which currently stands at 14.5%. In addition to this, we will be exploring more of a positive action and targeted engagement approach in the recruitment to senior leadership roles.

A range of initiatives are now in place to accelerate our progress against the target of 35%. Such initiatives include: reciprocal mentoring schemes; BAME staff representation on recruitment and selection panels for all posts at band 8a and above; and a proactive approach to recruiting BAME staff, considering positive action and targeted recruitment approaches. We are also progressing a recruitment and selection equality impact assessment, which should have a positive impact on equality and diversity in recruitment.

In 2020 our reciprocal mentoring scheme was launched and then had to be paused due to COVID-19 priorities. However, in February 2020 we launched our REACH mentoring scheme for BAME staff at Bands 8a and above with plans to re-launch the reciprocal mentoring scheme during 2021. Five BAME staff from across the Trust have been successful in obtaining a place.

We continue to focus our efforts in supporting and encouraging senior BAME colleagues on various leadership development programmes. We have recently selected two senior BAME colleagues who have been successful in obtaining places on the West Yorkshire and Harrogate Health Care Partnership BAME Fellowship.

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

3.4.2. WORKFORCE RACE EQUALITY STANDARD AND WORKFORCE DISABILITY EQUALITY STANDARD

Due to the pandemic, there was an initial announcement from NHS England which suggested this year's submissions for Workforce Race Equality Standard (WRES) and Workforce Disability Standard (WDES) had been suspended. However, due to the disproportionate impact on BAME communities and people with disabilities and long-term health conditions both submissions were reinstated. Both were submitted on 19 August 2020.

This year's action plans for both WRES and WDES included fewer, yet more focussed, objectives than in previous action plans. This was to ensure focussed attention on a key number of indicators/metrics which, if addressed in detail and positively, would have the biggest impact. In doing this, we anticipated that this would bring about positive change across the Trust resulting in an improvement in all WRES indicators/WDES metrics.

Our staff networks were instrumental in the development of both our WRES and WDES action plans, which were grouped into five themes to reflect both the WRES/WDES requirements and our People Strategy, including the revised NHS People Plan 2020/21, which places significant focus and attention to the wider system diversity and inclusion agenda.

3.4.2.1. Workforce Race Equality Standard

We have progress to make, and there is still work to be done, to improve our performance against the indicators. However, building on this platform we are now focussing on ensuring a culture of dignity and respect in the workplace, providing career development and support to staff at Agenda for Change bands 5 and above (including launch of a mentorship programme for BAME staff at bands 8a-plus) and ensuring HR processes (such as disciplinary and recruitment) are implemented fairly.

3.4.2.2. Workforce Disability Equality Standard

As with WRES, there some indicators require further improvement. However, building on this platform we are now focussing on raising the profile of disability equality in the Trust. In March 2021 we launched our equality census to increase the number of staff who feel able to share their equality data with the Trust (including a disability or long-term health condition).

3.4.3. GENDER PAY GAP

The Government Equalities Office (GEO) and the Equality and Human Rights Commission (EHRC) initially suspended gender pay gap reporting regulations for this year, due to the pandemic. Our data for the year 2019/2020 will now be published by no later than 5 October 2021 alongside data for the 2020/2021 submission. Our most recent data (2019/2020) suggests that our median pay gap has been reduced by 0.84% and the bonus pay gap remains the same. A dedicated action plan will be developed in response to our gender pay gap.

3.4.4. EQUALITY AND DIVERSITY TRAINING

The diversity and inclusion unit have worked closely with the organisational development team during 2020/2021 to co-produce EDI related courses which focus on inclusive and compassionate leadership and civility in the workplace. We are in the process of developing some training around anti-racism in response to the call for action from Preranar Issar, Chief People Officer for NHS England.

There has been a review of staff induction, ensuring the right messages are being given in terms of our diversity and inclusion agenda and how we link this agenda to patient care and patient experience agenda.

3.4.5. STAFF ADVOCATES

Our staff advocacy scheme was launched in 2018 and is now an established way of providing support to staff who have issues relating to, for example, discrimination, harassment and bullying or workplace conflict. It helps us to identify “hot spot” areas that may require additional action or focus to improve the working lives of staff. One of the objectives in our 2020 WRES and WDES action plans involved a review and refresh the role of the Trust’s Staff Advocacy service and work to ensure staff feel supported in the workplace, and there is a sense of belonging and respect.

3.4.6. STAFF NETWORKS

There is strong need to re-invigorate and re-energise existing staff equality networks in line with NHS England requirements. Work has already commenced in doing this and the re-launch of each of our three staff equality networks will take place in the coming months.

Prerana Issar recently presented five ambitions for all BAME staff networks in the NHS to develop:

- a thriving and effective BAME staff network;
- BAME networks that are not a single BAME conscience for an organisation but will work to increase understanding and make things fairer for all;
- BAME networks that will support organisations at board level to help make recruitment fairer, support talent management and career progression of BAME staff;
- a board-level champion – ideally, a non-BAME ally to provide sponsorship; and
- BAME network lead as a badge of honour – and there will be no fear of reprisal.

For each staff equality network, a core group of staff have been identified to work alongside the diversity and inclusion unit to explore and examine the above ambitions and to align network activity to ensure each staff network is 'thriving'.

There is recognition and acknowledgement that our leaders and managers play a vital role in creating an organisational culture which values diversity and promotes a culture of dignity and respect. To ensure that they can drive this forward we need to create leadership development opportunities around the diversity and inclusion agenda with aim of bringing the diversity agenda to life, where lived experiences of our staff can be shared in an open and safe space and uncomfortable but important conversations can take place.

Each of our three staff networks now has a place on our newly formed EDC, providing a real voice for our staff in influencing the actions of the Trust.

3.4.7. EQUALITY OBJECTIVES

We currently have a shared set of equality objectives with our Bradford district and Craven partners, and some that are unique to the Trust for which progress is reviewed every six months by our People Academy.

Our Head of Equality, Diversity and Inclusion is reviewing our equality objectives to ensure they are aligned with the objectives of the Equality and Diversity Council and other key areas of focus. In January 2020 we held an 'equality focus group' inviting a range of staff to discuss and explore some of the challenges and opportunities around EDI for staff, patients and communities. Over 50 members of staff from across the Trust joined the session, including members of our staff equality networks, representing a range of roles across the Trust.

This session was welcomed by staff with further requests for more similar sessions with emphasis on having a '*You Said – We did'* approach to engagement and involvement and feedback was presented at EDC on 24 March 2021. The feedback from this session will be used in developing a refreshed set of equality objectives, which will be accompanied by a dedicated three-year EDI strategy.

3.4.8. MODERN SLAVERY

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

3.4.9. STAFF SURVEY

As a result of the 2019/2020 staff survey, this year we have focussed on ensuring a culture of dignity and respect in the workplace and will continue to build on this throughout 2021/2022.

Results of the 2020/2021 Staff Survey have shown a slight decrease in two areas:

- **Q14** *Does your organisation act fairly with regard to career progression /promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?* Responses to this question have shown a slight drop from 95.3% to 94.3% agreement. However, despite this slight decrease from a Trust-wide perspective, this indicator has improved slightly for both BAME and disabled staff believing that the organisation provides equal opportunities for career progression or promotion (by approximately 1% improvement), which is a really positive reflection of the work that has taken place over the last 12 months to improve this.

- **Q15b** *In the last 12 months have you personally experienced discrimination at work from manager/team leader or other colleagues?* This indicator has shown an increase from 7.3% to 7.7%.

To address both these issues, the EDI team are working in collaboration with the organisational development team to increase awareness of inclusivity and civility in the workplace for leaders and managers through live webinars, plus EDI focus groups for all staff. With further projects planned for 2021 focusing on career and personal development. We have already launched our REACH mentoring programme for BAME staff which has been well received.

On an additional positive note, following the launch of our disability equality policy last year; we have now seen an improvement in disabled staff saying the Trust has provided reasonable adjustments.

3.5. NHS FOUNDATION TRUST CODE OF GOVERNANCE

3.5.1. STATEMENT OF COMPLIANCE

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

In May 2021, the Board of Directors reviewed our compliance with the NHS Foundation Trust Code of Governance to identify any areas for further development.

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

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

3.5.2. GOVERNANCE AND ORGANISATIONAL ARRANGEMENTS

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

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

3.5.3. OUR FOUNDATION TRUST MEMBERSHIP

Membership strengthens the links between healthcare services and the local community; it is voluntary, free of charge and obligation. Members can give their views on relevant issues to help improve the experience for patients, visitors and staff. Our Trust membership is made up of public, patients and staff. All members are required to be at least 16 years old.

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

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

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

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

3.5.3.1. Number of members

Figure 28 highlights our total membership on 31 March 2021. A breakdown is provided for each of the main membership constituencies and where applicable the sub-membership constituency or group.

Figure 28: Total membership on 31 March 2021 with a breakdown by constituency

Public Membership Constituency Breakdown	FT members	% membership	BMDC total population	% of BMDC population
Bradford East	8,571	24.41	118,931	22.06
Bradford South	8,217	23.41	106,064	19.67
Bradford West	8,693	24.74	119,432	22.15
Keighley	2,910	8.29	98,165	18.21
Shipley	6,462	18.40	96,621	17.92
Rest of England	254	0.75		
Total Public Membership	**35,107**	**100.00**	**539,213**	**100.00**
Total Patient Members	**6,171**			

Public Membership Constituency Breakdown	FT members	% membership	BMDC total population	% of BMDC population
Staff membership constituency breakdown		FT members	Total eligible staff population	Membership as % of total eligible staff population
Allied Health Professionals and Scientists		756	756	100
Nursing and Midwifery		1,626	1,626	100
Medical and Dental		837	837	100
All Other Staff Groups		2,506	2,506	100
Total Staff Membership		**5,725**	**5,725**	**100**

3.5.3.2. Membership representation, engagement and communications 2020/21

Representation

At the beginning of April 2020, total public and patient membership stood at 41,700. During the year, membership has declined overall by 422 members (1%) leaving a total public and patient membership of 41,278 on 31 March 2021.

The profile of the membership is monitored to determine whether it reflects our population. From a socio-economic and a health and well-being perspective our membership remains, on the whole, fairly representative of the communities we serve. The number of members within the 16-21 age group is under-represented, and whilst all our age groups from 22 years onwards are over-represented by between 2% and 6%, the number of members within 60-75 age group is over-represented by a 15%. With regard to ethnicity the Trust is fairly well represented with regard to the majority of the communities served. With regard to gender the trust is over-represented by 2% with regard to female members and under-represented by 2% with regard to male members. We have no members reporting that they are transgender however we do have

Work to develop a new membership plan was suspended in March 2020 in light of the Trust's response to the pandemic. In January 2021, the group leading this work was re-established. We anticipate that the plan will be published by the Board of Directors in September 2021.

Member and public engagement

During 2020/21 face to face engagement/involvement activities were stood down in line with the advice and guidance published by NHSE/I on 28 March 2020 on Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic[49]

Although the guidance suggested deferring the annual general meeting (AGM), the Trust decided to hold a virtual annual members meeting/annual general meeting[50] (AGM/AMM) in September 2020 to present the annual report and accounts 2019/20 to our members and the public and, provide the opportunity for questions to be raised and answered. A key element of the event was the screening of our video 'Still here for you: caring for Bradford in a

[49] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0113-reducing-burden-and-releasing-capacity-at-nhs-providers-and-commissioners.pdf
[50] https://www.youtube.com/watch?v=yfeQ40zwKqE

pandemic'[51] and, the e-circulation of our publication focussed on the activities of governors and members during the previous year.

Our council meetings resumed after the cancellation of the meeting scheduled for April 2020. Meetings held since October 2020 have been held virtually. Members and the public can now access the recordings which are posted online the day following the meeting with an annotated agenda to guide the viewer. We also now post our open board meetings. The links to view these have been widely circulated.

Papers and agendas for council of governor meetings are published on the Trust's website in advance of the meetings taking place.

Communications

The Trust provided e-bulletins from the Chairman in May and June 2020 and in February 2021). The membership bulletins[52] are available on our website. A key feature of the bulletins includes the provision of links to the regular Chief Executive videos, 'Mel's weekly news round ups'[53], which have proved incredibly popular and provide the very latest information on how our hospitals have coped with COVID-19 and, importantly, how we are still continuing to work towards improving our services.

General and targeted emails alongside the e-bulletins have continued to be sent to members and the public to publicise and seek nominations for our governor elections and during the last quarter of the year, to see individuals to participate in research programme and to provide support for the trusts communications with patients group (CPAG).

Contact procedures for the membership

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

Becoming a member

To join as a member please visit this link[54].

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

[51] https://www.youtube.com/watch?v=So-o_TX7zAo&t=27s
[52] https://www.bradfordhospitals.nhs.uk/our-trust/council-of-governors-and-foundation-trust-membership/
[53] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw
[54] https://secure.membra.co.uk/bradfordteachingapplicationform/

interests of NHS foundation trusts members and of the public. Governors are elected from the foundation trust's membership and most of the seats on a council of governors have to be held by elected public and patient governors (where a trust has patient governors).

3.5.4.1. Composition of the Council of Governors

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

Figure 29 provides details of the Trust's Council members in-year, the constituency, group or organisation they represent, their terms of office and a record of their attendance at the four formal meetings held in-year. These are the three Council of Governor meetings and the Annual General Meeting/Annual Members Meeting (AGM/AMM).

Figure 29: Members of the Council of Governors during 2020/21

Public Governors (elected)		**Term start date**	**Term end date**	**Meetings attended 2020/21**
Ms Stella Hall	Bradford East	04/2019	03/2022	4 of 4
Mr Kursh Siddique	Bradford East	05/2019	04/2022	1 of 4
Ms Hilary Meeghan	Bradford South	12/2018	07/2020	0 of 1
Mr Alan English	Bradford South	05/2019	03/2021	3 of 4
Mr Dermot Bolton	Bradford West	12/2019	11/2022	4 of 4
Mr Alan Edmonds	Bradford West	12/2018	01/2021	0 of 3
Dr David Robertshaw	Shipley	04/2019	10/2020	0 of 1
Mr David Wilmshurst	Shipley	12/2019	11/2022	4 of 4
Ms Wendy McQuillan	Keighley	04/2019	03/2022	4 of 4
Ms Marian Olonade-Taiwo	Keighley	12/2019	03/2021	1 of 4
Mr Amit Bhagwat	Rest of England and Wales	12/2019	12/2022	4 of 4
Patient Governors (elected)				
Ms Hardev Sohal		04/2019	03/2022	3 of 4
Mr Mark Chambers		12/2019	12/2022	3 of 4
Staff Governors (elected)				
Ms Pauline Garnett	Nursing and Midwifery	04/2019	03/2022	4 of 4
Dr Kavitha Nadesalingam	Medical and Dental	03/2020	02/2023	4 of 4
Ms Helen Wilson	AHPS	12/2019	11/2022	3 of 4
Ms Ruth Wood	All Other Staff Groups	03/2020	02/2023	3 of 4
Partner Governors (appointed by our stakeholders)				
Dr Andrew Clegg	University of Leeds	04/2020	03/2021	1 of 4
Professor Alastair Goldman	University of Bradford	06/2019	05/2022	4 of 4
Cllr Tariq Hussain	BMDC	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 can serve a maximum of nine consecutive years in total (generally equivalent to three full term lengths). Profile information about all of our Governors[55] is available on our website.

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

3.5.4.2. Election processes held in-year

At year end there were four vacancies in the Council of Governors as a result of resignations in-year. An election process to recruit to vacancies in the following constituencies was launched on 15 February 2021.

- Bradford South (two vacancies as a result of the resignation of Ms Hilary Meeghan and Mr Alan English)
- Bradford West (one vacancy as a result of the resignation of Mr Alan Edmonds)
- Shipley (one vacancy as a result of the resignation of Dr David Robertshaw)

The election process is due to conclude, where elections are held, in May 2021.

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

3.5.4.3. Council of Governors' Register of Interests

All governors are required to comply with the Council of Governors' Code of Conduct and declare any interests that may result in a potential conflict of interest in their role as governor. The Governors' Register of Interests[56] is publicly available on our website. In addition, the register can be obtained from the Associate Director of Corporate Governance/Board Secretary via the following methods:

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

3.5.4.4. Council of Governors Statutory Duties and responsibilities

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

The statutory duties of the Council of Governors are to:

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

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

- 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; and
- approve amendments to the Trust's Constitution.

3.5.4.5. Council of Governors Nominations and Remuneration Committee

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

Council of Governors' meetings

During 2020/21 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:

- People, Partners and Place[57];
- Board and Committee Review and the Development of the Trust's new Corporate Governance Model;
- Large-scale Fundraising Projects and the Hospital Charity Campaign[58];
- Act as One;
- Regular reports from the Chief Executive regarding the Trust's response to COVID-19; and
- Highlight reports from committee chairs.

The agendas and papers including the minutes for the Council of Governors[59] meetings are available on our website.

With regard to their statutory duties and responsibilities the governors have, during 2020/21:

- received the Annual Accounts, Auditor's Report and the Annual Report 2019/20;
- approved the remuneration of the non-executive directors for the period 2020/21;
- reappointed as non-executive directors Professor Laura Stroud, Ms Trudy Feaster-Gee, Mr Barrie Senior and Mr Jon Prashar for second terms of three years;
- Following the resignations of Mr Amjad Pervez (in 2019/20) appointed as new non-executive directors Mr Altaf Sadique and; appointed Ms Karen Walker following the resignation of Ms Trudy Feaster-Gee prior to the commencement of her second term;
- received the report from the Chairman on the outcome of the appraisal process of the non-executive directors 2020;

[57] https://www.bradfordhospitals.nhs.uk/ppp/
[58] https://bradfordhospitalscharity.org/big-neonatal-appeal/
[59] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/

- received the report from the Senior Independent Director on the outcome of the appraisal process of the chairperson 2020;
- received regular reports from the Governors Nominations and Remuneration Committee on the business conducted by the committee; and
- appointment of the external auditor.

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

- appointment of the Vice-Chair of the Council of Governors;
- Council of Governors' Standing Orders;
- terms of reference for the Council of Governors;
- terms of reference for the Governors' Nominations and Remuneration Committee;
- appointment process for the non-executive directors (including the Chairman appointment process);
- terms and conditions for non-executive director appointments made in-year;
- summary report from the closed council of governors' meetings held April 2020 and 16 July 2020;
- quarterly Chairman's reports;
- Governors' Code of Conduct;
- quarterly Nominations and Remuneration Committee reports;
- process for appointment of a chairman/non-executive director/associate non-executive director;
- Non-executive director terms and conditions;
- Nominations and Remuneration Committee Membership;
- annual general meeting/annual members meeting agenda review and establishment of governor planning group;
- NHS Providers: Governor Advisory Committee elections;
- requirements for the Quality Report 2020/21: locally selected indicator;
- restart of the planning group for the Foundation Trust membership plan;
- Governors' code of conduct;
- Governors' annual evaluation and, skills and knowledge audit;
- Governor induction programmes;
- Governor work programme 2021 to 2024; and
- quarterly reports from the Boards' Regulation and Assurance Committee and the Audit and Assurance Committee.

As a result of the pandemic the open Council of Governors meeting scheduled for April 2020 did not take place. Instead, a closed meeting of the Council was held to receive private Business. In July 2020, the Council's formal meeting schedule was resumed

3.5.4.6. Directors' attendance at the Council of Governors meetings

Executive and non-executive directors routinely attend the meetings of the Council of Governors.

In 2020/21 the Council of Governors has not exercised its "power under paragraph 10C of schedule 7 of the NHS Act 2006 to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the Trust's performance or its functions or the directors' performance of their duties".

3.5.4.7. Governors' effectiveness

In April 2021 the Chairman reviewed the Council's effectiveness with governors. The key areas of focus for 2021/22 were identified as:

- development of the governor induction programme;
- improving the way that the Council's business and decisions are communicated externally; and
- work to improve the Council's representation of the interests of the FT members and the local population.

As part of the review of effectiveness the Council considered the size of the Council of Governors and determined that at 20 members, it was adequate.

- Member engagement**:** In 2019/20 members of the Council worked with the Trust to develop the membership plan. In 2020 this group was stood down, in line with guidance from NHS England/Improvement as a result of the pandemic. A new membership plan will be developed during 2021/22.

- Input into operational planning and strategy development: This was also stood down in-year. These actions will therefore be carried over to 2021/22.

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

- Three informal sessions between governors and non-executive directors have been held and these 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 in developing their relationships.

- To support governors in their duty to hold the non-executives individually and collectively to account for the performance of the Board, governors, on a voluntary basis, observe at Board committee meetings. The principles regarding governors observing committees were developed in conjunction with the Council of 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[60] is available on our website.

3.5.4.8. Governor engagement with patients, visitors, and staff

In the main, engagement activities have been stood down in-year as a result of the pandemic in line with the guidance from NHS England/Improvement. A virtual annual general meeting/annual members meeting went ahead in September 2020. The governors were integral to the planning and delivery of the meetings. Mr David Wilmshurst, Vice-Chair of the Council of Governors presented the Governor and Membership report. This was

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

supplemented by the publication of the Governor and Membership report for 2019/20[61]. The event also included a keynote presentation on "Critical Care Without Walls - our clinical response to COVID-19" delivered by Dr Deborah Horner, Consultant/Clinical Director Anaesthetics and Critical Care. The AGM/AMM was streamed live, uploaded to you tube here[62] and has had in excess of 500 views. "Caring for Bradford during the Pandemic: Responding together[63]" was also screened as part of the event. The video has had more than 230 views.

3.5.4.9. 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 Ms Pauline Garnett, one of our Trust's governors is an elected member of the national body;
- NHS Providers' governors' sessions; and
- Deloitte 2020/21 year-end seminar for governors.

3.5.4.10. Governors' learning and development

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

3.5.4.11. Communicating with governors

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

- a quarterly Chairman's Bulletin from Dr Maxwell Mclean to ensure that governors are kept abreast of key developments, at the Trust and externally, as well as a key in-depth focus on Trust performance in selected areas. This important bulletin also includes news items and briefings from a range of statutory and non-statutory organisations which has included CQC, NHSI, NHS Providers and the King's Fund;
- 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;
- receiving the regular Chief Executive videos, 'Mel's weekly news round ups'[64], which provide the latest information on how our hospitals have coped during the pandemic and, importantly, how we are still continuing to work towards improving our services.

[61] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2020/09/HG2680-BTH-Govenors-Members-Summary3-2.pdf
[62] https://www.youtube.com/watch?v=yfeQ40zwKqE
[63] https://www.youtube.com/watch?v=So-o_TX7zAo
[64] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw

Members and the public are able to communicate with the Council of Governors 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. AUDIT AND COUNTER FRAUD SERVICES

3.5.5.1. External audit

The external auditor for the Trust is:

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

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

Figure 30: External audit fees

Fee (excluding VAT)	2020/21 £000	2019/20 £000
Audit of Trust	62	48
Value for money	20	0
Additional fees	0	5
Total audit services – statutory audit	**82**	**53**
Audit of Charity	6	6
Total	**88**	**59**

Process for the appointment of the external auditor

Deloitte LLP was appointed as the external auditor by the Council of Governors in May 2017 for a period of two years with an option to extend for a further one year. The option to extend was taken up and the contract expired on 31 May 2020. The Council of Governors began the process for the appointment of an external auditor in 2019/20 and concluded it in 2020/21.

In May 2019 the Council approved the establishment of the Auditor Appointment Working Group (AAWG) and agreed the process to be undertaken for the appointment. The membership of the AAWG was confirmed as:

- Mr Alan Edmonds, Public Governor
- Ms Jenny Scott, Public Governor
- Mr David Wilmshurst, Public Governor (appointed Chair of the AAWG)
- Mr Barrie Senior, Non-Exec Director, Audit and Assurance Committee Chair
- Ms Selina Ullah, Non-Exec Director, Audit and Assurance Committee
- Mr Jon Prashar, Non-Exec Director, Audit and Assurance Committee

- Mr Matthew Horner, Director of Finance
- Ms Adele Hartley Spencer, Associate Director of Nursing

In working towards the development of a recommendation the AAWG was supported by the following Foundation Trust members of staff:

- Mr Michael Quinlan, Deputy Director of Finance
- Mr Shahid Nazir, Strategic Head of Procurement
- Ms Jacqui Maurice, Head of Corporate Governance
- Mr Aubrey Sitch, Corporate Compliance Manager

Development of the recommendation

- The AAWG selected the North of England Commercial Procurement Collaborative as the most suitable procurement framework from three proposals.
- Following market testing, three responses were received from five expressions-of-interest requests sent.
- The AAWG agreed the composition of the evaluation team.
- The tender document was approved by the AAWG
- Three tenders were received and evaluated by the evaluation team
- Suppliers were invited to deliver presentations to the evaluation team
- The evaluation team confirmed with the AAWG its recommendation which was accepted
- All parties were notified of the outcome of the tender evaluations on 21 February 2020.
- The standstill period of 10 days completed on 2 March 2020 with no challenges received
- The Audit and Assurance Committee formally confirmed the recommendation to be presented to the Council of Governors by the Chair of the AAC.

In April 2020 the Council of Governors approved the appointment of Deloitte LLP, as the Foundation Trust's external auditor from 1 June 2020 to 31 May 2023 with an option to extend two years.

3.5.5.2. Internal audit and counter fraud service

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

An internal audit charter formally defines the purpose, authority and responsibility of internal audit activity. This document was last updated, reviewed and approved by the Audit and Assurance Committee in December 2019.

In-year the Audit and Assurance Committee approved the planning methodology to be used by internal audit to create the Internal Audit Plan for 2020/21, and gave formal approval of the Internal Audit Operational Plan in June 2020. The Internal Audit Operational Plan has not been fully delivered in-year as a result of the Trust responding to the pandemic. As a result a number of audits have been deferred to 2021/2022.

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 at least a quarterly basis.

This has continued to be an area of focus by the committee during the year and Trust management has worked hard with the support of internal audit to ensure that the process for responding to internal audit recommendations has been improved. This is evidenced by the significant reduction in the number of outstanding recommendations as at year end which was supported by the implementation of a new internal audit software system.

The Counter Fraud Plan was reviewed and approved by the Audit and Assurance Committee in June 2020. The local counter-fraud specialist (LCFS) presented regular reports detailing progress towards achievement of the plan, as well as summaries of investigations undertaken.

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

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

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; and
- Leadership and improvement capability (well-led).

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

3.6.2. SEGMENTATION

NHS Improvement has placed the Trust in segment two which maintains the rating achieved in 2019/20. This category is for providers that have been offered targeted support because there are concerns in relation to one or more of the themes.

This segmentation information is the Trust's position at 31 March 2020. Current segmentation information for NHS trusts and foundation trusts[65] is published on the NHS Improvement website.

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[66] 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-

[65] https://www.england.nhs.uk/financial-accounting-and-reporting/single-oversight-framework-segmentation/
[66] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2020-to-2021

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

Mel Pickup
Chief Executive
Date: 10 June 2021

3.8. ANNUAL GOVERNANCE STATEMENT

3.8.1. INTRODUCTION

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

3.8.2. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 2021 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 and Chief Medical Officer, who are the lead directors for risk management and the Associate Directors of Quality and Corporate Governance who develop and manage the corporate approach to the management of risk, including the risk management strategy and the use of the BAF. I routinely use the BAF, the 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 can discharge its statutory functions in a legally compliant manner.

As Chief Executive, I have delegated some key responsibilities to other executive directors as shown at figure 31. In addition, for selected roles there is an identified non-executive director sponsor.

Figure 31: Executive directors' key responsibilities

Role	Executive director Lead	Non-executive director sponsor
Accounting Officer	Chief Executive	
Allegations against professionals	Director of Human Resources	
Caldicott Guardian	Chief Medical Officer	
Controlled drugs	Chief Medical Officer	
Corporate governance	Director of Strategy and Integration	
Digitisation	Chief Digital and Information Officer	
Doctors in difficulty	Chief Medical Officer	
Emergency planning	Chief Operating Officer	•
End of life	Chief Nurse	•
Equality and diversity	Director of Human Resources	•
Fire safety	Chief Operating Officer	•

Role	Executive director Lead	Non-executive director sponsor
Freedom to Speak Up	Chief Nurse	●
Fundamental standards of quality and safety (CQC)	Chief Executive	
Health and safety	Director of Estates and Facilities	●
Infection prevention and control	Chief Nurse	
Learning from deaths	Chief Medical Officer	●
Patient safety	Chief Medical Officer Chief Nurse	●
Responsible Officer	Chief Medical Officer	
Senior Information Risk Owner	Chief Digital and Information Officer	

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

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

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

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

The Trust provides a comprehensive mandatory training programme, which includes governance and risk management awareness and training. Training is delivered centrally and within individual clinical business units/specialties.

The governance and risk management training programme was previously reviewed annually by the office of governance and corporate affairs, following restructure this is now undertaken by the quality governance team in conjunction with the Associate Director of Corporate Governance. In response to the COVID-19 pandemic all planned classroom-based training was suspended during 2020/21, promoting our web-based training offer. However, teams have continued to offer in-situ training on a one-to-one basis or in small groups whilst adhering to social distancing measures. The quality governance team have provided incident reporting and risk assessment training in response to staff needs. Whilst there is an acknowledgement of significant pressure on staff the Trust has continued to reinforce the requirements of the mandatory training policy, and the duty of staff to complete training deemed mandatory for their role and is a key element of the annual appraisal process.

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

The NHS has a key role in responding to large scale emergencies and major incidents and throughout 2020/21 the emergency planning team has worked to ensure that the Trust is adequately prepared for any such events. We have in place plans that are substantially compliant with the requirements of the NHS England Emergency Planning Resilience and Response Core Standards (2015) and associated guidance.

During 2020/21 the submission date for the core standards was 31 October 2020. The Trust's return was submitted on 6 October 2020. The return was very different to previous years due to the pandemic and therefore only three questions were asked, these are detailed below with the Trust response in bold:

- That, where relevant, your EPRR assurance action plans have been reviewed to improve your level of compliance against the 2019/2020 EPRR Assurance Core Standards and, where you have previously reported partial or non-compliance as your overall assurance rating, that you provide an updated assurance level following review and delivery of your ongoing action plans. **Not applicable – we declared substantial compliance with the 2019/2020 EPRR Assurance Core Standards, of the four that were outstanding, two more have been now achieved as per the action plan previously submitted.**

- That you have undertaken, or plan to undertake, a formal review process of your response to the COVID-19 pandemic to date and have associated plans to ensure that the lessons and recommendations from that review are embedded as part of your ongoing EPRR work programme. **We have done a number of reviews on our response to the Covid-19 pandemic, including a review of our command-and-control arrangements; staff survey and summary review of the lessons identified during phase one. Once completed the results of these will be consolidated and used for ongoing operational planning and, where applicable, will also be included into EPRR work streams.**

- That you have reviewed your response to the COVID-19 pandemic and taken steps to embed key lessons and actions in your planning for winter and associated system response arrangements. **We are working with the system and wider health economy to ensure key lessons are included in regional planning. Within the trust, the operational management of COVID-19 will be expanded to include the consequences of winter and any resulting plans/mitigation required to address them. This will ensure integration, both within the Trust, and wider health economy and also ensure response arrangements meet the requirements of both COVID-19 and winter.**

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

The Trust was inspected by the CQC in December 2019 and received an overall rating of 'good'. We continue to monitor and assure the effectiveness of actions being taken to address the findings of the inspection, including to address the finding of 'requires

improvement' in relation to Bradford Royal Infirmary and maternity services, as well as the findings of the CQC inspection in 2018 and the external well-led reviews in 2016 and 2017.

The effectiveness of our implementation of our BAF was audited by our internal auditors, Audit Yorkshire, during 2020/21 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 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.

Our Risk Management Strategy 2019-2025 was approved by the Board of Directors in January 2019. The strategy describes an integrated approach to ensure that all risks to the achievement of the Trust's objectives, are identified, evaluated, monitored, and managed appropriately. It defines how risks are linked to one or more of our strategic or operational objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust.

We have built on this approach to manage risk that has emerged and evolved throughout 2020/21 as a both a direct and indirect consequence of the pandemic.

Robust governance arrangements were put in place to respond to the pandemic, from tactical to strategic level groups. This included a clinical reference group to support safe clinical operations, cascade national guidance and present the highest priority clinical risks and issues to Gold Command.

Whilst there has been a continued commitment to effectively deliver the objectives of the Risk Management Strategy our primary focus over 2020/21 has been to effectively manage risks associated with the emergent pandemic, however we have ensured that the following continued to be 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 32);
- An effective 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 changes to services/staffing models 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 as service provision has changed and evolved;
- 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 emergent and evolving NHS and Public Health standards and Governmental guidelines;
- 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; and
- 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 BAF;
- 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; and
- An effective and responsive patient safety incident reporting system.

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 32: our risk appetite

The Board of Directors has a defined risk appetite statement (see below), which is aligned to the strategic objectives of the organisation, determining the amount of risk considered desired (both opportunistic related to delivery of the strategic objectives) and tolerated (usually related to operational risk). The appetite statement was approved in January 2020 and was reviewed by the Board in January 2021. It was agreed that the approved statement would continue to apply and would be reviewed at a Board Development Session during the first quarter of 2021/22, to enable a more detailed discussion. This will also align with the review of the Risk Management Strategy and BAF template, which will reconsider the clarity and effectiveness of the Trust's risk management processes and tools.

'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.

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

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

Figure 33: Risk escalation framework

Risk identified and assessed	An initial discussion takes place with a line manager (and the care group/specialty governance lead for assistance if required) and then be assessed, graded and added to the risk register as appropriate
Ward/specialty/clinical business unit/corporate service level	Monthly review of risks is undertaken at this service level. Where the ward specialty or department feel unable to manage the risk this should be formally escalated to the divisional governance lead for consideration at next meeting
Care group/corporate department level	Monthly review of risks escalated formally from ward/specialty/clinical business unit corporate service and all risk scored at nine or greater to be reviewed at care group level. Where the care group or corporate department are unable to manage or address the risk themselves this is escalated formally to the strategic risk register.
Strategic level	The Executive Team Meeting (ETM) reviews all risks newly escalated, considering whether to accept them onto the corporate risk register. Risks accepted are identified with an executive lead.
	All risks on the strategic risk register are reviewed monthly at the ETM and managed within the principal risk structure of the register to enable alignment to the BAF.
Academy/committee Level	The academies review the strategic risks within their remit. The Regulation and Assurance Committee reviews a high-level register of Trust-wide risks graded at 12 or greater at each meeting, receiving assurances and/or escalations from the academies and undertaking a review of these risks at each meeting. The Regulation and Assurance Committee also reviews the principal risks and their component risks assigned to them and considers their impact on the BAF and how they should be reflected.
Board Level	The Board receives the BAF and strategic risk register for information at each meeting, receiving assurances and/or escalations from the Regulation and Assurance Committee as appropriate.

We use 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 risk register, which is also held on Datix.

Risk is identified and managed 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 33.

3.8.5.2. Risk profile

Our strategic risk register provides a Trust-wide database of all extremely high, high, and moderately graded risks that have an impact on the delivery of the Trust's strategic objectives. All risks on the strategic risk register are analysed and themed into a suite of principal risks. These are presented in a matrix, shown in figure 34, together with their overall proposed risk rating.

Figure 33: Principal risk matrix for quarter 4 2020/21

		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	Minimal
2	Failure to recruit and retain an effective and engaged workforce	15	6	4	15	Seek
3	Failure to maintain operational performance	20	6	6	16	Cautious
4	Failure to maintain financial sustainability	6	6	6	9	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	9	Open
7	Failure to deliver the benefits of strategic partnerships	12	6	6	9	Seek
8	Failure to maintain a safe environment for staff patients and visitors	12	6	4	8	Cautious
9	Failure to meet regulatory expectations and comply with laws, regulations and standards	12	8	6	8	Cautious
10	Failure to demonstrate that the organisation is continually learning and improving the quality of care to our patients	12	8	6	8	Open

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

Currently (month 3, quarter 4 2020/21), the strategic risk register has four risks that are rated 20 or above. The risks are 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 meetings of the executive team and at the Academy.

- *There is a risk that patients with a mental health diagnosis may not be treated appropriately due to a lack in staff knowledge/awareness and provision of expert clinical advice (mental health) - includes restraint and de-escalation.*
- *There is a risk that patients may come to harm due to delays in the diagnostic pathway due to insufficient endoscopy capacity.*
- *If the Trust does not invest significant capital resources to reduce the identified backlog maintenance and critical infrastructure risk of its estate, significant business continuity impact due to failure of estates infrastructure/engineering systems/building fabric will be experienced.*
- *There is a risk that the inability to maintain normal operational delivery of services due to the impact of the COVID-19 outbreak could lead to patient harm.*

3.8.5.3. Control and assurance

We have an established assurance framework that 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; and
- supports the preparation of this Annual Governance Statement and regular governance reports.

The BAF describes the risks to achieving Trust's key strategic objectives, and the associated assurances and controls in place. The Board of Directors and Board Academies and Regulation and Assurance Committee receive regular reports, including an integrated dashboard, containing assurance related to key controls for the risks associated with the achievement of strategic objectives.

3.8.5.4. 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, 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; and
- 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.

3.8.5.5. Public stakeholder involvement in risk management

The Board of Directors actively engages with the Council of Governors and our respective public stakeholders in the reporting of the financial and performance management of the Trust and in the management of risks which impact on them. The Council of Governors is a key mechanism in ensuring that our public stakeholders are involved in the understanding and contextualisation of risk. The Council meets formally four times per year and receives reports and updates on performance, quality and safety. The Board of Directors meets in public and all papers are available on our website. During 2021/22 we will develop a new membership plan and will be seeking different and novel ways of engaging with our membership about a number of matters, including risk and governance.

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

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

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

3.8.5.6. Quality 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.

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

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

3.8.5.7. Management of risks to compliance with the NHS Foundation Trust licence condition four

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 2021. The review concluded that the Trust was compliant with all requirements.

During 2020/21 the Trust made significant changes to its board and committee governance structure. In response to the pandemic, all meetings were moved to a virtual platform and committee meetings were suspended initially. In their place a Regulation and Assurance (R&A) Committee was established to streamline governance processes and include a focus on COVID-19 and the Trust's response. Any urgent items that required Board oversight and

assurance which ordinarily went to a committee were escalated where required to the R&A Committee.

Audit and Assurance Committee meetings were suspended initially but meetings were held in June to review the Annual Report and Accounts and other deferred items. Meetings resumed as normal from July onwards. The Remuneration and Nomination and Charitable Funds Committees have also met as required throughout the year.

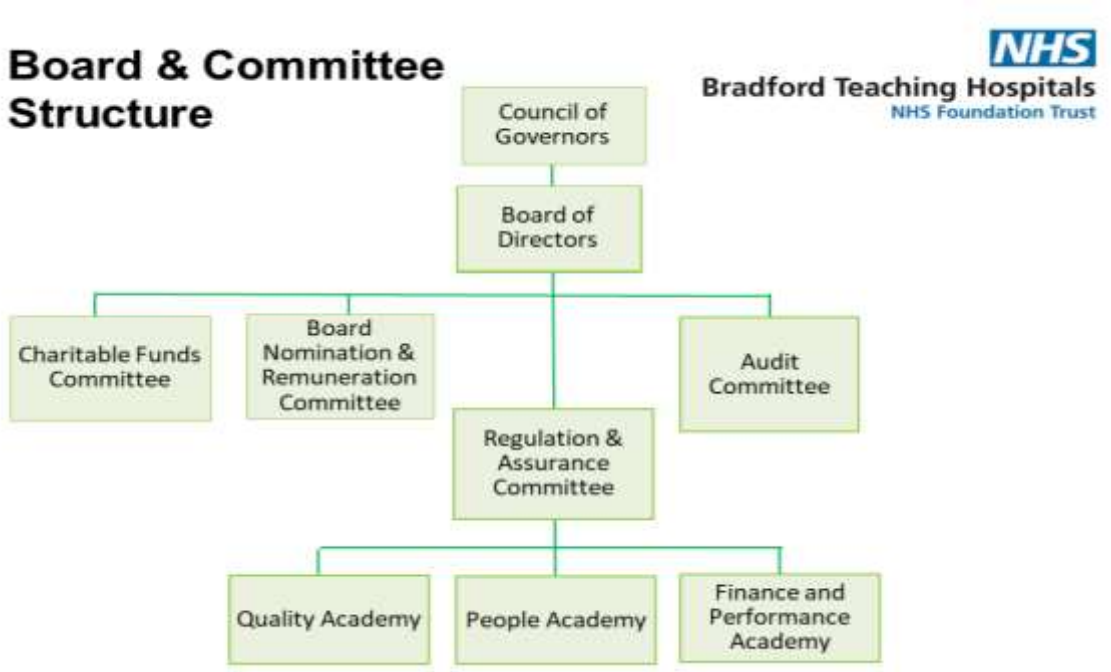
The Trust was previously considering a review of its governance structure and used this opportunity to review its committee structure and capitalise on the learning and efficiencies made during the first wave of COVID-19. The Board considered a new approach involving academies, which would focus on learning and improvement as well as assurance. An independent review was commissioned to develop this proposal and ensure that the transition to a new governance model was managed appropriately. The review took place during the Summer of 2020 and included discussions and workshops with Board members. The outcome of the review was presented to the R&A Committee in October where it was agreed to implement the new approach. An action plan and timeline have since been developed, to ensure the effective implementation of the changes. It is acknowledged that it will take up to a year for the new approach to become fully developed and embedded. Regular progress updates are presented to the R&A Committee. An interim review of the approach will be considered at the Board development session in October 2021, with a full review taking place during January to March 2022.

Whilst the implementation of the new model has been delayed due to the ongoing impact of the pandemic, the Regulation Committee has continued to meet on a regular basis. A new cycle of meetings was agreed in December, to ensure the flow of information from academies to the Regulation and Assurance Committee, to the Board. The academies will meet ten times per year and the R&A Committee and Board will meet six times per year, approximately one week apart to ensure that the R&A Committee can provide timely assurances to the Board.

The academies held planning meetings at the end of January and formal meetings were held at the end of February, with the full suite of agenda items. Work plans and terms of reference for the academies and R&A Committee were considered at the R&A Committee meeting in March 2021. These were agreed subject to any final comments from committee members being received. The R&A Committee’s terms of reference and work plan will be presented to the Board for approval on 20 May 2021.

The new structure is outlined below:

Figure 35: Governance structure



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

The focus of the **Regulation and Assurance Committee** is to seek assurance on the delivery of the Trust's strategic objectives and statutory duties.

The focus of the **Audit Committee** (known as the Audit and Assurance Committee until 20 May 2021) is to seek assurance on the relevance and robustness of governance **structures** and assurance **processes,** on which the R&A Committee and Board place reliance.

The role of the **academies** is to seek assurance, ensure learning and drive improvement in relation to their respective areas of responsibility. They have a broad membership to ensure that there is input from across the Trust and to enable learning and improvements to be shared widely. The Quality and People Academies are both chaired by the lead executive director(s). Four non-executive directors sit on each academy, including a NED champion and deputy NED champion. The Finance and Performance Academy is currently chaired by the NED champion whilst the new approach to learning and improvement is developed. This arrangement will be kept under review.

Quality Academy - the academy's role relates to all aspects of quality and is aligned to the NHS Patient Safety Strategy[67] and national quality standards. Several clinical working groups report to the Academy to provide assurance that safety, clinical outcomes, patient safety and patient experience across the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services.

People Academy - the academy's role relates to the effectiveness of the people management arrangements for the Trust. The academy seeks assurance of compliance with legal and regulatory requirements relating to people, oversees the delivery of action plans, for example relating to the staff survey and Workforce Race Equality Standard, and monitors

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

a range of metrics including safe staffing levels, sickness absence and turnover. Working groups have been set up to align with the commitments within the NHS People Plan, and these report to the Academy on a regular basis.

Finance and Performance Academy – the academy's remit includes the management of assets and resources in relation to the setting and achievement of financial targets, business objectives and the financial stability of the Trust, and the effective management of all performance-related matters. It has oversight of the development of the Trust's financial and business plans, performance against national standards, contractual indicators and trust-defined indicators, including benchmarking data where appropriate to ensure that opportunities for learning and improvement are identified.

The Regulation and Assurance Committee receives a Chair's report and supporting documents from each of the academies, to provide assurance and enable issues to be escalated where required. The Regulation and Assurance Committee then provides a Chair's report to the Board. This enables the Board to focus more of its attention on strategic matters, as ongoing assurances are dealt with through the academies and Regulation and Assurance Committee.

Risk management

All strategic risks are kept under review and are presented at the ETM on a monthly basis, including a summary of all strategic risks, a movement log showing additions, closures and changes in score, and any proposals to escalate a divisional risk to the strategic risk register (SRR). The academies then review the strategic risks within their remit, alongside a written update providing details of the ETM discussion. The full SRR and movement log are presented to the Regulation and Assurance Committee at each meeting (six times per year), alongside the chair's reports from the academies. They are also presented to the Board for information. Details of the Regulation and Assurance Committee's discussion of risks and any issues the committee wishes to escalate are included in the committee chair's report to the Board.

The BAF is reviewed and updated six times per year. The lead directors provide updates in relation to the individual risks, and this is then reviewed by ETM to ensure that the BAF is considered in its entirety and that the assurance rating for each objective is appropriate. The BAF is then presented to the Regulation and Assurance Committee to consider the level of assurance being provided and to ensure that the BAF is complete, accurate and up to date. It is presented to the Board for information only, however it will be discussed by the Board at least once per year as part of the annual review of the BAF and risk appetite.

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

3.8.5.8. Data security

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

The Trust ensures effective information governance through a number of mechanisms, including education, policies and procedures, IT controls, and IT vulnerability testing, and by demonstrating annual compliance with the Data Security Standards of the Data Protection

and Security Toolkit (DSPT). The Trust has also been awarded the international governance standard for IT and Data Security ISO27001.

3.8.5.9. Register of interests

Within the past 12 months, we have published on our website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) as required by the guidance on Managing Conflicts of Interest in the NHS[68].

3.8.5.10. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme[69], control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

3.8.5.11. Equality and diversity

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

3.8.5.12. Carbon reduction

We have risk assessments and a sustainable development management plan in place which take account of UK Climate Projections 2018[70] (UKCP18). The Trust ensures compliance with its obligations under the Climate Change Act and the Adaptation Reporting requirements.

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

It should be noted that the NHS has been operating under an interim financial regime during the period of the pandemic. As such, many of the normal funding arrangements have been suspended, the need to deliver efficiencies has been reduced on a temporary basis and interim internal financial governance arrangements have been put in place to facilitate agile responses to the pandemic.

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

[68] https://www.england.nhs.uk/publication/managing-conflicts-of-interest-in-the-nhs-guidance-for-staff-and-organisations/
[69] https://www.nhsbsa.nhs.uk/nhs-pensions
[70] https://www.metoffice.gov.uk/research/approach/collaboration/ukcp/index

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

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

Our external auditors are required to satisfy themselves that we have made proper arrangements for securing economy, efficiency and effectiveness in our use of resources. This is assessed in a separate value for money audit which seeks to validate our position in this respect and reports any significant weaknesses identified. We have complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information Guidance to the extent this has been possible during the interim COVID-19 financial regime under which the NHS has been operating since April 2020.

To ensure that any cost improvement schemes - developed through the 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 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, we have had three 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). Two incidents are under investigation at the time of this report. The ICO (the UK's data protection regulator) has confirmed no action is be taken on the first and second incident. The third investigation is incomplete. We cannot predict the outcome of the ICO's decision in relation to the third incident although, in the opinion of the data protection officer (DPO), there is unlikely to be a penalty. This is ultimately a decision that the ICO will make based on its findings and circumstances once the investigation is complete.

The ICO has previously confirmed it believes there are no systemic problems related to previous incidents in the Trust, that the incidents were caused by human error or individuals who blatantly acted outside of their obligations of confidentiality despite being trained, and informed of these obligations. The SIRO (Senior Information Risk Officer) and Caldicott Guardian are fully briefed on all reportable incidents, and any recommendations from the ICO are taken on board. In the event of notification of any action planned by the ICO all senior individuals involved would be fully briefed and actions agreed in close liaison with the ICO.

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

Details of data security and protection incidents (personal data breaches) are set out in the tables below. Figure 36 confirms externally reportable incidents. Figure 37 details all information governance incidents classified at lower-level security to 12 March 2021.

Figure 36: Personal data breaches reported to ICO 2020/21

Date of incident (month)	Nature of incident	Nature of data involved	Number of data subjects potentially affected	Notification steps
May 2020 WR97645	Unauthorised access	Clinical	1	Reported to ICO, no action taken, investigation complete
March 2021 WR107450	Incorrect email recipients	Clinical	1	Reported to ICO, investigation ongoing
March 2021 WR107600	Unauthorised access	Clinical	4	Reported to ICO, investigation ongoing

Figure 37: Other personal data incidents 2020/21

Category	Breach type (ICO categorisation)	Total number of incidents in this category	
Confidentiality	Unauthorised or accidental disclosure	37 11 0 15 18	Data emailed to incorrect recipient Data posted or faxed to incorrect recipient Failure to redact data Verbal disclosures Accessing patient records
Availability	Unauthorised or accidental loss	11 57	Loss or theft of paperwork Data left in insecure location
Availability	Unauthorised or accidental destruction	3	Insecure disposal of paperwork
Integrity	Unauthorised or accidental Alteration	47	Other principle seven failure (information on incorrect patient record)

3.8.8. DATA QUALITY AND GOVERNANCE

We have ensured that there are systems and processes in place for the collection, recording, analysis, and reporting of data. Robust controls are in place to continually evaluate data and ensure it remains accurate, valid, reliable, timely, relevant, and complete on use. These controls are visible via a Trust-wide data quality framework. All data collection and information systems used to record pathway data, clinical activity and/or administrative information across the Trust are within the scope of these controls which assure data across the entire lifecycle, from the point of capture through to disposal.

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

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

(DGB). Priority data quality issues are monitored via an online accessible dashboard and reported back into operational weekly access and performance meetings.

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

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

Our data quality maturity is assessed on a bi-annual basis through a standard model, reported and approved by the DGB through to the Audit and Assurance Committee and Quality Academy.

Formal education and training programmes support appropriate use of our key information systems for new starters (clinical and administrative) and refresher training is available for priority areas. The central data quality improvement team offers bespoke training through bi-weekly drop-in sessions, and one-to-one workshops for operational staff focusing on areas for improvement (approximately 70 delivered per annum).

3.8.9. REVIEW OF EFFECTIVENESS

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the 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 Committee on 3 June 2021. The opinion was that 'significant assurance can be given that there is a good system of governance, risk management and internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently'.
- Internal audits have provided a range of assurance levels, from limited to high assurance. For each internal audit report where a limited assurance opinion is given, the executive director responsible is asked to attend the Audit 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 is followed up by internal audit and reported to the Audit and Assurance Committee.
- The BAF and risk registers provide me with assurance of the effectiveness of the controls being used to manage the risks to the organisation in achieving its strategic objectives and that they have been regularly reviewed. The internal audit of the BAF carries an opinion of significant assurance.

- Through the use of an integrated dashboard the Board and its 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 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 in December 2019 at which the Trust was rated as 'good' overall.

Conclusion

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

Consideration was given to:

- the Trust's financial services provider NHS Shared Business Services[71] (SBS) receiving a qualified audit opinion in line with the requirement of the ISAE 3402 Standard. The qualification relates to two areas of audit testing. The first issue related to approval of credit notes; however, this only affected one SBS client and therefore didn't affect the controls operation by the Trust. The other qualification related to providing evidence of change controls reviews. Assurance has been provided that these reviews were carried out to the required standard.
- the Trust's workforce management provider (Electronic Staff Record (ESR)) receiving a qualified audit opinion in line with the requirement of the ISAE 3000 Standard. The exceptions identified by the service auditor have been reviewed, and it is not considered that there are any associated risks that will have an impact on the Trust.

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

Mel Pickup
Chief Executive
10 June 2021

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

4. APPENDICES

4.1. APPENDIX 1 – CODE OF GOVERNANCE DISCLOSURES

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

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

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
		of appointments of the non-executive directors, and how they may be terminated	
Nominations Committee(s)	B.2.10	A separate section of the annual report should describe the work of the nominations committee(s), including the process it has used in relation to board appointments.	3.2.3.2
Nominations Committee(s)	n/a	The disclosure in the annual report on the work of the nominations committee should include an explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-executive director.	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)	3.5.4.6
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.	3.8.4.
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	3.8.3

Relating to	FT Code of Governance reference	Summary of requirement	Section reference within the annual report
		internal controls.	
Audit Committee/control environment	C.2.2	A trust should disclose in the annual report: (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.	3.5.5.2
Audit Committee/ Council of Governors	C.3.5	If the council of governors does not accept the audit committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include in the annual report a statement from the audit committee explaining the recommendation and should set out reasons why the council of governors has taken a different position.	n/a
Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: • the significant issues that the committee considered in relation to financial statements, operations and compliance, and how these issues were addressed; • an explanation of how it has assessed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenure of the current audit firm and when a tender was last conducted; and • if the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence are safeguarded.	3.1.1 3.5.5.2
Board/Remuneration Committee	D.1.3	Where an NHS foundation trust releases an executive director, for example to serve as a non-executive director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	n/a
Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, for example through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	3.5.4.9
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.	3.5.3
Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership; • information on the number of members and the number of members in each constituency; and	3.5.3

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

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2021

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

CONTENTS

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: March 2021

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

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 2021 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.

We have also audited the information in the Remuneration Report and Staff Report that is subject to audit, being:

- the table of salaries and allowances of senior managers on pages 37 to 40;
- the table of pension benefits of senior managers on page 41;
- the table of pay multiples and related narrative notes on page 42; and
- the table of exit packages on page 48.

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

Basis for opinion

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

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

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the accounting officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.
Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the foundation trust's

ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

The going concern basis of accounting for the foundation trust is adopted in consideration of the requirements set out in the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts, which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it anticipated that the services which they provide will continue into the future.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The accounting officer is responsible for the other information contained within the annual report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether this gives rise to a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Responsibilities of accounting officer

As explained more fully in the statement of accounting officer's responsibilities, the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the accounting officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the accounting officer is responsible for assessing the foundation trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the foundation trust without the transfer of the foundation trust's services to another public sector entity.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Extent to which the audit was considered capable of detecting non-compliance with laws and regulations, including fraud

We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of non-compliance with laws and regulations, including fraud. The extent to which our procedures are capable of detecting non-compliance with laws and regulations, including fraud is detailed below.

We considered the nature of the foundation trust and its control environment, and reviewed the foundation trust's documentation of their policies and procedures relating to fraud and compliance with laws and regulations. We also enquired of management, internal audit and local counter fraud about their own identification and assessment of the risks of non- compliance with laws and regulations.

We obtained an understanding of the legal and regulatory framework that the foundation trust operates in, and identified the key laws and regulations that:

- had a direct effect on the determination of material amounts and disclosures in the financial statements. This included the National Health Service Act 2006.
- do not have a direct effect on the financial statements but compliance with which may be fundamental to the foundation trust's ability to operate or to avoid a material penalty. These included the Data Protection Act 2018 and relevant employment legislation.

We discussed among the audit engagement team regarding the opportunities and incentives that may exist within the organisation for fraud and how and where fraud might occur in the financial statements.

As a result of performing the above, we identified the greatest potential for fraud in the following areas, and our specific procedures performed to address it are described below:

- accounting for capital expenditure and specifically the risk that assets were incorrectly capitalised either due to cut off or incorrect application of the definition of a capital item:
- we tested the expenditure on a sample basis to assess whether they meet the relevant accounting requirements to be recognised as capital in nature; we agreed a sample of capital additions to supporting documentation and assessed whether the capitalised
- expenditure is recognised in the correct accounting period.

In common with all audits under ISAs (UK), we are also required to perform specific procedures to respond to the risk of management override. In addressing the risk of fraud through management override of controls, we tested the appropriateness of journal entries and other adjustments; assessed whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluated the business rationale of any significant transactions that are unusual or outside the normal course of business.

In addition to the above, our procedures to respond to the risks identified included the following:

- reviewing financial statement disclosures by testing to supporting documentation to assess compliance with provisions of relevant laws and regulations described as having
- a direct effect on the financial statements;
- performing analytical procedures to identify any unusual or unexpected relationships that may indicate risks of material misstatement due to fraud;
- enquiring of management, internal audit concerning actual and potential litigation and claims, and instances of non-compliance with laws and regulations;
- review of local counter fraud reports produced; and
- reading minutes of meetings of those charged with governance and reviewing internal audit reports.

Report on other legal and regulatory requirements

Opinions on other matters prescribed by the National Health Service Act 2006

In our opinion:

- the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the National Health Service Act 2006; and
- the information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the
- financial statements.

Matters on which we are required to report by exception use of resources

Under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 , we are required to report to you if we have not been able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Our work in respect of the foundation trust's arrangements is not complete at the date of our report on the financial statements. We will report the outcome of our work on the foundation trust's arrangements and include any additional exception reporting in respect of significant weaknesses in our audit completion certificate and our separate Auditor's Annual Report. We are satisfied that the remaining work is unlikely to have a material impact on the financial statements.

Respective responsibilities of the accounting officer and auditor relating to the foundation trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

The accounting officer is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in the use of the foundation trust's resources.

We are required under the Code of Audit Practice and Schedule 10(1(d)) of the National Health Service Act 2006 to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We undertake our work in accordance with the Code of Audit Practice, having regard to the guidance, published by the Comptroller & Auditor General in April 2021, as to whether the foundation trust has proper arrangements for securing economy, efficiency and effectiveness in the use of resources against the specified criteria of financial sustainability, governance, and improving economy, efficiency and effectiveness.

The Comptroller & Auditor General has determined that under the Code of Audit Practice, we discharge this responsibility by reporting by exception if we have reported to the foundation trust a significant weakness in arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021 by the time of the issue of our audit report. Other findings from our work, including our commentary on the foundation trust's arrangements, will be reported in our separate Auditor's Annual Report.

Annual governance statement and compilation of financial statements

Under the Code of Audit Practice, we are required to report to you if, in our opinion:

- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS

Foundation Trust Annual Reporting Manual, is misleading, or is inconsistent with information of which we are aware from our audit; or
- proper practices have not been observed in the compilation of the financial statements.

We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in respect of these matters.

Reports in the public interest or to the regulator

Under the Code of Audit Practice, we are also required to report to you if:

- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit; or
- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006 because we have reason to believe that the foundation trust, or a director or officer of the foundation trust, is about to make, or has made, a
- decision involving unlawful expenditure, or is about to take, or has taken, unlawful action likely to cause a loss or deficiency.

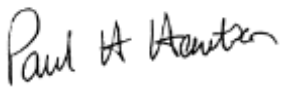
We have nothing to report in respect of these matters.

Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate until we have completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources (as reported in the Matters on which we are required to report by exception – Use of resources section of our report). We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements or on our value for money conclusion.

Use of our report

This report is made solely to the Council of Governors and Board of Directors ("the Boards") of Bradford NHS Foundation Trust, as a body, in accordance with paragraph 4 of Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Boards those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Boards as a body, for our audit work, for this report, or for the opinions we have formed.



Paul Hewitson (Key Audit Partner) For and on behalf of Deloitte LLP Appointed Auditor
Leeds, United Kingdom 14 June 2021

Independent auditor's certificate of completion of the audit

Issue of opinion on the audit of the financial statements

In our audit report for the year ended 31 March 2021 issued on 14 June 2021 we reported that, in our opinion, the financial statements:

- gave a true and fair view of the state of the foundation trust's affairs as at 31 March 2021 and of its income and expenditure for the year then ended;
- had been properly prepared in accordance with the accounting policies directed by NHS Improvement – Independent Regulator of NHS Foundation Trusts; and
- had been prepared in accordance with the requirements of the National Health Service Act 2006.

Foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

As part of our audit, we are required to report to you if we are not able to satisfy ourselves that the foundation trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

As at the date of issue of our audit report for the year ended 31 March 2021 on 14 June 2021, we had not completed our work on the foundation trust's arrangements, and had nothing to report in respect of this matter as at that date.

Certificate of completion of the audit

In our audit report for the year ended 31 March 2021 issued on 14 June 2021, we explained that we could not formally conclude the audit on that date until we had completed our work in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed our work in this area.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave our opinion.

We have nothing to report in respect of the foundation trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

We certify that we have completed the audit of Bradford Teaching Hospitals NHS Foundation Trust in accordance with requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Code of Audit Practice.

Paul Hewitson (Key Audit Partner) For and on behalf of Deloitte LLP Appointed Auditor
Leeds, United Kingdom 27 August 2021

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2021 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the NHS foundation trust) in accordance with paragraph 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed:

Name: Mel Pickup (Chief Executive)
Dated: 10 June 2021

1 STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2021

	Note	2020/21	2019/20
		£000	£000
Operating income from patient care activities	2.1	422,366	378,652
Other operating income	2.1	71,605	71,664
Operating expenses	3.1	(489,373)	(440,163)
OPERATING SURPLUS		**4,598**	**10,153**
FINANCE COSTS			
Finance income	5	0	258
Finance expense	6.1	(371)	(429)
Public dividend capital dividends payable	6.2	(3,329)	(4,433)
NET FINANCE COSTS		**(3,700)**	**(4,604)**
Losses on disposals of assets		(25)	(13)
SURPLUS FOR THE YEAR		**873**	**5,536**
Other comprehensive income **Will not be reclassified to income and expenditure:**			
Impairment losses	15.1	(9,381)	(1,080)
Revaluation gains	15.1	443	15,799
TOTAL COMPREHENSIVE (EXPENDITURE) / INCOME FOR THE YEAR		**(8,065)**	**20,255**

All income and expenses shown relate to continuing operations.

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

2 STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2021

	Note	31 Mar 2021 £000	31 Mar 2020 £000
Non-current assets			
Intangible assets	7.1	11,067	11,666
Property, plant and equipment	8.2	192,402	185,828
Trade and other receivables	10.1	2,183	2,718
Total non-current assets		**205,652**	**200,212**
Current assets			
Inventories	9	8,095	7,970
Trade and other receivables	10.1	20,355	28,306
Cash and cash equivalents	16.1	75,015	29,618
Total current assets		**103,465**	**65,894**
Current liabilities			
Trade and other payables	11	(68,048)	(37,312)
Borrowings	13.1	(3,117)	(3,129)
Provisions	14.1	(880)	(339)
Other liabilities	12	(14,612)	(7,672)
Total current liabilities		**(86,657)**	**(48,452)**
Total assets less current liabilities		**222,460**	**217,654**
Non-current liabilities			
Borrowings	13.1	(19,688)	(22,740)
Provisions	14.1	(4,725)	(4,116)
Other liabilities	12	(2,779)	(1,969)
Total non-current liabilities		**(27,192)**	**(28,825)**
Total assets employed		**195,268**	**188,829**
Financed by taxpayers' equity			
Public Dividend Capital		140,333	125,829
Revaluation reserve	15.1	49,706	60,415
Income and expenditure reserve		5,229	2,585
Total taxpayers' equity		**195,268**	**188,829**

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: 10 June 2021

3 STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Total £000	Public Dividend Capital £000	Revaluation reserve (see note 15.1) £000	Income and expenditure reserve £000
Taxpayers' equity at 1 April 2020	**188,829**	**125,829**	**60,415**	**2,585**
Surplus for the year	**873**	0	0	873
Other transfers between reserves	**0**	0	(1,771)	1,771
Net impairments	**(9,381)**	0	(9,381)	0
Revaluations – property, plant and equipment	**443**	0	443	0
Public dividend capital received	**14,504**	14,504	0	0
Taxpayers' equity at 31 March 2021	**195,268**	**140,333**	**49,706**	**5,229**
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**

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.

4 STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2021

	2020/21 £000	2019/20 £000
Cash flows from operating activities		
Operating surplus from continuing operations	4,598	10,153
Non-cash income and expense		
Depreciation and amortisation	14,653	10,260
Impairments and (reversals)	751	(5,147)
Income recognised in respect of capital donations (cash and non-cash)	(1,347)	(70)
Decrease in trade and other receivables	8,561	1,798
(Increase) in inventories	(125)	(557)
Increase in trade and other payables	20,316	2,873
Increase in other liabilities	7,750	2,870
Increase in provisions	1,181	1,164
Net cash generated from operations	**56,338**	**23,344**
Cash flows from investing activities		
Interest received	10	244
Purchase of intangible assets	(3,417)	(2,234)
Purchase of property, plant and equipment and investment property	(15,288)	(8,504)
Sale of property, plant and equipment and investment property	16	0
Receipt of cash donations to purchase capital assets	114	0
Net cash used in investing activities	**(18,565)**	**(10,494)**
Cash flows from financing activities		
Public dividend capital received	14,504	3,248
Movement in loans from the Department of Health and Social Care	(3,052)	(3,052)
Interest paid on DHSC loans	(414)	(455)
Public dividend capital dividend paid	(3,414)	(4,176)
Net cash generated from / (used in) financing activities	**7,624**	**(4,435)**
Increase/(decrease) in cash and cash equivalents	45,397	8,415
Cash and cash equivalents at 1 April	29,618	21,203
Cash and cash equivalents at 31 March	**75,015**	**29,618**

NOTES TO THE ACCOUNTS

5 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 (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2020/21 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.

5.1 Accounting convention

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

5.2 Going Concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

1.3 Interest in other Entities

Joint Venture

Joint Ventures are arrangements in which the NHS foundation trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint Ventures are accounted for using the equity method.

In 2015/16 the NHS foundation trust entered into two joint venture limited liability partnerships Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP. The NHS foundation trust currently holds a 33.33% equity investment in both organisations, with losses limited to £1 each, with Airedale NHS Foundation Trust and Harrogate and District NHS Foundation Trust (from October 2019). The joint ventures have been established to deliver and develop laboratory based pathology services. In applying the equity method the Trust will not show any grouped transactions from the Joint Ventures until such a time that their profits outweigh their losses. 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 of Bradford Hospitals Charity (the Charity), charity registration number 1061753, on the grounds of materiality.

The NHS foundation trust is the Corporate Trustee of the Charity and is governed by the law applicable to trusts, principally the Trustee Act 2000 and the Charities Act 1993, as amended by the

Charities Act 2011, the Charities (Accounts and Reports) Regulations 2008 (as modified by section 5 and the Schedule to Order) and the Statement of Recommended Practice (FRS 102, effective from 01 January 2015). The NHS foundation trust Board of Directors has devolved responsibility for the on-going management of funds to the Charitable Fund Committee, which administers the funds on behalf of the Corporate Trustee.

1.4 Income

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

<u>2020/21</u>

The main source of income for the NHS foundation trust is contracts with commissioners for health care services. In 2020/21, the majority of the trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

<u>Comparative period (2019/20)</u>

In the comparative period (2019/20), the NHS foundation trust's contracts with NHS commissioners included those where the trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of IFRS 15 entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment

for work completed was usually only dependent on the passage of time. The block contract arrangements in place during 2020/21 mean an equivalent accrual is not required.

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

The Trust received income from commissioners under Commissioning for Quality and Innovation (CQUIN) schemes. The Trust agreed schemes with its commissioner but they affected how care is provided to patients. That is, the CQUIN payments were not considered distinct performance obligations in their own right; instead they formed part of the transaction price for performance obligations under the contract. CQUIN schemes were suspended throughout 2020/21 as part of the block contract arrangements to support the response to the conronavirus pandemic.

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

In 2019/20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds was accounted for as variable consideration.

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 22.43%. (2019/20: 21.79%)

Grants and donations

Government grants are grants from government bodies other than income from commissioners or Trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grant is used to fund capital expenditure, it is credited to the consolidated statement of comprehensive income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the NHS foundation trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.5 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the annual accounts to the extent that employees are permitted to carry forward leave into the following period.

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care, in England and Wales. The schemes are not designed in a way that would enable employers to identify their share of the underlying assets and liabilities. Therefore the schemes are accounted for as though they are defined contribution scheme: the cost to the NHS foundation trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as they become due.

Additional pension liabilities arising from early retirements are not funded by the schemes except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the NHS foundation trust commits itself to the retirement, regardless of the method of payment.

1.6 Expenditure on other goods and services

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

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS foundation trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has a cost of at least £5,000; or
    - collectively, a number of items have a cost of at least £5,000 and individually have a cost of £250 or more, where the assets are functionally interdependent, had broadly

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

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

Revaluation gains and losses

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

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the SoCI as an item of 'other comprehensive income'.

Impairments

In accordance with the 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 2020/21 the impairment is £10,132,000 and in 2019/20 there was a reversal of impairment of £4,067,000.

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 the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued

except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

The gain or loss arising on the disposal or retirement of an asset is determined as the difference between the sales proceeds (if any) and the carrying amount of the asset and is recognised in the SoCI.

Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

In 2020/21 this includes assets donated to the NHS foundation trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the NHS foundation trust applies the principle of donated asset accounting to assets that the NHS foundation trust controls and is obtaining economic benefits from at the year end.

Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	17	53
Dwellings	28	36
Plant & machinery	5	15
Transport equipment	7	7
Information technology	4	10
Furniture & fittings	7	10

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

1.8 Intangible assets

Recognition

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

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised on a straight line basis over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

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

1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of pharmacy inventories is measured using weighted average historical cost method. The cost of other inventories is measured using the First In First Out (FIFO) method. Provision is made where necessary for obsolete, slow moving inventory where it is deemed that the costs incurred may not be recoverable through usage or sale.

In 2020/21, the NHS foundation trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the NHS foundation trust accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department of Health and Social Care.

1.10 Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS foundation trust's cash management. Cash, bank and overdraft balances are recorded at current values.

1.11 Climate Change Levy

Expenditure on the climate change levy is recognised in the SOCI as incurred, based on the prevailing chargeable rates for energy consumption.

1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the NHS foundation trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The 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.

1.13 Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

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.

1.14 Provisions

The NHS foundation trust recognises a provision:

- where it has a present legal or constructive obligation of uncertain timing or amount;
- for which it is probable that there will be a future outflow of cash or other resources; and
- where a reliable estimate can be made of the amount.

The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms (2019/20: minus 0.50%).

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.

1.15 Contingencies

Contingent assets (assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 18 unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.16 Public Dividend Capital

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

The Secretary of State can issue new PDC to, and require repayments of PDC from, the NHS foundation trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as Public Dividend Capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined in the PDC dividend policy issues by the DHSC. This policy is available at https://www.gov.uk/government/publications-on-financing-available-to-nhs-trusts-and-foundation-trusts.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.17 Value Added Tax

Most of the activities of the NHS foundation trust are an exempt VAT supply and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of both intangible assets and property, plant and equipment. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.18 Corporation Tax

The NHS foundation trust is a Health Service body within the meaning of s519 ICTA 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for the Treasury to disapply the exemption in relation to the specified actiities of a trust (s519A (3) to (8) ICTA 1988), but, as at 31 March 2021, this power has not been exercised. Accordingly, the NHS foundation trust is not within the scope of corporation tax.

1.19 Foreign exchange

The functional and presentational currencies of the NHS foundation trust are sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the NHS foundation trust has assets or liabilities denominated in a foreign currency at the SoFP date:

- monetary items are translated at the spot exchange rate on 31 March 2021;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the SoFP date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

1.20 Third party assets

Assets belonging to third parties in which the NHS foundation trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 16.1 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.21 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the NHS or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

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

1.22 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2020/21.

1.24 Standards, amendments and interpretations in issue but not yet effective or adopted

IFRS 16 Leases

IFRS 16 Leases will replace *IAS 17 Leases*, *IFRIC 4 Determining whether an arrangement contains a lease* and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the re-measurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The NHS foundation trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the NHS foundation trust will apply the standard retrospectively 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 2022 for existing finance leases.

For leases commencing in 2022/23, the NHS foundation trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation

The Department of Health & Social Care Group Accounting Manual does not require the following Standards and Interpretations to be applied in 2020/21.

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:

Valuation of land and buildings

The valuation of land and buildings has been identified as a critical accounting judgement. The valuation is provided by an independent valuer, Cushman Wakefield, who have applied the modern equivalent asset valuation. This approach assumes that the asset would be replaced with a modern equivalent, not a building of identical design. The modern equivalent may well be smaller than the existing asset, for example due to technological advances in plant and machinery or reduced operational use.

1.27 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. Total impairment losses charged to the Statement of Comprehensive Income for 2020/21 amounted to £751,000 (2019/20: £5,147,000 reversal of impairment).

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 2021 was £158,333,000 (31 March 2020: £167,715,000).

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. As at 31 March 2021 provisions amounted to £5,605,000 (31 March 2020: £4,455,000) and contingent liabilities amounted to £68,000 (31 March 2020: £857,000).

iv. The NHS foundation trust has a number of agreements in place to provide services over more than one year (for example, contracts relating to research and development). These 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 2021 amounted to £17,391,000 (31 March 2020: £8,155,000).

6 Note 2 Operating income

Note 2.1 Income from patient care (by nature)

	Note	2020/21 £000	2019/20 £000
Income from activities			
Block contract / system envelope income[1]		366,336	329,368
High cost drugs income from commissioners		36,297	36,095
Private patient income		49	323
Additional pension contribution central funding[2]		12,001	11,068
Other clinical income	2.2	7,683	1,798
Total income from activities		**422,366**	**378,652**
Other operating income from contracts with customers:			
Research and development		4,656	8,020
Education and training		19,631	19,881
Provider sustainability fund income (PSF) (2019/20 only)		0	5,120
Financial recovery fund (FRF) (2019/20 only)		0	14,271
Reimbursement and top up funding[3]		22,265	0
Income in respect of employee benefits accounted on a gross basis	2.3	4,197	4,458
Other Income	2.4	6,557	14,753
Other non-contract operating income			
Research and development (non-contract)		4,648	4,940
Education and training		628	0
Receipt of capital grants and donations		1,347	70
Charitable and other contributions to expenditure[4]		7,676	151
Total other operating income		**71,605**	**71,664**
Total		**493,971**	**450,316**

[1]As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system

envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

2019/20 Block Contract / system envelope income of £329,368,000 comprises of elective income £49,922,000, non-elective income £110,982,000, first outpatient income £30,954,000, follow Up outpatient income £30,598,000, accident and emergency income £18,958,000, Other NHS Clinical Income of £75,331,000 and Income from CCG's and NHS England £12,623,000.

[2]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. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

[3]Reimbursement and top up funding relates to funding provided to NHS providers throughout 2020/21 as part of the coronavirus pandemic response. This funding was provided in addition to the block contract amounts to ensure the NHS Foundation trust achieved a break even position despite the increase in costs for the coronavirus pandemic response.

[4]2020/21 Charitable and and other contributions to expenditure comprises consumables donated from DHSC group bodies for the COVID 19 response £7,420,000, charitable and other contributions from NHS bodies £171,000 and receipt of equipment donated from DHSC for COVID 19 response which were below the capitalisation threshold £85,000.

Note 2.2 Other clinical income

Other clinical income comprises of annual leave central funding £5,965,000 (2019/20: nil), central funding for overtime payments and pay during annual leave (Flowers) £438,000 (2019/20: nil), Road Traffic Accident (RTA) income £903,000 (2019/20: £1,500,000) and income from overseas patients £367,000 (2019/20: £266,000).

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

	2020/21 £000	2019/20 £000
Income recognised this year	367	266
Cash payments received in-year	52	110
Amounts added to provision for impairment of receivables	227	169
Amounts written off in-year	243	160

Note 2.3 Income in respect of employee benefits accounted for on a gross basis

Provider to provider income relates to services provided by the NHS foundation trust to other trusts or commissioners. Income recorded under this heading relates to areas including ear, nose and throat, ophthalmology and plastic surgeons working at Calderdale and Huddersfield NHS Foundation Trust £270,000 (2019/20: £200,000), Airedale NHS Foundation Trust £1,436,000 (2019/20: £1,300,000), individual posts and services charged to Leeds Teaching Hospitals £524,000 (2019/20: £400,000), Bradford District Care Trust £368,000 (2019/20: £200,000), other hospitals across Yorkshire £203,000 (2019/20: £100,000) and support to non NHS organisations £1,396,000 (2019/20: £1,400,000) including Macmillian Cancer Support and Marie Curie Hospice for doctors, nurses, AHPs and administrative staff.

Note 2.4 Other income

Other income, in the main, includes income associated with services provided to other NHS organisations £4,470,000 (2019/20: £9,400,000), pharmacy sales £1,448,000 (2019/20: £2,800,000), car parking income £27,000 (2019/20: £1,300,000), catering £210,000 (2019/20: £500,000), clinical excellence awards £161,000 (2019/20: £500,000) and staff accommodation £215,000 (2019/20: £186,000).

Note 2.5 Segmental analysis

The Chief Operating Decision Maker (CODM) is the Board of Directors because it is at this level where overall financial performance is measured and challenged. The Board of Directors primarily considers financial matters at a trust wide level. The Board of Directors is presented with information on clinical divisions but this is not the primary way in which financial matters are considered.

The NHS foundation trust has applied the aggregation criteria from IFRS 8 operating segments because the clinical divisions provide similar services, have homogenous customers, common production processes and a common regulatory environment. Therefore the NHS foundation trust believes that there is one segment and have reported under IFRS 8 on this basis.

Note 2.6 Income from patient care (by source)

Income from activities	**2020/21 £000**	**2019/20 £000**
NHS England	85,927	77,282
Clinical commissioning groups	334,561	298,908
NHS Foundation Trusts	350	104
NHS Trusts	193	226
NHS other (including Public Health England)	1	10
Non-NHS: private patients	49	323
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	367	266
Injury cost recovery scheme	903	1,533
Non-NHS: Other	15	0
Total income from activities	**422,366**	**378,652**
Of which:		
Related to continuing operations	422,366	378,652
Related to discontinued operations	0	0

Note 2.7 Income from activities arising from commissioner requested services

	2020/21 £000	2019/20 £000
Income for services designated as commissioner requested services	420,504	376,531
Income from services not designated as commissioner requested services	1,862	2,121
Total	**422,366**	**378,652**

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.

7 Note 3 Operating expenses

Note 3.1 Operating expenses

	Note	2020/21 £000	2019/20 £000
Purchase of healthcare from NHS and DHSC bodies		1,924	1,743
Purchase of healthcare from non NHS bodies and non-DHSC bodies		1,288	284
Staff and executive directors costs		303,061	271,743
Non-executive directors		98	137
Supplies and services – clinical (excluding drug costs)		51,725	43,229
Supplies and services – general		21,987	21,726
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		37,646	40,703
Inventories written down		344	0
Consultancy costs		984	846
Establishment		2,792	2,804
Premises – business rates collected by local authorities		1,950	1,974
Premises – other		7,486	6,981
Transport – (business travel only)		382	444
Transport – other (including patient travel)		2	23
Depreciation on property, plant & equipment		10,760	8,111
Amortisation on intangible assets		3,893	2,149
Impairments net of (reversals)		751	(5,147)
Movement in credit loss allowance: contract receivables / assets		51	86
Change in provisions discount rate		139	239
Audit services – statutory audit		83	64
Other auditor remuneration	3.2	0	1
Internal Audit – non-staff		195	176
Clinical negligence – amounts payable to the NHS Resolution (premium)		15,575	13,869
Legal fees		72	276
Insurance		360	107
Research and Development – staff costs		8,962	8,263
Research and development – non-staff		6,097	5,528
Education and training – staff costs		6,430	5,498
Education and training – non-staff		158	519
Education and training – notional expenditure funded from apprenticeship fund		628	0
Operating lease expenditure (net)	3.3	2,568	2,252
Car parking and security		12	11
Hospitality		1	20
Other losses and special payments – non-staff		18	121
Other services (e.g. external payroll)		951	810
Other[1]		0	4,573
Total		**489,373**	**440,163**

[1]2019/20 Other expenditure includes £4,573,000 as a result of unwinding a historic VAT reclaim which the NHS foundation trust qualified for in 2018/19 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

	2020/21	2019/20
	£000	£000
Audit related assurance services	0	1
Total	**0**	**1**

Note 3.3 Operating leases

	2020/21	2019/20
	£000	£000
Minimum lease payments	2,568	2,252
Total	**2,568**	**2,252**

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

Note 3.4 Future minimum lease payments

	2020/21	2019/20
	£000	£000
- not later than one year	4,815	3,898
- later than one year and not later than five years	1,950	1,183
Total	**6,765**	**5,081**

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 2021 is £1,000,000 (31 March 2020 £1,000,000).

Note 3.6 Impairment of assets

	2020/21 £000	2019/20 £000
Unforeseen obsolescence	0	86
Changes in market price	273	(5,233)
Other	478	0
Total net impairments charged to operating surplus	**751**	**(5,147)**
Impairments charged to the revaluation reserve	9,381	1,080
Total net impairments	**10,132**	**(4,067)**

8 Note 4 Employee expenses

Note 4.1 Employee expenses

	2020/21	2019/20
	£000	**£000**
Salaries and wages	243,348	220,099
Social security costs	24,523	20,194
Apprenticeship Levy	1,196	1,067
Pension cost – defined contribution plans, employer's contributions to NHS Pensions	41,599	35,885
Temporary Staff - Agency / contract staff	8,268	8,596
Total	**318,934**	**285,841**
Included within :		
Costs capitalised as part of assets	481	337

All employer pension contributions in 2020/21 and 2019/20 were paid to the NHS Pensions Agency.

The operating employee expense, excluding costs capitalised as part of assets, of £318,453,000 is reported in table 3.1 Operating expenses as Staff and executive directors costs (£303,061,000), Research and Development – staff costs (£8,962,000) and Education and training – staff costs (£6,430,000).

Salaries and wages include for internal temporary bank staff £16,649,000 (2019/20: £15,171,000).

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

	2020/21	2019/20

	£000	£000
Directors' remuneration	1,315	1,169
Employer pension contributions in respect of directors	155	122

Note 4.2 Average number of employees

	2020/21	2019/20
	WTE	WTE
Medical and dental	843	779
Administration and estates	1,892	1,848
Healthcare assistants and other support staff	712	671
Nursing, midwifery and health visiting staff	2,061	1,988
Scientific, therapeutic and technical staff	766	736
Other	2	3
Total	**6,276**	**6,025**
of which		
Number of employees engaged on capital projects	9	8

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

	2020/21	2019/20
	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	0
£25,001 - £50,000	0	0
£50,001 - £100,000	0	0
Total	**0**	**0**

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

	2020/21 Agreements	2020/21 Total value of agreements
	Number	£000
Contract payments in lieu of notice	4	16
Exit payments following employment tribunals or court orders	1	19

Total	**5**	**35**

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

Note 4.5 Early retirements due to ill health

	2020/21 £000	2020/21 Number	2019/20 £000	2019/20 Number
Number of early retirements on the grounds of ill-health	-	6	-	3
Value of early retirements on the grounds of ill-health	130	-	255	-

Note 4.6 Analysis of termination benefits

	2020/21 £000	2020/21 Number	2019/20 £000	2019/20 Number
Number of cases	-	0	-	0
Cost of cases	0	-	0	-

Note 4.7 Pension Costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2021, is based on valuation data as 31 March 2020, updated to 31 March 2021 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019 at 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

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. The contribution remains at 3% for 2020 & 2021 respectively.

Employees are permitted to opt out of the auto-enrolment, from either the NHS Pension Scheme or NEST, if they do not wish to pay into a pension, but they will lose the contribution made by the NHS foundation trust.

In the financial year to 31 Mar 2021, the NHS foundation trust made contributions totalling £89,000 into the NEST fund (31 March 2020 £79,000).

9 Note 5 Finance income

	2020/21 £000	2019/20 £000
Interest on bank accounts	0	141
Interest on other investments / financial assets	0	117
Total	**0**	**258**

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

2020/21 interest earned is nil due to the Bank of England base rate being set at 0.1% throughout the year.

10 Note 6 Finance costs and Public Dividend Capital dividend

Note 6.1 Finance costs

Interest expense amounted to £402,000 (2019/20: £446,000). This is interest due on the following loans taken from the DHSC.

Date Total Loan Taken	Duration of Loan	Total Loan Amount (£000)	Remaining Amount to Withdraw (£000)	Amount Repaid (£000)	Balance Outstanding (£000)	Total Interest (£000)
20 June 2016	20 Years	20,000	0	5,260	14,740	304
19 September 2016	8 Years	16,000	0	8,000	8,000	98
		36,000	**0**	**13,260**	**22,740**	**402**

The unwinding of discount on provisions amounted to negative £31,000 (2019/20 negative £17,000).

No interest or compensation has been paid under the Late Payment of Commercial Debts (Interest) Act 1998 during 2020/21 or 2019/20.

Note 6.2 Public dividend capital dividend

PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a

financial instrument within the meaning of IAS 32. A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable as PDC dividend. See accounting policy 1.17 for an explanation of how this dividend is calculated.

The amount payable this year is £3,329,000 (2019/20: £4,433,000), which is 3.50% of the year's average relevant net assets of £182,983,000 (2019/20: £165,603,000) less average daily cleared cash balance £87,873,000 (2019/20: £38,975,000) 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 223 (2019/20: 190) separate losses and special payments, totalling £335,000 (2019/20: £294,000). 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.

	2020/21 Total Number of Cases Number	2020/21 Total Value of Cases £000	2019/20 Total Number of Cases Number	2019/20 Total Value of Cases £000
Losses				
Cash losses	25	9	31	21
Bad debts and claims abandoned	174	264	126	185
Total losses	**199**	**273**	**157**	**206**
Special Payments				
Ex-gratia payments	24	62	33	88
Total special payments	**24**	**62**	**33**	**88**
Total losses and special payments	**223**	**335**	**190**	**294**

11 Note 7 Intangible assets

Note 7.1 Intangible assets 2020/21

	Total	Software licences	Assets under construction
	£000	£000	£000
Valuation / gross cost at 1 April	**24,365**	24,365	0
Additions – purchased / internally generated	**3,520**	3,520	0
Additions – donation of physical assets (non cash)	**5**	5	0
Reclassifications	**763**	763	0

Disposals / derecognition	**(8,675)**	(8,675)	
Gross cost at 31 March	**19,978**	**19,978**	**0**
Accumulated amortisation at 1 April	**12,699**	**12,699**	**0**
Provided during the year	**3,893**	3,893	0
Impairments	**68**	68	
Reclassifications	**926**	926	0
Disposals / derecognition	**(8,675)**	(8,675)	0
Amortisation at 31 March	**8,911**	**8,911**	**0**
Net book value at 31 March 2021	**11,067**	**11,067**	**0**
Net book value at 31 March 2020	**11,666**	**11,666**	**0**

Note 7.2 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 31 March 2019	**11,776**	**9,413**	**2,363**

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 £4,157,000 (2019/20: £5,196,000) which will be amortised over the life of the service contract which expires on 31 January 2025.

12 Note 8 Property, plant and equipment

Note 8.1 Property, plant and equipment 2020/21

	Total	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant and machinery	Transport equipment	Information technology	Furniture and fittings
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/Gross cost at 1 April	**229,914**	**8,662**	**155,843**	**3,210**	**0**	**35,819**	**42**	**25,941**	**397**
Additions – purchased	**25,491**	0	4,220	42	7,026	8,169	16	6,018	0
Additions – donations / grants	**1,342**	0	126	0	0	1,216	0	0	0
Impairments charged to operating expenses	**0**	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve	**(9,381)**	0	(9,249)	(132)	0	0	0	0	0
Reclassifications	**(763)**	0	0	0	0	969	0	(1,733)	1
Revaluations	**(4,389)**	400	(4,688)	(101)	0	0	0	0	0
Disposals	**(16,136)**	0	0	0	0	(2,901)	(19)	(13,095)	(121)
Valuation/Gross cost at 31 March	**226,078**	**9,062**	**146,252**	**3,019**	**7,026**	**43,272**	**39**	**17,131**	**277**
Accumulated depreciation at 1 April	**44,086**	**0**	**0**	**0**	**0**	**24,457**	**41**	**19,341**	**247**
Provided during the year	**10,760**	0	4,458	101	0	2,955	1	3,128	117
Impairments charged to operating expenses	**1,565**	0	1,155	0	0	326	0	82	2
Reversal of impairments charged to operating expenses	**(882)**	0	(882)	0	0	0	0	0	0
Revaluations	**(4,832)**	0	(4,731)	(101)	0	0	0	0	0

Reclassifications	**(926)**	0	0	0	0	479	0	(1,406)	1
Disposals	**(16,095)**	0	0	0	0	(2,860)	(19)	(13,095)	(121)
Accumulated depreciation at 31 March	**33,676**	**0**	**0**	**0**	**0**	**25,357**	**23**	**8,050**	**246**

A desktop valuation for land, buildings and dwellings was carried out at 31st March 2021 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.

Information Technology assets with a total gross value of £13,095,000 were disposed of in 2020/21 (2019/20: £0). These assets had a nil net book value. The large disposal includes assets which have been held for over 7 years and were no longer in use.

Note 8.2 Property, plant and equipment financing 2020/21

	Total	**Land**	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction**	**Plant and machinery**	**Transport equipment**	**Information technology**	**Furniture and fittings**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Owned - purchased	**188,891**	9,062	144,207	3,019	7,026	16,467	16	9,074	20
Donated	**3,511**	0	2,045	0	0	1,448	0	7	11
Net book value at 31 March	**192,402**	**9,062**	**146,252**	**3,019**	**7,026**	**17,915**	**16**	**9,081**	**31**

No assets were held under finance leases and hire purchase contracts at the SoFP date in either 2020/21 or 2019/20.

No depreciation was charged to the income and expenditure in respect of assets held under finance leases and hire purchase contracts in either 2020/21 or 2019/20.

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

Note 8.3 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 depreci**ation 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**

Note 8.4 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**

13 Note 9 Inventories

	31 Mar 21 £000	31 Mar 20 £000
Consumables	4,847	4,392
Drugs	3,187	3,512
Buildings and engineering	61	66
Total	**8,095**	**7,970**

Inventories recognised in expenses for the year were £44,597,000 (2019/20: £40,715,000). Write-down of inventories recognised as expenses for the year were £344,000 (2019/20: £0).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £7,420,000 of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

14 Note 10 Receivables

Note 10.1 Trade receivables and other receivables

	31 Mar 21 £000	31 Mar 20 £000
Current		
Contract receivables	14,166	23,731
Contract assets	0	724
Capital receivables	0	70
Allowance for impaired contract receivables / assets	(928)	(934)
Prepayments	4,608	3,147
Interest receivable	0	24
PDC dividend receivable	336	251
VAT receivables	1,360	652
Other receivables	813	641
Total	**20,355**	**28,306**
Non-current		
Contract receivables	1,071	1,688
Other receivables – revenue	1,112	1,030
Total	**2,183**	**2,718**

Of which receivables from NHS and DHSC group bodies

Current	7,624	19,651
Non-current	1,112	1,030

Note 10.2 Allowances for credit losses 2020/21

	Contract receivables and contract assets	All other
	£000	£000
Allowances as at 1 April 2020 – brought forward	**934**	**0**
New allowances arising	116	0
Reversals of allowances	(65)	0
Utilisation of allowances (write offs)	(57)	0
Total	**928**	**0**

Note 10.3 Allowances for credit losses 2019/20

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	All other
	£000	£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**

15 Note 11 Trade and other payables

	31 Mar 21	31 Mar 20
	£000	£000
Current		
Trade payables	15,384	14,453
Capital payables	13,321	2,901
Other taxes payable	6,529	5,986
Other payables	4,091	3,675
Accruals	28,723	10,297
Total	**68,048**	**37,312**

Of which payables from NHS and DHSC group bodies:

Current	4,733	5,533

16 Note 12 Other liabilities

	31 Mar 21 £000	31 Mar 20 £000
Current		
Deferred income: contract liabilities	14,612	7,145
Deferred grants	0	527
Total other current liabilities	**14,612**	**7,672**
Non-current		
Deferred income: contract liabilities	2,779	1,010
Deferred grants	0	959
Total other non-current liabilities	**2,779**	**1,969**

17 Note 13 Borrowings

Note 13.1 Borrowings

	31 Mar 21 £000	31 Mar 20 £000
Current		
Loans from DHSC (capital loans)	3,117	3,129
Total	**3,117**	**3,129**
Non-current		
Loans from DHSC (capital loans)	19,688	22,740
Total	**19,688**	**22,740**

Note 13.2 Borrowings Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Total
	£000	£000
Carrying value at 1 April 2020	**25,869**	**25,869**
Cash movements:		
Financing cash flows – payments and receipts of principal	(3,052)	(3,052)
Financing cash flows – payments of interest	(414)	(414)
Non-cash movements:		
Application of effective interest rate	402	402
Carrying value at 31 March 2021	**22,805**	**22,805**

18 Note 14 Provisions

Note 14.1 Provisions for liabilities and charges

	Current 31 Mar 21 £000	Current 31 Mar 20 £000	Non-current 31 Mar 21 £000	Non-current 31 Mar 20 £000
Pensions – Injury benefits	122	127	2,357	2,477
Legal claims	0	0	574	0
Equal pay	0	0	106	0
Other	758	212	1,688	1,639
Total	**880**	**339**	**4,725**	**4,116**

Note 14.2 Provisions for liabilities and charges analysis 2020/21

	Total £000	Pensions – Injury benefits £000	Legal Claims £000	Equal Pay £000	Other £000
At 1 April 2020	**4,455**	**2,604**	**0**	**0**	**1,851**
Change in the discount rate	**139**	125	0	0	14
Arising during the year	**1,452**	43	574	106	729
Utilised during the year – cash	**(116)**	(76)	0	0	(40)
Reversed unused	**(294)**	(193)	0	0	(101)
Unwinding of discount rate	**(31)**	(24)	0	0	(7)
At 31 March 2021	**5,605**	**2,479**	**574**	**106**	**2,446**
Expected timings of cash flows:					
-not later than one year	**880**	122	0	0	758
-later than one year and not later than five years	**4,725**	2,357	574	106	1,688
Total	**5,605**	**2,479**	**574**	**106**	**2,446**

Legal claims relate to a provision for claims relating to employment tribunals.

Equal pay claims relate to a provision for claims relating to employment contracts.

Other contains amounts due as a result of third party and employee liability claims of £782,000. The values are based on information provided by the NHS Resolution, NHS Business Services Authority and NHS Pensions.

Other also includes clinician pension tax reimbursement of £1,210,000. This relates to a commitment to repay clinicians the tax charge they incur when their pension grows above the annual allowance threshold. Payment will be made on retirement and the scheme is only open to members of the NHS Pension scheme. Additionally, Other also contains reimbursement of VAT recovery relating to salary sacrifice of £454,000.

As at 31 March 2021 the provisions of NHS Resolution include £253,381,000 (31 March 2020: £267,885,000) in respect of clinical negligence liabilities of the NHS foundation trust.

19 Note 15 Revaluation reserve movement

Note 15.1 Revaluation reserve movement – 2020/21

	Total revaluation	Revaluation reserve –	Revaluation reserve – property, plant

	reserve	intangibles	and equipment
	£000	£000	£000
Revaluation reserve at 1 April	60,415	0	60,415
Net Impairments	(9,381)	0	(9,381)
Revaluations	443	0	443
Transfers to other reserves	(1,771)	0	(1,771)
Revaluation reserve at 31 March	**49,706**	**0**	**49,706**

Note 15.2 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)
Other Reserve Movements	0	0	0
Revaluation reserve at 31 March	**60,415**	**0**	**60,415**

20 Note 16 Cash and cash equivalents

Note 16.1 Cash and cash equivalents

	2020/21	2019/20
	£000	£000
At 1 April	**29,618**	**21,203**
Net change in year	45,397	8,415
At 31 March	**75,015**	**29,618**
Broken down into:		
Cash at commercial banks and in hand	11	139
Cash with the Government Banking Service	75,004	29,479
Cash and cash equivalents as in SoFP and SoCF	**75,015**	**29,618**

Third party assets held by the NHS foundation trust at 31 March 2021 were £3,000 (31 March 2020: £3,000).

Note 16.2 Pooled budgets

The NHS foundation trust is not party to any pooled budget arrangements in 2020/21 or 2019/20.

21 Note 17 Contractual capital commitments and events after the reporting period

Note 17.1 Contractual capital commitments

Commitments under capital expenditure contracts at the reporting date were £1,048,000 (31 March 2020: £7,166,000). The NHS foundation trust has capital commitments for a number of capital schemes which include the

purchase of a number of pieces of IT hardware, the completion of the Trusts telephony system upgrade, the purchase of a number of pieces of medical equipment and a number of estates enabling work schemes.

Note 17.2 Other financial commitments

Other financial commitments at the reporting date were £5,097,000 (31 March 2020: £6,384,000). 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.

22 Note 18 Contingent liabilities / assets

	31 Mar 21 £000	31 Mar 20 £000
Value of contingent liabilities		
NHS Resolution legal claims	68	77
Employment Tribunal and other employment related litigation	0	780
Total	**68**	**857**

At 31 March 2021 the NHS foundation trust has £68,000 contingent liability (31 March 2020: £857,000). This includes £68,000 for legal expenses, which is based upon the information provided by NHS Resolution (31 March 2020: £77,000).

At 31 March 2020 the NHS foundation trust had £780,000 contingent liability for the Flowers legal case which sought to reimburse staff for holiday pay while working overtime. This case has now been concluded and the cost to the Trust is included as operational expenditure.

23 Note 19 Related party transactions

Note 19.1 Related party transactions

The NHS foundation trust is a public interest body authorised by NHSI, the Independent Regulator for NHS foundation trusts.

During the year none of the Board members nor members of the key management staff, nor parties related to them, has undertaken any material transactions with the NHS foundation trust.

The Register of Interests for the Council of Governors for 2020/21 has been compiled in accordance with the requirements of the Constitution of the NHS foundation trust.

The Department of Health and Social Care is regarded as a related party. During the year the NHS foundation trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These include NHS England, NHS Resolution, HM Revenue and Customs, NHS Pension Service, Health Education England, NHS Bradford Districts CCG, NHS Bradford City CCG and NHS Airedale, Wharfedale and Craven CCG.

The NHS foundation trust has also received capital payments from a number of funds held within the Charity, the trustee of which is the NHS foundation trust. Furthermore, the NHS foundation trust has levied a management charge on the Charity in respect of the services of its staff. The Charity accounts have not been consolidated into the NHS foundation trust's accounts (see note 1.3).

Note 19.2 Related party balances

	Income £000	Expenditure £000
Value of transactions with other related parties 2020/21		
Charitable fund	841	0
Non-consolidated joint ventures	141	11,302
Other bodies or persons outside of the whole of government accounting boundary	0	0
Total as at 31 March 2021	**982**	**11,302**
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**

	Receivables £000	Payables £000
Value of balances with other related parties 2020/21		
Charitable fund	155	0
Non-consolidated joint ventures	116	1,418
Other bodies or persons outside of the whole of government accounting boundary	0	0
Total as at 31 March 2021	**271**	**1,418**
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**

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.

24 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.

2020/21 interests in Joint Ventures accounted for using the equity method:

	Profit £000	Gross Assets £000	Net Assets £000
Integrated Laboratory Solutions LLP	432	3,309	(38)
Integrated Pathology Solutions LLP	644	148	(252)
Total	**1,076**	**3,457**	**(290)**

The combined profit of £1,076,000 (2019/20: profit of £319,000) therefore means the NHS foundation trust has not reflected any entries in the statement of comprehensive income for 2020/21 as there has been a cumulative loss since establishment of £291,000.

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)**

25 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.

26 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 predominantly incurred to deliver, one year, nationally mandated healthcare contracts with a range of Commissioners. Commisioners are financed from resources voted annually by

Parliament. In 2020/21 the NHS foundation trust received contract income in accordeance with nationally set block payments in response to the coronavirus pandemic. Cash was paid on a monthly basis with payment made one month in advance to ensure a robust cashflow within the NHS. In 2019/20 the NHS foundation trust received contract income in accordance with either the agreed block contract or PbR, which 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.

27 Note 23 Financial assets and liabilities

Note 23.1 Financial assets by category

	31 Mar 21 £000	31 Mar 20 £000
Assets as per SoFP at 31 March		
Trade and other receivables excluding non-financial assets – with NHS and DHSC bodies	8,400	20,430
Trade and other receivables excluding non-financial assets – with other bodies	7,834	6,544
Cash and cash equivalents at bank and in hand	75,015	29,618
Total	**91,249**	**56,592**

All financial assets are held at amortised cost.

Note 23.2 Financial liabilities by category

	31 Mar 21	31 Mar 20
	£000	£000
Liabilities as per SoFP at 31 March		
Borrowings excluding finance lease and PFI liabilities	22,805	25,869
Trade and other payables excluding non-financial liabilities – with NHS and DHSC bodies	4,638	5,490
Trade and other payables excluding non-financial liabilities – with other bodies	56,568	25,836
Provisions under contract	2,344	1,030
Total	**86,355**	**58,225**

All financial liabilities fall within "other financial liabilities" and are held at amortised cost.

Note 23.3 Fair values

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

Note 23.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	31 Mar 21	31 Mar 20 restated*
	£000	£000
In one year or less	65,234	34,857
In more than one year but not more than five years	13,018	14,414
In more than five years	10,347	11,599
Total	**88,599**	**60,870**

* This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

28 ACRONYMS

CCG	Clinical Commissioning Group
CODM	Chief Operating Decision Maker
CQUIN	Commissioning for Quality and Innovation
CSU	Commissioning Support Unit
DAS	Digital Apprenticeship Service
DHSC	Department of Health and Social Care
DHSC GAM	Department of Health and Social Care Group Accounting Manual
DRC	Depreciation Replacement Cost
EU	European Union
FIFO	First In First Out
FRF	Financial Recovery Fund
FT ARM	NHS Foundation Trust Annual Reporting Manual
FReM	Financial Reporting Manual
FSA	Financial Services Authority
HMRC	Her Majesty's Revenue and Customs
IAS	International Accounting Standards
ICTA	Income and Corporate Taxes Act
IFRIC	International Financial Reporting Interpretations Committee
IFRS	International Financial Reporting Standards
MEA	Modern Equivalent Asset
NEST	National Employment Savings Trust
NHS	National Health Service
NHSI	National Health Service Improvement
ONS	Office for National Statistics
PbR	Payment by Results
PDC	Public Dividend Capital
PSF	Provider Sustainability Fund
RTA	Road Traffic Accident
SoCI	Statement of Comprehensive Income

SoCF	Statement of Cash Flows
SoFP	Statement of Financial Position
The Charity	Bradford Hospitals' Charity
VAT	Value Added Tax
WOS	Wholly Owned Subsidiary
WTE	Whole Time Equivalents