Bradford Teaching Hospitals
NHS Foundation Trust

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Annual Report and Accounts 2025/26

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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 667,000 and employs over 7,500 people working across seven sites.

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

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

Our vision is ***"to be an outstanding provider of healthcare, research and education, and a great place to work."*** Our values encapsulate who we are as an organisation – ***we care, we value people, we are one team.***

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

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

2025/26 has been another year of significant challenge and progress for the Trust. Against a backdrop of sustained operational pressure, including high demand and workforce challenges, our colleagues have continued to show exceptional professionalism, resilience and compassion, ensuring patients remain our number one priority.

We have continued to respond to increasing demand across urgent and emergency care, while maintaining a strong focus on improving access and delivery across the breadth of constitutional standards. Our teams have embraced innovation and new ways of working to deliver safe, high-quality care in often challenging circumstances.

Our performance continues to be recognised nationally. NHS England's new dashboard ranked us in the top third of trusts when it was launched, placing us 37th out of 134 acute trusts and the highest scoring trust in West Yorkshire. The dashboard is updated quarterly, and we remain firmly in the top half nationally. As at quarter 4 2025/26, we are ranked at 56th out of 134 acute trusts. Importantly, based on operational performance alone, we would rank even higher, demonstrating the strength of our frontline services.

We were pleased to see further recognition of the quality of our services through Care Quality Commission (CQC) inspections this year. Our outpatient services at St. Luke's Hospital were rated 'Good', with inspectors highlighting the kind and compassionate care provided by colleagues, strong multi-disciplinary working and the proactive involvement of patients in their care. Our

maternity services were also rated ‘Good’, marking a significant improvement from the previous ‘Requires Improvement’ rating, and reflecting the sustained effort of teams to enhance safety, outcomes and personalised care for families.

Alongside our ‘Outstanding’ neonatal services, these ratings provide continued assurance to our communities and partners about the quality of care we deliver, whilst reinforcing our commitment to continuous improvement. Further detail of our CQC inspections can be found at section 3.1.3.

We have made important progress in enhancing our facilities and infrastructure. Our new £25m endoscopy unit, one of the largest NHS schemes of its kind in the country, has now welcomed its first patients. The unit is providing more appointments, increasing diagnostic capacity and supporting earlier diagnosis and treatment. Alongside this, we have continued to invest in modern, patient-centred environments across our hospitals.

Innovation and research remain central to our approach. We have expanded the use of digital technology and artificial intelligence in radiology to support faster diagnosis and improved outcomes. The launch of the Commercial Research Delivery Centre further strengthens our role in developing the next generation of treatments, while bringing research opportunities closer to our communities.

Looking after our people remains a key priority. This year we launched our People Strategy 2025–2030, focused on improving health, wellbeing and belonging; creating a great place to work through strong leadership and development; and enabling new ways of working through digital investment and smarter use of skills.

We are proud of the continued achievements of our colleagues, whose work has been recognised locally and nationally. With the support of Bradford Hospitals Charity, we have also enhanced the experience of patients, families and staff, including progress towards the ‘Home from Home’ facility for families of babies in our Neonatal Unit.

As we look ahead, we remain focused on delivering outstanding care, reducing health inequalities and improving outcomes for the communities we serve. Whilst challenges remain, we are confident in our direction and in the strength and dedication of our people.

On behalf of the Board, I would like to thank all our colleagues for their continued commitment and care. Their efforts make a real difference to the lives of our patients every day.

2.1.3. Purpose and activities of the Foundation Trust

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

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

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

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

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

[1] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2024/11/BTHFT-Constitution-November-2024-Final.pdf

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

1. Provide outstanding care for patients, delivered with kindness;
2. Be a continually learning organisation and recognised as leaders in research, education and innovation;
3. Be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion;
4. Collaborate effectively with local and regional partners to reduce health inequalities and achieve shared goals; and
5. Deliver our financial plan and key performance targets.

These objectives frame the practical steps we take to help deliver our vision and implement our corporate strategy, which was published in June 2022. We developed the strategy with our patients, our people, the public and our partner organisations. It explains how our ambitions are not simply a list of things we want to do. They are coherent and mutually reinforcing and will ensure that we meet our strategic objectives.

Progress against the objectives is reported through the dashboard reports which are presented to the relevant committees of the Board and to the Board[2] at each meeting.

In March 2025, the Board approved a new Strategic Framework for the last two years of the corporate strategy. The framework reaffirms the vision, values and strategic objectives, improves the monitoring and reporting arrangements and confirms the Trust's improvement method to support implementation.

We are proud to be part of the Bradford District and Craven Health and Care Partnership, with a shared ambition to 'Act as One' to keep people 'happy, healthy at home'.

A summary of our vision, objectives and values is as follows:

[2] https://www.bradfordhospitals.nhs.uk/our-trust/bod-meetings/

Our Vision, Objectives and Values

Image shows our vision, objectives and values

In terms of the operational leadership structure, the Trust has a Clinical Service Unit (CSU) model.

This structure enables multidisciplinary and multidimensional operational leadership, with decision making and accountability within the CSU structure.

2.1.4. History of the Trust and statutory background

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

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 and medical, diagnostic and support services provided at St Luke's Hospital.

In addition to Bradford Royal Infirmary and St Luke's Hospital, the Trust provides a range of services from community sites at Westbourne Green, Westwood Park, Eccleshill, Skipton and the Bradford Macula Centre. It serves a population of around 667,000 people from Bradford and the surrounding area. We have approximately 617 acute beds for overnight stays, 61 intermediate/community care beds, and 152 beds for day only admissions, plus a further 145 beds/cots within the Maternity and Neonatal Units. We employ over 7,500 members of staff and following a redesign of Voluntary Services since the pandemic, we have new and exciting volunteer roles being developed, with more than 232 active volunteers currently supporting our services. In 2025/26 our Trust services delivered 5,200 babies, performed 14,200 operations in theatre (total patients treated in theatres) and handled 594,445 outpatient appointments (attended). We had 163,338 attendances (all types) at our Emergency Department, and a further 12,492 emergency attendances to other parts of the hospital.

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 and are reviewed and agreed by the Board of Directors. The mitigation of these risks is scrutinised by the Non-Executive Directors at Committee and Board meetings. The strategic risk profile underpinning the BAF is directly influenced by the high scoring operational risks identified by wards, specialties, CSUs or corporate departments which may impact the effective delivery of the strategic objectives.

The highest scoring principal risks that the Trust has been exposed to during 2025/26 are the delivery of the financial plan, maintenance and development of the care environment, and management of patient flow.

The BAF risks were agreed by the Board of Directors in May 2025. No additional BAF risks have been raised during the year, and none have been closed.

The risks have been mitigated through a range of controls which are reported on the BAF. This includes additional financial controls for vacancies and non pay expenditure, securing additional funding to support backlog maintenance and exploration of collaborative opportunities to make best use of space across Bradford District and Craven, and the implementation of an improvement programme within the Accident and Emergency department.

It is anticipated that the financial position will continue to be challenging during 2026/27. This reflects the national position for the NHS and the requirement to make productivity and efficiency savings. For 2026/27, the Trust has a breakeven plan, which requires cost improvement savings of £58m.

Further details, including the Trust's highest scoring operational risks as of March 2026 are described in the Performance Analysis (section 2.2.2.).

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

In terms of opportunities, the Trust will continue to work with its partners across Bradford District and Craven and West Yorkshire to achieve the 'triple aim' duty to support better health and wellbeing for everyone, better quality of health services for all and sustainable use of NHS resources. We are also creating opportunities to improve our services and patient experience through our new capital developments, including a new endoscopy suite which opened in March 2026.

The BAF was maintained by the Executive Directors throughout the year and presented to the Board of Directors on a quarterly basis. 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 assurances were presented in the BAF. The Board therefore has had clear sight of significant risks and ensured actions were prioritised appropriately. Further details regarding the Trust's risk management arrangements are included in the Annual Governance Statement (section 3.8).

2.1.6. GOING CONCERN DISCLOSURE

After making enquiries, the directors have a reasonable expectation that the services provided by the Trust will continue to be provided by the public sector for the foreseeable future being a minimum of 12 months from the date of signing these accounts. 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. JOINT FORWARD PLANS AND CAPITAL RESOURCE PLANS

NHS West Yorkshire Integrated Care Board (ICB) has developed its Joint Forward Plan with its partners to help deliver the West Yorkshire Integrated Care Strategy.

The Joint Forward Plan sets out how the ICB will meet local population's health needs and how the partnership intends to arrange and / or provide NHS services to meet the physical and mental health needs of its population.

The NHS capital plan for West Yorkshire was developed between the ICB and its partner NHS Trusts and Foundation Trusts. Whilst the ICB was only formally established from 1 July 2022, partners worked together under the pre-existing West Yorkshire Health and Care Partnership arrangements on this system capital plan.

The West Yorkshire system worked together successfully to deliver an operational capital plan for 2025/26 which is fully utilised. The capital plan for 2025/26 combines the system operational capital allocation, reflecting year one of a multi-year settlement and other confirmed national programme funding. The NHS provider system allocation is resourced through internally generated funding (cash and depreciation within organisations). National programme schemes are resourced through the issue of public dividend capital.

The ICB has allocated the provider system operation capital to the ten NHS providers in West Yorkshire based on the national methodology utilised by NHS England to derive the system allocation. This incorporates factors such as the level of backlog maintenance in each organisation and the value of the depreciation charge on assets. NHS providers use this resource to support 'business as usual' capital schemes, such as backlog maintenance, equipment replacement and IT expenditure.

The system aims to best deploy operational and national capital to support strategic priorities. It is, however, recognised that the level of capital resource available to West Yorkshire does not allow all strategic priorities to be delivered. The extent to which this creates risks for organisations, places and the wider system is captured through established risk management systems and processes.

2.1.8. SUMMARY OF PERFORMANCE

2.1.8.1. Performance summary

During the 2025/26 financial year, the Trust has been working to improve its performance against the core contractual targets, including those indicated within the NHS Oversight Framework (NOF) and those aligned to the operational priorities within the 2025/26 Planning Guidance.

The table below describes the results achieved against some of the specific Key Performance Indicators (KPIs) within the NOF, which we have tracked consistently in our annual reports. Further analysis is included at section 2.2.1, and the highlights are captured here.

Figure 1 - Monthly results achieved against selected NHS Oversight Framework 2025/26 KPIs

KPI	4 Hour Emergency Care Standard	28-day Cancer FDS	62-day Cancer first treatment	18 weeks RTT Incomplete	MRSA Infections	Summary Hospital-Level Mortality Indicator
Apr-25	82.82%	82.09%	74.37%	63.19%	0	1.16
May-25	82.75%	84.54%	72.56%	65.85%	0	1.14
Jun-25	82.76%	81.17%	69.97%	66.72%	1	1.13
Jul-25	83.91%	81.58%	74.32%	66.25%	0	1.14
Aug-25	82.96%	75.48%	75.00%	65.61%	0	1.14
Sep-25	83.77%	77.84%	67.86%	66.18%	0	1.15
Oct-25	83.52%	79.36%	72.02%	65.37%	0	1.16
Nov-25	81.89%	75.53%	74.40%	64.69%	1	1.16
Dec-25	82.57%	76.46%	75.54%	64.83%	0	1.15
Jan-26	84.20%	74.61%	68.28%	64.11%	0	1.13
Feb-26	84.12%	79.99%	67.30%	64.49%	2	
Mar-26	82.94%	85.26%	78.65%	66.17%	0	
2025/26	**83.19%**	**79.43%**	**72.46%**	**65.30%**	**4**	
2024/25	**82.47%**	**79.57%**	**70.74%**	**62.58%**	**3**	

* Latest available Summary Hospital-Level Mortality Indicator (SHMI) is up to January 2026

During 2025/26 the Trust has increased the amount of elective activity it has undertaken with significant improvement in theatre operating and outpatient attendances. GP referrals, especially for suspected cancer and other urgent conditions have remained higher than previous years and attendances to the Emergency Department (ED) also remained high.

Patients attending the ED waited less time for a decision about their care during 2025/26 compared to the previous year. The Trust's position compared to other acute providers improved further over this period. The Ambulatory Emergency Care Unit and Urgent Treatment Centre co-located with our main ED has supported patients to be seen in the area that best meets their needs and reduced overcrowding. An Acute Care Programme known as EXCEL was launched in 2024/25 and focussed on improving patient experience and staff morale by decompressing the ED through improved flow. This work continued during 2025/26 with broad ranging stakeholder engagement to ensure work-streams progressed actions focussed on the needs of the local community.

Performance for the Faster Diagnosis Standard (FDS), where patients are informed of their diagnosis or have cancer ruled out within 28 days of their referral, deteriorated slightly compared to the previous year. Cancer treatment has improved during the year, with performance against the overall 62-day first treatment standard improving by 1.47% compared to 2024/25. An improvement

plan aligned to the National Cancer Plan remains in place and will progress key work-streams in support of waiting time improvements into 2026/27.

Referral to Treatment (RTT) performance at the end of 2025/26 was 66.17% which, while slightly below the planned target of 66.70%, demonstrated improvement on the previous year, being 62.39% for March 2025. The overall waiting list size reduced in line with increased activity and the Trust further improved its position for those waiting the longest, with a reduction in those over 52 weeks and performance in the upper quartile nationally for this metric. In addition to increasing activity, the Trust has reviewed the effectiveness of outpatient appointments to progress and conclude episodes of care with a focus on referral optimisation and the ability to make decisions earlier in a patient's journey. This has reduced the volume of waits for first appointments.

Quality of care has continued to be at the forefront of the Trust's priorities, with our focus on building on our success and continuously improving the patient and service user experience. Despite the challenges faced by clinical services, the Trust has continued to have high-level oversight of quality, with executive led daily safety huddles and weekly meetings of the Quality of Care Panel to facilitate the review of quality and safety issues on a real time basis. This includes the review and oversight of patient safety events, patient experience and the identification of learning and improvement opportunities.

Quality metrics have continued to be monitored at the Quality Committee, a committee of the Board chaired by a Non-Executive Director. The Quality Dashboard has been reviewed to reflect our quality priorities with a mix of process and outcome measures. Further metrics to support our improvement work around the safe prescription, dispensing and administration of medicines are currently being tested. Our quality metrics are reviewed with clinical teams to support ownership and accountability at the point of care delivery as part of the Trust's Accountability and Governance Frameworks.

The Trust has continued to embed the Medical Examiner (ME) role, achieving reviews of 100% of in-hospital patient deaths. This role has now extended into Primary Care to support review of deaths in the community. The requirement for ME review of all deaths became statutory from 1 September 2024.

We have maintained focus on all elements of the National Patient Safety Strategy including embedding of the Patient Safety Incident Response Framework (PSIRF) and moving to the new national Learning from Patient Safety Events (LFPSE) platform. This includes progress in the improvement programmes identified as part of our Patient Safety Incident Response Plan.

We continue to build our culture of learning which is underpinned by our work on 'civility in the workplace' and 'just culture' by aligning our Human Resources policies, the development of our People Plan and behavioural framework to ensure staff feel supported and empowered to raise concerns.

2.1.8.2. **Finance summary**

The Trust's Income and Expenditure plan for 2025/26 was to deliver a deficit of £2.7m (based on NHS England measured performance not absolute accounting deficit). In December it became clear that meeting this plan was not going to be possible, so the Trust put itself into financial recovery, as it could not state with confidence that it would achieve its financial plan. A recovery plan was developed, and the Trust agreed a revised deficit plan of £17.8m with NHS England (NHSE) by the end of the year. This revised deficit was delivered.

The Trust delivered a £17.8m deficit position. The Trust has reported a £10m operating deficit for 2025/26. However, this includes an adjustment for net finance costs, Public Dividend Capital (PDC) dividend expense and share of joint venture profit. NHSE excludes these adjustments from its assessment of a Trust's operating results, and when these are removed the relevant margin for

the year is a deficit of £17.8m, which is £15.1m worse than the planned £2.7m deficit position, but in line with the expected recovery position.

Figure 2 – Financial Position

	24/25 Actual	25/26 Plan	25/26 Actual	25/26 Variance	Change vs 24/25
Income	656.19	686.80	686.19	(0.61)	30.00
Pay	(430.02)	(452.39)	(467.10)	(14.71)	(37.08)
Non-Pay	(227.74)	(229.55)	(231.80)	(2.24)	(4.06)
Non Operating Items	(3.27)	(7.56)	(5.09)	2.47	(1.82)
TOTAL Provider Surplus/(Deficit)	**(4.84)**	**(2.71)**	**(17.80)**	**(15.09)**	**(12.95)**

Income

The total income reported for the 2025/26 financial year was £686.9m compared to £656.9m in 2024/25, which is split as follows:

	2025/26	2024/25
• Aligned payment & incentive (API)	£512.5m	£482.0m
• High-cost drugs	£59.3m	£56.9m
• Other clinical income	£32.3m	£32.0m
• Research and development	£23.5m	£30.2m
• Education and training	£32.9m	£30.0m
• Other operating income	£26.5m	£25.8m

API contract income is primarily income from Integrated Care Boards (ICBs) and NHSE in relation to the provision of patient treatment services. Other income is primarily non-patient related income and includes income for education and training, research activities, catering, car parking and other services.

Expenditure

Including the impairment and donations for capital purchases, the total expenditure reported for 2025/26 was £720.3m compared to £666.9m in 2024/25, which is split as follows:

	2025/26	2024/25
• Payroll bill for employed and agency staff	£440.2m	£404.4m
• Non-pay costs including drug costs	£238.4m	£234.3m
• Depreciation and amortisation (nil cash impact)	£20.6m	£19.7m
• Impairments (nil cash impact)	£21.1m	£8.6m

2.1.8.3. **Capital Investment**

In 2025/26, the Trust delivered £60.0 million of capital investment, underpinned by a combination of external funding sources and internally generated resources. This level of investment reflects continued progress in strengthening the Trust's capital programme to support service transformation, estate improvement and digital enablement.

Figures 3 and 4 illustrate the sustained growth in capital expenditure over the last five years, demonstrating the Trust's increasing capacity to plan and deliver significant investment at scale. This growth has been enabled through a strengthened capital governance framework, improved financial discipline and successful access to external investment opportunities.

The expansion of the capital programme has supported the delivery of key strategic priorities, including modernising clinical environments, improving patient experience, enhancing operational efficiency and ensuring that the Trust's estate and infrastructure remain safe, resilient and fit for the future. This trajectory of investment also reflects prudent long-term planning, ensuring that capital resources are aligned with clinical and operational needs, while remaining affordable and sustainable within the wider NHS capital regime.

Figure 3 - Capital Spend Total 2021 – 2026

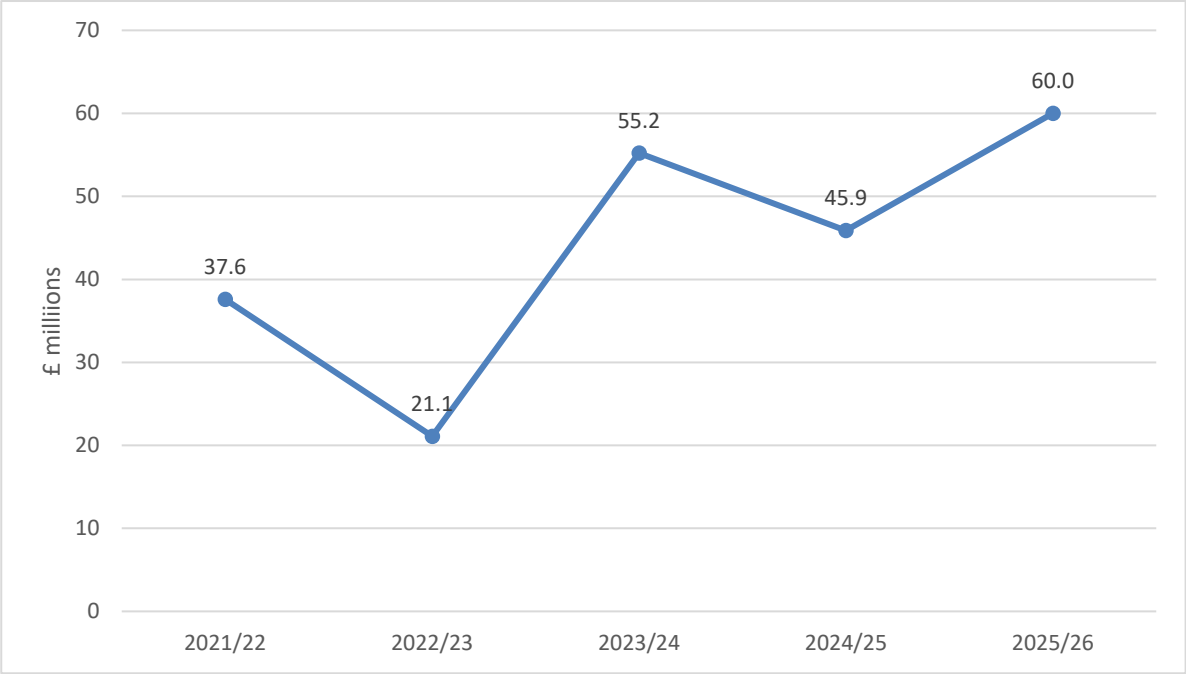


Figure 4 - Capital Spend by Type 2021 – 2026

	2021/22 £m	2022/23 £m	2023/24 £m	2024/25 £m	2025/26 £m	Total £m
Building and Engineering	24.2	5.7	31.3	29.2	42.2	**132.6**
Medical and Surgical Equipment	4.2	9.5	14.8	9.6	5.6	**43.7**
Digital (including software)	9.2	5.9	9.1	7.1	12.2	**43.5**
Total	**37.6**	**21.1**	**55.2**	**45.9**	**60.0**	**219.8**

Looking to the Future

Historically, the Spending Review provided the NHS with a one-year capital settlement. This position was subsequently strengthened by the outcome of the 2025 Spending Review, which confirmed a multi-year capital settlement for the NHS, providing greater medium-term certainty to support capital planning and investment decisions.

Notwithstanding this improved national context, the financial environment during 2025/26 remained challenging. Persistent inflationary pressures, together with continued supply-chain volatility, impacted construction costs, medical equipment pricing, and delivery timescales. These factors increased both affordability and delivery risks across the capital programme and continue to require active management.

The Trust has a medium-term capital investment plan of £122.0m over the next four years. The programme has been developed to support delivery of the Trust's clinical strategy and operational priorities, with investment focused on:

- Maintaining and improving the estate, including addressing backlog maintenance and statutory compliance to ensure a safe and sustainable environment for patients and staff.

- Investment in medical equipment, supporting the replacement of end-of-life assets and enhancing diagnostic and treatment capability.

- Digital and IT infrastructure, including cyber security, systems resilience, and the continued rollout of digital solutions that support productivity, clinical quality, and patient experience.

- Targeted service enhancements and enabling schemes, aligned to national priorities and local transformation plans.

While the Trust recognises that risks remain, particularly in relation to inflation, contractor capacity, and supply-chain resilience, it remains confident in its ability to deliver a high level of capital expenditure in the medium term. This confidence is underpinned by a strong capital delivery track record, robust programme governance arrangements, and close engagement with system and national partners to maximise the effective use of available funding and to manage delivery risks.

2.2. PERFORMANCE ANALYSIS

2.2.1. MEASUREMENT OF PERFORMANCE

Performance monitoring

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

The Trust is regulated primarily by NHS England (NHSE) and the Care Quality Commission (CQC). It has contractual relationships with NHS commissioning bodies and the West Yorkshire Integrated Care Board (ICB). The Trust has made monthly submissions to these bodies throughout 2025/26.

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

- NHS Oversight Framework KPIs.
- NHS Use of Resources KPIs.
- NHS Model Health System measures.
- Getting it Right First Time (GIRFT) and GIRFT Further Faster resource packs.
- National contract quality measures.
- Internally agreed performance measures aligned to strategic objectives and improvement priorities.

The Trust is contractually obliged to provide regular performance monitoring and assurance reports to its regulators and continues to meet these obligations. These returns include routine daily, monthly and quarterly reports, and have also included ad hoc reports when requested. For relevant indicators, the Trust uses the nationally mandated definitions as provided by:

- NHS Oversight Framework.
- NHS Data Dictionary definitions.
- NHS Planning Framework technical guidance.

The Board of Directors retains overall responsibility for ensuring effective systems and controls are in place to mitigate any significant risks which may threaten the achievement of the organisation's strategic objectives. The Trust uses the Board Assurance Framework (BAF) to govern these assurance processes and provide assurance that the performance of the organisation is systematic, consistent, independently verified, and incorporated within a robust governance framework.

The Trust's Performance and Accountability Framework

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

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

The approach to performance monitoring is set out in the Framework and supports delivery of the Trust's strategic objectives via:

- Alignment of service plans and ambitions to overarching objectives.
- Measures that are relevant in the context of these plans.
- Progress and improvements being considered in this same context.
- Shared principles throughout the organisation (vertical and horizontal alignment).
- Clear action when targets are not being met or improvement plans are off track.

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

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

Performance information is used daily across the organisation to support decision making. Weekly reviews are in place to track selected KPIs and a committee structure which supports the BAF meets monthly to ensure learning and improvement is driving the agenda forward.

KPIs are selected across the domains of quality, workforce, operational performance, and finance using the Trust's objectives for the given year. These are informed by internal and external priorities and include mandated indicators from the NHS Oversight Framework and NHS planning returns alongside KPIs aligned to Trust specific goals. Individual committees monitor the specific domains related to their work plans and the Board has oversight of the balanced view of all domains together through the integrated performance report.

Clinical Service Units (CSUs) replicate these approaches, and regular Executive Team and CSU Leadership Team meetings are scheduled where the breadth of performance and delivery against plans can be discussed with a balance between assurance sought and support given. Senior leadership and corporate departments provide further support to this process and lead on any cross-cutting improvement objectives aligned to committee work plans.

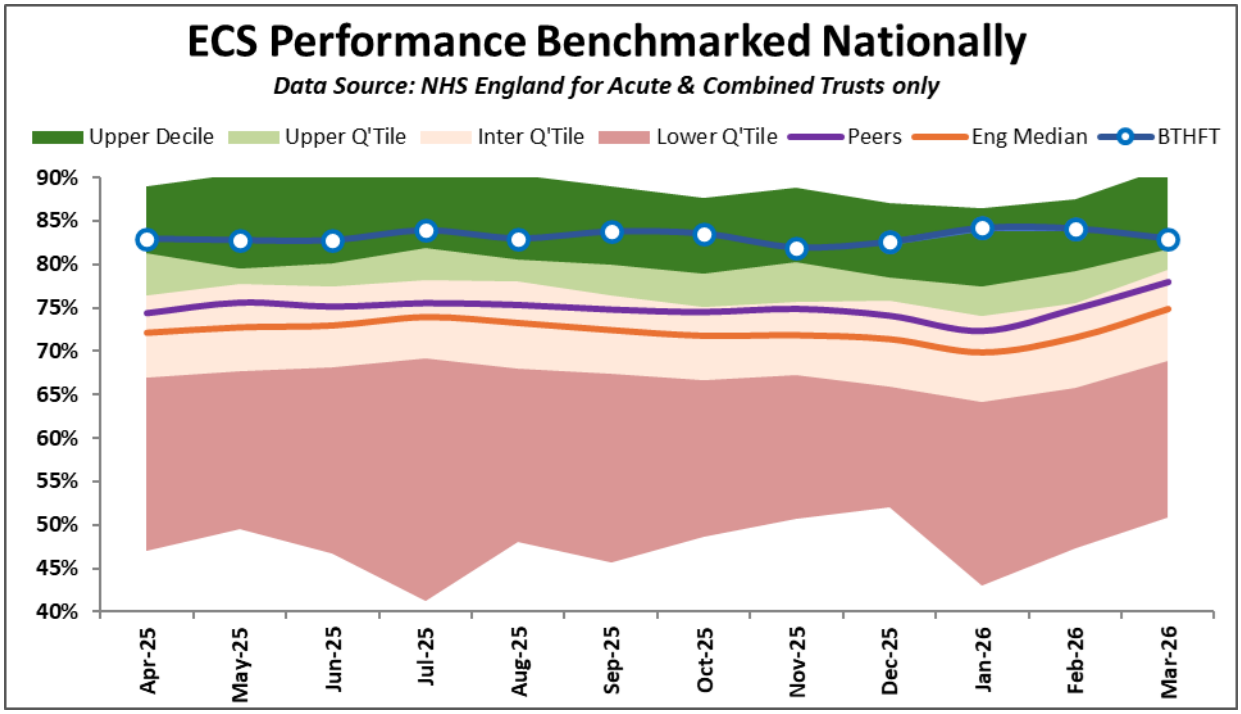
2.2.2. Analysis of Performance

2.2.2.1. Operational performance

Emergency Care Standard (ECS)

The aim of this standard is for patients to be admitted, transferred, or discharged within four hours of arrival at the Emergency Department (ED). The Trust sustained a comparatively strong ECS performance throughout 2025/26, remaining in the upper decile nationally. This again included a challenging winter where demand increased earlier than forecast.

Figure 5 – 4-hour Emergency Care Standard (Types 1,2 &3) Performance 2025/26



In 2025/26 we strengthened the streaming model to ensure patients were seen in the most appropriate setting. This built on the co-located Urgent Treatment Centre (UTC) and increased utilisation of Same Day Emergency Care pathways, which in November 2023 had become the Ambulatory Emergency Care Unit (AECU). This supported reduced demand on the ED and is preventing admission into hospital wards.

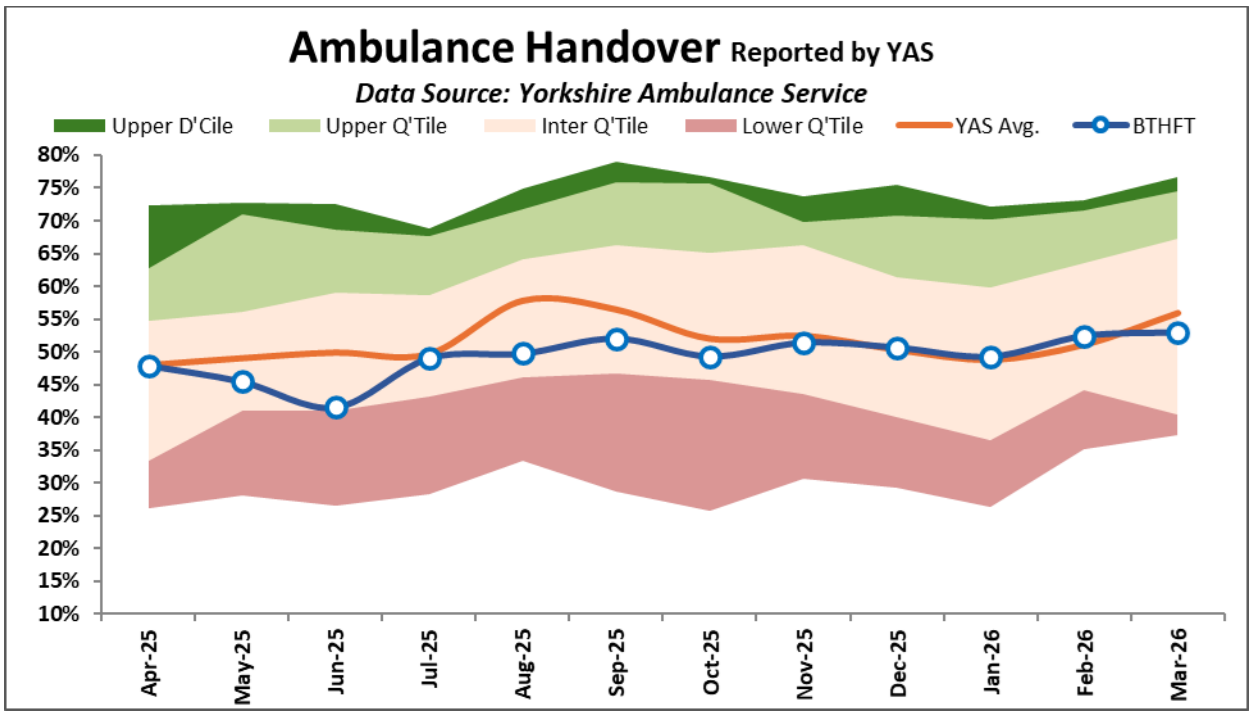
The Trust maintained the multi-disciplinary approaches to the whole patient journey from arrival to discharge which have fostered a significant culture shift in terms of joined up processes and real time support for emerging pressures. Despite this, the availability of hospital beds remains a challenge and ensuring patients are discharged from care as soon as ready remains critical to improvements in this area. To progress this the Trust has supported improvements in intermediate care provision, the 'Home Fast' (H-FAST) discharge model in partnership with social care and implemented improved discharge coordination. Further work is planned to increase the percentage of patients discharged on the day they are first ready to be, and to increase therapy input so patients are ready for discharge sooner.

In 2025/26 the Trust's Acute Care Programme known as EXCEL continued with the aim to improve patient experience and improving staff morale and decompress the ED through better flow. Through stakeholder engagement the programme developed its priorities for 2025/26, aligning to internal and external expectations. This process included workshops with colleagues, health planners, and architects for an 'ED redesign'.

Ambulance Handover

A national priority for 2025/26 was to continue work with Ambulance Trusts to reduce the delay seen in releasing ambulance crews after they bring a patient to an Emergency Department. Average handover performance, as reported by Yorkshire Ambulance Service NHS Trust (YAS), has continued to benchmark well against other Trusts within the region.

Figure 6 – 15 minutes Ambulance Handover Performance 2025/26

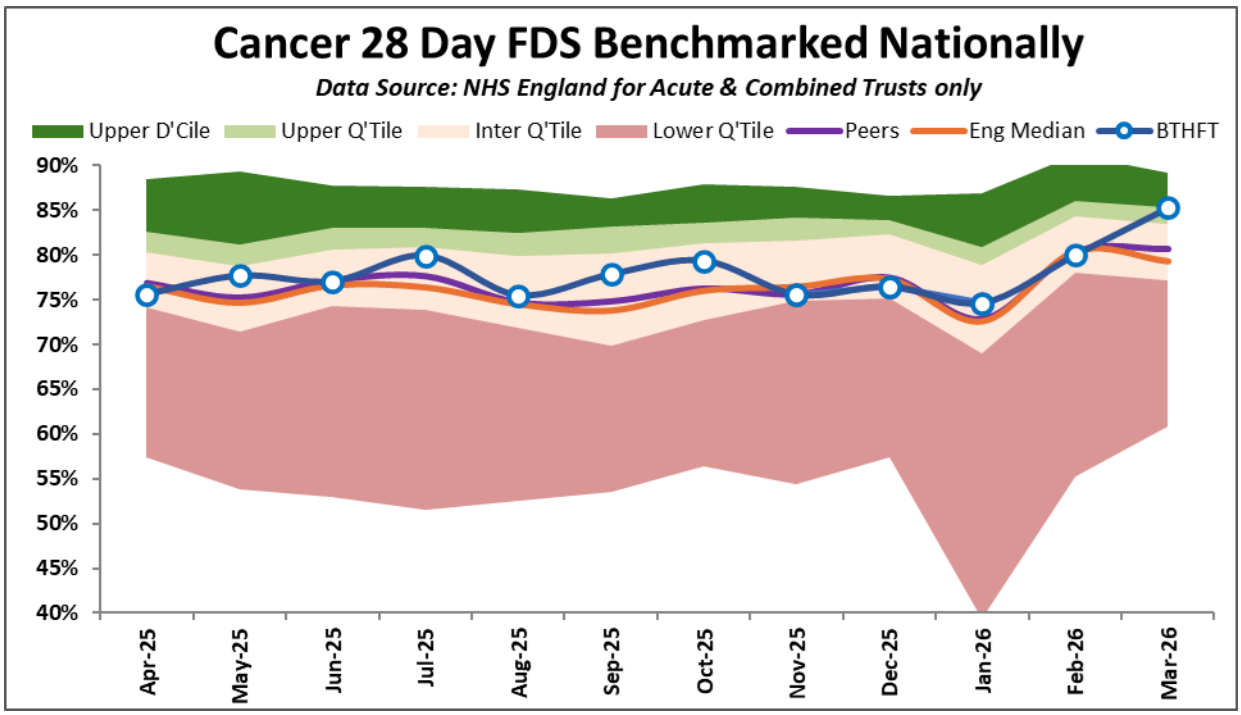


Senior YAS presence to support crew clear times and data capture accuracy has been in place during 2025/26. The YAS Liaison Officer (HALO) also provided valuable support to the Trust, targeting delays to handover and crew clear times and providing critical support during peak demand. The implementation of the Transfer of Care protocol has ensured timely patient flow, where patients are transferred to a trolley within 45 minutes and enabling YAS crews to return to service more quickly.

Cancer 28-day Faster Diagnosis Standard (FDS)

The aim of this standard is to ensure that patients will be diagnosed or have cancer ruled out within 28 days of their referral. The national target for 2025/26 was for improvement from 75% to 80% performance by March 2026, which we have achieved.

Figure 7 – Cancer 28-day FDS Performance 2025/26

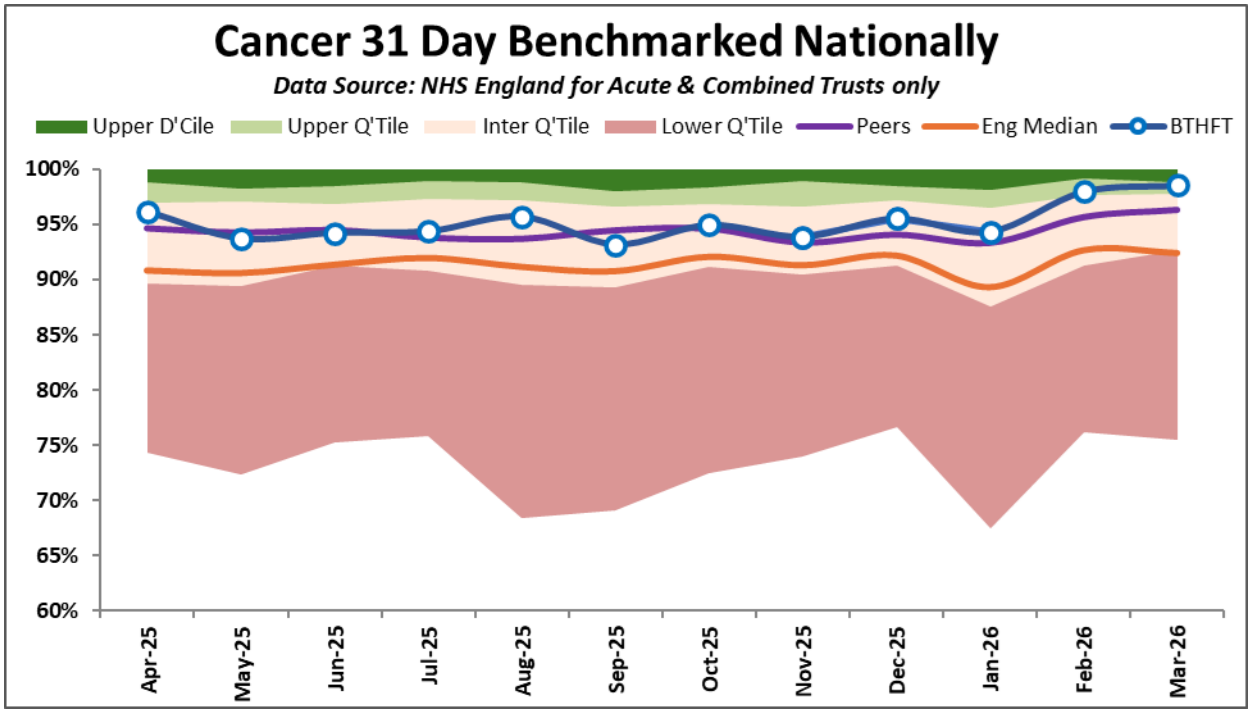


Previous improvements through one stop clinics and straight to test pathways were sustained. Further enhancements to pathways have been identified through a targeted improvement work but during 2025/26 we encountered challenges with matching diagnostic capacity to demand that delayed the benefits of these changes. In responding to growing demand and pressures from short term capacity loss the Trust has sought to strengthen service resilience through longer term recruitment plans and ongoing pathway review against best practice. As we progress into 2026/27, we are confident this foundational work will produce improved FDS performance above the 80% target.

Cancer 31-day First Treatment

The aim of this measure is to ensure treatment is provided within 31-days of a decision that treatment is needed. The Trust has tracked above the national and peer average for much of 2025/26, meeting the 93% target for the year. This was an area of focus for our Cancer Board in December 2024 and since then performance has improved in line with the actions the Board has overseen.

Figure 8 – Cancer 31-Day First Treatment Performance 2025/26

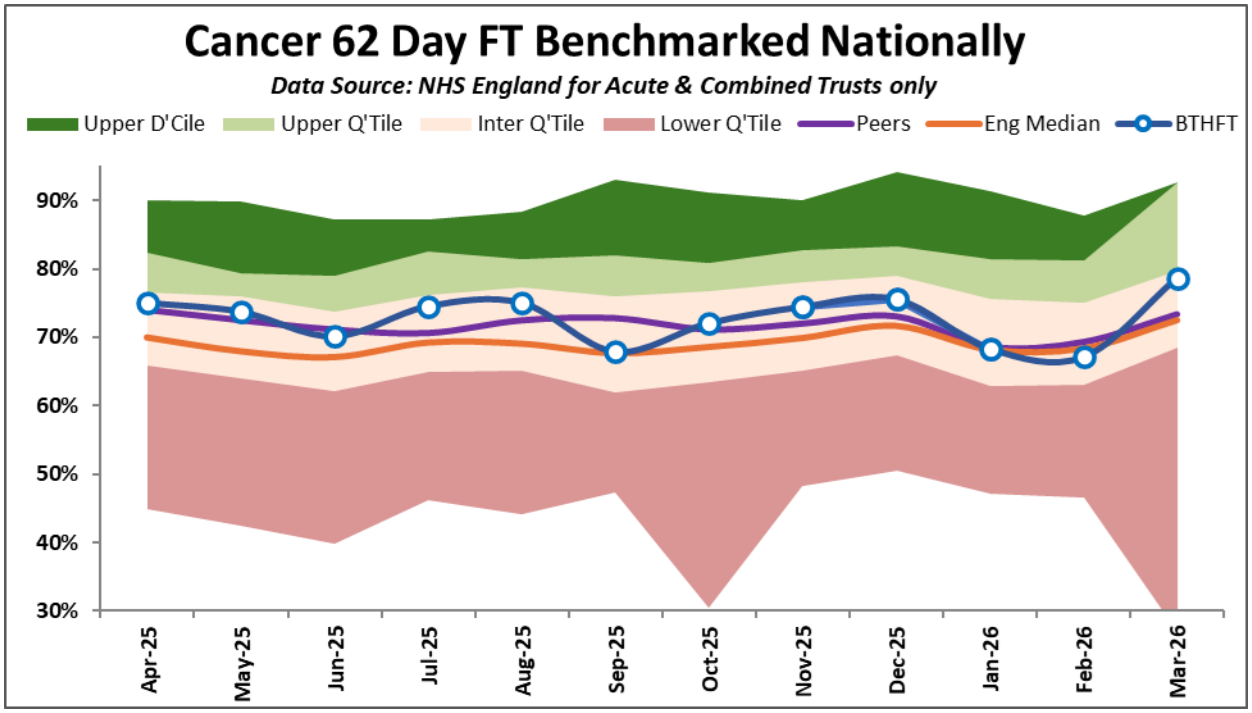


The Trust targeted improvement work on the first treatment phase during 2025/26. Analysis by tumour group, patient demographic, and primary care network created a better service level understanding of this KPI and local oversight of waiting times and treatment capacity has been central to the improved position.

Cancer 62-day First Treatment

This standard aims for patients to receive first definitive treatment within 62 days of a referral, either from a GP, cancer screening, or a consultant upgrade. During 2025/26 we have continued to prioritise cancer treatment within available capacity and progressed performance against this standard in line with our planning trajectory and to above the previous year.

Figure 9 – Cancer 62-Day First Treatment Performance 2025/26



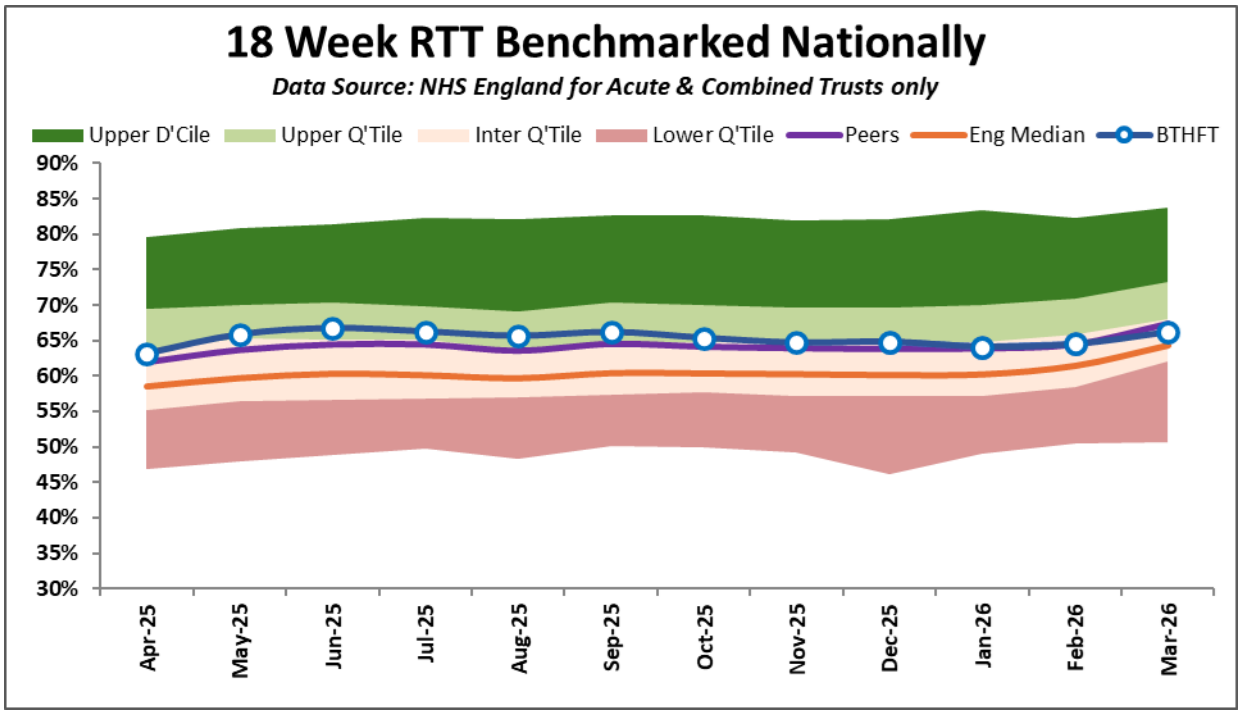
The Trust has engaged proactively with national priorities relating to Cancer services, supporting the West Yorkshire Cancer Alliance to deliver service developments including initiatives focussed on patient experience during and after cancer treatment. The Trust has also worked in collaboration with primary care to increase earlier presentation and identification of cancer whilst also ensuring resource is still able to focus on the most urgent cases.

We have an ambitious programme of work relating to Cancer pathways which includes the ongoing roll out of optimal pathways and Multi-disciplinary Team optimisation to minimise any potential delays to treatment. Continuous improvement is embedded within this approach, and tumour groups have been quick to adopt best practice and seek out further opportunities to streamline cancer care.

18-week Referral to Treatment (RTT)

The RTT standard aims for patients to receive first definitive treatment within 18 weeks of a GP referral. During 2025/26 the Trust has reduced the total number of people waiting for treatment and managed capacity so that performance improved to 66.17% by year end. This was only slightly behind the target agreed with NHS England and a significant improvement from the end of the previous year performance of 62.39%.

Figure 10 – 18 Week Referral to Treatment Acute Trust Performance 2025/26



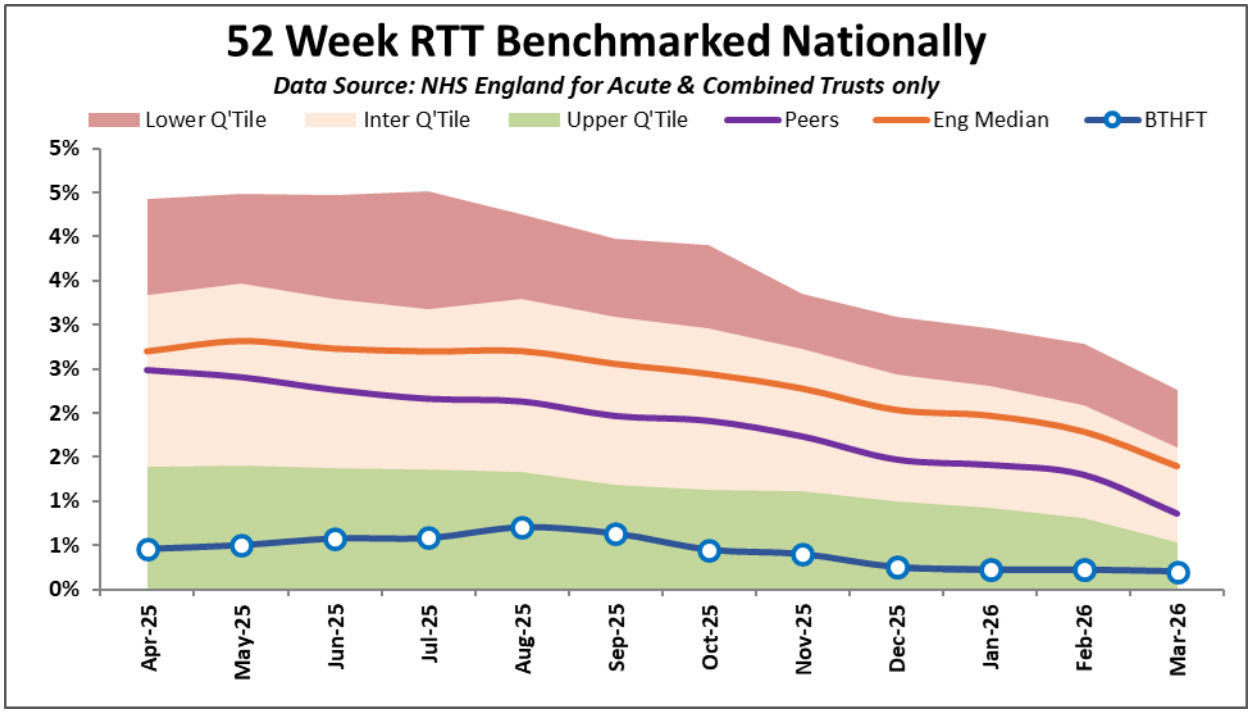
Throughout 2025/26 the Trust has continued to increase both its inpatient and outpatient activity. Reducing workforce supply challenges and increasing the number of cases per theatre session or outpatient clinic have supported this. Broader pathway reform opportunities have also been progressed with a focus on optimising referrals and reducing time to first appointment helping manage demand and provide earlier intervention.

In line with national priorities the additional capacity has been allocated to reducing the longest wait times. We have continued to work with other organisations across West Yorkshire to provide alternative appointments or treatment dates earlier in the patient journey. In addition, we have further strengthened our approach to waiting list management and validation. These processes ensure our waiting list is accurate and patient care progressed as required in as timely a manner as possible. One marker of this is the national wating list data quality dashboard, against which the Trust has a 99.8% confidence rating, which is one of the best in the country.

52-week Referral to Treatment (RTT)

The Trust has successfully eliminated 65-week waits and has been able to make significant progress in reducing waits over 52-weeks with performance comparing favourably to others and ahead of the 1% target set by NHS England for 2025/26.

Figure 11 – 52 Week Referral to Treatment Performance 2025/26

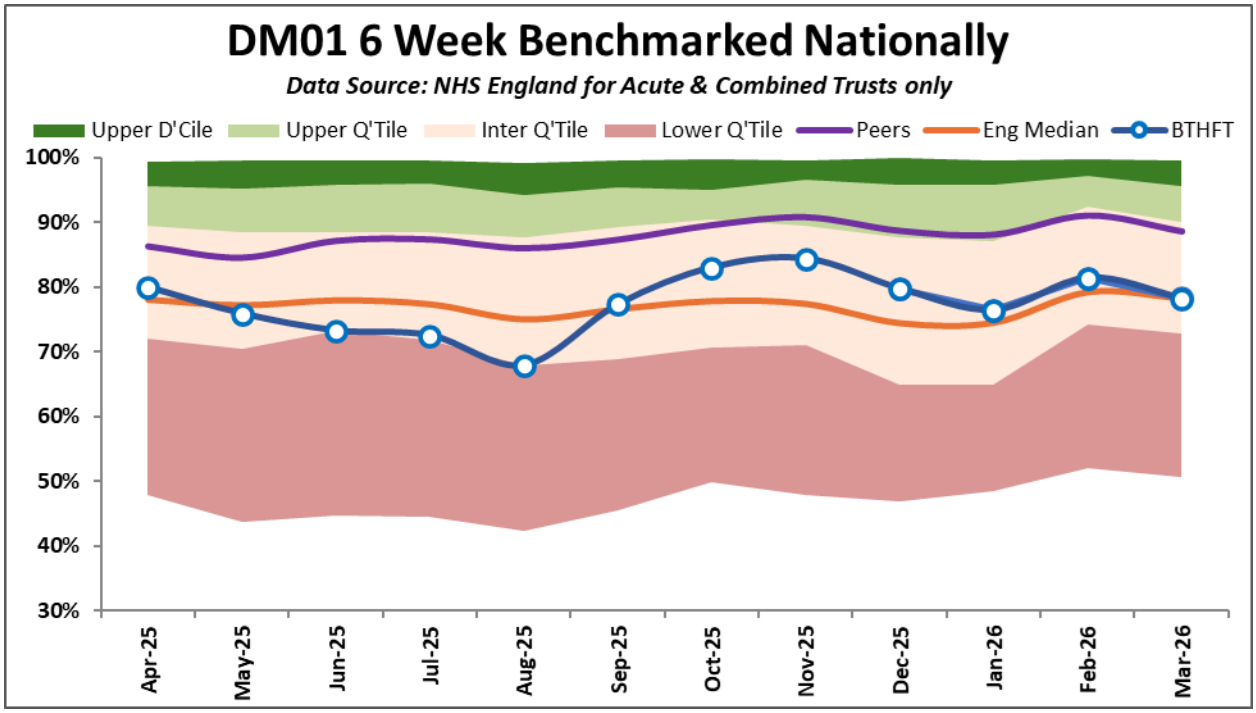


Daily and weekly management processes are in place to monitor future performance against this KPI and expedite care when delays are identified. Targeted support has been in place across three specialties with ongoing long wait challenges during 2025/26 which has helped to recover their position.

Diagnostic Waiting Times

Diagnostic wait times have reduced during 2025/26, but the Trust was unable to fully recover performance to national target due to high demand and ongoing resource challenges in key modalities. This standard aims to ensure patients wait no longer than 6 weeks for a diagnostic test, with a national expectation that performance improves to 95%.

Figure 12 – DM01 6-week Diagnostic Performance 2025/26



The Trust hosts a Community Diagnostic Centre (CDC) which now provides tests for all commissioned modalities. This resource has helped to increase activity and mitigate some of the challenges posed by increasing demand. Where capacity was available through the CDC the Trust has commissioned other parties to provide support through insourcing arrangements. Despite these efforts, demand for certain tests could not be met within target timescales during 2025/26, and additional capacity has been arranged to support improvement during 2026/27.

2.2.2.2. Risk Profile

The Trust considers both strategic and operational risks. As part of the Board Assurance Framework, key strategic risks are identified and linked to our strategic objectives.

We began the 2025/26 year with 15 strategic risks identified as having the potential to impact delivery of our organisational priorities. This provided a clear starting point for targeted monitoring and mitigation activity throughout the year. The most significant risk as we entered the year related to our ability to deliver responsive patient care, reflecting the persistent challenges within the Urgent and Emergency Care pathway. The highest-scoring strategic risks that the Trust has been exposed to during 2025/26 are as follows:

Risk: If we fail to maintain and develop our care environment, **then** we may not be able to deliver modern, outstanding care for our patients, **resulting in** poor patient experience and outcomes and limited ability to deliver services. The risk was scored at 20 at the start of the year and remained at 20 throughout the year.

Key controls in place include:

- Robust Governance and Oversight Framework
- Policies, Procedures, and Performance Monitoring
- Estate Condition Assessment and Backlog Management
- Facilities Improvement and Capital Development Programme
- Strategic Estate Transformation and Collaboration

Risk: If we fail to manage patient flow, **then** we will have patients staying in hospital longer than necessary, **resulting in** increased risk of deconditioning, hospital acquired infection and patients not being able to be seen in the emergency department and acute admission areas.

The risk was scored at 20 at the start of the year and remained at 20 throughout the year.

Key controls in place include:

- Daily Operational Oversight and Escalation processes
- Structured Performance Monitoring and Data-Driven Assurance
- Executive and Quality Governance Structures
- Implementation of the Enhancing eXperience, reduCing waits and shortEning Length of stay (EXCEL) Programme to drive sustained quality, patient flow and operational performance improvement.

Risk: If we fail to have a robust clinical workforce model that meets increasing demand, **then** we will not be able to deliver elective and non-elective care in a timely manner, **resulting** in delays for our patients, impacting on quality, safety and widening health inequalities

The risk was scored at 16 and the start of the year and remained at 16 throughout the year.

Key controls in place include:

- Daily Operational Oversight and Escalation
- Performance Management and Executive Assurance
- Workforce Recruitment, Development, and Retention
- Targeted Quality Improvement Programmes

Risk: If we and/or our Integrated Care System (ICS) partners in aggregate fail to deliver our financial plan in the short and medium term, including failure to secure an adequate capital funding allocation, **then** we may fail to maintain financial stability and sustainability, we may have insufficient internal cash and liquidity to support ongoing day to day expenditure and to support the necessary revenue and capital investments required to maintain safe and sustainable services and to support the corporate strategy, **resulting in** reduced ability to meet demand, develop services and to maintain / improve the safety and quality of care, impaired patient experience, an increased likelihood of system intervention and / or regulatory action including the potential loss of decision making autonomy and a negative impact on the Trust's reputation

The risk was scored at 20 at the start of the year and remained at 20 throughout the year. The wording of the risk itself was altered in Q2 2025/26 in light of the changes brought on by the Government concerning the role of NHS England and Integrated Care Boards. At the close of the year, the risk read:

Risk: ***If*** *we are unable to deliver our financial plan,* ***then*** *we will not be financially sustainable,* ***resulting in*** *poor outcomes for staff, patients and the public, including loss of services.*

Key controls in place include:

- Financial Governance & Accountability
- Financial Controls & Assurance
- Efficiency, Recovery & Transformation Programmes
- Capital Governance & Long-Term Planning

Risk: If we don't have effective Board leadership or robust governance arrangements in place, **then** the Board won't be able to lead and direct the organisation effectively, **resulting in** poor decision making, a failure to manage risks, failure to achieve strategic objectives, regulatory intervention and damage to the Trust's reputation.

The risk was scored at 15 at the start of the year and reduced to 10 throughout the year.
Key controls in place include:

- Board Governance Framework
- Board Capability, Conduct & Development
- Strategic Risk & Assurance Management
- Engagement, Visibility & Accountability

Operational Risk

Our escalation process involves all risks scoring 15 and above being escalated to the Executive Team, Committees and Board via the high-level risk register. The high-level risk register is reviewed monthly by the Executive Team and the relevant Board Committee, where the effectiveness of the mitigating actions is assessed

As of April 2026, the high-level risk register contains 22 risks, five of which are scored at 20. These risks are described below, and mitigating actions have been developed and are recorded on the high-level risk register, along with details of the action-plan lead and the target completion date for each action. As we close the year, the register provides assurance that key strategic risks are being actively managed and that oversight arrangements remain robust.

- There is a risk that there is insufficient capacity for in-centre (hospital) haemodialysis, meaning we may be unable to provide timely dialysis for new patients, potentially resulting in death or serious harm.

- There is a risk of Estates Critical Infrastructure Failure due to backlog maintenance, which could lead to loss of premises, harm to patients or staff, and reputational damage.

- There is a risk that the number of patients attending the Emergency Department will exceed its designed capacity and available resources, making it challenging to provide safe, timely and efficient care to current and incoming patients, and increasing the likelihood of unsafe care and heightened staff stress.

- From 30 September 2025, the supplier will change the shape of the Tc99m generator, meaning it will no longer fit the lead housing within the isolator. This renders the generator unusable and will result in the loss of Tc99m supply. Without a viable solution, this would cause a Nuclear Medicine service failure.

- If we are unable to see, treat, and admit or discharge patients within four hours, patients are increasingly likely to experience prolonged stays in the Emergency Department, with associated risks of increased mortality and morbidity.

Other risks included on the high-level risk register relate to harms from cyber-security threats, as well as capacity constraints in Haematology, Histopathology and Non-Surgical Oncology.

2.2.3. DELIVERING A NET ZERO HEALTH SERVICE

Introduction

In line with the NHS strategy for *Delivering a Net Zero National Health Service* (2020), which establishes a clear pathway for reducing carbon emissions across healthcare, the Trust is working towards the following Net Zero target dates as mandated by central government:

- **By 2032** – Reduce direct emissions (Scope 1) and emissions from purchased electricity (Scope 2) by **80%** against a 1990 baseline.
- **By 2040** – Achieve **net zero emissions for sources directly controlled by the Trust**, including fuels, electricity, water, fleet, business travel, and gases related to anaesthesia and inhalers.
- **By 2045** – Achieve **full net zero status**, including emissions outside of the Trust's direct control (e.g. staff commuting, supply chain, construction, consumables and medicines).

Context

The Trust has been publicly reporting its carbon footprint for over ten years. The Trust paid £1.45m of allowances for the carbon emitted across 2010/11 to 2018/19. Carbon emissions for the Trust were re-calculated in FY 2019 to include an estimation of emissions from a 2010 baseline. Estimations were determined in line with best practice guidance for environmental reporting and to determine approximate consumption for the period.

The assessment boundary was expanded as part of the 2019 re-calculation to align the Trust's carbon assessment with the scope of the 'NHS Carbon Footprint', contributing to national efforts to deliver a Net Zero NHS. Emissions relating to fugitive gases, hotel stays, air travel, rail travel, NHS fleet vehicles, metered dose inhalers and anaesthetic gases were included as part of this re-assessment. The boundary has again been expanded as part of this year's carbon footprint calculation. Notably, the inclusion of a spend-based assessment of purchased goods and services has been carried out, to estimate emissions associated with supply chain activities.

Additions to reporting boundary

For this reporting year, the assessment boundary has been broadened to include all relevant Scope 3 emission sources, subject to data availability. This ensures a more comprehensive representation of the Trust's total carbon impact. In the previous year, our analysis was limited to the NHS Carbon Footprint and Carbon Footprint Plus categories, in line with national reporting guidance at that time. By extending the scope, this year's assessment provides a more complete picture of the Trust's indirect emissions across its value chain, supporting more informed decision-making and aligning with the NHS commitment to a consistent, transparent, and robust approach to Net Zero reporting. Voluntary emissions sources are reported as part of the Enhanced Scope 3 assessment, which is presented in the report.

Taskforce on Climate-Related Financial Disclosures

The Board of Directors has overall accountability for climate-related risks and opportunities and oversees the delivery of the Trust's Green Plan, Net Zero commitments and climate adaptation activities. Climate-related matters are considered through Green Plan reporting, corporate risk management processes, business case approvals and strategic planning.

Responsibility for managing climate-related risks is delegated to executive and operational management teams, led by Estates and Facilities and supported by the Procurement, Emergency Preparedness, Resilience and Response (EPRR), Facilities and clinical teams. Management oversees delivery of the Green Plan, climate risk management, organisational resilience and

progress towards NHS Net Zero targets. A Net Zero Clinical Lead role has been approved and is expected to commence during 2026/27.

Climate-Related Risks

The Trust has identified a range of climate-related risks that could affect the delivery of healthcare services, the resilience of its estate and infrastructure, and its ability to meet strategic objectives. See further detail in section 2.2.2.2 (Risk Profile) and section 3.8.5 (Climate Change and the Green Plan).

Physical Risks

The principal physical risks arise from the increasing frequency and severity of extreme weather events associated with climate change. These include:

- Overheating and extreme temperatures affecting patients, staff, buildings and critical infrastructure;
- Severe weather events, including storms and localised flooding, disrupting estate operations, site access and service delivery;
- Increased healthcare demand arising from climate-related health impacts, particularly respiratory, cardiovascular and heat-related illness;
- Disruptions to critical utilities and supply chains affecting the availability of energy, water, equipment and essential supplies; and
- Long-term estate resilience challenges requiring buildings and infrastructure to be adapted to future climate conditions.

Transition Risks

The transition to a low-carbon and climate-resilient healthcare system presents a number of strategic and operational risks, including:

- Evolving regulatory, policy and reporting requirements associated with NHS Net Zero commitments;
- Financial pressures associated with estate decarbonisation and climate adaptation programmes;
- Supply chain risks arising from increasing sustainability expectations and changing market conditions; and
- The need to modernise infrastructure, technologies and working practices to support the delivery of sustainable healthcare services.

The Trust manages these risks through its Green Plan, corporate risk management processes, capital investment programmes, and EPRR.

Green Plan initiatives completed across reporting period

- **Solar Photovoltaic (PV) panels installed at Bradford Royal Infirmary and St Luke's Hospital**, generating 926,000 kWh/year (c.167 tCO_2e saved).
- **Trust-wide LED upgrade completed**, with 3,984 fittings replaced.
- **Removal of remaining nitrous oxide manifolds**, saving c.344 tCO_2e/year.
- **£308k of funding secured** to support electrification of the Estates fleet.
- **£11.4m Public Sector Decarbonisation Scheme (PSDS) funding secured** to decarbonise heating at St Luke's Hospital.
- **28 Green Champions identified** to support Green Plan delivery.
- **Board-level sustainability training delivered** in December 2025.
- **Carbon reporting expanded** to include emissions from revenue and capital spend.

Summary of mandatory Greenhouse Gas (GHG) emissions

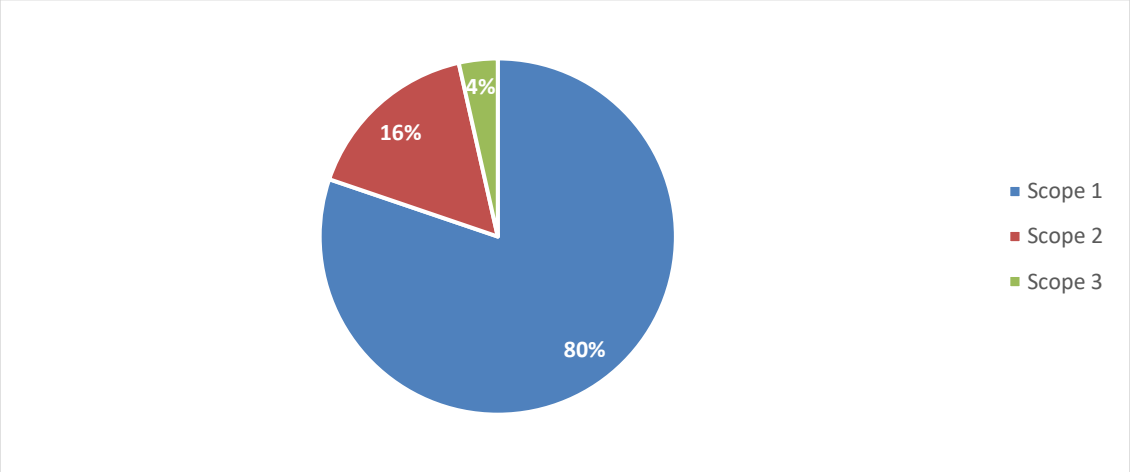
The Trust's GHG emissions from operations are summarised in Figure 13. The emissions data presented relates to the 2024 reporting year, which was the latest available dataset at the time of publication. This is consistent with previous years and reflects the established reporting cycle for emissions data. It is important to note that total emissions (tCO_2e) quantified in this table represent emissions sources associated with the NHS Carbon Footprint and Footprint Plus assessment boundary. Scope 3 emissions outside of the mandatory NHS boundary have been excluded from this table, however, are presented as part of the broader enhanced assessment towards the end of this section of the report.

Figure 13 – Summary of GHG emissions

Scope	FY2024 tCO_2e	%
Scope 1	11,558	80%
Scope 2	2,343	16%
Scope 3	507	4%
Total Emissions (tCO_2e)	**14,408**	**100%**

The emissions breakdown in Figure 14 shows the Trust's carbon footprint in line with the mandatory NHS Carbon Footprint assessment boundary. Scope 1 makes up 80% of total emissions, driven mainly by grid-supplied natural gas (11,558 tCO_2e). Scope 2 contributes 16%, while water, waste treatment, business travel and the supply of Metered Dose Inhalers (MDI) account for the remaining 4% (Scope 3).

Figure 14 – GHG emissions by scope



GHG Emissions by Source (NHS Carbon Footprint and Footprint Plus Boundary)

The following analysis provides detailed breakdown of the Trust's Scope 1 and Scope 2 footprint, along with emissions from waste, water, Metered Dose Inhalers (MDI) and business travel. GHG emissions associated with each source are set out in Figure 15 below. The assessment boundary is again limited to the NHS Carbon Footprint and Footprint Plus for consistency with previous reporting periods and to provide a clear year-on-year comparison of the Trust's annual carbon emissions.

An analysis of emissions associated with procurement activities is provided as part of the following section, which provides an assessment of the Trust's carbon footprint from Capital and Revenue purchases.

Figure 15 – Summary of GHG emissions (NHS Carbon Footprint and Carbon Footprint Plus)

Key

NHS Carbon Footprint Boundary (Scopes 1-2)

NHS Carbon Footprint Plus Boundary (Scope 3)

Emissions Source	2010/2011 (tCO_2e)	2023/2024 (tCO_2e)	2024/2025 (tCO_2e)	Baseline Var (%)	Annual Var (%)
Grid natural gas consumption	6,894	7,850	9,093	32%	16%
Gas Oil (on-Site generation)	121	298	150	24%	50%
Anaesthetic gases (sevoflurane, Entonox, N_2O)	-	10,633	1,793	-	-83%
Refrigerants	-	176	338	-	92%
Transport (Business and Grey fleet)	-	189	184	-	-3%
Grid electricity consumption (location-based)	7,090	2,549	2,343	-67%	-8%
Grid electricity consumption (market-based)	0	320	0	-	-
Water (supplied and treated)	175	48	50	-72%	4%
Waste treatment	-	219	272	-	24%
Metered Dose Inhalers	-	122	123	-	0%
Air Travel	-	49	38	-	-23%
Rail Travel	-	18	13	-	-26%
Hotel Stays	-	14	12	-	-17%
Total	**14,279**	**22,165**	**14,408**		

Summary

Across the reporting period, emissions from natural gas consumption saw a significant increase (16%) in annual emissions, which is largely attributed to increased consumption from on-site boilers for internal space heating. Additionally, Gas Oil usage saw a 50% year on year increase for the same reason. At the same time location-based emissions from grid electricity use fell by 8% following reductions in consumption and national efforts to decarbonise the national grid, which resulted in a positive impact to the overall carbon emission factor. Furthermore, efforts made by the Trust to address the environmental impact from harmful anaesthetic gases saw a reduction in associated carbon emissions by 83%.

In total, the Trust's annual emissions have fallen by 35% across the organisation's mandatory reporting boundary. This is largely due to the significant progress made in Theatres to limit the use of potent anaesthetic gases with high global warming potentials.

The following section illustrates the Trust's Carbon Footprint following the inclusion of a broader subset of Scope 3 emissions sources, which largely relate to procurement-based activities.

Enhanced Scope 3 Assessment

This year, the Trust has voluntarily expanded its carbon footprint assessment to include emissions from purchased goods & services, and capital goods. These reflect the embedded carbon in the production, transport, and supply of materials and infrastructure.

In the absence of direct activity data, spend-based emission factors were used to convert capital expenditure and operating expenditure into total GHG emissions (tCO_2e), based on average carbon intensity per pound spent in each sector. While aligned with NHS England's guidance, this method is inherently less accurate than activity-based approaches. The Trust aims to improve its methodology by adopting a hybrid model using more precise activity-based data in future assessments.

As seen in Figure 16 below, there has been an uplift in Scope 3 emissions of 46,067.12 tCO_2e, which now follows the inclusion of Scope 3 activities relating to Revenue and Capital Spend. Scope 3 emissions now represent 77% of the Trust's total carbon footprint.

Figure 16 – Recalculated Summary of GHG emissions

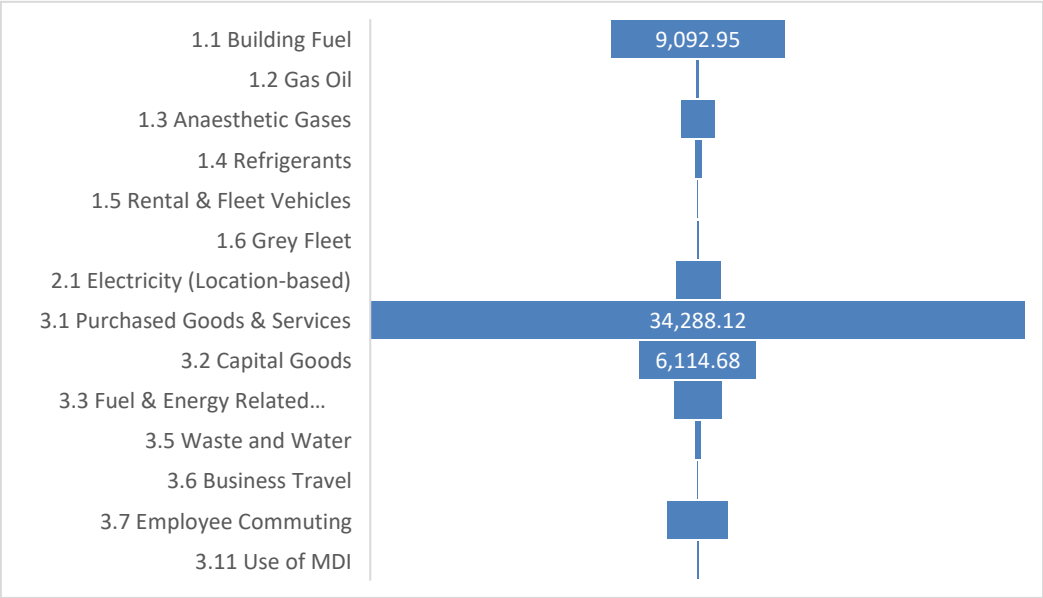
Scopes	FY2024 tCO_2e	%
Scope 1	11,558	19%
Scope 2	2,343	4%
Scope 3	46,426	77%
Total Emissions (tCO_2e)	**60,327**	**100%**

The spend-based figures shown in the table above reflect nominal expenditure for the 2024/25 financial year, meaning they have not been adjusted for inflation. The Trust's Scope 3 footprint would in fact account for 83% of total emissions, when taking inflation into consideration as part of the spend-based assessment. Inflation-adjusted values are presented alongside nominal figures.

GHG Emissions by Source (Revised)

Figure 17 illustrates the Trust's revised carbon footprint following the inclusion of emissions sources relating to purchased goods and services and capital goods.

Figure 17 – Revised GHG emissions by source



Carbon Intensity

Carbon intensity ratios have been established to assess the normalised carbon performance of Trust operations, using employee headcount, building floor area and financial spend as reference factors. These metrics enable the Trust to compare carbon performance over time on a like-for-like basis, while accounting for growth and changes in operational activity. Carbon intensity ratios are presented in figure 18 below.

Floor Area (sqm)

Performance has been assessed using an intensity ratio of tCO_2e per sqm of operational floor area.

The floor area occupancy associated with premises operated by the Trust across 2024/25 is understood to total 149,672.4 m^2.

Number of Employees

Performance is also assessed using a carbon intensity ratio of tCO_2e per employee. Across the 2024/25 financial period, the Trust had a workforce consisting of 6,404 Full Time Equivalent (FTE) employees.

Capital and Revenue Spend

Performance is also assessed on financial spend, which uses an intensity ratio of tCO_2e per £1,000,000 spent on both Capital and Revenue purchases across the reporting year. The total value of Capital and Revenue spent across 2024/25 was £98,706,231.

Figure 18 – Carbon Intensity

	Value	Unit	Carbon Intensity
Floor Area*	149,672m^2	kgCO_2e / m^2	92.87
Employees**	6,404	tCO_2e / FTE employee	9.4
Financial Spend**	£98,706,231	tCO_2e / £m	612.7

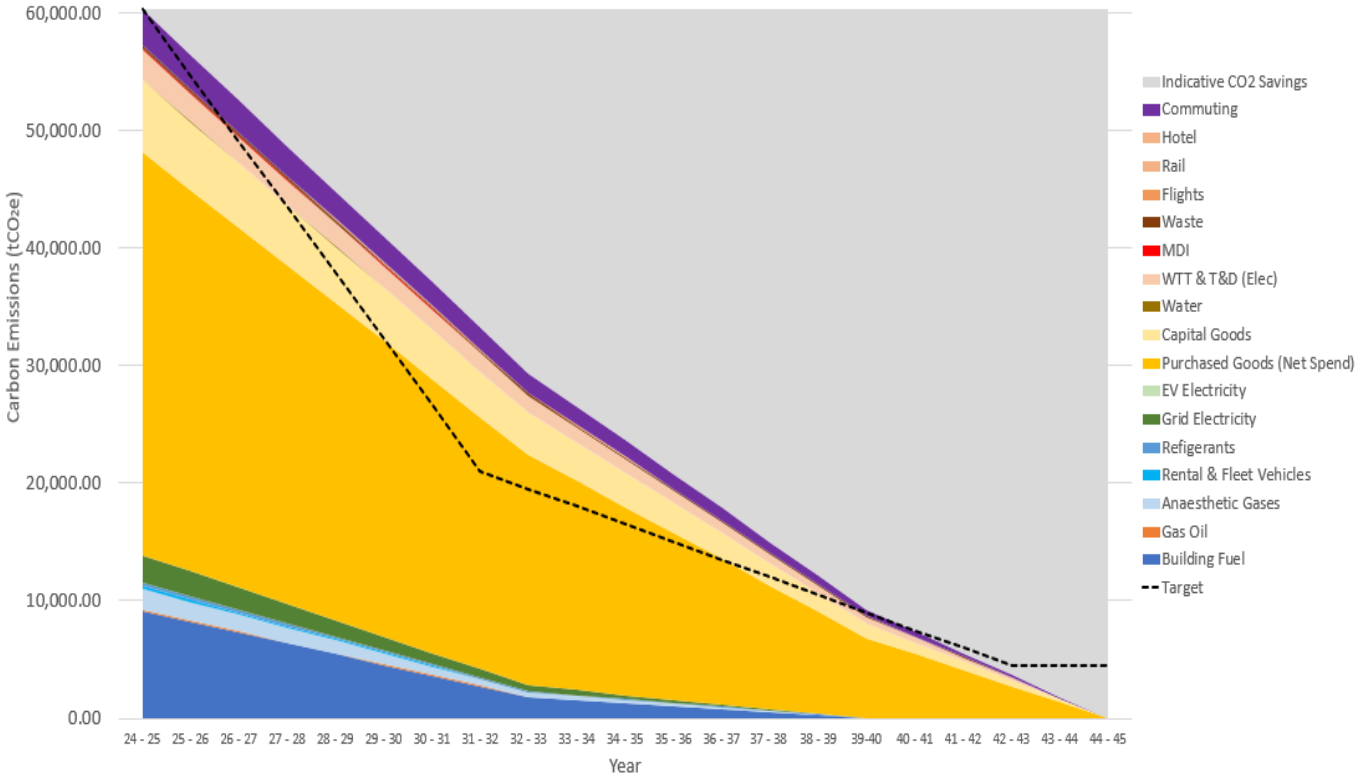
* Intensity ratio for floor area is representative of Scope 1 & 2 emissions only.
** Intensity relating to employees and financial spend, accounts for all Scope 1-3 emissions sources.

Decarbonisation Pathway

Figure 19 shows the Trust's Net Zero trajectory, setting out how emissions are expected to reduce between 2024/25 and 2044/45. The stacked areas show the main sources of emissions. Early reductions are expected in the Trust's direct Scope 1 and 2 emissions, reflecting the NHS ambition to achieve an 80% reduction in these sources by 2032. Longer term reductions are also projected for indirect emissions from supply chain activities (Scope 3) leading to 2045.

Figure 19 shows the Trust's carbon footprint reducing to zero, however, in practice some residual emissions are likely to remain and would need to be addressed separately; these are not represented here.

Figure 19 – Indicative Decarbonisation Pathway



2.2.4. Preventing Ill Health and Reducing Health Inequalities

Health Inequalities Statement

The Trust's Health Inequalities Statement 2025/26 sets out how the Trust understands, measures, and acts on health inequalities across the populations it serves. It describes Bradford's demographic profile including healthy life expectancy disparities between the most and least

deprived areas and projected rises in long-term conditions by 2040. The Statement details the Trust's governance arrangements, including the Health Equity Oversight Group established in August 2025, and aligns its work to the Core20PLUS5 framework. It reports on inequalities in access, experience and outcomes drawn from secondary care data, patient engagement and Listen In community sessions. It also sets out actions taken in 2025/26 across maternity equity, the 'Making Improvements Shaping Services for Meaningful Equity' (MISSME) renal programme, Make Every Contact Count, digital inclusion, language access, and the Trust's role as an anchor institution. A measurement framework is embedded within the Statement and tracks progress against NHS England's suggested indicators. The full Health Inequalities Statement can be found on the Trust website[3].

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

The Trust has forged strong links with the local communities, and this is outlined in our Patient Experience and Engagement Strategy[4]. Work undertaken in 2025/26 in respect of Equality, Diversity and Inclusion can be found on the Trust website[5]. During the year we worked in partnership with other local health economy partners to engage and consult with the local community on our progress and to gather feedback on key areas of focus for 2026/27. Consideration to the impact on Human Rights (Fairness, Respect, Equality, Dignity and Autonomy) is integral to everything we do as a Trust and is embedded into our Equality, Diversity & Inclusion training for managers. It also forms part of our Trust wide equality impact process, ensuring that policies and practices, including our building design and renovations, take these principles into consideration. These issues are very important to the Trust, so we have opted to include a full Equality Report in section 3.4. Information about the Trust's anti-fraud, bribery and corruption policy can be found in section 3.3.2 (Staff Policies).

2.2.6. Events since year end

There are no events to report since the end of 2025/26.

2.2.7. Overseas Operations

The Trust has no overseas operations.

2.2.8. Disclosure on equality of service delivery

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

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

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

Our Equality, Diversity and Inclusion (EDI) strategy (see 3.4.1) and the roll out of the refreshed Equality Delivery System2 (see section 3.4.5), along with other statutory equality frameworks (such as the Workforce Race Equality and Workforce Disability Equality Standards – see Equality Report, section 3.4) play a crucial role in ensuring we are meeting the requirements of the public sector equality duty.

[3] https://www.bradfordhospitals.nhs.uk/health-equity/

[4] https://www.bradfordhospitals.nhs.uk/patient-stories-and-patient-public-involvement/

[5] https://www.bradfordhospitals.nhs.uk/equality-and-diversity/

2025/26 Equality Delivery System2 review (EDS2): Our Patient Experience and Involvement team once again played a pivotal role in the implementation of this year's EDS2 review, participating in task and finish group discussions and supporting clinical colleagues from our three chosen Domain 1 service areas to showcase some of the fantastic engagement work they have supported over the previous 12 months, demonstrating how this work is positively impacting the provision of care for our diverse patients and communities.

EDS2 Domain 1 (which assesses equality performance for commissioned or provided services), the Trust worked collaboratively with organisations across Bradford District & Craven focussing on three services or clinical pathways which align with the Core20PLUS5 approach to reducing health inequalities (information about Core20PLUS5 can be found in the equality hub section of the NHS England website[6]). The Trust chose to focus on Maternity Services (Intrapartum Care/Labour Ward), Bradford Nutrition & Dietetics Service and Mental Health Provision within our Emergency Department. Each of these areas have provided considerable focus to patient and community engagement and involvement, and advancing EDI. The Trust showcased evidence and insights at a community engagement event on 12 February 2026, where stakeholder feedback was gathered from a diverse range of participants and the Trust received a rating of *Achieving* for each of the Domain 1 outcome measures focussing on: access, outcomes, safety and experience.

The EDI team worked alongside the Patient Experience and Involvement team to ensure EDI is incorporated in the Patient Experience and Engagement Strategy and its six key objectives. The Patient Experience and Involvement Team provide focus and engage with under-represented groups and communities, sharing lived experiences and supporting teams and departments to address some of the potential health inequalities and challenges that exist in the Bradford district. This co-production is key to meaningful change, and the team regularly share their learning at the Trust's Equality and Diversity Council and at Board meetings through patient stories.

The Trust continues to use the equality impact assessment methodology and processes in ensuring equality impact assessments are being carried out on new policies and practices, including building design and renovations. Several completed assessments have taken place with equality considerations built in from the outset, including building and service development projects such as the new "Home from Home" at Bradford Royal Infirmary to ensure this facility is as inclusive as possible. The facility will provide free, on-site accommodation for families with critically ill or premature babies in the Neonatal Intensive Care Unit, including five new en-suite bedrooms, a kitchen, and a lounge.

In January 2026 the newly developed Sexual Misconduct Policy underwent a full equality impact assessment to ensure that any potential impacts were considered and mitigated by colleagues, taking into consideration the diverse needs of colleagues. In September 2025, an equality impact assessment of the Trust's Complaints Policy led to the development of improved equality monitoring and supporting FAQ documents for patients, outlining the importance of declaring personal diversity information, how their information will be used and managed, and how this can support the Trust in making services more accessible and inclusive for everyone.

Equality of service delivery data

The Trust collects data about age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation as part of several 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 thousands of patient contacts per year, and national Care Quality Commission (CQC) surveys[9] in which the Trust participates.

[6] https://www.england.nhs.uk/about/equality/equality-hub/national-healthcare-inequalities-improvement-programme/core20plus5/
[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

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

In addition to the work being undertaken across the Bradford District and Craven Health and Care Partnership, several initiatives are being undertaken with the Trust's Patient Experience and Chief Nurse Team to promote equality in relation to all protected characteristics, as defined by the Equality Act 2010. There are continued learning opportunities from patient feedback and complaints, and the lead for EDI is involved in the review of any complaints pertaining to equality and diversity issues. Examples of our work can be found on the Trust website.

During 2025, NHS England (NHSE) published a revised version of the Accessible Information Standard (AIS) which included an additional standard and a future requirement to complete a Self-Assessment Framework template which organisations will be required to publish annually from 2027 onwards. It is anticipated that AIS training will become mandatory and a training needs analysis is being developed in conjunction with the Education Department to deliver and collate evidence of AIS training being completed.

British Sign Language Training for staff is available, and the Trust adheres to the AIS[10] and provides information in different formats which include easy read, large print braille, and text-phone for hearing and speech difficulties. Our interpreting services provide written and verbal translations where required and support clinic appointments. The Trust continues to work collaboratively with the Royal National Institute of Blind People (RNIB) with links to national improvement work and shared learning to reshape services.

The Trust continues to work with AccessAble[11] to create detailed access guides for all the Trust's hospitals. These guides are facts, figures and photographs that provide useful information on how to access the Trust for people with individual requirements, including parking, hearing loops, walking distances and accessible toilets. These guides are under continual review. Further developments during 2025 included the addition of bespoke visual maps to several key locations on the Bradford Royal Infirmary site.

During 2025 the Trust continued to commission work with CardMedic. CardMedic is a healthcare translation application helping patients and staff overcome communication issues with instant access to thousands of clinically interpreted interactions in more than 50 languages and formats. CardMedic bridges the communication gap with immediate access to ready-made content.

An Independent review of the Trust's website by the Equality and Human Rights Commission was conducted and the Trust continues to partner with a company called EIDO Healthcare which specialises in patient information. The EIDO Inform service now provides access to range of procedure-specific leaflets written and updated by health professionals to provide clear, accurate and updated medical information. The comprehensive resources support healthcare professionals by facilitating effective patient education and improving patient satisfaction, whilst helping the Trust to mitigate and reduce the risk of litigation and legal claims.

Signed

Professor Mel Pickup
Chief Executive
26th June 2026

[10] http://www.england.nhs.uk/ourwork/accessibleinfo/
[11] https://www.bradfordhospitals.nhs.uk/patients-and-visitors/accessible-information/

3. ACCOUNTABILITY REPORT

3.1 DIRECTORS' REPORT

The Board of Directors consists of people with the range of experience and expertise necessary to govern 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[12], they each share the same responsibility and liability. The Chair 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 sets out the matters reserved for the Board of Directors in full.

In 2025/26, the Chair and Chief Executive (and their deputies) were as follows:

- Sarah Jones, Chair*
- Karen Walker, Deputy Chair (from 1 September 2025) and Acting Chair*
- Julie Lawreniuk, Deputy Chair (up to 31 August 2025)
- Professor Mel Pickup, Chief Executive
- Sajid Azeb, Chief Operating Officer / Deputy Chief Executive

*The Council of Governors supported Sarah Jones' appointment as Chair at Airedale NHS Foundation Trust from 1 February 2026, and as Interim Chair in Common with Bradford District Care NHS Foundation Trust from 1 March 2026. As a result, she stepped away from her day-to-day involvement with Bradford Teaching Hospitals NHS Foundation Trust with effect from 1 February 2026. During this period, the Deputy Chair, Karen Walker has taken on the role of Acting Chair, in line with the Constitution.

All directors are required to meet the standards of the fit and proper persons requirement[13] and to make annual declarations. The register 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[15] was last approved by the Council of Governors and Board in October and November 2024 respectively.

Further information about the Board of Directors[16] is available on our website, or from the Associate Director of Corporate Governance/Board Secretary at:

- email: corporate.governance@bthft.nhs.uk;
- telephone: 01274 364794; or
- in writing to Corporate Governance Office, Trust Headquarters, Chestnut House, Bradford Royal Infirmary, Bradford, Duckworth Lane, Bradford, BD9 6RJ.

[12] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2026/04/CG04-2026-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
[15] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2024/11/BTHFT-Constitution-November-2024-Final.pdf
[16] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/

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.

The Chair is responsible for ensuring that the Board focuses on the strategic development of the Trust and that robust governance and accountability arrangements are in place. The Chair of the Trust is the Chair of both the Board of Directors and the Council of Governors, and has a responsibility to ensure there is effective communication between the two bodies and that, where necessary, the views of the Governors are taken account of by the Board.

Whilst individual Executive Directors 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, values and strategic objectives[17]. In March 2022 the Board approved our corporate strategy for 2022-2027 titled 'Our Patients, Our People, Our Place and Our Partners'[18]. The strategy explains how we will work towards our vision to be an "outstanding provider of healthcare, research and education and a great place to work". We are proud to be part of the Bradford District and Craven Health and Care Partnership, with a shared ambition to Act as One to keep people happy, healthy at home.

The Board is made up of individuals who have the appropriate balance of skills, experience, independence and knowledge to enable the Board to discharge its duties and responsibilities effectively. It provides leadership in a transparent manner, subscribes to the Trust's values, and adheres to the accepted standards of behaviour in public life, including the seven principles of public life more commonly referred to as the 'Nolan Principles'. The make-up of the Board is prescribed within the Trust's Constitution[19].

During 2025/26 the Trust has continued to be subject to additional licence conditions which require the Trust to ensure it has in place the required leadership capacity and capability to deal with the

[17] https://www.bradfordhospitals.nhs.uk/our-trust/strategy/
[18] https://www.bradfordhospitals.nhs.uk/our-trust/strategy/
[19] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2024/11/BTHFT-Constitution-November-2024-Final.pdf

issues facing the Trust, and that the Council of Governors implements arrangements to ensure it discharges its role and responsibilities effectively, including holding Non-Executive Directors to account and representing interests of members, the public and staff.

The Trust has complied with the regime put in place and continues to work with NHS England, reporting through to the Integrated Quality Improvement Group (IQIG). The Board and Council of Governors remain quorate with meetings taking place. An ongoing programme of board development is in place, and improvements have been made to governance arrangements during 2025/26 including board committees as part of effectiveness reviews.

During 2025/26, the Trust was subject to a CQC Well Led inspection, the outcome of which was 'Good'.

Figure 20 shows the non-executive members of the Board in 2025/26.

Figure 20 – Non-Executive Directors 2025/26

Name	Role
Sarah Jones	Substantive Chair*
Zafir Ali	Non-Executive Director
Justine Andrew	Non-Executive Director (from 1 October 2025)
Professor Louise Bryant	Non-Executive Director (to 31 May 2025)
Professor Geoff Hall	Non-Executive Director (from 26 November 2025 to 30 April 2026)
Mohammed Hussain	Non-Executive Director (to 31 August 2025)
Julie Lawreniuk	Non-Executive Director (to 31 August 2025)
Bryan Machin	Non-Executive Director
Altaf Sadique	Non-Executive Director
Tim Swift	Non-Executive Director (from 1 September 2025)
Karen Walker	Non-Executive Director Acting Chair (from 1 February 2026)

*See note at section 3.1.

Figure 21 shows the executive members of the Board in 2025/26.

Figure 21 – Executive Directors 2025/26

Name	Role
Professor Mel Pickup	Chief Executive
Sajid Azeb	Chief Operating Officer / Deputy Chief Executive
Dr John Bolton	Chief Medical Officer (from 1 June 2025)
Reneé Bullock*	Chief People and Purpose Officer (to 30 September 2025)
Professor Karen Dawber	Chief Nurse
Mark Hindmarsh	Director of Strategy and Transformation
Faeem Lal*	Director of Human Resources (from 1 October 2025)
Vikki Lewis*	Chief Digital and Information Officer (from 9 June 2025)
David Moss*	Director of Estates and Facilities
Dr Paul Rice*	Chief Digital and Information Officer (up to 31 May 2025)
Ben Roberts	Chief Finance Officer
Dr Ray Smith	Chief Medical Officer (up to 31 May 2025)
**Non-voting Executive Director*	

Profiles of our Board members are available on our website[20].

About our Board of Directors

The Board continuously reviews its make-up to determine gaps in skills and knowledge required to support the Board in achieving the Trust objectives. The report on the work of the Governors Nominations and Remuneration Committee is reported on further under section 3.2.3.3 (Governors Nominations and Remuneration Committee (for Non-Executive Directors)).

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

The Board of Directors considered the independence of the Board at its meeting on 21 May 2026 and confirms that it considers all of the Non-Executive Directors (including the Chair) to be independent in character and judgement.

The Board has assured itself that there are no relationships or circumstances which have affected or appear to have affected, the directors' judgement.

Attendance at meetings of the Board of Directors during 2025/26

Board meetings in public take place bi-monthly. Agendas and meeting papers can be accessed on the Trust's website[21].

Figure 22 reports on the number of meetings attended by Board members in-year.

Figure 22 – 2025/26 Attendance at Board of Directors meetings held in public

Board member		Role	Attendances	Total meetings
Sarah	**Jones**	Substantive Chair	5	5
Karen	**Walker**	Non-Executive Director / Acting Chair	6	6
Mel	**Pickup**	Chief Executive	6	6
Zafir	**Ali**	Non-Executive Director	4	6
Justine	**Andrew**	Non-Executive Director	2	3
Sajid	**Azeb**	Chief Operating Officer / Deputy Chief Executive	4	6
John	**Bolton**	Chief Medical Officer	6	6
Louise	**Bryant**	Non-Executive Director	1	1
Reneé	**Bullock**	Chief People & Purpose Officer	2	3
Karen	**Dawber**	Chief Nurse	5	6
Geoff	**Hall**	Non-Executive Director	2	3
Mark	**Hindmarsh**	Director of Strategy & Transformation	6	6
Mohammed	**Hussain**	Non-Executive Director	0	2
Faeem	**Lal**	Director of Human Resources	4	4
Julie	**Lawreniuk**	Non-Executive Director	2	2
Vikki	**Lewis**	Chief Digital & Information Officer	5	6
Bryan	**Machin**	Non-Executive Director	6	6
David	**Moss**	Director of Estates & Facilities	6	6
Paul	**Rice**	Chief Digital & Information Officer	1	1
Ben	**Roberts**	Chief Finance Officer	6	6
Altaf	**Sadique**	Non-Executive Director	6	6
Ray	**Smith**	Chief Medical Officer	0	1
Tim	**Swift**	Non-Executive Director	3	4

Reasons for non-attendance at Board meetings are not provided here for Data Protection purposes.

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 in section 3.2.3.2). The work of the Audit Committee is detailed further in this section. In addition, the Board

[21] https://www.bradfordhospitals.nhs.uk/our-trust/bod-meetings/

has a Charitable Funds Committee, Quality Committee, Finance and Performance Committee and People Academy. The Terms of Reference for all Board Committees and the Academy are available on the Trust's website[22].

Reports from the Chairs of the committees are presented at the Board of Directors meetings held in public, and as part of the Council of Governors meetings.

Audit Committee 2025/26

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

The Audit Committee supports the Board by critically reviewing and reporting on the relevance and robustness of the governance structures and assurance processes on which the Board places reliance.

The matters to be considered by the Audit Committee are included within the Audit Committee Terms of Reference which are reviewed annually and approved by the Board of Directors.

Regarding the work of the Audit Committee during 2025/26, the Committee considered and reviewed regular progress reports from Internal Audit and Counter Fraud, as well as agreeing their annual plans of work.

The Audit Committee also considered and reviewed a number of reports from the Trust including the Annual Report and Accounts, reviews of the performance of the internal and external auditors, compliance with the Risk Management Strategy and reports on losses and special payments and single source tenders.

Throughout 2025/26 the Audit Committee considered the following significant risks highlighted by the External Auditor, Deloitte LLP:

- **Management override of controls**
  In accordance with ISA (UK) 240 management override is a significant risk. This risk area includes the potential for management to use their judgement to influence the financial statements as well as the potential to override the Trust's controls for specific transactions.

- **Completeness of expenditure**
  Under auditing standards, there is a presumed risk of fraud in revenue recognition. In their preliminary risk assessment, the External Auditor rebutted this risk in line with their approach in the prior year. Instead, they believe the fraud risk lies within the completeness of expenditure, driven by the overall NHS financial environment which has become significantly more challenging, creating incentives for organisations to understate judgemental liabilities and related expenditure to achieve their required performance against control totals.

In-year, the Committee members also held private meetings with Internal Audit (Audit Yorkshire) and the External Auditor (Deloitte).

During 2025/26 the Audit Committee did not meet with the independent examiner (Moore Kingston Smith) for the Charity Accounts.

[22] https://www.bradfordhospitals.nhs.uk/our-trust/corp-gov/

The Committee's membership has been as follows:

- Bryan Machin, Non-Executive Director, Audit Committee Chair (to 31 August 2025) and Audit Committee member (from 1 September 2025)
- Zafir Ali, Non-Executive Director, Audit Committee member (to 31 August 2025) and Audit Committee Chair (from 1 September 2025)
- Professor Geoff Hall, Non-Executive Director (from 26 November 2025 to 30 April 2026)

The Audit Committee met five times during the year. Attendance at these meetings is detailed in Figure 23 below.

Figure 23 – 2025/26 Audit Committee attendance

Committee member	Role	Attendances	Total meetings
Bryan Machin	Chair to 31 August 2025, Member from 1 September 2025	5	5
Zafir Ali	Member to 31 August 2025, Chair from 1 September 2025	5	5
Professor Geoff Hall	Member from 26 November 2025 to 30 April 2026	0	1

Reasons for non-attendance at Committee meetings are not provided here for Data Protection purposes.

Audit Committee meetings are also attended by the Chief Finance Officer, Deputy Director of Finance, the Associate Director of Corporate Governance / Board Secretary and the Head of Corporate Governance. The Chief Executive attends at least one meeting per year to present the Annual Governance Statement. Representatives of both Internal and External Audit and Counter Fraud also routinely attend meetings. Executive Directors attend in response to any limited assurance reports received, and routinely one Executive Director attends the meetings to support any feedback required to the Executive team.

3.1.2. Better Payment Practice Code

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

Figure 24 - Better Payment Practice Code

	2025/26		2024/25	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in-year	46,605	244,540	50,870	242,630
Total non-NHS trade invoices paid within target	41,856	223,759	46,458	222,793
Percentage of non-NHS trade invoices paid within target	90%	92%	91%	92%
Total NHS trade invoices paid in-year	1,487	23,686	1,657	21,727
Total NHS trade invoices paid within target	1,337	20,483	1,475	18,091
Percentage of NHS trade invoices paid within target	90%	87%	89%	83%

The Trust aims to pay all invoices within the 30 day target whilst maintaining a balance on appropriate authorisation and validation of invoices. Performance has remained consistent over the past twelve months and collectively over 90% of invoices are paid within the BPPC target by volume and value. Over the next 12 months the Trust will seek to improve the timeliness of invoice approval to achieve the target.

The 2024/25 non-trade invoices by number and value have been revised to exclude payments to Inland Revenue which are not paid by invoice. In total there were 12 payments with a total value of £104,452,000 that have been excluded. All payments were made within the target leading to performance of 91% of invoices paid within target by number and 94% by value.

As at 31 March 2026, the total liability to pay interest due to failing to pay invoices within 30 days was nil (31 March 2025: nil).

3.1.3. The Care Quality Commission and NHS England Well-Led Framework

CQC Inspections

During 2025/26, the Trust was subject to a well led inspection and a number of service inspections, as follows:

- The well led inspection was carried out between 3 to 6 November 2025. This rated the Trust as Good, with clear improvement since the previous inspection. No regulatory breaches were identified; however further improvements were identified across four quality statements:

  - **Shared Direction and Culture:** absence of a clearly articulated clinical services strategy and the need to further strengthen organisational culture.
  - **Capable, Compassionate and Inclusive Leaders**: continued focus required on Board development and leadership effectiveness.
  - **Freedom to Speak Up:** while the CQC noted variable staff confidence in speaking up and in consistent leadership response, this feedback was drawn from a qualitative analysis of CQC feedback and the National staff survey.
  - **Workforce Equality, Diversity and Inclusion:** Workforce Race Quality Standard (WRES) data indicating workforce inequalities, discrimination, and underrepresentation at senior levels.

  A focused and proportionate action plan has been developed, aligned to existing strategy programmes to ensure integration rather than duplication.

- The unannounced Maternity CQC inspection, undertaken on 16-17 September 2025, reviewed elements of the Safe domain and all elements of the Effective, Caring and Responsive domains. The service was rated Good across all domains, resulting in an overall rating of Good. An action plan is in place to address identified improvements.
- The Outpatients unannounced inspection, undertaken on 23-24 September 2025 as part of routine activity in preparation for the Trust level well led inspection, resulted in a Good rating across all domains. Two regulatory breaches were identified (Regulations 15 and 17). A comprehensive action plan is in place.
- The Community Hospital inpatient services inspection, undertaken on 22-23 October 2025, resulted in a Good rating across all domains.
- The Urgent and Emergency Care CQC action plan remains in progress following the unannounced inspection conducted on 16 to18 September 2025. Actions continue to be implemented as we await the final inspection report.

Additionally, the evidence for the Independent Investigation into Maternity and Neonatal Services in England was submitted on 15 January 2026 following the initial site visit. As a Trust, we await the outcome of the review which is expected to be reported in July 2026. On 9 December 2025, Baroness Amos published her reflections and initial impressions[23].

[23] https://www.matneoinv.org.uk/updates/independent-investigation-into-maternity-and-neonatal-services-in-england-reflections-and-initial-impressions/

NHS England Integrated Quality Improvement Group

The Trust was moved from segment 2 to segment 3 of the NHS Oversight Framework in May 2024 due to the issues facing the Trust and continued governance concerns including a deterioration in relationships between members of the Board. Furthermore, NHS England imposed additional licence conditions on the Trust pursuant to section 111 of the Health and Social Care Act 2012, and the Trust agreed to a number of enforcement undertakings to address the concerns raised.

An Integrated Quality Improvement Group (IQIG) has been set up by NHS England to oversee and support the Trust in addressing the concerns and making the required improvements. The Trust is fully committed to resolving these matters as quickly as possible and welcomes NHS England's and other partners support in this work.

Quality Objectives

The Trust's quality priorities are assigned to the appropriate committee of the Board where regular reports are received from the leads providing updates and progress. The granularity of the priorities is addressed at the relevant working group which report to the committees monthly.

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

1. Improving the management of deteriorating patients including the implementation of Martha's Rule.
2. Implementing the 3 -year plan for maternity and neonatal services based on the Ockenden review and Saving Babies Lives.
3. Understanding and tackling health inequalities.
4. Embedding the Trust's patient Safety Incident Response Plan including the development of metrics to demonstrate its effectiveness.

Progress against key metrics is monitored at the Board's Quality Committee and further detail is included in the Trust's Quality Account 2025/26.

Patient Experience and Engagement Strategy

During 2025/26, the Patient Experience and Engagement Strategy 2023-2028 has continued to be embedded. This strategy takes the work on "*embedding kindness*" from the previous patient experience strategy, to "*kindness at every step, no decision about you without you*". The aim of the strategy sets out how the Trust is committed to ensure it works towards including patients, families, and carers in decisions about the care that is being provided. Further details of the work carried out by the Trust can be found in the Trust's Quality Account 2025/26.

Spiritual, Pastoral and Religious Care (SPaRC) team

The SPaRC model (formally chaplaincy) focuses on collaborative working with patients and their families and becoming part of the wider hospital team. The model is underpinned by 7 anchors – Equality, Person Centred Care, Belief Based Care, Spiritual and Reflective Spaces, Collaborative Practice, Professional Practice and Data and Data Organising. The model has been well received by staff and patients and is used by both alike. During 2025/26 the team carried out a staggering 38,787 visits, as shown in Figure 25 below.

Figure 25 - SPaRC visits for patients and visitors during 2025/26

Month	Patient Visits
Apr-25	2,733
May-25	2,687
Jun-25	3,104
Jul-25	3,413
Aug-25	3,170
Sep-25	3,781
Oct-25	3,685
Nov-25	3,175
Dec-25	3,554
Jan-26	3,006
Feb-25	2,992
March-26	3,487
Total	**38,787**

There has been external recognition and enquiries about SPaRC *Fast Packs* which were first developed in 2022. These include pop up prayer facility packs that have helped managers support their colleagues during the Ramadan period and an organised campaign commenced for the Holy month of Ramadan in mid-February 2026, accessed by approximately 1200 staff members. This rewarding work has led to national and local nominations for awards as follows:

- Bradford District and Craven health and Partnership Awards (Celebrate as One). **Team of the Year** (delivering frontline service) Ramadan Allies, October 2023.
- Health Service Journal (wellbeing category) **Winner** for Ramadan Allies work, November 2023.
- Nursing Times **Finalist** for Ramadan Allies work, November 2023.
- APNA Awards, **Winner** for Ramadan Allies, October 2025.

The Additional Needs Team

From its creation in 2023 the Additional Needs Team has evolved both in its care for patients and team growth. The team consists of a Lead Nurse for Learning Disabilities, Mental Health Specialist Practitioner and a Care Navigator. The role of the team is to support people with additional needs to access equitable healthcare whilst an inpatient. This incorporates reasonable adjustments, use of the Mental Capacity Act and providing staff training to meet the needs of some of our most vulnerable people.

The Trust implemented the Oliver McGowan Training with 93% of staff completing Tier 1 by December 2025. Tier 2 has started its roll out across the organisation with the Additional Needs Team part of this training. The VIP red bags and VIP passports remain a consistent identifier of people with a learning disability when accessing healthcare at the Trust.

Mental Health

There continues to be ongoing involvement with partner agencies in relation to *Right Care Right Person,* which aims to ensure vulnerable people get the right support from the right emergency service when they are in crisis. There has also been a specific focus with colleagues from Bradford District Care NHS Foundation Trust, West Yorkshire Police and the Local Authority in relation to Section 136 of the Mental Health Act detentions, specifically in looking at the appropriateness of the use of the Emergency Department (ED) as a place of safety. Workshops have commenced to support the redesign of the ED in relation to diagnostics, support, and management of mental health assessment, including work with the Same Day Emergency Care Unit. Trauma informed

practice is developing across the Trust and there are trauma informed practitioners within the workforce to support this. Simulation training has been established, providing in house scenarios based on real life events, supporting a trauma informed approach, guiding staff development and confidence to navigate legal and physical pathways. This is part of the ongoing work to ensure the Trust is trauma informed by 2030.

Dementia

Dementia Workforce Training and Development

Training and development of the Trust's workforce continues to be a priority to ensure clinical and non-clinical colleagues are equipped to support individuals living with dementia or cognitive impairment. Embedding dementia awareness across the Trust strengthens compassionate care, improves patient experience, and supports a positive organisational culture.

This year, dedicated funding enabled the Trust to host the Dementia Bus, a 15-minute immersive simulation experience that recreates the sensory and cognitive challenges faced by people living with dementia, to provide an understanding of how everyday clinical environments can increase distressed behaviours, confusion or anxiety. Two Dementia Bus training days have already taken place, with almost 100 staff participating. A further two sessions are planned. Due to exceptional feedback and demonstrable impact on staff confidence and communication, the Trust intends to submit a further funding bid for 2026/27 to expand access.

To date, 201 staff have completed dementia awareness training, an additional 143 colleagues have undertaken the Dementia Awareness Bus immersive training over the past four months. A further 126 staff have completed dementia awareness training delivered through in-house programmes, supporting the Trust's commitment to improving care and experience for people living with dementia.

Dementia-Friendly Estates Standard

In collaboration with colleagues across Estates and clinical teams, the Trust has developed a Dementia-Friendly Estates Standard. This new framework outlines required design considerations for all future capital projects and refurbishment schemes. It now forms part of the Trust's Estates Project Standard, ensuring dementia-friendly principles are embedded consistently and systematically across the organisation.

National Audit of Dementia

The National Audit of Dementia is undergoing a full redesign across a three-year period and will apply to both general acute hospitals and dementia diagnostic services. As a result, no data collection took place nationally during 2025. The redesign aims to increase the use of routine data and reduce the administrative burden of audit participation.

Voluntary services

Our dedicated volunteers offer their time, expertise and enthusiasm to the Trust, providing a vital role in enhancing patient experience and adding value to our services. This year has seen Voluntary Services work as business as usual, after a complete redesign of the service last year. We have seen the development of many new volunteer roles across the Trust, along with services choosing to recruit further to their existing volunteer roles. **46** volunteer roles are currently available at our Trust.

Figure 26 – A selection of the volunteer opportunities available during 2025/26

Activity Support Volunteer	Neonatal Volunteer
Volunteer Amputee Support	Maternity Support Volunteer
Children's Therapy OPD Volunteer	Feedback Volunteer (Alcohol Care Team)
ICU Support Volunteer	Paediatric Unit Volunteer
Charity Volunteer (Bradford Hospitals Charity)	SPaRC Volunteers
AMU Volunteer	Paediatric Volunteer
Renal Support Volunteer	Mealtime Companions
Haematology/Oncology Volunteer	Knit and Natter Volunteer (Staff group)
Volunteer Guides (Various locations)	Patient Public Engagement Volunteer
Ward Support Volunteers (Falls Prevention)	Emergency Department Volunteer
Children's Outpatient Play Volunteer (SLH)	Gardening Volunteer (Westwood Park)
PAT Dog Volunteer	Volunteer PLACE Assessors
End of Life Companions	Volunteer Research Champions
Eye Clinic Support Volunteer	Friends of Tea Bar Volunteers (BRI/SLH)
Radio Volunteers	DXA Department Volunteer

Friends and Family Test (FFT)

The FFT format encourages patients to complete the questions multiple times throughout their journey in the healthcare system. As a result, the Trust, and other Trusts can no longer measure the response rate based on admission or discharge per clinical area. During 2025 the Trust continued to work with its contractor to improve and analyse all the FFT data and feedback by collecting data in multiple ways, including texts following outpatient visits, admissions and emergency department visits, scanning of QR codes, via iPads in clinical areas and through traditional paper format (including accessible and child friendly content).

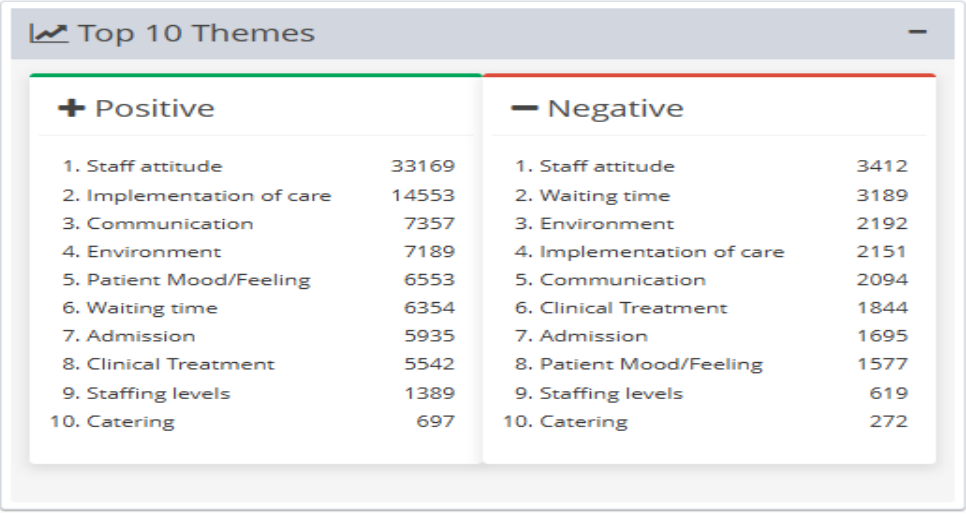
Figure 27 – Friends and Family Test Responses 2025/26

	Very Good	Good	Neither good nor poor	Poor	Very poor	Don't Know	25/26 Grand Total
A&E Feedback	5701↑	2056↓	741↓	721↑	1867↑	53↓	11139↑
Inpatient Feedback	7087↓	1337↓	223↓	153↓	230↓	18↓	9048↓
Outpatient Feedback	23370↑	2744↑	469↑	330↑	425↑	61↑	27399↑
Women's (Maternity) Feedback	1857↑	243↑	60↑	63↑	114↑	4↓	2341↑
Totals	38015↓	6380↓	1493↓	1267↑	2636↑	136↓	49927↓
Percentage	76.14%↑	12.78%↓	2.99%↓	2.54%↑	5.28%↑	0.27%↓	

Although the overall total responses have gone down from the previous year, the Very Good and Good response sits at 88.92% of the total responses falling in these two categories. This is marginally down on last year's 89.15%. There is ongoing work with the Data Warehouse Team to review the current pipelines which provide the specific feedback from individual areas. Further

analysis of the top positive words within the FFT feedback contain positive comments about our staff and teams and most negative comments received pertain to the long waits.

The image below shows the top positive and negative themes extracted from the overall FFT feedback



Patient Led Assessment of the Care Environment

Patient Led Assessments of the Care Environment (PLACE) is a voluntary self-assessment of the care environment, which contributes to health delivered in the NHS and Independent/ Private Healthcare sector in England. PLACE aims to promote the principles established by the NHS Constitution, that focus on the areas that matters to patients, families and carers; committing to ensure that services are provided in a clean and safe environment that is fit for purpose. The findings and scores are used by the CQC to form part of their assessment of the services that we provide.

PLACE promotes being open and honest and making a point-in-time assessment, against set criteria. Unannounced assessments for PLACE were carried out in both clinical and non-clinical areas of all Trust sites between September and December 2025. The inspections were undertaken by teams of public volunteers (Assessors) facilitated by Trust staff members (Facilitators). The assessments are not reflective of the whole Trust but provide a framework for assessing quality against common guidelines and standards to quantify our facility's cleanliness, food and hydration provision, the extent to which the provision of care with dignity is supported, and whether the premises are equipped to meet the needs of people with dementia or with a disability.

Unannounced inspections were carried out at Bradford Royal Infirmary, St Luke's Hospital and the Community Hospital sites. Assessments included wards, outpatient areas, Emergency Department, communal and external areas. The number of areas to be assessed is clearly defined in the guidance and on all sites; the assessments met or exceeded these requirements. The PLACE scores are weighted in several ways to take account of a range of variables (such as the size of the site defined by the number of beds).

The guidance aims to make scoring consistent and as objective as possible; however, there are subjective elements to the process which cannot be eliminated (such as food tasting).

The PLACE data (collated and distributed by NHS Digital) has been scrutinised and developed into several informative charts.

Figure 28 - PLACE Assessment Results 2025 and 2024

	BRADFORD TEACHING HOSPITALS NHS FOUNDATION TRUST		
Domain	2025 score	2024 score	% Difference
Cleanliness Score %	96.51%	95.63%	0.88%
Combined Food Score %	84.30%	85.98%	-1.68%
Organisational Food Score %	76.06%	73.61%	2.45%
Ward Food Score %	86.56%	89.49%	-2.93%
Privacy, Dignity and Wellbeing Score %	88.75%	86.21%	2.54%
Condition, Appearance and Maintenance Score %	96.18%	97.31%	-1.13%
Dementia Score %	81.32%	83.84%	-2.52%
Disability Score %	80.78%	83.50%	-2.72%

The above table highlights the scores obtained for each domain. The improvements in the privacy and dignity and disability scores are pleasing, particularly as various projects have taken place to improve the environment and have included walk arounds from people with different disabilities to enable constructive feedback and improvements to be made.

Patient Information

Patient information is used to provide patients with information to self-manage their condition. In the last 12 months the Communicating with Patients Approval Group (CPAG) continued to update the Trust's on-line patient leaflet library to make it more accessible to all.

Complaints

The Patient Experience team receive complaints, Patient Advice and Liaison Service (PALS) contacts and compliments into the organisation and support the Clinical Service Units (CSUs) in responding to concerns. The number of complaints as shown in Figure 29 has increased overall to date in comparison to the previous year. Many complaints are now resolved through face-to-face meetings with complainants. Arranging to meet with complainants has led to a timelier investigation/response.

Figure 29 – Complaints Comparison between 2024/25 and 2025/26

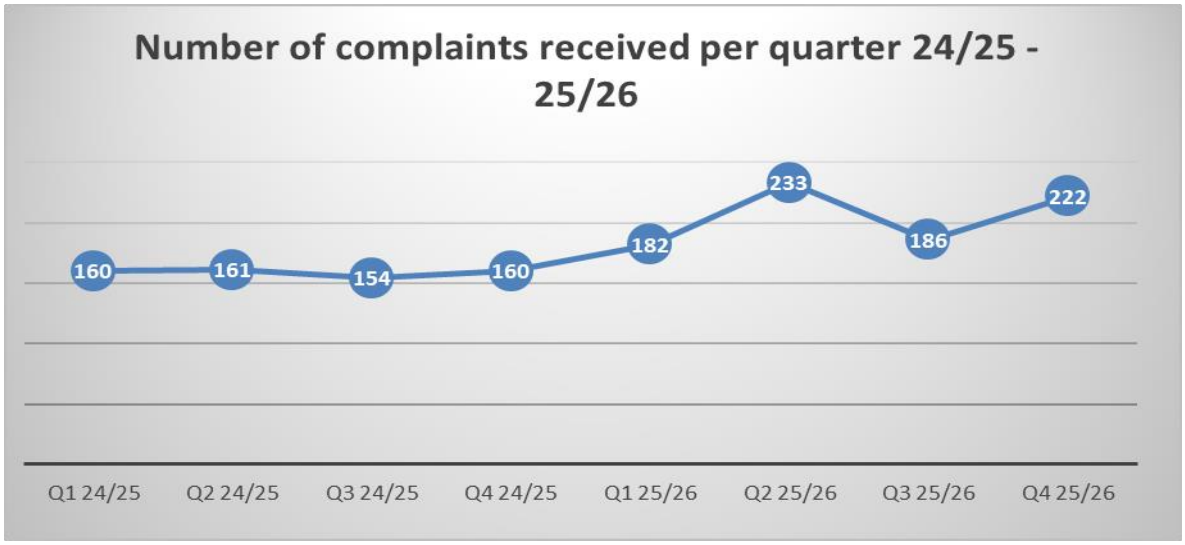
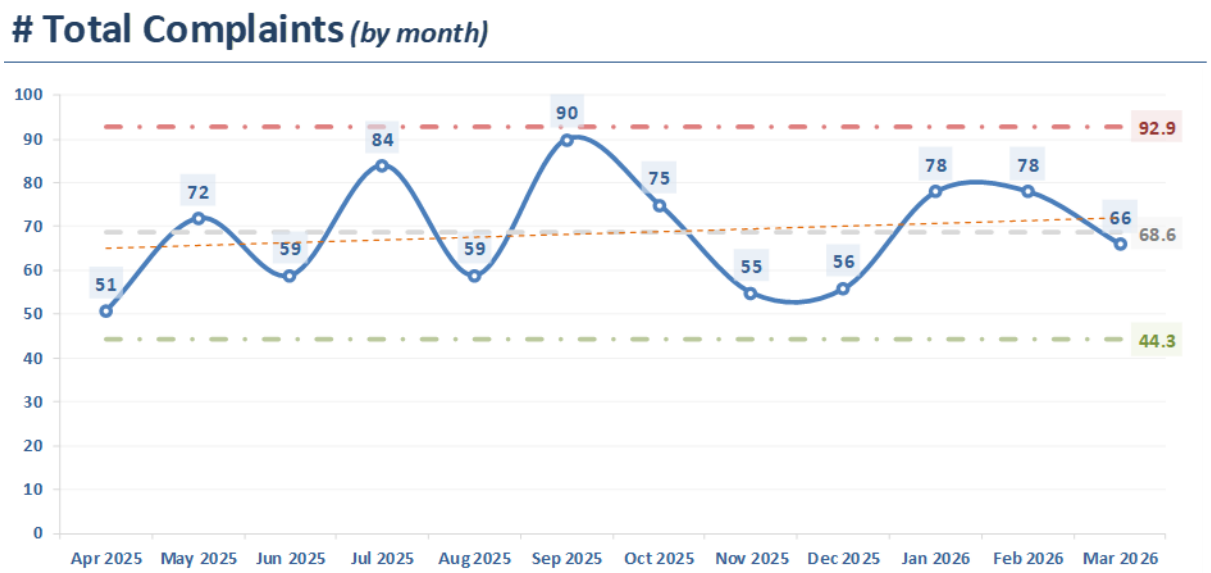


Figure 30 – Annual complaints against the actual upper and lower limited against the calculated fields based on the averages



- The red and green lines show the upper and lower control limits (these are calculated fields based on the actuals).
- The blue lines are the actuals, i.e. the number of complaints.
- The grey line is the average of the actuals.
- The orange dotted line is the trend (again, based on the actuals).

Peaks above the average are seen in several months through the year with no trend on previous years. Work is underway to triangulate data from complaints, and other patient experience metric to enhance learning.

Learning from complaints is being shared via different forums and in liaison with patients and the Equality, Diversity and Inclusion (EDI) service. Patient stories are shared at the Trust Board meetings in public with patients who are keen to feedback where improvements could be made and further learning. The stories are heard from a diverse range of backgrounds and specialities to diversify learning and promote inclusivity.

Partnership Working and Engagement

The patient and public involvement team continues to work with partners in the district to improve patient experience and engagement with meetings set up to facilitate and share work in this area. The Trust is a member of the Citizen Voice Forum, which has membership from across the Bradford District and Craven Health and Care Partnership.

The patient and public involvement team also took part in the health education and wellbeing events for people with learning disabilities and neurodiversity, in association with Bradford People First. The event provided the opportunity to learn about healthy eating, bowel, breast and cervical screening programmes and provided information about the stop smoking service along with information on how to get involved in mixed ability sports.

The Trust has been an active member in the '*Listen in'* events which have been held at various locations throughout the district and provided the opportunity for community members to have access to different staff members from statutory and voluntary organisation to enable their voices and concerns to be heard. The programme for 2025 focused on white working-class men.
The success of the Trust Community Engagement meeting has continued with an open forum to enable different community services and teams (both statutory and voluntary) to request and share concerns internally at the Trust and listen regarding new and planned projects.

The EXCEL programme is being undertaken as the Trust believes by working collaboratively with staff, patients, families and carers, the local communities and partner organisations it can design services to improve the quality and experience of care in an equitable and sustainable way. The patient and public involvement team has been supporting the EXCEL programme to meet with various community groups to discuss their past experiences in the Emergency Department (ED). This engagement work has been undertaken by attending meetings of the various community groups, having pop-up events and on the back of these events inviting representatives from these community groups to come in and undertake the '15 steps' challenge.

A range of engagement projects have been undertaken by the patient and public involvement team:

- ✓ Feedback from patients regarding the changes made to the frequency stroke/neurology patients receive physiotherapy and occupational therapy as part of their treatment plan whilst in hospital.
- ✓ Following the publication of the 2025 CQC in-patient survey which highlighted *worse than expected* pain scores from patients, a survey was undertaken to identify areas for improvement.
- ✓ The Paediatric Palliative Care Service Pilot set up to enhance local service provision with an increase in workforce capacity, enhanced psychology and medical consulting time, to increase resilience and senior level decision making during admission and in the community to prevent avoidable admissions.
- ✓ The Rapid Respiratory Response Pilot for Children with Complex Needs set up to keep children in their own home, where possible, to improve the care for the child and support the family.
- ✓ The Friends and Family Test (FFT) iPad vs Yellow FFT cards project to understand if the volume of FFT feedback is affected and the impact on staff time.

Stakeholder relations

During 2025/26, we have continued to work closely with our partners across both Bradford District and Craven and West Yorkshire, including:

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

Working closely with our partners in WYAAT we aim to improve care for patients and deliver efficiencies through a number of joint projects spanning areas such as procurement, workforce and radiology. Some of the WYAAT highlights from 2025/26 are set out below:

- We rolled out AI technology to support the diagnosis of lung cancer across our trusts. Every year, approximately 400,000 chest X-rays are taken across WYAAT. The software will act like a second pair of eyes for clinicians, allowing them to prioritise the review of the chest X-rays identified as suspicious or requiring further investigation.
- We conducted a service review of clinical and non-clinical services, aligning our strategy to the 10 Year Health Plan, documented in a Case for Change which was approved by all trust boards and determined our priority areas of focus.
- We changed our ways of working – delivering an organisational change exercise responding to the national mandate to reduce corporate costs, reviewed and reset our support office from Health Innovation Yorkshire and Humber, and undertook the preparatory work for WYAAT to host the West Yorkshire and Harrogate Cancer Alliance from 1 April 2026.
- Our pharmacy network delivered over 16k bags of PipTaz from our hub directly to WYAAT trusts, freeing up nearly 200 days of nursing time back to patient care.
- Our radiology shared reporting system enabled WYAAT to report nearly 2.5k scans by sharing work across the network. The shared reporting solution became available for use

in December 2025, enabling clinicians to undertake additional 'insourced' work, reducing the reporting work we outsource to independent providers.
- Our collaborative procurement approach delivered £2.3 million through purchasing goods for our trusts collectively.

- **West Yorkshire Health and Care Partnership - Integrated Care System (ICS)**

We have continued to work in partnership as part of the West Yorkshire Health and Care Partnership, which was placed on a statutory footing from July 2022, in line with the Health and Care Act 2022. We have participated in shared programmes of work and have contributed to the development of plans for the future of integrated care. The Partnership launched a five year integrated care strategy in 2020 which was published in March 2023 along with a five year Joint Forward Plan and this was reviewed and published in July 2024 in line with updated guidance from NHS England.

- **Bradford District and Craven Health and Care Partnership – Place Based Partnership**

Each place-based partnership must have arrangements which provide strategic leadership of place and ensure clear and aligned leadership and line management of place-based staff.

'Act as One' describes the approach for our partnership that serves a population of around 650,000 people, with a health and care workforce of around 33,000, supported by over 5,000 voluntary and community sector organisations. The partnership is made up of NHS, local authority, Healthwatch, community and voluntary sector organisations and independent care providers working towards a vision of people living 'happy, healthy at home'. The Partnership is governed by the Bradford District and Craven Health and Care Partnership Board, which became a committee of the West Yorkshire Integrated Care Board following its establishment as a statutory body in July 2022. Our Chair and Chief Executive are members of the Partnership Board.

Our partnership arrangements are underpinned by the Strategic Partnering Agreement (SPA), which documents the way we work together, how we reach decisions collectively, and confirms our shared ambition.

- **Joint Ventures (JVs)**

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

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 2025/26, Bradford Hospitals Charity[24] received income of £795,000 (2024/25: £376,000), representing a substantial increase compared to the previous year. This growth reflects the continued generosity of our supporters and strong engagement with charitable fundraising activity across the Trust.

[24] https://bradfordhospitalscharity.org/

Income received during the year was directed towards key priority areas, with a particular emphasis on the Neonatal 'Home from Home' Appeal. This ensured that charitable funds were focused on delivering meaningful benefits for patients, their families, and our staff, targeting areas where donations could have the greatest impact alongside core NHS provision.

In partnership with The Sick Children's Trust, Bradford Hospitals Charity is raising £3million to create a vital Home from Home facility at Bradford Royal Infirmary. This will provide a warm, welcoming place for families to stay free of charge, located close to the Neonatal Intensive Care Unit, enabling parents to remain near their babies during critical periods of care.

Throughout the year, charitable funds were used to support a wide range of initiatives that enhance patient care and staff wellbeing beyond what statutory funding alone can provide. This included investment in specialist equipment, education and training opportunities, and projects designed to improve patient experience and clinical outcomes.

Charitable funding has enabled the Trust to go further in delivering compassionate, innovative, and high-quality care, benefitting patients, their families, and the staff who care for them. The continued commitment of donors and fundraisers has been instrumental in achieving these improvements, and the Charity remains focused on ensuring that all funds are used effectively, responsibly, and in line with donor intent to maximise positive impact.

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

Professor Mel Pickup
Chief Executive
On behalf of the Board of Directors
26th June 2026

3.2. REMUNERATION REPORT

3.2.1 ANNUAL STATEMENT

Annual statement from the Chair 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 2025/26.

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

Major decisions on remuneration

The Committee met on three occasions in the year.

In June 2025, the Committee considered the recommendations of the Senior Salaries Review body (SSRB) to award the annual pay increase of 3.25% to Executive Directors. Some executive directors had been appointed after 1 April 2025, and their remuneration was negotiated and agreed as part of the recruitment process during 2025/26. The annual pay increase of 3.25% was awarded to Executive Directors who were in post prior to 1 April 2025.

The annual pay increase for April 2026 is yet to be determined. However, it is our intention to accept recommendations made by the Senior Salaries Review body (SSRB).

The Committee has also reviewed the new NHS Very Senior Managers Pay Framework and has agreed some adjustments to executive pay to align with the framework.

Finally, the Committee approved the search and selection process and remuneration for the new Chief Digital and Information Officer and Chief Medical Officer.

Signed

Karen Walker
Acting Chair
26th June 2026

3.2.2 SENIOR MANAGERS' REMUNERATION POLICY

Figure 31 – 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.	New directors are now appointed on a spot salary, in accordance with the NHS Very Senior Managers Pay Framework. In determining the appropriate starting salary, the Committee considers: • NHS Very Senior Managers Pay Framework – May 2025; • Salary levels for similar positions through the NHS Providers Annual Remuneration Survey and knowledge of market; • Individual skills and experience; • 'Established' pay ranges in acute NHS Trusts and Foundation Trusts published by NHSE; • Cost of living increases awarded in line with any pay award made by the Senior Salaries Review Body as advised by NHS England. No annual bonuses are paid; and • Any opinion received by NHSE. These factors are taken into account when setting and reviewing the salaries of staff who earn over £150,000. The contract of employment authorises deductions from salary on any amount owed to us including but not limited to any overpayment or rent.	The committee on occasion will also recognise changes in the role, and/or duties of a director and salary progression for newly appointed directors.	No change to policy, however remuneration has been reviewed in line with the NHS Very Senior Managers Pay Framework, published in May 2025.
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
Pension	To enable the Foundation Trust to attract, retain and motivate suitably skilled and experienced executive	The standard NHS Pension Scheme is operated. The Trust does not operate a pension recycling scheme. (Pensions recycling is where an employer passes on	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
	directors.	unused employer contributions to an employee who has opted out of the employer's pension scheme).		

Figure 32 – Non-executive directors' remuneration policy

Position	Remuneration	Policy
Chair	£58,500	The remuneration for all Non-Executive Directors (including the Chair) is reviewed by the Governors' Nominations and Remuneration Committee (NRC) in line with section 7.13 of the Governors' NRC terms of reference[25]. The Council of Governors last considered the remuneration of the Chair and Non-Executive Directors in January 2026. Non-Executive Director remuneration was increased from £13,785 to £15,000. This is higher than the national rate of £13,000 per annum recommended in NHSE guidance (issued in 2019). Prior to this, there had been no increase in Non-Executive Director remuneration since 2011. In reaching its decision, the Council took account of the annual remuneration benchmarking undertaken by NHS Providers and noted that the NHSE guidance from 2019 has not been subject to the expected review. Chair remuneration was increased from £55,000 per annum to £58,500 per annum and is in line with the NHSE guidance. As the Deputy Chair has been undertaking additional duties as Acting Chair since 1 February 2026, with support from the Senior Independent Director, the Council approved an additional allowance of £12,500 per annum for the Deputy Chair, and an additional allowance of £2,000 per year for the Senior Independent Director. These additional allowances will be kept under review during 2026/27. There are no additional fees payable for other duties and no other items that are considered to be remuneration in nature. The Non-Executive Directors (including the Chair) do not receive pensionable remuneration.
Non-Executive Directors	£15,000	

[25] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2023/08/NRC-Terms-of-Reference-approved-COG-July-2023.pdf

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 2025/26 for loss of office for Directors.

Statement of consideration of employment conditions elsewhere in the Foundation Trust

The Trust has not consulted with employees when determining its remuneration policy for executive directors. The Trust considers available benchmarking data and the guidance on pay for very senior managers published by NHSE 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 executive 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 comprises the Chair and all Non-Executive Directors. The Chief Executive is in attendance and will discuss Board composition, succession planning, remuneration and performance of executive directors. The Chief Executive is not present during discussions relating to her own performance or remuneration. The Director of Human Resources is in attendance and will provide employment advice and guidance as necessary. He withdraws from the meeting when any discussions are held regarding his performance or remuneration. The Associate Director of Corporate Governance/Board Secretary acts as Committee Secretary.

The Committee met three times during the year. Recruitment took place during 2025/26 in respect of Executive appointments. The Committee approved the selection process for the Chief Digital and Information Officer and the Chief Medical Officer. They agreed to the appointment of Populo Consulting (Robertson Bell) as a reputable recruitment experts signed up to the Crown Commercial Services Framework to manage the process for recruitment to the Chief Digital and Information Officer. The Committee also agreed for the recruitment of the Chief Medical Officer to be led internally and agreed the maximum remuneration package which could be offered based on the benchmarking data from the NHS Providers Remuneration Report.

The Committee also:

- Awarded the annual pay increase of 3.25% to Executive Directors as recommended by the Senior Salaries Review Body.
- Noted the approach being taken to Executive Director appraisals.
- Reviewed the terms of reference.

Figure 33 – Attendance and membership during 2025/26

Board NRC membership	Meetings attended
Sarah Jones, Chair	2 of 2
Julie Lawreniuk, Non-Executive Director	1 of 1
Karen Walker, Non-Executive Director / Acting Chair (from 1 February 2026)	3 of 3
Zafir Ali, Non-Executive Director	2 of 3
Justine Andrew, Non-Executive Director	1 of 1
Geoff Hall, Non-Executive Director	0 of 1
Bryan Machin, Non-Executive Director	3 of 3
Altaf Sadique, Non-Executive Director	2 of 3
Tim Swift, Non-Executive Director	2 of 2

Reasons for non-attendance at Committee meetings are not provided here for Data Protection purposes.

The meetings were routinely attended by the Chief Executive, Director of Human Resources and the Associate Director of Corporate Governance / Board Secretary where required.

See section 3.3.2 (Staff Policies and Actions) for the policies used by the Nominations and Remunerations Committee (for directors).

3.2.3.3 Governors' Nominations and Remuneration Committee (for Non-Executive Directors)

The Council of Governors has established a Nominations and Remuneration Committee (NRC). Its responsibilities include consideration of matters relevant to the appointment, remuneration and associated terms of service for Non-Executive Directors (including the Chair).

The Committee comprises the Chair and at least six Governors including at least three Public/Patient Governors, all appointed by the full Council of Governors. The terms of reference for the Committee are available on the Trust's website[26].

The Committee met five times during the year, including meetings by exception, to consider confidential matters. Reports from the Committee are routinely shared with the full Council for information, assurance or approval.

The membership and attendance at the Committee for 2025/26 is outlined in Figure 34.

[26] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2023/08/NRC-Terms-of-Reference-approved-COG-July-2023.pdf

Figure 34 – Attendance and membership during 2025/26

Governors' NRC membership		Meetings attended
Sarah Jones	Chair	2 of 2
Karen Walker	Acting Chair	1 of 1
Dermot Bolton	Public Governor	4 of 5
Mark Chambers	Public Governor	4 of 5
Ruth Houghton	Staff Governor	1 of 1
Helen Jepps	Staff Governor	1 of 3
Osman Rafiq	Public Governor	0 of 1
Philip Turner	Public Governor	3 of 4
Andy Waller	Public Governor	3 of 5
David Wilmshurst	Public Governor	3 of 3

Reasons for non-attendance at Committee meetings are not provided here for Data Protection purposes.

The meetings are routinely supported by the Associate Director of Corporate Governance / Board Secretary and the Director of Human Resources.

Non-Executive Director (NED) appointments in year

In June 2025 the Governors NRC commenced a search for two new Non-Executive Directors to join the Board.

The Governors NRC, in line with their terms of reference and the 'Process for the appointment of a Chair / Non-Executive Director / Associate Non-Executive Director':

- Approved the appointment of Alumni Global, Executive Search Agency to support the recruitment process. *Alumni Global had no previous connection with the Trust or individual directors.*
- Agreed the full brief for the appointments, the job description and person specification for the positions and the schedule for the appointment process.
- Agreed that the process would include candidates engaging with both a stakeholder panel and an interview panel.

A dedicated micro-site for candidates was developed and promoted widely, including via the NHS England NED appointments website.

The stakeholder panel included seven members comprising the following:

- Staff governor
- Public governor
- Chief Medical Officer
- Head of Corporate Governance
- Chair of the 'Race Equality Staff Inclusion Network' (RESIN)
- Deputy Chair of Airedale NHS Foundation Trust (external stakeholder)

The interview panel comprised the following:

- Trust Chair
- 1 Staff Governor
- 2 Public Governors
- 1 Partner Governor
- Chief Executive
- Interim Chair, NHS West Yorkshire Integrated Care Board (external stakeholder)

Recommendations for the appointments of Justine Andrew and Tim Swift were approved by the Council of Governors on 6 August 2025.

Approval of nominated NED from the University of Leeds

Professor Louise Bryant resigned from her position as the nominated Non-Executive Director representing the Leeds Medical School from 31 May 2025. Following this, Professor Geoff Hall was recommended by the Leeds Medical School as their nominated Non-Executive Director representative on the Board of Directors. The nomination was formally approved on behalf of the University. The Council noted that Professor Hall also met with Sarah Jones, Chair and Mel Pickup, Chief Executive who endorsed the recommendation which was approved by the Council of Governors on 9 October 2025. Professor Geoff Hall commenced his appointment on 26 November 2025.

3.2.3.4 Disclosures required by Health and Social Care Act

Salaries over £150,000

There were no new appointments made in 2025/26 where a salary was over £150,000. The Trust reviews salaries against the established pay ranges in acute NHS Trusts and Foundation Trusts and the salaries remain within these ranges. There were three directors with a salary of over £150,000 during 2025/26. These are the Chief Executive Officer, Deputy Chief Executive/Chief Operating Officer and the Chief Nurse.

Expenses claimed by directors

The total number of directors holding office during 2025/26 was 23 (the number in 2024/25 was 21). The number of directors receiving expenses during 2025/26 was 7 (the number in 2024/25 was 4). The aggregate sum of expenses paid to directors in 2025/26 was £4,160 (in 2024/25 it was £165).

Expenses claimed by Governors

The total number of Governors holding office during 2025/26 is 27 (the number in 2024/25 was 23). The number of Governors receiving expenses during 2025/26 is 1 (the number in 2024/25 was 2). The aggregate sum of expenses paid to Governors in 2025/26 is £270 (in 2024/25 it was £152).

Figure 35 – Remuneration of senior managers 2025/26 (subject to audit)

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

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long term performance related bonuses	All pension related benefits	Total
2025/26	(Bands of £5,000)	(to the nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000's	£00's	£000's	£000's	£000's	£000's
Sarah Jones (Chair)[27]	45-50	0	0	0	0	45-50
Karen Walker (Non Executive Director)(Acting Chair)[28]	15-20	0	0	0	0	15-20
Mel Pickup (Chief Executive)	260-265	0	0	0	100-102.5	360-365
Sajid Azeb (Chief Operating Officer / Deputy Chief Executive)	165-170	0	0	0	0	165-170
John Bolton (Chief Medical Officer)[29]	185-190	0	0	0	410-412.5	595-600
Renee Bullock (Chief People and Purpose Officer)[30]	65-70	0	0	0	5-7.5	70-75
Karen Dawber (Chief Nurse)	160-165	0	0	0	0	160-165
Mark Hindmarsh (Director of Strategy and Transformation)	125-130	0	0	0	45-47.5	175-180
Faeem Lal (Director of Human Resources)[31]	60-65	0	0	0	10-12.5	70-75
Helen Lewis (Vikki) (Chief Digital & Information Officer)[32]	115-120	0	0	0	7.5-10	125-130
David Moss (Director of Estates and Facilities)	140-145	0	0	0	47.5-50	190-195
Benjamin Roberts (Ben) (Chief Finance Officer)	140-145	0	0	0	35-37.5	175-180
Paul Rice (Chief Digital & Information Officer)[33]	25-30	0	0	0	0	25-30

[27] Sarah Jones (Chair) – temporary absence from role due to secondment to role of Chair at Airedale NHS Foundation Trust from 1 February 2026. Remuneration is being paid by Airedale NHS Foundation Trust for the duration of the secondment.
[28] Karen Walker (Non Executive Director) – Acting Chair from 1 February 2026
[29] John Bolton (Chief Medical Officer) – From 1 June 2025
[30] Rennee Bullock (Chief People and Purpose Officer) – Until 30 September 2025
[31] Faeem Lal (Director of Human Resources) – From 1 October 2025
[32] Helen Lewis (Chief Digital & Information Officer) – From 9 June 2025
[33] Paul Rice (Chief Digital & Information Officer) – Until 31 May 2025

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long term performance related bonuses	All pension related benefits	Total
Ray Smith (Chief Medical Officer)[34]	35-40	0	0	0	0	35-40
Justine Andrew (Non-Executive Director)[35]	5-10	0	0	0	0	5-10
Zafir Ali (Non-Executive Director)	10-15	0	0	0	0	10-15
Louise Bryant (Non-Executive Director)[36]	0-5	0	0	0	0	0-5
Geoff Hall (Non-Executive Director)[37]	5-10	0	0	0	0	5-10
Mohammed Hussain (Non-Executive Director)[38]	5-10	0	0	0	0	5-10
Julie Lawreniuk (Non-Executive Director)[39]	5-10	0	0	0	0	5-10
Bryan Machin (Non-Executive Director)	10-15	0	0	0	0	10-15
Altaf Sadique (Non-Executive Director)	10-15	0	0	0	0	10-15
Tim Swift (Non-Executive Director)[40]	5-10	0	0	0	0	5-10

[34] Ray Smith (Chief Medical Officer) – Until 31 May 2025
[35] Justine Andrew (Non-Executive Director) – From 1 October 2025
[36] Louise Bryant (Non-Executive Director) – Until 31 May 2025
[37] Geoff Hall (Non-Executive Director) – From 26 November 2025
[38] Mohammed Hussain (Non-Executive Director) - Until 31 August 2025
[39] Julie Lawreniuk (Non-Executive Director) – Until 31 August 2025
[40] Tim Swift (Non-Executive Director) – From 1 September 2025

Figure 36 – Remuneration of senior managers 2024/25 - restated

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

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long term performance related bonuses	All pension related benefits	Total
2024/25	(Bands of £5,000)	(to the nearest £100)	(Bands of £5,000)	(Bands of £5,000)	(Bands of £2,500)	(Bands of £5,000)
	£000's	£00's	£000's	£000's	£000's	£000's
Sarah Jones (Chair)	50-55	0	0	0	0	50-55
Mel Pickup (Chief Executive)	250-255	0	0	0	22.5-25	275-280
Sajid Azeb (Chief Operating Officer / Deputy Chief Executive)	160-165	0	0	0	25-27.5	190-195
Mark Hindmarsh (Director of Strategy and Transformation)[41]	120-125	0	0	0	97.5-100	220-225
Ray Smith (Chief Medical Officer)	230-235	0	0	0	87.5-90	320-325
Karen Dawber (Chief Nurse)	155-160	0	0	0	110-112.5	270-275
Matthew Horner (Director of Finance)[42]	40-45	0	0	0	0	40-45
Chris Smith (Interim Director of Finance)[43]	15-20	0	0	0	5-7.5	20-25
Ben Roberts (Chief Financial Officer)[44]	80-85	0	0	0	15-17.5	95-100
Paul Rice (Chief Digital & Information Officer)[45]	85-90	0	0	0	90-92.5	180-185
Renee Bullock (Chief People & Purpose Officer)[46]	135-140	0	0	0	37.5-40	170-175
David Moss (Director of Estates & Facilities)[47]	90-95	0	0	0	72.5-75	160-165
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
Altaf Sadique (Non-Executive Director)	10-15	0	0	0	0	10-15
Karen Walker (Non-Executive Director)	10-15	0	0	0	0	10-15

[41] Mark Hindmarsh (Director of Strategy and Transformation) – from 14 April 2024
[42] Matthew Horner (Director of Finance) – until 7 July 2024
[43] Chris Smith (Interim Director of Finance) – from 8 July 2024 to 31 August 2024
[44] Ben Roberts (Chief Financial Officer) – from 1 September 2024
[45] Paul Rice (Chief Digital & Information Officer) - In addition to this role, Paul Rice is also the Chief Digital & Information Officer at Airedale NHS Foundation Trust. A recharge at 40% was made by Airedale NHS foundation Trust to Bradford Teaching Hospitals NHS Foundation Trust.
[46] Renee Bullock (Chief People & Purpose Officer) – from 1 April 2024
[47] David Moss (Director of Estates & Facilities) – from 5 August 2024

Name and title	Salary and fees	All taxable benefits	Annual performance related bonuses	Long term performance related bonuses	All pension related benefits	Total
Sughra Nazir (Non-Executive Director)	10-15	0	0	0	0	10-15
Louise Bryant (Non-Executive Director)	10-15	0	0	0	0	10-15
Bryan Machin (Non-Executive Director)	10-15	0	0	0	0	10-15
Zafir Ali (Non-Executive Director)	10-15	0	0	0	0	10-15

Note: Remuneration of senior managers 2024/25 has been restated to include two Non-Executive Director's omitted in the prior year annual report.
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.
Mel Pickup, Karen Dawber, Matthew Horner, Mark Holloway, Paul Rice, Ray Smith, Sajid Azeb and Faeem Lal are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values for pension related benefit are not disclosed in this table but are substituted with a zero.

Figure 37 – Pension entitlements of senior managers 2025/26 (subject to audit)

Name and Title	Real increase in pension at pension age	Real increase in pension lump sum at pension age	Total accrued pension at pension age at 31st March 2026	Lump sum at pension age related to accrued pension at 31st March 2026	CETV at 1st April 2025	Real increase in CETV	CETV at 31st March 2026	Employers contribution o stakeholder pension
2025/26	(Bands of £2,500)	(Bands of £2,500)	(Bands of £5,000)	(Bands of £5,000)	(Nearest £1,000)	(Nearest £1,000)	(Nearest £1,000)	(Nearest £1,000)
Mel Pickup (Chief Executive)	5-7.5	2.5-5	130-135	340-345	3,039	137	3,260	37
Sajid Azeb (Chief Operating Officer/Deputy Chief Executive)	0-2.5	0-2.5	55-60	125-130	1,043	0	1,069	23
Renee Bullock (Chief People and Purpose Officer)	0-2.5	0-2.5	25-30	0-5	383	5	417	10
John Bolton (Chief Medical Officer)	17.5-20	50-52.5	65-70	165-170	864	411	1,453	18
Karen Dawber (Chief Nurse)	0-2.5	0-2.5	60-65	155-160	1,420	0	1,443	22
Mark Hindmarsh (Director of Strategy and Transformation)	2.5-5	0-2.5	30-35	75-80	570	35	630	18
Faeem Lal (Director of Human Resources)	0-2.5	0-2.5	20-25	0-5	215	3	255	9
Helen Lewis (Vikki) (Chief Digital & Information Officer)	0-2.5	0-2.5	45-50	115-120	1,078	15	1,133	17
David Moss (Director of Estates and Facilities)	2.5-5	0-2.5	40-45	0-5	579	38	643	20
Ben Roberts (Chief Financial Officer)	2.5-5	0-2.5	5-10	0-5	75	17	110	20
Paul Rice (Chief Digital & Information Officer)	0-2.5	0-2.5	55-60	135-140	1,135	24	1,319	4
Ray Smith (Chief Medical Officer)	0-2.5	0-2.5	95-100	265-270	2,422	0	107	5

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

3.2.3.5 Fair pay multiples (subject to audit)

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

The banded remuneration of the highest paid director in the Trust in the financial year 2025/26 was £260,000 - £265,000 (2024/25: £250,000 - £255,000). This is a change between years of 3.96% (2024/25: 4.12% change).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions. No performance pay or bonus payments were made to the highest paid director.

For employees of the Trust as a whole, the range of remuneration in 2025/26 was from £262,500 to £12,500 (2024/25: £252,500 to £12,500). The percentage change in average employee remuneration (based on total for all employees on an annualised basis divided by the full time equivalent number of employees) between years is 4.22% (2024/25: 7.64%). Average employee remuneration has increased due to the 3.6% pay award issued to staff and a significant increase in the workforce which has increased the average. No employees received remuneration more than the highest-paid director in 2025/26 (2024/25: nil). No performance pay or bonus payments were made in year.

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

Figure 38 – Pay Ratio Information

2025/26	25th percentile	Median	75th percentile
Salary component of pay	£24,937	£33,487	£47,810
Total pay and benefits excluding pension benefits	£24,937	£33,487	£47,810
Pay and benefits excluding pension: pay ratio for highest paid director	10.5: 1	7.8: 1	5.5: 1

2024/25	25th percentile	Median	75th percentile
Salary component of pay	£24,071	£36,483	£46,148
Total pay and benefits excluding pension benefits	£24,071	£36,483	£46,148
Pay and benefits excluding pension: pay ratio for highest paid director	10.5: 1	6.9: 1	5.5: 1

Following the 3.6% pay award issued to staff in 2025/26, median pay has decreased to £33,487 (2024/25: £36,483).

Signed

Professor Mel Pickup
Chief Executive
26th June 2026

3.3 STAFF REPORT

3.3.1 ANALYSIS OF STAFF COSTS AND NUMBERS

Figure 39 – Staff Costs 2025/26 (£'000) (subject to audit)

Staff Costs	Permanently employed	Other	2025/26 Total	2024/25 Total
Salaries and wages	350,467	867	351,334	326,270
Social security costs	42,759	0	42,759	33,506
Apprenticeship Levy (pay element)	1,708	0	1,708	1,640
Pension cost - defined contribution plans employer's contributions to NHS pensions	40,465	0	40,465	38,460
Pension cost - employer contributions paid by NHSE on provider's behalf	26,591	0	26,591	25,121
Pension cost - other	0	0	0	0
Termination benefits	0	0	0	0
Temporary staff - agency/contract staff	0	5,488	5,488	6,280
Total gross staff costs	**461,990**	**6,355**	**468,345**	**431,277**

Figure 40 – Average number of employees Whole Time Equivalent for 2025/26 (subject to audit)

	Total Number	Permanent Number	Other Number
Medical and dental	1,074	1,019	55
Administration and estates	2,159	1,969	190
Healthcare assistants and other support staff	830	822	8
Nursing, midwifery and health visiting staff	2,468	2,023	445
Scientific, therapeutic and technical staff	991	943	48
Other	0	0	0
Total average numbers	**7,522**	**6,776**	**746**
Of which, number of employees (WTE) engaged on capital projects	0	0	0

Figure 41 – Average number of employees Whole Time Equivalent for 2024/25

	Total Number	Permanent Number	Other Number
Medical and dental	1,036	985	51
Administration and estates	2,159	1,955	204
Healthcare assistants and other support staff	825	813	12
Nursing, midwifery and health visiting staff	2,406	1,960	446
Scientific, therapeutic and technical staff	963	906	57
Other	5	3	2
Total average numbers	**7,394**	**6,622**	**772**
Of which, number of employees (WTE) engaged on capital projects	13	11	2

Figure 42 – 31 March 2026 distribution of staff, male and female

At 31 March 2026 – headcount figures, excluding agency and contract and bank staff			
Group	**Female**	**Male**	**Total**
Directors	6	11	17
Senior Managers	303	156	459
Other Employees	5,589	1,687	7,274
Total	**5,896**	**1,854**	**7,750**

Figure 43 – 31 March 2025 distribution of staff, male and female

At 31 March 2025 – headcount figures, excluding agency and contract and bank staff			
Group	**Female**	**Male**	**Total**
Directors	8	10	18
Senior Managers	315	156	471
Other Employees	5,544	1,643	7,187
Total	**5,867**	**1,809**	**7,676**

Figure 44 - Sickness Absence Data 1 January 2025 – 31 December 2025

Figures Converted by DH to Best Estimates of Required Data Items			Statistics Published by NHS Digital from ESR Data Warehouse	
Average FTE 2025	**Adjusted FTE days lost to Cabinet Office definitions**	**Average Sick Days per FTE**	**FTE-Days Available**	**FTE-Days recorded Sickness Absence**
6,727	98,091	14.6	2,455,354	159,126

The Department of Health and Social Care Group Accounting Manual 2025/26[48] requires that sickness absence data be reported by each individual body in their annual report. The sickness absence figures are reported on a calendar year basis, rather than for the financial year. This is because we are obliged to use only the published statistics which are produced using data from the ESR Data Warehouse. The sickness absence rate for the period 1 January 2025 to 31 December 2025 was 6.3%.

Information about staff turnover for 2025/26 is also available on the website of NHS Digital[49].

3.3.2 Staff Policies and Actions

Harassment and Bullying Policy

The Trust Harassment and Bullying Policy was updated in September 2025 and aims to ensure that all employees can seek, obtain and retain employment without bullying, harassment and intimidation. The Policy is supported by Good Practice Guidance.

Leave from Work Policy

This policy was reviewed and updated in March 2026. The policy covers all aspects of leave for employees within the Trust. Further clarity was provided within the review about the carryover of statutory minimum annual leave when off sick and going into a new annual leave year.

Menopause Policy

A new policy has been developed to make support managers to understand the peri menopause, menopause and related issues and how they can affect employees, their partners, families and work colleagues. The policy raises awareness and understanding among all employees and outlines that support and reasonable adjustments may be available to subsequently reduce perimenopause, menopause and related sickness to remain in work and retaining their valuable skills and experience.

[48] https://www.gov.uk/government/publications/dhsc-group-accounting-manual-2024-to-2025
[49] https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

Recruitment and Selection Policy and Practices

Our Recruitment and Selection Policy and practices are reviewed regularly to reflect changes in legislation, best practice, and workforce trends, with the most recent review completed in May 2025. The policy emphasises the Trust's commitment to promoting a positive, inclusive working environment to attract, recruit, retain, and support a diverse and talented workforce. A new section has been introduced to address the management of AI-generated applications, ensuring recruitment processes remain fair, transparent, and equitable. A comprehensive recruitment candidate pack has been introduced to support applicants, highlighting the benefits of living and working in Bradford and the advantages of working at the Trust. The pack also provides guidance on completing applications and preparing for interviews.

In addition, the onboarding pack has been revised to promote access to health and wellbeing support and includes enhanced guidance and information for overseas employees who are new to the UK, supporting their transition into the organisation and local community. Recruitment and Selection training for recruiting managers has also been reviewed through an Equality, Diversity and Inclusion (EDI) lens. The training is designed to equip managers with the knowledge, skills, and awareness to undertake fair and inclusive recruitment practices. Managers are signposted to the West Yorkshire Health and Care Partnership Inclusive Recruitment Toolkit, which provides practical resources to support inclusive recruitment processes across the Trust.

Trans Equality Policy

The Trans Equality Policy for staff and patients provides a clear protocol to support the provision of high-quality care for trans people using NHS services in the region.

Anti-Fraud, Bribery and Corruption Policy

This policy relates to all forms of fraud, bribery and corruption and is intended to provide direction and help to colleagues who may identify suspected illegality. It provides a framework for responding to suspicions of fraud, bribery, and corruption (advice and information), and the implications of an investigation, with the overall aim of improving the knowledge and understanding of everyone in and associated with the Trust (irrespective of their position) about the risk of fraud, bribery and corruption within the organisation and its unacceptability.

The policy demonstrates the Trust's commitment to the prevention of fraud, bribery and corruption and the recovery of losses when fraud is proven, freeing up public resources for better patient care.

Health and Safety

The Trust's People Strategy 2025 commits to prioritising the health, safety and wellbeing of our staff and others. The Trust aims to identify and proactively manage the risks to health, safety and wellbeing of our staff and others.

The Health and Safety Committee is a bi-monthly meeting that provides assurance to the Trust and allows a proactive response to issues raised. A review of the terms of reference and associated governance was undertaken and completed for the Trust's Health and Safety Committee to ensure that the committee was effective. This instigated broader membership of the Committee to ensure a full holistic overview of health and safety. The Committee

receives several reports relating to staff health and safety from subgroups covering risk assessments, incidents and a more focused review on issues identified.

In 2025/26, 1,964 health and safety incidents were reported. These incidents were monitored centrally, as well as within the Clinical Service Units or departments via formal governance processes. To strengthen expertise, a Health and Safety Advisor focused on Estates and Facilities was appointed in January 2026. Throughout 2025/26, the health and safety team completed numerous risk assessments, investigations, and policy reviews. The department also continues to work collaboratively with NHS partners across the Yorkshire and Humberside region to share best practices.

Moving into 2026/27, the health and safety team will remain focused on addressing these identified gaps and maintaining legislative compliance. This period will involve a review of relevant health and safety policies and procedures and primarily focus on achieving the specific actions identified within the organisational improvement plan. A significant priority this year is our partnership with security specialists to ensure the organisation is fully prepared for Martyn's Law (the Terrorism (Protection of Premises) Act 2025) compliance.

Occupational Health

See the following section (Staff Experience and Engagement).

3.3.3 STAFF SURVEY

3.3.3.1 Staff Experience and 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 their performance and therefore on patient experience and outcomes. Over the last year, we have grown and developed our 'Thrive' approach. An essential part of the Thrive approach is our Thrive online portal that all staff can access via a laptop, smartphone or tablet device. This is a 'one stop shop' for all the things that staff need to know/are entitled to as a member of staff at the Trust and includes wellbeing support, development opportunities, rewards and benefits, and opportunities for staff to have their say on what matters to them. However, Thrive is much more than just a portal – it is our ethos and our way to create a community at the Trust where everyone can learn, grow, and reach their full potential.

Thrive

We have a very clear objective – to be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion and our 'Thrive' approach supports us to achieve this. The aim of Thrive is to ensure that we create a community where all our people can learn, grow and reach their full potential, that the Trust is a place where everyone is heard, is treated with dignity and respect and trusted to do their job.

In 2025, the Thrive portal (our online hub) had over 105,000 hits and continued to grow. Colleagues are accessing the portal from desktops, mobiles and tablets illustrating the accessibility of the site and since it launched in 2021 there have been almost 600,000 views of the 60 pages of content.

During 2025/26, we have continued 'Thrive Live' – a regular 'live' conversation between services and the Executive Management Team. Between April – December 2025, 25 Thrive

Live sessions were arranged. We also introduced a new ‘Back to The Floor’ initiative, supporting the Executive Management Team to make regular visits to services and meet colleagues.

In 2025/26, we launched a new five year People Strategy for the organisation. This brings our aspirations for Thrive to life and has three key ambitions: health, wellbeing and belonging; making BTHFT a great place to work; and our people, working differently.

Alongside Thrive, we continue to run ‘Thrive Live’ sessions, a fortnightly question and answer session with the Executive Team and different services/teams. This enables colleagues to ask any question they may have and increases the visibility of leadership.

This year we have also developed our approach to increase Board visibility across our sites by introducing a new ‘Back to The Floor’ initiative, supporting Board to make regular visits to services and meet colleagues.

Development

In 2025, we developed a new offer, ‘Leading at a Higher Level’ which is a leadership and management development programme for managers at all levels at the Trust. The course explores purpose and values, worthwhile work and standards, leadership and empowerment, and reinforcement and continuous improvement. 11 cohorts have been held and over 1000 colleagues engaged with the course, each taking away a personalised action plan and collectively, committing to over 5000 actions to build on their capability and confidence as managers.

The NHS England Mary Seacole programme is an accredited leadership development initiative designed for aspiring first-time leaders in health and care settings. It equips participants with the skills, knowledge, and confidence to effectively manage teams, drive change, and enhance patient care. The programme emphasises practical learning, enabling participants to develop leadership strategies that align with the NHS's values and challenges. By focusing on self-awareness, communication, and problem-solving, it fosters resilient, inclusive, and effective leaders who can inspire their teams and improve service delivery. Ultimately, the programme supports the creation of a capable leadership pipeline to sustain and advance healthcare excellence. During 2024/25, in partnership with colleagues at Airedale, we obtained a licence to deliver the Mary Seacole programme in house and trained a team of facilitators. The first cohort began in 2024 with 28 colleagues enrolled and in 2025, two further cohorts were held with an additional 35 colleagues enrolled.

From January to December 2025, 26 corporate induction sessions were delivered by the Trust, supporting a total of 990 new starters at the Trust. During 2025/26, we have continued to deliver a Board Development Programme. Underpinned by the NHS Board Leadership Competency Framework, sessions have focused on supporting Board to develop around a number of themes including health inequalities, compassionate leadership, values and vision, creating a high performing team, sustainability and managing risks and issues.

In June 2025, we held a Thrive Leadership Conference. This year, the theme was ‘creating a sense of belonging’ and colleagues contributed to the formation of the organisations’ new strategic framework. 236 colleagues attended.

To support better, more inclusive, career progression planning, we have created a new online platform which showcases all 1310 job roles at the Trust, the skills, experience and knowledge required for them, and how colleagues can access development in order to grow into that role. This will support us to invest in our people and grow and retain our own talent in the future. This will be launched in Autumn 2026.

Health and Wellbeing

In July 2025, we launched, after a successful pilot, a new approach to 1-1s: 'Dynamic Conversations' and appraisals: 'Dynamic Conversation Appraisal' which supports managers and colleagues to have effective conversations around four key areas:

1. Health and Wellbeing
2. Performance Enablement
3. Prioritisation
4. Motivations and Aspirations

Feedback has been positive, and there has been an increase in compliance rates of non-medical appraisals. 13 development sessions on how to have an effective 1-1/appraisal conversation have also been delivered to over 160 colleagues.

Managers refer staff to Occupational Health (OH) for support with return to work planning, fitness for work assessments, reasonable adjustments and medical redeployment. Referral volumes remain consistently high, comparable to those experienced during the pandemic.

Over the past year, targeted management actions have reduced OH Nurse Advisor wait times from seven weeks to two days. These actions included a tighter discharge process, improved appointment notification, realignment of workloads, and enhanced manager support at triage. Skill mix adjustments have supported continuity of service despite recruitment challenges and two Band 5 nurses commenced specialist OH training in September 2025**.** The introduction of an on-line referral system now enables managers to monitor case progress more easily and improves communication with OH.

New pathways between OH and the staff gym provide staff with rehabilitation support through physical activity. An automated recall system has also been implemented for staff requiring occupational vaccinations, with additional automation developments planned for next year.

Reward

The following reward initiatives were celebrated during 2025/26:

- 247 colleagues attended the Brilliant Bradford Awards – our internal celebration of colleagues. This year's ceremony was a chance to celebrate and say thank you for our colleagues incredibly hard work over the past year.
- 50 colleagues who received their Long Service Awards in 2025, recognising their outstanding contribution over many dedicated years working for the Trust and NHS.
- 1567 colleagues sent a 'Greatix Award' - a Trust initiative created to allow colleagues to give an instant thank you for a job well done or to recognise an achievement.

3.3.3.2 NHS staff survey

The NHS staff survey is conducted annually. From 2021/22 the survey questions have aligned to the seven elements of the 'NHS People Promise' and retain the two previous themes of 'engagement' and 'morale'. These replaced the ten indicator themes used in previous years. All indicators are based on a score of 10 for specific questions with the indicator score being the average of those.
The response rate to the 2025 survey among Trust staff was 43%. There was a 7% decrease in the Trust's staff engaging with the survey compared to the 2024 staff survey (2024 response rate - 50%). We have performed well in the areas that were identified as

priorities in 2024 – specifically around improving the quality of appraisals and supporting flexible working.

In summary, we remain above the national average (compared to other Acute and Acute and Community Trusts) in all the People Promise themes and elements, including all 21 'sub-themes'. Scores for each indicator, together with that of the survey benchmarking group (which is comprised of Acute and Acute and Community NHS Trusts) is presented below:

Figure 45 – NHS Staff Survey People Promise Indicators Scores

Indicators	2025/26		2024/25		2023/24	
	Trust Score	Benchmarking Group Score	Trust Score	Benchmark Group Score	Trust Score	Benchmarking Group Score
People Promise Themes:						
We are compassionate and inclusive	7.37	7.28	7.32	7.21	7.37	7.24
We are recognised and rewarded	6.04	5.87	6.06	5.92	6.12	5.94
We have a voice that counts	6.79	6.60	6.18	6.67	6.87	6.7
We are safe and healthy	6.21	6.07	6.80	6.09	6.12	6.06
We are always learning	5.88	5.57	5.83	5.64	5.94	5.61
We work flexibly	6.23	6.22	6.23	6.24	6.28	6.20
We are a team	6.87	6.75	6.88	6.74	6.88	6.75
Other elements:						
Staff engagement	6.95	6.74	6.94	6.84	7.02	6.91
Morale	6.06	5.84	6.06	5.93	6.06	5.91

Comparing our results from 2024/25 to 2025/26, four themes have increased positively (we are always learning, we work flexibly, engagement and morale), one remains the same (we are safe and healthy) and four have slightly decreased since 2024/25 (we are compassionate and inclusive, we are recognised and rewarded, we each have a voice that counts and we are a team). However, none of these decreases are statistically significant.

Future Priorities and Targets

The survey has highlighted the following key priority areas for particular focus over the next year, Wellbeing, Colleague Voice and Discrimination.

Our aim is to continue to improve our scores across all the People Promise themes, building on the successes we have put in place over past years. Actions to achieve our priority areas are underway and timely objectives have been set. These will be monitored on a quarterly basis through the People Academy.

Equality and Diversity

The staff survey plays a major part in the annual Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap data collection and action plans. These action plans are aligned not only to our evolving workforce data, along with legal and contractual requirements, but with dedicated focus on engagement and involvement with our diverse staff in understanding where we need to focus our activity to have the greatest impact. This engagement with our staff equality networks and in understanding our staff survey results is key to our progress on EDI.

Our EDI staff survey results for 2025 remain above average, and we have seen a very slight improvement in our overall 'Equality & Diversity' score, increasing from 8.39 to 8.40 (higher than the national average of 8.37). We have seen a very slight decrease in the overall 'inclusion' score from 6.94 to 6.93 (but still higher than the national average of 6.80). These elements fall under the 'We are compassionate and inclusive' element of the People Promise for 2025 and will be a key focus of activity over the next 12 months. We will be further analysing the most recent staff survey results with an equality lens ensuring any key trends or themes are considered within the 2026/27 action plans when they are next reviewed and refreshed.

3.3.4 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 Trust to constitute employment must be paid through payroll. The Trust also requires all roles required in statute, such as the Chief Executive, Chief Nurse, Chief Medical Officer and Chief Finance Officer to be on payroll.

The Trust did not engage in any off-payroll worker engagements at any point during the year ended 31 March 2026 earning £245 per day or greater (nil in 2024/25).

The Trust did not engage off-payroll board members, and/or senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026.

Figure 46 - Off-Payroll and On-Payroll with significant financial responsibility 2025-26

Number of off-payroll engagements of board members, and/or senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	12

In 2025/26 the Trust spent £1,039,000 on consultancy (£1,271,000 in 2024/25).

3.3.5 EXIT PACKAGES (SUBJECT TO AUDIT)

Figure 47 - All exit packages 2025/26

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Exit package cost band (including any special payment element)			
<£10,000	1	0	1
£10,000 - £25,000	1	0	1
£25,001 - 50,000	0	0	0
£50,001 - £100,000	1	0	1
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	3	0	3
Total resource cost (£)	72,000	0	72,000

Figure 48 - All exit packages 2024/25

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages by cost band
Exit package cost band (including any special payment element)			
<£10,000	0	0	0
£10,000 - £25,000	0	0	0
£25,001 - 50,000	0	0	0
£50,001 - £100,000	0	0	0
£100,001 - £150,000	0	0	0
£150,001 - £200,000	0	0	0
>£200,000	0	0	0
Total number of exit packages by type	0	0	0
Total resource cost (£)	0	0	0

Figure 49 - Exit packages, non-compulsory departure

	2025/26 Number of agreements	2025/26 Value of agreements £000	2024/25 Number of agreements	2024/25 Value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following employment tribunals or court orders	0	0	0	0
Non-contractual payment requiring HM Treasury (HMT) approval	0	0	0	0
Total	**0**	**0**	**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

3.3.6 GENDER PAY GAP

See section 3.4.10 of the Equality Report.

3.4 EQUALITY REPORT

3.4.1 EQUALITY AND DIVERSITY STRATEGY

Our 3-year Equality Diversity and Inclusion (EDI) strategy was launched in March 2023 and sets out the Trust's ambitions and plan of action to promote and advance equality of opportunity, with sharp focus on belonging and inclusion. Developed in collaboration with our diverse colleagues, patients and communities, the strategy aims to drive a step change in the culture of our organisation, helping us to embed and advance equality, diversity and inclusion across the Trust. It sets out the principles and actions by which Bradford Teaching Hospitals NHS Foundation Trust intends to achieve its mandate of 'We are Bradford: *we value diversity and champion inclusion*'[50], as well as meeting our legal and contractual obligations.

The strategy includes **5 key strategic objectives** which are accompanied by an EDI Strategy Implementation Plan. These are:

1 Education, Empowerment and Support
2 Effective Staff and Community Engagement and Involvement
3 Population Health Inequalities
4 Promoting Inclusive Behaviours
5 Reflective and Diverse Workforce

The EDI strategy supports our aims of being an employer of choice for all our current and prospective staff and a provider of great care for our patients not because it 'must be done' but because it is the right thing to do. Our EDI Strategy is our commitment to addressing inequalities for our people, patients and community with real purpose and action. We value the diversity of our people and commit to championing inclusion and a compassionate workplace. For our patients and community, we want to ensure our services will be accessible and truly inclusive to all.

Throughout 2025 we have been working with staff networks and key stakeholders to ensure the EDI Strategy continues to be implemented across the Trust. Our 3-year strategy came to an end in December 2025 and we are now focusing on engagement and collaboration with key stakeholders to refresh our strategic EDI objectives, ensuring our priorities and activity continues to meet both current needs and legal/contractual requirements, including our ambitions around wider partnership work in developing anti-racist approaches at a district wide level.

3.4.2 DEVELOPING LOCAL EDI ACTION PLANS

A key enabler to implementing the EDI strategy across the Trust has been the development of local EDI action plans (aligned to the five strategic equality objectives) which will create a more targeted approach and greater ownership of the actions within departments and CSUs. Over the last 12 months the EDI team have continued to engage with CSU/ Departmental managers and teams on their role and remit as part of the EDI strategy and supporting them to develop local action plans which are tailored to their individual needs. Our departments have a proactive EDI plan in place that will advance EDI for both our patients and the wider workforce with a focus on exploring and monitoring departmental equality data, ensuring local action plans have measurable targets. This work will continue to be developed throughout 2026/27, and progress will be shared with the Equality and Diversity Council, the Board Assurance Committees and Trust Board.

[50] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2024/04/24040507-EDI-Strategy-2023-2025-PRINT.pdf

3.4.3 Equality, Diversity & Inclusion Conference

Our first-ever Equality, Diversity and Inclusion Conference took place on 22 October 2025 at the Cedar Court Hotel in Bradford with the theme of "Belonging at BTHFT: Thriving on Inclusion". Hosted by the Chief Executive and the Head of Equality, Diversity and Inclusion; over 230 colleagues from across the Trust (including some external partners) heard from a range of speakers, including Professor Habib Naqvi MBE from the NHS Race & Health Observatory who shared examples of how evidence-led reviews are helping to make a difference. The trust is aiming to adopt the Observatory's '7 Principles for Anti-Racism'.

Collingwood Learning provided a live action interactive theatre experience encouraging colleagues to explore common experiences of discrimination in the workplace and the Yorkshire Women's Forum led a creative workshop asking colleagues to create colourful 'Mandalas of Belonging'.

The Chief Operating Officer and Deputy Chief Executive spoke of his own personal challenges in respect of inclusion throughout his career in the NHS before introducing the final session of the day – a 'Question & Answer panel' featuring colleagues from our four staff equality networks.

3.4.4 Maintaining the success of our Equality and Diversity Council (EDC)

The Trust's EDC provides an essential mechanism for strategic level discussion and decision making around current EDI issues from both a workforce perspective and including the Trust's approach in tackling population health inequalities. The EDC continues to meet regularly and is chaired by the Chief Executive who is also the Trust's Executive Sponsor for equality, diversity, and inclusion. Our four Staff Equality Networks have dedicated agenda time at each meeting ensuring we provide a voice to our diverse staff groups at a strategic level. Key updates from each quarterly meeting are reported directly to our Trust Board. Membership of the EDC is reviewed regularly with a focus on ensuring its role and remit is fit for purpose and the terms of reference for EDC are reviewed annually.

3.4.5 Staff Equality Networks

Staff equality networks are a key building block to the Trust's diversity and inclusion activities, where staff can share their lived experiences and effectively influence the Trust's diversity and inclusion agenda. Our staff equality networks continue to thrive and in 2025 we launched a fourth network, the Gender Equality Staff Network. Demonstrating the Trust's approach to inclusive leadership, each network benefits from having an Executive Sponsor, to support, guide and advocate for the network and to provide networking opportunities. Each network chair is an active member of the Equality and Diversity Council (EDC) where they have a voice in influencing EDI across the organisation. They are supported with 4 hours per month facility time and are allocated a small budget per annum to support their work. Network Chairs also work collaboratively as part of a new 'Chair of Chairs' forum to ensure network work plans are aligned, and to acknowledge the intersectionality of members. We have continued our efforts to further engage with diverse staff across the Trust, with the aim of providing safe spaces, responding to risks, concerns and issues and with a view to understanding their lived experience and using this to bring about change in the culture of the organisation.

Our staff networks are established and proactive in helping to raise the profile of EDI across the Trust and have been instrumental in planning and organising a range of national and international celebratory days throughout 2025/26, including South Asian Heritage Month,

Black History Month, LGBT+ History Month, Disability History Month, International Women's Day and National Staff Equality Networks Day.

On 26 February 2026, as part of the holy month of Ramadan, we held our first ever 'Community Iftar'. Diverse colleagues from across the Trust (including both Muslim and non-Muslim individuals), family and friends from across the community came together to celebrate the opening of the fast with dates, and to share with colleagues the associated rituals and traditions (including communal prayers and donations made to charity).

3.4.6 Engagement and Implementation of the Equality Delivery System 2022

Implementation of the Equality Delivery System (EDS)[51] is a requirement on both NHS commissioners and NHS providers. It is the foundation of equality improvement within the NHS, acting as an accountability and improvement tool for NHS organisations in active conversations with patients, public, staff, staff networks and trade unions - to review and develop their services, workforce, and leadership. Implementation of EDS2022 supports NHS organisations to deliver on the Public Sector Equality Duty.

As part of our refreshed annual Equality Delivery System[52] Review 2025/2026; we held task and finish groups with key stakeholders across the organisation to gather evidence to showcase our progress around key outcome measures for the three EDS Domains: Domain 1: Commissioned or Provided Services (sampling 3 services : Bradford Nutrition & Dietetics Service, Maternity (Labour Ward/Intrapartum Care) and Accident & Emergency (from a Mental Health perspective), Domain 2: Workforce Health & Wellbeing, and Domain 3: Inclusive Leadership.

We have continued to ensure staff are engaged and informed on a range of equality related events and held two engagement events for staff equality network members and trade union representatives and for the wider community, where representatives from the voluntary and community sector were invited. The latter event was organised in collaboration with Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust. Both events provided an opportunity for the Trust to engage in discussion and to showcase evidence of our progress. Participants were invited to provide their scores for each outcome measure (in accordance with the EDS rating & scoring guidance[53]), along with any feedback and recommendations for improvement. The Trust was rated as 'achieving' for each outcome measure, with an EDS rating of 'achieving' for the organisation.

3.4.7 WORKFORCE RACE EQUALITY STANDARD (WRES) & RACE EQUALITY

Improved performance for both WRES and the Workforce Disability Standard (WDES) is essential in ensuring the Trust is continuing to reduce the gap in some of the workforce inequalities that are evident. We have good organisational infrastructure and strong foundations in place which will enable us to improve our performance over the next 12 months.

We have exceeded our Trust target set in 2020 to have a workforce that is representative of the local community by March 2025 (at 35%). Our 6 monthly updates to the People Academy dashboard demonstrate that the percentage of Ethnic Minority staff in the workforce continues to rise and has risen over the past 18 months from 41% in March 2024 to 45% in September 2025. However, we recognise there is still work to do to ensure we

[51] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/eds2/

[52] https://www.england.nhs.uk/about/equality/equality-hub/patient-equalities-programme/equality-frameworks-and-information-standards/eds/

[53] https://www.england.nhs.uk/publication/equality-delivery-system-2022-guidance-and-resources/#guidance

have a representative workforce at *all* levels of the organisation. Our People Academy dashboard update for November 2025 reflected an improving 3% increase in representation of Ethnic Minority staff at senior leadership levels over the last 18 months (where Ethnic Minority staff currently represent 22% of senior leaders at the Trust). However, although we are making a steady improvement, we were still below our original target of 35% representation. To ensure there is renewed focus with realistic targets set, we developed refreshed targets for senior leadership representation as part of our 2025-2030 People Strategy. Our refreshed 2025/26 WRES action plan provides continued focus on improving representation at senior management levels to ensure we are meeting our target of 28% representation by 2027 and 40% representation by 2030.

Our refreshed (2025/26) WRES action plan[54] was approved by the People Academy in November 2025. It has been co-produced with our Race Equality Staff Inclusion Network and in collaboration with key stakeholders from across the Trust and has been developed to reflect targeted focus for all the WRES indicators that require improvement[55], with the aim of bringing about positive change across the Trust in terms of race equality and improving our performance on WRES. Key areas of improvement for the Trust include focus on:

- Diversifying our senior leadership.
- Staff experience in relation to workplace dignity and respect.
- Further embedding a 'Just Culture' approach in our policies and practices, including training for line managers.
- Further embedding our EDI strategy, including everyone's role in raising the profile of EDI.
- Equity in career development opportunities and developing confidence that approaches are fair.

3.4.8 WORKFORCE DISABILITY STANDARD (WDES) & DISABILITY EQUALITY

Considerable efforts have been made over the last few years to improve the working lives of colleagues with a disability or long-term health condition, including the introduction of a disability equality policy, disability related leave, carer's passport, staff advocacy support and health & wellbeing offers. We co-produced a disability equality video (with funding achieved from the NHS England WDES innovation fund) to raise the profile of disability equality and the trust has shared this widely with other NHS organisations.

To improve disclosure rates we have developed an 'Equality Census' leaflet to inform staff of the benefits of sharing their personal diversity information and how their information will be handled and stored and recognise we have work to do to ensure those with a disability or long-term health condition feel fully supported and confident to declare their disability status. The percentage of staff sharing their disability status on the Electronic Staff Record (ESR) system has remained static over the last few years, however we have seen a slight rise of just 1% (6% overall) in the last 12 months. Consequently, as part of the newly launched People Strategy (2025-2030) we have identified targets for declaration of 10% by 2027 and 15% by 2030, and there is renewed focus on improving declaration rates in our 2025/26 WDES action plan. The refreshed WDES action plan[56] was approved by the People Academy in November 2025 and has been co-produced with our Enable Staff Equality Network and in collaboration with key stakeholders from across the Trust; developed to reflect targeted focus for all the WDES metrics that require improvement[57].

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[54] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2025/11/WRES-Action-Plan-2025-2026-Final.pdf
[55] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2025/11/WRES-2025-Data-Analysis.pdf
[56] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2025/11/WDES-Action-Plan-2025-2026-.pdf
[57] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2025/11/WDES-2025-Data-Analysis.pdf

3.4.9 LGBT+ EQUALITY

Our LGBT+ staff network continues their efforts in raising the profile of LGBT+ equality, and under the leadership of a new chair membership is starting to increase and the network is beginning to thrive. LGBT+ colleagues and network members continue to explore different options in ensuring the network reaches out to wider LGBT staff across the organisation and to engage more actively with other LGBT+ networks across the patch, with whom they recently held a successful LGBT+ History month celebration event on 25 February 2026. The event was open to colleagues, friends and family from across the community.

The network is in the process of developing their work plan, aligned to the Trust EDI ambitions. In June they celebrated PRIDE month and are in the process of collecting member stories, some of which have already been published as part of a series of Network Member spotlights in Let's Talk (staff newsletter). In July 2025, the network supported the EDI Team on re-launching the Rainbow Badge initiative, with a roadshow and a series of online training sessions, ensuring our hospital continues to provide an open, non-judgemental and inclusive place for LGBT+ people. Details of our Trans and non-binary policy for patients and staff can be found in section 3.3.2 (Staff Policies and Actions).

3.4.10 Gender Pay Gap and Gender Equality

The Trust's information on the gender pay gap can be found at https://gender-pay-gap.service.gov.uk.

Women continue to make up a significant proportion of our workforce. On 31 March 2025 our workforce comprised 7,491 staff, of which 5,753 (76.8%) were women and 1,738 (23.2%) were men.

Despite a 0.1% increase in our mean gender pay gap this year to 22.2%, overall it is decreasing and has reduced by 9.1% since we started reporting in March 2017. However, our annual gender pay gap analysis report has identified that women continue to be under-represented at more senior levels and over-represented at supervisory and middle management levels. We also recognise that men are significantly under-represented in Nursing & Midwifery and some other traditionally female professions.

Our gender equality action plan[58] has been developed in collaboration with our Gender Equality Staff Network who, under the leadership of their newly appointed Chair and with support from their executive sponsor (the Chief Digital and Information Officer), are continuously looking at ways we can accelerate our progress on Gender Equality.

The action plan has again been based around the three key areas of focus:

- **Representation of women in leadership:** further increasing our engagement with aspiring females and further exploring some of the 'barriers to senior level development' with particular focus on intersectionality, personal development and talent management.

- **Continued focus on improving the working lives of women at BTHFT**, addressing some of the barriers to retention and progression.

[58] https://www.bradfordhospitals.nhs.uk/equality-and-diversity/

- **Raising the profile of Gender Equality across the Trust**, with focus on addressing the under-representation of men in traditionally female roles and challenging gender stereotypes in the workplace.

Some positive steps have been taken to raise the profile of gender equality across the Trust. In March 2025 we celebrated **International Women's Day** with an event that generated a lot of focus in this area. The event was an opportunity for a diverse range of colleagues to share their inspiring lived stories, including perspectives from men, women and non-binary colleagues and discussion on the issue of intersectionality and additional challenges.

The event also provided a platform for the launch of a newly developed **Gender Equality Staff Network**, and with a focus on inclusivity and allyship, as well as progress**.** As with other staff equality networks there are key core group roles for network members and the network has already developed their terms of reference, branding and presented their network work plan to the Equality & Diversity Council in July 2025. The chair of the network has joined our **Chair of Chairs Network** (ensuring all our staff networks are working collaboratively with focus on **intersectionality**).

3.4.11 Supporting Young Disabled People with Learning Disabilities

We continue to support and host 'Project Search', an initiative aimed at young people with learning difficulties and continue to make a positive impact on all interns and their families. We held our annual graduation ceremony in the Sovereign Lecture theatre on 25 June 2025, and 11 interns have been recruited for the subsequent 2025/2026 intake.

3.4.12 Equality and Diversity Training and System Wide Charter

Our half day face-to-face EDI Managers training course provides managers and team leaders with key awareness and knowledge in managing diversity in the workplace with sharp focus on the Trust being an inclusive and compassionate employer. The course has been welcomed by participants and provides opportunity for open discussion around real life case studies and has received excellent feedback.

'Leading at a Higher Level' is a new two-day course for managers launched in 2025 (with over 1,000 leaders trained to date). The course focuses on setting expectations of a trust manager and empowers leaders to act. Leaders at all levels can access other development opportunities such as the Mary Seacole Programme, coaching, mentoring and NHS Elect. In addition to this, a Trust Board Development Programme has been introduced and includes a session on compassionate leadership. The Trust Board has been supported to develop their own 'Code of Conduct'.

Development of a System Wide Anti Racist Charter

In collaboration with other EDI experts, and in partnership with the Race Equality Network (REN), we have embarked on developing a district wide Anti-Racist Charter/framework. This is a system-wide activity aligned with our place level EDI priorities and with oversight from the Bradford District Health & Wellbeing Board. The Charter will be structured and measurable via a framework through which organisations can demonstrate their commitment to anti racism. The model will place particular emphasis on embedding anti-racism approaches across governance and leadership, employment practices, organisational culture, and access to services.

3.4.13 Bullying and Harassment Policies

See section 3.3.2 (Staff Policies and Actions).

3.4.14 Recruitment and Selection Policy and Practices

See section 3.3.2 (Staff Policies and Actions).

3.4.15 Interpreting Services

Bradford has a very diverse and multi-cultural population, which is reflected in its patient profile. The language Interpreters play a vital role in ensuring the Trust provides high quality, safe and equitable care to all patients. Accurate communication between clinicians and patients is essential for diagnosis conversations, treatment and care.

The Trust's interpreting services team supported people on no fewer than 56,094 occasions, and in over 60 different languages. It meets the needs of non-English speakers and British Sign Language (BSL) users, primarily through face-to-face interpreting. There is also the ability to support via telephone and video consultation, to ensure 24-hour access, seven days a week. Requests for support in other formats, such as Braille, are also met through the team. The top 10 languages requested are shown below.

Figure 50 - Top 10 languages requested through interpreting services 2025/26

Urdu/Punjabi	29,068
Czech/Slovak	6,590
Polish	3,424
Arabic	3,413
Bengali	3,262
Kurdish	1,387
Hungarian	1,131
Pushto	1,027
Russian	762
BSL	756

Interpreters communicate with patients about their medical history to obtain information about their current problem, to discuss diagnosis and treatment options and obtain consent for any treatment or procedure, as well as delivering bad news. Use of other methods of interpreting to increase efficiencies, improve responsiveness and adapt digital delivery of services continues. The use of remote Interpreting Services (Telephone/Video) has increased to over 20% during 2025/26 and BSL Interpreting has delivered over 756 sessions.

3.5 CODE OF GOVERNANCE FOR NHS PROVIDER TRUSTS

3.5.1 STATEMENT OF COMPLIANCE

We have applied the principles of the Code of Governance for NHS Provider Trusts[59] ('the code') on a 'comply or explain' basis.

In May 2026, the Board of Directors reviewed our compliance with the code to identify any areas for further development. The review concluded that the Trust is compliant with all provisions other than provision E2.2, for which there is partial compliance.

Regarding E2.2, there is an element of non-compliance regarding the annual remuneration of the Non-Executive Directors (NEDs), whereby their level of remuneration is above the cap set within NHS England guidance[60] .

The disclosures required under the code are located at section 4.1 of this annual report along with those additional disclosures required by NHS England. Figure 51 below sets out in detail the area of non–compliance with the code for 2025/26.

Figure 51 - Areas of non-compliance with the code for 2025/26

Provision from the code of governance for NHS Provider Trusts	Explanatory statement for 2025/26
E2.2 Levels of remuneration for the chair and other non-executive directors should reflect the Chair and non-executive director remuneration structure.	In year, the Council approved an increase to NED remuneration to £15,000 (£2,000 above the recommended cap for NEDs within the NHSE Guidance). Prior to this, there had been no increase in NED remuneration of £13,785 since 2011. In reaching its decision, the Council took account of the annual remuneration benchmarking undertaken by NHS Providers and noted that the NHS England guidance from 2019 has not been subject to the expected review.

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 our Trust and is set out in our Constitution[61].

3.5.3 OUR FOUNDATION TRUST MEMBERSHIP

Our membership is made up of public, patients, and staff. All members are required to be at least 16 years old.

During the year, local people and those accessing our services as a patient or carer, or those with any other connection to our trust, have been able to become a member of the Trust by completing the online membership form[62].

[59] https://www.england.nhs.uk/publication/code-of-governance-for-nhs-provider-trusts/
[60] https://www.england.nhs.uk/non-executive-opportunities/about-the-team/remuneration-structure-nhs-provider-chairs-and-non-executive-directors/
[61] https://www.bradfordhospitals.nhs.uk/wp-content/uploads/2024/11/BTHFT-Constitution-November-2024-Final.pdf
[62] https://secure.membra.co.uk/Join/BradfordTeaching

Public membership: Our public membership is divided into six sub-constituencies which cover Keighley, Shipley, Bradford East, Bradford South, Bradford West and the 'rest of England and Wales.' Postcode determines the membership constituency.

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

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

Number of members

Figure 52 highlights our membership at the start of the year and at the end showing changes in between. The previous year's information is also provided for comparison.

Figure 52 - Membership for the period 2025/26 and 2024/25

Membership size and movements		
Public constituency	2025/26	2024/25
At year start (April 1)	32,229	32,535
New members	25	39
Members leaving	689	345
At year end (March 31)	31,565	32,229
Patient constituency	2025/26	2024/25
At year start (April 1)	5,419	5,475
New members	4	2
Members leaving	53	58
At year end (March 31)	5,370	5,419
Staff constituency (eligible members)	2025/26	2024/25
At year start (April 1)	6,728	6,196
New members	240	675
Members leaving	192	143
At year end (March 31)	6,776	6,728

Membership representation, engagement and communications

In year, public and patient membership has declined overall by 742 members (2%) leaving the Trust with a total public and patient membership of 36,935 on 31 March 2026. 29 new public and patient members have joined the Trust in year.

Public membership socio-economic profile

The following classifications based on the 'occupation of the chief income earner within a household' have been applied to our membership. On 31 March 2026, our public membership reflects the following compared to our local (Bradford Metropolitan District Council (BMDC)) population.

Figure 53 - Socio-Economic profile of the Trust's Membership at 31 March 2026

	Public Membership	% of Membership	Base (BMDC)	% of base (BMDC) area
ONS Classifications	31,537	99.91	207,179	100.00
AB: Higher managerial roles, administrative or professional. Intermediate managerial roles, administrative or professional.	6,640	21.04	33,961	16.39
C1: Supervisory or clerical and junior managerial roles, administrative or professional.	8,564	27.13	59,573	28.75
C2: Skilled manual workers.	7,208	22.84	43,122	20.81
DE: Semi-skilled and unskilled manual workers. State pensioners, casual and lowest grade workers, unemployed with state benefits only.	9,125	28.91	70,523	34.04

Further information about social grade data is available on the ONS website[63].

Our membership remains representative of the communities we serve who form part of groups C1 and C2 (supervisory or clerical and junior managerial roles, administrative or professional, and skilled manual workers). For group AB we are over-represented by approximately 5% and for group DE we are under-represented by approximately 5%.

Member and public engagement

The Trust is currently reviewing membership engagement and recruitment activity. The following provides a snapshot of the key areas of membership engagement / involvement and communications that have continued to take place in year.

- **Annual Members Meeting:** The Trust held an Annual Members Meeting[64] (AMM) on 24 March 2026 to present the Annual Report and Accounts 2024/25 to our members and the public.

  Opportunities were provided in advance of the event for questions to be submitted which were addressed at the meeting. All presentations from the AMM are available on the Trust's website[65].

- **Patient-Led Assessments of the Care Environment (PLACE) programme:** Members signed up to become patient assessors as part of the Trust drive to deliver the PLACE programme.

- **Volunteering:** Members have been encouraged to sign up to become volunteers at our Trust. Information about volunteering at our Trust is available on the Trust's website[66].

Membership Communications

We have continued to improve our communications with our members and the public in year through the routine provision of our (at least) bi-monthly e-communications bulletins. These

[63] https://www.ons.gov.uk/census/aboutcensus/censusproducts/approximatedsocialgradedata

[64] https://www.bradfordhospitals.nhs.uk/2026-annual-members-meeting/
[65] https://www.bradfordhospitals.nhs.uk/2026-annual-members-meeting/
[66] https://www.bradfordhospitals.nhs.uk/our-people/volunteering/

include links to 'Mel's monthly news round ups'[67] introduced by our Chief Executive, Mel Pickup. These videos provide the very latest information on news from our Trust, and have been very well received. All of our recent and past videos are available on our YouTube site[68].

All membership communications bulletins published during year are available on the Trust's website[69].

Contact procedures for the membership

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

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

Becoming a member

To join as a member of our Foundation Trust please complete the membership form[70].

3.5.4 Council of Governors

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

The role of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors and to represent the interests of the Trust's members and members of the public. Governors are elected from the Trust's membership and most of the seats on a Council of Governors are required to be held by elected public and patient governors (where a trust has patient governors).

Composition of the Council of Governors

Figure 54 provides details of the Trust's Council members in-year, including the constituency, group, or organisation they represent, their terms of office and a record of their attendance at the formal meetings held in-year.

Figure 54 - Members of the Council of Governors during 2025/26

Public Governors (elected)		Start date	Current term end date	Meetings attended 2025/26
Imran Ellam	Bradford East	25/06/25	24/06/28	2 of 3
Kursh Siddique	Bradford East	26/05/19	25/05/25	1 of 1
John Waterhouse	Bradford East	24/06/24	23/06/27	4 of 4
Dr Farideh Javid	Bradford South	13/01/23	12/01/29	3 of 4
Sharon Taylor	Bradford South	20/08/24	19/08/27	4 of 4
Dermot Bolton	Bradford West	06/12/19	05/12/28	4 of 4

[67] https://www.youtube.com/channel/UCbMe0YV6GzoCOXcm34U2uRw
[68] https://www.youtube.com/@BTHFTBradfordTeachingHospitals/videos
[69] https://www.bradfordhospitals.nhs.uk/our-trust/membership-news/
[70] https://secure.membra.co.uk/bradfordteachingapplicationform/

Public Governors (elected)		Start date	Current term end date	Meetings attended 2025/26
Ibrar Hussain	Bradford West	01/05/21	02/08/27	2 of 4
Khalid Choudhry	Keighley	26/05/22	25/05/25	0 of 1
Osman Rafiq	Keighley	03/07/25	02/07/28	2 of 3
Philip Turner	Keighley	20/06/24	19/02/26	2 of 4
Andy Waller	Rest of England and Wales	02/07/24	01/07/27	2 of 4
Alex Atanaskovic	Shipley	03/01/23	02/01/26	2 of 3
Fiona Thompson	Shipley	10/11/25	09/11/28	1 of 1
David Wilmshurst	Shipley	01/07/16	05/12/25	3 of 3
Patient Governors (elected)				
Mark Chambers (Lead Governor)	Patient (Out of Bradford)	06/12/19	05/12/28	2 of 4
Staff Governors (elected)				
Ruth Houghton	All Other Staff Groups*	03/03/20	31/01/29	3 of 4
Charlotte Szpara	All Other Staff Groups*	01/03/25	28/02/28	2 of 4
Kameel Khan	Allied Health Professionals and Scientists	27/10/25	26/10/28	1 of 1
Helen Wilson	Allied Health Professionals and Scientists	06/12/19	20/06/25	0 of 1
Dr Helen Jepps	Medical & Dental	27/05/25	07/01/26	0 of 2
Dr Farzana Khan	Medical & Dental	22/03/23	26/05/25	1 of 1
Helen Fearnley	Nursing & Midwifery	01/03/25	28/02/28	4 of 4
Emma Fleary	Nursing & Midwifery	01/03/25	28/02/28	4 of 4
Partner Governors (appointed by our stakeholders)				
Professor Anne Forster	University of Leeds	01/05/21	30/04/27	3 of 4
Dr William Martin	University of Bradford	01/03/25	28/02/28	4 of 4
Helen Rushworth	Healthwatch Bradford	16/01/25	15/01/28	3 of 4
Cllr Fozia Shaheen	Bradford Metropolitan District Council	01/11/22	31/10/28	2 of 4

**'All Other Staff Groups' comprises the following staff: admin and clerical, estates and facilities and additional clinical services.*

The maximum term length for a governor is three years. In line with the Constitution, governors can serve a maximum of nine consecutive years (equivalent to three full term lengths). Profile information on all our governors is available on our website[71].

Election processes held in-year

Two election processes were completed in year (May 2025 and November 2025), and the following governors were elected / re-elected:

May 2025
- Public Keighley – Osman Rafiq
- Public Bradford East – Imran Ellam
- Staff: Medical & Dental - Dr Helen Jepps

November 2025
- Patient (Out of Bradford) - Mark Chambers
- Public Bradford South - Dr Farideh Javid
- Public Bradford West - Dermot Bolton
- Public Shipley - Fiona Thompson
- Staff: All Other Staff Groups - Ruth Houghton
- Staff: Allied Health Professionals and Scientists (AHPS) - Kameel Khan

A further election process commenced on 26 January 2026 and completed on 9 April 2026. The results of this election will be reported in our next Annual Report. Elections have been conducted in line with our Constitution and were provided by Civica Election Services

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

(formerly Electoral Reform Services), The Election Centre, 33 Clarendon Rd, London N8 0NW.

Information regarding our elections is available on the Trust's website[72].

Council of Governors' Register of Interests

All governors are required to comply with the Code of Conduct and declare any interests that may result in a potential conflict of interest in their role as governor. The interests are publicly available on our website[73] as part of the Trust's register of interests. The latest extract from the register is also included with the papers at each Council of Governors meeting. In addition, the register can be obtained from the Associate Director of Corporate Governance/Board Secretary via the following methods:

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

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 the NHS Act 2006 (as amended)[74]. 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.

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 (NEDs) and the Chair. Their purview includes remuneration, terms of office and NED/Chair 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 during 2025/26.

Council of Governors meetings

During 2025/26 the Council of Governors meetings have routinely included the delivery of key presentations and agenda items that have elicited challenge and supportive discussion between governors and directors.

The agendas and papers including the minutes for the Council of Governors[75] meetings are available on our website. Regarding their statutory duties and responsibilities, the Council has, during 2025/26:

- Received the Annual Accounts, Auditor's Report, and the Annual Report.
- Received regular reports from the Governors Nominations and Remuneration Committee (NRC) on its business.
- Approved the appointment of the External Auditor.
- Appointed two new Non-Executive Directors.

[72] https://www.bradfordhospitals.nhs.uk/our-trust/become-a-governor/
[73] https://bthft.mydeclarations.co.uk/
[74] https://www.legislation.gov.uk/ukpga/2006/41
[75] https://www.bradfordhospitals.nhs.uk/our-trust/how-we-make-decisions/

To support the delivery of their duties, Council members have also, in year, been invited to attend a series of in-depth briefing sessions. Governors have also observed the Board of Directors meetings and Board Committees throughout the year.

Directors' attendance at the Council of Governors meetings

Executive and Non-Executive Directors routinely attend the meetings of the Council of Governors. In 2025/26 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'.

Governors' effectiveness

To support Governor effectiveness, the Council participated in development sessions in July 2025 and in September 2025 facilitated by external consultants.

Governors continue to be in receipt of the agenda for Board meetings which are circulated in tandem with the meeting documents to Board members and prior to publication on the Trust's website.

Governor engagement with patients, visitors, and staff

Governors have been invited to attend activities that bring them into contact with staff, patients, and visitors. The Council meeting agenda includes as a regular item on matters raised with Governors by members, patients and the public.

External engagement

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

Governors' learning and development

Learning and development has been provided to the full Council through additional in-depth briefing sessions. All new members of the Council have taken part in the Governor induction programme which includes mandated attendance at the Core Skills training session delivered by Governwell (NHS Providers), and participation in an internally delivered session providing an overview of our Foundation Trust, the type of information Governors receive, the role of a Governor and, how Governors should carry this out.

The Trust ensures that Governors 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.

Communicating with Governors

Members and the public can 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

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 11 July 2025.

Figure 55 - External audit fees

Fee (excluding VAT)	2025/26 £000	2024/25 £000
Audit of Trust	321	210
Additional fees	12	0
Total	**333**	**210**

- *Additional fees charged in 2025/26 relate to external audit services received in 2024/25*

The independent examiner for Bradford Hospitals Charity is Moore Kingston Smith:

Moore Kingston Smith LLP
6th Floor
9 Appold Street
London EC2A 2AP

Moore Kingston Smith was appointed as the independent examiner by the Charitable Funds Committee on 18 October 2023.

Total independent examination for the audit of the charity accounts is expected to be £4,000 in 2025/26 (the 2024/25 independent examination was £4,000). The 2025/26 independent examination of the Charity Accounts will take place during 2026/27.

Internal audit and counter fraud service

Internal audit and counter fraud services are provided by Audit Yorkshire. The Trust's Chief Finance Officer is a member of the Audit Yorkshire Board, which provides strategic oversight of the organisation.

An Internal Audit Charter is in place, formally defining the purpose, authority and responsibilities of the internal audit function. The Charter was last approved by the Audit Committee in February 2025.

The Audit Committee approved the internal audit planning methodology for the development of the 2025/26 Internal Audit Plan and formally approved the Internal Audit Operational Plan

in February 2025. While the Operational Plan was not fully delivered during the year, with a number of audits deferred to 2026/27, this was reported to and monitored by the Audit Committee.

The conclusions, together with all findings and recommendations from finalised internal audit reports, are reported to the Audit Committee. The Committee routinely challenges both internal audit and management on the assurances provided and requests additional information, clarification or follow-up work where necessary. Executive Directors responsible for areas receiving limited or low assurance opinions are required to attend the Audit Committee to provide further assurance.

Arrangements are in place to ensure effective monitoring of internal audit recommendations. All recommendations are shared monthly with the Chief Finance Officer and circulated to the Executive Directors. Progress against agreed actions, including full details of outstanding recommendations, is reported at least quarterly to both the Executive Management Team and the Audit Committee. This has remained an area of focus for the Committee during the year. Trust management, supported by internal audit, has continued to strengthen the approach to responding to recommendations, resulting in a significant reduction in the number of outstanding actions at year-end. This improvement has been supported by the implementation of a new internal audit software system.

To provide additional assurance, a further process has been introduced whereby internal audit selects and tests a sample of major and moderate recommendations that have been reported as completed.

The Counter Fraud Annual Plan for 2025/26 was reviewed and approved by the Audit Committee in May 2025. The Trust's Local Counter Fraud Specialist (LCFS) provides regular reports to the Committee, setting out progress against the plan and summarising investigations undertaken.

The Trust operates a well-communicated zero-tolerance approach to fraud, implemented through its counter fraud policy. Regular newsletters are issued to all staff, covering a wide range of fraud-related topics and promoting awareness, vigilance and the reporting of suspected fraud through established routes. This approach actively informs and involves staff in the prevention and deterrence of fraud.

These messages are reinforced through the Trust's counter fraud intranet pages, which provide LCFS contact details and information on how to report suspected fraud through a variety of channels. Staff also receive information at induction, including a welcome email from the LCFS with full contact details. During the year, Fraud Prevention Masterclasses have been delivered alongside targeted presentations on specific fraud risks, and the circulation of national fraud alerts and prevention notices issued by the NHS Counter Fraud Authority.

The Counter Fraud Functional Standard is a government initiative that sets expectations for the management of fraud risk within public sector organisations. The Trust is progressing towards full compliance in line with NHS Counter Fraud Authority timelines.

Fraud Risk Descriptors have been assessed and scored by the LCFS throughout the year and allocated to senior risk owners for review and reassessment where appropriate. These assessments will continue to inform the focus and delivery of counter fraud activity going forward.

The Trust's Anti-Fraud, Bribery and Corruption Policy continues to provide a robust framework for the prevention, detection and management of fraud, bribery and corruption

risks. The policy was last reviewed and updated in August 2025 to incorporate the requirements of the new Failure to Prevent Fraud legislation, ensuring that the Trust remains aligned with current regulatory and legislative expectations.

The policy clearly sets out the Trust's zero-tolerance approach to fraud and related misconduct, defines roles and responsibilities, and supports a strong culture of integrity, accountability and transparency across the organisation. The next scheduled review of the policy is due in April 2027, or sooner should there be any further changes in legislation, guidance or assessed fraud risk.

3.6 NHS OVERSIGHT FRAMEWORK

3.6.1. INTRODUCTION

NHS England's *NHS Oversight Framework (NOF) 2025/26*[76] is the framework for assessing health systems including providers. It promotes transparency, improvement, and helps identify potential support or intervention needs. NHS organisations are allocated to one of five segments.

Segmentation indicates performance and whether improvement is required, from high performing across all domains (segment 1) to low performance across a range of domains (segment 4). An organisation assessed as segment 4 combined with a low capability to improve is allocated to segment 5.

NHS England's oversight response to an organisation is based on:

a) its segment derived from scored metrics under five performance domains (being access to services, effectiveness and experience of care, patient safety, people and workforce, and finance and productivity);
b) considering financial override which may limit a segment to be no better than 3;
c) contextual metrics which are not scored (for example those under sixth domain of improving health and reducing inequality); and
d) capability assessments which consider the organisation's leadership and governance.

3.6.2. SEGMENTATION

NHS England has placed the Trust in segment three. This means NHS England regional improvement teams will work collaboratively with the Trust to undertake a diagnostic stocktake to better understand where support is needed and agree improvement actions. This segmentation information is the Trust's position as of 20 March 2026.

As part of the NOF, NHS England assesses NHS trust boards' capability, using this alongside their NOF segment to determine what actions and/or support may be needed. As a key element of this, NHS trust boards were asked to self-assess their organisation's capability against a range of expectations across six areas derived from *The Insightful Provider Board*, namely:

- Strategy, leadership and planning
- Quality of Care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

The regional team reviewed the Trust's submission statements and evidence, which was triangulated with other relevant regional data/intelligence, its historical track record of delivery, any recent regulatory history, and relevant third-party information (including ICB and CQC) to support NHS England in reaching a holistic view across the six domains and to assign a single overall capability rating. These ratings were then subject to review and final ratification by NHS England's Executive Board.

Following this process the Trust was allocated capability rating of amber-red for 2025/26.

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

This means that there are some concerns of varying seriousness across one or more areas to be addressed. NHS England will work with providers to ensure that appropriate support is in place. The Trust has continued to be subject to enforcement undertakings and additional licence conditions during 2025/26. For further information please see section 3.8 (Annual Governance Statement). Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website.[77] The Trust is included on the acute trust dashboard.

[77] https://www.england.nhs.uk/nhs-oversight-framework/segmentation-and-league-tables/

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 England.

NHS England 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's Group Accounting Manual and in particular to:

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

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

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signed

Professor Mel Pickup
Chief Executive
26th June 2026

3.8 ANNUAL GOVERNANCE STATEMENT

3.8.1 INTRODUCTION

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

3.8.2 SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

3.8.3 THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 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 fully acknowledge that the delivery of healthcare services and the associated responsibilities of caring for patients, employing staff, maintaining premises, and managing financial resources are inherently risk bearing activities. These risks are present on a day-to-day basis throughout the Trust. In response, we take proportionate and proactive action to manage these risks to a level that is both tolerable and aligned with our organisational risk appetite. We acknowledge that risk can rarely be completely eradicated, and therefore a level of well-controlled and monitored 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. This ensures that risk considerations are embedded in operational practice, strategic decision-making, and continuous improvement processes.

Our Risk Management strategy provides a framework for managing risk throughout the Trust. This includes the way that risks are identified, evaluated, transferred and controlled. It describes the process for managing risks, the roles and responsibilities of the Board and its committees to provide a clear, structured and systematic approach to the management of risk to ensure that risk assessment is an integral part of our clinical, managerial and financial processes.

Our policy also includes a Risk Appetite Statement, which we use to determine target risk scores and the level of risk reduction by introducing additional controls. We have reviewed the Risk Appetite Statement during the year and in line with best practice.

As Chief Executive, I am the Accounting Officer for the Trust. I have overall responsibility for ensuring effective risk management arrangements are in place. I am supported by the Chief Nurse, who is the lead director for risk management, and the Associate Directors of Quality and Corporate Governance who together develop and manage the corporate approach to the management of risk, including the risk management strategy and the use of the Board Assurance Framework (BAF). In exercising these responsibilities, I routinely draw on a range of assurance mechanisms including the BAF, the Trust's high-level risk register, internal audit reports, the local counter-fraud service, and external audit findings to verify that appropriate systems, controls, and processes are established and operating effectively. These activities ensure that the Trust is able to discharge its statutory functions in a safe, transparent, and legally compliant manner, and that any identified risks are promptly detected, escalated, and addressed.

As Chief Executive, I have delegated some key responsibilities to other executive directors as shown at Figure 56.

Figure 56 - Executive directors' key responsibilities

Executive director	Responsibilities
Chief Finance Officer	Finance Procurement Contracting Capital Corporate Services (Bradford District & Craven) Yorkshire & Humber Secure Data Environment Joint Venture – Pathology Service
Chief Operating Officer / Deputy Chief Executive	Planned Services Unplanned Services Diagnostics and Corporate Operations Accountable Emergency Officer / Emergency Preparedness, Resilience and Response (EPRR) Performance Team Pharmacy Corporate Governance Equality, Diversion and Inclusion ABCAS (Airedale & Bradford Collaboration of Acute Services) NSO (Non-Surgical Oncology) West Yorkshire & Harrogate Cancer Alliance
Chief Nurse	Nurse Leadership and Regulation Patient Experience and Patient Engagement Complaints / Patient Advice and Liaison Service (PALS) End of Life Care Freedom to Speak Up Bereavement / Spiritual, Pastoral and Religious Care (SPaRC) / Volunteers Dementia Safeguarding Learning Disabilities Patient Safety including Tissue Viability, Falls and Ward Accreditation Infection Prevention & Control Allied Health Professional (AHP) / Healthcare Scientists (HCS) Leadership Quality Governance Clinical Governance Risk Management and Board Assurance Framework CQC and Regulatory Standards

Executive director	Responsibilities
	Maternity Safety Champion
Chief Medical Officer	Medical Leadership and Regulation Medicolegal Issues Medical Examiner's Office Coronial Inquiries/Inquests Controlled Drugs Accountable Officer Caldicott Guardian Responsible Officer Quality Effectiveness Education Joint Venture – Pathology Service Research National Audits Organ Donation Committee Transfusion Committee Drug & Therapeutics Committee
Director of Strategy and Transformation	Strategy Innovation Programme Management Partnerships Bradford Hospitals Charity Improvement Deputy Accountable Emergency Officer Health Equity and Health Inequalities
Director of Human Resources	Human Resources Business Partnering Recruitment Temporary Nurse Recruitment (TNR) and E-Rostering Employee Health and Wellbeing Flexible Workforce Workforce Information Apprenticeship and Widening Participation
Chief Digital and Information Officer	Information Technology Information Management Information Governance Senior Information Risk Owner (SIRO) Clinical Coding Clinical Digital, Data and Technology Data Quality Clinical Systems Optimisation Business Intelligence
Director of Estates and Facilities	Estates Facilities Capital Programme Health & Safety Fire Clinical Engineering Medical Engineering Sustainability Violence Prevention and Reduction

The executive 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 Chair of the Trust for my performance and to NHS England (NHSE) 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 Chair. They are expected to hold the Executive Directors to account and to use their skills and experience to make sure that the interests of patients, staff and the Trust as a whole, remain paramount. They have a significant responsibility for scrutinising the business of the Trust, particularly in relation to risk and assurance.

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

During 2025/26, the Quality Governance Team have provided incident reporting and risk management training in response to staff needs. In additional to risk management standard training. 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. The innovative Risk Management 'masterclass' provided to frontline staff was designed and delivered to ensure that the revised Risk Management Strategy will continue to be embedded across the organisation.

We have continued with our focus on developing awareness and skills in relation to high quality and focussed risk assessment and business continuity planning amongst clinical and non-clinical staff.

The NHS has a key role in responding to large scale emergencies and major incidents and throughout 2025/26, the emergency planning team has worked to ensure that the Trust is adequately prepared for any such events. Each year we assess our compliance with the requirements of the NHS England Emergency Planning Resilience and Response Core Standards (2015) and associated guidance and submit our assessment for review by NHS England.

The most recent submission date for the core standards was 31 October 2025. The Trust's return was submitted by the deadline.

The Trust reported 60 core standards as fully compliant and 2 partially compliant, this is up from 50 fully compliant and 12 partially compliant standards last year. An action plan has been produced for standards that are partially compliant.

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 Finance and Performance Committee and ensures that it has all other health and safety related committees in place.

The effectiveness of our implementation of our BAF was audited by our internal auditors, Audit Yorkshire, during 2025/26 who found there was limited assurance relating to the processes we have in place. A number of recommendations have been made which the Trust is implementing. A new format will be introduced for the BAF to better demonstrate the level of assurance in place in relation to each strategic risk, and to ensure clearer linkages with the risk appetite statement.

3.8.5 THE RISK AND CONTROL FRAMEWORK

Our strategic approach to risk management

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

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

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

Our Risk Management Strategy was approved by the Board of Directors in July 2022 (with further minor updates approved in March 2024). 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 objectives, and clearly defines the risk management structures, risk tolerance, accountabilities, and responsibilities throughout the Trust. The Risk Management Strategy is to be revisited and revised throughout Q1 2026/27.

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

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

Strategic risk management

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

The Board of Directors is responsible for identifying strategic risks. The BAF is reviewed and monitored by the Executive Team and Board four times per year. Our committees also review the strategic risks within their remit four times per year and provide assurance to the Board that the risks are being managed appropriately.

Operational risk management

The Trust uses an 'Integrated Reporting and Learning System' (IRIS) provided by Ideagen. The system is used to record our operational risks, which links all key elements (including incidents reporting, complaints, claims and inquest management). All of these elements are used to inform the high level risk register, which is also held on the system.

The Trust has recently added further modules to support regulatory activity, policy management as well as an oversight module to support the further development of the 'INSIGHT' report.

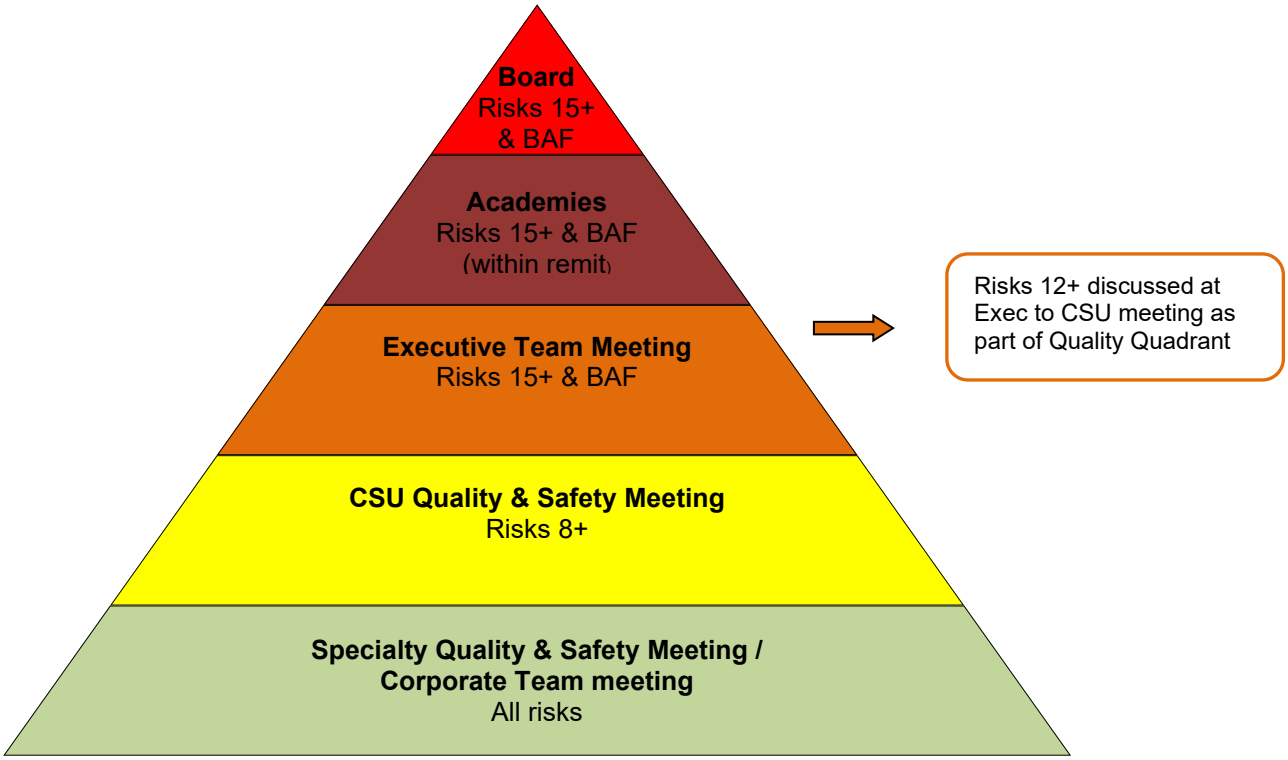


Image shows risk the Trust risk escalation framework

We manage risks at Board, Committee, Executive, corporate department, CSU and specialty level. All types of risk identified are graded using a common grading matrix, which measures the risks on a scale from 1 to 5 in terms of both consequence and likelihood. The consequence and likelihood scores are then multiplied together to give an overall score between 1 and 25.

Risks are escalated and de-escalated through these different levels depending on the current risk score. The current risk score is the score at the time of each review of the risk, considering the mitigations which are in place. Any risks with a current score of 15 or above are reported to the Trust Executive Team for discussion. If the Executive Team agree that the current score is 15 or above from a Trust-wide perspective, it is included on the High Level Risk Register.

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

The High Level Risk Register is fully reviewed every month at the Executive Team Meeting alongside a summary of the key changes and progress against mitigating actions. High Level Risks are assigned to one or more of the three Committees or the Board (as appropriate), who will have oversight of the actions being taken to mitigate the risks. At each meeting the Committees review the High Level Risks within their remit. The purpose of these reviews is to provide assurance to the Board that all relevant risks are appropriately

recognised and that all appropriate actions are being taken on appropriate timescales where risks are not appropriately controlled.

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

Risks with a current score of 12 and above are reported as part of the CSU to Executive meetings, to provide the Executive team with an overview of risks which have the potential to become high level risks. The Board receives and reviews the full High Level Risk Register (risks with a current score of 15 and above) at each meeting. The Board also receives details of the discussions held at the Executive Team Meeting via the risk report, and at the Committees via the Chairs' reports.

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

Risk appetite

The Board of Directors has a defined risk appetite statement (image 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 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 "Good" rating applied to the Trust by the CQC in 2020 has an influence on the risk appetite of the organisation.

The Board of Directors believes that our risk appetite appropriately reflects the progress that the Trust has made in implementing and assuring its Corporate Strategy 2022-2027 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 of Directors, and without exception, there is a minimal appetite in relation to any risks to patient safety, staff safety or regulatory compliance.

Strategic objective	Risk appetite	Description
Quality - To provide outstanding care for our patients, delivered with kindness	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*Our mission is to provide high quality care to our patients at all times and we will not accept risks that could affect our ability to do this. Our mission is our key organisational driver that directly supports our strategic objective to provide outstanding care for patients, delivered with kindness, improving outcomes for our patients and their carers by providing safe, effective, personal and responsive care. We will hold patient safety in the highest regard and are strongly averse to any risk, clinical, operational, workforce or related to strategic partnerships that may jeopardise it. But we have insight, we manage risk, we engage and involve, we improve and innovate and we assure, which enables us to have an open risk appetite in relation to our strategic objective to provide outstanding care for our patients, we are willing to consider all potential delivery options and choose, while also providing an acceptable level of reward.*
Improvement - To be a continually learning organisation and recognised as leaders in research,	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*The Trust recognises that to be a continually learning organisation it must have a broadly open approach that aligns the different areas of risk. These areas of risk include those associated with education and training, research translation, new technology, engagement and the learning management system. We are committed to identifying, developing, deploying and embedding learning at every level of the organisation to improve the quality of care for patients.*

education and innovation		
People - To be one of the best NHS employers, prioritising the health and wellbeing of our people and embracing equality, diversity and inclusion	**Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	*The Trust is clear that we will not accept risk where it involves potential exposure to significant harm for employees. Examples include:* • *Bullying or harassment of employees by their managers or colleagues* • *Discrimination of employees by their managers or colleagues* • *Exposing employees to faulty machines or equipment* • *Exposing employees to machines or equipment where this may result in a detrimental known impact on the health of the employee.* *However in relation to all other elements of achieving our strategic objective to be one of the best NHS employers the Trust will pursue workforce innovation and be pro-active around developing and trialling new ways of working and new job role/career pathway opportunities. By doing this we will seek to both increase workforce supply and improve the skills and capabilities of our people, ensuring we provide high quality care to our patients at all times.*
To collaborate effectively with local and regional partners, to reduce health inequalities and achieve shared goals	**Seek -** We are eager to be innovative and to choose options offering higher business rewards (despite greater inherent risk)	*We will actively collaborate to increase our influence. We will actively explore opportunities for value added innovation.*
To deliver our financial plan and key performance targets	**Open -** We are willing to consider all potential delivery options and choose while also providing an acceptable level of reward	*We will not tolerate risk to patient safety in order to deliver the Financial Plan, however we will accept a degree of compromise on optimum levels of care, but actively avoiding any safety concerns. We will strive to meet regulatory requirements but will not set unrealistic challenges that compromise the delivery of clinical strategic ambitions. We will provide realistic forecasts to regulators under 'no surprises' expectation. We will maintain an open and honest relationship with our Integrated Care Board colleagues and jointly recognise the financial challenges we face. The Trust will ensure that cash balances will be maintained at a level that protects the Trust's ongoing trading liabilities. Subject to sufficient reserves the Trust will invest to transform, but only when the realisable benefits are fully tested and assured and adequate liquidity is preserved.* *Patient safety is our highest priority in all aspects of performance management and operational delivery. Where we have the ability to increase activity in order to achieve our performance targets. We will do this as long as it does not create other areas of unacceptable risk in relation to quality, patient safety, workforce and finance. We will work with other acute providers, other health and social care agencies including the independent sector and voluntary services to deliver activity, day to day operations to safely achieve our performance targets.*

Image above shows our risk appetite

Risk profile

Our risk profile is described in section 2.2.2.2.

Quality governance

A revised Quality Governance Framework was approved by the Executive Team on 4 April 2022 and implemented on 5 September 2022 alongside the new operational management model. The Quality Governance Framework sets out a model that is supported by the alignment of a centralised team of Quality and Patient Safety Facilitators to the Clinical Service Unit (CSU) operational structure. These posts support the CSU managerial and leadership triumvirate in the same way that Finance and Human Resource Business

partners currently support CSUs. This ensures that all CSUs are supported equally, that quality governance arrangements are aligned to current national strategies and are fit for purpose to support the organisation as well as the revised regulation and commissioning arrangements as they develop. The current Framework is due for review in 2026/27.

The Quality Governance Framework seeks to ensure that CSUs are able to perform effectively, enabling clear information flow, escalation and accountability within the CSU and through to Board, and back to wards and departments. Monthly CSU Quality and Safety meetings have a standardised agenda and terms of reference based around the Care Quality Commission's 5 regulatory domains (Safe, Effective, Caring, Responsive and Well Led). The agenda includes a review of the CSU risk register, identifying new and emerging risks as well as a review of current mitigation and relating scores. The Trust's Quality Governance arrangements received 'significant assurance' from our internal auditors in July 2023. The review found that the Trust had an effective governance structure and accountability framework in place, commenting that there was clear connectivity between clinical services to corporate and executive functions, and ultimately to the Trust Board.

Management of risks to compliance with NHS provider licence section 4 (governance)

On 23 May 2024 the Trust was advised by NHS England of a change to the support segment category for the Trust from segment 2 to segment 3 of the NHS Oversight Framework. The letter explained that issues involving several members of the Trust Board had led to concerns escalating about the Board's collective ability to lead the Trust in delivering high quality patient care; and focus on the requirements for the 2024/25 NHS Planning round. In light of the issues facing the Trust and current governance concerns, NHS England determined that the Trust should be moved into support segment 3 with immediate effect. Further, on 6 June 2024, the Trust received a letter from NHS England setting out the actions required in response to this regulatory action.

The Board has worked closely with NHS England as part of the Integrated Quality Improvement Group and has made good progress in addressing the issues raised.

In line with the NHS Oversight Framework, enforcement undertakings have been agreed, as follows:

- review of board leadership and governance and subsequent implementation of any recommendations;
- co-operation with individuals selected or appointed by NHS England to support the Trust Board or executive leadership; and
- implementing sufficient governance arrangements to enable delivery of the undertakings.

NHS England has also imposed additional licence conditions on the Trust pursuant to section 111 of the Health and Social Care Act 2012. In particular, the additional licence conditions require the Trust to ensure it has in place the required leadership capacity and capability to deal with the issues facing the Trust and that the Council of Governors implements arrangements to ensure it discharges its role and responsibilities effectively, including holding non-executive directors to account and representing interests of members, the public and staff. The additional licence conditions were published on 15 August 2024.

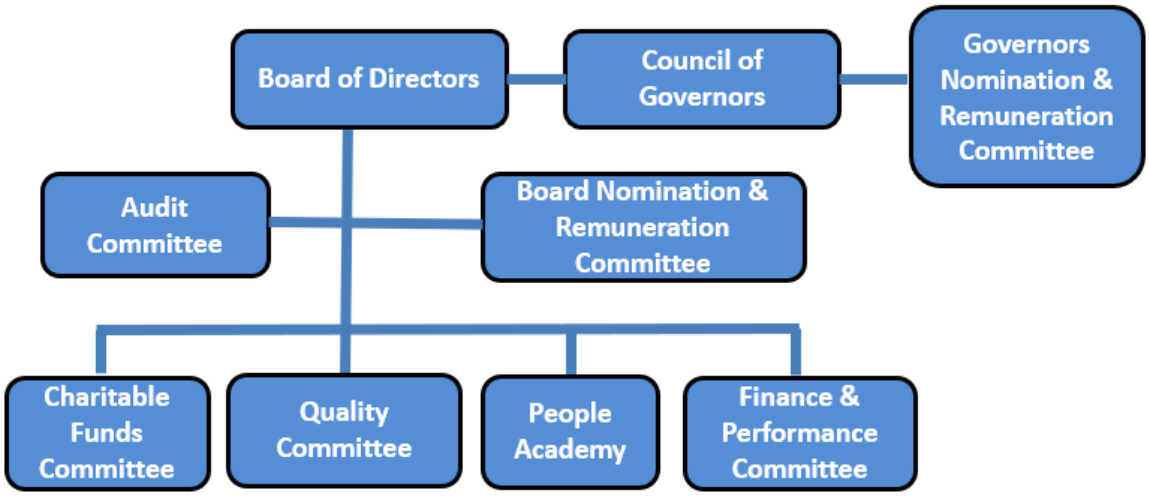
Compliance with the NHS provider licence is formally reviewed on an annual basis. This was last carried out by the Executive Management Team and reported to the Audit Committee and Board of Directors in May 2026. The Board agreed the outcome of the review which was that the Trust was compliant with all conditions of the licence, other than those for which NHS England has reported a suspected breach (NHS2.2, 2.4, 2.5(a), (b), (d)

and (f) and 2(6)). In respect of the additional licence condition, the Trust has complied with the regime put in place and continues to work with NHS England, reporting through to the Integrated Quality Improvement Group (IQIG). The Board and Council of Governors remain quorate with meetings taking place. An ongoing programme of board development is in place, and improvements have been made to governance arrangements during 2025/26 including board committees as part of effectiveness reviews. All investigations have been completed.

Compliance with the code of governance for NHS provider trusts is also formally reviewed on an annual basis. The review for 2025/26 concluded that the Trust is compliant with all provisions other than E2.2. Full information regarding these provisions is available within this annual report at section 3.5.1. (statement of compliance).

The current governance structure is outlined below.

Figure 57 – Governance Structure



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

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

The role of the **committees and academy** is to seek assurance, ensure learning and drive improvement in relation to their respective areas of responsibility. Three non-executive directors sit on each committee, one of whom acts as the Chair.
Quality Committee - the committee's role relates to all aspects of quality and is aligned to the NHS Patient Safety Strategy[78] and national quality standards. Several clinical working groups report to the Academy to provide assurance that safety, clinical outcomes, patient safety and patient experience across the Trust's services is compliant with national standards and the requirements of NHS regulators and commissioners of services.

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

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

Finance and Performance Committee – the committee'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, the effective management of all performance-related matters and estates and facilities functions. 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 Board receives a Chair's 'Alert, Advise, Assure' report and supporting documents from each of the committees, to provide assurance and enable issues to be escalated where required.

The Committees reviewed their effectiveness in March 2026 via a survey conducted live at each meeting. The outcome showed that most members felt that the meetings had improved over the previous 12 months and were clear on their role and the remit of the Committee. Suggestions for further improvement included introducing more in person meetings; reducing the number of attendees who are present for the full meeting to ensure best use of time, and that meetings are manageable and are focused on their role as a committee of the Board; providing more focused papers and better use of data; and ensuring the timeliness of papers. The feedback was aligned across the committees, and this will be taken forward during 2026/27.

Embedding risk management in the activity of the organisation

Risk management is embedded within the Trust at all levels, with risks being considered by specialties, clinical service units and corporate departments. This has been enhanced by the introduction of the revised Quality Governance Framework in 2022/23, as described above.

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.

I lead the Trust's executive team in developing positive relationships with stakeholder partners including the local authority, and other partner organisations across Bradford and across the region through the West Yorkshire Association of Acute Trusts (WYAAT) – an acute provider collaborative - 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 & Craven Partnership Board, Bradford District Wellbeing Board, the Health and Social Care Scrutiny Committee and Safeguarding Boards, as well as a range of other forums for service planning, performance and contracting.

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

Workforce and staffing assurance

On behalf of the Board, the People Academy seeks assurance that the Trust has robust workforce strategies and staffing processes that are safe, sustainable and effective. Reports are also presented to the Board to ensure that the information and discussions are open and transparent. Throughout 2025/26, the Academy has also received updates relating to the Trust's response to the NHS People Plan and updates on our nursing recruitment and retention plans.

The People Academy also receives a monthly report providing an update on the mandatory nurse and midwifery staffing data in line with the requirements outlined in both the Hard Truths (2013) and the subsequent National Quality Board Reports (2018). This information relates to the staffing levels in all inpatient wards including adult, children, and maternity. There are six monthly establishment reviews to ensure safe, effective and sustainable staffing in the right place, at the right time with the right skills. This is undertaken with consideration given to NHSE Professional judgement Framework for Safe Staffing.

CQC registration requirements

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

Register of interests

The Foundation Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS[79] guidance.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme[80], 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.

Equality and Diversity

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. I chair the organisation's Equality, Diversity and Inclusion Council which reports to the Trust Board.

Climate change

The Foundation Trust has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

[79] https://www.england.nhs.uk/long-read/managing-conflicts-of-interest-in-the-nhs/
[80] https://www.nhsbsa.nhs.uk/nhs-pensions

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

Financial Performance and Resource Management

The Trust is committed to responsible financial management and the efficient use of resources. Although we didn't achieve our financial targets for the 2025/26 financial year, we have worked hard to deliver the agreed revised position, implementing a number of mitigating actions, increasing grip and control across all areas of expenditure. We continue to adopt robust performance management practices alongside the implementation of targeted financial improvement initiatives to meet national and Integrated Care System (ICS) goals.

Effective Governance and Resource Management Tools

The Trust employs a comprehensive framework to ensure the economical, efficient, and effective use of resources. This framework includes:

- Monthly reporting: Regular finance and performance reports are presented to the Executive Team and the Finance and Performance Committee, complemented by a comprehensive finance and performance dashboard.
- Board oversight: The Board of Directors utilises an integrated dashboard alongside detailed reports to monitor key metrics. This allows for both general and exception-based management, supported by the BAF, which ensures the Trust prioritises effective resource utilisation.
- Transparent financial information sharing: The Trust proactively shares financial performance data and forecasts with relevant stakeholders, including NHS England/Improvement, the West Yorkshire Integrated Care Board, and the Bradford District and Craven Health & Care Partnership, monthly.

Strong Financial Controls and Risk Management

The Trust adheres to established guidelines, including the Standing Financial Instructions, performance management and accountability frameworks, and budgetary management frameworks. These frameworks emphasise budgetary control, efficient resource allocation, and sound financial management. Additionally, service development initiatives are implemented with appropriate financial safeguards.

Furthermore, the Trust maintains a risk-based three-year internal audit plan. During 2025/26, eight internal audits were conducted within the Finance Domain, with one receiving full assurance (working day one reporting), six receiving significant assurance (Sessional payments, Ward Level Stock, Estates Invoicing, Report Recommendations, Budgetary Framework, Capital Programme), and one receiving low assurance (Closing the Gap).

External Validation and Value for Money

Our external auditors independently assess the effectiveness of our resource management strategies. The most recent Value for Money review (June 2025, covering the 2024/25 financial year) identified a significant weakness concerning the Trust's governance arrangements, which was first reported in the 2023/24 audit. Last year the auditors recommended that management ensure that the Trust acts upon the recommendations made by NHS England and addresses any findings that may be made by the Care Quality Commission (CQC) when they report the results of their review.

Further to inspections undertaken between September and November 2025, the CQC published several reports. Neonatal Services were rated as 'Outstanding' overall, Maternity

Services improved to ‘Good’ overall, Well Led ‘Good’ overall and Community Health Inpatients services rated as ‘Good’ overall. Medical services at Bradford Royal Infirmary and St Luke’s Hospital were both rated as ‘Good’.

The Trust has worked closely with NHS England through regular Integrated Quality Improvement Group (IQIG) meetings since July 2024. The meetings have been positive, and good progress has been made to address governance concerns, including the implementation of a development plan for the Board and the Council of Governors, improvements to Board meetings and committee arrangements, and ongoing investigations have been progressed as quickly as possible. IQIG meetings had been taking place monthly, and this has now reduced to every other month due to the assurances provided and the progress made.

Cost Allocation and Quality Assurance

The Trust adheres to cost allocation and charging requirements outlined by HM Treasury and the Office of Public Sector Information. To safeguard patient care quality, cost-improvement initiatives, developed through clinical service units and departmental structures, undergo a Trust-approved quality impact assessment. Low-risk initiatives undergo review by a multi-disciplinary team chaired by the Deputy Chief Medical Officer to confirm the absence of unintended consequences.

3.8.7 Information Governance

During the last financial year, the organisation has had 2 externally reportable incidents where personal data has been compromised. That is, high risk information governance incidents that have been reported to the Information Commissioner’s Office (ICO). No action has been taken against the Trust.

When an incident (data breach) of this type occurs the Senior Information Risk Owner (SIRO) and Caldicott Guardian are fully briefed, and any recommendations from the ICO are taken on board. In the event of notification of any action that is planned by the ICO as a result of the incident all senior individuals involved are fully briefed and actions agreed in close liaison with the ICO and taking advice from the Trust Data Protection Officer. Staff awareness around information governance, plus training and awareness, is strong and helps to reduce information risk and avoid data breaches.

Details of data security and protection incidents (personal data breaches or information governance incidents) are set out below. This includes any externally reportable incidents and all incidents classified at lower-level security to 31 March 2026.

Figure 58 - Personal data breaches reported to ICO 2025/26

Date of incident (month)	Nature of incident	Nature of Data involved	Number of Data subjects potentially affected	Notification steps
April 2025 IRIS 30751 ICO 42116	Unauthorised Disclosure	Personal	3	Reported to ICO, no action taken
May 2025 IRIS 19486 ICO 42306	Unauthorised Loss	Personal	>100	Reported to ICO, no action taken. Documents were recovered.

Figure 59 - Other personal data incidents 2025/26

Category	Breach type (ICO categorisation)	Total number of incidents in this category	
Confidentiality	Unauthorised or accidental disclosure	91	Data emailed to wrong recipient
		63	Data posted to wrong recipient
		8	Failure to redact data
		16	Verbal disclosures
		27	Accessing records.
		2	Cyber security misconfiguration (e.g. inadvertent publishing of data on website; default passwords
Availability	Unauthorised or accidental loss	17	Loss or theft of paperwork
		4	Data left in insecure location
Availability	Unauthorised or accidental destruction	0	Insecure disposal of paperwork
Integrity	Unauthorised or accidental alteration	7	Other principle seven failure (information incorrect on patient record)

3.8.8 Data Quality and Governance

We have ensured that there are systems and processes in place for the collection, recording, analysis, and reporting of data. Robust controls are in place to continually evaluate data and ensure it remains accurate, valid, dependable, 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 crucial to enable the right decisions to be made regarding patient care. To support this objective within the last twelve months we have developed a Clinical Coding Strategy. To improve the documentation of information within patients records across all our clinical systems.

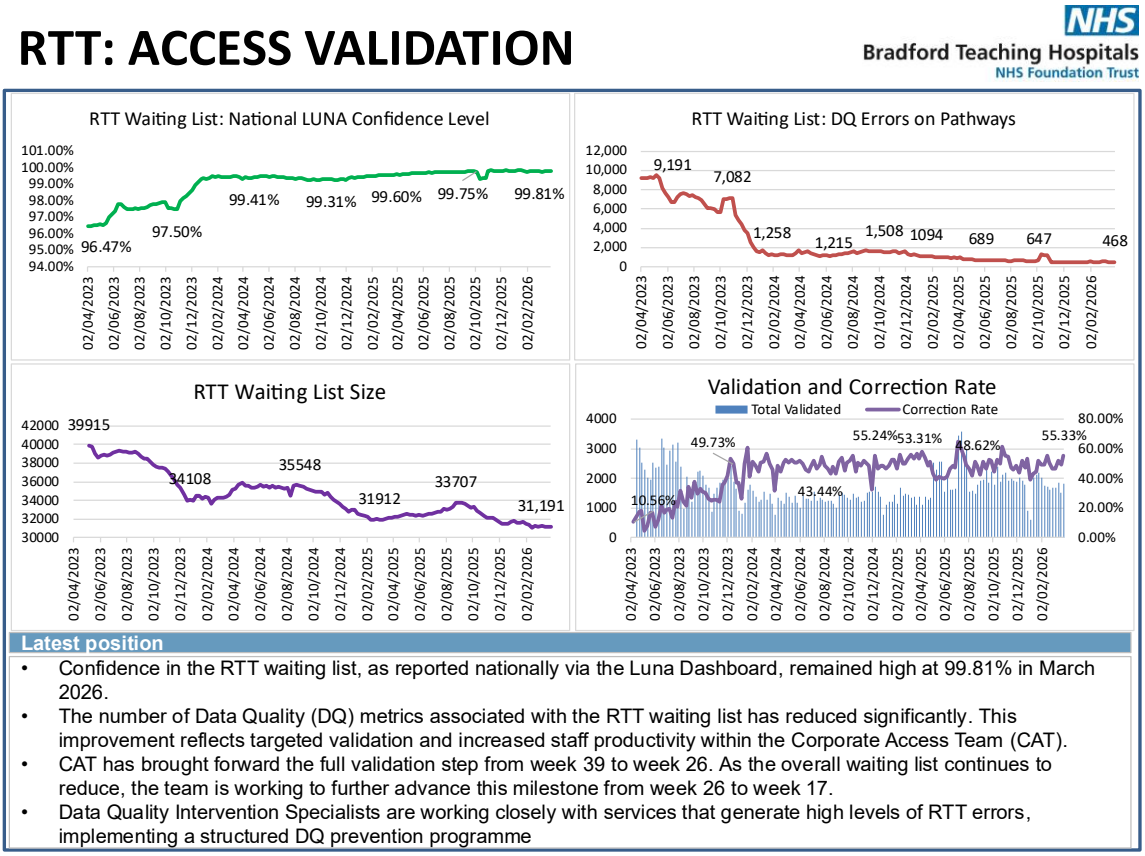
Delivery of the coding strategy is a multi-disciplinary approach, and the clinical voice is represented via the Chief Clinical Information Officer and the Chief Nursing Information Officer. Progress on improvement is monitored via the digital strategy group and the quality committee.
This approach provides focus to ensure there is 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.

It is particularly important for us to assure the quality and accuracy of elective waiting time and patient pathway 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 an application that provides near real time waiting list validation for Access colleagues, service sign-off processes for mandatory reports, and meaningful engagement with services in validation and development. We are applying Making Data Count principles to Board reports and an all-user accessible Insights Centre by using clear, meaningful data

visualisations, reducing reliance on tables, and providing real-time insights to encourage ownership, engagement, and informed decision-making across all levels of the organisation.

Figure 60 - Shows positive progress in relation to waiting list management



Priority data quality issues are monitored through a suite of exception reports and an associated tracking and resolution system, which represents anomalies to operational teams to support visibility, proactive management and timely resolution. A further suite of data quality dashboards targeting specific data quality issues is currently in development. Oversight of data quality has transitioned to the Trust's Digital Strategy Group consisting of subject matter expertise from operational, clinical, informatics and business intelligence teams.

There is an increased organisational focus on improving data capture to support the Trust's recovery programme over the next three years. Accurate and timely recording of activity is a key priority, underpinning service planning, performance management and patient care. Work is underway to strengthen data capture processes at the point of care, with an emphasis on consistency, completeness and real-time validation to meet the NHS 10-year plan requirements for the effective tracking of conditions across systems.

The Maternity Data Quality Committee meets monthly to review data completeness and reporting, ensuring compliance with national and regional requirements while driving improvements in patient and safety experience. A similar framework of metrics and governance is being embedded following the Theatres, Anaesthetics and Critical Care (TACC) Electronic Patient Record (EPR) solution go-live.

Formal education and training programmes continue to support the effective use of key information systems for both new starters and existing staff. The Data Quality team remains

available for administrative and clinical staff, providing a forum to raise issues and focus on priorities relating to error prevention, correction and validation at an operational level.

3.8.9 REVIEW OF EFFECTIVENESS

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

In support of this:

- The final Head of Internal Audit Opinion on the effectiveness of the system of internal control was presented to the Trust's Audit Committee on 17 June 2026. The overall opinion for the 2025/26 reporting period is as follows – 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 low to high assurance. For each internal audit report where a low or limited assurance opinion is given, the executive director responsible is asked to attend the Audit Committee to discuss the action being taken as a result of the audit. For all internal audit reports, detailed lists of prioritised recommendations are agreed, and the implementation of these recommendations is followed up by internal audit and reported to the Audit Committee.
- The BAF and risk registers provide me with assurance of the effectiveness of the controls being used to manage the risks to the organisation in achieving its strategic objectives and that they have been regularly reviewed. The internal audit of the BAF carries an opinion of limited assurance and actions are already in place to address the recommendations made.
- Using an integrated dashboard the Board and its Committees routinely review contemporaneous and quality assured data in relation to quality, finance, performance and workforce.
- The Audit Committee reviews the system of integrated governance, risk management and internal control, across the whole of the organisation's activities – both clinical and non-clinical. The committee maintains an oversight of general risk management structures and ensures appropriate information flows to the Audit Committee in relation to the Trust's overall internal control and risk management position. In carrying out this work, the Committee primarily utilises the work of internal audit, external audit and other assurance functions, but it is not limited to these audit and assurance functions. It also seeks reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.
- The CQC undertook a well-led inspection in November 2025 at which the Trust was rated as 'good' overall. An action plan has been developed and will be monitored by the Board.
- The Board and its Committees have continued to function in line with its legal and regulatory requirements and meetings have continued to take place and have been quorate.

- The Trust has fully engaged in the Integrated Quality Improvement Group process with NHS England and has made good progress in addressing the enforcement undertakings.
- The Trust has continued to perform strongly operationally in comparison to its peers and is within the top quartile of Trusts nationally in relation to several performance targets.
- In the 2025 staff survey we scored above the national average on all the People Promise elements and themes, and sub-themes. Comparing results from 2024 to 2025, four themes have increased positively (we are always learning, we work flexibly, engagement and morale), one remains the same (we are safe and healthy) and four have slightly decreased since 2024, although the report states that these changes are not statistically significant.

Conclusion

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

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

Professor Mel Pickup
Chief Executive
26th June 2026

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 Code of Governance for NHS Provider Trusts and the additional requirements of the NHSE Annual Reporting Manual are listed below along with the section identifying where they are located within this Annual Report.

Relating to	Code section	Summary of requirement	Section reference within the annual report
Board	A.2.1	The board of directors should assess the basis on which the trust ensures its effectiveness, efficiency and economy, as well as the quality of its healthcare delivery over the long term, and contribution to the objectives of the ICP and ICB, and place-based partnerships. The board of directors should ensure the trust actively addresses opportunities to work with other providers to tackle shared challenges through entering into partnership arrangements such as provider collaboratives. The trust should describe in its annual report how opportunities and risks to future sustainability have been considered and addressed, and how its governance is contributing to the delivery of its strategy.	2.1.3 3.8.6
Board	A.2.3	The board of directors should assess and monitor culture. Where it is not satisfied that policy, practices or behaviour throughout the business are aligned with the trust's vision, values and strategy, it should seek assurance that management has taken corrective action. The annual report should explain the board's activities and any action taken, and the trust's approach to investing in, rewarding and promoting the wellbeing of its workforce.	2.1.3 2.1.5 2.1.8 2.2.2
Board	A.2.8	The board of directors should describe in the annual report how the interests of stakeholders, including system and place-based partners, have been considered in their discussions and decision-making, and set out the key partnerships for collaboration with other providers into which the trust has entered. The board of directors should keep engagement mechanisms under review so that they remain effective. The board should set out how the organisation's governance processes oversee its collaboration with other organisations and any associated risk management arrangements.	2.1.3 2.1.5 2.2.2 3.5.4 3.8 3.8
Board	B.2.6	The board of directors should identify in the annual report each non-executive director it considers to be independent. Circumstances which are likely to impair, or could appear to impair, a non-executive director's independence include, but are not limited to, whether a director: • has been an employee of the trust within the last two years • has, or has had within the last two years, a material business relationship with the trust either directly or as a partner, shareholder, director or senior employee of a body that has such a relationship with the trust • has received or receives remuneration from the trust apart from a director's fee, participates in the trust's performance-related pay scheme or is a member of the trust's pension scheme • has close family ties with any of the trust's advisers, directors or senior employees • holds cross-directorships or has significant links with other directors through involvement with other companies or bodies • has served on the trust board for more than six years from the date of	3.1.1

Relating to	Code section	Summary of requirement	Section reference within the annual report
		their first appointment • is an appointed representative of the trust's university medical or dental school. Where any of these or other relevant circumstances apply, and the board of directors nonetheless considers that the non-executive director is independent, it needs to be clearly explained why.	
Board	B.2.13	The annual report should give the number of times the board and its committees met, and individual director attendance.	3.1.1
Chair/Council of Governors	B.2.17	For foundation trusts, this schedule 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 the board, the council of governors, board committees and the types of decisions which are delegated to the executive management of the board of directors.	3.5.4
Board	C.2.5	If an external consultancy is engaged, it should be identified in the annual report alongside a statement about any other connection it has with the trust or individual directors.	3.2.3.2
Nomin ations Commit tee(s)	C.2.8	The annual report should describe the process followed by the council of governors to appoint the chair and non-executive directors. The main role and responsibilities of the nominations committee should be set out in publicly available written terms of reference.	3.2.3.3
Board	C.4.2	The board of directors should include in the annual report a description of each director's skills, expertise and experience.	3.1.1
Board	C.4.7	All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	3.1.1
Nominations Committee(s)	C.4.13	The annual report should describe the work of the nominations committee(s), including: • the process used in relation to appointments, its approach to succession planning and how both support the development of a diverse pipeline • how the board has been evaluated, the nature and extent of an external evaluator's contact with the board of directors and individual directors, the outcomes and actions taken, and how these have or will influence board composition • the policy on diversity and inclusion including in relation to disability, its objectives and linkage to trust vision, how it has been implemented and progress on achieving the objectives • the ethnic diversity of the board and senior managers, with reference to indicator nine of the NHS Workforce Race Equality Standard and how far the board reflects the ethnic diversity of the trust's workforce and communities served • the gender balance of senior management and their direct reports.	3.2.1 3.2.3.2 3.2.3.3 3.4.7 3.5.4
Chair/Council	C.5.15	Foundation trust governors should canvass the opinion of the trust's	3.5.4

Relating to	Code section	Summary of requirement	Section reference within the annual report
of Governors		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.	
Audit Committee	D.2.4	The annual report should include: • the significant issues relating to the financial statements that the audit committee considered, and how these issues were addressed • an explanation of how the audit committee (and/or auditor panel for an NHS trust) has assessed the independence and effectiveness of the external audit process and its approach to the appointment or reappointment of the external auditor; length of tenure of the current audit firm, when a tender was last conducted and advance notice of any retendering plans • where there is no internal audit function, an explanation for the absence, how internal assurance is achieved and how this affects the external audit • an explanation of how auditor independence and objectivity are safeguarded if the external auditor provides non-audit services.	3.1.1 3.5.5 3.8.6 3.8.9
Board	D.2.6	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, is fair, balanced and understandable, and provides the information necessary for stakeholders to assess the trust's performance, business model and strategy.	3.1.1 3.7
Board	D.2.7	The board of directors should carry out a robust assessment of the trust's emerging and principal risks. The relevant reporting manuals will prescribe associated disclosure requirements for the annual report.	3.8.5
Board	D.2.8	The board of directors should monitor the trust's risk management and internal control systems and, at least annually, review their effectiveness and report on that review in the annual report. The monitoring and review should cover all material controls, including financial, operational and compliance controls. The board should report on internal control through the annual governance statement in the annual report.	3.8.3 3.8.5
Board	D.2.9	In the annual accounts, the board of directors should state whether it considered it appropriate to adopt the going concern basis of accounting when preparing them and identify any material uncertainties regarding going concern. Trusts should refer to the DHSC group accounting manual and NHS foundation trust annual reporting manual which explain that this assessment should be based on whether a trust anticipates it will continue to provide its services in the public sector. As a result, material uncertainties over going concern are expected to be rare.	2.1.6
Board/ Remuneration Committee	E.2.3	Where a trust releases an executive director, e.g. to serve as a non-executive director elsewhere, the remuneration disclosures in the annual report should include a statement as to whether or not the director will retain such earnings.	n/a
Chair/Council	Appendix B,	The annual report should identify the members of the council of	3.5.4

Relating to	Code section	Summary of requirement	Section reference within the annual report
of Governors	para 2.3 (not in Schedule A)	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.	
Chair/Council of Governors	Appendix B, para 2.14 (not in Schedule A)	The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	3.5.4
Board	Appendix B, para 2.15 (not in Schedule A)	The board of directors should state in the annual report the steps it has 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, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	3.5.4
Chair/Council of Governors	Additional requirement of FT ARM resulting from legislation	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

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2026

Bradford Teaching Hospitals NHS Foundation Trust

Annual Accounts

for the year ended 31 March 2026

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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 2026 and of the Foundation Trust's income and expenditure for the year then ended;
- have been properly prepared in accordance with the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

We have audited the financial statements which comprise:

- the Statement of Comprehensive Income;
- the Statement of Financial Position;
- the Statement of Changes in Taxpayers' Equity;
- the Statement of Cash Flows; and
- the related notes 1 to 23.

The financial reporting framework that has been applied in their preparation is applicable law and the accounting requirements of the Department of Health and Social Care Group Accounting Manual, as directed by NHS England.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)), the Code of Audit Practice issued by the Comptroller & Auditor General 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 Department of Health and Social Care Group Accounting Manual which require entities to adopt the going concern basis of accounting in the preparation of the financial statements where it is anticipated that the services which they provide will continue into the future.

Other information

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

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

We have nothing to report in this regard.

Responsibilities of accounting officer

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

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

Auditor's responsibilities for the audit of the financial statements

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

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

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

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, 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 irregularities, including those that are specific to the National Health Service and public sector.

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; and
- 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 area, and our specific procedures performed to address it is described below:

- the completeness and timing of recognition of liabilities at the year-end is subject to potential management bias - we tested a sample of post year-end payments and invoices to test whether items representing liabilities at 31 March 2026 had been appropriately recognised; and we performed analytical review of accruals and provisions to identify significant movements in these balances from prior year.

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

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

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

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 in all material respects; 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.

We have nothing to report in respect of this matter.

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 Auditor Guidance Notes issued by the Comptroller & Auditor General, 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 2026 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

As at the date of this audit report, we have not yet completed our work in respect of the Trust's consolidation returns for the year ended 31 March 2026 and have not received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete.

In accordance with Auditor Guidance Note 07, we are therefore unable to certify that we have completed our audit of Bradford Teaching Hospitals NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of the National Health Service Act 2006 and the National Audit Office Code of Audit Practice. We are satisfied that our remaining work in this area is unlikely to have a material impact on the financial statements.

Use of our report

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

Nicola Wright

Nicola Wright (Key Audit Partner)
For and on behalf of Deloitte LLP
Appointed Auditor
Newcastle upon Tyne, United Kingdom
26 June 2026

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2026 have been prepared by Bradford Teaching Hospitals NHS Foundation Trust (the NHS foundation trust) in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed:

Name: Mel Pickup (Chief Executive)
Dated: 26/06/2026

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2026

	Note	2025/26 £000	2024/25 £000
Operating income from patient care activities	3.1	604,050	570,866
Other operating income	3.1	82,897	85,992
Operating expenses	4.1	(720,294)	(666,883)
OPERATING DEFICIT		**(33,347)**	**(10,025)**
FINANCE COSTS			
Finance income	6	1,946	3,025
Finance expense	7.1	(468)	(497)
Public Dividend Capital dividends payable		(6,726)	(5,711)
NET FINANCE COSTS		**(5,248)**	**(3,183)**
Other gains / (losses)	7.2	1	(250)
Share of profit of associates / joint ventures	11	158	160
DEFICIT FOR THE YEAR		**(38,438)**	**(13,298)**
Other comprehensive income **Will not be reclassified to income and expenditure:**			
Impairment losses	4.4	(1,737)	(1,380)
Revaluation gains	9.1	1,058	396
Total other comprehensive income for the period		**(679)**	**(984)**
TOTAL COMPREHENSIVE EXPENDITURE FOR THE YEAR		**(39,117)**	**(14,282)**

All income and expenses shown relate to continuing operations.

The notes on pages 13 to 55 form part of these accounts.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2026

	Note	31 Mar 2026 £000	31 Mar 2025 £000
Non-current assets			
Intangible assets	8.1	11,698	10,418
Property, plant and equipment	9.2, 9.4	271,898	254,083
Right of use assets	10.1	7,312	7,997
Investments in associates and joint ventures	11	313	299
Trade and other receivables	13.1	2,220	1,962
Total non-current assets		**293,441**	**274,759**
Current assets			
Inventories	12	11,340	11,561
Trade and other receivables	13.1	24,605	19,609
Cash and cash equivalents	18.1	25,849	31,857
Total current assets		**61,794**	**63,027**
Current liabilities			
Trade and other payables	14	(75,129)	(72,603)
Borrowings	16.1	(1,073)	(1,075)
Lease liabilities	16.1	(1,349)	(1,294)
Provisions	17.1	(3,269)	(2,865)
Other liabilities	15	(15,976)	(11,433)
Total current liabilities		**(96,796)**	**(89,270)**
Total assets less current liabilities		**258,439**	**248,516**
Non-current liabilities			
Borrowings	16.1	(8,428)	(9,480)
Lease liabilities	16.1	(5,869)	(6,867)
Provisions	17.1	(2,961)	(3,351)
Other liabilities	15	0	0
Total non-current liabilities		**(17,258)**	**(19,698)**
Total assets employed		**241,181**	**228,818**
Financed by taxpayers' equity			
Public Dividend Capital		259,802	208,322
Revaluation reserve		35,803	37,791
Income and expenditure reserve		(54,424)	(17,295)
Total taxpayers' equity		**241,181**	**228,818**

These accounts together with notes on pages 13 to 55 were approved by the Board of Directors on 24 June 2026.

Signed:

Name: Mel Pickup (Chief Executive)
Dated: 26/06/2026

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2026

	Total £000	Public Dividend Capital £000	Revaluation reserve £000	Income and expenditure reserve £000
Taxpayers' equity at 1 April 2025	**228,818**	**208,322**	**37,791**	**(17,295)**
(Deficit) for the year	**(38,438)**	0	0	(38,438)
Other transfers between reserves	**0**	0	(1,309)	1,309
Net impairments	**(1,737)**	0	(1,737)	0
Revaluations – property, plant and equipment	**1,058**	0	1,058	0
Public Dividend Capital received	**51,480**	51,480	0	0
Taxpayers' equity at 31 March 2026	**241,181**	**259,802**	**35,803**	**(54,424)**
Taxpayers' equity at 1 April 2024	**223,299**	**188,522**	**40,009**	**(5,232)**
(Deficit) for the year	**(13,297)**	0	0	(13,297)
Other transfers between reserves	**0**	0	(1,234)	1,234
Net impairments	**(1,380)**	0	(1,380)	0
Revaluations – property, plant and equipment	**396**	0	396	0
Public Dividend Capital received	**19,800**	19,800	0	0
Taxpayers' equity at 31 March 2025	**228,818**	**208,322**	**37,791**	**(17,295)**

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 NHS trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the NHS foundation trust, is payable to the DHSC as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating expenditure. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

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

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2026

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating (deficit)		(33,347)	(10,025)
Non-cash income and expense			
Depreciation and amortisation	4.1	20,609	19,650
Net impairments	4.4	21,057	8,559
Income recognised in respect of capital donations (cash and non-cash)	3.1	(756)	(669)
(Increase) / decrease in trade and other receivables	13.1	(4,415)	2,096
Decrease / (increase) in inventories	12	221	(1,547)
(Decrease) in trade and other payables	14	(4,572)	(4,887)
Increase / (decrease) in other liabilities	15	4,543	(1,909)
(Decrease) in provisions	17	(48)	(3,931)
Net cash flows from operating activities		**3,292**	**7,337**
Cash flows from investing activities			
Interest received		1,761	3,025
Proceeds from sales joint ventures		144	149
Purchase of intangible assets		(4,645)	(5,028)
Purchase of property, plant and equipment		(48,176)	(48,785)
Sale of property, plant and equipment		0	101
Initial direct costs or up front payments in respect of new right of use asset (lessee)	10.1	(340)	0
Receipt of cash donations to purchase capital assets	9.1	658	584
Net cash flows used in investing activities		**(50,598)**	**(49,954)**
Cash flows from financing activities			
Public Dividend Capital received		51,480	19,801
Repayment of loans to the DHSC	16.2	(1,052)	(3,052)
Capital element of lease liability repayments	16.2	(1,326)	(1,289)
Interest paid on DHSC loans	16.2	(202)	(240)
Interest element of lease liability repayments	16.2	(207)	(211)
Public Dividend Capital dividend paid		(7,395)	(4,689)
Net cash flows from financing activities		**41,298**	**10,320**
Decrease in cash and cash equivalents		(6,008)	(32,297)
Cash and cash equivalents at 1 April		31,857	64,154
Cash and cash equivalents at 31 March	18.1	**25,849**	**31,857**

NOTES TO THE ACCOUNTS

Note 1 Accounting policies and other information

NHS England has directed that the financial statements of all NHS foundation trusts shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (DHSC GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DHSC GAM 2025/26 issued by the DHSC. The accounting policies contained in the DHSC GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the DHSC GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS foundation trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 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 Consolidation

NHS Charitable Fund

The Trust is the Corporate Trustee to Bradford Hospitals Charity NHS Charitable Fund (the Charity). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to, or has rights to, variable returns and other benefits for itself, patients and staff from its involvement with the charitable fund and has the ability to affect those returns and other benefits through its power over the fund. 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.

The NHS foundation trust has not consolidated the financial statements of the Charity on the grounds of materiality.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102.

Joint Venture

Joint Ventures are arrangements in which the NHS foundation trust has joint control with one or more other parties, and has the rights to the assets, and obligations for the liabilities, relating to 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.

1.4 Income

Revenue from contracts with customers

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

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

Fixed income from commissioners is received in the month that performance obligations are delivered. All other activity is invoiced in arrears based on 30 day credit terms.

Revenue from NHS contracts

The main source of income for the NHS foundation trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the NHS foundation trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to NHS trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The NHS foundation trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under this scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the fixed element of API contracts and paid in line with actual activity performed. Additional payments for specialised services reflecting patient complexity are included within the fixed element of API contracts. This is accounted for as variable consideration under IFRS 15.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

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. For these contracts income is recognised in line with expenditure incurred to deliver the performance obligation. 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 24.62% (2024/25: 24.45%).

Grants and donations

Government grants are grants from government bodies other than income from NHS 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 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. Total apprentice service income for 2025/26 was £1,184,000 (2024/25: £1,238,000). Where these funds are paid directly to an accredited training provider from the NHS foundation trust's apprenticeship service 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 a 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 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 or an increase in inventory.

1.7 Insurance contracts

An insurance contract is a contract under which the Trust has accepted significant pre-existing insurance risk from the policyholder by agreeing to compensate the policyholder if a specified uncertain future event adversely affects the policyholder. The NHS foundation trust does not hold any insurance contract in either 2025/26 or 2024/25.

1.8 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised where:

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

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

Subsequent expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset, when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income (SoCI) in the period in which it is incurred.

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (i.e. 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 is defined as market value except where a building is so specialised in nature no active market exists from which to draw satisfactory transactional evidence. In this case a valuer will adopt a depreciated replacement cost (DRC) model on a modern equivalent asset (MEA) basis.

A DRC model estimates current value in existing use 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. 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 valued on an alternative site basis where this would meet the location requirements.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

For non-operational properties, including surplus land, the valuations are carried out at open market value. Any new building construction or an enhancement to an existing building or building related expenditure of greater than, or equal to, £1,000,000 will necessitate a formal impairment valuation.

Depreciation

Items of property, plant and equipment are depreciated on a straight line basis over their useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land

is considered to have an infinite life and is not depreciated.

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction 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 Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment. In 2025/26 the impairment is £22,794,000 and in 2024/25 there was an impairment of £9,939,000.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

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

De-recognition

Assets, intended for disposal, are reclassified as 'Held for Sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

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

Donated, government grant and other grant funded assets

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

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

Useful lives of property, plant and equipment

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

	Min life Years	Max life Years
Land	-	-
Buildings, excluding dwellings	20	60
Dwellings	25	31
Plant & machinery	5	15
Transport equipment	7	7
Information technology	4	10
Furniture & fittings	7	10

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the NHS foundation trust. They are capable of being sold separately from the rest of the NHS foundation trust's business or arise from contractual or other legal rights. Intangible assets 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 where it meets the recognition criteria.

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. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve. As there was no balance requiring transfer from the revaluation reserve on 1 April 2025, no movement has been recognised.

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

Impairments

Where indicators of impairment exist, the recoverable amount is assessed as the higher of its fair value and the cost to replace the service capacity. Where this is lower than the carrying value an impairment

is recognised in expenditure. The recoverable amount of intangible assets under construction is assessed annually, irrespective of indicators of impairment.

Amortisation

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

Useful lives reflect the total life of an asset and not the remaining life of an asset. The only intangible assets held by the NHS foundation trust are software licences which have useful lives between 2 and 10 years.

1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of pharmacy inventories is measured using weighted average historical cost method. The cost of other inventories is measured using the First In First Out (FIFO) method.

1.11 Cash and cash equivalents

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

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

1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the NHS foundation trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The DHSC GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS foundation trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs, i.e. when receipt or delivery of the goods or services is made.

Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the DHSC, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets the NHS foundation trust recognises an allowance for expected credit losses.

The NHS foundation trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are calculated by applying a rolling 3 year average write off percentage against Non-NHS aged debt. The write off percentage for each financial year is based upon the total invoice written off against total invoices raised in the respective financial year. This approach is applied to a number of income streams to capture their different risk profiles.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the NHS foundation trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.13 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The NHS foundation trust does not apply lease accounting to new contracts for the use of intangible assets.

The NHS foundation trust determines the term of the lease with reference to the non-cancellable period and any options to extend or terminate the lease which the NHS foundation trust is reasonably certain to exercise.

The NHS foundation trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the NHS foundation trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the NHS foundation trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The NHS foundation trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the NHS foundation trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The NHS foundation trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The NHS foundation trust as a lessor

The NHS foundation trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the NHS foundation trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance leases

The NHS foundation trust does not currently hold finance leases.

Operating leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

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 post-employment benefits discount rate of 2.95% in real terms (2024/25: 2.40%). Discounted clinical pension provision disclosures are shared annually by NHS England.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHS Resolution, which, in return, settles all clinical negligence claims. Although the NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHS Resolution on behalf of the NHS foundation trust is disclosed at note 17 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 20 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 20. 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/guidance-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 outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of 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 Trust considers that it does not have a liability to Corporation Tax for the year ended 31 March 2026. Under sections 985 and 986 of the Corporation Tax Act 2010, NHS Foundation Trusts are classified as *health service bodies* and are therefore specifically exempt from Corporation Tax on their core activities.

The Trust has reviewed its activities during the financial year and confirms that it has not undertaken any commercial activities that would fall outside this statutory exemption.

1.19 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.

1.20 Foreign exchange

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

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

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

- monetary items are translated at the spot exchange rate on 31 March 2026;
- non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction; and
- non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

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

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

1.21 Third party assets

Assets belonging to third parties in which the NHS foundation trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in note 18.1 to the accounts in accordance with the requirements of HM Treasury's FReM.

1.22 Losses and special payments

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

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

1.23 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements

The Standard has been adopted by the UK Endorsement Board to be effective for accounting periods beginning on or after 1 January 2027. The Standard has not yet been adopted by the FReM and early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability: Disclosures

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

Changes to valuation of property, plant and equipment (PPE) assets

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £209,437,000 as at 31 March 2026.

The current accounting policy for property assets measures the cost of replacing the service potential using a 'modern equivalent asset'. This policy is not changing. In deriving the modern equivalent asset, the Trust and its valuers currently adopt an 'alternative site' assumption for some of its specialised buildings, meaning the replaced service potential may be in a different location. The option of using this assumption is being withdrawn for NHS bodies from 1 April 2028. Therefore the hypothetical modern equivalent asset will change to be located on current sites in asset valuations from 2028/29. Assets valued on an alternative site basis have a total book value of £179,138,000 at 31 March 2026.

1.25 Critical accounting judgements

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the NHS foundation trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements:

Valuation of land and buildings

The valuation of land and buildings has been identified as a critical accounting judgement. The valuation is provided by an independent valuer, Cushman & Wakefield, who have applied the modern equivalent asset valuation. This assumes that rather the NHS foundation trust would rebuild the hospital to a modern design that is significantly different than the existing estate. The modern equivalent is based on a single site and has a more efficient use of space due to technological advances in plant and machinery or reduced operational use. The rebuild cost reflects improvements to the estate such as the need to meet current energy efficiency standards and consideration of flood risk.

1.26 Sources of estimation uncertainty

The following are assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

i. The NHS foundation trust hold a number of provisions where the actual outcome may vary from the amount recognised in the financial statements. Provisions are based on the most reliable evidence available at the year-end, however by their nature they are a matter of estimation. Provisions that carry a high degree of uncertainty include those relating to legal settlements yet to be finalised. These include employment tribunals, claims relating to employee contracts and third party and employee liability claims. Details surrounding provisions held at the year-end are included in Note 17 Provisions. Uncertainties and issues arising from provisions and contingent liabilities are assessed and reported in Note 17 Provisions and Note 20 Contingent liabilities / assets. As at 31 March 2026 provisions amounted to £6,230,000 (31 March 2025: £6,216,000) and contingent liabilities amounted to £90,000 (31 March 2025: £67,000).

ii. When accounting for lease agreements the NHS foundation trust has applied a deemed life where appropriate to estimate the period for which the lease will be in place. This can include assumptions around taking up contractual extension periods or estimating the period a lease will be in place for a rolling contract. The total liability arising for these lease arrangements as at 31 March 2026 amounted to £7,218,000 (31 March 2025: £8,161,000).

iii. The valuation of the NHS foundation trust's estate is based on reports from a Chartered Surveyor on a five-year rolling basis. The last full valuation was carried out at 31 March 2023. Desktop valuations are used to update the valuation in the intervening period. These property valuations and useful economic lives are based on the Royal Institute of Chartered Surveyors valuation standards. The valuation indices include estimates for building costs including materials and adjustments for local market values. The net book value of the NHS foundation trust's land, buildings and dwellings as at 31 March 2026 was £194,964,000 (31 March 2025: £170,634,000). For every 5% change, the valuation could differ by £8,500,000, with a consequent effect on the PDC dividend payable which is charged at 3.5% of the average balance of relevant net assets.

Note 2 Operating Segments

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 NHS foundation trust wide level. The Board of Directors is presented with information on clinical divisions but this is not the primary way in which financial matters are considered.

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

To effectively manage financial performance the Board of Directors review organisation wide income and expenditure, cash, liquidity and capital programme delivery against an approved annual plan. The Board of Directors also review operational performance including waiting lists, achievement of the emergency care standard, length of stage and bed occupancy.

Note 3 Operating income

Note 3.1 Income from patient care (by nature)

	Note	2025/26 £000	2024/25 £000
Income from activities			
Income from commissioners under API contracts element[1]		512,509	481,955
High cost drugs income from commissioners		59,281	56,872
Other NHS clinical income		3,309	3,128
Private patient income		271	342
Agenda for change pay award central funding[2]		0	1,323
Additional pension contribution central funding[3]		26,591	25,121
Other clinical income	3.2	2,089	2,125
Total income from activities		**604,050**	**570,866**
Other operating income from contracts with customers			
Research and development		14,209	21,469
Education and training		31,674	28,758
Income in respect of employee benefits accounted for on a gross basis	3.4	5,689	6,948
Other income	3.5	19,141	17,641
Other non-contract operating income			
Research and development (non-contract)		9,325	8,704
Education and training – notional income from apprenticeship fund		1,184	1,238
Receipt of capital grants and donations		756	669
Charitable and other contributions to expenditure		471	158
Revenue from operating leases	3.8	448	407
Total other operating income		**82,897**	**85,992**
Total		**686,947**	**656,858**

[1]Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 National Tariff payment systems documents. NHS England » 2025/26 NHS Payment Scheme

[2]Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

[3]Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

Note 3.2 Other clinical income

Other clinical income of £2,089,000 (2024/25: £2,125,000) in the main comprises Road Traffic Accident (RTA) income £1,323,000 (2024/25: £1,097,000), cystic fibrosis £244,000 (2024/25: £245,000), and income from overseas patients £521,000 (2024/25: £779,000).

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2025/26 £000	2024/25 £000
Income recognised this year	521	779
Cash payments received in-year	64	30
Amounts added to provision for impairment of receivables	476	507
Amounts written off in-year	431	263

Note 3.4 Income in respect of employee benefits accounted for on a gross basis

	2025/26 £000	2024/25 £000
Provider to provider income[1]		
Calderdale and Huddersfield NHS Foundation Trust	459	501
Airedale NHS Foundation Trust	1,975	1,819
Individual posts and services:		
Leeds Teaching Hospitals NHS Trust	314	318
Bradford District Care Trust	616	606
Other hospitals across Yorkshire	146	498
Funding for other initiatives		
West Yorkshire ICB	107	505
DHSC and NHS England	119	235
Non-NHS organisations including MacMillian Cancer Support and Marie Curie Hospice for doctors, nurses, Allied Health Professionals and administrative staff	1,953	2,466
Total	**5,689**	**6,948**

[1]Provider to provider income relates to services provided by the NHS foundation trust to other NHS trusts or commissioners. Income recorded under this heading relates to Oral Surgery work, Ear, Nose and Throat, Ophthalmology, Vascular, Orthodontics and Optical services.

Note 3.5 Other income

Other income, in the main, includes income associated with services provided to other NHS and Non NHS organisations and local authorities £15,701,000 (2024/25: £14,420,000), pharmacy sales £1,128,000 (2024/25: £1,190,000), car parking income £1,374,000 (2024/25: £1,134,000), catering £284,000 (2024/25: £205,000), clinical excellence awards £296,000 (2024/25: £357,000) and staff accommodation £358,000 (2024/25: £335,000).

Note 3.6 Income from patient care (by source)

Income from activities	2025/26 £000	2024/25 £000
NHS England	64,205	116,092
Integrated care boards	537,486	452,311
NHS Foundation Trusts	0	9
NHS Trusts	244	236
NHS other (including Public Health England)	0	0
Non-NHS: private patients	271	342
Non-NHS: overseas patients (non-reciprocal, chargeable to patient)	521	779
Injury cost recovery scheme	1,323	1,097
Total income from activities	**604,050**	**570,866**

Note 3.7 Income from activities arising from commissioner requested services

	2025/26 £000	2024/25 £000
Income for services designated as commissioner requested services	601,691	568,403
Income from services not designated as commissioner requested services	2,359	2,463
Total	**604,050**	**570,866**

Under the terms of its provider license, the NHS foundation trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure.

Note 3.8 Operating leases - NHS foundation trust as lessor

This note discloses income generated in operating lease agreements where Bradford Teaching Hospitals NHS Foundation Trust is the lessor.

Operating lease income relates to letting out catering and retail space within both the Bradford Royal Infirmary and St Luke’s Hospital and for the housing of telephone masts.

Operating lease income

	2025/26 £000	2024/25 £000
Lease receipts recognised as income in year:		
Variable lease receipts / contingent rents	448	407
Total in-year operating lease income	**448**	**407**

3.9 Future lease receipts

	31 March 2026 £000	31 March 2025 £000
Future minimum lease receipts due at 31 March:		
- not later than one year	447	431
- later than one year and not later than two years	450	436
- later than two years and not later than three years	463	439
- later than three years and not later than four years	47	452
- later than four years and not later than five years	21	47
- later than five years	86	29
Total	**1,514**	**1,834**

Note 4 Operating expenses

Note 4.1 Operating expenses

	Note	2025/26 £000	2024/25 £000
Purchase of healthcare from NHS and DHSC bodies		2,223	1,920
Purchase of healthcare from non NHS bodies and non-DHSC bodies		4,072	4,059
Staff and executive directors costs		440,237	404,417
Remuneration of non-executive directors		102	113
Supplies and services – clinical (excluding drug costs)		67,993	61,394
Supplies and services – general		29,821	25,513
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)		56,726	59,527
Consultancy costs		1,039	1,217
Establishment		2,147	2,770
Premises – business rates collected by local authorities		2,003	2,174
Premises – other		10,678	11,399
Transport – business travel only		548	501
Transport – other (including patient travel)		9	6
Depreciation on property, plant & equipment and right of use assets		17,071	16,255
Amortisation on intangible assets		3,538	3,395
Net impairments	4.4	21,057	8,559
Movement in credit loss allowance: contract receivables / assets		250	235
Change in provisions discount rate[1]		(83)	(37)
Audit services – statutory audit[2]		399	254
Internal audit costs		265	240
Clinical negligence – amounts payable to the NHS Resolution (premium)		18,504	16,907
Legal fees		1,153	766
Insurance		539	712
Research and development – staff costs		14,177	12,833
Research and development – non-staff		8,357	14,666
Education and training – staff costs		12,615	12,772
Education and training – non-staff		1,688	1,214
Education and training – notional expenditure funded from apprenticeship fund		1,184	1,238
Expenditure on short term leases (current year only)		620	518
Redundancy		72	0
Car parking and security		56	23
Hospitality		(8)	(4)
Losses, ex gratia & special payments		116	129
Other services (e.g. external payroll)		1,126	1,198
Total		**720,294**	**666,883**

[1]2025/26 Change in provisions discount rate excludes £56,000 relating to the 2019/20 clinicians pension reimbursement which is reported within provisions but is held by NHS England and excluded from operational expenditure (2024/25: £8,000).

[2] 2025/26 Audit Services – statutory audit includes fees of £385,000 for the 2025/26 audit and £14,000 additional fee relating to the 2024/25 audit. Statutory audit fees includes irrecoverable VAT. The 2025/26 audit fee net of VAT is £321,000 (2024/25: £210,000).

Note 4.2 Other audit remuneration

There were no non-audit fees payable to the external auditor in 2025/26 (2024/25: nil).

Note 4.3 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 2026 is £2,000,000 (31 March 2025 £1,000,000).

Note 4.4 Impairment of assets

	2025/26 £000	2024/25 £000
Changes in market price[1]	21,057	8,559
Total net impairments charged to operating surplus	**21,057**	**8,559**
Impairments charged to the revaluation reserve	1,737	1,380
Total net impairments	**22,794**	**9,939**

[1]2025/26 Changes in market price includes an impairment of £14,200,000 of the new Endoscopy unit upon opening.

Note 5 Employee expenses

Note 5.1 Employee expenses

	2025/26 £000	2024/25 £000
Salaries and wages	351,334	326,270
Social security costs	42,759	33,506
Apprenticeship Levy	1,708	1,640
Employer's contributions to NHS Pensions	67,056	63,581
Temporary staff - Agency / contract staff	5,488	6,280
Total	**468,345**	**431,277**
Of which:		
Costs capitalised as part of assets	**1,244**	**1,255**

All employer pension contributions in 2025/26 and 2024/25 were paid to the NHS Pensions Agency.

The operating employee expense, excluding costs capitalised as part of assets, of £467,101,000 (2024/25: £430,022,000) is reported in note 4.1 Operating expenses as Staff and executive directors costs of £440,237,000 (2024/25: £404,417,000), Research and Development – staff costs £14,177,000 (2024/25: £12,833,000), Education and training – staff costs £12,615,000 (2024/25: £12,772,000) and Redundancy £72,000 (2024/25: nil).

Salaries and wages include £26,591,000 for internal temporary bank staff (2024/25: £30,230,000).

Note 5.2 Early retirements due to ill health

	2025/26 £000	2025/26 Number	2024/25 £000	2024/25 Number
Number of early retirements on the grounds of ill-health		7		11
Value of early retirements on the grounds of ill-health	250		440	

The costs of early retirement due to ill health are estimated on an average basis and the costs will be borne by the NHS Pension Scheme.

Note 5.3 Pension Costs

Past and present employees are covered by the provisions of the 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 the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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. The costs for 2025/26 and 2024/25 are shown in Note 5.1.

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 2026, is based on valuation data as 31 March 2024, updated to 31 March 2026 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 Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account

through the economic cost cap cost of the scheme, the cost of the cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contributions rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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 NHS trust; or
- are absent from work due to long-term sickness, maternity leave, etc. when the statutory duty to automatically enrol applies.

The NHS foundation trust is required to make contributions to the NEST pension fund for any such employees enrolled. From April 2019 onwards the combined contribution rate (employee and employer) is 8%, with a contribution of 3% from the NHS Foundation Trust.
Employees are permitted to opt out of the auto-enrolment, from either the NHS Pension Scheme or NEST, if they do not wish to pay into a pension, but they will lose the contribution made by the NHS foundation trust.

In the financial year to 31 March 2026, the NHS foundation trust made contributions totalling £61,000 into the NEST fund (31 March 2025 £56,000).

Note 6 Finance income

	2025/26 £000	2024/25 £000
Interest on bank accounts	1,946	3,025
Total	**1,946**	**3,025**

Interest receivable relates to interest earned with the Government Banking Service.

Note 7 Finance costs

Note 7.1 Finance costs

Finance expenditure represents interest and other charges in the borrowing of money or asset financing.

	2025/26 £000	2024/25 £000
Interest expense:		
Interest on loans from the DHSC	200	229
Interest on lease obligations	207	211
Total interest expense	**407**	**440**
Unwinding of discount on provisions	61	57
Total finance costs	**468**	**497**

Note 7.2 Other gains / (losses)

	2025/26 £000	2024/25 £000
Gains on disposal of assets	1	4
Losses on disposal of assets	0	(254)
Total gains (losses) on disposal of assets	**1**	**(250)**
Total other gains / (losses)	**1**	**(250)**

Note 7.3 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 2025/26 the NHS foundation trust has had 212 (2024/25: 254) separate losses and special payments, totalling £555,000 (2024/25: £412,000). The bulk of these were in relation to bad debts and ex gratia payments in respect of personal injury claims.

Losses and special payments are reported on an accruals basis but excluding provisions for future losses.

No gifts were made in 2025/26 (2024/25: nil).

	2025/26 Total Number of Cases Number	2025/26 Total Value of Cases £000	2024/25 Total Number of Cases Number	2024/25 Total Value of Cases £000
Losses				
Cash losses	23	15	77	27
Fruitless payments and constructive losses	2	1	0	0
Bad debts and claims abandoned	146	434	143	276
Total losses	**171**	**450**	**220**	**303**
Special Payments				
Compensation under court order or legally binding arbitration award	3	5	0	0
Ex-gratia payments	38	100	34	109
Total special payments	**41**	**105**	**34**	**109**
Total losses and special payments	**212**	**555**	**254**	**412**

Note 8 Intangible assets

Note 8.1 Intangible assets 2025/26

	Total	Software licences
	£000	£000
Valuation / gross cost at 1 April	**32,150**	**32,150**
Additions – purchased / internally generated	4,818	4,818
Disposals / derecognition	(1,207)	(1,207)
Gross cost at 31 March	**35,761**	**35,761**
Accumulated amortisation at 1 April	**21,732**	**21,732**
Provided during the year	3,538	3,538
Disposals / derecognition	(1,207)	(1,207)
Amortisation at 31 March	**24,063**	**24,063**
Net book value at 31 March 2026	**11,698**	**11,698**
Net book value at 31 March 2025	**10,418**	**10,418**

Note 8.2 Intangible assets 2024/25

	Total	Software licences
	£000	£000
Valuation / gross cost at 1 April	**27,122**	**27,122**
Additions – purchased / internally generated	5,028	5,028
Gross cost at 31 March	**32,150**	**32,150**
Accumulated amortisation at 1 April	**18,337**	**18,337**
Provided during the year	3,395	3,395
Amortisation at 31 March	**21,732**	**21,732**
Net book value at 31 March 2025	**10,418**	**10,418**
Net book value at 31 March 2024	**8,785**	**8,785**

All assets classed as intangible meet the criteria set out in IAS 38 (2) in terms of identifiability, control (power to obtain benefits from the asset), and future economic benefits (such as revenues or reduced future costs). The cost less residual value of an intangible asset with a finite useful life is amortised on a systematic basis over that life, as required by IAS 38 (97).

Note 9 Property, plant and equipment

Note 9.1 Property, plant and equipment 2025/26

	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	**297,064**	**11,062**	**158,335**	**2,993**	**29,309**	**63,875**	**177**	**31,191**	**122**
Additions – purchased	**54,469**	0	25,698	443	15,030	5,554	166	7,413	165
Additions – donations / grants	**744**	0	272	0	318	130	0	0	24
Impairments charged to revaluation reserve	**(2,800)**	0	(2,466)	(334)	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	**1,063**	0	1,047	16	0	0	0	0	0
Revaluations	**(24,889)**	55	(24,834)	(110)	0	0	0	0	0
Reclassifications	**0**	0	25,853	0	(26,042)	0	189	0	0
Disposals	**(4,261)**	0	0	0	0	(1,655)	0	(2,606)	0
Valuation/Gross cost at 31 March	**321,390**	**11,117**	**183,905**	**3,008**	**18,615**	**67,904**	**532**	**35,998**	**311**
Accumulated depreciation at 1 April	**42,981**	**0**	**1,756**	**0**	**0**	**22,854**	**74**	**18,185**	**112**
Provided during the year	**15,662**	0	6,090	110	0	5,443	33	3,984	2
Impairments	**21,797**	73	21,724	0	0	0	0	0	0
Reversal of impairments	**(740)**	0	(740)	0	0	0	0	0	0
Revaluations	**(25,947)**	(73)	(25,764)	(110)	0	0	0	0	0
Disposals	**(4,261)**	0	0	0	0	(1,655)	0	(2,606)	0
Accumulated depreciation at 31 March	**49,492**	**0**	**3,066**	**0**	**0**	**26,642**	**107**	**19,563**	**114**
Net book value at 31 March 2026	**271,898**	**11,117**	**180,839**	**3,008**	**18,615**	**41,262**	**425**	**16,435**	**197**
Net book value at 31 March 2025	**254,083**	**11,062**	**156,579**	**2,993**	**29,309**	**41,021**	**103**	**13,006**	**10**

A desktop valuation for land, buildings and dwellings was carried out at 31 March 2026 by the independent valuer Cushman & Wakefield. The modern equivalent asset valuation was applied based on the reprovision of the buildings based at the Bradford Royal Infirmary on an alternative site based in the Bradford locality.

Note 9.2 Property, plant and equipment financing 2025/26

	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	**267,711**	11,117	178,853	3,008	18,342	39,532	250	16,435	174
Donated	**4,187**	0	1,986	0	273	1,730	175	0	23
Net book value at 31 March	**271,898**	**11,117**	**180,839**	**3,008**	**18,615**	**41,262**	**425**	**16,435**	**197**

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

Note 9.3 Property, plant and equipment 2024/25

	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	**276,083**	**10,330**	**157,043**	**3,095**	**16,315**	**59,939**	**170**	**29,071**	**120**
Additions – purchased	**40,235**	69	16,108	(3)	12,910	9,022	7	2,120	2
Additions – donations / grants	**669**	0	51	0	84	534	0	0	0
Impairments charged to revaluation reserve	**(1,521)**	0	(1,518)	(3)	0	0	0	0	0
Reversal of impairments credited to revaluation reserve	**141**	0	131	10	0	0	0	0	0
Revaluations	**(12,923)**	663	(13,480)	(106)	0	0	0	0	0
Disposals	**(5,620)**	0	0	0	0	(5,620)	0	0	0
Valuation/Gross cost at 31 March	**297,064**	**11,062**	**158,335**	**2,993**	**29,309**	**63,875**	**177**	**31,191**	**122**
Accumulated depreciation at 1 April	**38,150**	**0**	**457**	**0**	**0**	**23,117**	**55**	**14,410**	**111**
Provided during the year	**14,859**	0	5,953	106	0	5,005	19	3,775	1
Impairments	**9,254**	0	9,254	0	0	0	0	0	0
Reversal of impairments	**(695)**	(430)	(265)	0	0	0	0	0	0
Revaluations	**(13,319)**	430	(13,643)	(106)	0	0	0	0	0
Disposals	**(5,268)**	0	0	0	0	(5,268)	0	0	0
Accumulated depreciation at 31 March	**42,981**	**0**	**1,756**	**0**	**0**	**22,854**	**74**	**18,185**	**112**
Net book value at 31 March 2025	**254,083**	**11,062**	**156,579**	**2,993**	**29,309**	**41,021**	**103**	**13,006**	**10**
Net book value at 1 April 2024	**237,933**	**10,330**	**156,586**	**3,095**	**16,315**	**36,822**	**115**	**14,661**	**9**

Note 9.4 Property, plant and equipment financing 2024/25

	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	**250,242**	11,062	154,761	2,993	29,164	39,143	103	13,006	10
Donated	**3,841**	0	1,818	0	145	1,878	0	0	0
Net book value at 31 March	**254,083**	**11,062**	**156,579**	**2,993**	**29,309**	**41,021**	**103**	**13,006**	**10**

Note 10 Leases

This note details information about leases for which the NHS foundation trust is a lessee. In the main the NHS foundation trust leases community based buildings from other NHS organisations. The NHS foundation trust also leases some items for medical equipment which are used for a range of services.

Note 10.1 Right of use assets 2025/26

	Total	Property (land and buildings)	Plant & machinery	Transport Equipment	Of Which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025	**11,887**	**11,072**	**815**	**0**	**10,296**
Additions	**512**	172	0	340	172
Remeasurements of the lease liability	**277**	277	0	0	277
Disposals / derecognition	**(172)**	(114)	(58)	0	(114)
Valuation/gross cost at 31 March 2026	**12,504**	**11,407**	**757**	**340**	**10,631**
Accumulated depreciation at 1 April 2025	**3,890**	**3,400**	**490**	**0**	**3,042**
Provided during the year	**1,409**	1,240	160	9	1,120
Disposals / derecognition	**(107)**	(49)	(58)	0	(49)
Accumulated depreciation at 31 March 2026	**5,192**	**4,591**	**592**	**9**	**4,113**
Net book value at 31 March 2026	**7,312**	**6,816**	**165**	**331**	**6,518**
Net book value at 31 March 2025	**7,997**	**7,672**	**325**	**0**	**7,254**
Net book value of right of use assets leased from NHS providers					906
Net book value of right of use assets leased from other DHSC group bodies					5,612

Note 10.2 Right of use assets 2024/25

	Total	Property (land and buildings)	Plant & machinery	Of Which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024	**12,597**	**11,551**	**1,046**	**10,730**
Additions	**430**	430	0	430
Remeasurements of the lease liability	**(424)**	(463)	39	(463)
Disposals / derecognition	**(716)**	(446)	(270)	(401)
Valuation/gross cost at 31 March 2025	**11,887**	**11,072**	**815**	**10,296**
Accumulated depreciation at 1 April 2024	**2,847**	**2,365**	**482**	**2,094**
Provided during the year	**1,396**	1,191	205	1,059
Disposals / derecognition	**(353)**	(156)	(197)	(111)
Accumulated depreciation at 31 March 2025	**3,890**	**3,400**	**490**	**3,042**
Net book value at 31 March 2025	**7,997**	**7,672**	**325**	**7,254**
Net book value at 1 April 2024	**9,750**	**9,186**	**564**	**8,636**
Net book value of right of use assets leased from NHS providers				941
Net book value of right of use assets leased from other DHSC group bodies				6,313

Note 10.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position. A breakdown of borrowings is disclosed in note 16.

	2025/26	2024/25
	£000	£000
Carrying value at 31 March	**8,161**	**9,808**
Lease additions	172	430
Lease liability remeasurements	277	(424)
Interest charge arising in year	207	211
Early terminations	(66)	(364)
Lease payments (cash outflows)	(1,533)	(1,500)
Carrying value at 31 March	**7,218**	**8,161**

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure. These payments are disclosed in Note 3.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 10.4 Maturity analysis of future lease payments at 31 March 2026

	Total 31 March 2026 £000	Of which leased from DHSC group bodies: 31 March 2026 £000	Total 31 March 2025 £000	Of which leased from DHSC group bodies: 31 March 2025 £000
Undiscounted future lease payments payable in:				
- not later than one year	1,533	1,279	1,490	1,203
- later than one year and not later than five years	5,158	4,955	5,158	4,723
- later than five years	1,110	1,088	2,229	2,186
Total gross future lease payments	**7,801**	**7,322**	**8,877**	**8,112**
Finance charges allocated to future periods	(583)	(576)	(716)	(702)
Net lease liabilities at 31 March	**7,218**	**6,746**	**8,161**	**7,410**
Of which:				
- Leased from other NHS providers		922		954
- Leased from other DHSC group bodies		5,824		6,456

Note 11 Investments in joint ventures

	2025/26 £000	2024/25 £000
Carrying value at 1 April - brought forward	**299**	**288**
Share of profit	158	160
Disbursements / dividends received	(144)	(149)
Carrying value at 31 March	**313**	**299**

The NHS foundation trust has a 33.33% equity share and voting rights in both Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP, with losses limited to £1 each. Neither Integrated Pathology Solutions, nor Integrated Laboratory Solutions hold capital assets.

The NHS foundation trust established Integrated Pathology Solutions LLP and Integrated Laboratory Solutions LLP with Airedale NHS Foundation Trust in February 2016. Both organisations held a 50% equity share. In October 2019 Harrogate and District NHS Foundation Trust became a partner in both organisations and all three partners now hold a 33.33% equity share. Control is shared equally between the three partners and both organisations are considered to be joint ventures. As at 31 March 2026 Integrated Laboratory Solutions LLP has net assets of £854,000 (31 March 2025: £807,000) and Integrated Pathology Solutions LLP has net assets of £83,000 (31 March 2025: £92,000).

Note 12 Inventories

	31 Mar 26 £000	31 Mar 25 £000
Consumables	5,661	5,223
Drugs	5,230	6,038
Energy	449	300
Total	**11,340**	**11,561**

Inventories recognised in expenses for the year were £56,726,000 (2024/25: £59,527,000). Write-down of inventories recognised as expenses for the year were nil (2024/25: nil).

Note 13 Receivables

Note 13.1 Trade receivables and other receivables

	31 Mar 26 £000	31 Mar 25 £000
Current		
Contract receivables	13,061	10,395
Allowance for impaired contract receivables / assets	(1,361)	(1,319)
Prepayments	8,440	8,019
Interest Receivable	185	0
PDC dividend receivable	654	0
VAT receivables	2,603	1,805
Other receivables	1,023	709
Total	**24,605**	**19,609**
Non-current		
Contract receivables	1,513	1,141
Other receivables – revenue	707	821
Total	**2,220**	**1,962**
Of which receivables from NHS and DHSC group bodies		
Current	6,126	3,589
Non-current	707	821

Note 13.2 Allowances for credit losses 2025/26

	2025/26 Contract receivables and contract assets £000	2024/25 Contract receivables and contract assets £000
Allowances as at 1 April – brought forward	**1,319**	**1,250**
New allowances arising	336	337
Changes in existing allowances	(51)	(70)
Reversals of allowances	(35)	(32)
Utilisation of allowances (write offs)	(208)	(166)
Total	**1,361**	**1,319**

Note 13.3 Exposure to credit risk

The NHS foundation trust receives the majority of its income from West Yorkshire ICB, NHS England and statutory bodies and therefore the credit risk is negligible.

Note 14 Trade and other payables

	31 Mar 26 £000	31 Mar 25 £000
Current		
Trade payables	15,060	14,127
Capital payables	20,599	13,486
Accruals	19,211	26,300
Other taxes payable	9,934	8,805
PDC dividend payable	0	15
Pension contributions payable	5,628	5,342
Other payables	4,697	4,528
Total	**75,129**	**72,603**
Of which payables from NHS and DHSC group bodies:		
Current	2,853	3,528

Note 15 Other liabilities

	31 Mar 26 £000	31 Mar 25 £000
Current		
Deferred income: contract liabilities	15,811	11,304
Deferred grants	165	129
Total other current liabilities	**15,976**	**11,433**

Note 16 Borrowings

Note 16.1 Borrowings

	31 Mar 26	31 Mar 25
	£000	£000
Current		
Loans from DHSC (capital loans)	1,073	1,075
Lease liabilities	1,349	1,294
Total	**2,422**	**2,369**
Non-current		
Loans from DHSC (capital loans)	8,428	9,480
Lease liabilities	5,869	6,867
Total	**14,297**	**16,347**

Note 16.2 Borrowings Reconciliation of liabilities arising from financing activities 2025/26

	Loans from DHSC	Lease Liability	Total
	£000	£000	£000
Carrying value at 1 April 2025	**10,555**	**8,161**	**18,716**
Cash movements:			
Financing cash flows – payments and receipts of principal	(1,052)	(1,326)	(2,378)
Financing cash flows – payments of interest	(202)	(207)	(409)
Non-cash movements:			
Additions	0	172	172
Lease liability remeasurements	0	277	277
Application of effective interest rate	200	207	407
Early terminations	0	(66)	(66)
Carrying value at 31 March 2026	**9,501**	**7,218**	**16,719**

Note 16.3 Borrowings Reconciliation of liabilities arising from financing activities 2024/25

	Loans from DHSC	Lease Liability	Total
	£000	£000	£000
Carrying value at 1 April 2024	**13,618**	**9,808**	**23,426**
Cash movements:			
Financing cash flows – payments and receipts of principal	(3,052)	(1,289)	(4,341)
Financing cash flows – payments of interest	(240)	(211)	(451)
Non-cash movements:			
Additions	0	430	430
Lease liability remeasurements	0	(424)	(424)
Application of effective interest rate	229	211	440
Early terminations	0	(364)	(364)
Carrying value at 31 March 2025	**10,555**	**8,161**	**18,716**

Note 17 Provisions

Note 17.1 Provisions for liabilities and charges analysis 2025/26

	Total	Pensions – Injury benefits	Legal Claims	Equal Pay	Other
	£000	£000	£000	£000	£000
At 1 April 2025	**6,216**	**1,882**	**459**	**2,231**	**1,644**
Change in the discount rate	**(139)**	(76)	0	0	(63)
Arising during the year	**769**	28	0	557	184
Utilised during the year	**(243)**	(102)	0	0	(141)
Reversed unused	**(482)**	(144)	0	0	(338)
Unwinding of discount rate	**109**	50	0	0	59
At 31 March 2026	**6,230**	**1,638**	**459**	**2,788**	**1,345**
Expected timings of cash flows:					
-not later than one year	**3,269**	140	0	2,788	341
-later than one year and not later than five years	**2,961**	1,498	459	0	1,004
Total	**6,230**	**1,638**	**459**	**2,788**	**1,345**

Pensions related provisions represent amounts payable to the NHS Business Services Authority - Pensions Division to meet the costs of early retirements and industrial injury benefits.

Legal claims relate to a provision for claims relating to high risk employment relations. 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 £596,000. 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 £749,000 (2024/25: £856,000). 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.

As at 31 March 2026 the provisions of NHS Resolution include £258,613,000 (31 March 2025: £256,432,000) in respect of clinical negligence liabilities of the NHS foundation trust.

Note 18 Cash and cash equivalents

Note 18.1 Cash and cash equivalents

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

	2025/26 £000	2024/25 £000
At 1 April	**31,857**	**64,154**
Net change in year	(6,008)	(32,297)
At 31 March	**25,849**	**31,857**
Broken down into:		
Cash at commercial banks and in hand	14	20
Cash with the Government Banking Service	25,835	31,837
Cash and cash equivalents as in SoFP and SoCF	**25,849**	**31,857**

Third party assets held by the NHS foundation trust at 31 March 2026 were £3,000 (31 March 2025: £3,000). Third party assets are held separately from the cash and cash equivalents.

Note 19 Contractual capital commitments and events after the reporting period

Note 19.1 Contractual capital commitments

Commitments under capital expenditure contracts at the reporting date were £3,855,000 (31 March 2025: £18,910,000). Capital commitments include £3,717,000 for property, plant and equipment additional and £138,000 for intangible asset additions.

Note 19.2 Other financial commitments

Other financial commitments at the reporting date were £7,400,000 (31 March 2025: £1,889,000). The NHS foundation trust has financial commitments for the ongoing support and maintenance charges for the electronic patient records system.

Note 19.3 Events after the reporting period

There are no events after the reporting period to disclose.

Note 20 Contingent liabilities / assets

	31 Mar 26 £000	31 Mar 25 £000
Value of contingent liabilities		
NHS Resolution legal claims	90	67
Total	**90**	**67**

NHS Resolution contingent liabilities consist entirely of non-clinical claims, such as for personal injury, where the probability of settlement is very low.

Note 21 Related party transactions

Note 21.1 Related party transactions

The NHS foundation trust is a public interest body authorised by NHSE, 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 remuneration of key management personnel is included in the annual report.

The Register of Interests for the Council of Governors for 2025/26 has been compiled in accordance with the requirements of the Constitution of the NHS foundation trust.

The DHSC 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 Business Service Authority and West Yorkshire ICB.

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 21.2 Related party balances

	2025/26 Income £000	2025/26 Expenditure £000	2024/25 Income £000	2024/25 Expenditure £000
Value of transactions with other related parties				
Charitable fund	1,065	0	936	0
Non-consolidated joint ventures	180	14,794	85	13,070
Other bodies	42	7	0	0
Total	**1,287**	**14,801**	**1,021**	**13,070**

	2025/26 Receivables £000	2025/26 Payables £000	2024/25 Receivables £000	2024/25 Payables £000
Value of balances with other related parties				
Charitable fund	116	0	53	0
Non-consolidated joint ventures	0	2,383	17	211
Other	0	1	0	0
Total as at 31 March	116	**2,384**	**70**	**211**

In line with the DHSC interpretation of IAS 24 related parties the NHS foundation trust only disclose details of transactions and balances with bodies or persons outside of the whole of government accounts boundary.

Note 22 Financial instruments

IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The NHS foundation trust actively seeks to minimise its financial risks. In line with this policy, the NHS foundation trust neither buys nor sells financial instruments. Financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS foundation trust in undertaking its activities.

Liquidity risk

Liquidity risk is the NHS foundation trust's ability to meet its cash obligations in delivering services to patients.

The NHS foundation trust's net operating costs are predominantly incurred to deliver, one year, nationally mandated healthcare contracts with a range of commissioners. Commissioners are financed from resources voted annually by Parliament. In 2025/26 and 2024/25 the NHS foundation trust received contract income in accordance with set block payments paid on a monthly basis.

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

Interest rate risk is the NHS foundation trust's exposure to interest rates fluctuations.

With the exception of cash balances, the NHS foundation trust's financial assets and financial liabilities carry nil or fixed rates of interest. The NHS foundation trust monitors the risk but does not consider it appropriate to purchase protection against it.

Foreign currency risk

Foreign currency risk is the NHS foundation trust's exposure to changing currency exchange rates impacting income, expenditure or the value of assets and liabilities.

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

Credit risk

Credit risk is the potential for lost income should creditors be unable to pay debts owed to the NHS foundation trust.

The NHS foundation trust receives the majority of its income from NHS England, West Yorkshire ICB 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 £12,000,000 for no more than 6 months.

Price risk

Price risk is due to increases or decreasing market prices leading to high costs or reduced income for the NHS foundation trust.

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

Note 23 Financial assets and liabilities

Note 23.1 Financial assets by category

	31 Mar 26 £000	31 Mar 25 £000
Assets as per SoFP at 31 March		
Trade and other receivables excluding non-financial assets – with NHS and DHSC bodies	6,179	4,406
Trade and other receivables excluding non-financial assets – with other bodies	8,949	7,341
Cash and cash equivalents at bank and in hand	25,849	31,857
Total	**40,977**	**43,604**

All financial assets are held at amortised cost.

Note 23.2 Financial liabilities by category

	31 Mar 26	31 Mar 25
	£000	£000
Liabilities as per SoFP at 31 March		
Borrowings excluding finance lease	9,501	10,555
Obligations under leases	7,218	8,161
Trade and other payables excluding non-financial liabilities – with NHS and DHSC bodies	2,781	3,045
Trade and other payables excluding non-financial liabilities – with other bodies	54,858	53,249
Provisions under contract	3,996	3,701
Total	**78,354**	**78,711**

All financial liabilities fall within "other financial liabilities" and are held at amortised cost.

Note 23.3 Fair values

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

Note 23.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

	31 Mar 26	31 Mar 25
	£000	£000
In one year or less	63,254	61,481
In more than one year but not more than five years	11,042	11,238
In more than five years	5,508	7,775
Total	**79,804**	**80,494**

ACRONYMS

API	Aligned payment and incentive
DHSC	Department of Health and Social Care
DHSC GAM	Department of Health and Social Care Group Accounting Manual
FReM	Financial Reporting Manual
FSA	Financial Services Authority
IAS	International Accounting Standards
ICB	Integrated Care Board
IFRS	International Financial Reporting Standards
MEA	Modern Equivalent Asset
NEST	National Employment Savings Trust
NHS	National Health Service
PDC	Public Dividend Capital
SoCI	Statement of Comprehensive Income
SoCF	Statement of Cash Flows
SoFP	Statement of Financial Position
The Charity	Bradford Hospitals' Charity
VAT	Value Added Tax