



Bradford District Care
NHS Foundation Trust

Annual Report and Accounts

2025 – 2026

Bradford District Care NHS Foundation Trust

Annual Report and Accounts

1 April 2025 to 31 March 2026

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

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1. Welcome from our Chair in Common and Chief Executive

We are pleased to present the Annual Report and Accounts for 2025/26, which reflects a year of sustained commitment, care and resilience across the Trust. Throughout the year, colleagues across clinical and corporate services have continued to show deep dedication to the people and communities we serve. The Trust's strong, values led culture, compassionate and visible leadership, and shared ambition to improve outcomes have been evident in how staff have supported one another and maintained a clear focus on quality and safety, even as pressures have intensified.

Despite significant financial, workforce and system pressures facing the NHS, the Board has remained assured that our services are safe, accessible and of high quality. Demand continues to grow, driven by an ageing population and widening health inequalities. These challenges reinforce our determination to improve care, reduce inequality and enhance the experience of those who rely on our services.

During the reporting period, the Trust Board and Council of Governors agreed to an interim joint appointment for a Trust Chair in partnership with Airedale NHS Foundation Trust. The 'Chair in Common' model, where a single individual is appointed to chair two Trusts, aims to enhance collaboration, strengthen strategic alignment and maximise opportunities for shared learning and improved outcomes for the populations we serve.

We have commenced the refresh of our organisational strategy for 2026 and beyond. This work reflects our shared commitment with system partners across Bradford District and Craven to deepen collaboration and strengthen our role as a leading place-based partner. We remain a committed partner within the West Yorkshire Health and Care Partnership and locally through the 'Act as One' partnership, working together to help people stay healthy and independent at home.

As a Trust, and with our partners, we continue to work hard to deliver the best with the resources we have. We do this through good financial decision making and considering the environmental and social-economic impact we have on sustainability.

A significant achievement this year was approval of the Full Business Case for the £65 million redevelopment of Lynfield Mount Hospital. Approved in January 2026, the scheme will commence construction in April 2026 and deliver a new two ward block, refurbished legacy wards and significantly enhanced therapeutic environments, improving the experience of care for service users and staff.

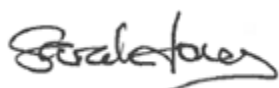
We continue to invest in creative and therapeutic approaches, supported by Better Lives Charity, and we are grateful for the generosity that enables this work. Volunteers remain integral to our organisation; 239 volunteers contributed 8,399 hours during 2025/26, and we thank them sincerely.

Our services span the full life course, and we remain committed to delivering high quality, compassionate and sustainable care through the dedication of our workforce and strong partnerships across health and social care.

While the year has brought significant challenge and change, it has also highlighted the strength of our people, partnerships and shared purpose. We remain committed to being an excellent place to work, to delivering high-quality and sustainable care, and to acting as a trusted and effective partner within our local health and care system as we continue to serve our communities.

We would also like to recognise and thank all colleagues who left the Trust during the year, and those governors who reached the end of their term of office. We wish to record our appreciation for the service and leadership of Dr David Sims, retired Medical Director; Dr Linda Patterson, retired Trust Chair; and Simon Lewis, retired Interim Chair, Deputy Chair and Non-Executive Director. Their contribution has helped shape the Trust's direction and culture, and we thank them for their commitment and dedication.

Finally, on behalf of the Board of Directors, we would like to offer our sincere thanks to everyone who contributes to the life and work of the Trust. This includes our staff, partners and volunteers; our involvement partners and governors; and our service users, carers and wider communities. Your insight, commitment and support continue to shape our services and strengthen our organisation, and we are grateful for the trust you place in us.



.....
Date: 25 June 2026
Sarah Jones
Chair in Common



.....
Date: 25 June 2026
Therese Patten
Chief Executive

2. About our Trust

Welcome to Bradford District Care NHS Foundation Trust

Bradford District Care NHS Foundation Trust ('the Trust') has been a Foundation Trust since 1 May 2015. It is a Public Benefit Corporation and offers a wide range of services covering mental health, learning disabilities, physical health (including specialist dental services) and children's public health, from before birth to the end of people's lives. We provide 51 different services across over 60 sites, including two mental health hospitals, for people of all ages across Bradford District and Craven.

Supporting people in our communities throughout their lives is a real privilege and means that we have many opportunities to help make a difference to their health and wellbeing. This means helping people to keep healthy for as long as they can be, as well as treating people when they become unwell.

As well as thinking creatively about how we support our people and how we make our services accessible to everyone in our communities who need them, we continue to work with our partners across health and care, to consider all the factors that impact on a person's health and wellbeing and create joined-up, holistic service offers that put the person at the centre of decision making. We continue to build on our strong relationships with partners to look outwards across Bradford District and Craven, West Yorkshire, and beyond.

Bradford District and Craven stretches from Bradford city centre, past Keighley in the Aire Valley, through the large market towns of Ilkley and Skipton, to Ingletton in the Craven basin. Our community has a population of over 600,000 people in a mixed urban and rural area, covering 595 square miles.

The population we serve is one of the most multicultural in Britain. Bradford is one of the most multilingual areas in the UK, with a very wide range of languages (estimated over 100 different languages) spoken across the district.

Some areas of Bradford are amongst the most deprived in the country, reflected in higher-than-average demand for health services and reduced life expectancy. Bradford is the Fifth largest metropolitan authority in England. The population of Bradford District is approximately 550,000–565,000 (ONS 2021–2024 estimates), and Craven is around 57,000. Circa 27.9% of the population are aged under 20 years old, making Bradford the youngest city in the UK. Craven has a population of circa 57,100, with a rise of circa 28% of people aged 65 – 74 years old. Craven is both less densely populated than Bradford and has an older age profile, with a notably higher proportion of residents aged 65+ compared to Bradford. With over 50% of the total population of Craven reporting their health as 'very good', with 10% registered as disabled.

We employ over 3,000 people who, directly and indirectly, provide healthcare and specialist services to local people, including registered nurses (health visitors, school

nurses, district nurses, specialist nurses), non-clinical roles (digital, estates and facilities, finance, people matters, administration, governance), health support workers, psychological therapy roles, allied health professionals (AHPs), social workers, dental and medical roles, AHP clinical support roles and pharmacy roles.

Further information about the Trust services, and priorities for improvement capability and statements relating to the quality of NHS services provided are included in the Quality Account 2025/26.

Working Together

The Trust's values—We care, We listen, We deliver—guide how we work with colleagues to provide high quality services, and how we collaborate with partners to meet the needs of our local communities. Partnership working with the Voluntary and Community Sector (VCS) remains a key part of our strategy, particularly in fulfilling the Trust's role as a community connector. We continue to maintain strong relationships with a wide range of VCS organisations and actively contribute to initiatives supporting the shared 'Happy, Healthy and at Home' vision across Bradford District and Craven.

Engaging with elected Members of Parliament and local authority representatives is also an important aspect of our work. Board members and senior leaders work closely with elected members, providing updates and insight through Overview and Scrutiny Committees as well as through routine business interactions. Our Chair and Chief Executive hold regular meetings with local MPs to share developments within the Trust, listen to feedback, and understand the experiences of the people and communities we serve.

Creating Better Lives, Together: From Ambition to Action – 2023 to 2026

Our Ambition to Action strategy set out our four strategic priorities of being the best place to work, delivering the best quality services, ensuring the best use of resources, and being the best partner. Our strategy included a focus on reducing inequalities, both in terms of health inequalities and equality and inclusion within our workforce.

From Ambition to Action

2023-2026 strategy refresh



Diagram 1: From Ambition to Action 2023-2026 strategy

With the Better Lives, Together strategy reaching its natural end point in 2026, a programme of work has been established to support the development of our future strategy. As with our previous strategic development work, this will include engagement, listening exercises, coproduction, and using insights, all of which will be supported by the Care Trust Way framework.

Assurance and delivery of the strategy and strategy deployment

The Board and the Committees continue to align to the priorities and support these groups in obtaining the assurances they are required to seek.

For the strategy to have the continuous impact it is vital that the intent and ambitions are successfully deployed through the organisation. This is supported by a clear understanding, and adaptation of tools, which support tactical and operational oversight and assurance activity across the organisation. Below is a diagram which demonstrates how the strategic priorities will flow through our Trust structures to provide assurance of delivery. This has been reviewed by our internal audit process, with significant assurance rating awarded.

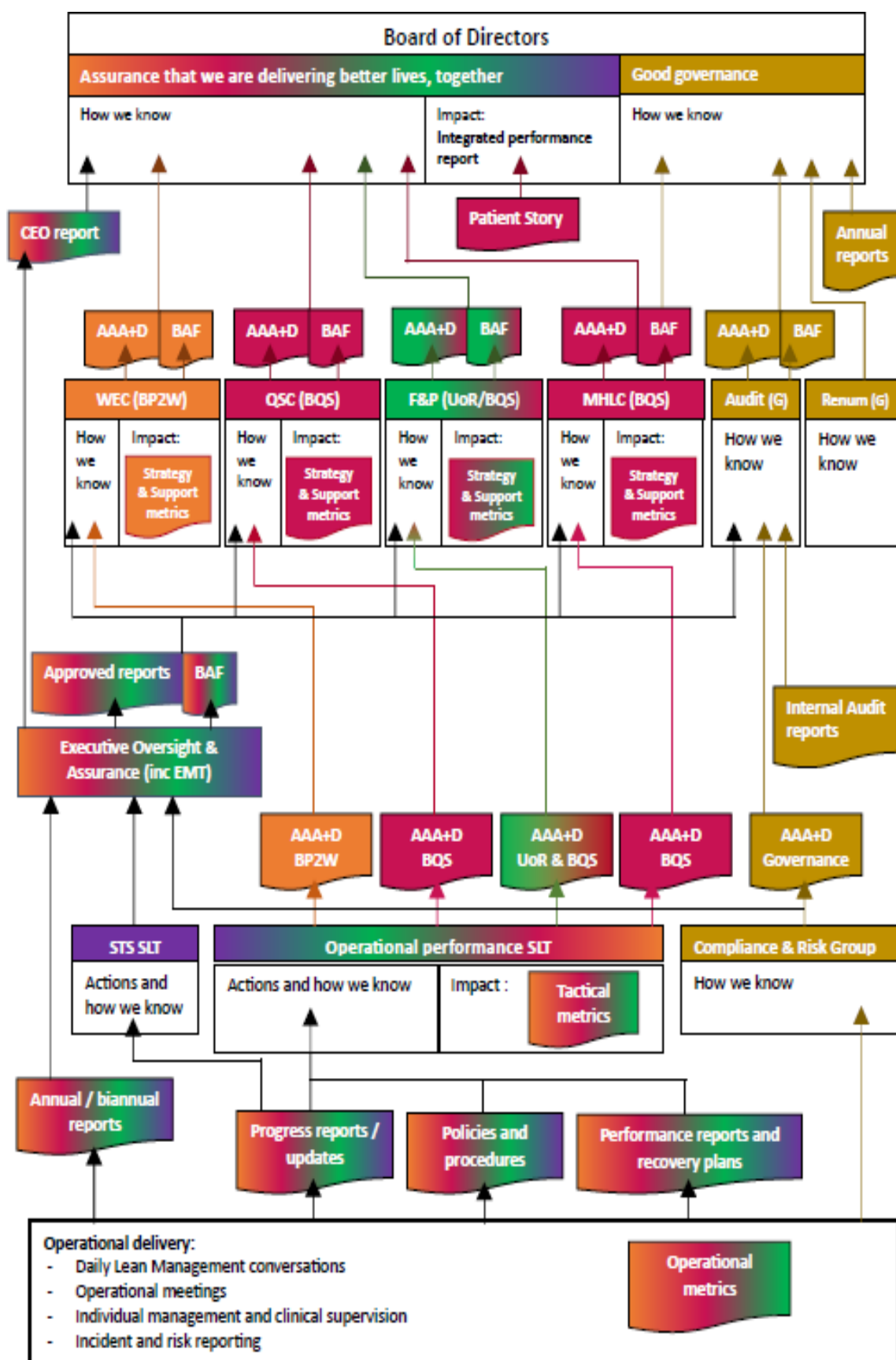


Diagram 2: Governance Structure and Flow

The Regional Context: The system we operate within

West Yorkshire Health and Care Partnership, an integrated care system

Integrated care systems were established to organise health and care services to support people and communities to be healthier and happier. They bring together partners across one area, including local councils, the NHS, care providers, charities, and voluntary and community organisations.

In West Yorkshire the system is called the West Yorkshire Health and Care Partnership. Their work focuses on four main areas:

- Improving health and care outcomes for people
- Addressing health inequalities
- Increasing productivity and efficiency
- Supporting broader social and economic development.

Within the West Yorkshire Health and Care Partnership, there is a Partnership Board. The Board is an important group for the Partnership which covers Bradford District and Craven, Calderdale, Kirklees, Leeds, and Wakefield District. Elected members, partner executives, and non-executives are brought together in one decision-making process. Our Chief Executive and Chair, Therese Patten and Sarah Jones, are Board members.

The Partnership includes an NHS body known as the NHS West Yorkshire Integrated Care Board (ICB). As a result of the Health and Care Act 2022, the ICB became a statutory organisation from 1 July 2022. In simple terms, it became an officially recognised and authorised body under the law, with the legal power to carry out its responsibilities in the Partnership.

Together across West Yorkshire, the Partnership supports 2.4 million people, living in urban and rural areas. 770,000 are children and young people. 530,000 people live in areas ranked as the poorest 10% of England. 20% of people are from minority ethnic communities. There are an estimated 400,000 unpaid carers, as many don't access support. Together the Partnership employs over 100,000 staff and works alongside thousands of volunteers.

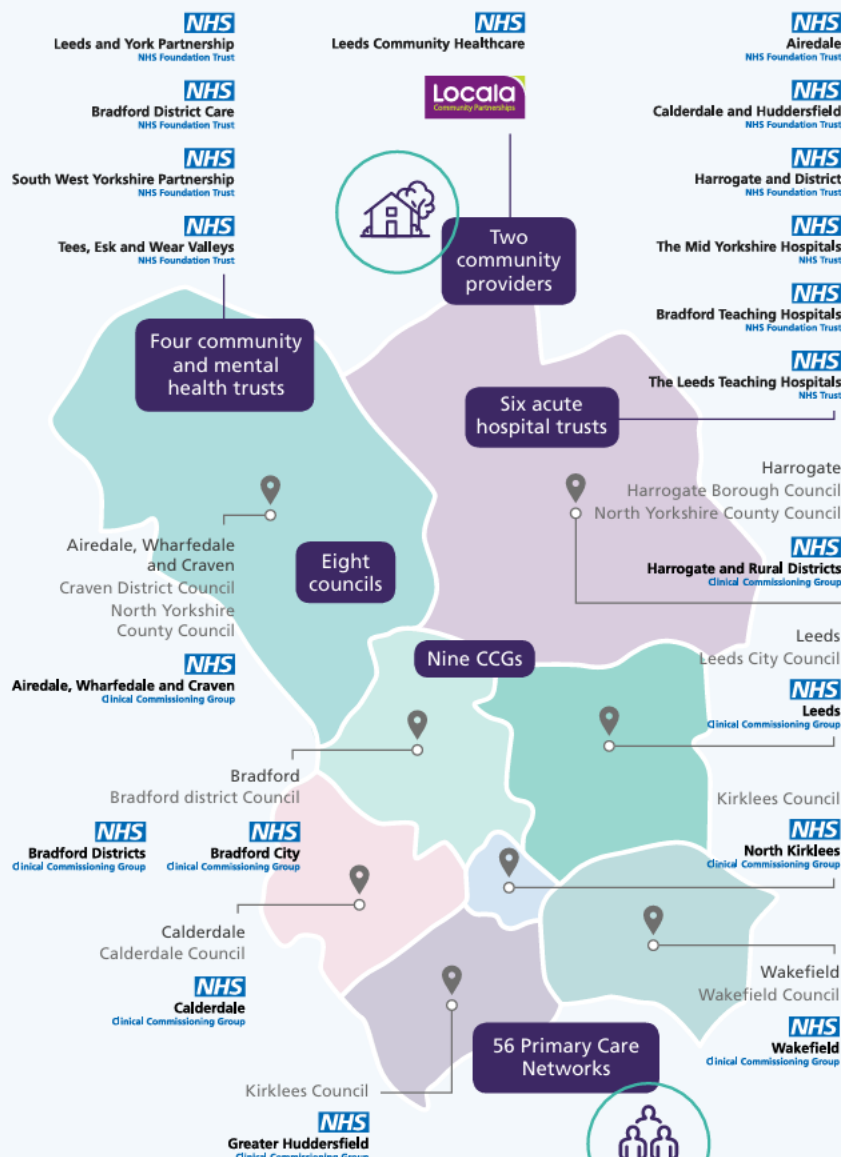
Our health and care landscape

Our councils



- 316 GP practices
- 555 community pharmacies, plus 38 online
- 431 providers of services in people's homes
- More than 611 care homes
- 11 hospices
- Thousands of voluntary and community organisations
- Hundreds of independent care providers

Figures accurate at November 2019.



West Yorkshire and Harrogate Health and Care Partnership is made up of six local places: Bradford district and Craven; Calderdale, Harrogate, Kirklees, Leeds and Wakefield

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Diagram 3: Our Health and Care Landscape

The Partnership's work to improve people's health and wellbeing is supported by West Yorkshire priority programmes such as cancer care, maternity services, mental health support, addressing health inequalities, and supporting children, young people and families.

This agreed way of working is set out in a constitution.

Across West Yorkshire there are also strong care provider collaboratives, including West Yorkshire Association of Acute Trusts, the Mental Health, Learning Disabilities and Autism Collaborative (MHLDA), the Community Healthcare Collaborative and the Hospice Collaborative.

Provider collaboratives are often partnerships between two or more NHS trusts, such as hospitals and mental health services. NHS providers face big challenges, such as more people needing services, and staff recruitment and retention concerns. These challenges are too big for one organisation to handle alone. So, the idea of collaboratives is to bring providers together to tackle these challenges together, whilst sharing good practice. Working together provides greater opportunities to deliver the West Yorkshire Integrated Care Strategy and Joint Forward Plan - which aims to make sure that all people are given the best start in life and can remain healthy and age well.

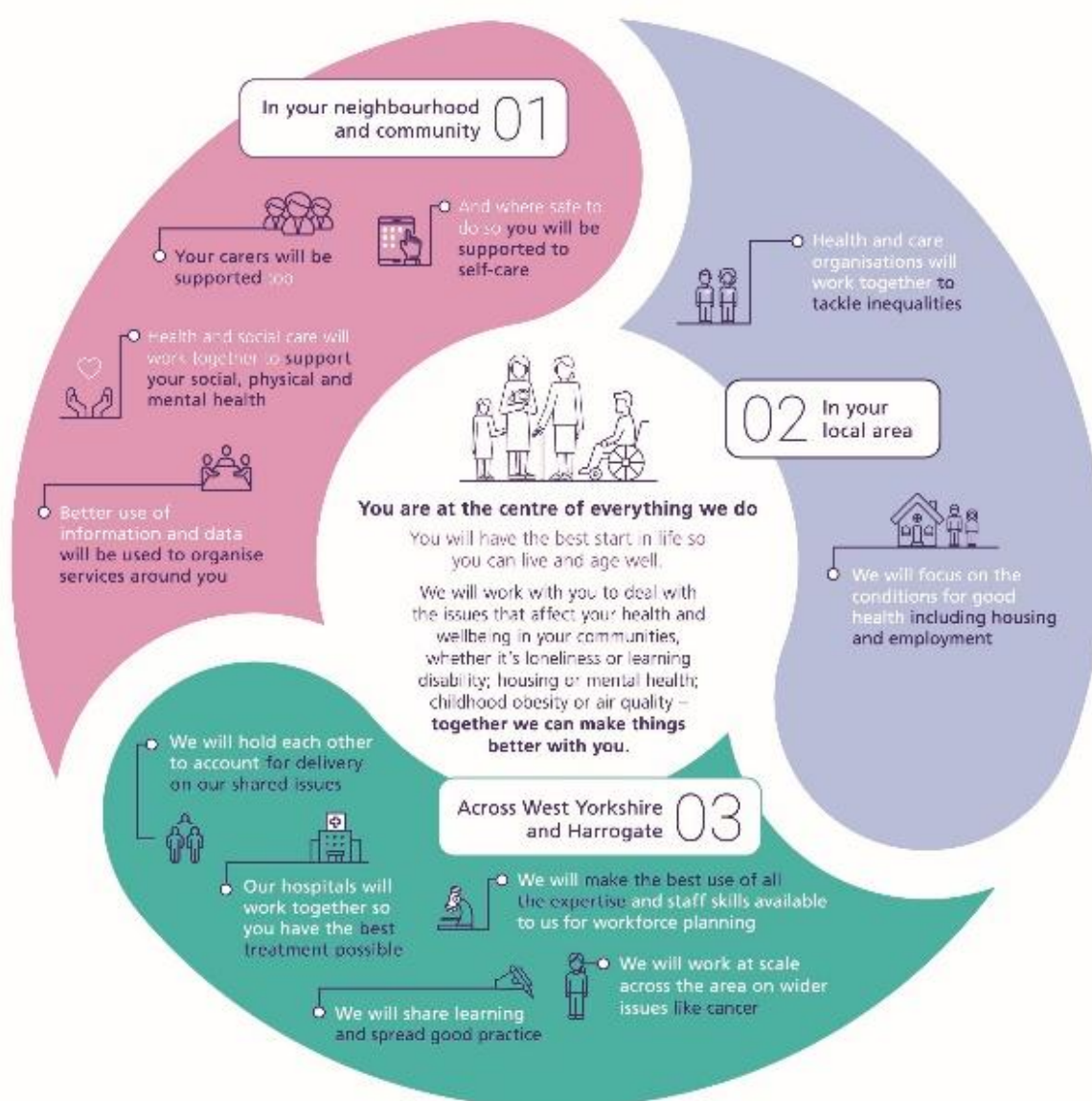


Diagram 4: Our Health & Care Partnership

This has been another challenging year for our system. In March 2025, NHS England (NHSE) mandated that all integrated care boards (ICBs) reduce their running costs by 50 per cent as part of a wider financial and operational reset, building on earlier cost reduction measures. This requirement has necessitated significant change across the

health and care system. Prolonged uncertainty regarding the future of the ICB, its functions, teams and individual roles has placed considerable pressure on staff resilience and adaptability, with this uncertainty set to continue into 2026-2027.

Despite these challenges, over the past year, staff have consistently demonstrated strong commitment to shared West Yorkshire priorities, as well as to supporting colleagues, system partners and local communities. Throughout this period, a clear focus on quality, productivity and effective ways of working has been maintained. Partners across the system have continued to address issues within maternity services to ensure the highest possible standards of care for women and babies. This is an area subject to particular scrutiny, with Donna Ockenden due to lead an independent review of maternity services while there will also be a national maternity review led by Baroness Amos within the NHS.

The ICB has focused on improving national standards to reflect the targets set by NHSE. Significant improvements have been made on elective recovery, ambulance response times, waiting in A&E, access to primary care and cancer care. Across the range of targets as an ICB, we have achieved over 65% of patients waiting no more than 18 weeks referral to treatment (RTT), less than 1.0% of people waiting over 52 weeks RTT, over 67% reliable improvement and 48% reliable recovery rates for talking therapies and continued increases in CYP access to mental health services as well as increases in the number appointments in general practice (GP) and a higher proportion of same day GP appointments.

Further work is required to continue to improve RTT 18 week performance to work towards 92% by March 2029 whilst continuing to reduce the total RTT waiting list size and the number of people waiting over 52 weeks. Other areas of continued work towards achieving national targets are the continued reduction in out of area placements for mental health beds, 62 day waits for cancer, diagnostic test waiting times, access to perinatal mental health services and talking therapies. There is also continue work to improve access through Primary care and support elective reform in line with national frameworks. Across West Yorkshire there is also continued work to reduce variability in the achievement of the targets particularly in areas such as 4 hour A&E performance and the 62 day cancer standard.

Substantial effort was directed towards preparing for what was anticipated to be an exceptionally challenging winter period. Colleagues across the Partnership worked proactively to mitigate risks, prioritising patient safety and quality of care while seeking to minimise the impact on service users, carers, communities and staff.

Resident doctors undertook three periods of national industrial action in 2025 and there was also additional local industrial action by some staff groups within West Yorkshire. The West Yorkshire health and social care system worked together to manage the response to industrial action as well as issues such as IT outages that affected GP practices and other NHS organisations. The ICB attends the West

Yorkshire Resilience Forum to ensure that the NHS is involved in multi-agency emergency planning and response.

During the year, the West Yorkshire Health and Care Partnership Board has received regular updates on collective progress against shared ambitions. These include increasing leadership diversity; reducing health inequalities for children living in low income households, particularly in relation to long term conditions, dental care and mental health services; reducing suicide rates; narrowing the life expectancy gap for people with mental health conditions, learning disabilities and/or autism; tackling antimicrobial resistance; and reducing the number of people unable to work due to ill health. With the West Yorkshire Combined Authority, we have supported over 4,000 people to stay in work through partnerships with NHS, local authority and third sector partners; a growing range of case studies illustrates the tangible impact of this work. Together, we have also made progress on creative health. Continued progress in these areas, despite significant system pressures, reflects the strength of partnership working and the commitment of colleagues across West Yorkshire.

Significant effort has also been invested in developing one , three and five year plans to support delivery of the Government's 10 Year Health Plan. These plans have been shaped through collaboration across the Partnership and informed by extensive data and engagement with local communities. They will play a key role in guiding future commissioning intentions. Ongoing engagement with communities remains central to this approach, ensuring that lived experience and service user and carer voice continue to influence service design and decision making. The development of a West Yorkshire wide insight library represents an important step in strengthening shared understanding across partners.

Work to shape the future of integrated neighbourhood health has continued at pace. Collaboration across partner organisations has been a defining feature of this programme, with around 750 people registering interest in working groups, webinars or receiving updates. The level of engagement and enthusiasm demonstrated reflects a shared ambition to deliver meaningful improvements for staff, carers, service users and the public across West Yorkshire.

Looking ahead, the ICB will become a much more streamlined organisation in 2026-27 as it moves to become a strategic commissioner and system convenor, in line with NHS England's Model ICB Blueprint. To make sure the important work of the West Yorkshire Partnership continues, work has been taking place for the past year to establish strong foundations for the future health and care system. Each Place has agreed to develop a Place Provider Partnership (PPP), working with local partners to shape membership and design arrangements that reflect local needs. PPPs will bring together providers across health, care and the voluntary, community and social enterprise (VCSE) sector, with joint responsibility for planning and delivering services at Place level. Their ambition is to enable smarter use of resources, targeting support where it is needed most, reducing duplication and delivering greater value for money.

Within the future operating model, the ICB's strategic commissioning function will operate at West Yorkshire level, using robust qualitative and quantitative insight to understand population needs, set strategic direction and translate this into contractual arrangements. Integrator teams, working with emerging PPPs in the five places, will support the development of integrated local services aligned to agreed outcomes and contracts. As PPPs mature, these Integrator teams will transition into the host partnerships.

During 2026–27, PPP joint committees will operate in shadow form alongside existing ICB Place Committees. This transitional year will focus on developing local priorities, service models and resource allocation, with recommendations made to Place Committees for decision-making. Full operation of PPPs across all five Places is expected by April 2027, aligned with the mobilisation of formal contracting arrangements.

The Place we operate within

Our Place operating model of 'Act as One' shows our clear commitment to a model of mutual accountability; joint decision-making with a shared responsibility for managing collective performance, resources, and the totality of population health. This is not just through services, but also by supporting people to take good care of their own health and wellbeing; helping more people to take control of their lives and to have more of a say in how their health and wellbeing needs are met. The Partnership 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 allows us to reflect our local priorities, with a shared analysis of problems and issues as the basis for acting, together. Alongside this, the work continues to progress in our place to implement the Place Provider Partnership as a way of integrating services locally, ready to be effective and accept delegated responsibility as of 2027.



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Date: 25 June 2026
Therese Patten
Chief Executive

3. Our Year in Review

Lynfield Mount Hospital Redevelopment

We are delighted that, after many years of planning, bidding and lobbying, the redevelopment of Lynfield Mount Hospital will commence in April 2026. The Full Business Case was signed off by the Department for Health and Social Care and by NHS England in January 2026 and contracts have now been negotiated and signed with our contractors. This significant capital scheme (£65m) will take around 3½ years to complete and will deliver a brand new two-ward block, fully refurbished legacy wards, and improved communal, therapeutic and outdoor spaces. This work will dramatically improve the experience and outcomes for our service users while they receive care from us, and our staff.

Our Year: A year of Innovation, Collaboration, and Impact

Over the past year, the Trust has made significant strides in improving service user outcomes, strengthening services, and driving innovation across corporate, clinical and community care. Through a focus on prevention, partnership working, workforce development and service user and carer experience, teams across the Trust have delivered measurable improvements while continuing to place people at the centre of everything we do.

Improving Outcomes through prevention and innovation

A major highlight this year has been the success of the Well Leg Service Pilot, which demonstrates the impact of proactive, preventative care. Designed to support service users following the healing of venous leg ulcers, the service provides structured follow-up, education, and individualised care planning. Within just one year, the clinic achieved a reduction in recurrence rates from 6% to 0%, highlighting the effectiveness of sustained engagement, service user and carer education and early intervention. This model not only improves service user quality of life but also reduces demand on community healthcare services, offering a scalable approach to long-term condition management.

Innovation in clinical pathways has also been evident within Podiatry services, where the introduction of a new prescribing pathway has transformed service user access to treatment. Between October 2025 and March 2026, podiatry prescribers completed 314 prescriptions, with most urgent cases resolved within two hours. This has significantly improved service user experience while reducing pressure on GP services. Further enhancements include direct referral pathways to vascular services, leading to faster assessment and intervention for



complex service users, and improved outcomes through more timely care. Nationally, the team has achieved exceptional results, recording the third highest healing rates for diabetic foot ulcers at 12 weeks across England and Wales, significantly exceeding the national average.

Strengthening Workforce and Clinical Leadership

Developing and supporting the workforce has remained a key priority. Within Unplanned Care Community Nursing, teams have created an outstanding learning environment for students, with consistently excellent feedback. Students frequently described placements as the best they had experienced, highlighting the supportive culture, strong mentorship and opportunities to build confidence. This positive experience is helping to inspire the next generation of community nurses and strengthen future recruitment.



Leadership in advanced clinical practice has also progressed significantly. The introduction of the Advanced Practice Clinical Lead role in January 2026 has strengthened governance, safety and professional

development. Key achievements include mapping workforce capabilities, introducing a preceptorship framework, and implementing structured learning needs analysis. Enhanced governance processes, such as prescribing audits and improved clinical oversight, are supporting high-quality, evidence-based care while preparing for future regulatory requirements.

Enhancing Service User Experience and Reducing Inequalities

Improving service user and carer experience and addressing inequalities have been central themes throughout the year. The Trust has continued to perform highly in the Patient-Led Assessment of the Care Environment (PLACE), consistently exceeding national benchmarks. Ongoing investment in facilities—including refurbishments, improved therapeutic spaces and enhanced accessibility—has ensured environments that support dignity, recovery and wellbeing.

Innovative approaches to service user engagement are also making a tangible difference. A pilot “Waiting Well” volunteer programme within the Memory Assessment Team demonstrates this impact. Volunteers contacted patients awaiting assessment to provide support, update information and connect them with community services. This resulted in a dramatic reduction in non-attendance rates to just 3.3%, compared



to the national average of 25%, as well as a 41% increase in referrals to community support. The initiative not only improved efficiency but also reassured patients and enabled earlier identification of risks.

The Trust has also strengthened its approach to physical health in mental health care, supporting over 2,200 service users with severe mental illness through proactive monitoring and intervention. Alongside this, the Smokefree programme has expanded significantly, embedding tobacco dependency support across inpatient settings and contributing to improved health outcomes and reduced inequalities

Medicines Optimisation

During the year the Trust continued to strengthen medicines optimisation through a strong focus on medicines safety, workforce innovation, digital improvement and strategic leadership. Pharmacy teams provided national and system leadership on medicines safety through collaboration with the Specialist Pharmacy Service, including participation in the Time Critical Medication Collaborative. This work improved the reliability of administration of time critical medicines through enhanced electronic prescribing alerts, clearer standards, improved reporting and targeted staff education, contributing to safer care and stronger assurance. Alongside this, embedding pharmacy technicians within community and proactive care services increased capacity, reduced pressure on nursing teams and supported safer medicines use, service user independence and improved experience. Ongoing optimisation of electronic prescribing systems and medicines workflows further strengthened oversight, safety and sustainability.

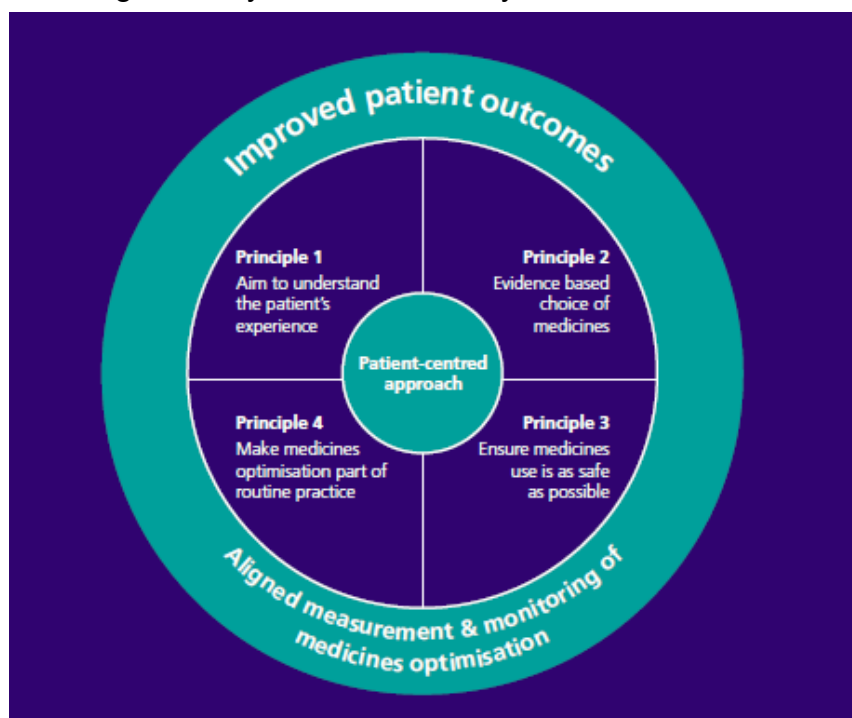


Diagram 5: Patient-centred approach to medicine optimisation

The Trust also refreshed its Medicines Optimisation Strategy during the year, setting a clear strategic direction aligned to patient safety, workforce development, digital

transformation and system collaboration. This has provided a framework to support consistent, person centred use of medicines across services and to guide future improvement priorities. In parallel, the Trust has demonstrated wider system leadership in medicines optimisation for people with complex and long-term needs, particularly older people, through education, guidance and data driven quality improvement. Governance arrangements have continued to mature through updated clinical pharmacy standards and dedicated medicines safety forums, supporting learning from incidents and continuous improvement. While research and innovation activity continues to complement this work, the primary focus remains on translating evidence into everyday practice and delivering measurable improvements in safety, quality and outcomes for service users and carers across Bradford District and Craven.

The Trust has also demonstrated its commitment to sustainability, achieving Bronze accreditation through the Royal Pharmaceutical Society's Greener Pharmacy Toolkit, recognising efforts to reduce medicines waste and environmental impact.

Creativity, Recovery and Community Connection

Creative and community-based approaches have played an increasingly important role in supporting recovery and wellbeing. The Creative Connections festival, delivered in partnership with local organisations, brought arts and culture directly into inpatient wards. Over 75 service users participated in activities including music, poetry and visual arts, with feedback highlighting significant improvements in mood, wellbeing and engagement.



Similarly, the Voyage to Recovery initiative within Early Intervention in Psychosis showcased the power of innovative therapy. Service users participated in a six-day sailing experience, travelling over 300 miles while building confidence, resilience and social connection. The success of this programme has led to plans for future expansion.

The Green Therapy project has significantly expanded access to nature based activities across the Trust, embedding connection with nature into both community and inpatient mental health services.

The work includes the redevelopment of an adult community allotment, delivery of regular gardening, walking, canoeing and outdoor activity groups, and extensive partnership working with local and regional. Creative and cultural elements have been integrated through nature based art, poetry and Bradford 2025 initiatives, alongside volunteering pathways that support confidence, skills development and progression into community roles.



Bradford's designation as UK City of Culture 2025 provided a unique opportunity to support community wellbeing through creativity. More than thirty projects formed part of the Creative Health programme, using cultural engagement to address health and social challenges. In November 2025, the Trust hosted a two-week programme of music, dance and visual arts activities, enabling service users to engage in creative approaches to recovery.

Summary

Looking to the future, the Trust is investing in digital innovation to support workforce growth, including the development of an immersive classroom for mental health training. This cutting-edge, multi-sensory learning environment will provide realistic, hands-on experience for staff and students, improving preparedness and supporting recruitment into mental health services.

This year has been marked by strong progress across all areas of the Trust. From measurable clinical improvements and enhanced service user and carer experience to workforce development and innovative models of care, the achievements highlighted here reflect a shared commitment to excellence, collaboration and continuous improvement.

By focusing on prevention, embracing innovation, and strengthening partnerships, the Trust is not only improving outcomes today but also building a sustainable, high-quality healthcare system for the future.

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Date: 25 June 2026
Sarah Jones
Chair in Common

.....
Date: 25 June 2026
Therese Patten
Chief Executive

4. An overview of our performance

Performance Analysis

The Integrated Performance Management Framework

The Trust's performance management framework outlines our performance management approach, systems, structures and supporting arrangements. The current framework covering 2025-2026 is in line with the framework used following a full refresh in July 2023. Following the publication of the National Oversight Framework (NOF), and 10-year planning guidance, a review of the Trusts strategic performance reporting is underway and will be implemented during 2026-2027. This will include alignment to the new Trust strategy following its approval.

Performance management in our Trust identifies and tracks progress against operational plan targets and milestones. It is also focused on continuous improvement and the delivery of the best outcomes for service users and carers. This approach is intended to support transparency of expectation and performance, with ownership and accountability for activity, targets, standards and objectives.

The integrated performance management framework aims to provide a comprehensive understanding of how services are performing across quality and safety, outcomes, workforce, activity, finance and regulatory requirements. The framework supports operational processes to ensure continuous improvement in the quality and delivery of services and the assurances required by the Board and Committees, with a clear and dynamic line of sight of issues and celebrations from 'ward to Board'.

The following principles underpin the Trust's performance management framework:

- **Culture of improvement:** these arrangements are intended to drive an organisational culture of continuous quality improvement, delivered for the benefit of patients/service users and carers. The Trust's approach to performance management will recognise and share learning and best practice (internally and externally) and celebrate success. Using the Care Trust Way methodology, particularly Daily Lean Management, the expectation is that feedback in relation to the effectiveness of processes that underpin strong performance will be dynamic and daily (where needed) and that the mechanisms to develop and role model rapid process improvement will be complementary to, and support, performance management.
- **Accountability:** The measures and evidence used to assess performance will be clear, with defined roles and responsibilities across Care Groups and corporate functions, with strong assurance and oversight. This will be supported by clear objectives at all levels which drive a culture of high performance and accountability, supported by the Trust's appraisal process.
- **Delivery focus:** The performance management approach will be action oriented with empowerment and ownership of decision making. The focus will be on delivering planned performance and sharing good practice, to develop and provide

excellent services and support to our partners to do the same. A balance between challenge and support will be maintained with the aim of achieving continuous improvement both internally and when benchmarked against the best in the country.

Throughout 2025-2026, performance has been affected by the combined impact of:

- High service demands and increased acuity and complexity.
- Workforce challenges, with high turnover and vacancies in some services, some difficulties in attracting and retaining professionally qualified staff, and continued sickness absence.

The table on the next page outlines our performance against metrics used by NHS England to monitor and gather insights as part of the NHS oversight framework.

Metric	2025/26 goal	2025/26 performance	Trust position	Comment
Urgent Community Response - referrals that achieved the two-hour response standard	70%	83%*	Achieved target	The standard applies to teams that provide urgent care to people in their homes. Urgent referrals to the district nursing service are in scope.
Community dental service – proportion of patients waiting less than 18-weeks to commence dental treatment under general anaesthesia.	92%	66.8%**	Target not met	The increased complexity of patients accessing dental service has increased the numbers requiring a general anaesthetic (GA) for their care. The service has had some impact during the year from industrial action. Targeted waiting list initiatives are in place.
Community dental service – number of patients waiting over 52 weeks to commence dental treatment under general anaesthesia.	0	14**	Target not met	An average of 10 per month during the year. Targeted waiting list initiatives are in place.
Improving Access to NHS Talking Therapies - % of people reaching reliable recovery	48%	49.6% (average monthly performance)	Achieved target	Targets are being routinely met despite a national shortage of qualified practitioners and service users with increased complexities.
Improving Access to NHS Talking Therapies - % of people reaching reliable improvement	67%	70.2% (average monthly performance)	Achieved target	Targets are being routinely met despite a national shortage of qualified practitioners and service users with increased complexities.
Inappropriate out of area placements for adult mental health services – total number of bed days patients have spent out of area.	0	956*** bed days	Target not met	Significant reduction in inappropriate days during 2025/26 but still impacted by acuity of service users and delayed discharges.

* December 2025 data

** February 2026 data

*** Includes data from April 2025 to February 2026

Table 1: Performance against national metrics

The Care Trust Way – our approach to innovation and improvement

Delivering Best Quality Services for our Community

The Trust continues to strengthen its approach to quality improvement (QI), embedding a culture that supports better outcomes for service users, carers and staff. This report summarises progress and impact over 2025-2026 and sets out our 2026-2027 forward look, including how we will build on improvements in access to care, collaborative working and service user experience using our established improvement methodology: the Care Trust Way (CTW).

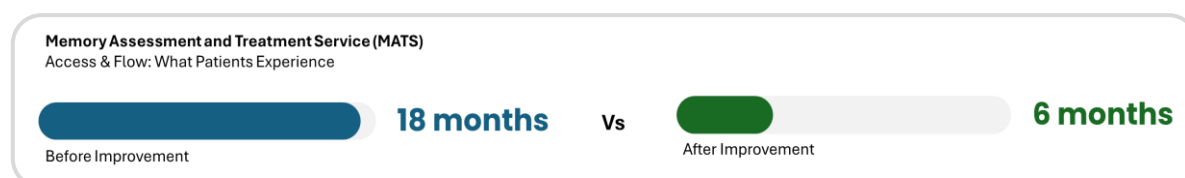
QI Priorities and Progress – 2025-2026

Last year, we identified three strategic QI priority themes under our ambition to deliver the best quality services. Each priority was designed to drive tangible improvements over a multi-year period.

Together, these principles frame how the Trust approaches improvement in practice. Our first priority focuses on where improvement has the most immediate impact for service users and services: access to care and the flow of people through our pathways.

Priority Theme 1 – Improving Access and Flow

We are committed to ensuring the right care, in the right place, at the right time—reducing waits and improving continuity of care. Using structured improvement methods, teams have redesigned pathways, strengthened triage and improved communication to make better use of clinical capacity.



Our Memory Assessment and Treatment Service (MATS) has improved access, flow and service user experience across the district. Waiting times have reduced from around 18 months to approximately six months despite rising demand. A standardised pathway is now in place across all localities, supported by clearer referral criteria and improved digital processes. Service user and carer experience has been strengthened through clearer communication at referral, a co-designed pathway leaflet and the introduction of a “Waiting Well” volunteer programme to support people while they await assessment.

Talking Therapies, working with Limbic, implemented AI-enabled triage and care support tools (Limbic Access and Limbic Care). This collaboration, recognised through the HSJ Digitising Patient Care Award (2025), has widened access for people who may struggle with traditional referral routes. Notably, 39% of referrals are

completed outside normal working hours, with a 90% conversion rate from intake to assessment, while also reducing avoidable demand on clinical teams.

We are also expanding digital communication and access across community services by extending Patient Knows Best (PKB), rolling out e-referrals to improve referral quality and reduce administrative delay, and widening the use of SMS messaging to support clearer and more timely communication.

Overall, this work provides assurance that services are better able to respond to demand while maintaining quality and safety, with more consistent access across localities and improved use of clinical capacity.

While improving access and flow is critical, sustaining these gains depends on how effectively we learn from practice. Our second priority therefore focuses on strengthening learning for improvement, ensuring teams are supported to understand what works, adapt in real time and spread learning across services.

Priority Theme 2 – Learning for Improvement

We aimed to strengthen how we learn from practice and apply that learning systematically to improve quality, safety and outcomes. In 2025/26, this increasingly focused on ‘learning through doing’—using coaching, collaboration and data to test change, understand what works and spread effective practice.

A key example is the Culture of Care programme in inpatient services, delivered through the CTW and aligned with NHS England’s Culture of Care standards. Three inpatient wards participated during the year, supported by improvement coaching, executive sponsorship and lived-experience partners. Ward teams tested changes focused on therapeutic relationships, communication, ward routines and staff wellbeing. Learning is shared through regular networks and Trust-wide report-outs, helping teams reflect on progress and build confidence in improvement methods.

Learning for improvement is also central to Community Mental Health Team (CMHT) transformation. Improvement activity brought together care co-ordinators, medics, psychologists, managers and partners to examine the end-to-end assessment and allocation process. Through value-stream mapping and data review, teams developed shared evidence-based priorities for change, including waiting-list management, role clarity and releasing time to care—enabling targeted testing rather than reliance on anecdote.

Across the Trust, improvement coaching, structured report-outs and learning networks continue to strengthen how learning is captured and applied, grounded in real-time data, lived experience and frontline insight.

Learning alone is not sufficient unless it translates into meaningful change for the people who use our services. Our third priority therefore centres on patient experience and involvement, ensuring that improvement is shaped by lived experience and results in care that feels compassionate, respectful and responsive.

Priority Theme 3 – Enhancing Service User Experience and Involvement

We set out to ensure care is consistently person-centred, trauma-informed and shaped in partnership with people who use our services. In 2025/26, this focused on turning lived-experience insight into practical, visible improvements.

Within MATS, service user and carer experience has been central to pathway redesign. A co-designed, accessible pathway leaflet helps people understand what to expect from referral through to diagnosis, supported by clearer communication and additional non-clinical support while waiting.

In inpatient services, feedback through the Culture of Care programme highlighted that standard personal care products did not meet the needs of people with different hair types and cultural backgrounds. In response, ward teams tested the provision of multicultural haircare products using a structured PDSA approach. This recognised hair care as part of dignity and inclusion, and learning is being shared to support wider adoption.

Across the Trust, co-production, peer support, volunteering and QI activity continue to embed lived experience into service design and delivery, supporting care that is compassionate, respectful and inclusive.

Embedding the approach across the Trust

Quality improvement is increasingly everyone's business at the Trust. The CTW continued to mature in 2025/26, with a focus on building improvement capability at scale. To date, over 1,000 staff have received some form of QI training—from introductory awareness and local QI champions through to CTW Practitioners and a growing cohort of CTW Sensei who coach and support others.

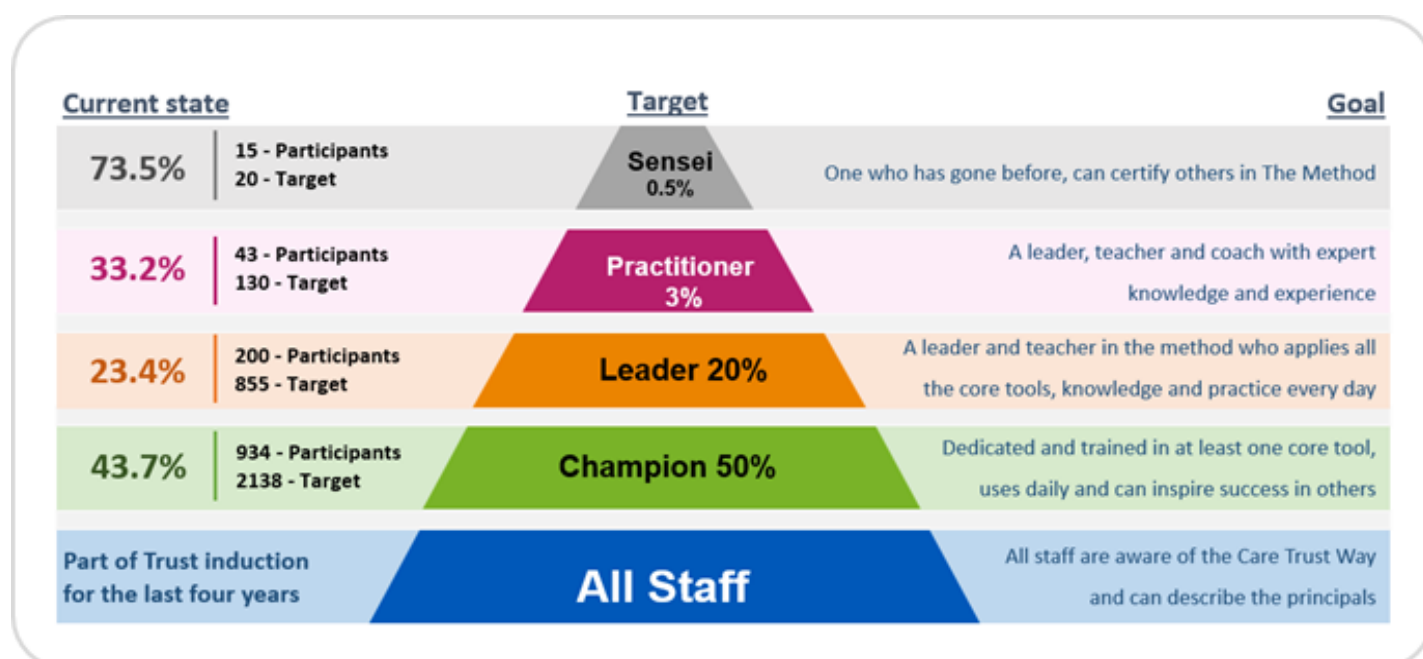


Diagram 6: Care Trust Way Training

Daily Lean Management (DLM) huddles are now routine in many teams, enabling frontline staff to identify and solve problems in real time. Alignment with NHS Impact has been strengthened, with the Trust sharing learning at regional forums on how a common QI language supports quality during challenging periods.

QI also underpins the Better Lives, Together 2023–26 strategy, supporting full implementation of Patient Safety Incident Response Framework, a shift towards learning-focused safety responses, and growing staff engagement in improvement. Sustainability is embedded through work that reduces waste, paper use and environmental impact in line with the Green Plan.

Looking Ahead: QI Priorities for 2026-2027

In 2026-2027, we will continue to focus on access and flow, learning for improvement and service user experience, while strengthening the systems and capabilities that sustain improvement.

Key developments include embedding the Trust-wide Quality Management System, taking a more systemic approach to staff sickness absence and workforce productivity, and making purposeful use of innovation, AI and automation. The establishment of a Strategic Innovation Lead role will help ensure innovation activity is focused, evidence-led and aligned with Trust priorities.

We will also expand development opportunities through Multiverse digital, data and Artificial Intelligence programmes. This will complement the CTW training offer and strengthen internal capacity for sustainable productivity improvement.

Taken together, this report reflects a Trust that is increasingly confident in how it improves. By combining clear priorities, disciplined improvement methods, strategic innovation and sustained investment in people, the Trust is continuing to strengthen its ability to deliver high-quality, responsive and sustainable care.

Digital Services Performance

Our progress over the past year

Over the past year, we have continued to make it easier for people to use and engage with our services. Building on the success of the Patient Engagement Platform (PEP), we have expanded digital tools that link our systems with the NHS App. This makes it simpler for service users to access information and supports national plans to move away from paper-based processes towards more convenient digital options.

Children and Adolescent Mental Health Service, the Community Mental Health Team and the Intensive Home Treatment Team services have now introduced digital letters. The Trust has sent more than 30,000 letters electronically, helping teams communicate with service users quickly while also reducing postage costs. Around 18,000 people have signed up to the platform so far, with approximately 4,000 letters already read online. Teams continue to add new services each month, giving

increasing numbers of service users the choice to receive information in a way that works best for them.

Teams have also continued to improve clinical systems to better support safe and effective care. This work includes:

- Providing clearer information to support the management of service users receiving care out of area.
- Improving training for staff through more engaging and practical learning materials.
- Simplifying how units are set up within children's services.
- Introducing a new Acute Unit, helping staff manage crisis assessments more effectively and meet national reporting requirements.
- Strengthening the collaborative approach to prioritising system changes, keeping patient safety, experience and quality of care at the centre.

Embedding Clinical Safety and Governance

Keeping service user's safe remains at the heart of our digital work. This year, the Trust introduced a new Chief Nursing Information Officer / Clinical Safety Officer (CNIO/CSO) role and made it permanent. This step demonstrates the Trust's continued commitment to ensuring digital systems support safe, high-quality care.

All new digital developments now go through a structured clinical safety review. This process helps teams understand potential impacts and introduce changes safely, including those involving new and emerging technologies.

Infrastructure, Security and Resilience

Digital Services is supporting the development of the new Lynfield Mount Hospital by ensuring reliable digital connectivity is in place throughout the build programme. This work helps minimise disruption and maintains continuity of services during a period of significant change.

The Trust has made important improvements to cyber security during the year. With support from NHS England, teams have introduced new tools that improve visibility of potential cyber threats and strengthen the protection of service users and staff information. Board-level discussions on cyber risk and resilience have also increased. Teams continue to keep systems and devices up to date, including the successful move to Windows 11.

Protecting personal information remains a priority across all digital activity. Teams build privacy and data protection into the design and management of systems, supporting ongoing compliance with the Data Security and Protection Toolkit.

Looking Ahead: 2026-2027 and beyond

Guided by the Digital for Better Lives strategy, the Trust is increasing its use of digital innovation to support patient care and staff wellbeing. This approach includes using

Artificial Intelligence (AI) to support clinical decision-making and help manage demand.

National organisations have recognised this work, with the Bradford District and Craven Talking Therapies service winning the Digitising Patient Care Award at the 2025 HSJ Awards. The Trust has strong governance arrangements in place to ensure teams use AI in a safe, transparent and ethical way.

Teams are also exploring technologies that reduce administrative workload for staff. A small group of staff, mainly in corporate services, is currently using Microsoft Copilot, with opportunities to expand use over time. Clinical and operational teams are introducing Ambient Voice Technology (AVT) across a range of settings to support more efficient documentation.

Together, these clinically led digital developments will continue to support the Trust's digital transformation. They will be reflected in the new Trust Strategy and refreshed Digital Strategy, with a clear focus on improving care, experience and outcomes for service users, carers, and communities across Bradford and the surrounding areas.

Addressing Inequalities and our commitment to partnership working

Reducing health inequalities continues to be of core significance for our Trust, embedded within our strategic priority to deliver best quality services within our Ambition to Action Strategy. Over the last financial year, we have taken significant steps to strengthen our approach to identifying, addressing and monitoring health inequalities - both within our services and across our wider partnerships.

In 2025 we invested in health equity through the recruitment of a dedicated Health Inequalities Lead and the establishment of an Equality Diversity and Inclusion (EDI) Influencers Network and Culture of Care Programme, these have enabled greater focus and coordination across the organisation. Our Belonging and Inclusion Plan can be found on our website, and includes our commitment to equitable service delivery and sets out clear actions to reduce disparities in access, experience, and outcomes.

We have a strategic approach to delivering health equity. We have produced our annual Public Sector Equality Report which includes examples of our work to address health inequalities which can be viewed online, in line with the aims of the public sector equality duty.

We are continuously enhancing our ability to monitor, report, and act on disparities across our services. Our internal Business Intelligence dashboards enable mental health services to view live caseload data disaggregated by age, ethnicity, sex and multiple deprivation. There are plans in place to expand this capability across additional services within the Trust. This has been an integral source of information

to support the equality impact assessments we have done on three services every year using the NHS Equality Delivery System.

As part of our commitment to the NHS England statement on information on health inequalities, which outlines the requirement for NHS organisations to systematically identify, address and report on health inequalities, we aim to produce routine transparent reporting in line with the requirements of the statement and have assessed our governance processes in 2025. A summary of our compliance is included below.

We continue to meet the requirement to disaggregate Mental Health Act detention data by ethnicity, deprivation level, gender, and age. This information is readily accessible for staff through our internal dashboard. We partially fulfil the reporting requirement for restrictive interventions. A new Patient Carer Race Equality Framework (PCREF) dashboard has been developed to provide this data. An EDI check box has been implemented to enable staff to identify incidents that relate to equality and health equity. These are monitored, responded to and used to support learning.

We can analyse snapshots of Child and Adolescent Mental Health Service access data by the same demographic indicators, this partially meets the statement requirements. Work is underway to ensure real time reporting by demographic group is incorporated into future health equity reporting. This data will sit alongside Talking Therapies (IAPT) recovery metrics and smoking cessation support for inpatients. This will make the Trust fully consistent with the statement. The Trust is rolling out Patient Related Outcome Measures which sit within the dashboard and can be analysed by the same equality groups.

Work is ongoing across the trust to drive reduction of health inequalities in priority areas such as in Mental Health via the Culture of Care Programme.

As our reporting capabilities continue to evolve, available metrics can be accessed online.

Over the last three years, nine of our services have been supported through the NHS Equality Delivery System 22 (EDS22) equality assessment process. These include:

- Child and Adolescent Mental Health Services
- Specialist Mother and Baby Service
- School Nursing
- Intensive Home Treatment
- Physical Health and Wellbeing
- Palliative Care
- Learning Disability Inpatient Services
- City Community Mental Health Service
- Proactive Care Team

You can view these performance reports and action plans on our website. We have delivered this in partnership with our NHS local partners.

We have made further progress to ensure inclusive and responsive services, for example:

- Ongoing compliance work with the Accessible Information Standard and preparation to launch the reasonable adjustments digital flag.
- Updates to our patient record systems, guidance and policies, including guidance on records management when caring for service users who have a gender recognition certificate.
- Launch of a new Spiritual and Pastoral Care Reference Group and closer working with the Trusts Chaplains supporting the spiritual wellbeing of both service users and staff.
- Development of a guide for interpreters that support psychological therapy to support improvement of health outcomes for this cohort of service users.
- Development of a neuro-affirmative practice group and strategic approach with a range of guidance and support to improve access, experience and outcome for neurodiverse service users.
- Creation of a toolkit and associated training for our staff to support the identification and reduction of inequalities within services.
- Identification of best practice through our network of EDI influencers and creation of case studies for dissemination across the organisation.
- We are delivering against the NHS Patient and Carer Race Equality Framework (PCREF). Our PCREF programme plan has been developed in partnership with staff and community members, ensuring co-production and meaningful involvement. We have an Accountability Group and seven workstreams.

We are proud to have developed our partnership with Hope and Light, a voluntary and community sector-led programme delivering culturally adapted mental health support for people from ethnically diverse communities within Bradford District and Craven. This collaboration is supporting implementation of PCREF and strengthening approaches to reciprocal mentoring, co-production, and inclusive practice.

A summary of this is provided in the PCREF Annual Report and Action Plan 2026.

All documents referenced can be found on our Equality and Diversity Page on our website: www.bdct.nhs.uk/about-us/key-information-publication-scheme/publication-scheme-and-key-information/equality-and-diversity/

Chief Medical Officer's report

Introduction from Dr Sal Uka, Interim Chief Medical Officer

It is a privilege to introduce this section, which reflects the dedication and professionalism of colleagues across the Trust. Over the past year, our teams have continued to deliver safe, effective and compassionate care, while also strengthening the governance and assurance that underpins high quality services.

This update highlights important progress in areas that matter to service users, carers and staff over the past year: preparation for the implementation of the Mental Health Act 2025, improvements in Mental Capacity Act compliance, continued partnership working across the system, and the growing maturity of our digital clinical safety approach. It also showcases the value of learning and development, from our university teaching sessions to the excellent feedback we receive from students and trainees, and the ambition of our Research and Knowledge Services to widen opportunities for local communities to participate in high quality studies.

I would like to thank everyone who has contributed to the achievements captured here and, importantly, to the improvements that are not always visible in a written report, including everyday acts of leadership, thoughtful multidisciplinary working, and the consistent focus on service user experience.

I hope you find this update informative and that it provides a clear sense of our direction of travel as we continue to improve care, reduce risk and support our workforce.

Digital Clinical Safety

Digital Clinical Safety has been a key focus for the Trust this year, supporting both 'Safe' and 'Well Led' CQC domains.

Strong executive leadership and clear accountability have ensured that digital systems supporting care are clinically risk assessed, safely implemented and effectively governed. The establishment of the Digital Clinical Safety and Prioritisation Group has strengthened oversight, prioritisation and assurance across digital change. Compliance with national clinical safety standards (DCB0129 and DCB0160) has been embedded through structured safety documentation, hazard management, and clinical sign off.

This approach has enabled innovation and digital transformation to progress safely, transparently and with clinical confidence, supporting high quality, safe care for service users

Update from the Mental Health Act Office

The Mental Health Act Office saw significant progress this year, including proactive preparations for the implementation of the Mental Health Act 2025, through team expansion and improved processes. Staff development and strong legislative knowledge helped reduce tribunal delays, while high training compliance and enhanced Mental Capacity Act practices strengthened safe and effective care delivery. Operational improvements, such as transitioning to electronic documentation and expanding volunteer Hospital Managers, have increased efficiency and service user access to hearings. The team also provided effective cross-trust support, managed complex service user transfers, and maintained strong performance in meeting Court of Protection requirements, alongside contributing to education through well-received university teaching sessions.

The Trust received feedback from a Lecturer in Mental Health Nursing at the University of Bradford following the teaching session: “The session went very well and certainly in the lecture theatre, all the students seemed engrossed in the subject matter. Terese O’Keefe (Mental Health Act Advisor) delivered the information in a very clear concise way and this was very helpful for a lot of our students who sometimes struggle with terminology.”

Feedback from Associate Hospital Managers highlighted the value of representation on the Mental Health Legislation Committee, noting that it provides vital insight into Trust operations, strengthens understanding of legislation and performance, and ensures an independent voice to raise concerns and offer constructive challenge. They also emphasised that participation in these forums supports professional development, enhances governance awareness, and reinforces confidence in the Trust’s patient-centred approach and commitment to high standards of care.

Feedback from Undergraduate Medical Students

The Trust continues to provide highly regarded psychiatry placements, maintaining its position as a regional leader for over five years. Students consistently highlight the excellent learning environment and structured teaching programme, supported by a wide multidisciplinary team including doctors of all grades and other healthcare professionals. This is reflected in outstanding feedback, including 27 ‘green cards’ for teaching excellence and a rare 100% overall placement satisfaction rating, achieved for the second time and unmatched by other Trusts in the region. The feedback was taken from fourth year medical students from Leeds Medical School who have psychiatry placements within the Trust.

Professional Development and Support

The Trust has continued to strengthen support for International Medical Graduates (IMGs), with a clear focus on reducing differential attainment and enhancing development opportunities. This has been achieved through structured initiatives including a regional network, dedicated resources such as an IMG handbook and dashboard, and tailored conferences and workshops. The work has gained national

recognition, including an Royal College of Psychiatry award, while ongoing priorities include expanding engagement, developing formal mentoring, and improving access to training and career progression for IMGs.

The Continuing Professional Development (CPD) programme plays a key role in supporting workforce development, retention, and clinical quality through a well-established range of funded educational opportunities and in-house training. Since 2023, it has delivered a successful series of regional conferences with strong attendance, high-quality speakers, and consistently excellent feedback, enhancing the Trust's profile and reducing reliance on external training. While the programme demonstrates clear impact and growing engagement, future priorities include securing sustainable funding, embedding digital resources, and evolving content to reflect emerging areas such as AI, with ambition to position the Trust as a regional CPD hub.

Task Force on Climate-related Financial Disclosures

Task Force

NHS foundation trusts must contribute to the Government's statutory environmental targets and adapt to any current or predicted impacts of climate change as identified in the most recent report under section 56 of the Climate Change Act 2008.

NHS England's NHS Foundation Trust Annual Reporting Manual adopted a phased approach to incorporate the Climate-related Financial Disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures are as interpreted and adapted for the public sector by HM Treasury. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. However, for many years the Trust has calculated carbon emissions associated with our activities and continues to do so as detailed in the sustainability section of our annual reports.

The phased approach incorporates the disclosure requirements of the strategy, governance, risk management and metrics and targets pillars. These disclosures are provided below with appropriate cross referencing to relevant information elsewhere in the annual report and accounts and in other external publications. TCFD disclosures provide a structured framework to explain how these risks and opportunities may affect future performance and delivery of the organisation.

Board Oversight of Climate Related Issues

The Board receives climate related information, including quarterly key performance indicators (KPI) and Green Plan progress and more detailed information is available if required. The Board does not currently consider climate-related issues when reviewing organisational plans or as part of decision making, however, all new policies now have a requirement to complete a sustainability impact assessment (SIA). The SIA includes consideration of a range of environmental issues including climate change adaptation.

Management's role in assessing and managing climate related issues

NHS foundation trusts have a duty as per section 63B of the National Health Service Act 2006 to contribute to the governments statutory environmental targets and adapt to any current or predicted impacts of climate change. Work centres on carbon mitigation activities, in particular delivery of the Green Plan (further details in the Sustainability section of the annual report), and the team consider climate change risks and adaptation requirements.

Assessing and managing climate change (mitigation and adaptation) issues are devolved from Board to the Energy, Waste and Sustainability Team who work with clinical, corporate, estates and facilities colleagues to address areas of concern. In

particular, to meet the requirements from NHS England regarding carbon reduction. Senior management have several opportunities within the governance and reporting framework illustrated below to receive and review sustainability information, with additional ad hoc papers presented to the senior leadership team when necessary or on request. Sustainability metrics are starting to be integrated in quality improvement (through our SusQI Beacon Site Status) and future transformation plans.

All Trust senior leaders continue to have oversight and remain informed about climate related issues through several routes; Green Plan progress and important updates are provided to the Green Strategy Group (quarterly), the Finance and Performance Committee and the Board, twice per year. The Trust also completes an annual climate-related financial disclosure questionnaire for internal audit. Quarterly KPI information is provided through these routes and to all staff via the electronic green newsletter. Governance and communications internally, and partnership working regionally, is illustrated below.



Diagram 7: Green Plan Governance, Communication and Engagement

Climate Change Strategy

The climate crisis affects our ability to safeguard the health of the population and therefore tackling it as a determinant of health is crucial to our role as health and care professionals. Adaptation for health and social care falls into two categories:

Patient volume and need	Operational delivery
Climate change could negatively impact the physical and mental health and wellbeing of our residents which could affect the volume and pattern of demand.	Our infrastructure and supply chains need to be prepared for and resilient to weather events and other crises (e.g. buildings, communications, emergency service vehicles, models of care) and supply chain (e.g. fuel, food, consumables and medical equipment supplies)

Table 2: Impact of Climate Change

The Trust has developed a Climate Change Adaptation plan with neighbouring acute Trusts. This identifies the climate-related risks and opportunities to the organisation. The most significant risks relate to temperature - overheating and water - drought, and flooding. Using our location data and the Met Office climate projections for different levels of global warming, the Sustainability team has identified the climate change projections for our largest sites, see Table 3. The table shows the weather impact locally, if global temperatures rise by two or four degrees. In the Bradford District, our buildings and populations will have to adapt to higher maximum temperatures, more hot days and more rain but on fewer days in summer. Winters will be milder and drier. This means a change to how we address severe weather planning and how we mitigate for summer pressures and not just traditional winter pressures.

Table 4 shows the surface water and river flood risk at these same sites. These risks are likely to manifest in the medium to long-term, i.e. 5-10+ years, however we do have over-heating (for example Horton Park Health Centre) and flood risks (e.g. New Mill), which are present now.

The sustainability team will continue to review climate change risk in 2026-27 and work with estates and emergency preparedness, resilience and response (EPRR) colleagues to assess the local impacts.

Season	Weather impact	Global temperature	Airedale Centre for Mental health	Lynfield Mount Hospital	New Mill	Horton Park
			BD20 6PD	BD9 6DP	BD18 3LD	BD7 3EG
Summer	Hottest day	Current	32.3C	32.9C	32.9C	33.2C
		2C global warming	33.6C	34.3C	34.3C	34.7C
		4C global warming	38.1C	38.6C	38.6C	38.9C
	Summer days above 25C per month (on average)	Current	1	1	1	1
		2C global warming	2	3	3	3
		4C global warming	7	8	8	9
	Rainy days	Current	12	11	11	11
		2C global warming	11	10	10	11
		4C global warming	9	9	9	9
	Wettest days	Current	69mm	66mm	66mm	63mm
		2C global warming	72mm	80mm	80mm	74mm
		4C global warming	82mm	78mm	78mm	75mm
Winter	Hottest day	Current	18.1C	18C	18C	17.9C
		2C global warming	18.1C	17.9C	17.9C	17.9C
		4C global warming	19.7C	19.6C	19.6C	19.5C
	Rainy days	Current	15	14	14	14
		2C global warming	15	14	14	14
		4C global warming	15	14	14	14
	Wettest days	Current	75mm	64mm	64mm	56mm
		2C global warming	80mm	69mm	69mm	61mm
		4C global warming	81mm	70mm	70mm	61mm

Table 3: Climate Change Projections for largest Trust sites

Site	Risk level	
	Surface water flooding	River flooding
Airedale Centre for Mental Health	Low	Very low
Lynfield Mount Hospital	Medium	Very low
New Mill	Medium	High
Horton Park	Low	Very low

Table 4: Flood Risk at largest Trust sites

As well as the risks to our core sites, using the Local Climate Adaptation Tool* at local authority level for the Bradford District and Craven, the following health impacts have been identified and red, amber, green (RAG) rated. However, at this macro level, it can hide vulnerabilities by geography or demography. Further research will be needed to consider the local impacts on our estate, staff, service users and the goods and services we depend on.

*The Local Climate Adaptation Tool is currently in beta testing stage

Health impact	Bradford & Craven	
Cold related deaths	Decreasing	Green
Cardiovascular deaths	Increasing	Red
Cerebrovascular deaths	Increasing	Red
Cognitive performance & the ability to learn	Decreasing	Red
Sleep disruption & disorders	Increasing	Red
Cold related morbidity	Decreasing	Green
Respiratory deaths	Increasing	Red

Table 5: Health Impacts statuses

The Climate Change Adaptation plan details the above, and actions required for estates, procurement and supply chain, fleet/ transport, operational preparedness, partnership working and governance. The Trust has considered how these risks may affect operations but has not yet quantified the risks and opportunities or identified which could have a material impact on the Trust in terms of service delivery or financial planning.

Risk Management

As per 2025-26, climate related issues are not currently identified as a principal risk for the Trust. Climate change risks are long term and as such are not included in the Trust's risk register. Further work is needed to assess and prioritise risks and judge materiality.

The Trust has severe weather plans and business continuity plans for all services, and often must implement some aspects of these, primarily due to travel and transport restrictions. The Trust is also affected by staff having to take time off e.g. when schools close, which can lead to postponed or cancelled clinics and routine services, additional support to staffing needs e.g. use of Trust vehicles for commuting. However, the impacts are not collectively reported and therefore it is not possible to quantify the full impact of climate change on our services. The Trust will need to identify, assess and manage climate change risks more comprehensively in future and consider how it will make decisions to mitigate, transfer, accept or control the risks.

The table below shows some of the additional risks to consider.

Climate related risks	Trust impacts
Policy and Legal	Potential increased cost of insurance, e.g. of buildings in flood risk areas Changes in the valuation of buildings/ Trust assets Potential increased operating costs during periods of extreme weather
Technology	Increased cost of estates assets to achieve decarbonisation and cool buildings.
Market	Increased costs for goods e.g. food. Increased utility costs
Reputation	Lack of investment in buildings leading to negative feedback from staff and service users e.g. if buildings overheat or (quality) services cannot be delivered due to extreme weather.
Acute physical risks	Increased costs due to supply chain interruptions/ service continuity. Higher costs from negative impacts on workforce (e.g., health, safety, absenteeism) Write-offs and early retirement of existing assets (e.g. damage to property and assets in “high-risk” locations)
Chronic	Changes in precipitation patterns and extreme variability in weather patterns and rising temperatures leading to increased operating concerns and therefore costs e.g. inadequate water supply.

Table 6: Additional Risks to Consider

When conducting incident reports, it is now possible to choose environmental factors as a secondary cause.

Metrics and Targets

NHS foundation trusts are not required to disclose or develop processes to disclose scope 1, 2 and 3 emissions under the ‘metrics and targets pillar’ in the HM Treasury guidance. However, for many years the Trust has calculated carbon emissions associated with our activities as detailed in the sustainability section of the annual reports. This is the key metric to measure Trust impact on the environment. The Trust currently only reports flooding and overheating climate related risks through incident reporting.



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Date: 25 June 2026
Therese Patten
Chief Executive

5. Staff Report

Our Staff Team

Introduction

The Trust has again this year delivered a number of remarkable improvements and innovations under the umbrella of “people matters”, as well as some major inroads in relation to looking after our people, that reinforce the strategic theme of being the “Best Place to Work”. Our people are our most valuable, valued and costly assets and therefore it is so important to ensure that we have a workforce of the right numbers, with the right skills and values and representative of the populations that we serve. We take great pride in providing an employee life cycle that ensures a high quality experience from start to finish and a relationship between us and our colleagues that reflects the Trust values.

The Trust has continued work to create a supportive environment for staff with a continued commitment to the Care Trust Way, Best Place to Work strategic theme and other local initiatives including and maintaining our enhanced reward and recognition schemes such as “Thanks a Bunch”, “Living Our Values” and “You’re a Star” awards, which enables the celebration of colleagues who go the extra mile to support each other, service users and carers and support the delivery of the best quality care.

Over the past year, the Trust has delivered a robust, values led and forward thinking recruitment programme that has supported workforce growth, strengthened service stability, and enhanced the experience of both candidates and staff. Despite ongoing national workforce challenges, by combining strong operational delivery with creative recruitment approaches, inclusive practice and long term workforce planning, the Trust continues to position itself as an employer of choice and a Trust that delivers tangible benefits for staff, service users, carers and communities.

Recruitment

Our Recruitment performance during 2025–26 has significantly exceeded Trust and national expectations, supporting a strong and sustained pipeline of candidates progressing efficiently from advert through to appointment. Average time from advert to unconditional offer is 23.61 days, significantly outperforming the Trust KPI of 65 days and the national NHS average of approximately 14 weeks, and comfortably exceeding NHS England’s 8 week Time to Hire ambition introduced from February 2025.

A major highlight of the year has been the successful recruitment and onboarding of Registered Mental Health Nurses (RMNs). Over the autumn period, the Trust welcomed a cohort of over 30 new Band 5 Registered Mental Health Nurses (RMN) across inpatient mental health services.

As a direct result:

- All Band 5 nursing posts at Lynfield Mount Hospital are now fully staffed.
- Vacancy levels at Airedale Centre for Mental Health have reduced significantly.
- A strong pipeline of RMN starters throughout 2026 is already in place, supporting long term workforce stability.

This success reflects a sustained, strategic approach to recruitment and retention, including early engagement with candidates, support throughout training, and a strong focus on values based recruitment.

As part of our “Growing our Workforce” theme, we have delivered a sustained programme of values based Healthcare Support Workers (HCSW) assessment centres, supporting safe staffing and service resilience through high volume, fair and consistent recruitment. This approach aligns with national best practice promoted by NHS England supporting innovative, structured and candidate centred recruitment while embedding continuous learning to refine communications, selection processes and assessment methods, and improve candidate experience and outcomes over time.

Recruitment delivered 8 HCSW assessment centres covering substantive Band 2 and Band 3 roles and Staff Bank Band 2 recruitment. These events generated 768 applications, with 279 candidates progressing to interview or assessment, resulting in 64 job offers. This included 40 offers to Band 2 substantive roles, 21 offers to Band 2 Staff Bank roles, and three offers to Band 3 substantive roles.

Assessment centres are designed to allow candidates to demonstrate both role relevant skills and behaviours. Typically, the day includes a short role/service overview, group based activities, literacy and numeracy checks, a handover exercise to test safe communication, and a values based interview aligned to the person specification and Trust values.

A key highlight has been the bespoke assessment centre model delivered in partnership with Dementia Assessment Unit (DAU). Following two DAU assessment centres, the service achieved full staffing for Band 2 HCSW vacancies, with a further 6 candidates offered Staff Bank positions. The DAU team has since demonstrated the capability to independently deliver an assessment centre approach, evidencing a sustainable, service owned model supported by Recruitment.

Transformation

We are always looking for and implementing transformational activity across teams. This year we have developed and implemented a workforce transformation project completed in January involved transitioning Estates and Facilities staff from agency arrangements to the Trust’s internal Staff Bank when undertaking additional hours. As part of this work, over 100 additional bank assignments were created, alongside

the development of supporting training materials and clear manager guidance to ensure consistent implementation.

This initiative has reduced reliance on external agencies, improved workforce continuity and operational control, strengthened financial sustainability, and enhanced staff experience through clearer processes and direct Trust support. The project demonstrates the Trust's ability to deliver large scale workforce change in a planned, joined up and effective manner. Building on this success, the Trust will continue to work collaboratively with services to identify further opportunities to reduce agency reliance, supporting a more sustainable and internally focused workforce model.

This has also led to a time limited pilot within one of our inpatient wards, to test a strengthened Bank First model through a time limited 16 week period, proposed to commence in Quarter 3 of 2026, subject to readiness and approval. The pilot will focus on improving early roster planning, ensuring the earlier and more consistent release of shifts, and maximising the use of internal and collaborative bank capacity. Anticipated benefits include eliminating reliance on agency staffing, improved workforce continuity, increased bank shift uptake, better value for money, and alignment with NHS England guidance to minimise avoidable agency use and strengthen internal workforce solutions. Service User safety would remain paramount throughout, with a clearly defined exception and escalation pathway in place if needed.

Recognising the importance of our bank workers has seen the Trust strengthened mandatory training compliance across its Temporary workforce to ensure that bank staff only undertake work when fully training compliant, improving service user safety and workforce assurance. This has been delivered through close collaboration with the Training and Rostering teams, combining clear communication of expectations, phased system-based restrictions, and expanded training capacity including additional and weekend sessions.

As a result, compliance has increased significantly across core subjects, including Fire Safety (46.99% to 83.41%) and Moving and Handling (45.65% to 85.28%). This approach has created a safer, more reliable bank workforce, reduced operational and regulatory risk, and strengthened assurance with minimal impact on services.

In developing and maintaining an inclusive and diverse culture, we continued to promote membership and belonging to the three Staff Networks: Rainbow Alliance, Beacon, and Aspiring Cultures, which enriched the experiences of our colleagues and promoted awareness of protected characteristics within their networks.

Trust Welcome Events

Our monthly and mandatory Trust Welcome events “New In” have continued to be a cornerstone of the new starter experience at the Trust.

These highly engaging sessions, consistently fronted by Executive team members, demonstrate visible leadership commitment and set a strong tone from day one highlighting our Trust’s values, behaviours and strategies. We cover all aspects of the Trust including our Care Trust Way methodology and our wellbeing offer.

Participation rates have remained exceptionally high, with 485 attendees taking part over the year, with the majority of employees attending within their first month. Over the year, we have further enhanced the programme, expanding the internal marketplace to showcase a wider range of services, teams, and opportunities across the Trust.

A key innovation has been the introduction of the World Café model, creating a more interactive and conversational environment. This approach has enabled meaningful dialogue, encouraged knowledge sharing, and strengthened cross-organisational connections.

Feedback has been overwhelmingly positive, with the sessions consistently scoring highly for usefulness, inclusivity, and overall experience. Networking opportunities are particularly valued, with new colleagues highlighting the events as an important platform for building relationships and a sense of belonging early in their journey with at the Trust.



Workforce Planning

The recent planning rounds has again seen workforce plans being produced at Trust level over the previous and following twelve months. This then translated into service specific plans, based on the following principles:

- Workforce plans are triangulated with financial and operational activity information and linked to the Clinical Workforce Strategy, with oversight on progress of workforce plans at the Workforce Optimisation Accountability

and Guidance Group (AGG) which reports to the People and Culture Committee and to Board.

- Workforce planning at service level is undertaken by analysing capacity and demand within these services and using professional judgement to set staffing levels. The outputs of the planning ensure recruitment and training plans are in place to deliver the safe staffing levels required.
- We are continuing to roll out the e-Rostering system across the Trust and have successfully undertaken this in both patient facing and corporate teams.
- The monitoring of staffing levels to Board is reported via the Deputy Director of Nursing through Safer Staffing Steering Group, which reviews staffing levels daily (as part of operational oversight meetings), weekly (as part of e-Rostering planning meetings), and reported monthly to the Compliance Group and Safer Staffing Steering Group as exception reporting on Care Hours Per Patient Day, unused contract hours, working time directive breaches and fill rates / staffing levels; and over the next few months, estimated costs (calculated at bottom of Band) will be reportable for Substantive and Temporary staffing including Agency.

Workforce Targets

Our efforts to drive up the quality of the care we deliver through more efficient and effective use of our people has seen some major progress, particularly in how we commission and deploy temporary staffing. Across our rostered services which include Mental Health inpatients areas, we are consistently fulfilling an average of 84% of the demand for temporary staff, of which 80% are Bank Workers and 4.5% Agency Workers. This enables us to have more control over the quality and regularity of training the workers receive and through the appointment of a dedicated role; better oversee the supervision of temporary workers from a clinical professional perspective.

We have several workforce targets, which are monitored by the Board to scrutinise performance including mandatory training and appraisal rates. Performance compared to the previous year is shown below:

Internal Board indicators	2025/26	2025/26	2024/25	Trust Position
	Target	Performance	Performance	
Mandatory training (excluding information governance compliance)	80%	89.76%	93.59%	Achieved target
Information Governance training	95%	94.35%	93.58%	Not achieved
Staff receiving appraisal	80%	78.83%	73.81%	Not achieved
Labour turnover	10%	10.43%	11.21%	Not achieved

Table 7: Workforce performance targets

Workforce Analysis

An analysis of average staff numbers in permanent roles and other staff is broken down by occupational group below:

Average number of employees	2025/26 Total Number	2025/26 Permanent Number	2025/26 Other Number
Medical and dental	104	71	33
Ambulance staff	0		
Administration and estates	825	798	27
Healthcare assistants and other support staff	462	447	15
Nursing, midwifery and health visiting staff	1067	1042	25
Nursing, midwifery and health visiting learners	0		
Scientific, therapeutic and technical staff	696	640	56
Healthcare science staff	0		
Social care staff	0		
Other	0		
Total average numbers	3155	2999	156
Number of employees (WTE) engaged on capital projects			

Table 8: Staff breakdown by occupational group

Note: Figures for Agency, Contract and Bank workers are reported within the Finance section

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

Category	Female	Male
Directors (voting members of the Board)	5	8
Other senior employees	86	26
Employees	2718	683
Total	2809	717

Table 9: Breakdown of Directors and senior employees by gender

Sickness Absence

It is recognised that sickness absence can have a detrimental impact on the organisation from both a service quality and financial perspective. During the year the Board and Finance and Performance Committee regularly reviewed sickness performance against a target set at 4.00%. At the end of March 2026, we recorded an average sickness level of 7.00%. Sickness absence is discussed at people and Culture Committee and operational quality and operational performance meetings, and we offer a wide range of support through our Wellbeing@Work programme.

Details of our sickness absence rates from previous years are shown on the next page.

Occupational Health

We continue to purchase a shared Occupational Health Service from South West Yorkshire Partnership NHS Foundation Trust. It remains a nurse-led service created to meet the specific needs of colleagues in mental health, learning disability and community services. The team now provides an overall occupational health service for 20,000 employees in the region and continues to operate service level agreements for external contracts.

During 2025/26 our Occupational Health Service provided pre-employment screening and guidance, a general advice line for managers and colleagues from Monday to Friday, with support from Clinic Nurses, a Physiotherapist, Occupational Therapists, and a Mental Health Nurse. The service also provides specialist immunisation and vaccination services, as well as referrals for employee sickness absences and disability related reasonable adjustments. The increased provision of more specialist roles provided by this service demonstrates the wide variety of need and usage by our workforce.

The service works effectively with our in-house Wellbeing and Benefits Team, to provide other specialist services including menopause awareness sessions, line management training on writing a referral and training for our Health and Wellbeing Champions

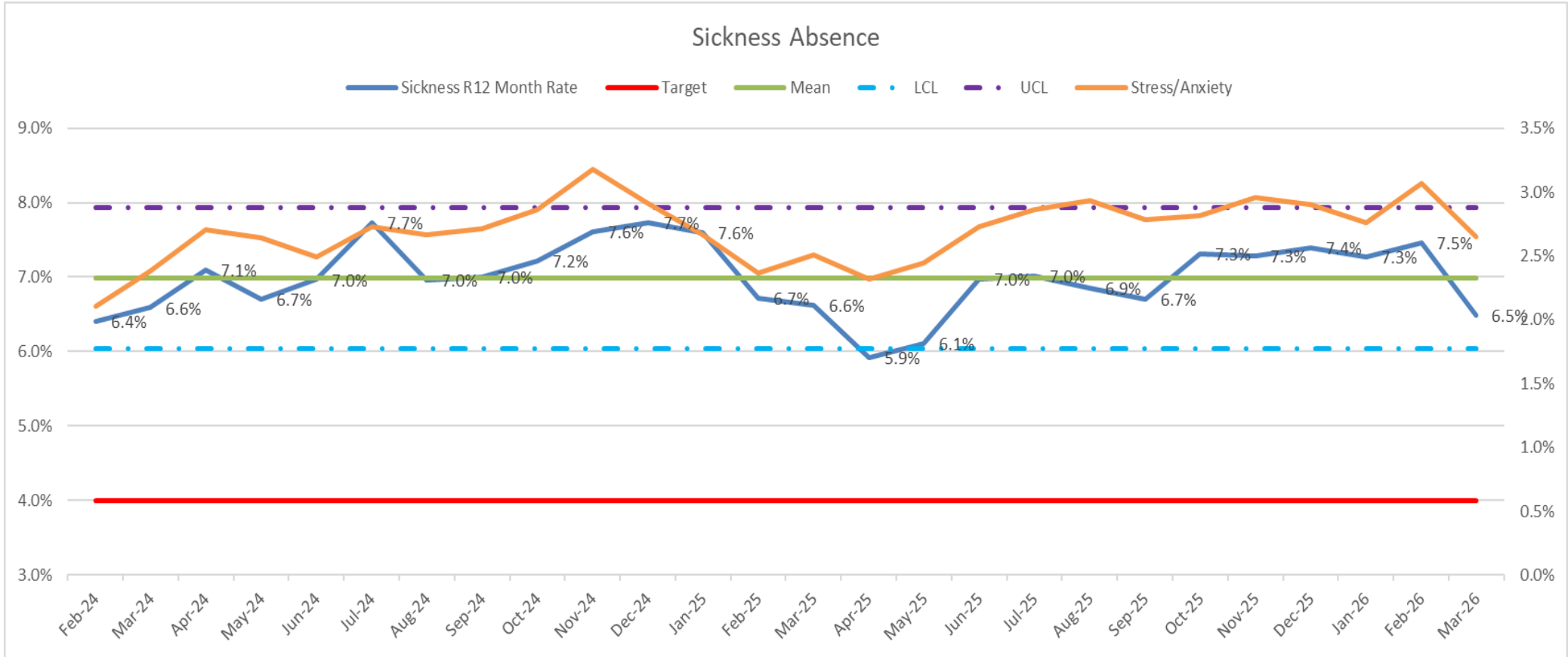


Diagram 8: Sickness absence over the last two years

Health & Safety

The Trust continues to demonstrate a mature, proactive and well-governed approach to health and safety management. ISO 45001 certification was successfully maintained following the April 2025 audit, and the RoSPA President's Award (11 consecutive Gold Awards) provides strong independent assurance of the effectiveness of systems and controls. Strategic direction remains aligned through the Health, Safety and Security Strategy 2024–2027, supported by robust governance arrangements. Key developments during the year include the comprehensive review and reissue of the Health and Safety Policy (January 2026), and the integration of emerging legislative requirements, including Martyn's Law, with preparatory work underway to ensure compliance ahead of the April 2027 implementation deadline. The introduction and live testing of the revised Lockdown Policy further demonstrates the Trust's responsiveness and organisational resilience.

Performance indicators show continued improvement, with a 15% reduction in total incidents and stable levels of moderate and above harm. While RIDDOR-reportable incidents have increased slightly, this is primarily linked to violence and aggression within inpatient settings. Assaults on staff have risen marginally, with the majority occurring on wards, and targeted interventions remain focused on high-incidence areas, including Clover ward. Increased reporting of security incidents reflects effective detection and control measures, while highlighting ongoing ward-based challenges.

The Trust has maintained strong compliance with mandatory training (97.3%) and continues to invest in safety improvements, including enhancements to lone worker protection systems. Medical device governance has been strengthened through the introduction of a consolidated Medical Device Management Policy, supported by improved oversight and inventory controls.

Overall, the Trust maintains effective, well-embedded systems for managing health, safety, and security risks, demonstrating continuous improvement, strong governance, and a clear focus on emerging risks and priority areas

Labour Turnover

Left unaddressed, we know that labour turnover can also have a detrimental impact on us from a business continuity, service quality and financial perspective. During the year the Board, Finance and Performance Committee, Quality and Safety Committee, and People and Culture Committee regularly reviewed turnover performance against a target set at 10.00%.

At the end of March 2026, we recorded an average turnover level of 11.80%. Labour turnover has been scrutinised at People and Culture Committee and operational quality and operational performance meetings and exception reports highlighting hotspot areas escalated to Compliance and Risk Group and Board.

Details of our labour turnover rates for 2025/26 are shown below:

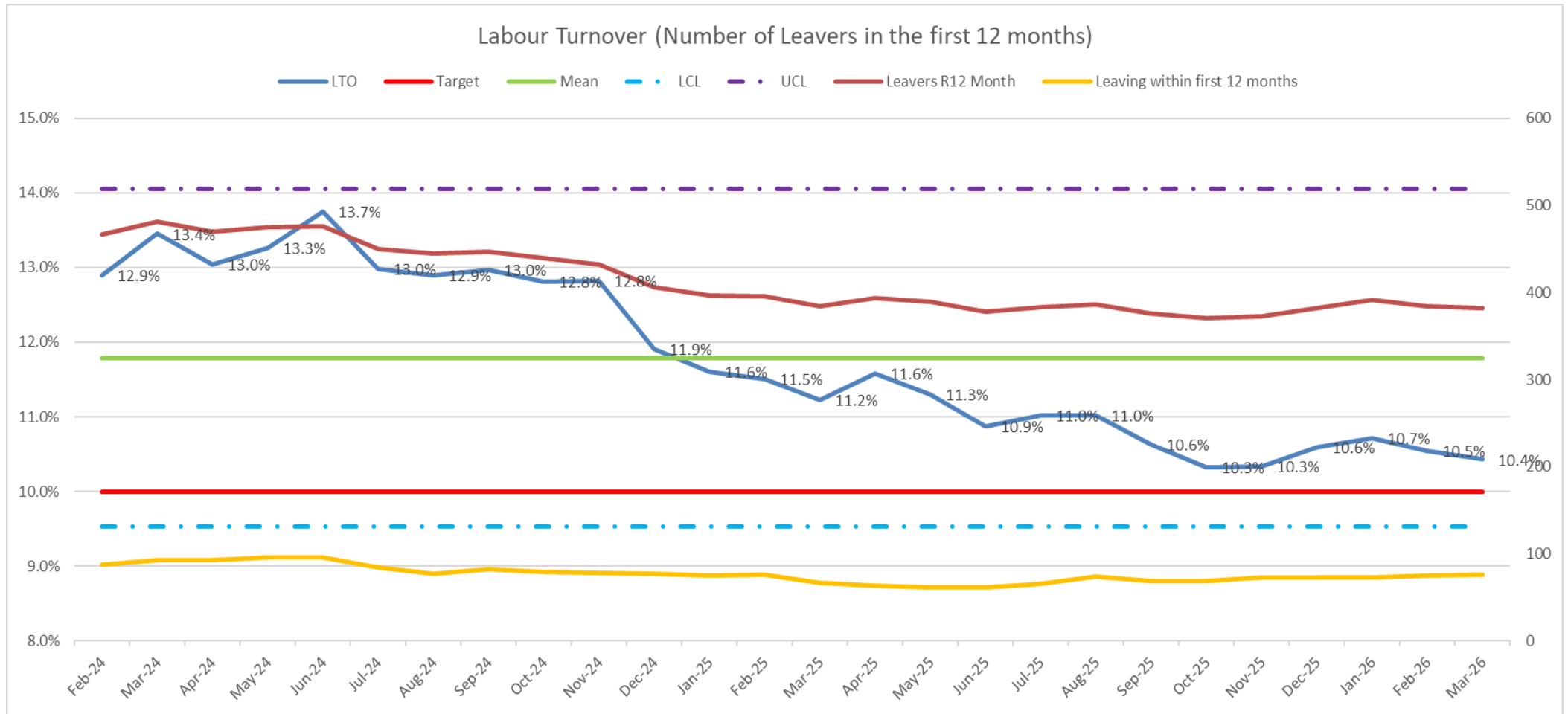


Diagram 9: Labour turnover data for 2024/25 to 2025/26

Gender Pay Gap

We monitor our pay gaps annually, publishing the information on the Cabinet Office website and our Trust Website.

Our mean pay gap on the 31 March 2025 was 6.30%. The Trust also monitors the ethnicity and disability pay gaps of our workforce and our most recent detailed reports are available on our website

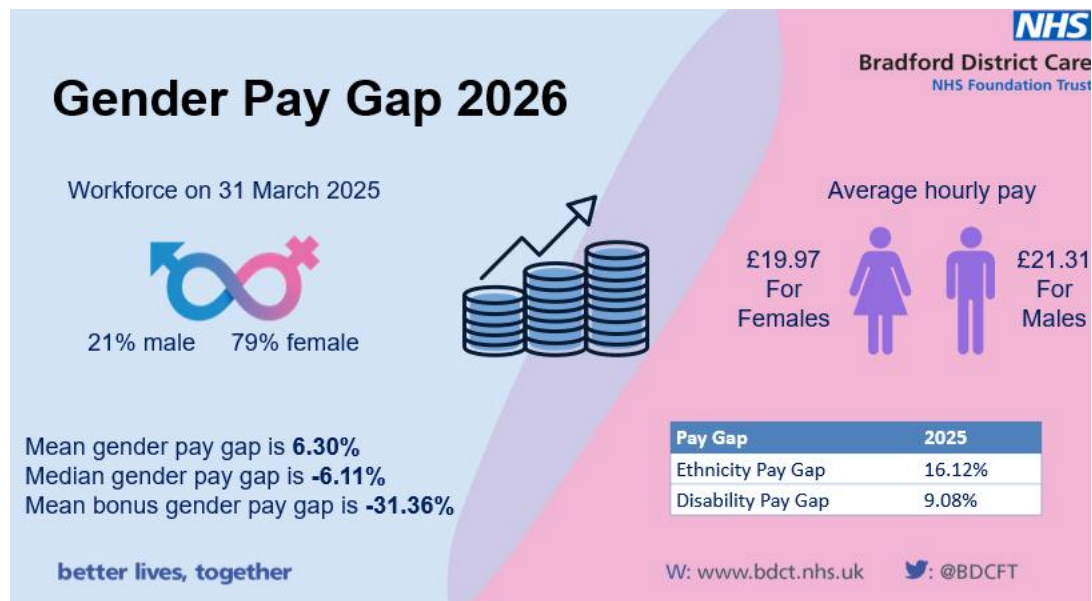


Diagram 10: Gender Pay Gap 2026

Staff Policies and Procedures

As an employer, the aim is to ensure that we are fully compliant with legal, statutory, regulatory, and moral obligations and the basis of that compliance is a commitment to constantly reviewing policies and procedures, which impact on our people. The Trust ensures review existing documentation and creates new approaches in partnership and through consultation with key stakeholders, within and external to the organisation. Benchmarking also takes place with partners in Place, System and further, to ensure we are consistent in employment practices and at the forefront of legislative requirements and best practice.

Over the past year, there has been a continued review and refresh of policies, practice, and ways of working to continuously improve people services. This has included the implementation of new systems to provide and monitor data (Allocate Employee Relations tracker and Hornbill client relationship management tool) and the introduction of new policies such as the Menopause Policy, a refresh of the Supporting Attendance Policy and development of resources and a refresh of the Resourcing and Recruitment Strategy. In addition, the Trust was awarded the 'Henpicked' accreditation for the menopause support it provides to colleagues.

All the policy and procedural documentation is available via the intranet facility 'Connect' and document repository 'SharePoint' and advice, guidance and training on interpretation and implementation is provided through our People Services teams, which include Business Partnering, Payroll and Pensions, People Development, Resourcing and Workforce Intelligence, Systems, Planning and Analysis. Work has been undertaken over the last 12 months to increase the support offered to managers via a wide range of face-to-face and online training and learning resources to further develop management skills.

During the second half of the year a training needs analysis exercise was undertaken with 435 managers across all services, to establish their levels of skill and confidence in a range of people management processes and systems. The analysis outcomes were compared with workforce performance data to triangulate perceived levels of skill against actual impact of management behaviours and activities. The subsequent training package targeted at the areas of most need was commenced in January and will progress over the next 12 months.

Staff Health and Wellbeing

We have a comprehensive health and wellbeing offer available to all colleagues. This comprises an in-house Staff Support and Therapy Service which provides a range of diagnostic and talking therapies and workshops to support mental health; a dedicated physiotherapy service is commissioned; an Employee Assistance Programme which can provide support to staff in a broad range of areas, access to salary sacrifice schemes, financial planning workshops, staff discounts and schemes, childcare support, men's health initiative, carer's passport and a wellbeing room where staff can access health checks and useful resources. Several face-to-face wellbeing and benefits roadshows have taken place across the district to promote the offers and resources available, including out of hours sessions directed at colleagues who work evenings, nights and weekends.

Partnership Working with Colleagues

We continue to enjoy a positive and harmonious relationship with our Staff Side representatives. The Staff Partnership Forum and its subsidiary groups, continue to meet regularly and have been actively engaged in all our transformational change processes and job evaluation process.

With a workforce the shape and size of ours and the volume and complexity of the work that many of us undertake, it's inevitable that there will be some dissatisfaction or behavioural concerns amongst our colleagues. In 2026 we are introducing our "Avoidable Harm" approach to our people policies and process. This includes taking our managers and leaders through a training programme aligned to a more proactive just culture and learning approach to situations.

Staff Side representatives, who are accredited members of the recognised trade unions, are critical to the success of these change programmes and other ongoing

projects and are key partners in health and safety activities. Staff side colleagues also have critical input to policy reviews and remain very supportive of the partnership approach to helping address colleagues concerns about environmental, economic and health inequality issues.

Close relationships with our union representatives have been integral to us maintaining essential services during periods of industrial action and ensuring no decline in the quality of care.

Trade Union Representatives

Full time equivalents

There are 12 Trade Union Representatives. This equates to a full-time equivalent (FTE) of 9.97 Trade Union representative

Percentage of working hours spent on facility time

0% of working hours: 0 representatives

1 to 50% of working hours: 11 representatives

51 to 99% of working hours: 0 representatives

100% of working hours: 1 representatives

Total Pay Bill and Facility Time Costs

Total pay bill: £166,418,000.00

Total cost of facility time: £63,868.82

Percentage of pay spent on facility time: 0.04%

Paid Trade Union Activities

Hours spent on paid facility time: 2713

Hours spent on paid trade union activities: 117

Percentage of total paid facility time hours spent on paid TU activities: 4.31%

Recognition and Awards

Thanks a Bunch awards

The Thanks A Bunch scheme recognises colleagues who have gone above and beyond in their current role and made a positive impact. The scheme enables colleagues to nominate their colleagues for a Thanks A Bunch award. Nominations are considered every month by the Executive Management Team and up to ten awards are made. During 2025/26 112 awards were made to individual staff and teams.

Long Service Awards

The Trust recognises colleagues for their long-term commitment to NHS health care services. In this last year 38 colleagues had achieved 25 years' service and 14 had achieved 40 years' service which was recognised and celebrated at a Long Service

Event. Health care support workers, safeguarding adults and children's practitioners, community and mental health nurses, palliative care specialists, and dental service and administrative colleagues were amongst those recognised.

Living Our Values

The Trust values of **we care**, **we listen**, and **we deliver**, run through everything that the Trust does. They shape how staff behave with each other and the people they serve and work with.

Every month, colleagues submit nominations that are reviewed by the Chief Executive, and certificates are then awarded to the three winners – one for each of the values. The monthly winners are then all reviewed, with an overall champion from each category being recognised at the annual You're A Star Awards

You're a Star Awards

The You're a Star Awards (YASA) celebrate the work of clinical and non-clinical staff, service users, carers and volunteers who have made an outstanding contribution to Trust work and services over the last twelve months.

All staff members can nominate an individual or team who they feel deserves recognition. This year the Trust introduced a new theatre-style awards format, with pre-event drinks and canapes which had positive feedback from staff. The evening event presented 18 awards to recognise colleagues at care group and directorate level, alongside two Trust-wide awards. The Trust also recognised the overall winners for the monthly Living our Values awards (see further below).

The post-event feedback evidences the value of staff recognition with 95 per cent of respondents rating the awards 'excellent' or 'good', 75 per cent feeling valued, and 85 per cent positive about the event format



Our 2025-2026 winners are below:

Care Group / Directorate	Team of the Year	Teammate of the Year	Unsung Hero
Children's (inc. administration)	Community Infant Feeding Team	Toni Brady, Practitioner, Vulnerable Children Information team	Rebecca Badon, Specialist Public Health Nurse for Children in Care
Mental health	Dementia Assessment Unit	Aqeela Hussain, Assistant Psychologist, North SMHT	Aqeela Hussain, Assistant Psychologist, North SMHT
Community Health services	General Anaesthetic Team, Community Dental service	Leeroy Golding, Team Leader Podiatry services	Anne-Marie Dorrington, Head of Community Dental service
Corporate	People Matters	Claire Ingle Head of People Matters	Natalie Barnett, People Business Partner, People Matters
Working Together Award		Practice Education Leads - Adele Humphrey, Julie Crabtree and Vicki Connell	
Service User, Carer, and Volunteer Contribution Award		Sue Stewart	
Living Our Values Award		We care – Jen Wilson We listen – Terry Best We deliver – Sian Bardgett	

Table 10: You're a Star Award Winners

External Recognition

External recognition is also important, and we encourage staff to benchmark themselves against other providers through regional and national external awards.

IPS Employment Service Review achieves exemplary status in fidelity review

The Trust's Individual Placement and Support (IPS) Employment Service, known as 'Making Work Work', was awarded the highest possible rating of 'exemplary' following its latest fidelity review, maintaining its IPS Quality Kitemark. This recognition underscores the service's unwavering commitment to supporting individuals with enduring mental health needs in securing and sustaining paid employment.



Health Visiting Team achieves UNICEF Gold

The Trust's Health Visiting team was awarded UNICEF's most prestigious award, marking their continuing excellence in supporting local families with feeding and developing close, loving relationships with their babies.



Care Trust achieves Veteran Aware accreditation

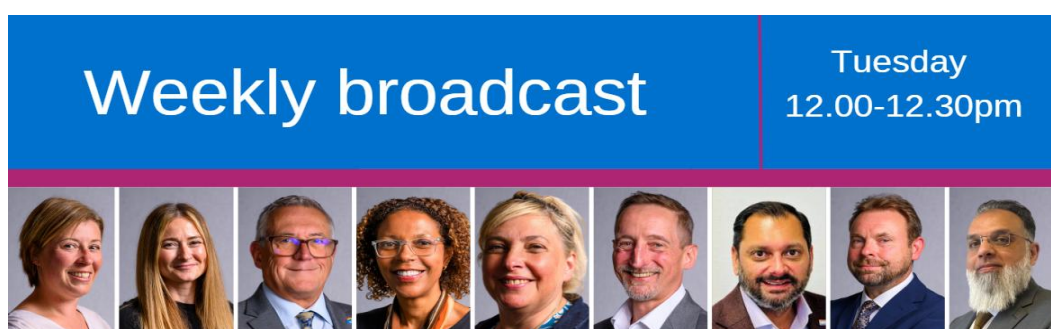
The Trust has received NHS Veteran Aware accreditation after meeting eight national standards which demonstrate commitment to the Armed Forces Covenant.



Internal Communication with staff members

The Trust has a range of communication channels to update colleagues, gather their views and ensure two-way engagement, so staff are involved in key developments and have direct communication routes to the Senior Leadership Team.

We have a range of digital communication channels where staff can access information: our weekly e-bulletin, our staff intranet, the Chief Executive's weekly vlog, Teams chat (Viva Engage), outlook (global emails), and our weekly staff broadcast that is hosted by an Executive lead and supported by area specialists, and it covers key operational issues, with an open question and answer session .



This ensures that all staff who are working in different ways and across a broad geographical area, have an opportunity to connect and hear Trust news.

Schwartz Rounds

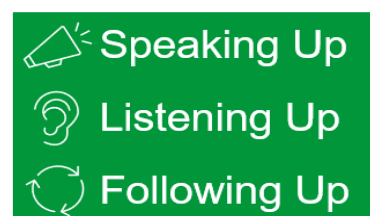
The Trust continues to prioritise staff wellbeing through the provision of Schwartz Rounds with in-person events and via MS teams. Research shows that regular attendance at Schwartz Rounds, a reflective forum open to both clinical and non-clinical staff throughout the Trust, improves service user care through improving staff morale, resilience and empathy and reducing staff turnover. The Schwartz community in the Trust is developing with an expansion of the Schwartz Steering Group to include staff from a wider range of teams.

Since Schwartz Rounds began in 2018 the Trust has held over 70 Rounds with an average staff attendance of 30 people. Schwartz Round themes have included 'Removing the barriers,' 'the power of gratitude' and 'What, you too? I thought I was the only one!' 'COVID the Ripples 5 years on'. The Trust has also facilitated two time-out sessions for Child and Adolescent Mental Health Services, and a Round for the Senior Leadership team. Most recently, members of the Schwartz Steering Group are planning to put, together an anthology of previous stories with members of the Lynfield Mount Hospital Library Team to mark Bradford City of Culture. The Schwartz steering group continue to attend the monthly Trust inductions to introduce Schwartz Rounds to new starters.

Freedom to Speak Up

Fundamental to making quality improvements is hearing what our staff have to say about the safety and quality of Trust services.

Freedom to Speak Up is part of a wider strategic approach to positive cultural transformation and improvement and the Trust wants to create a culture of listening, where all staff feel safe and able to speak up about any obstacles to delivering high quality care.



The Freedom to Speak Up Guardian (FTSUG) and Deputy Guardian are independent, impartial and work alongside the Senior Leadership Team to ensure concerns are addressed promptly and effectively. All staff can speak to them in confidence and the service is promoted widely.

During the year, 130 cases were raised through the FTSUG route (an increase of 18 cases compared to 2024/25). These are all opportunities for us to learn and improve. Further information about FTSU is included in the Trust's Quality Report.

Staff Survey

Summary

The Trust's NHS Staff Survey response of 50% for 2025 was down slightly from 2024 (53%) but retained the overall improvement over the last three years. All NHS People Promise and themes are slightly **higher** than those of the sector. All the themes are also very **similar** to 2024 Trust scores. The Board, People and Culture Committee and senior leaders are identifying responses and actions to the Trust consistent results; alongside an innovative approach supporting teams and services to interpret their varied results at the local level and embed their intentions.

Staff experience and engagement

Staff satisfaction and engagement are key to delivering high quality, value-based care and are directly associated with service user experience and outcomes. The NHS People Plan states 'we each have a voice that counts', and the annual NHS Staff Survey is one important element in our many methods of engaging with colleagues towards being the 'Best Place to Work'. This blended approach to engagement includes Trust-wide conversations; learning weeks; the engagement of senior leadership with colleagues through workshops; vlogs, live broadcasts and question and answer sessions; engagement, wellbeing and topic related; and quarterly engagement through the NHS Quarterly Staff Pulse Survey. In addition, staff networks, staff governors and Staff Side continue to provide support and avenues for two-way feedback. Results of the varied elements of colleague engagement are monitored, triangulated, actioned, and fed back to colleagues by senior leaders in a timely manner.

As part of a new 'ground-up' approach to responding to the 2025 Staff Survey results, the Trust has held a series of World-Café style events for groups of local teams during March and April 2026. These facilitated, supported spaces enabled teams to reflect on their results and determine strengths and priorities. Bespoke infographic reports were prepared for each of the 90+ team groupings and creative tools enabled colleagues to turn their voices into clear intentions, aligned with the NHS People Promise themes. Executive Directors supported and promoted the events.

Staff Survey Results 2025-2026

The NHS Staff Survey 2025 (NSS2025) took place from 22 September to 28 November 2025, along with a comprehensive, effective and targeted engagement programme, amongst substantive staff and Bank workers. Quarterly Pulse Staff Surveys (QSS) were also held in April and July 2025 and January 2026, which repeated the staff engagement questions from the annual survey. The NHS Staff Survey is conducted annually. The survey questions align to the seven elements of the NHS People Promise and with the two themes of engagement and morale. All themes are based on a score out of ten. Beneath the nine themes lie 21 sub-themes and 111 questions.

Response rate

- The Trust-wide response rate to NSS2025 was 50% or 1,690 staff. This was down slightly from 2024 (53%) but retained the overall improvement over the last three years. The overall national response rate was 49%, and all Trusts in our sector averaged 52%*.
- The Bank Survey response rate was 22% or 88 staff – representing a significant reduction on the 2024 response of 35%, but similar to the previous year and to average for all for comparable Trusts* (national bank results yet to be released at time of preparing the annual report)
- 48 Mental Health Learning Disability Community Trusts in benchmark group nationally

Theme Scores

- In 2025, All NHS People Promise and themes are slightly higher than those of the sector, with most significant being 'We work flexibly', 'Morale', 'We are recognised and rewarded' and 'We are safe and healthy'. All the themes are also very similar to 2024 Trust scores, with most improved being 'We work flexibly', 'Morale', 'We are compassionate and inclusive' and most declined being 'We are always learning'.
- For Bank workers*, four of the theme scores were significantly lower than those for substantive staff, and one was significantly higher, 'We are safe and healthy'. Three of the theme scores were significantly higher than 2024, the remainder similar to 2024.
- Bank scores are based on early indicative scores and not on final published scores, as these are yet to be released at the time of preparing the Annual Report. The following results relate to substantive staff scores only.

Question Scores

- Of the 111 individual questions in NSS2025, 70% of scores (Trust-wide) had no significant difference to sector, with 33% significantly better and 4% significantly worse. 96% had no significant difference to last year, with 2% significantly better and 2% significantly worse.
- There were improvements from both the 2024 and sector scores to effectiveness of team working, treating staff fairly in relation to incidences and taking positive action on health and well-being.
- The scores showed reduction in reporting bullying and harassment, and less colleagues finding the appraisal process helped them do their job. Despite Appraisal scores being reduced from 2024, the 5-year trend for this sub-theme is positive

Free text comments

- 238 detailed comments were received from staff as part of a 'free text' option at the end of the survey. Detailed analysis is underway using AI, the new NHS

qualitative analysis framework and personal reflection. The themes and issues arising will be shared with senior leaders, for consideration alongside the quantitative results, and with clear response back to colleagues.

Communications

- Summary Trust-wide results have been shared with all colleagues, including a dedicated Broadcast, e-Updates, detailed intranet page, and summary screensavers / posters of key results.
- Local results have been shared across all services and teams, utilising bespoke reporting and the innovative 'world café' events as described above.
- Our Staff Networks for protected characteristics are working with the Equality and Inclusion Team to explore the Workforce Race and Disability scores and other diversity related results alongside the Belonging and Inclusion Plan

Service and Team level results

- The local results indicated a wide variance of experience and engagement across different work areas and other categories, such as demographics or staff group.
- This granular level reporting provided intelligence to senior leaders and corporate services to enable comparisons, corporate response, and action planning at a Trust-wide level, such as in workforce planning, wellbeing support, learning and development or raising concerns. It also enabled triangulation with other data, such as management skills analysis or records of services impacted by employee relation cases.

Local action planning

- Summaries of local results reports, detailed results tables, and collation of team intention plans from the World Café events and further team discussions are being shared with senior leaders to embed and inform the Trust-wide response.
- Further manager coaching drop-ins, and team support sessions are planned for May-June 2025, including for teams or services showing a decline in scores or those unable to attend the facilitated sessions. This ensures all are encouraged to view their results, explore together areas for improvement and celebration in their service and identify and embed required actions into existing improvement work or new action plans.
- Services and teams that have particularly positive scores are being identified and analysed as examples of good practice

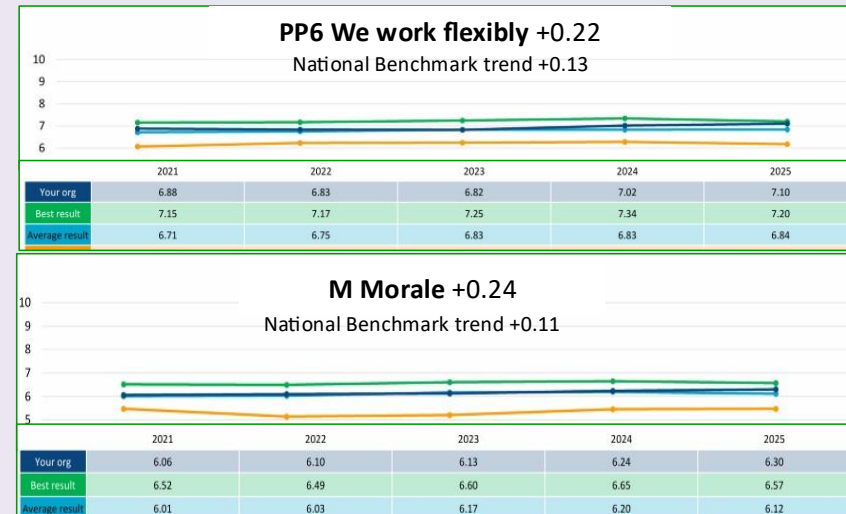
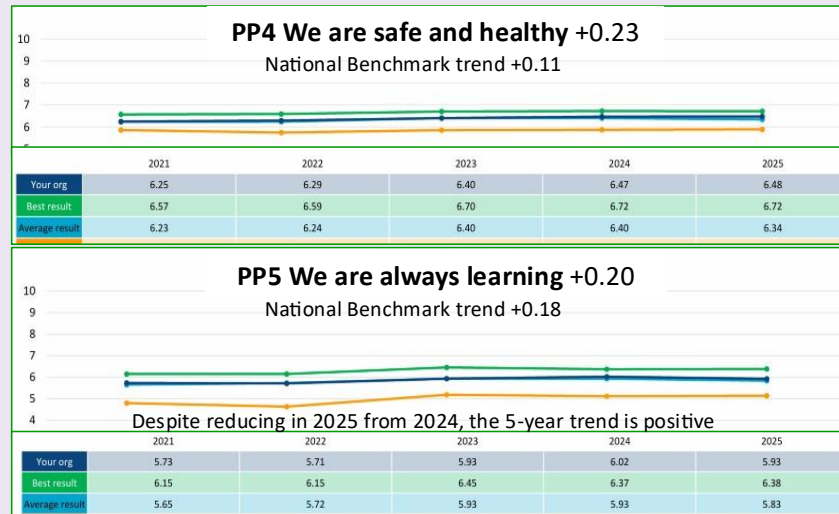
NHS Staff Survey 2025 Summary Trends

Based on final released national results March 2026

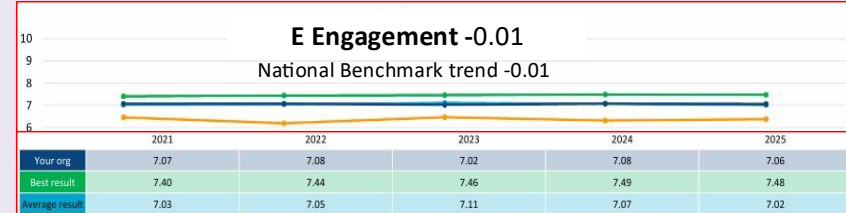
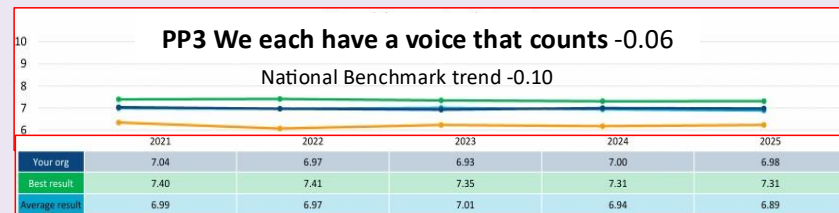


Bradford District Care
NHS Foundation Trust

Seven People Promise/ theme scores have improved since 2021, four significantly so



Two People Promise/ theme scores have reduced since 2021, both only slightly



better lives, together

Benchmarked against 48 Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

W: www.bdct.nhs.uk

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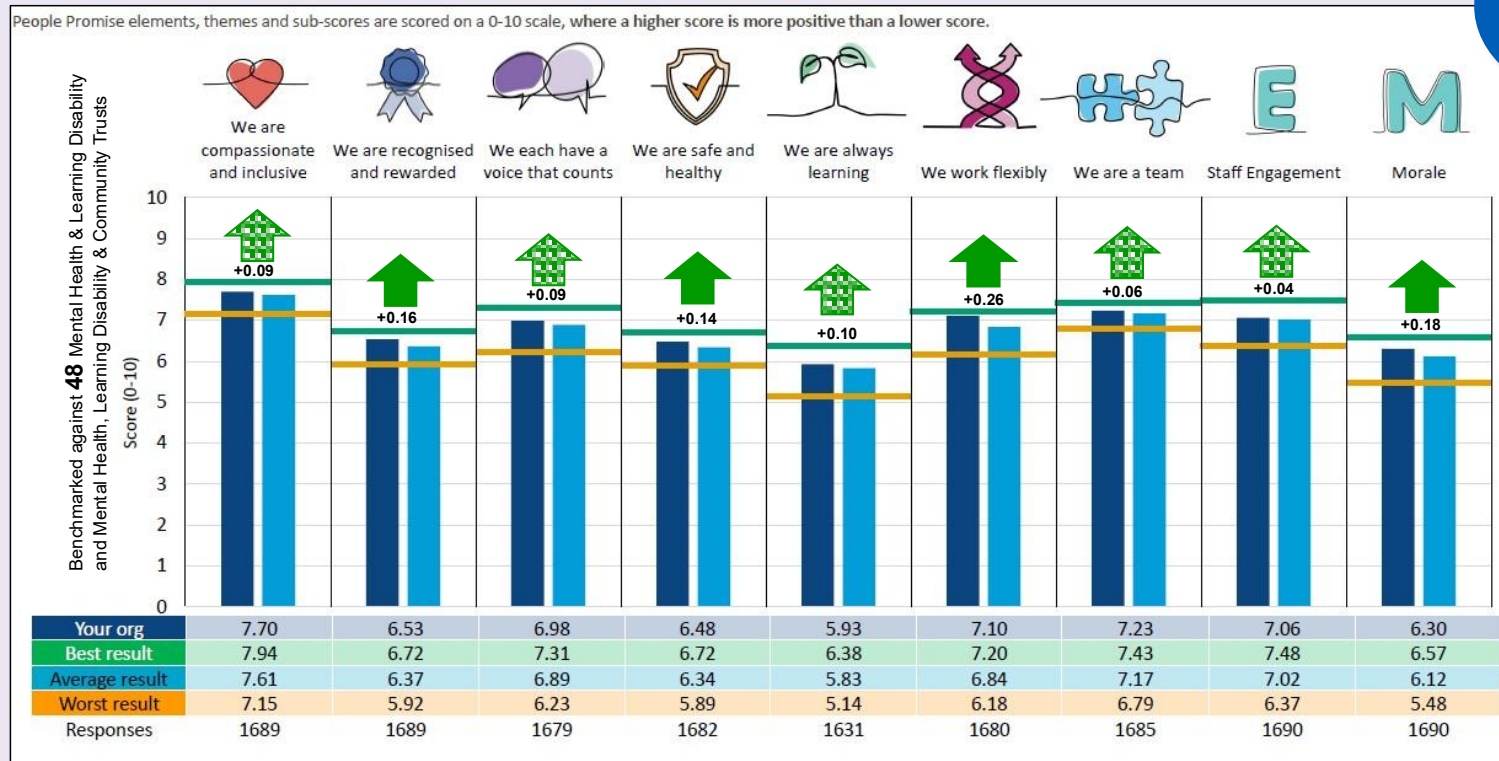
Diagram 11: NHS Staff Survey 2025 Summary Trends

NHS Staff Survey 2025 Summary Results



Bradford District Care
NHS Foundation Trust

People Promise elements and themes against national average (benchmark group)



2025
Response
Rate
50%

2024: 53%
Sector: 52%

All People Promise/
theme scores
slightly **higher** than
the rest of our
benchmark group

Most significant:

- **We work flexibly**
- **Morale**
- **We are recognised & rewarded**
- **We are safe & healthy**

Based on final released national results March 2026

better lives, together

W: www.bdct.nhs.uk

Twitter: @BDCFT

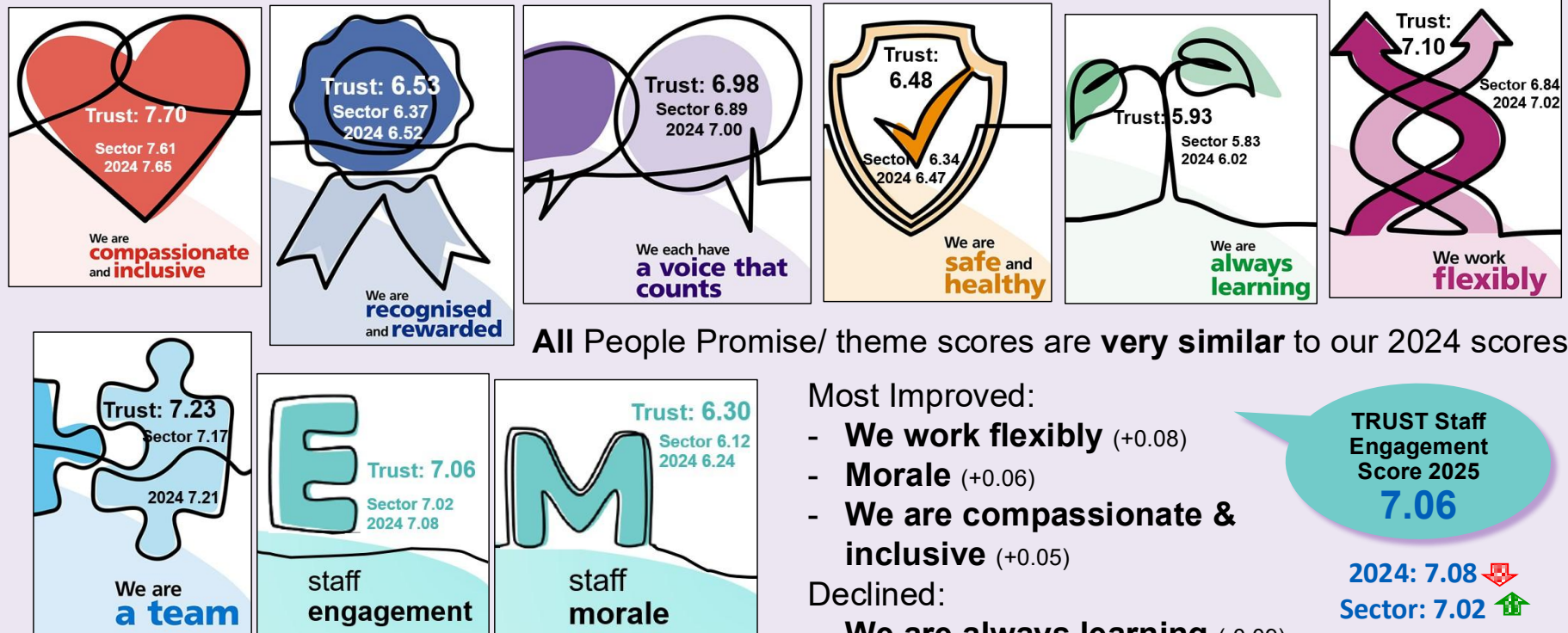
Diagram 12: NHS Staff Survey Results for People Promise Themes

NHS Staff Survey 2025 Summary Results



Bradford District Care
NHS Foundation Trust

People Promise elements and themes against 2024 scores



Based on final released national results March 2026

better lives, together

W: www.bdct.nhs.uk

Twitter: @BDCFT

Diagram 13: People Promise Themes against 2024 Scores

NHS Staff Survey 2025 Summary Trends

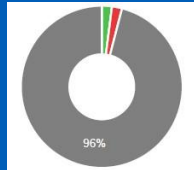
Based on final released national results March 2026



Bradford District Care
NHS Foundation Trust

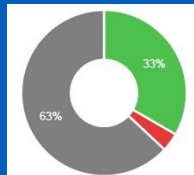
Significant question results compared to 2024

2% significantly better
96% no significant change
2% significantly worse



Significant question results compared to Sector

33% significantly better
70% no significant change
4% significantly worse



“ KEY QUESTIONS ”

76.3% say **care of patients/service users is my Trust's top priority** (25a) (2024: 76.2%; Sector 75.9%)

65.4% would **recommend Trust as a place to work** (25c) (2024: 64.2%; Sector 64.0%)

64.3% would be **happy with the standard of care provided by this Trust**, if a friend or relative needed treatment (25d) (2024: 64.0%; Sector 64.5%)

Question trends since 2024

Top question scores BETTER compared to 2024 and to our sector

59.2% say **teams within Trust work well together to achieve their objectives** (2024 +4.8%, Sector +5.4%) (8a)

67.7% say **Trust treats staff who are involved in an error, near miss or incident fairly** (2024 +3.9%, Sector +7.6%) (19a)

Also significantly better than sector:

69.3% say **Trust takes positive action on health and well-being** (Sector +8.9%) (11a)

Top question scores WORSE compared to 2024 and to our sector

61% say **last time they experienced harassment, bullying or abuse at work, they or a colleague reported it** (2024 -3.8%, Sector -3.5%) (14d)

23% say **appraisal helped me to improve how I do my job** (2024 -3.2%, Sector -2.4%) (23b)

Also significantly worse than sector:

19.6% of those experiencing discrimination - on **grounds of religion** (Sector -13%) (16c7)

better lives, together

Benchmarked against 48 Mental Health & Learning Disability and Mental Health, Learning Disability & Community Trusts

W: www.bdct.nhs.uk

Twitter: @BDCFT

Diagram 14: Staff Survey Question trends compared with 2024

Next steps, monitoring, and future priorities

- There is ongoing consideration of the results by the Board, People and Culture Committee, Executive Management Team, and Senior Leadership Team. This supports detailed reviews with managers and staff, the benchmarking of results against Place and Integrated Care Board scores, and the review of Bank worker scores. It will be informed by additional engagement activity such as the Quarterly pulse surveys.
- Trust senior leaders will give support and feedback to address issues arising from notable scores; and themes arising from the analyses of free text comments. This will feed in to and support proposed engagement around the Better Lives Together Strategy Development during 2026.
- Consideration of an in-house interactive results portal/dashboard to enable smarter data triangulation, results dissemination and sharing of feedback and actions across all levels of the Trust, has been deferred to the 2026 Staff Survey.
- The Board's People and Culture Committee and the Senior Leadership Team will monitor and track outcomes and actions arising from the 2025 Staff Survey, feed these back to staff, and roll these into preparation for the 2026 Staff Survey, as part of a continuum of engagement.

Staff Survey performance over last three years

The following table demonstrates a picture of consistency over the last three years. Now the People Promise themes have been used over a five-year period, further analysis of trends is underway, see illustration below.

	2025/6		2024/5*		2023/24*	
THEME	BDCFT	Benchmark Group	BDCFT	Benchmark Group	BDCFT	Benchmark Group
PP1: We are compassionate and inclusive	7.7	7.6	7.7	7.6	7.6	7.7
PP2: We are recognised and rewarded	6.5	6.4	6.5	6.4	6.5	6.4
PP3: We each have a voice that counts	7.0	6.9	7.0	6.9	7.0	7.0
PP4: We are safe and healthy	6.5	6.3	6.5	6.4	6.4	6.4
PP5: We are always learning	5.9	5.8	6.0	6.0	5.9	5.9
PP6: We work flexibly	7.1	6.8	7.0	6.8	6.8	6.8
PP7: We are team	7.2	7.2	7.2	7.2	7.2	7.2
Staff engagement	7.1	7.0	7.1	7.1	7.0	7.1
Morale	6.3	6.1	6.2	6.2	6.1	6.2

Scores rounded to 1 decimal point

*Note: due to some question wording changes in 2025, some previous year's theme scores have been slightly adjusted in the national results to enable comparisons, and these are reflected here.

Table 11 – Staff Survey Performance over the last three years

Equality, Diversity and Inclusion

The Trust has a set of Equality Objectives which run from 2024 – 2028, they guide our Equality, Diversity and Inclusion (EDI) work. The objectives flow from our Ambition to Action strategy, 2023-2026 and enable us to fulfil our Public Sector Equality Duties and our NHS EDI standard contract requirements.

The equality objectives are:

To be the best place to work for everyone.

- We will identify and address inequality of experience and under-representation within the workforce.
- We will identify, celebrate and spread good practice.
- We will engage with stakeholders in this work to inform and provide scrutiny of our performance.

To deliver the best quality services to all.

- We will identify and address inequalities of access, patient experience and health outcomes.
- We will identify, celebrate and spread good practice within and outside of the Trust.
- We will engage with stakeholders in this work to inform and provide scrutiny of our performance.

These equality objectives support the pledge to equality, diversity and inclusion made by our Chief Executive, Therese Patten.

The three-point pledge is:

1. To treat everyone as a unique individual, valuing the difference they bring.
2. To continue with preparedness programmes ensuring everyone has the skills, experience and knowledge needed to take their next career step and to match that preparation with real opportunity.
3. To have robust systems in place to ensure that the Trust measures success.

To support delivery of these ambitions our EDI Strategy, the Belonging and Inclusion Plan was reviewed, refreshed and relaunched in 2025. The plan summarises the progress we have made since 2021 and our plans for making further workplace equality improvements.

The vision for the plan is threefold:

1. **Deliver the Best Quality Services:** To provide the best quality care which is trauma informed and meets the individual needs of our service users.
2. **An Inclusive and Representative Workforce:** To have a workforce that fully reflects and understands the communities we serve, fostering a fair and compassionate culture where everyone feels that they belong, are included, valued and respected and can progress as a unique individual. A happy, valued, and healthy workforce is essential for delivering high quality care. By

addressing health inequalities, we not only improve care for our communities but also support our workforce - 65% of whom live locally.

3. **Commitment to Lead and Act:** to collectively, consistently, and actively work to dismantle inequality wherever it is found at all levels and in all its forms, including identifying and addressing barriers to progression. Through this commitment, we will strive to be a leader in the field nationally.

This plan also aligns to the Trust's values of we care, we listen, and we deliver. The Care Trust Way advocates making changes in locally owned work practice, leading to improvements for staff colleagues and improvement for people using our services and carers.



Diagram 15: Word Cloud from Staff Engagement Exercise

Statutory Reporting Requirement

- Met all our equality workforce assessment, reporting and publication requirements. Information about these reports is available on our website: (www.bdct.nhs.uk/about-us/key-information-publication-scheme/publication-scheme-and-key-information/equality-and-diversity/)
- Delivered on the NHS EDI Improvement Plan, the West Yorkshire Integrated Care Boards Fairness and Equity Strategy, and the NHS England requirements relating to Sexual Safety and Work and Religion and Belief.

Increasing Staff Capability and Awareness of EDI

- Developed an online resource bank and trained 430 managers through our EDI training offer. As a result of delivering training on our EDI policies.
- Coordinated an EDI Calendar which marks and celebrates key events and campaigns throughout the year. These dates provide an opportunity for staff to learn about things that matter and impact on the care of our diverse Bradford, Airedale and Craven communities ensuring that we can better meet their needs.
- Developed a network of 'EDI Influencers' to deliver on our Belonging and Inclusion Plan priorities across our clinical teams.

Improved representation and ensuring that everyone has a voice that counts

- Increased the number of staff sharing personal information about their long-term health conditions, sexuality and religion or belief which enables us to analyse the experience and representation data of our workforce and make improvements or celebrate good practice.
- We ran another successful reciprocal mentoring programme aimed at supporting ethnically diverse staff in bands 5 and 6 to progress in their careers and ensure our senior managers have an opportunity to connect with and support ethnically diverse colleagues in their career journey, learning from their lived experiences.
- Maintained ethnically and culturally diverse (ECD) leadership in bands 8a and above to be equal to the whole organisation's ECD representation.
- Supported 15% of our workforce to be a member of our three staff networks. The Rainbow Alliance, Aspiring Cultures Staff Network and Beacon Networks offer support, mentoring and ensure that all staff have a voice that counts. The networks feed into our governance processes directly through representation and a bi-monthly network report. Trust Board members sponsor the networks regularly attending and supporting delivery of their objectives.

Developed and implemented effective policies and procedures

- Implemented a See it, Say it, Stop it campaign to reduce abuse to our staff from service users and the public. We have monitored reports of abuse and sexual safety incidents affecting our colleagues on a weekly basis and targeted training, wellbeing support and positive and proactive care interventions into hotspot areas.
- Reduced the length of time that disciplinary processes take to complete and developed new information about wellbeing support for colleagues within the process. We have held learning events with clinical managers in hotspot areas to explore the root causes of higher levels of disciplinarys.

We have sought to collaborate and work in partnership within the Bradford, Airedale and Craven Health and Care Partnership, the NHS West Yorkshire Integrated Care System, the West Yorkshire Mental Health Collaborative and with our EDI colleagues across the country to share resources, develop evidence-based practice and work effectively.

Diversity and Inclusion Policies

The Trust has a range of policies and procedures in place to safeguard and promote equality, diversity and inclusion. These are developed in partnership with stakeholders and regularly reviewed, many have training and evaluations associated with them. The policies include:

- Trans Equality Policy.
- Inpatients Standard Operating Procedure.
- Spiritual Care Policy.
- Interpreting and Translation Policy.
- Equality Impact Assessment Policy.
- Management of Racial and Other Forms of Discrimination and Harassment.
- Disability Policy.
- Flexible Working Policy.
- Menopause Policy.



.....
Date: 25 June 2026
Sarah Jones
Chair in Common



.....
Date: 25 June 2026
Therese Patten
Chief Executive

6. Financial Report

Financial Performance

Summary

The financial year ending on 31 March 2026 has been another challenging year for the Trust with continued service demand and acuity pressures and workforce supply shortages. Despite this, the Trust has achieved its financial objectives for the year.

The financial highlights for 2025/26 include:

- delivering an adjusted surplus, after technical adjustments, of £2.021 million (m)
- approval of the Full Business Case for the Lynfield Mount redevelopment which has secured circa (c) £65million (m) of capital funding (£50m from national capital funding plus c£15m contribution from West Yorkshire NHS partners)
- continued investment in the Trust's estates and digital infrastructure, which is critical in supporting service delivery
- retaining a healthy cash balance of £22.8m
- prompt payment of invoices resulting in 97% of non-NHS organisations and 96% of NHS organisations being paid within 30 days.

All of this has been possible due to the contributions from all members of staff across the Trust, not least those in the Finance Team.

The Trust had turnover of £256.3m in 2025/26 and after expending £254.3m, generated a surplus excluding technical adjustment of £2.021m, or 0.79%.

Income and expenditure performance for the year ending 31 March 2026:

	2025/26 £000's
Income - Patient Care Activities	£245,626
Other Operating Income	£10,678
Total Income	£256,304
Operating Expenses	(£256,895)
Interest Paid and Received	£772
Public Dividend Capital	(£957)
Total expenditure (incl. technical adjustments)	(£257,080)
Technical adjustment: Impairments charged to statement of comprehensive income	£2,823
Technical adjustment: Movement in PFI revenue costs on a IFRS 16 basis versus a UK GAAP basis	(£26)
Total expenditure (excl. technical adjustments)	(£254,283)
Adjusted financial performance surplus/(deficit) for the year	£2,021

Table 12: Income and expenditure summary

Income

Income from Patient Care Activities was £245.6m and represented 95.8% of total income, and Other Operating Income was £10.7m and represented 4.2% of total income. The table below summarises the source of the Trust's income, and the diagram demonstrates where each £1 comes from:

Income Source		£000's	%
Integrated Care Board	Mental Health and Community Healthcare Contracts, Dental services	£208,149	81.2%
Local Authority	0-19 Service Contract	£14,099	5.5%
NHS England	NHSE centrally funded pension contributions; Child Health Informatics Service; Sexual Health	£12,077	4.7%
Locala Community Partnerships CIC	Vaccination and Immunisation services	£1,115	0.4%
Provider Collaborative	Adult Secure Service Contract	£7,958	3.1%
Provider Collaborative	Learning Disabilities Assessment & Treatment Contract	£2,165	0.8%
Other	Other patient care	£63	0.0%
Income from Patient Care Activities		£245,626	95.8%
Other Operating Income		£10,678	4.2%
Total income		£256,304	100.0%

Table 13: Income summary

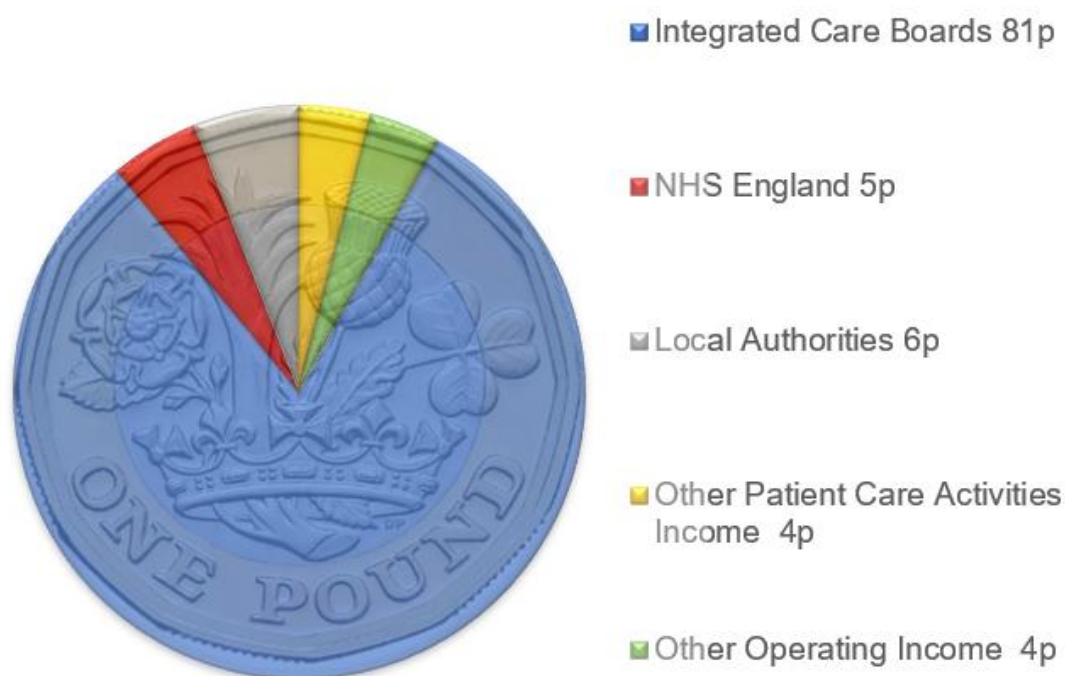


Diagram 16: Where each £1 comes from

Expenditure

Operating expenses, including finance costs and technical adjustments, were £254.3m. Staffing costs were the largest driver of cost and represent £193.4m, or 76.1% of the Trust's Operating Expenditure

Expenditure source	£000's	%
Staff Costs	£193,399	76.1%
Supplies and Services	£38,172	15.0%
Establishment & Premises	£11,936	4.7%
Depreciation & Amortisation	£6,400	2.5%
Other	£4,165	1.6%
Financing Costs	£185	0.1%
Technical Adjustment	£26	0.0%
Operating expenditure	£254,283	100.0%

Table 14: Expenditure summary

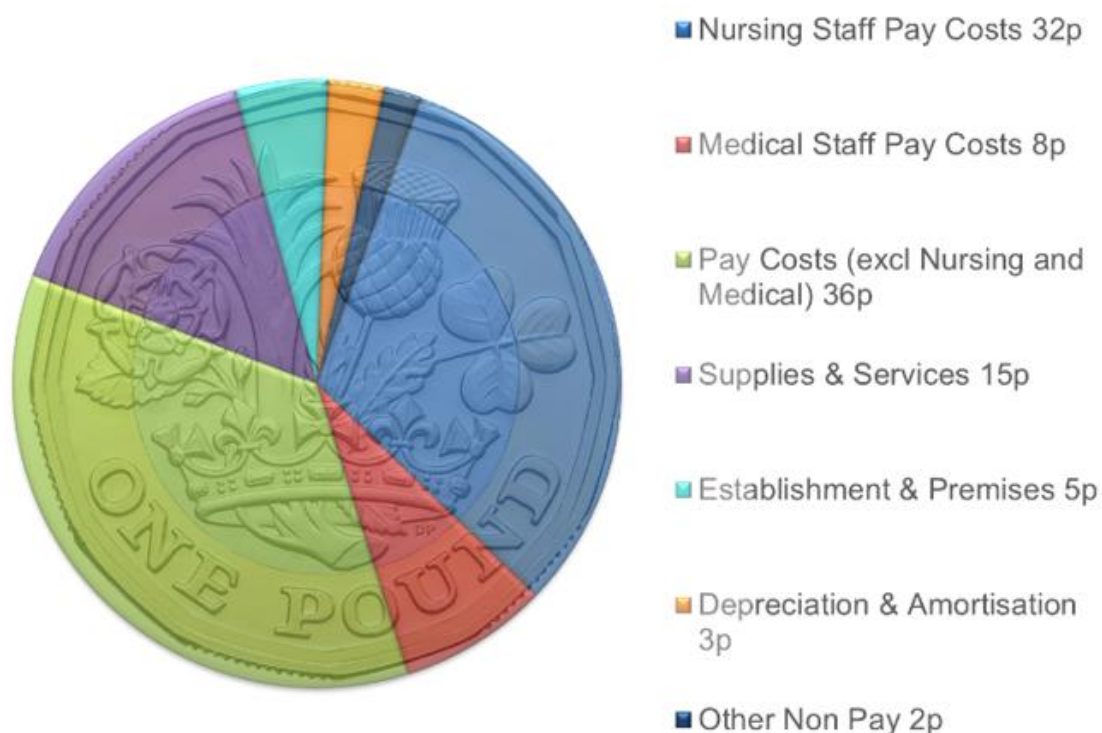


Diagram 17: How each £1 is spent

Improving efficiency and ensuring value for money

The Trust has continued to focus on value for money alongside delivering its service objectives. Savings and efficiency improvements have been achieved, amounting to £12.4m, which have been further supplemented by £5.9m of other one-off measures that have contributed towards the Trust meeting its statutory financial duties.

Capital Expenditure

The Trust has secured capital funding totalling £14.4m for the year through multiple routes, including operational capital from the West Yorkshire central allocation; capital funding for lease costs; and additional in-year national capital funding.

The Trust capital allocation has been invested in developing and maintaining the Trust's assets and infrastructure, with the following investments made:

- £4.0m on the Lynfield Mount Hospital redevelopment;
- £2.5m improving our inpatient estate;
- £5.9m has been invested across the wider Trust estate, including leases;
- £1.7m has been invested in our Digital infrastructure;
- £0.3m has been spent on equipment.

Cash

The Trust planned and maintained a positive cash balance throughout the year with a balance of £22.8m as at 31st March 2026.

Auditor remuneration

External Auditor fees for 2025/26 were £209k (including VAT) and incorporate fees relating to the Trust's Annual Accounts and the additional responsibilities in assessing whether there are any significant weaknesses in the Trust's arrangements to secure value for money. The charitable fund accounts are not audited by the Trust's external audit and is a separate contractual arrangement.

Accounting information and Directors' Statement

The accounts are independently audited by KPMG LLP as external auditors in accordance with the National Health Service Act 2006 and the National Audit Office's Code of Audit Practice. As far as the Directors are aware, all relevant audit information has been fully disclosed to the auditor. No relevant audit information has been withheld or not made available and there have been no undisclosed post balance sheet events.

The Trust made no political or charitable donations during the year ending 31 March 2026.

Accounting for pensions and other retirement benefits are set out in Notes to the full annual accounts and details of senior managers' remuneration can be found in Section 8 of the Annual Report.

Better Payment Practice Code

The Better Payment Practice code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. Performance for the year to 31 March 2026 was as follows:

	No. of invoices	Value of invoices £000's
Non NHS		
Total bills paid in the year	15,380	£55,613
Total bills paid within target	14,827	£52,544
Percentage of bills paid within target	96.4%	94.5%
NHS		
Total bills paid in the year	970	£11,988
Total bills paid within target	924	£10,995
Percentage of bills paid within target	95.3%	91.7%

Table 15: Performance against the Better Payment Practice Code

Going Concern Disclosure

The Trust has delivered the agreed plan for 2025/26, reporting an adjusted surplus of £2.021m. Through the financial statements and financial performance indicators, the Trust can demonstrate strong financial management and a clear understanding of its underlying financial position. The Trust's liquidity remains very strong with £22.8m cash balances at the year-end.

After consideration of the funding agreed through 2026/27 commissioning contracts, including investment in Mental Health services and the risk assessment of the efficiency programme, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, these accounts have been prepared on a going concern basis.

Financial Outlook for 2026-2027

The Trust Board has approved a break-even plan for 2026-2027, in line with its statutory duties. However, there remains a significant level of uncertainty and risk in these plans, not least because of:

- increased demand and acuity in our services;
- continuing pressure on inpatient beds, necessitating the use of Independent Sector beds;
- workforce availability and the resulting need to supplement with temporary staffing;
- industrial action for resident doctors;
- high levels of staff absence and sickness;

- delivery of the challenging efficiency target of £14m (5.9% of income), to meet our break-even duty;
- decaying Trust estate that is driving up maintenance costs and impacting on patient length of stays;
- pay inflationary costs remaining higher than funded levels; and
- system wide NHS reorganisation and staffing cuts, with the potential to delay or disrupt Trust plans.

Our Trust has robust risk management arrangements in place and continues to identify mitigations in respect of the key financial risks to fully de-risk the plan. The Trust has developed a range of strategic programmes and targets which will help to deliver its overall £14m efficiency target.

The Trust's capital allocation for 2026-2027 is £42.5m which includes £36.4m to support the development of Lynfield Mount (£33.6m funding from the Department of Health and Social Care and a £2.8m contribution from the West Yorkshire operational capital allocation), £3.6m for routine operational capital priorities, funding for lease renewals in year of £1.1m and £0.9m Estates Safety Funding and £0.5m Community Digital Integration Funding (funded from additional PDC).

In summary, the Trust has a strong history of effective financial management but recognises that there are significant risks to the achievement of our statutory duties in 2026-2027.

Provider Selection Regime

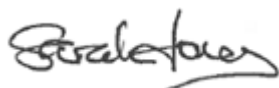
In accordance with Regulation 25 of the Health Care Services (Provider Selection Regime) Regulations 2023, the Trust is required to produce an annual summary of contracting activity for the provision of relevant health care services.

The relevant information is provided below:

Provider Selection Regime Annual Summary of contracting activity for the Provision of Relevant Health Care Services. 01 January 2025 - 31 March 2026	
(a) the number of contracts awarded in the year to which the summary relates where Direct Award Process A, Direct Award Process B or Direct Award Process C was followed;	Direct Award Process A: 0 Direct Award Process B: 0 Direct Award Process C: 0
(b) the number of contracts awarded in the year to which the summary relates where the Most Suitable Provider Process was followed;	0
(c) the number of contracts awarded in the year to which the summary relates where the Competitive Process was followed;	0
(d) the number of framework agreements concluded in the year to which the summary relates;	0

(e) the number of contracts awarded based on a framework agreement in the year to which the summary relates;	0
(f) the number of contracts awarded and modifications made in reliance on regulation 14 (urgent award or modification) in the year to which the summary relates;	0
(g) the number of new providers to whom a contract was awarded in the year to which the summary relates;	0
(h) the number of providers who held a contract in the previous year but no longer hold any contracts in the year to which the summary relates;	0
(i) the number of written representations made in accordance with regulation 12(3) and received during standstill periods which ended in the year to which the summary relates and a summary of the nature and impact of those representations.	0

Table 16: Provider Selection Regime Annual Summary of contracting activity for the Provision of Relevant Health Care Services.



.....
Date: 25 June 2026
Sarah Jones
Chair in Common



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Date: 25 June 2026
Therese Patten
Chief Executive

7. Accountability Report

How the Trust is governed

Board of Directors

The Board is the body legally responsible for the day-to-day management of the Trust and is accountable for the operational delivery of services, targets and performance, as well as the definition and implementation of the Trust strategy. It has a duty to ensure the provision of safe and effective services for service users and carers. It does this by having in place effective governance structures and by:

- Establishing and upholding Trust values and culture.
- Setting the strategic direction.
- Ensuring the Trust provides high quality, safe and effective service user and carer focused 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.
- Ensuring high standards of governance are applied across the Trust.

The Chair is responsible for ensuring that the Board of Directors focuses on the strategic development of the Trust and that robust governance and accountability arrangements are in place. The Chair is also the meeting Chair of both the Board of Directors as well as the Council of Governors ensuring there is effective communication between the two bodies and that, where necessary, the views of the Governors are considered by the Board.

Whilst the Executive and Associate Directors individually are accountable to the Chief Executive for the day-to-day operational management of the Trust, they, along with the Non-Executive Directors, are 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 will assure themselves of performance by holding the Executive Directors to account for the achievement of the agreed goals, objectives, targets and measures.

The Board sets out the Trust's vision, values and standards of conduct, whilst ensuring that its obligations to Trust members and the wider public are understood, clearly communicated and met. This is achieved by ensuring that 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. The Board provides entrepreneurial leadership in a

transparent manner, supports Trust colleagues in accordance with the Trust's values and accepted standards of behaviour in public life, including the Nolan Principles of:

- Selflessness
- Integrity
- Objectivity
- Accountability
- Openness
- Honesty
- Leadership

The composition of the Board is in accordance with the Trust's Constitution. During 2025/26 there were five changes to individual members of the Board, outlined as follows:

- Linda Patterson retired on 31 December 2025 after 50 years' NHS service, with over 25 years in both clinical leadership and board level roles.
- Simon Lewis was appointed for one additional year commencing 19 November 2024 to 18 November 2025 as a Non-Executive Director and Deputy Chair of the Trust. He was then appointed as Acting Trust Chair from 19 January 2026 to 19 March 2026.
- Sarah Jones was appointed for one year from 1 March 2026 as Chair in Common with Airedale Foundation Trust and Bradford District Care NHS Foundation Trust.
- Chris Malish was re-appointed for a second term of office starting 1 January 2026 for three years.
- Mark Rawcliffe was appointed as Deputy Chair 1 January 2026, alongside his current role as Non-Executive Director.
- Sal Uka was appointed through a competitive recruitment process as Interim Chief Medical Officer, starting in post 6 October 2025, following the retirement of Medical Director David Sims.
- Warren Brown was appointed through a competitive recruitment process as Non-Executive Director, replacing Simon Lewis as Non-Executive Director, starting in post 19 January 2026.

The Board comprises seven Non-Executive Directors (including the Chair of the Trust), six Executive Directors (including the Chief Executive Officer) and two Associate Director (Chief Information Officer and Director of Transformation, Improvement and Productivity). Considering the wide experience of the whole Board, the Board believes that its membership is balanced, complete and appropriate and that no individual or group of individuals dominate the Board.

Continuing in attendance at the Board is Iain MacBeath, Director of Integration (joint role introduced 2022 between the Trust and Bradford District Council).

Non-Executive Directors including the Chair, are appointed by the Council of Governors. Following the Trust Constitution and national guidance on Board

appointments, including the NHS Code of Governance. Where there is an incumbent Non-Executive Director who is eligible for re-appointment by virtue of the number of years they have served and where they wish to be considered for re-appointment, this would be done based on a satisfactory appraisal and approval by the Council of Governors.

Should it be necessary to remove either the Chair of the Trust or any of the other Non-Executive Directors this would be done by the Council of Governors. A decision to remove the Chair of the Trust or another Non-Executive Director must be done in accordance with our Constitution.

The Board of Directors considers that it is balanced, complete and appropriate and this can be seen in the biographical details of Board members as set out in this Annual Report. All the Non-Executive Directors are independent in both judgement and character, and the Board has confirmed there are no relationships or circumstances which are likely to affect, or could appear to affect, judgment in this respect.

There is a clear division of responsibilities between the Chair and Chief Executive which ensures a balance of power and authority. The Board has a wide range of skills and a significant number of members have a medical, nursing or other health professional background. Non-Executive Directors have wide-ranging expertise and experience with backgrounds in finance, audit and regulation, business and organisational development, healthcare, human resources, commercial, legal, and third sector.

Further details about the role and responsibilities of the Board are included in Annex seven of the Trust's Constitution (Standing Orders of the Board of Directors). All Non-Executive are considered to be independent (demonstrated through annual appraisals, declarations of interest and independence, and Board and Committee minutes).

Directors consider the Annual Report and Accounts, taken as a whole, to be a fair, balanced and understandable report which provides the information necessary for service users and carers, regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Non-Executive Directors



Dr Linda Patterson OBE FRCP, Chair of the Trust, until December 2025

Dr Patterson has strong clinical leadership experience in both community and hospital settings, specialising in care for older people, and 25-years working in Board level roles.

Alongside her clinical practice, she has held NHS leadership positions at both a local and national level, including Medical Director at Burnley Health Care NHS Trust, Medical Director for the Commission for Health Improvement, now the Care Quality Commission, and Clinical Vice President of the Royal College of Physicians.

Dr Patterson's former roles include Non-Executive Director for the National Patient Safety Agency, with responsibilities including equality and diversity, and a Board member for the Healthcare Quality Improvement Partnership. She was also Chair of a national NHS England Patient Safety Expert Group. A former Trustee of the Alzheimer's Society charity, her experience includes Non-Executive Director of Calderdale and Huddersfield NHS Foundation Trust.

Alongside her Board role, Dr Patterson is doing clinical advisory work both in the UK and internationally, and is a commissioner for the independent think tank, the Health Devolution Commission, looking at ways to join up health and social care, whilst considering the social factors that impact on health.



Simon Lewis, Non-Executive Director, Chair of the Mental Health Legislation Committee, and Deputy Chair from September 2023, and Interim Chair of the Trust from January 2026 to March 2026.

Simon Lewis brings considerable legal and professional experience to the Board and is the Chair of the Mental Health Legislation Committee

Simon is a barrister, whose areas of interest include employment issues, equality and anti-discrimination, safeguarding and mental health legislation. He is a part-time judge. He also brings experience from a number of other board-level roles in relevant sectors and from various independent regulatory roles within sport, healthcare and business.



Sarah Jones, Interim Chair in Common, from March 2026

Sarah Jones is the Chair in Common for the Trust, alongside Airedale NHS Foundation Trust where she is the substantive Chair.

Sarah brings considerable experience of chairing NHS trusts. Previously she served as the Chair of Sheffield Children's Hospital NHS Foundation Trust and, most recently, at Bradford Teaching Hospitals NHS Foundation Trust.

Whilst in South Yorkshire, Sarah also chaired the Mental Health, Learning Disability and Autism Provider Collaborative, as well as being a member of the Acute Federation and Sheffield Health and Care Partnership.



**Maz Ahmed, Non-Executive Director,
Chair of the Finance and Performance
Committee**

Maz, who is a qualified chartered accountant, is currently Finance Director - Trading and Marketing for Morrisons Supermarkets plc. and has held several senior finance roles for the national retailer.

Previously he was Finance Director responsible for leadership of the finance team, with financial accountability for Morrisons' 18 manufacturing sites, as well as the fresh trading division. Maz brings extensive commercial and financial experience to the role.

He has a strong track record of leading organisational change and wide-ranging improvement initiatives, to meet customer needs.

Maz started his career at Morrisons in 2008 as part of the newly formed internal audit function. He has led the implementation of a business-wide financial reporting system and strategic reviews of the manufacturing division, including the acquisition of new businesses. His leadership role includes building and promoting a culture of talent management, building capability and improving diversity. He is also the sponsor of Morrison's Black, Asian and Ethnic Minority programme, to improve diversity of staff from minority groups, and has recently been recognised in the 2020 Empower Ethnic Minority Role Model list. Prior to Morrisons, Maz worked in external audit with a national audit firm, supporting clients across a range of industries including the public sector.



Mark Rawcliffe, Non-Executive Director, Chair of the People and Culture Committee, and the Charitable Funds Committee, and Deputy Chair from January 2026.

Mark has held senior roles in the financial sector for over 21-years and is currently responsible for building and delivering the Banking Digital Transformation Strategy for Lloyds Banking Group. His banking-based career quickly adapted from frontline posts in diverse communities, to more strategic roles including managing operations teams and leading large regulatory change programmes.

Mark has successfully created and led change strategies whilst managing budgets at times when cost savings have been key, but also being cognisant of risks and complex regulation. The initiatives he has delivered have positively impacted millions of customers and he has been proactive in innovatively supporting vulnerable customers. His financial acumen and digital expertise broadens the Board's wealth of knowledge in these areas. He is also a member of various senior committees within the banking group.

Outside work, Mark is a family man and is passionate around supporting charities that have helped his family. He actively fundraises for them to make positive contributions to the lives of people in the community.



Alyson McGregor MBE, Non-Executive Director, Chair of the Quality and Safety Committee

Alyson has almost 40-years' experience working in a range of health roles in the public, private and voluntary sector as well as over nine years Board level experience with Bradford and Airedale Primary Care Trusts. Alyson started her working life in public health in Bradford and Airedale in 1983, managing health improvement services.

She has worked at district, regional and national levels and is the co-founder and National Director of Altogether Better, an NHS network organisation. She has many years' experience of using systems' approaches and working collaboratively across organisational boundaries with people, to codesign solutions to the challenges and problems that both the NHS and people in communities are facing. Alyson is a member of the NHS Leadership Academy faculty and part of NHS England's Personalised Care Leadership Programme team. She was a member of the Prime Minister's GP Challenge Advisory Group, is a founding member of the National Social Prescribing Network Steering Group and is currently a member of the Volunteering Taskforce set up by the Cabinet Office.

She was voted by the Health Service Journal as one of the top 50 inspirational women leaders in the NHS and was awarded an MBE for services to Collaborative Practice and service development in the NHS, in the 2021 New Year Honours list.



Chris Malish, Non-Executive Director, Chair of the Audit Committee

Chris has extensive experience in the finance, education, audit and risk in the public sectors and was the Executive lead for both Finance and General Purposes Committee and Audit Committee within his role.

This follows eight years at the University of Bradford, as the Interim Director of Finance, after progressing through a range of senior finance roles within the education sector.

As a local resident, Chris has lived in Bradford for the last 17-years and is very passionate about supporting the local communities served by the Trust, in line with the Trust's values.



Sally Napper, Non-Executive Director and Senior Independent Director

Sally has worked within the NHS for 37-years originally qualifying as a Children's and Adult nurse. She has worked in a wide range of acute and community services within Acute, Specialist and Children's Trusts. Sally was a director within the NHS for 20-years covering Chief Nurse and Chief Operating Officer roles before moving to NHS England as Director of Nursing for Lancashire and South Cumbria. Sally worked at Bradford Teaching Hospital Foundation Trust around 10 years ago and worked closely with the Trust during this time.

Since 2018, Sally has been Chief Executive of Rotherham Hospice leading the development of End-of-Life Services across South Yorkshire working closely with the Integrated Care System and other hospices. She is an attendee of the Board as a Non-Executive Director.



Warren Brown, Non-Executive Director

Warren has considerable senior-level experience across the public sector at the Department of Health, where he was responsible for key policy areas like the NHS Foundation Trust roll out and NHS Operating Framework.

More recently, following a number of Director level roles, he was Director of Performance and Improvement for NHS England and NHS Improvement across the North East and Yorkshire region, before retiring from the role.

Warren is actively involved in local

community initiatives, including supporting public safety measures and leading NHS wellbeing walks.

Executive and Associate Directors



Therese Patten, Chief Executive, Accountable Officer

Therese has extensive NHS Board level experience, working across community, mental health, acute and specialist healthcare in the NHS.

Therese joined the Trust from Southport and Ormskirk Hospital NHS Trust, where she was Deputy Chief Executive and Director of Strategy. In this role, Therese led both Trust and district-wide sustainability programmes, working closely with clinicians and key stakeholders. She was also Chair of a provider alliance of 15 health, care and voluntary organisations, working together to provide an integrated service and improve health outcomes for local people.

Therese joined Southport and Ormskirk from Alder Hey Children's NHS Foundation Trust in 2016 and previously worked at Five Boroughs Partnership NHS Foundation Trust, and Liverpool Community Health. She also spent a short period working in the private sector with GP provider companies. Before joining the NHS in 1999, Therese spent nine-years working in health development in Zimbabwe, Somaliland and Pakistan



Kelly Barker, Chief Operating Officer

Kelly's career spans over 20-years with the NHS, starting as a Health Care Support Worker, before qualifying as a Mental Health Nurse, working clinically across the breadth of inpatient and community settings. She then moved into several senior operational roles, including Deputy Director of Operations at the Care Trust.

Kelly has worked in Bradford since 2004 and is passionate and committed to leading and delivering high quality services to our communities.

She has operationally led services spanning both community and mental health, with a strong focus on system and partnership working and has delivered several key service improvements and innovations.

Kelly is a values driven leader, committed to creating 'Better Lives, Together' by using the Care Trust Way, our continuous improvement methodology, and having co-production at the heart of everything the Trust does.



Phillipa Hubbard, Director of Nursing, Professions and Care Standards, Director of Infection Prevention and Control and Deputy Chief Executive

Phil's career spans 39-years across hospital, primary, mental health and community care settings. Since joining the Trust in 2012, she has held several senior roles and has a strong track record of leading large-scale service improvements, working with partners across the district.

Phil, who is a registered nurse, was instrumental in reshaping the Trust's children's service and also worked alongside primary care providers to establish new community partnerships, to better support local communities' health

and care needs.

Previously, as a nurse consultant at Bradford and Airedale Community Health services, Phil was responsible for several initiatives including developing a specialist clinical service to support people with learning disabilities.



Bob Champion, Chief People Officer

Bob is a Chartered Fellow of the Chartered Institute for Personal Development and has worked in and around the NHS for around 49-years, starting as a hospital porter in Birmingham, before training as an operating department assistant working in theatres.

His extensive experience includes almost 20- years working across the West Midlands and North Yorkshire Ambulance Services, where he was one of the first operational paramedics.

Whilst there he went onto become Assistant Director of Personnel with the North Yorkshire Service, where Bob studied for his human resources degree.

Since the late 1990's, Bob has led human resources and organisational development functions at or around board level in a range of NHS organisations, in substantive, consultancy and interim roles.

Bob is passionate about employee engagement, health and wellbeing, and partnership working with staff side colleagues, alongside equality and diversity, having chaired the National Equalities Forum in a previous role.



Dr Sal Uka, Interim Chief Medical Officer

Dr Salim Uka known as Sal qualified from the University of Leeds in 1999. Following postgraduate training across Yorkshire and Humber Sal was appointed as a Consultant in Paediatrics in Calderdale and Huddersfield NHS Foundation Trust in 2009.

Whilst there Sal held several medical leadership roles including Clinical Director for Children's Services, Divisional Director for Diagnostic and Therapeutic Services, Associate Medical Director initially for Quality and Safety followed by Medical Workforce.

Sal has extensive operational and corporate leadership experience with a passion for improvement and transformation. In 2020, Sal was appointed as the Medical Lead for the West Yorkshire Association of Acute Trusts, the acute provider collaborative in West Yorkshire. Subsequently, Sal also has relatively unique system leadership experience which has shaped his collaborative and strategic approach.

Sal joins the Trust having been the interim Executive Medical Director at Airedale Foundation NHS Foundation Trust. Sal is also a Trustee for Overgate Hospice in Halifax.



Mike Woodhead, Chief Financial Officer

Mike is a highly experienced finance professional with a broad range of experience in the public sector, in senior leadership roles across health and care organisations.

Prior to joining our Trust, Mike was joint Chief Finance Officer (CFO) for Bury Clinical Commissioning Group and Bury Council, where he was also Vice-Chair of the Bury Strategic Estates Group. Mike has 17 years in consultancy roles

including interim Deputy Chief Financial Officer for Bury Clinical Commissioning Group (CCG), where he led the outline financial case for Greater Manchester Devolution, working with providers, CCGs and national commissioners. His experience also includes leading the learning disability and mental health workstreams at Tameside and Glossop CCG, as part of a wider programme to establish an integrated care organisation.



Tim Rycroft, Chief Information Officer

Tim joined the organisation from Airedale NHS Foundation Trust, following 7 years as Head of Information Technology (IT) and Information Governance. During his time at Airedale, Tim managed the pilots and early implementation of the multi-agency telemedicine service for people with long term conditions. This was developed further by the 'Airedale Hub' that achieved national award recognition for its innovative work in supporting care homes.

Before joining Airedale, Tim was Head of Technology Business Solutions at the National Policing Improvements Agency where he led the IT delivery for a new state-of-the-art £12million forensic training centre and introduced a range of innovative technologies to support operational learning. Tim brings considerable information management and technology experience to the role, both within the NHS and national policing agencies. He is a non-voting member of the Board as an Associate Director.



Iain MacBeath, Director of Integration

Iain joined the Trust in 2022 as a joint role at Place between the Trust and Bradford District Council. He is the Director of Integration in the joint role, whilst still holding the post of Strategic Director of Health and Wellbeing for Bradford District Council. He has responsibility for adult social care, public health and is a system partner in the Bradford Integrated Care Partnership. Prior to this Iain was Director of Adult Care Services for Hertfordshire County Council.

Iain started work as a civil servant for the Benefits Agency (as was). He then worked for Social Services in his hometown of Barnsley in both Children's and Adult's Services. After moving to Hertfordshire in 1999, he spent 5 years working for the Probation Service, returned to Social Services for the London Borough of Barnet and became Assistant Director of Adult Care Services for Hertfordshire in 2008. He became Director in 2013.

Iain is a Trustee of the national Association of Directors of Adult Social Services as Honorary Treasurer and is Network Chair for Care Commissioning in the Yorkshire and Humber regional branch. He is in attendance at the Board.

Farhan Rafiq, Director of Transformation, Improvement and Productivity

Farhan is an accomplished leader with a passion for driving transformation, innovation, and improvement within the healthcare sector.

As the Director of Transformation, Productivity and Improvement, Farhan brings a wealth of experience in leading cross-functional teams to deliver impactful, outcome-driven results. With a background spanning business



development, programme implementation, and strategic partnership building, he has successfully secured significant funding and led initiatives that have transformed services across community health and care.

Farhan is committed to fostering collaboration, developing innovative solutions, and ensuring the efficient delivery of services that align with local priorities.

His leadership in the establishment of the Innovation Hub for Bradford District and Craven, exemplifies his dedication to accelerating healthcare advancements. This is complemented by transformational experience of leading and managing a multi- million-pound private sector training business in the further education and apprenticeships sector.

Outside of work, Farhan is a devoted family man, committed to his faith, and is very involved in community and voluntary activities, including his role as a Parent Governor at a further education college in Leeds, and a volunteer caseworker for a charity, all demonstrating his commitment to social impact and public service.

He is a non-voting member of the Board as an Associate Director.

Removal of a Non-Executive Director requires the approval of three quarters of the members of the Council of Governors at a general meeting as outlined in the Standing Orders (Annex 6 in the Trust Constitution).

The Board holds monthly private meetings and bi-monthly public meetings and discharges its day-to-day management of the Trust through the Chief Executive,

individual Executive and Associate Directors and senior staff through a scheme of delegation which is approved by the Audit Committee.

Four extraordinary Board in Private meetings were held to consider the system financial risk share, Well Led review, Provider Capability Assessment, and approval of the annual audited accounts and submissions. This included External Audit reports (Letter of Representation, ISA 260, Auditor's Statement), approval of the Trust Annual Report 2023/24 and NHS England self certifications (CoS7 and Licence G6), alongside review of CQC compliance, updates on the CQC assessment framework, and consideration of the Strategic Partnering Agreement and Governance Handbook refresh 2025/26 for Place.

Attendance at Board meetings is outlined below.

Name	Number of business meetings attended	1 May 2025	5 June 2025	10 June 2025**	26 June 2025**	24 July 2025	2 Oct 2025	16 Oct 2025**	6 Nov 2025	4 Dec 2025	15 Jan 2026	5 Feb 2026	5 Mar 2026
Linda Patterson	8/9	✓*	✓*	✓*	✓*	-	✓*	✓*	✓*	✓*	N/A		
Maz Ahmed	4/12	✓	✓	✓	-	✓	-	-	-	-	-	-	-
Simon Lewis	8/12	✓	✓	✓	-	-	-	✓	✓	-	✓*	✓*	✓
Alyson McGregor	11/12	✓	-	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chris Malish	8/12	✓	✓	-	✓	✓	-	✓	✓	-	-	✓	✓
Mark Rawcliffe	11/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	-	✓	✓
Sally Napper	9/12	✓	-	✓	✓	✓*	-	✓	✓	-	✓	✓	✓
Warren Brown	2/2	N/A										✓	✓
Sarah Jones	2/2	N/A										0	✓*
Therese Patten	9/12	✓	-	✓	✓	-	✓	✓	✓	✓	✓	✓	-
Kelly Barker	11/12	✓	✓	✓	✓	-	✓	✓	✓	✓	✓	✓	✓
Bob Champion	9/12	✓	-	-	✓	-	✓	✓	✓	✓	✓	✓	✓
Phil Hubbard	12/12	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Iain MacBeath	1/12	✓	-	-	-	-	-	-	-	-	-	-	-
Tim Rycroft	8/12	✓	-	✓	-	✓	✓	-	-	✓	✓	✓	✓
Farhan Rafiq	10/12	✓	-	✓	✓	✓	✓	✓	-	✓	✓	✓	✓
David Sims	5/5	✓	✓	✓	✓	✓	N/A						
Sal Uka	7/7	N/A					✓	✓	✓	✓	✓	✓	✓
Mike Woodhead	10/12	✓	✓	✓	✓	-	✓	✓	✓	-	✓	✓	✓

0 indicates observed

- indicates apologies

* indicates Chair

** indicates Extraordinary Board meeting held in private

Table 18: Attendance of Board members at formal Board meetings

There is an opportunity for members of the public to raise questions with the Board. Board members can be contacted via the Trust Secretary, details of which are on the Trust website. Information about how members of the public can raise questions in advance of a Board meeting held in public can be found on the agenda for that meeting.

The Board receives an integrated performance report at each public Board meeting measuring performance against national and local targets relating to finance, quality and workforce indicators. Where there is any deviation from plan, exception reports are presented for consideration of any necessary remedial action. The report has, over the year, been refined to reflect new targets or other areas requested by the Board to ensure it monitors new areas of performance. The Board maintained a strong level of governance across the Trust. Areas of continuous improvement for key priority areas for the Trust and where developments continue to be made include:

- Well led and governance.
- Risk management.
- Improving oversight and assurance practices.
- Care Trust Way continuous improvement framework.

The Trust has robust processes in place for annual performance evaluation of the Board, its Directors, and Board Committees in relation to performance. The main components of this are:

- The Chair conducts individual performance evaluations of the Non-Executive Directors and the Chief Executive, which involves obtaining feedback from a variety of stakeholders.
- The Senior Independent Director conducts a performance evaluation of the Chair, which involves obtaining feedback from a variety of stakeholders.
- The Chief Executive conducts performance evaluations of the Executive and Associate Directors.
- The Board has an ongoing development programme in place and held eight sessions during the year comprising of several different topics.
- The outcomes of the performance evaluation of the Chair and Non-Executive Directors is presented to the Council of Governors' Nominations and Remuneration Committee and reported to the Council in line with the process agreed by the Council.
- The outcomes of the performance evaluation of the Chief Executive, Executive and Associate Directors are presented to the Board of Directors' Nominations and Remuneration Committee.
- Annual effectiveness review looking at performance of the meetings.

Other governance activities

The Trust introduced Joint Committee sessions a few years ago. They were originally set up to bring together two Committee's to discuss a specific topic that covered both areas. The model has evolved over the last few years due to the Trust being a learning organisation and ensuring that effectiveness reviews take place supported by opportunity to capture people's experience.

During 2025-2026 no Joint Committees were held.

In January 2023, the Board of Directors at the Trust approved a development plan based on analysis conducted from October to December 2022. This plan aimed to enhance the Trust's governance, oversight, and accountability framework. The focus included targeted improvements to reporting systems, culture development plans, and the adoption of the Care Trust Way methodology. The iterative process involves regular effectiveness reviews and benchmarking.

Simultaneously, a review of the Board Assurance Framework (BAF) and Integrated Performance Report (IPR) occurred, aligning with the refreshed Trust Strategy, Better Lives, Together, approved in July 2023. The BAF and IPR review incorporated feedback, external benchmarking, and consultations with specialists. The transition was in support of moving from a 'risk based' Board Assurance Framework (BAF) which is the traditional format for a BAF, to an 'assurance based' BAF. The reason for this was to better align conversations at Board and Committees with the responsibilities of those groups in obtaining assurance as to delivery of the Trust's strategic priorities. The new BAF format was introduced in October 2023 and works in partnership with the Integrated Strategic Performance Report for Board and Committee's.

Board Sub-Committees

The Board discharges its responsibilities through seven Committees. The main duties of each Committee are set out below. Information on the Nomination and Remuneration Committee is contained separately in the remuneration report. To support effectiveness reviews, Committees undertake an annual evaluation and submit an Annual Report to the Board. These reports are considered by the Board as assurance against the wider context of the Annual Report.

At each Board meeting following a Committee meeting, there is a report from Committee Chairs which takes the form of ‘Effective Oversight: Escalation and Assurance. The framework has been recognised as good practice by partners across the West Yorkshire System, with the Trust’s template being adopted by some partnership collaborations. In January 2025, changes were made to the templates of the ‘Effective Oversight: Escalation and Assurance reports’. This streamlined the process, with an additional box added for feedback from the Board. The reports were also reported back into the next sub-committee with the feedback from the Board, which closes the loop of feedback back down to the sub- committee, strengthening triangulation.

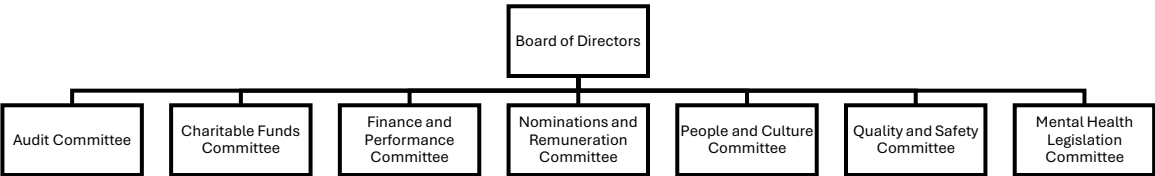


Diagram 18: Board Sub-Committees that support the Trust Board of Directors

Audit Committee

(Chair: Chris Malish)

The Audit Committee is responsible for monitoring and reporting on the Trust’s systems of internal control and comprises solely of Non-Executive Directors, supported by the Trust Secretary, Chief Finance Officer and senior colleagues from

the Finance Directorate. It provides the Board with an independent and objective review of financial and corporate governance, risk management, external and internal audit programmes. It is responsible for making sure the Trust is well governed. Taking a risk-based approach, the Committee has worked to an annual plan covering the main elements of the Assurance Framework.

The Committee validates the information it receives through the work of internal audit and external audit, again through reports and attendance by key personnel at its meetings to present papers on specific matters. Assurance is also brought to the Committee through the knowledge that Non-Executive Directors gain from other areas of their work, not least their own specialist areas of expertise, visiting services, and talking to colleagues and Governors.

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

- Reviewing the maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the objectives.
- Ensuring that there is an effective internal audit function established by management that meets mandatory NHS Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board.
- Reviewing the work and findings of the external auditors and considering the implications and management's responses to their work.
- Satisfying itself that the Trust has adequate arrangements in place for countering fraud and shall review outcomes of counter fraud work.

The Committee has appointed internal auditors (Audit Yorkshire) and during the year they:

- Reviewed and approved the internal audit strategy, operational plan and more detailed programme of work.
- Considered the major findings of internal audit work (and management's response).
- Considered whether the internal audit function is adequately resourced/has the appropriate standing within the Trust.
- Considered the Head of Internal Audit Opinion on the overall adequacy and effectiveness of its system of internal controls.

KPMG LLP are the Trust's appointed external auditors. The Committee has also:

- Received the audit of the Trust's financial statement and auditors' opinion.
- Received briefings and learning from Local Counter Fraud.
- Received technical updates from the external auditors on issues relevant to operating in a health and care environment.

During 2024/25, the Audit Committee undertook a self-review exercise, and comparison (which included benchmarking) of the terms of reference. The findings will be considered alongside consideration to the Audit Committee's role in reviewing the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust, that supports the achievement of the Trust's strategic objectives in the next financial year.

The Audit Committee met six times in 2025/26 as outlined below:

Name	Number of business meetings attended	19 June 2025	23 July 2025	25 September 2025	27 November 2025	29 January 2026	26 March 2026
Bob Champion	1/6	N/A	N/A	N/A	✓	N/A	N/A
Claire Risdon	4/6	✓	✓	-	✓	✓	-
Simon Lewis	1/6	N/A	N/A	N/A	✓	N/A	N/A
Chris Malish	6/6	✓*	✓*	✓*	✓*	✓*	✓*
Sally Napper	5/6	✓	✓	-	✓	✓	-
Tim Rycroft	1/6	N/A	N/A	✓	N/A	N/A	N/A
Mike Woodhead	3/6	N/A	N/A	✓	N/A	✓	✓
Warren Brown	2/6	N/A	N/A	N/A	N/A	✓	✓
Farhan Rafiq	1/6	N/A	N/A	N/A	✓	N/A	N/A
Kelly Barker	1/6	N/A	N/A	N/A	✓	N/A	N/A

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 19: Attendance of members at Audit Committee

Charitable Funds Committee

(Chair: Mark Rawcliffe)

The Charitable Funds Committee has a wide cross section of attendance comprising Non-Executive and Executive Directors, Head of Charity, Volunteer Service Manager and Volunteers. During the year the Committee focused its discussions on reports received Charity Risk Register, Charity Strategic update, Charity Annual Accounts (close down of accounts), Charity Annual Accounts (final), External Audit: ISA 260, External Audit: Letter of Representation, Approval of fund objectives and managers, Annual Review of Investment Performance and Transactions and balances.

The Charitable Funds Committee has responsibility for the Trust's charitable activities and provides assurance that these are managed in accordance with charity law and the regulations set by the Charity Commission for England and Wales. The Board of Directors acts as the Corporate Trustee; however, this Committee considers charitable matters in greater detail on the Board's behalf and supports effective oversight of charitable funds and activities. Where required, the Committee works with the Charity Commission and seeks appropriate assurance to ensure continued compliance and proper stewardship of charitable resources.

The Charitable Funds Committee met two times in 2025/26 as outlined below:

Name	Number of business meetings attended	29 October 2025	19 February 2026
Maz Ahmed	0/2	-	-
Kelly Barker	0/2	-	-
Alyson McGregor	2/2	N/A	✓
Mark Rawcliffe	2/2	-✓*	✓*
Mike Woodhead	2/2	✓	✓
Catherine Jowitt	2/2	✓	✓

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 20: Attendance of members at Charitable Funds Committee

Finance and Performance Committee

(Chair: Maz Ahmed)

The Finance and Performance Committee has responsibility for monitoring financial performance of the Trust against plan (reporting any proposed remedial action to the Board as necessary), to consider the Trust's medium to longer term financial strategy and provide an oversight of the development and implementation of financial systems across the Trust.

During the year, the Committee received assurance on the Trust's overall performance, financial position and key system wide priorities, including strategic performance, system finance and care group assurance arrangements. This provided oversight of how the Trust is delivering its objectives in the context of wider NHS system expectations.

The Committee also considered a range of reports and updates covering financial and operational planning, governance effectiveness, contracts, digital developments, sustainability, estates redevelopment and data quality. In addition, the Committee reviewed strategic risks, compliance and safety matters, and progress with the Well Led programme, supporting transparency and assurance to the Board on the Trust's governance, performance and sustainability.

The Committee's membership was adjusted during the reporting period due to changes in the Executive Management Team of the Trust. Dr David Sims, Medical Director, retired from his position with his final Committee meeting held on 23 July 2025. In October 2025, Dr Sal Uka, Interim Chief Medical Officer, joined the Trust and his first meeting was 18 December 2026.

The Finance and Performance Committee met six times in 2025/26 as outlined below:

Name	Number of business meetings attended	28 May 2025	23 July 2025	24 September 2025	26 November 2025	28 January 2026	25 March 2026
Maz Ahmed	3/6	√*	√*	-	-	√*	-
Kelly Barker	5/6	√	-	√	√	√	√
Bob Champion	5/6	√	√	√	-	√	√
Phil Hubbard	4/6	√	√	-	-	√	√
Therese Patten	3/6	-	-	√	-	√	√
Mark Rawcliffe	6/6	√	√	√*	√*	√	√*
Tim Rycroft	5/6	-	√	√	√	√	√
Dr David Sims	2/2	√	√	N/A			
Mike Woodhead	6/6	√	√	√	√	√	√
Farhan Rafiq	6/6	√	√	√	√	√	√
Alyson McGregor	1/1	N/A		√	N/A		
Sally Napper	1/1	N/A					√
Dr Sal Uka	2/3	N/A			√	√	-

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 21: Attendance of members at the Finance and Performance Committee

Mental Health Legislation Committee

(Chair: Warren Brown)

The Mental Health Legislation Committee has a wide cross section of attendance comprising Non-Executive and Executive Directors, two Associate Hospital Managers, senior clinicians and Involvement Partners. The Committee has responsibility to monitor, review and report to the Board on the adequacy of the Trust's processes relating to all mental health legislation. During the year the Committee focused its discussions on reports received on Mental Health Act visits by the CQC, reports from the Associate Hospital Manager meetings, on the Mental Capacity Act including Audits, its integrated strategic performance report, relevant strategic risks and specific items such as a review of Community Treatment Orders, timeliness of reports to tribunals and hospital managers, searching of service users and their property. In addition, the committee had a standing item preparing for the Mental Health Act 2025.

The Committee's membership was adjusted during the reporting period due to changes in the Non-Executive portfolio and the Executive Management Team of the Trust. Dr David Sims, Medical Director, retired from his position with his final Committee meeting held on 17 July 2025. In October 2025, Dr Sal Uka, Interim Chief Medical Officer, assumed responsibilities as Executive Lead for the Committee. Additionally, the Committee's long standing Chair, Simon Lewis, Non-Executive

Director retired from post with his last Committee taking place on 20 November 2025. From January 2026, Warren Brown, Non-Executive Director became Chair of the Committee.

The Mental Health Legislation Committee met six times in 2025/26 as outlined below:

Name	Number of business meetings attended	22 May 2025	17 July 2025	10 October 2025	20 November 2025	22 January 2026	19 March 2026
Warren Brown		N/A				✓	✓
Kelly Barker		-	-	✓	✓	✓	-
Phil Hubbard		-	✓	✓	✓	✓	-
Simon Lewis		-	✓*	✓*	✓*	N/A	
Alyson McGregor		✓*	✓	-	✓	✓*	✓
Dr David Sims		✓	✓	N/A			
Dr Sal Uka		N/A		✓	✓	✓	-

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 22: Attendance of members at Mental Health Legislation Committee

Quality and Safety Committee

(Chair: Alyson McGregor)

The Quality and Safety Committee has a wide cross section of attendance comprising Non-Executive and Executive Directors, Deputy Directors, Patient Safety Lead and Heads of Nursing. The Quality and Safety Committee has responsibility to monitor, review and report to the Board on the adequacy of the Trust's processes in the areas of clinical governance and, where appropriate, facilitate and support existing systems operating across the Trust. This includes monitoring of incidents and complaints, research and development, and service improvements.

During the year, Committee business has included receiving feedback from Involvement Partners; updates from the Clinical Board, Safer Staffing Group, Patient Safety and Learning Group, Involvement and Participation Strategic Group, Allied Health Professionals, System Quality Committee and Patient and Carer Involvement, and Volunteering. It also received assurance on the Quality Assurance Framework, Equality Impact Assessments and quarterly patient safety, incidents and experience and feedback. Further assurance was received in relation to risk management and incident management. In addition, it was provided with regular feedback from CQC visits and the CQC inspection reports.

The Committee's membership was adjusted during the reporting period due to changes of the Executive Management Team of the Trust. Dr David Sims, Medical

Director, retired from his position with his final Committee meeting held on 17 July 2025. In November 2025, Dr Sal Uka, Interim Chief Medical Officer, assumed responsibilities as a Committee member.

The Quality and Safety Committee met seven times in 2025/26 as outlined below

Name	Number of business meetings attended	21 May 2025	16 July 2025	17 September 2025	19 November 2025	21 January 2026	18 February 2026	18 March 2026
Alyson McGregor	6/7	√*	√*	√*	√*	-	√*	√*
Kelly Barker	3/7	√	-	√	-	√	-	-
Bob Champion	4/7	√	-	-	√	-	√	√
Phil Hubbard	5/7	√	-	-	√	√	√	√
Simon Lewis	1/1	N/A				√**	N/A	
Sally Napper	4/7	√	-	-	-	√*	√	√
Sal Uka	5/7	N/A			√	√	√	

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 23: Attendance of members at Quality & Safety Committee

People and Culture Committee

(Chair: Mark Rawcliffe)

During 2025/26 the People and Culture Committee focused on workforce and equality topics for members of staff. The purpose of the Committee is defined as providing oversight of significant workforce and equality matters. The Committee is an assurance receiver on behalf of the Board.

During the year, the Committee reviewed a wide range of reports and updates to provide assurance on the Trust's approach to its workforce, culture and leadership. This included oversight of workforce performance, recruitment, staffing, staff experience, wellbeing and equality, alongside national, regional and local priorities.

The Committee also considered annual and statutory reports on governance arrangements, leadership development, workforce planning and equality standards, as well as themed discussions on key people related risks. This work supports transparency and provides assurance on how the Trust supports, develops and engages its staff.

The Committee's membership was adjusted during the reporting period due to changes in the Executive Management Team of the Trust. Dr David Sims, Medical Director, retired from his position with his final Committee meeting held on 17 July 2025. In October 2025, Dr Sal Uka, Interim Chief Medical Officer, joined the Trust, his first meeting was 18 December 2026.

The People and Culture Committee met six times during 2025/26 as outlined below:

Name	Number of business meetings attended	22 May 2025	17 July 2025	18 September 2025	18 December 2025	22 January 2026	19 March 2026
Mark Rawcliffe	6/6	√*	√*	√*	√*	√*	√*
Kelly Barker	3/6	√	-	√	-	√	-
Bob Champion	5/6	√	-	√	√	√	√
Phil Hubbard	2/6	√	√	-	-	-	-
Sally Napper	6/6	√	√	√	√	√	√
Therese Patten	2/6	-	-	√	-	√	-
David Sims	1/2	-	√	N/A			
Mike Woodhead	2/6	-	√	√	-	-	-
Sal Uka	2/3	N/A			√	√	-

* indicates Chair of the meeting

- indicates apologies at the meeting

Table 24: Attendance of members at People & Culture Committee

Go See Visits

Overview

The Board has continued to undertake 'Go See' visits which incorporate quality and safety walkabouts. These visits, some virtual and mostly face-to-face, offer an opportunity for Board members to gain an overview of what is happening in the workplace, listen to staff and gain insights into potential improvement opportunities. Board members report back on their experiences at public Board meetings and identify any actions to be followed up with teams. More details of the 'Go See' Framework can be found in the 2025/26 Quality Report.

Go See Visits during 2025-2026

During 2025/26, there were 45 'Go See' Visits to a variety of the Trust's services. Table 25 reflects the services and details which Non-Executives and Executives attended each visit. In January 2025, the 'Go See' invitation was extended to the Governors of the Trust. The response rate for this extension was positive.

Service/Department	Date of Visit	Executive Management Team	NED	Governor
EIP ARMS Team	01.04.2025	Mike Woodhead		
Community Planned Care South	04.04.2025	Philippa Hubbard		
Palliative Care Team	16/04/2025	Mike Woodhead	Maz Ahmed	
Dental services	16.04.2025	Kelly Barker	Alyson McGregor	Mufeed Ansari
Podiatry Team	17.04.2025	Bob Champion	Chris Malish	Arshad Ali
Practical Training Unit	22.04.2025	Tim Rycroft		
Social Work Team	20.02.2025	Therese Patten		
IT Service Delivery & Ops Team	29.05.2025	Bob Champion		
Tissue Viability Team	09.06.2025	Therese Patten		Mike Lodge
CMHT Psych Therapy Service	13.06.2025	Tim Rycroft	Maz Ahmed	
Primary Care Wellbeing Service	25.06.2025	Mike Woodhead		
Little Minds Matter	30.06.2025	Kelly Barker		
Bracken Ward	04.07.2025	Kelly Barker		
Compliance & System	09.07.2025	Mike Woodhead		

Aire Wharf CMHT	20.08.2025	Tim Rycroft		
BDCFT Safeguarding Team	17.09.2025	Mike Woodhead	Linda Patterson	
First Response Team	22.09.2025	Therese Patten	Alyson McGregor	
SALT Children's Team	26.09.2025	Farhan Rafiq		
City EIP Team	30.09.2025	Bob Champion	Sally Napper	
Community Planned Care North	27.10.2025	Therese Patten		
Vocational Mandatory Training Team	14.10.2025	Fran Stead		
Employee Health & Wellbeing	15.10.2025	Farhan Rafiq		
Heather Ward	15.10.2025	Kelly Barker		
Medical Staffing / Junior Doctors / EIP Staffing Team	23.10.2025	Phillipa Hubbard		
Physical Health Admin HUB	30.10.2025	Tim Rycroft		
Inpatient Administration (Hospital Receptionist & Hospital Cashier) Team	07.11.2025	Tim Rycroft		
Core CAMHS Team	11.11.2025	Fran Stead	Chris Malish	Mike Lodge
Forensic Therapy & Education Team	21.11.2025	Farhan Rafiq		Aurangzeb Khan
Oakburn Ward	17.11.2025	Therese Patten		Masira Hans
0-19 Children's Services West Team	26.11.2025	Phillipa Hubbard	Linda Patterson	David Hesford
Najurally Centre	08.12.2025	Therese Patten		Hitesh Govan
Community Planned Care City Team	10.12.2025	Fran Stead		
Ilkley Ward	11.12.2025	Bob Champion		
Baldon Ward	17.12.2025	Phillipa Hubbard	Alyson McGregor	

Baildon Ward	23.12.2025	Farhan Rafiq		Alyson McGregor
ALPS Airedale Team	06.01.2026	Tim Rycroft		
Payroll & Pensions Team	13.01.2026	Fran Stead		
Bradford North Network DN Team	19.01.2026	Therese Patten		Mike Lodge
DAU - Dementia Assessment Unit	21.01.2026	Tim Rycroft		
Thornton Ward	23.01.2026	Kelly Barker		
Craven LD Team	23.01.2026	Sal Uka		
CIC Team	12.02.2026	Sal Uka		
SMABS Specialist Mother & Baby Mental Health Service / Perinatal Team	12.02.2026	Farhan Rafiq		
Information Governance Team	12.02.2026	Therese Patten		Mike Lodge
Flow Management Team	16.02.2026	Farhan Rafiq		
South & West CMHT (OPMH)	09.03.2026	Kelly Barker		
Central IAPT Team	11.03.2026	Phillipa Hubbard		
Proactive Care Team	23.03.2026	Therese Patten		
Early Support for Every Child	26.03.2025	Farhan Rafiq		

Table 25: Summary of Go See Visits

Division of responsibilities between the Chair and Chief Executive

Chair responsibilities and objectives

The Chair is responsible for the leadership of the Board and is pivotal in the creation of the conditions necessary for good governance and overall Board and individual Director effectiveness, both inside and outside of the boardroom.

Each year a discussion takes place on the performance achieved on objectives and role delivery that is linked to agreeing future objectives to be achieved. For the Non-Executive Directors, including the Chair, this discussion includes the Lead Governor and Deputy Lead Governor, with the Chair discussion being facilitated by the Senior Independent Director.

The 2025-2026 objectives for the Trust Chair, Dr Linda Patterson, until 31st December 2025, were:

- To set the Trust's agenda for the year, continuing to lead the board and ensuring good Corporate Governance, maintaining effective and positive relationships with Board members and Trust management colleagues
- To plan and implement a smooth transition of responsibility and handover for the new Chair
- To increase service user engagement within the Board and Sub-Committees by supporting the development of a new Engagement Strategy
- Continue Partnership working at local place and across West Yorkshire

Sarah Jones joined as Chair in Common on 1 March 2026. The Chair in Common chairs the boards of Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust (AFT) in accordance with the terms of appointment applying to each role, and the relevant provisions of each foundation trust constitution and governor arrangements.

The Chair in Common shall lead each board effectively, promote high standards of corporate governance, ensure each board receives timely and relevant assurance, support constructive relationships between executive and non-executive directors, and encourage collaboration where this is lawful and beneficial. The role will act with the authority given to it through statutory requirements and Trust's governance documentation. The objectives of the Chair in Common are to:

- Strengthen collaboration between the foundation Trusts
- Support the delivery of safe, effective and sustainable services
- Align strategy where appropriate
- Foster collective leadership across the Trusts and their wider system relationships

Chief Executive responsibilities and objectives

The Chief Executive is responsible for the day-to-day leadership and management of the Trust, in line with regulatory requirements and the strategy and objectives approved by the Board.

The 2025-2026 objectives for the Chief Executive, Therese Patten, were:

- Continue to support the development of individual Directors and progress with the high performing teams development programme.
- Continue to lead for inclusion, delivering the Chief Executive Pledge and the Belonging and Inclusion Plan.
- Continue to connect with Staff, Service User, and Service Users through Visible Leadership, including through the Go See Framework, Back to the Floor visits, planned visits, and drop ins.
- Support the Chair and Board in moving forward with Quality Improvement to build on the recommendations from the Well Led review and the CQC.
- Support the Delivery of the New Hospital programme for Lynfield Mount Hospital.
- Lead the Executive team to ensure we deliver on our challenging operational and financial plan.
- Work with the ICB at Place and West Yorkshire to transition from the current Place Lead role to Chief Executive Lead for the Committee in Common and embed the new governance structure for the Place Provider Partnership.
- Continue to play an active role within the Mental Health provider collaborative.
- Continue to work with the NHS England System Architecture team to advocate and develop policy about how places fit in to emerging delivery structures.

Register of Directors' Interests

Under the provisions of the Trust's Constitution, the Trust is required to have a register of interests to formally record any declarations of interests of members of the Board of Directors. The register includes details of all directorships and other relevant material interests, which Executive, Associate and Non-Executive Directors have declared. This can be found in Appendix 1.

On appointment and at least annually thereafter, members of the Board declare any interests, which might place, or be seen to place them in a potential conflict of interest between their personal or private interests and those arising from their membership of the Board. None of the interests declared, conflict with their role as a Director.

Directors are also offered the opportunity to make a declaration in respect of agenda items to be discussed during the formal meetings. The register of interests is maintained by the Corporate Governance team and is available for inspection on the Trust's website.

It is also reported that Dr Linda Patterson OBE FRCP, Chair of the Trust had no other significant commitments during the year that affected their ability to carry out the duties of the Chair role, and Dr Patterson was able to dedicate sufficient time to undertake the duties. Following Dr Patterson's departure on 31 December 2025, Simon Lewis acted as interim Chair of the Trust from 1 January 2026. Simon Lewis' interests were reported, and Simon was able to dedicate sufficient time to undertake the duties. Sarah Jones was appointed as the Chair in Common on 1 March 2026, and Ms Jones' role as the Chair in Common at Airedale NHS Foundation Trust was recognised as an interest. Ms Jones was able to dedicate sufficient time to each organisation to undertake the duties of a Chair in Common.

The Board has also demonstrated a clear balance in its membership through extensive development. All Directors have declared they meet the Fit and Proper Persons Test described in the NHS Provider License and aligned to the NHS England Guidance. With all Non-Executive Directors, including the Chair of the Trust, able to fulfil the role, and demonstrating independence.

Council of Governors

Overview

An integral part of the Trust is the Council of Governors who bring the views and interests of the public, service users, staff colleagues and other stakeholders into the heart of the Trust's governance framework.

This group of committed individuals has an essential involvement with the Trust and contributes to its work and future developments to help improve the quality of services and care for all our service users and carers. The Council of Governors is chaired by the Chair, who ensures a link between the Council and the Board of Directors; the Deputy Chair of the Trust is also the Deputy Chair of the Council of Governors.

Role of the Council of Governors

Governors do not undertake operational management of the Trust - they hold the NED to account for the proper functioning of the Board. They help shape the Trust's future direction in a joint endeavour with the Board. The overriding responsibility of the Council 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 members of the Trust and the wider public.

This includes scrutinising how well the Board is working, challenging the Board in respect of its effectiveness and asking the Board to demonstrate that it has sufficient quality assurance in respect of the overall performance of the Trust, questioning Non-Executive Directors about the performance of the Board and of the Trust, and to ensure that the interests of the Trust's members and public are represented.

Governors on the Council meet the 'fit and proper persons test' described in the Trust's Provider License and outlined in the Trust Constitution.

The roles and responsibilities of the Council are set out in the Trust's Constitution. The Council's statutory responsibilities include:

- To appoint or remove the Chair and other Non-Executive Directors of the Trust.
- To decide the remuneration and allowances, and the other terms and conditions of office, of the Chair and Non-Executive Directors.
- To approve the appointment by Non-Executive Directors of the Chief Executive.
- To appoint or remove the Trust's external auditor.
- To be consulted on and provide views to the Board in the preparation of the Trust's annual plan.
- To receive the Trust's Annual Report and Accounts, and the report of the auditor on them.
- To take decisions on significant transactions and on non-NHS income.
- To amend/approve amendments to the Trust's Constitution.

The Health and Social Care Act 2012 requires the Board of Directors to empower Governors by:

- Holding open Board meetings.
- Providing a copy of the agenda to the Council in advance of every Board meeting.
- Providing copies of the approved minutes to the Council as soon as practicable after holding a Board meeting.
- Ensuring that Governors are equipped with the skills and knowledge they need to undertake their role.

Composition of the Council

During 2025-2026, there were no changes to the composition of seats within our Council of Governors. The composition ensures the Council is representative of our members and the public. Table 26 shows the composition of seats within the Council of Governors.

	Constituency	Number of seats
Elected	Public: Bradford East	3
	Public: Bradford South	3
	Public: Bradford West	3
	Public: Craven	1
	Public: Keighley	2
	Public: Rest of England	1
	Public: Shipley	2
	Staff: Clinical	3
	Staff: Non-clinical	2
Appointed	Barnardo's	1
	Bradford Assembly	1
	Bradford Council	2
	Bradford University	1
	Craven Council	1
	Noor Service	1
	Total	27

Table 26: Composition of our Council of Governors

Governors are either elected or appointed to seats on the Council of Governors for a period of up to three-years. Elected governors consist of public and staff (clinical and non-clinical) Governors. Appointed governors are nominated individuals from partner organisations as outlined in the Trust's Constitution. Elected governors can stand to be re-elected for two terms of office holding a seat for up to a maximum of six-years. Elections are carried out in accordance with the election rules in Annex four of the Trust Constitution. Further details about the elections we have held during 2025/26

can be found below. Appointed Governors can be nominated by their partner organisation again as their representative and can serve a maximum of two-terms of three-years on the Council of Governors.

Elected Governors

During 2025-2026, the Trust concluded an election campaign on behalf of the Council of Governors on 18 August 2025. This included a digital campaign delivered in partnership with Civica Election Services. The election returned two seats by ballot and resulted in three new Public Governors and two new Staff Governors.

The seats were filled as outlined below:

Constituency	Result	Number of seats included in the election
Public: Bradford South	Hitesh Govan	2
Public: Keighley	James Hobson	1
Public: Bradford West	Yasmin License	1
Staff: Clinical	David Hesford	1
Staff: Non-Clinical	Aidan Jones	1

Table 27: Results of the 2025-2026 Election Campaign

The Trust thanked all outgoing Governors for their hard work and commitment to the Trust and welcomed the new Governors to the Trust with a welcome and induction session that took place on 4 September 2025.

During 2025-2026, there were a number of resignations from the Council of Governors:

- Public Governor: Keighley, Connor Brett, resigned on 6 August 2025 with the seat remaining vacant
- Public Governor: Shipley, Paul Hodgson, resigned November 2025 with the seat remaining vacant
- Public Governor: Bradford West, Yasmin License, resigned 11 December 2025

In line with our Constitution and Foundation Trust election rules, the Bradford West seat was eligible to be filled by the next highest polling candidate until the next scheduled election. On that basis, the eligible candidate was Trevor Ramsay. Trevor commenced in role on 17 December 2025.

The Trust thanked the Governors who resigned from their seats for both their commitment and hard work whilst in office.

No. of seats	Constituency	Name	Filled	Date term of office end	No. of Terms
3	Public: Bradford East	Michael Frazer	Yes	02.05.2027	2 nd
		Aurangzeb Khan	Yes	02.05.2027	1 st
		Mufeed Ansari	Yes	02.05.2027	2 nd
3	Public: Bradford South	Umar Ghafoor	Yes	02.05.2027	1 st
		Hitesh Govan	Yes	18.08.2028	1 st
		Vacancy	No		
3	Public: Bradford West	Imran Khan	Yes	02.05.2027	1 st
		Emmerson Walgrove	Yes	02.05.2027	1 st
		Trevor Ramsay	Yes	17.12.2028	2 nd
1	Public: Craven	Vacancy	No		
2	Public: Keighley	James Hobson	Yes	18.08.2028	1 st
		Vacancy	No		
1	Public: Rest of England	Michael Lodge	Yes	02.05.2027	1 st
2	Public: Shipley	Vacancy	No		
		Vacancy	No		
3	Staff: Clinical	Arshad Ali	Yes	02.05.2027	1 st
		Tabaro Rwegema	Yes	02.05.2027	1 st
		David Hesford	Yes	06.09.2028	1 st
2	Staff: Non-clinical	Terry Henry	Yes	02.05.2027	1 st
		Aidan Jones	Yes	06.09.2028	1 st
Total Elected Governors = 20					

Table 28: List of seats and constituency areas within the Council of Governors, and individuals in post

Appointed Governors

Appointed Governors are nominated by those organisations the Trust has identified as our partner organisations, for the purpose of the Council of Governors, and are set out in Table 29.

During 2025-2026 there were one change to the Appointed Governors, as follows:

- Interim cover for the Appointed Governor position for Bradford Council: Councillor Allison Coates was undertaken by Councillor Debbie Davies who took over the role on 20 August 2025.

Two Appointed Governors were also reappointed to the Council of Governors for a second term:

- Barnardo's – Deborah Buxton
- Bradford Council – Councillor Sabiya Khan

The Trust would like to thank all the Appointed Governors it has worked with throughout the year for all their hard work, supporting the development of the services the Trust provides.

No. of seats	Constituency	Name	Filled	Date term of office end	No. of Terms
1	Barnardo's	Deborah Buxton	Yes	06.09.2028	2nd
1	Bradford Assembly	Vacancy	No		
2	Bradford Council	Cllr Sabiya Khan	Yes	16.07.2027	2nd
		Cllr Debbie Davies	Yes	20.08.2028	1st
1	Bradford University	Robert James	Yes	16.08.2027	1st
1	North Yorkshire Council	Cllr Andy Brown	Yes	17.05.2026	1 st
1	Noor Project - Hope and Light	Masira Hans	Yes	28.05.2028	1st
Total Appointed Governors = 7					

Table 29: List of seats from appointed constituencies within the Council of Governors and individuals in post

Lead Governor

NHS England requires each foundation trust to have a Lead Governor. Mike Lodge (Public Governor for the Rest of England) was elected to the Lead Governor post in November 2024

The role of the Lead Governor is to:

- In exceptional circumstances when it is not appropriate for the Chair or another Non-Executive Director to do so, chair the formal Council of Governors and sub- committee meetings, this would be when there was a conflict of interest in a particular agenda item.
- In partnership with the Senior Independent Director, lead on the annual appraisal for the Chair of the Trust and contribute with fellow Governors to the annual appraisal for all Non-Executive Directors.
- Present an account on the membership and work of the Council of Governors through the Annual Members' Meeting.
- Act as a point of contact and liaison for the Chair and Senior Independent Director.
- Raise issues with the Chair and Chief Executive on behalf of other Governors and act as a point of contact with NHS England or the CQC, where necessary.

Deputy Lead Governor Elections

In October 2025, expressions of interests for the role of Deputy Lead Governor were opened. This role represents the Governors as a collective and does not present any additional responsibility or powers on the individual Governor fulfilling the role. The Deputy Lead Governor works closely with the Lead Governor and steps in for the Lead Governor on the occasions when the Lead Governor cannot fulfil the Lead Governor role due to a conflict or unavailability. The Deputy Lead Governor role will be for a maximum of two years and Governors can be re-elected to the role after their term ends.

To ensure fairness, the same approach used for the Lead Governor nominations was followed: Governors were invited to self-nominate by submitting a short statement referencing the job description, with expressions of interest closing on 11 November 2025. Two expressions of interest were received. Nomination forms were then circulated to the Council of Governors, who were asked to vote via an MS Form between 12 and 26 November 2025. Following the close of voting, Terry Henry was confirmed as the successful nominee, and after ratification at the Council of Governors meeting on 10 December 2025, Terry began their two-year tenure as Deputy Lead Governor.

The role of the Deputy Lead Governor is to:

- Support the Lead Governor in fulfilling their duties. The role is not a regulatory requirement but is recognised as vital in strengthening governance and representation across the Trust.
- To assist and deputise for the Lead Governor when required, ensuring continuity and effectiveness in governance leadership.
- Act as a conduit between Governors and the Board and support harmonious working relationships across the organisation.

Council of Governors Meetings

The Council of Governors is required to meet 'sufficiently regularly to discharge its duties effectively, but in any event, shall meet not less than four times each financial year'.

During 2025-2026, the Council of Governors had four business meetings, all general business meetings with one informal session in April 2025.

All general Council meetings are held in public, although items which are of a confidential nature (as defined by pre-determined criteria and in accordance with the Constitution) will be taken in a private session. The table below shows attendance at those four meetings.

Notice of public Council of Governors' meetings along with the agenda and papers are published on the Trust's website. Governors also hold an Annual Members' Meeting, which took place on 25 September 2025. It is a public meeting, and members are encouraged to attend to hear more about the work of the Trust and the Council of Governors.

Attendance to observe Board Committees has increased with Governors reporting that the opportunities were accessible. The Trust continues to maintain oversight of its work to ensure that accessibility to workstreams is maintained, with bespoke approaches taking place to support inclusion.

Name	Appointed (A) or Elected (E)	Number of business meetings attended	18 June 2025	10 September 2025	25 September 2025 (AMM)	10 December 2025	19 February 2026	
Arshad Ali	E	2/5	✓	✓	O	O	O	
Mufeed Ansari	E	3/5	✓	O	O	✓	✓	
Connor Brett	E	0/1	O	N/A				
Deborah Buxton	A	1/5	-	-	O	✓	-	
Cllr Andy Brown	A	4/5	✓	✓	O	✓	✓	
Cllr Allison Coates	A	0/2	-	-	N/A			
Cllr Debbie Davies	A	0/3	N/A		-	-	-	
Sue Francis	E	1/1	✓	N/A				
Michael Frazer	E	0/5	O	O	O	O	O	
Umar Ghafoor	E	4/5	✓	✓	-	✓	✓	
Hitesh Govan	E	2/4	N/A	✓	-	✓	-	
Masira Hans	A	4/5	✓	✓	✓	✓	-	
Terry Henry	E	4/5	✓	✓	✓	✓	-	
David Hesford	E	1/4	N/A	✓	-	-	-	
Paul Hodgson	E	2/3	✓	O	✓	N/A		
James Hobson	E	2/4	N/A	✓	-	-	✓	
Robert James	A	3/5	✓	-	-	✓	✓	
Aidan Jones	E	1/4	N/A	✓	-	-	✓	
Aurangzeb Khan	E	1/5	O	O	✓	-	-	
Imran Khan	E	0/5	O	O	O	O	O	
Cllr Sabiya Khan	A	3/5	✓	✓	O	✓	-	
Mike Lodge	E	5/5	✓**	✓**	✓**	✓**	✓**	
Linzi Maybin	E	1/1	✓^	N/A				
Hannah Nutting	E	0/1	O	N/A				
Trevor Ramsay	E	1/1	N/A					✓
Tabaro Rwegema	E	0/1	O	O	O	O	O	
Emmerson Walgrove	E	4/5	✓	✓	✓	✓	-	

** Indicates Lead Governor

^ Indicates Deputy Lead Governor

- indicates apologies given

O indicates absence, no apologies given

Table 30: Attendance at formal Council of Governor Meetings

Working Together

The Chair of the Trust is responsible for the leadership of both the Council of Governors and the Board of Directors. The Chair has overall responsibility for ensuring that the views of the Council and Trust members are communicated to the Board as a whole and considered as part of decision-making processes and that the two bodies work effectively together. The respective powers and roles of the Board and Council are set out in their respective Standing orders within the Trust Constitution. The Chair works closely with the elected Lead Governor and Deputy Lead Governor.

The Executive and Non-Executive Directors regularly attend Council meetings, presenting agenda items as required and participating in open discussions that form part of each meeting.

The Senior Independent Director actively pursues an effective relationship between the Council and the Board and regularly attends Council meetings. Governors can contact the Senior Independent Director if they have concerns regarding any issues which have not been addressed by the Chair, Chief Executive, or the Trust Secretary.

Governors continue to have an open invitation to attend all Board meetings held in public and can ask questions of the Board on matters relating to agenda items through pre-submitting questions. Governors are also invited to observe the Board Committee meetings which provides further opportunity for Governors to witness the Non-Executive Directors holding the Executive Directors to account for the performance of the Trust. Governors have also attended alongside Non-Executive Directors and Executive Directors Go See Visits. Go See Visits are an opportunity for Executive Directors, Non-Executive Directors, and Leaders across the Trust to gain an insight into the day-to-day workings of the Trusts services that they are visiting, but also to discuss potential improvements within that service.

The Board values the relationship it has with the Council and recognises that its work promotes the Trust's strategic objectives and assists in shaping the culture of the Trust. Both the Board and the Council are committed to continuing to promote enhanced joint working so that they can deliver their respective statutory roles and responsibilities in the most effective way possible.

Name	Number of business meetings attended	18 June 2025	10 September 2025	25 September 2025 - AMM	10 December 2025	19 February 2026
Linda Patterson	4/4	✓	✓	✓	✓	N/A
Maz Ahmed	2/5	✓	✓	-	-	-
Kelly Barker	3/5	✓	✓	✓	-	-
Bob Champion	4/5	-	✓	✓	✓	✓
Phillipa Hubbard	4/5	✓	-	✓	✓	✓
Simon Lewis	4/5	✓	✓	-	✓	✓ (Interim Chair)
Chris Malish	5/5	✓	✓	✓	✓	✓
Alyson McGregor	2/5	-	-	✓	-	✓
Sally Napper	3/5	✓	✓	-	✓	-
Therese Patten	5/5	✓	✓	✓	✓	✓
Farhan Rafiq	1/5	✓	-	-	-	-
Mark Rawcliffe	4/5	✓	✓	-	✓	✓
Tim Rycroft	2/5	-	-	-	✓	✓
David Sims	1/1	✓	N/A			
Mike Woodhead	2/5	-	✓	✓	-	-
Sal Uka	2/2	N/A			✓	✓

- indicates apologies given

Table 31: Indicates Board Member attendance at Formal Council of Governor Meetings

The Council of Governors has not, during the financial year, exercised its powers under paragraph 10C of Schedule seven of the NHS Act 2016 to require any Director to attend a Council of Governors meeting.

Governor Training and Development

The Chair of the Trust ensures that there are effective and robust training and development arrangements in place to develop Governors' skills, knowledge and capabilities enabling them to be confident, effective, engaged and informed members of the Council. This is to ensure the Council as a body remains fit for purpose and is developed to deliver its responsibilities effectively.

During the year the Trust has hosted or provided Governors with access to a range of training and development opportunities with the purpose of enhancing their

knowledge and understanding of the organisation. Governors undertake a comprehensive induction programme which is regularly reviewed and updated.

Induction is mandatory for new Governors but is also made available as a refresher for more experienced Governors.

During 2025-2026 there have been various opportunities for providing support to Governors with their training and development including:

- NHS Providers GovernWell conferences and training sessions
- refresh of the Trust's governor development programme, rolled out 2026
- attendance at System and National training events facilitated by NHS Providers on the GovernWell programme
- Lead Governor and Deputy Lead Governor meetings with the Chair
- Lead Governor and Chair meetings with partners at Place
- ongoing opportunities to observe Board and Committee meetings as part of the Governor role, with many Governors highlighting how accessible they are delivered digitally
- a series of visits to the Trust's services to enable Governors to achieve an overview of the breadth and depth of the services the Trust provides and have an opportunity to witness the performance of the Non-Executive Directors.

The Trust has also kept Governors informed of training and development workshops and conferences hosted by other organisations and encouraged all to utilise these development opportunities. Governors are encouraged to share their experiences of events attended through written feedback circulated to the wider Council. Governors are also kept regularly informed through regular emails with key information, details of regular meetings and other opportunities.

The Council of Governors undertook an Annual Effectiveness Review in the form of a survey sent to all Governors in May and June 2025. The results and actions from the Annual Effectiveness Review were combined with the two other effectiveness reviews:

- External governance review aligned to the Care Quality Commission Well Led framework.
- The Trust's Well Led Quality Assurance Framework which is an annual internal audit which is aligned to the CQC Well Led Framework; the NHS Trust Code of Governance, and The Healthy NHS Board guidance.

This bringing together of the three processes resulted in a new 'Well Led Development Plan' being established. The plan was an action log which acted as an assurance report within year on governance improvement activity and was a new tool for the Trust to assess and enable the supporting principle for the strategy of, good governance, effective oversight, accountability'.

Council of Governors Sub Committees

The Council of Governors has established two Committees to carry out its functions. The membership and terms of reference for each have been approved by the Council of Governors and are reviewed regularly.

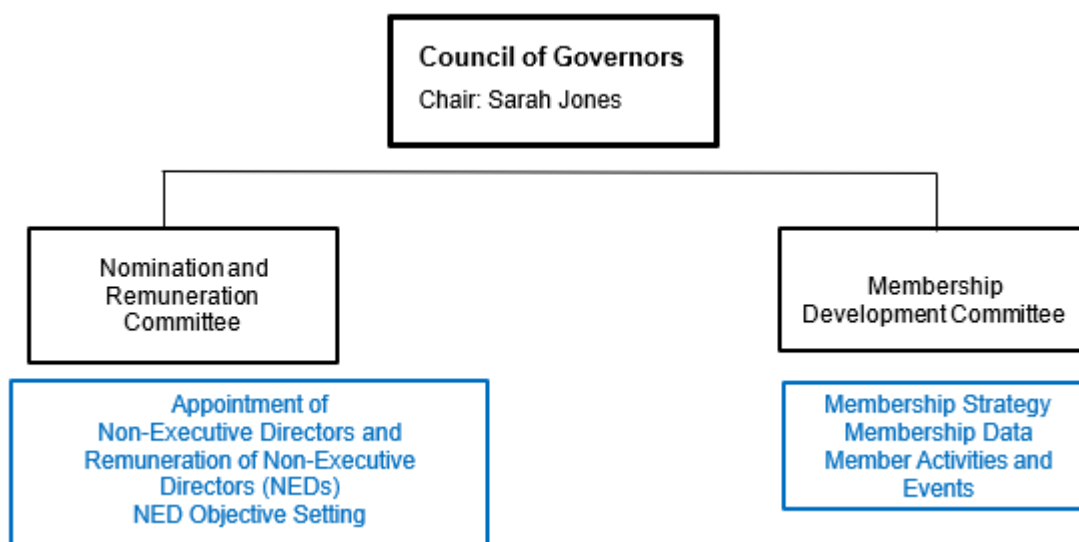


Diagram 19: Formal Meeting Structure for Council of Governors and sub-committees

Council of Governors Nomination and Remuneration Committee

The Council of Governors Nomination and Remuneration Committee is responsible for the process of appointing Non-Executive Directors (including the Chair) when a vacancy arises or the re-appointment of existing Non-Executive Directors once their term in office expires and for considering the remuneration and allowances set for the Chair and Non-Executive Directors of the Board. The Council of Governors Nomination and Remuneration Committee met four times during 2025-2026:

- 16 October 2025
- 25 November 2025
- 5 January 2026
- 9 February 2026

During the year, the Board Nomination and Remuneration Committee met twice and considered the Interim Chief Medical Officer recruitment, Very Senior Manager pay framework, Fit and Proper Person compliance and Non-Executive Director succession planning, while the Council of Governors Nomination and Remuneration Committee held four meetings covering Chair recruitment, remuneration arrangements for the Acting Chair, the Chair in Common appointment and the outcome of the Non-Executive Director recruitment process.

Membership Development Committee

This Committee is responsible for developing the membership of the Trust and considering how the interests of members might be better represented. The Committee did not meet during 2025/26. The Council of Governors had previously

established the Membership Development Committee to ensure the Trust recruited a membership which was representative of the local community and offered opportunities for members to engage in the work of the Trust.

Resolution of Disputes between the Council of Governors and the Board of Directors

The Code of Governance requires the Trust to hold a clear statement explaining how disagreements between the Council of Governors and the Board of Directors would be resolved. This is included in Annex six of the Trust's Constitution (Standing Orders for the Council of Governors). If Governors have concerns they wish to raise, they have been advised to contact the Chair, Senior Independent Director or Trust Secretary as appropriate.

Report from Lead and Deputy Lead Governor

On behalf of the Council of Governors, we would like to thank all Governors for their continuing support, commitment and hard work in supporting and challenging the Trust to continue to deliver high quality services to our communities across Bradford and Craven. Several new Governors joined the Council of Governors in April 2025 and have made a strong contribution to the work of the Council of Governors.

Linzi Maybin stepped down as Deputy Lead Governor in September 2025, and we would like to thank her for all her work and commitment as Deputy Lead Governor, in particular her work in the Trust with young people.

Dr Linda Patterson OBE FRCP stood down as Chair of the Trust in December 2025 and on behalf of the Governors we would also like to thank her for her support for Governors both as Chair of our formal meetings and throughout other Governor activities. Her work on a national and regional level as Board chair meant that she has always brought us an informed and thoughtful perspective on all matters NHS.

We look forward to developing an equally effective relationship with our new interim Chair in Common, Sarah Jones. The Chair in Common is a new role covering the chair role of both Bradford District Care NHS Foundation Trust and Airedale NHS Foundation Trust. We are hopeful that through the role we can create opportunities for closer collaboration within the wider system that will be to the benefit of the people of Bradford District and Craven. We would also like to thank Simon Lewis, one of our long-standing Board members, who stood in as our interim Chair between Linda leaving and Sarah joining.

The Council of Governors has met regularly throughout the year. Governors have had opportunities to contribute the views of constituents and the wider public through their involvement in a variety of meetings and events. These activities enable Governors to develop their knowledge about the work of the Trust and provide them with opportunities to feedback on behalf of the membership and the wider public.

The Council of Governors and the Nominations and Remuneration Committee took the decision in early 2026 to appoint Sarah Jones as our Chair in Common with Airedale Foundation Trust for a twelve-month period from March 2026. This was a new and innovative approach and required the Council of Governors to take care that the best interests of the Trust were pursued and that due process was followed. As Lead Governor and Deputy Lead Governor, we are happy to report that we are satisfied that this has happened. Sarah has agreed that there should be frequent meetings to check how these arrangements are working and we will report back to the Council of Governors from these meetings. Supported by a formal process.

Two new non-executive directors – Cleveland Henry and Warren Brown - were also appointed by the Council of Governors following involvement in the appointment process by a number of governors. Welcome to Cleveland and Warren and we look forward to working with them.

Governors have carried out their duties in many ways during 2025/26 including; the strategic direction of the Trust, engaging with members and formally representing their constituents at the Council of Governors meetings, receiving the Annual Report and Accounts and Auditors Report at the Annual Members meeting, holding the non-executive directors to account, agreeing the remuneration of non-executive directors in line with NHS England Guidance and finally in engaging with their constituents and the wider public throughout the membership work stream. At the formal Council of Governors meetings non-executive Directors present reports from their committees on areas of assurance and areas for further development or further scrutiny.

The Trust's Governance Team have arranged an extensive programme of "Go See" visits where Governors can meet the people who provide the Trust's extensive range of services and learn about their successes and the challenges they face. It is also an opportunity for Governors to cross-correlate what they hear in meetings and see in reports, with what is actually happening at the 'coal face'. We have found these visits a great experience and very valuable. The programme will continue throughout 2026 and we encourage all Governors to attend them.

Governors have had the opportunity to take part in national training for Governors and we have attended several of these training events. As well as being a good learning experience, they are a great opportunity to talk with Governors from other Trusts and to share experiences. Governors have also observed Board and Committee meetings.

There has been no occasion during the year for the Council of Governors to contact either NHS England or CQC.

In January 2025 we learnt of the Government's decision to undertake a major restructure of the NHS and of the requirement nationally, regionally and at Trust level to find very significant "back-office" financial savings. The Chief Executive has

regularly reported to the Council of Governors on the changes that have been put in place to achieve this.

These changes have meant fundamental changes at the West Yorkshire Integrated Care Board and the Council of Governors should continue to consider regular reports from the chair and non-executive directors on the impact of these changes.

The restructure of the NHS announced in 2025 also signalled that there will no longer be a requirement for Foundation Trusts to have a Council of Governors and it is anticipated that, following legislation, this change will be implemented in April 2027. Governors are one way of ensuring that the voices of the general public are heard and that there can be a “lay” challenge to the decisions that are taken by Foundation Trusts. The Council of Governors should discuss with the chair and non-executive directors ways in which this can happen after April 2027.

The shared priority must of course be to ensure the provision of high quality, effective and safe services to the people of Bradford and Craven. Too often, in the past, services to people with mental ill health have become “Cinderella” services and we all need to work together to prevent this happening again. Effective preventive services are an important way of improving outcomes for people in our district and the Council of Governors should discuss with non-executive directors how they ensure effective partnership working with colleagues in the acute sector and primary care, local authorities and the community sector to improve prevention.

This report describes a number of the activities that the Council of Governors have been involved in and we hope that it demonstrates how the Governors have been effectively carrying out their duties and how the Trust continues to benefit from their input.

Mike Lodge, Lead Governor

Terry Henry, Deputy Lead Governor

April 2026

Membership Report

Foundation Trust membership is designed to offer local people, service users, carers and staff a greater influence on how the Trust’s services are provided and developed. The membership structure reflects this composition and is made up of three categories of membership:

- **Public:** All members of the public aged 14 years or older can join the Trust and fall within a constituency area based on their postal address. From the outset, the Trust made the conscious decision not to create separate membership categories for service users or carers. Both service users and carers are represented within the public membership group of the Council

of Governors. The Trust's involvement and participation framework ensures that the voice of carers and service users is heard in other ways in the Trust.

- **Staff members:** All Trust staff are automatically part of the staff membership group provided they are on a permanent contract or on a fixed-term contract of at least 12-months' duration. Staff can opt out of membership if they wish, although few choose to do so.
- **Appointed:** As outlined in the Trust's Constitution, there are seven seats available on the Council of Governors for appointed representatives from a selection of our partner organisations. They cover the voluntary and community sector; education; and local authority, representing these key sectors.

Demographic	Number of Members
Age:	
0-16	4
17-21	45
22+	8,581
Not Stated	525
Gender:	
Unspecified	151
Male	3478
Female	5,526
Ethnicity:	9,120
White	5,007
Mixed	216
Asian or Asian British	3,128
Black or Black British	420
Other	98
Not Stated	251
Total	9,155

Table 32: Foundation Trust Public membership

Representativeness by constituency areas (as at 31 March 2026):

Constituency	Current Membership	Number of Governors
Bradford East	1,944	3
Bradford South	1,208	2
Bradford West	2,041	3
Shipley	1,059	2
Keighley	1,047	1
Craven	419	1
Rest of England	1,421	1

Table 33: Representation by constituency area

Staff membership:

Constituency	Current Membership	Number of Governors
Clinical	2648	3
Non-Clinical	894	2
Total	3,542	

Table 34: Foundation Trust Staff Membership

Continually developing a representative membership

Working with the Governors, the Trust is responsible for ensuring that the membership is representative of our local people. The profile of the current membership in terms of ethnicity, gender and age continues to be broadly in line with that of the respective constituencies, although work is currently being undertaken to increase the numbers of younger members. A review of membership has been undertaken by the Trust and results from this confirmed that membership numbers are largely representative.

The Trust values the contribution of membership, and focus will be on qualitative rather than quantitative membership levels and engagement. A focused approach to membership engagement and recruitment continues, this allows for campaigns to maintain a representative membership. The Trust has a varied approach to facilitating engagement between Governors, members and the wider public. Each year, the Trust holds the Annual Members' Meeting. This not only incorporates the statutory annual meeting where the Council accounts for how it has carried out its duties on behalf of members, it also has an opportunity for engagement. The Trust continues to ensure that Governors are central to the event which allows them to engage with a diverse range of individuals whilst fulfilling their statutory duties.

In line with the refresh of the overarching Trust Strategy, which will take place in Summer 2026, the Trust will also be refreshing the Membership Engagement Strategy. This will be reported on in the next review.



.....
Date: 25 June 2026
Therese Patten
Chief Executive

8. Nomination and Remuneration Report

Nomination and Remuneration Committee

The Nomination and Remuneration Committee comprises exclusively of Non-Executive Directors and has delegated authority from the Board to decide appropriate remuneration and terms of service for the Chief Executive and Executive and Associate Directors, including all aspects of salary, provision for other benefits including pensions and cars, arrangements for termination of employment including redundancy and other contractual terms. It also agrees the recruitment strategy for recruitment to those roles, leads the recruitment process and selects candidates.

The Committee also has a key role in:

- Reviewing pay, terms and conditions for the most senior staff below Executive Director level.
- The applicability of any national agreements for staff on local terms and conditions or pay arrangements that are not determined nationally.
- Reviewing and approving all redundancy business cases and any proposed payments to staff that do not fall within contractual entitlements e.g. settlement agreements.
- Reviewing Trust strategies and proposals around pay and reward including Foundation Trust freedoms, flexibilities and options.
- Receiving assurance on compliance with the Fit and Proper Person requirements for NHS Board members.
- Agrees the recruitment strategy and appointment criteria for selected candidates,

Bob Champion provided advice and guidance to the Committee as Chief People Officer. The Trust Secretary also attends to provide advice and support. The Committee is provided with administrative support by the Corporate Governance team. The Chief Executive is in attendance when appropriate to provide advice. Executive Directors and the Chief Executive are remunerated on a spot salary in line with the benchmarking evidence referred to. No other external support or advice was sought by the Committee during 2025-2026.

The Committee met two times in 2025-2026, to consider the in-year performance and future objectives of the Chief Executive Officer and Executive Directors, an update on the National Pay Award for Very Senior Managers, Fit and Proper Person compliance, succession planning and the appointment the Interim Chief Medical Officer.

Attendance is shown below:

Name	29 May 2025	17 Sept 2025
Linda Patterson (member)	✓*	✓*
Maz Ahmed (Member)	-	-
Bob Champion	✓^	✓^
Phil Hubbard	✓	N/A
Simon Lewis (member)	✓	✓
Chris Malish (member)	-	-
Alyson McGregor (member)	-	✓
Sally Napper (member)	✓	-
Therese Patten	-	✓
Mark Rawcliffe (member)	✓	-

*indicates Chair of the meeting

- indicates apologies

^ indicates attended as an attendee

Table 34: Attendance at the Board Nominations and Remuneration Committee

Service Contract Obligations

Following the introduction of the Fit and Proper Persons Requirements (FPPR) for Executive Directors and Non-Executive Directors, Regulation 5 of the Health and Social Care Act, the Trust continues to discharge its responsibility in ensuring that existing and new post holders are reviewed against the FPPR standards and has incorporated this following the initial self-declaration into the appraisal process, also ensuring inclusion in employment contracts. There were no issues of concern arising from the declarations within the year.

Remuneration Framework

Executive Director Remuneration

Executive Directors and the Chief Executive are remunerated on a spot salary in line with the NHS England Pay Framework for Very Senior Managers (VSM) and benchmarking evidence provided by NHS England and NHS Providers. Variations to the VSM pay, such as cost of living uplifts are subject to the recommendations of the Government Review Body on Senior Salaries and are subject to approval by the Nominations and Remuneration Committee.

There is one officer in the Trust at Executive level who are paid more than £150,000. Pay for Executive Directors has been benchmarked in the past using nationally available data through e-Reward, NHS England and NHS Providers information. A revision of the VSM pay framework remains under development.

Senior Managers' Remuneration Policy / Pay Framework

The Trust is obliged to adhere to the requirements of the NHS England Very Senior Managers' Pay Framework as established in 2025, which is informed by the findings of the UK Government Review Body on Senior Salaries. Local interpretation of the framework is determined by the Board's Nominations & Remuneration Committee and all proposed remuneration arrangements for VSMs are required to be endorsed by the NHS England Trust Governance & Advisory Team.

Remuneration arrangements for senior Medical & Dental colleagues are subject to reviews and instructions of the DDRB (Doctors and Dentists Review Body). The National Clinical Impact Award (NCIA) scheme in England and Wales - formerly the National Clinical Excellence Awards (NCEA) scheme - aims to reward consultants who contribute most to the delivery of safe and high-quality care and the improvement of NHS services.

Non-Executive Directors are appointed for a three-year term and can be re-appointed for a further term; any term beyond six-years (e.g. two, three-year terms) is subject to rigorous review. All Executive Directors are subject to a three-month notice period, no provision for compensation for early termination is included in employment contracts and any provision for compensation for termination would be considered on an individual basis by the Nominations and Remuneration Committee.

Non-Executive Directors are appointed for a fixed term. All other Directors of the Trust are appointed on substantive contracts apart from the current Interim Chief Medical Officer, who is engaged on a twelve-month fixed term contract. There is therefore one unexpired term but contracts do not contain provision for early termination. The information contained below relating to the salary and pension entitlements of senior managers within the Trust is subject to audit and is taken from the Trust's accounts for 2025-2026.

Policy on payment for loss of office and notice periods

All contracts for executive directors are permanent and open-ended. The period of notice for each executive director is set out in their contract. Non-executive directors are not subject to employment law or regulations and as such do not have a formal period of notice.

The executive directors' contract contains details of the grounds on which a director's contract may be terminated. The contract also contains information about the circumstances under which payment in lieu of notice may be paid.

Payment for loss of office or in lieu of notice does not apply to non-executive directors as they are appointed not employed.

Expenses

The Trust is required to indicate in the annual report the expenses paid to Directors in the financial year, and the sum paid in 2025/26 was £1,929* to 3 Directors and Non- Executive Directors (against a total of £1,955 in 2024/25 to 2 Directors and Non- Executive Directors).

* Includes expenses for Therese Patten at 0.8 FTE, reflective of her shared role with the ICB.

There were no expenses paid to Governors in 2025-2026 or 2024-2025. As of 31st March 2026, the Trust had 27 seats, 22 in post and 5 vacancies.

Remuneration Report for 2025-2026

Name and Title	2025/26			
	Salary	Expense payments (taxable) to nearest £100 *	All pension-related benefits**	Total
	(Bands of £5,000) £ 000	Rounded to nearest £100	(Bands of £2,500) £ 000	(Bands of £5,000) £ 000
L Patterson - Chair (to 31st December 2025)	35 - 40	0	0	35 - 40
S Jones - Interim Chair in Common (from 1st March 2026) (a)	0 - 5	0	0	0 - 5
S Lewis - Non Executive Director (1st April to 31st December 2025, and 1st to 31st March 2026)	17.5 - 20	0	0	17.5 - 20
S Lewis - Interim Chair (1st January to 28th February 2026)	0 - 2.5	0	0	0 - 2.5
M Ahmed - Non Executive Director	15 - 20	0	0	15 - 20
A McGregor - Non Executive Director	10 - 15	0	0	10 - 15
M Rawcliffe - Non Executive Director	10 - 15	0	0	10 - 15
C Malish - Non Executive Director	10 - 15	0	0	10 - 15
S Napper - Non Executive Director	20 - 25	0	0	20 - 25
W Brown - Non Executive Director (from 19th January 2026)	0 - 5	0	0	0 - 5
T Patten - Chief Executive (b)	150 - 155	1,200	57.5 - 60	210 - 215
P Hubbard - Director of Nursing, Professions & Care Standards, and Deputy Chief Executive	135 - 140	0	247.5 - 250	385 - 390
M Woodhead - Chief Finance Officer	145 - 150	1,100	42.5 - 50	190 - 195
B Champion - Chief People Officer (c)	130 - 135	0	0	130 - 135
T Rycroft - Chief Information Officer	115 - 120	1,600	30 - 32.5	145 - 150
D Sims - Medical Director (to 31st August 2025)	55 - 60	500	0	55 - 60
S Uka - Medical Director (from 6th October 2025)	85 - 90	0	40 - 42.5	130 - 135

K Barker - Chief Operating Officer	125 - 130	2,000	32.5 - 40	160 - 165
F Rafiq - Executive Director TIP (from 14th April 2025)	115 - 120	2,700	30 - 32.5	145 - 150

Table 34: Executive Director Remuneration 2025-2026

Remuneration Report for 2024-2025

Name and Title	2024/25			
	Salary	Expense payments (taxable) to nearest £100 *	All pension-related benefits**	Total
	(Bands of £5,000) £ 000	Rounded to nearest £100	(Bands of £2,500) £ 000	(Bands of £5,000) £ 000
L Patterson - Chair	40 - 45	0	0	40 - 45
S Lewis - Non Executive Director	10 - 15	0	0	10 - 15
M Ahmed - Non Executive Director	15 - 20	0	0	15 - 20
A McGregor - Non Executive Director	10 - 15	0	0	10 - 15
M Rawcliffe - Non Executive Director	10 - 15	0	0	10 - 15
C Malish - Non Executive Director	15 - 20	0	0	15 - 20
S Napper - Non Executive Director	10 - 15	0	0	10 - 15
T Patten - Chief Executive	180 - 185	1,100	22.5 - 25	205 - 210
P Hubbard - Director of Nursing, Professions & Care Standards, and Deputy Chief Executive	140 - 145	0	0	140 - 145
M Woodhead - Chief Finance Officer	145 - 150	0	42.5 - 45	190 - 195
B Champion - Chief People Officer (a)	130 - 135	0	0	130 - 135
T Rycroft - Chief Information Officer	115 - 120	800	2.5 - 5	115 - 120
D Sims - Medical Director	130 - 135	900	0	135 - 140
K Barker - Chief Operating Officer	125 - 130	1,100	30 - 32.5	155 - 160

Table 35: Executive Director Remuneration 2024-2025

NOTES:

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

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

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

Staff sharing arrangements with other entities have been in place during 2025/26. Bradford District Care NHS Foundation Trust's share of the relevant components of remuneration are reported in the table above:

(a) Sarah Jones (Interim Chair In Common) has been in her role from 1st March 2026. She works 40% FTE with Bradford District Care NHS Foundation Trust and 40% with Airedale NHS Foundation Trust. The figures reported above are therefore 50% of Sarah's earnings from 1st to 31st March 2026. The full-time equivalent annual salary across all organisations they are engaged by is in the range £80,000 to £85,000.

(b) Therese Patten (Chief Executive) worked 80% FTE with Bradford District Care NHS Foundation Trust and 20% FTE with NHS West Yorkshire ICB (effective from 1st April 2025 to 31st March 2026). The figures reported above are therefore 80% of Therese's earnings and pension benefits in 2025/26. The full-time equivalent salary across all organisations they are engaged by is in the range £185,000 to £190,000 (£180,000 to £185,000 for 24/25).

(c) There are no pension related benefits for Bob Champion, as he is already drawing his NHS Pension.

Iain MacBeath served as Director of Integration during 2025/26, in attendance at Board Meetings. This is a joint role between the Trust and Bradford District Council. All funding for this role sits with Bradford District Council. Iain received no remuneration from the Trust in 2025/26.

The Trust has one Executive for whom their total salary plus expenses is above £150,000. The value includes a salary sacrifice lease car within expenses. This has

been reviewed by the Trust and deemed to be reasonable, including by reference to benchmarks for other similar organisations.

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.

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

All pension related benefits in the table above are adjusted for inflation at the CPI rate of 1.70% in 2025/26 (6.70% in 2024/25).

Remuneration Report for 2025/26 - Pension Benefits

Name and title	Real increase in pension at pension age (Bands of £2,500) £000	Real increase in Pension Lump sum at pension age (Bands of £2,500) £000	Total accrued pension at pension age at 31 March 2026 (Bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (Bands of £5,000) £000	Cash Equivalent Transfer Value at 01 April 2025 £000	Real Increase in Cash Equivalent Transfer Value £000	Cash Equivalent Transfer Value at 31 March 2026 £000
T Patten - Chief Executive (a)	2.5 - 5	0 - 2.5	61 - 65	140 - 145	1,327	83	1,452
P Hubbard - Director of Nursing, Professions & Care Standards and Deputy Chief Executive (b)	10 - 12.5	27.5 - 30	75 - 80	205 - 210	129	28	177
M Woodhead - Chief Finance Officer	2.5 - 5	0	25 - 30	0	397	37	459
T Rycroft - Chief Information Officer	0 - 2.5	0	30 - 35	0	514	28	566
D Sims - Medical Director (to 31st August 2025) (c)	0	0	65 - 70	170 - 175	131	2	155
S Uka - Medical Director (from 6th October 2025)	5 - 7.5	2.5 - 5	65 - 70	160 - 165	1,282	40	1,410
K Barker - Chief Operating Officer	0 - 2.5	0	10 - 15	5 - 10	128	20	166
F Rafiq - Executive Director TIP	0 - 2.5	0	15 - 20	0	186	17	223

Table 36: Pension Information 2025-2026

NOTES:

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

"(a) Staff sharing arrangements with another entity were in place during 2025/26. Bradford District Care NHS Foundation Trust's share of the relevant components of remuneration are reported in the table above.

Therese Patten (Chief Executive) worked 80% FTE with Bradford District Care NHS Foundation Trust and 20% with NHS West Yorkshire ICB (effective from 1st April 2025 to 31st March 2026). The figures reported above are representative of 100% of Therese's pension benefits for 2025/26. However, only 80% of the total cumulative pension benefit is reported within the Single Total Figure Table."

(b) The March 2026 CETV value shown for P Hubbard relates to the 2015 Pension Scheme only. P Hubbard claimed her Pension Benefits relating to the 1995/2008 Pension scheme in January 2025.

(c) The March 2026 CETV value shown for D Sims relates to the 2015 Pension Scheme only. This is because D Sims reached the Normal Retiring Age for the 1995/2008 Pension Scheme during a previous year.

All the directors in the table above, with the exception of K Barker, are affected by the Public Service Pensions Remedy. Their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership

of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. CPI inflation of 1.70% has been used in accordance with NHS Business Services Authority guidance in 2025/26 (6.70% in 2024/25).

No Director has a stakeholder pension.

Pension benefits only relate to Officer Scheme membership and do not include any practitioner i.e. GP pension benefits. This was only applicable to D Sims.

Fair Pay Disclosure

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 organisation in the financial year 2025-2026 was £185,000 - £190,000 (2024-2025 was £180,000 - £185,000). This is a change between years of 3.78% (The comparative change between 2023/24 and 2024/25 was 4.43%). The relationship to the remuneration of the organisation's workforce is disclosed in the below table.

Total remuneration includes salary, non-consolidated performance-related pay, benefits-in-kind, but not severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

For employees of the Trust as a whole, the range of remuneration in 2025-2026 was from £21,321 to £244,608 (2024/25 £18,120 to £283,703). The percentage change in average employee remuneration (based on total for all employees) between years is 4.95% (The comparative change between 2023-2024 and 2024-2025 was 10.81%). Seventeen employees received remuneration in excess of the highest-paid Director in 2025-2026 (2024-2025 thirteen employees).

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.

2025-26	25th percentile	Median	75th percentile
Total remuneration (£)	28,439	36,949	48,376
Salary component of total remuneration (£)	28,439	36,949	48,376
Pay ratio information	6.7	5.1	3.9
2024-25	25th percentile	Median	75th percentile
Total remuneration (£)	26,530	35,090	46,356
Salary component of total remuneration (£)	26,530	35,090	46,356
Pay ratio information	6.9	5.2	3.9

Table 37: Median Salary Costs

The median, 25th percentile and 75th percentile salaries have been calculated by using the salary costs for all employees as at 31 March 2026. Where employees work part time, the salary cost has been grossed up to the full-time equivalent salary. The calculations include bank and agency staff.

Other Remuneration Information

The Trust is required to report on other remuneration related information. Exit packages for 2025-2026 and 2024-2025, and off payroll expenditure are shown below. Expenditure on consultancy costs in 2025-2026 was £528K.

Exit Packages

Exit costs in this section would be accounted for in full. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in this section of the Annual Report. The disclosure must report the number and value of exit packages agreed in the year.

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000)	Number of other departures agreed	Cost of other departures agreed (£000)
<£10,000	3	20		
£10,001 - £25,000	5	89		
£25,001 - £50,000				
£50,001 - £100,000	1	61		
£100,001 - £150,000	3	358		
£150,001 - £200,000				
>£200,000				
Total number of exit packages by type	12	528		

Table 38: Exit Packages 2025-2026

Exit package cost band	Number of compulsory redundancies	Cost of compulsory redundancies (£000)	Number of other departures agreed	Cost of other departures agreed (£000)
<£10,000	1	8		
£10,001 - £25,000				
£25,001 - £50,000				

£50,001 - £100,000				
£100,001 - £150,000	1	137		
£150,001 - £200,000				
>£200,000				
Total number of exit packages by type	2	145		

Table 39: Exit Packages 2024-2025

Exit costs in this note are accounted for in full. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table. This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

There were no other non-compulsory departure payments made in 2025-2026 or in 2024-2025.

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

Off Payroll Engagements

In 2025-2026, the Trust had no off-payroll engagements. The Trust also had no off-payroll engagements of board members, and or, senior officials with significant financial responsibility, between 1 April 2025 and 31 March 2026.



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Date: 25 June 2026
Therese Patten
Chief Executive

9. Modern Day Slavery and Human Trafficking Act Annual Statement – 2025-2026

Bradford District Care NHS Foundation Trust offers the following statement regarding its efforts to prevent slavery and human trafficking in its supply chain.

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

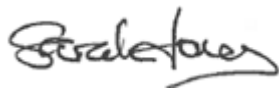
The Trust recognises its responsibilities to comply with the UK Modern Slavery Act 2015 and implement a strategic approach to managing business risk in relation to human rights and slavery breaches that the legislation seeks to protect.

The Trust conforms to the NHS Employment Check Standards within its workforce recruitment and selection practices and national procurement frameworks for temporary resourcing requirements with its Managed Service Provider contract arrangements. The strategic approach incorporates work to analyse the Trust's supply chains and its partners to assess risk exposure and management on modern slavery.

The Trust has policies and procedures in place, for example the Domestic Abuse and Safeguarding Policies. Training is available to ensure staff are aware of policies, the associated risks and how to act when risk is identified.

A Risk Management Policy and system enables staff to report and collate incidents and risk in real time.

Regular risk management, safeguarding reports and policy updates are shared within our governance structures to assess performance and agree appropriate organisational response. The Trust works with multiagency partners sharing information and collaborating on these matters.



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Date: 25 June 2026
Sarah Jones
Chair in Common



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Date: 25 June 2026
Therese Patten
Chief Executive

10. The Chief Executive's statement of Responsibilities as the Bradford District Care NHS Foundation Trust Accounting Officer

The NHS Act 2006 states that the chief executive is the Accounting Officer of the NHS foundation trust, including undertaking all relevant duties and responsibilities as set out in legislation. This includes their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, as set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England, in exercise of the powers conferred by the NHS Act 2006, has given Accounts Directions which require our 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 the 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 our Trust's performance, business model and strategy.
- 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 Trust and to enable them to ensure that the accounts comply with requirements outlined in the

Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and 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 our 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.

A handwritten signature in black ink, appearing to read 'Therese Patten', with a horizontal line underneath.

.....
Date: 25 June 2026
Therese Patten
Chief Executive

11. Annual Governance Statement

Overview

Scope of Responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Trust for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Trust's Board of Directors has overall responsibility for the governance and provides high level leadership for risk management. The Directors (both Executive and Non-Executive) have appropriate skills and experience to carry out this function effectively. Each member of the Board has corporate and joint responsibility for the management of risk; to mitigate, reduce, eliminate risk to create safer services and resilience, to protect the reputation of the Trust and to ensure an open and honest culture is developed where mistakes, errors and incidents are identified quickly and dealt with in a positive and constructive way. Non-Executive Directors provide an independent judgement in relation to the working of the Trusts risk management programme.

The Board is responsible for reviewing the effectiveness of the system of internal control, including systems and resources for managing all types of risk. The cycle of Board meetings continues to ensure that it devotes sufficient time to setting and monitoring strategy and having oversight of the key risks to achieving the strategic objectives. The Board also monitors performance against key targets and measures and considers any risks to achieving these.

As Chief Executive, I have delegated responsibility for implementation of risk management and the overall coordination of risk management to the Director of Nursing, Professions and Care Standards. The table below summarises where members of the Executive Management Team have a lead for specific areas of risk:

Lead Director role	Area of responsibility
Chief Medical Officer	Leads on medicines management, safe standards of medical practice, learning from deaths and is the Trust's Caldicott Guardian. Has joint responsibility with the Director of Nursing, Professions and Care Standards for quality and patient safety, and the implementation and operation of the Mental Health Act.
Director of Nursing, Professions and Care Standards	Has delegated responsibility for management of the risk management operational processes and has joint responsibility with the Medical Director for quality and patient safety. Has continued oversight of the Board Assurance Framework and leadership of patient experience and involvement.
Chief Operating Officer	Has responsibility for ensuring that effective operational arrangements are in place throughout the Trust and across all sites, this includes the management of operational risks including those associated with the implementation and operation of the Mental Health Act. Leads Emergency Planning, Preparedness and Response and the management of associated risks through this framework.
Chief Finance Officer	Leads on financial risk and manages risk in relation to the development, management and maintenance of the Trust estate, procurement and matters relating to fire safety and wider health and safety.
Chief People Officer	Leads on workforce capacity, retention of staff, absence management, business development and equality and diversity, as well as communications.
Chief Information Officer	Leads on informatics and information governance risks and is the Trust's Senior Information Risk Owner (SIRO).
Director of Transformation, Improvement and Productivity	Leads on continuous improvement, management of risks relating to innovation and change programmes. Has responsibility for Trust-wide performance related risks.
Trust Secretary	Leads on corporate governance risks.

Table 40: Director responsibilities for risk areas

Conflict of Interest Management

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance. All decision-making meetings within the Trust have a standing agenda item at the start of the meeting for anyone to make a new declaration.

Compliance with NHS Foundation Trust Condition Four

As reported to the Board of Directors June 2026 following the annual compliance check, the Trust has maintained compliance with the NHS Foundation Trust Condition Four.

Risk Management

Overview

Each 'operational' Care Group unit has a Quality and Operations Group in place which is responsible for obtaining evidence of assurance on the adequacy of the Quality and Safety and Risk processes within each of our Care Groups.

Deputy Directors have specific responsibilities to review locality risks and ensure the high quality of risk registers. They ensure that risk management processes are implemented and functional within their respective services. To enable them to fulfil these duties effectively, the Risk Management team provide them with risk data packs on a monthly basis which contain information regarding risks in their areas.

Heads of Services are responsible for the effective application of all risk management procedural documents, maintaining their service risk registers, implementing action plans and ensuring systems are in place to identify, analyse, evaluate, treat and reduce risks. They ensure risk registers are used as a live dynamic process across all their services / wards and departments and review risks to the achievement of objectives and delivery of services.

Service Managers, Clinical Managers, Ward Managers and team leaders have a responsibility to develop and apply risk management processes in line with the overall strategy for the Trust. Risk registers should be included as regular agenda items in appropriate meetings. Risks are subject to a regular review process with risks being escalated as required in accordance with the Risk Management Policy and Procedure.

Risk guardians are responsible for the logging of risks and the maintenance of their relevant risk register. They ensure the risk register is reviewed and updated by an appropriate group.

Risk Management Training

All staff across the Trust have a responsibility to deliver high quality, safe care and we ensure there are high quality training packages in place to support staff in this responsibility. Experienced staff specialising in risk management, develop, coordinate, and deliver a variety of risk management training packages. All colleagues are required to attend a corporate induction on commencing work within the Trust and are required to complete a mandatory refresher risk management session on a five-yearly basis.

Specialist training is required for the specific roles of risk guardians and incident managers. Risk guardian training is delivered before access to the risk register is given, for risk guardians, and refresher training is offered on a quarterly basis. Quarterly incident manager training is also offered to support incident managers fulfil their role adequately. This helps to support these staff in how to accurately manage their IR-es and reinforces the need to report all incidents and how this contributes to an overall safer environment for both staff and service users.

Our risk management team are available to answer queries or support any training needs at any point between the refresher training dates. An e-learning package is offered for the completion and management of electronic incident reports (IR-es). Training is available as e-learning and the risk management team offer face to face training if this is preferred.

Risk and Control Framework

The Trust's Risk Management Strategy has recently been refreshed and was approved at the end of 2025/26. Work is planned in the early part of 2026/27 to strengthen our Trust's approach to risk appetite and risk tolerance. To aid with determining risk appetite, our Board uses an amended version of the Good Governance Institute matrix.

The Risk Management Policy and Procedure was ratified by the Quality and Safety Committee in June 2023. It sets out the structures and processes to systematically identify, manage, monitor and review risk and put in place robust plans for mitigation. This will be reviewed in summer 2026.

Risk Management Process

The Trust uses several different risk assessment tools additional to the five by five risk matrix.

Examples include clinical risk assessments, equality and quality impact assessments, Control of Substances Hazardous to Health (COSHH) assessments and falls assessments. Risks are identified, assessed and logged on a risk register and the Trust seeks to anticipate potential risks by proactively putting controls and mitigating actions in place to prevent the risk materialising where possible.

Additional sources for identifying risks are varied and can include, but are not limited to:

- Incident reports
- Coroner reports
- Patient and staff surveys
- Multi-disciplinary reviews
- Safety Huddles
- Service reviews
- Audits (clinical and non-clinical)
- Quality and Operational Care Group meetings
- Patient safety incidents
- Quality and Safety visits
- Complaints and Patient Experience
- Freedom to Speak Up cases
- Health and Safety Assessments
- Fire Assessments
- National guidance and reports
- Trust 'Go See' Visits
- Deep Dive reviews
- Activation of Business Continuity Plans
- Validation Exercise of Major Incident Plans
- Care Trust Way methodology

NHS organisations are required to produce a comprehensive organisation-wide risk register that can record all types of risk. The Safeguard risk module hosts the Trust's risk registers.

The Trust recognises that identified risks should be managed at the appropriate level and decisions on whether to act or otherwise are taken within an appropriate timescale.

Therefore, a structure of risk registers is managed and monitored by guardians at all levels. The risk registers are living dynamic documents which support and inform decision making.

There are currently four levels of risk register used within the Trust: local, service manager, care group and directorate risk register.

Each risk has an initial, current and residual risk rating recorded, and mitigating actions identified. Closed risks are reviewed periodically to confirm they are still under control. If not fully mitigated, they can be reopened, if they have been satisfactorily mitigated, then they can be archived. All archived risks can be accessed at any point and reopened, should this be required.

The Audit Committee monitor, review and report to the Board on internal control and risk management processes, ensuring they are efficient and effective. Individual

Directors have responsibility for ensuring the Trust's services continue to deliver efficient and effective care and compassion in a safe environment. The Quality and Safety Committee has responsibility for oversight of the Risk Management Policy. And Procedure

As a learning organisation, the reporting of incidents is actively encouraged in the Trust. Guidance is provided at Trust Induction, training is available, and the discussion of incident data is routinely embedded in Care Group governance processes.

Board Assurance Framework and Organisational Risk Register

The Board Assurance Framework (BAF) is a key reporting document and process for the Board, it enables the Board to track its progress in achieving its strategic priorities by monitoring the risks to progress and the mitigation. Accountability for seeking assurance for the delivery of these objectives has been delegated to responsible Board committees as described below:

Committee	Strategic Priority	Theme
Finance and Performance Committee	Best Use of Resources	Theme 1: Financial sustainability
		Theme 2: Our environment and workspaces
		Theme 3: Giving back to our communities
	Best Quality Services	Theme 1 – Access & flow (performance perspective)
Quality and Safety Committee	Best Quality Services	Theme 1 – Access & flow (quality perspective)
		Theme 2 – Learning for improvement
		Theme 3 – Improving the experience of people using our services
Workforce and Equality Committee	Best Place to Work	Theme 1 – Looking after our people
		Theme 2 – Belonging in our organisation
		Theme 3 – New ways of working and delivering care
		Theme 4 – Growing for the future
Mental Health Legislation Committee	Best Quality Services	Theme 3 – Improving the experience of people using our services (specifically in relation to restrictive practices)
Board / All	Best Partner	Partnership
Audit Committee	Good Governance	Governance, accountability and effective oversight

Table 41: BAF Delegated responsibility for themes

In 2023-2024, the Board moved away from a risk-based approach to managing the delivery of the BAF objectives, to a more positive-assurance based approach and introduced the use of the following definitions to identify the level of assurance that the Trust is making sufficient progress against its strategic priorities.

Assurance Level	Definition
High (Strong)	High assurance can be given that there is strong evidence that this ambition is being achieved and is embedded within usual practice. There are examples of outstanding practice and/or innovation in this area which can be evidenced.
Significant (Good)	Significant assurance can be given that there is good evidence that this standard is this ambition is being achieved across the majority of areas / reviews undertaken. Whilst there may be some gaps, these are infrequent and there is evidence these are mitigated / responded to rapidly and appropriately.
Limited (Improvement Required)	Limited assurance can be given as whilst there is evidence that some elements of the ambition are being achieved across some areas, there are areas that require improvement in order to bring them up to the required standard.
Low (Weak)	Low assurance can be given as there is weak or no evidence that the ambitions are being achieved. There are significant gaps with little evidence of effective plans to address and significant works needs to be undertaken to bring these areas up to standard.

Table 42: Definitions of assurance levels

What this means in practice is that each Committee receives a number of key documents which include a Strategic Narrative Report, Strategic Performance Report and Strategic Risk Report which directly align to those priority areas delegated to each Committee. Within these reports, informed by Executive oversight of operational grip and control systems, is a proposed BAF assurance rating for each priority and theme. At the end of each Committee meeting the chair makes a formal decision to either ratify that assurance level or change it, based on the intelligence considered across the entirety of the business of the Committee. There is also opportunity for the Committee to raise any new risks that arose during the discussion. This is supported by the identification of the top strategic risks and supporting narrative within each Committee's AAA+D report.

All Committee identified strategic risks are then reported within the Board Strategic Risk Assurance Report to show the full picture of strategic risk associated with delivery of the Better Lives, Together strategy. This report provides an update in support of ensuring dynamic governance. Within this report, each strategic risk has a Committee approved 'assurance rating', which is aligned to the internal audit assurance for consistency.



As a learning organisation, benchmarking and self-reflection has taken place in support of developing this report to ensure it is robust, and can be used as a tool for Board and Committee, to help action management. A new template for this Strategic Risk Assurance Report was introduced in January 2025 which has been refined throughout the year.

The Trust is committed to continually improving and undertook a pre-planned effectiveness review. The review found areas of success and areas for improvement. This included:

- the identification of strategic risks
- the reporting template for monitoring of strategic risks
- Board development on strategic risk management and alignment to Trust strategy

During 2025-2026 work took place to progress each area, with a further commitment to review the effectiveness of the recent changes during 2026/27. This review will also consider benchmarking, discussion with independent experts and further Board Development. All improvements will continue to be tracked through formal reporting.

Throughout the process, discussion with the Board has taken place on the overarching strategic risks, which have largely remained the same as:

1. There is a risk that the **inability to recruit and retain an appropriately skilled substantive workforce** will continue to negatively impact on the Trust's financial sustainability; the safety and experience of people who use our services and, on the morale, and experience of colleagues.
2. There is a risk that **continued increase in demand across many of our services** will continue to negatively impact on the quality of services we can offer, including maintaining unacceptable waits for treatment, safety concerns and potential impacts on outcome; that this will continue to negatively impact on the financial sustainability by driving the need for additional staffing related to additional activity and acuity of patients relating to the impact of waiting for treatment, and that this will impact on colleague experience due to increased workload and associated pressures as well as a lack of time to invest in development and support.
3. There is a risk that the **continued lack of available recurrent funding to invest across the Trust** will lead to patient and colleague safety incidents as well as continued poor experiences for patients and colleagues.

Consideration has been made to how the AAAD reports flow up from Committee to Board, with feedback gathered at Board then reporting back into Committee as an

ongoing cycle. The feedback gathered at Board has been fed back in the meetings via the AAAD from March 2025 and initial feedback has been positive on the triangulation this reporting brings between Board and its Committees.

Managing Conflicts of Interest

The Trust has remained compliant with national guidance on Managing Conflicts of Interest in the NHS, compliant with the Constitution and policy. The Trust has published on its website an up to date register of interests for decision making staff. The Trust works with partners to ensure consistency of records and reporting recognising that Trust staff are members of external partnership meetings.

Equality and Quality Impact Assessments

The Trust has an established equality impact assessment process outlined in an Equality Impact Assessment Policy. The policy covers when and how an equality impact assessment should be carried out and how the outcome should be addressed. Training is available for colleagues to support them in carrying out effective equality impact assessments. The Trust has established Health Equity resource pages and an integrated dashboard which includes population and case load data broken down by ethnicity, sex, age and index of deprivation. The Trust produces six monthly workforce diversity reports which can be used to support the EQIA process.

All policies are equality impact assessed, quality assured and reviewed as part of the policy approval process.

The template for governance reports includes reference to equality impacts and a requirement for authors to outline how they have been considered. These are reviewed within the Trusts committees and Trust Board. Trust Board members have taken part in training and development workshops relating to health equity.

Service EIA reports carried out annually as part the NHS Equality Delivery System process are published on the Trust website along with the associated action plans.

In addition to these processes the Trust's Equality and Quality Impact Assessment (EQIA) Framework was approved in December 2020 and has been reviewed and refreshed during 2025. This framework sets out an impact assessment process which considers both quality impacts and impacts on equality, diversity and inclusion.

In line with the Trust's strategic priorities, all business cases, service changes and transformational plans have their impact assessed at the very earliest stage of the development process using this framework. This ensures that business cases are developed that reflect appropriate mitigations of any risks identified and reduces the likelihood of adverse impacts on quality or equality.

Well Led

The Board has overall responsibility for the administration of sound corporate governance throughout the organisation. The NHS Trust Code of Governance (the Code) is published by NHS England (previously Monitor). The purpose of the Code is to assist with ensuring good governance, and to bring together best practice from public and private sector corporate governance.

The Code is issued as best practice, but also contains several main principles, supporting principles and code provisions on a 'comply or explain' basis.

The Trust has applied the principles of the NHS Code on a 'comply or explain' basis, and carried out a self-assessment which confirmed the Trust continues to comply with the principles of the Code. The Board is responsible for all aspects of the leadership of our Trust. The Board has a duty to conduct their affairs effectively and demonstrate measurable outcomes that build service user, carer, public and stakeholder confidence that the Trust is providing high quality, sustainable care.

With due regard to the positive duty, the Trust has to meet the NHS' triple aim of improving the quality of healthcare; improving the health of the population, and achieving value and financial sustainability, the Board is committed to continually review its effectiveness. Building on its ambition to embed a culture of continuous learning and improvement across the organisation, the Board has approved a framework, which will allow it to regularly review its activity, makes changes to support improvement and continually assess its effectiveness.

In order to provide a consistent means of understanding the structure of the framework, the Trust has decided to align it with the quality statements described within the CQC's key questions relating to the well-led aspect of their framework. The Trust has then aligned the expectations of the NHS Trust Code of Governance with those statements, to help in identifying the specific behaviours and activities that the Board must enact in order to demonstrate effectiveness in this area.

The first Well Led internal audit took place in Autum 2023 with a further commenced in Autumn 2024, both received significant assurance. During the year, an Internal Audit took place as part of this, specifically reviewing the Trust's compliance with the NHS Code of Governance. This was rated as high assurance.

For the Well Led internal audit is based on three national frameworks and is in place to test assurance levels across eight categories on an annual basis. The three frameworks are: CQC Wel Led; The Healthy NHS Board; and the NHS Trust Code of Governance. The eight categories are:

- shared direction and culture
- capable, compassionate and inclusive leaders
- Freedom to Speak Up
- workforce equality, diversity and inclusion

- governance, management and sustainability
- partnerships and communities
- learning, improvement and innovation
- environmental sustainability – sustainable development

This work will be complemented by the CQC Well Led reviews, internal effectiveness reviews and governance developments, and the requirement to undertake an external Well Led review every three-years. During Spring 2025, an external independent Well Led review took place. This resulted in a number of recommendations being agreed by management, which is being tracked through a new oversight report. The report highlighted many strengths for the Trust and identified areas for improvement.

Aligned to new NHS England requirements the Trust undertook an exercise to deliver the Provider Capability Assessment. The Board decided to use a Care Trust Way coach to help facilitate the reflective exercise for Board members. The exercise was supported by an evidence gathering process should further assurance be required by NHS England. The evidence was not used by the Board, the coach facilitated discussion, using high quality questions, for the Board to consider the key lines of enquiry across the six domains. This created a reflective and challenge-based discussion, resulting in formal agreement by all Board members on the submission. The Trust received confirmation from NHS England that it had been rated green-amber.

In support of integrated governance, a triangulation exercise has taken place to consider the findings of the external independent Well Led review; Provider Capability Assessment; effectiveness reviews. All of which will be considered during 2026/27, including discussion on areas for improvement and Board Development.

As an improvement organisation the Trust welcomed the opportunity to review the effectiveness of existing work and utilise national guidance to supplement wider reflection and compliance requirements. This supports the Trust's commitment as an NHS provider to ensure safe, high-quality, compassionate care is provided to service users and communities.

In support of tracking progress against our Well Led framework and Board ambition, a Well Led Development Plan has been created. The plan will be an action log, act as an assurance report within year on governance improvement activity and be a new tool for our Trust to assess and enable the supporting principle for the strategy of, 'good governance, effective oversight, accountability'.

The Plan is the culmination of three effectiveness review processes, they are:

- annual reviews, considering experience and quantitative data
- annual internal audit aligned to the CQC Well Led quality statements
- external and independent well led review aligned to the CQC Well Led quality statements.

Each action is assigned to a lead and is presented to an oversight meeting to track progress. The Audit Committee is responsible for monitoring the compliance against delivery of this plan, and discussions will continue throughout the year ahead to review ongoing improvements. The improvements are tracked throughout the year, looking at delivery of the actions and how the actions have been embedded.

To support this work, Board Development and formal discussion has also taken place on the NHS England guidance, Insightful Board.

Patient Advice and Complaints

Enquiries and complaints handling

It is important to us that any person using the services of our organisation can seek advice, raise concerns or make a complaint. The Patient Advice and Complaints Service (PACS) team provide a point of contact for signposting enquiries, and listening to concerns and complaints.

When a person using our services makes a complaint, this is handled in accordance with regulatory requirements. The PACS team aims to offer an accessible, robust complaints service that is responsive in addressing the complaint in an effective and timely way.

We understand that the complaints process is not always the best pathway for users of our service to receive a response to their concerns. This might be when there is a case of more urgent need for support or when it is possible for us to respond in a way that provides a faster solution to a problem (we call this local resolution).

During 2025-2026 the PACS handled 556 enquiries (of which 297 required signposting elsewhere) and 668 complaints.

Learning from complaints

In 2025-2026 the top three most complained about areas were:

- Lack of support. (Where the complainant felt that the service user, patient or themselves, were not provided with the support they needed from services or staff)
- Information. (Where the complainant felt that insufficient information was provided to them or the patient, service user or carer. This could be information about the service, their care plan, or something else.)
- Length of waiting list. (Where the complainant felt the length of time they were on a waiting list prior to assessment or treatment was too long.)

The table below demonstrates examples of actions taken in response to complaints made in 2025-2026, to improve our services:

Service Area	Improvement action taken
Unplanned Care Team	The pathway has been reviewed to ensure that it is sufficiently robust in order that suction machines are easily accessible when required.
A&E Liaison	A focused reflective session took place for the team to look at cultural competence, trauma-informed communication, and responding appropriately to disclosures of previous discriminatory or harmful contact with police.
Pharmacy	Additional training delivered to ensure pharmacy staff can interpret external medication administration charts correctly.
First Response Service	Noise cancelling equipment has been introduced, to significantly reduce background noise on calls.
Podiatry	Incorrect information removed from the Trust's Podiatry webpage.

Table 43: Actions taken in response to complaints

Compliments

When compliments are received within our services, we try to ensure these are recorded to reflect our positive feedback.

During 2025-2026 the Trust recorded 199 compliments. Compliments are an important measure of service user experience. We recognise that as an organisation we could improve the recording of compliments alongside our other methods of feedback so that we can see a full picture of the experience of users of our services.

Compliance with the NHS Code of Governance

The Trust has applied the principles of the NHS Code on a 'comply or explain' basis and carried out a self-assessment which confirmed the Trust continues to comply with the principles of the Code. The Board is responsible for all aspects of the leadership of our Trust. The Board has a duty to conduct their affairs effectively and demonstrate measurable outcomes that build service user, carer, public and stakeholder confidence that the Trust is providing high quality, sustainable care.

With due regard to the positive duty, the Trust must meet the NHS' triple aim of improving the quality of healthcare; improving the health of the population, and achieving value and financial sustainability, the Board is committed to continually review its effectiveness. Building on its ambition to embed a culture of continuous learning and improvement across the Trust the Board has approved a framework, which will allow it to regularly review its activity, makes changes to support improvement and continually assess its effectiveness.

An external and independent Well Led internal review took place, with actions agreed by management. The review involved observing board, committees and key meetings. The review is based on CQC Well Led framework and is based on the new regulatory process, this includes analysis on the NHS Trust Code of Governance.

In order to provide a consistent means of understanding the structure of the framework, the Trust has decided to align it with the quality statements described within the CQC's key questions relating to the well-led aspect of their framework. The Trust has then aligned the expectations of the NHS Foundation Trust Code of Governance with those statements, to help in identifying the specific behaviours and activities that the Board must enact to demonstrate effectiveness in this area.

During the year an internal audit took place on compliance with the NHS Code of Governance, which received a 'high assurance' rating.

Compliance with Care Quality Commission (CQC) requirements

The Trust is required to register with the Care Quality Commission and our current rating is 'Good'.

The Care Quality Commission has not taken enforcement action against Bradford District Care NHS Foundation Trust during 2025-2026.

The CQC have not undertaken any formal investigations into the Trust in 2025-2026.

Seven Mental Health Act visits took place in 2025-2026.

- A focussed visit took place on 28 August 2025 which saw the MHA team visit the following wards: Thornton, Ashbrook, Willow, Maplebeck and the Najurally Centre.
- Clover ward received 2 unannounced visits – in June 2025 and February 2026.
- Maplebeck ward received an unannounced visit in October 2025
- Najurally Centre received an unannounced visit in February 2026
- Thornton ward received an unannounced visit in February 2026
- Oakburn ward was visited on 11 February

Two CQC inspections were undertaken during 2025/26.

- Step Forward Centre (SFC) – September 2025
- Low Secure Services – October 2025

During this period the Trust has made one change to its registration status with the CQC.

The Trust submitted a statutory notification under Regulation 12(3) regarding updates to the descriptions of services at Lynfield Mount Hospital and the Airedale Centre for Mental Health, effective from 6 November 2025.

- Lynfield Mount Hospital (LMH): Removal of Willow Ward.
- Airedale Centre for Mental Health (ACMH): Addition of Fern Ward, designated as an acute inpatient ward for males aged 18–65 experiencing acute mental illness.

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

Information Governance

Data Quality, Governance and Data Security

High quality data underpins safe, effective patient care and informed decision making. The Trust is committed to ensuring that the data we use is accurate, reliable and used consistently across services.

Clinical information is recorded and managed using three core electronic systems covering community, mental health, learning disability, talking therapies and community dental services. The Trust's Data Quality Policy provides a clear framework for maintaining strong standards across both clinical and non clinical information. This is supported by agreed data definitions aligned to national standards, regular audit and review, and clear accountability within services for the quality of data recorded.

Data quality is overseen through established governance arrangements, including a Data Quality Group, alongside routine service level reviews. Issues are identified and addressed at source wherever possible, supported by targeted training and guidance, with escalation arrangements in place where required.

Data Security and Cyber Resilience

Protecting staff and patient information remains a priority for the Trust. The Trust continues to operate in an increasingly challenging cyber security environment and have strengthened both technical and organisational controls to manage risk.

During the year, we worked closely with national cyber security teams and system partners to enhance protections, introduce new controls and adopt best practice. Robust security assurance processes are applied to new systems and third-party suppliers to ensure information remains protected both at rest and in transit, including where emerging technologies such as Artificial Intelligence are introduced.

The Trust regularly tests the disaster recovery, back up and business continuity arrangements to ensure services can continue safely in the event of a cyber incident. Ongoing staff awareness activity, improved monitoring and prompt responses to emerging threats all form part of the Trust's approach to information security.

Information Governance Incidents 2025-2026

All information governance incidents and near misses are reported through the Trust's incident reporting system and managed in line with statutory requirements. The Information Governance Group receives regular reports, oversees investigations and ensures learning is shared and embedded.

During 2025-2026, one incident was reported to the Information Commissioner's Office (ICO). This related to the unintended distribution of automated "welcome" emails to a large number of recipients. The incident was identified and contained promptly, appropriate communications were issued, and partner organisations were informed. The ICO reviewed the incident and closed the case with no further action required.

A root cause review identified process and change management improvements, which have since been implemented to strengthen controls and reduce the risk of recurrence.

NHS National Oversight Framework

The National Oversight Framework (NOF) was introduced in early 2025-2026. It describes a consistent and transparent approach to assessing integrated care boards (ICBs), NHS trusts and NHS foundation trusts, supporting public accountability for performance. The framework reflects the ambitions and priorities set out in the Ten-Year Plan and is structured across the following domains:

- access to services;
- effectiveness and experience;
- patient safety;
- people and workforce; and
- finance and productivity.

Using average scores across these measures, and following benchmarking against similar organisations, each trust is allocated a segment score. Segments are numbered 1 to 4, with Segment 1 indicating the highest-performing organisations and Segment 4 indicating those with the lowest scores.

We are pleased to report that, in financial year 2025-2026, the organisation improved its segmentation to Segment 3, ranking 43 out of 61 Trusts. While we recognise that further improvement is required, this represents a significant step forward from our initial Quarter 1 position in Segment 4 (ranked 53 of 61). This upward trajectory reflects the early impact of actions implemented to strengthen performance, supported by a combination of operational improvements and enhanced data quality.

Areas where we have made particularly rapid improvements include performance against the 52-week standard for community services and the proportion of urgent referrals to crisis care teams receiving a first face-to-face contact within 24 hours. Over the next financial year, key areas of focus for further improvement will include

workforce sickness absence, mental health access for children and young people and patient outcome measures.

We are embedding the NOF within our Integrated Strategic Performance Planning framework. This is being done to provide clear line of sight from high-level metrics to individual service lines and support a culture of continuous improvement across all levels of the organisation, helping to deliver improved health outcomes for our population.

Workforce Strategy and Safer Staffing

Over the last four years, delivery of the Trust's workforce priorities has been led through consistent HR operational and resourcing oversight, evidenced through regular correspondence, briefings and actions aligned to the Trust Strategy and the ambition to be the "Best Place to Work". Regular updates, narrative and assurance on workforce activity for Board, Committee and Annual Report purposes have been provided

Operational leadership has supported the translation of workforce strategy into practice across recruitment, employee relations, workforce data, policy development and service sustainability. This is evidenced by frequent engagement in correspondence regarding recruitment activity, workforce planning, data utilisation, and emerging risks, with clear actions and follow up undertaken through the People Services Function.

Governance and assurance arrangements have been maintained through close working with the Deputy Chief People Officer and other Executive Leads, with teams providing timely analysis, escalation and resolution of workforce issues. There has been routine escalation of complex employment matters, overpayments, case outcomes and operational risks to Executive and Board level, ensuring transparency and organisational assurance.

Collaboration across clinical and corporate services has supported local workforce planning and system alignment, including Place based and Integrated Care System initiatives. involvement in workforce transformation activity, future workforce programmes and the alignment of operational delivery to system priorities

Working closely with our internal audit colleagues and Corporate Governance teams we have provided ongoing assurance that statutory and contractual employment obligations are met. Demonstrating operational oversight of leaver processes, financial settlements, overpayments and payroll actions, with escalation to and oversight from senior leaders where required to ensure compliance and organisational risk management.

Assurance in relation to pay, pensions and contractual changes is further demonstrated through correspondence confirming employer actions, approvals and implementation through Electronic Staff Record (ESR), supporting compliance with NHS Pension Scheme and employment regulations.

Equality, diversity and people governance considerations are embedded within People Services operational delivery, supported by policies, workforce practices and active leadership engagement with an involvement in staff survey review, workforce wellbeing discussions and inclusive workforce development activity, ensuring that people risks and employee experience are reflected in operational and strategic decision making. Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with.

Regular communication with the Deputy Chief People Officer provides documented assurance that all activity continues to support fair, consistent and compliant people management across the Trust, with issues escalated appropriately and managed within established governance frameworks.

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

Effective Use of Resources

The Trust's resources are managed within an approved framework set by the Board, which includes Standing Financial Instructions, with an annual review and any subsequent updates reviewed in detail by the Audit Committee.

Financial governance arrangements are supported by internal and external audit to ensure economic, efficient and effective use of resources.

The Senior Leadership Team (SLT), comprising Directors, Deputy Directors and Heads of Professions meets weekly to oversee strategy, business delivery and quality and performance issues. During the year, SLT meetings continued to operate a themed approach with meetings covering the following areas during each calendar month: Care Group Accountability; Quality, Safety and Governance; People Plan and Innovation. Supported by Care Trust Way methodology, the meetings are chaired by lead Directors, with an assurance and escalation route as appropriate to the Board Committees.

The Executive Management Team (EMT), comprising the Trust's Executive Directors and chaired by the Chief Executive, continued to meet on a weekly basis throughout the reporting period. In response to the significant financial constraints faced by the organisation, the EMT assumed direct oversight of all workforce and pay-related requests. This approach ensured that existing resources were utilised effectively and that any recruitment proposals were both essential and justified, particularly given the financial pressures affecting the wider NHS and the Trust.

During 2025-2026, our Organisational Sustainability Programme Board (OSPB) continued to meet fortnightly to oversee delivery of the Trusts Strategic Programmes and workstreams. Membership of the group includes Directors, relevant Deputy Directors, PMO and finance. The meeting is chaired by the Director of Transformation, Improvement and Productivity and formally reports to the Finance and Performance Committee.

The Trust has undertaken risk assessments on the effects of climate change and severe weather and 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 Adaption Reporting requirements are complied with.

Internal Audit

Internal Audit undertakes a review and reports on the risk management processes annually, reporting to the Audit Committee. This Committee has a timely reporting process in place to ensure that identified actions from audit reports are progressed to satisfactory conclusion through the implementation of the agreed recommendations. Internal Audit's opinion for 2025/26 (based upon and limited to the work performed) was that significant assurance would be given that there is a generally sound system of internal control, designed to meet the Trust's objectives, and that controls are generally being applied consistently. During the year, the Trust received 13 assurance ratings; 3 high assurance ratings; 5 significant assurance ratings; 4 limited assurance ratings; and 1 low assurance ratings (4 benchmarking reports which were not assigned an assurance rating). When low or limited assurance ratings are received, Trust management are requested to attend the Audit Committee to provide an update on the work and receive challenge to ensure further assurance is received.

Counter Fraud

In terms of deterrents against fraud, the Trust has a very proactive nominated Local Counter Fraud Specialist provided via Audit Yorkshire, who is fully accredited by the NHS Counter Fraud Authority. The Audit Committee approved the Annual Counter Fraud Plan and received regular updates on progress of counter fraud work during the year.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit, 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. Any findings are reported to me, where I will seek assurance to ensure that lessons are learnt, and a plan to address weaknesses is in place, to ensure continuous improvement.

My review is informed in several other ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the BAF and on the controls reviewed as part of the internal audit work. A significant assurance opinion has been given for 2025/26.

Executive and Associate Directors who have responsibility for the development and maintenance of the system of internal control, also provide me with assurance. The

Trust's BAF provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its strategic intents have been reviewed.

The Trust has established a governance, accountability, assurance and performance framework which sets out the Trust's overarching principles and approach to delivering a quality service. As a learning organisation, regular review of effectiveness takes place. The framework aims to ensure the Trust successfully delivers national standards for governance and performance through clear lines of accountability. The framework describes how the Trust will use information, alongside clear governance and accountability to deliver better performance and make decisions. The review, which has been approved by the Board, supports several actions taking place over the next year to introduce of a tiered performance management process which demonstrates rigour, support, challenge, timely escalation and a consistent approach at all levels of the organisation.

Supporting this workstream, the Trust has developed a Well Led quality assurance framework, which was approved by the Board. The framework will support the Trust to undertake an annual review, supported by the Internal Audit function. During the year, an Internal Audit took place as part of this, specifically reviewing the Trust's compliance with the NHS Code of Governance. This was rated as high assurance.

This work will be complemented by the CQC Well Led reviews, internal effectiveness reviews and governance developments, and the requirement to undertake an external Well Led review every three-years. During Spring 2025, an external independent Well Led review took place. This resulted in a number of recommendations being agreed by management, which is being tracked through a new oversight report. The report highlighted many strengths for the Trust and identified areas for improvement.

Aligned to new NHS England requirements the Trust undertook an exercise to deliver the Provider Capability Assessment. The Board decided to use a Care Trust Way coach to help facilitate the reflective exercise for Board members. The exercise was supported by an evidence gathering process should further assurance be required by NHS England. The evidence was not used by the Board, the coach facilitated discussion, using high quality questions, for the Board to consider the key lines of enquiry across the six domains. This created a reflective and challenge based discussion, resulting in formal agreement by all Board members on the submission. The Trust received confirmation from NHS England that it had been rated green-amber.

In support of integrated governance, a triangulation exercise has taken place to consider the findings of the external independent Well Led review; Provider Capability Assessment; effectiveness reviews. All of which will be considered during 2026/27, including discussion on areas for improvement and Board Development.

In 2022 the Board agreed to change the process for the Board Assurance Framework. The new approach aimed to integrate assurance reporting with committee responsibilities and strategic priorities to enhance governance and oversight. Including:

- Focus shift from operational to strategic risk: The BAF has been restructured to move committee discussions away from operational risk management towards assurance on progress in delivering strategic objectives. This change was based on observations and consultations with board members and governance experts.
- Delegation of assurance responsibilities: Each committee was assigned responsibility for assurance on specific strategic elements, clarified through visual controls in meeting papers that link agenda items to strategic priorities.
- Integration with performance reports: The BAF was merged with committee data dashboards into an Integrated Strategic Performance Report (ISPR), adopting an assurance-based reporting style consistent with Internal Audit definitions. Lead Executives propose assurance levels based on data, operational insights, and broader intelligence.
- Supporting narrative and compliance reporting: Alongside the ISPR, committees receive a Strategic Narrative Report explaining the rationale for assurance levels, plus outputs from the Compliance and Risk Group, including operational compliance and high-risk update reports tailored to committee responsibilities.
- Committee decision-making on assurance levels: Committees review and ratify or adjust proposed assurance levels during meetings, making these decisions formal and integrating them into the Board-level ISPR and BAF papers. This embeds the BAF within committee work rather than treating it as an isolated document.
- Identification and reporting of top strategic risks: Committees identify strategic risks based on their delegated priorities, which are reported in the Alert, Advise, Assure + Decision paper shared with the Board to present a comprehensive risk picture.
- Process and scheduling adjustments: The rollout involved reviewing and closing old BAF actions, aligning committee scheduling for consistent data reporting, and differentiating meeting content between full data-driven sessions and intermediate meetings focused on deep dives and narrative reporting to support triangulation and assurance.

As an improvement organisation, the Trust is committed to continually improving and undertook a pre-planned effectiveness review. The review found areas of success and areas for improvement. This included:

- the identification of strategic risks
- the reporting template for monitoring of strategic risks

- Board development on strategic risk management and alignment to Trust strategy

During 2025-2026 work took place to progress each area, with a further commitment to review the effectiveness of the recent changes during 2026-2027. This review will also consider benchmarking, discussion with independent experts and further Board Development. All improvements will continue to be tracked through formal reporting.

Throughout the process, discussion with the Board has taken place on the overarching strategic risks, which have largely remained the same as:

1. There is a risk that the inability to recruit and retain an appropriately skilled substantive workforce will continue to negatively impact on the Trust's financial sustainability; the safety and experience of people who use our services and, on the morale, and experience of colleagues.
2. There is a risk that continued increase in demand across many of our services will continue to negatively impact on the quality of services we can offer, including maintaining unacceptable waits for treatment, safety concerns and potential impacts on outcome; that this will continue to negatively impact on the financial sustainability by driving the need for additional staffing related to additional activity and acuity of patients relating to the impact of waiting for treatment, and that this will impact on colleague experience due to increased workload and associated pressures as well as a lack of time to invest in development and support.
3. There is a risk that the continued lack of available recurrent funding to invest across the Trust will lead to patient and colleague safety incidents as well as continued poor experiences for patients and colleagues.

Following discussion with committees, Board members formally and through Board Development, 13 strategic risks have been agreed. Each of which has a lead Director, and oversight meeting. A new reporting template was rolled out, which has been refined further following feedback received. All strategic risks will be monitored monthly, with changes tracked at each reporting cycle. Each will have an associated tolerance level, which will be agreed annually by the Board; and each will have an assurance rating (low; limited; significant; high) that will be tracked.

As part of the planned development for the Audit Committee, consideration will be given to how the Audit Committee receives assurance from the other committees on the process for monitoring risk and good governance. A Benchmarking exercise has taken place to support this improvement, along with review of the Committee against national guidance within the Healthcare Financial Management Association model Audit Committee.

The Trust involves stakeholders and partners in identifying and managing risks to its strategic objectives, including:

- Working in partnership to develop system-wide plans with stakeholders across both the Bradford and Craven District (Place), and the wider West Yorkshire System.
- Working in partnership to in the Mental Health Learning Disability and Autism Collaborative Committee in Common.
- Working in partnership to in the Community Collaborative Committee in Common.

Conclusion

No significant internal control issues have been identified.



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Date: 25 June 2026
Therese Patten
Chief Executive

12. Sustainability Report

2024-2027 Green Plan

Our second Green Plan for 2024-27 was ratified by our Board in 2024 and has been reviewed annually. Our ambition remains to be recognised as a leader in sustainability and environmental improvements within the NHS and our local community.

Improvements and achievements in 2025-2026 include:

- We met our Green Plan target with 10% staff completing the delivering net zero NHS training.
- We continue to engage and develop the Green Champions and leadership network (243 and 44 respectively).
- The Trust appointed a clinical lead for sustainability.
- The Community Dental Service and Pharmacy have both achieved bronze status in their respective green impact toolkits.
- In travel and transport:
 - business mileage reduced by 6%,
 - electric vehicle infrastructure expanded and fleet transition continues,
 - provision of two e-bikes for use by staff to deliver services or commute by active travel,
 - sustainable travel campaigns delivered to staff.
- Digital transformation is delivering sustainability benefits:
 - reduction in printer devices and printing volumes
 - increase in electronic letters and service user communications through continued rollout of digital tools.

Additional achievements are included in the sections below.

Carbon Emissions

The Trust continues to generate more carbon emissions than our target. Following a review of our internal data, and taking account of inflation, our emissions for 24-25 are different to that reported in last year's annual report. Emissions are lower than the baseline year but are on an upwards trajectory. However, staff numbers have increased, suggesting increased organisational activity. The emissions per person have reduced from 4.46 tonnes CO² in 24-25 to 4.43 tonnes CO² in 25-26. In 2026-27, the Sustainability team will review the targets alongside planned increases in staffing and activity to ensure a realistic target trajectory.

	Baseline	20/21	21/22	22/23	23/24	24/25	25/26
Total target		15,680	13,952	12,420	11,062	9,857	8,787
Total actual	17,633	18,912	16,439	13,806	14,305	14,892	15,398
Difference from target		3,232	2,487	1,386	3,243	5,035	6,610
Difference from previous year		1,279	-2,473	-2,633	499	588	505

Table 44: BDCFT Carbon Emissions (Tonnes of CO²)

The chart below shows the carbon footprint (within our control) and carbon footprint plus (we can influence) compared to targets. Our targets are more challenging than NHSE propose, however our emissions are increasing meaning even modest reduction targets will not be achieved. The Sustainability team will review targets and opportunities to plan future carbon reduction forecasts.

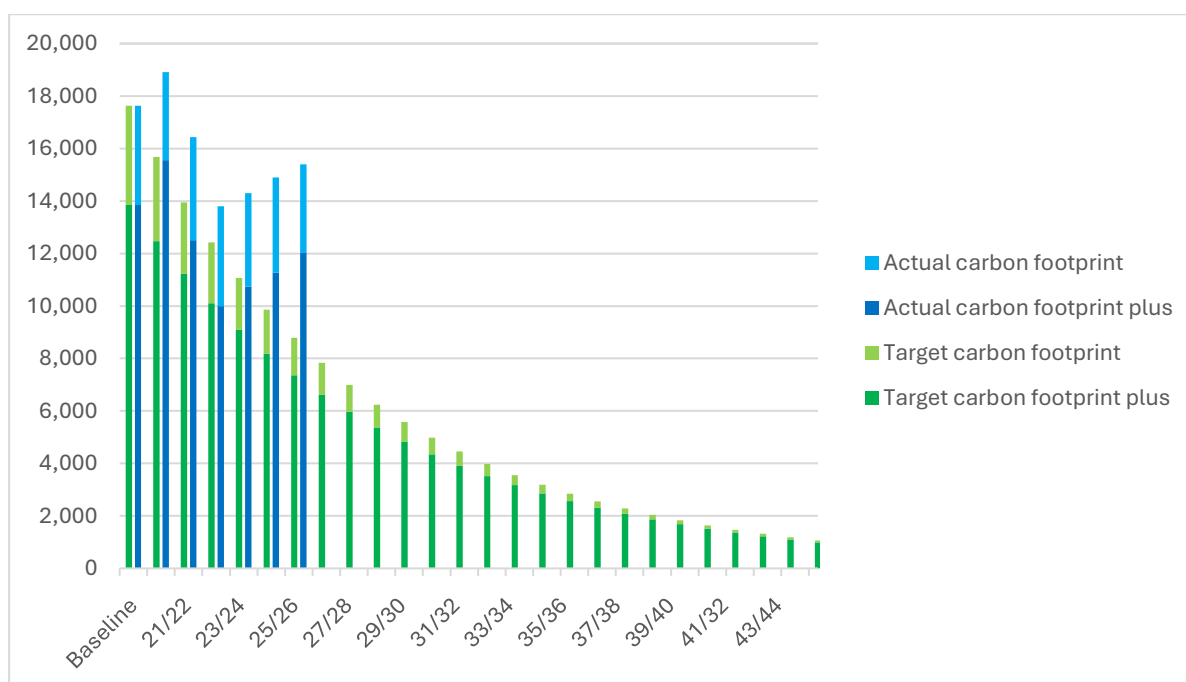


Diagram 20: BDCFT Carbon Footprint Progress

The Trust is expanding its use of artificial intelligence, particularly through the use of Microsoft Copilot. The full impact of this is not yet known but the Sustainability team are aware of the environmental impact of AI and considering how best to address this in future carbon emissions calculations.

Heat Decarbonisation

The Trust published a new five-year estates strategy, with sustainability one of the core considerations. The sustainability team are liaising closely with the neighbouring acute Trusts to identify the most appropriate long-term solution for our inpatient sites.

At the Airedale Centre for Mental Health this involves the New Hospital Programme and at Lynfield Mount Hospital, the team are assessing options to join the Bradford Heat Network, collaborate with Bradford Teaching Hospital NHS Foundation Trust on geothermal heating and obtaining green hydrogen from the Bradford Low Carbon Hydrogen project. In the short term, end-of-life boilers are being replaced with more efficient gas boilers which will provide back-up heat to a future low carbon solution.

Onsite energy generation

At Lynfield Mount Hospital 38,543kWh (3% of site electricity needs) and at Airedale Centre for Mental Health 64051kWh (20% of site electricity) was generated in 25-26. Solar generation will reduce in 26-27 due to the demolition of bungalows on Lynfield Mount Site, as enabling works for the redevelopment. However, the new building will have some solar generation capacity from 2027-28.

Fleet and Taxis

The Trust has more electric and hybrid vehicles than previous years, with a small reduction in diesel and petrol consumption compared to 2024-25.

The Trust trialled a digital platform to enable fleet to be shared amongst Estates teams. The aim is to reduce mileage claims and switch travel to 'cleaner' vehicles to reduce carbon however the trial has been discontinued, while alternative solutions with improved functionality are sourced.

However, a new taxi booking system is showing promising results with an expectation for a reduction in service user and staff journeys. Further analysis and engagement with teams in 2026 will help to reduce this further.

Display Energy Certificate Performance

The Trust has six properties over 1,000m² requiring annual Display Energy Certificate (DECs). A performance rating of 100 (grade D) is typical performance compared with other buildings of the same type and use. All six have either a C or D rating. Other buildings which require a DEC (albeit less frequently), are also grade D.

Waste and Resources

The weight of clinical waste produced increased by 14% (over 3,400 tonnes) compared to the previous year however this was predominantly as a result of supporting a service user in their own home and clinical teams moving from non-Trust to Trust sites. At Lynfield Mount Hospital, the Trust generated more than 50% non-infectious waste, with Airedale Centre for Mental Health generating 94% non-infectious waste (compared with a national target of 60%). This means our inpatient wards have made significant improvements in the correct segregation of clinical wastes, and reducing the production of infectious waste as required by NHS England.

The Trust recycling rate reduced by 1% compared to the previous year, and there has been a 15% increase in waste volumes. Work will continue to reduce, reuse and recycle our waste and understand what is driving the increase in quantity.

In 2025-2026 the Trust implemented food waste collections at all sites to meet government regulations. This has increased our food waste arisings but has contributed to the reduction in general waste arisings.

The Trust Admin team continued to reuse surplus uniform, and it has now been expanded to more professions. In 2025, spend on uniform reduced by nearly £5,000 saving more than 3t/CO² which is the equivalent of three return flights from Leeds-Bradford airport to Kos.

Clean Air

We continue to action the Clean Air Hospital Framework by monitoring fleet miles and vehicle types and communicating with suppliers about their impact. The sustainability team are also working with Bradford Council to consider how to provide air pollution data and advice to service users to support public health.

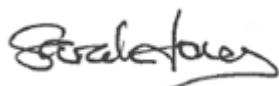
Biodiversity and Green therapy

The green therapy programme expanded in 2025 through a project with Bradford District and Craven Mind: Nature in Mind. This has enabled more people with a serious mental illness in Bradford to have the opportunity to participate in green therapy. We continue to have strong partnerships with Natural England and local organisations, which has led to a national reputation for good practice in this area. This culminated in our Head of Allied Health Professions being featured on a 'Gardeners World' podcast.

In 2026-27 the Trust welcomes a Nature Recovery Ranger, one of nine rangers at Trusts throughout England employed by the Centre for Sustainable Healthcare. The rangers' role will be to support green therapy opportunities but also provide opportunities for staff to access nature and help nature thrive on our sites.

Lynfield Mount Redevelopment

Sustainability is embedded in the Lynfield Mount Hospital redevelopment contract and building specification through the BREEAM environmental accreditation and completion of the NHS Net Zero Building Standard. In addition, Biodiversity Net Gain is not mandatory on this project but the Trust is striving to improve the outside space across the site.



.....
Date: 25 June 2026
Sarah Jones
Chair in Common



.....
Date: 25 June 2026
Therese Patten
Chief Executive

13. Annual Accounts – Summary of Financial Statements

Bradford District Care NHS Foundation Trust

Annual accounts for the year ended 31 March 2026

Foreword to the accounts

Bradford District Care NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Bradford District Care NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

A handwritten signature in black ink, appearing to read 'Therese Patten', with a long horizontal line extending from the end of the signature.

.....
Date: 25 June 2026
Therese Patten
Chief Executive

Statement of Comprehensive Income

		2025/26	2024/25
	Note	£000	£000
Operating income from patient care activities	3.1	245,626	220,320
Other operating income	4	10,678	12,934
Operating expenses	5,7	(256,895)	(242,326)
Operating surplus/(deficit) from continuing operations		(591)	(9,072)
Finance income	9	1,038	1,457
Finance expenses	10.1	(266)	(128)
PDC dividends payable		(957)	(831)
Net finance costs		(185)	498
Surplus / (deficit) for the year		(776)	(8,574)
Impairments charged to statement of comprehensive income	5	2,823	8,890
Surplus for the year before impairment accounted for through statement of comprehensive income		2,047	316
Technical adjustment for reporting the movement in PFI revenue costs on a IFRS 16 basis versus a UK GAAP basis		(26)	(137)
Adjusted financial performance surplus/(deficit) for the year		2,021	179

Statement of Financial Position

		31 March 2026 £000	31 March 2025 £000
	Note		
Non-current assets			
Property, plant and equipment	13	50,924	48,159
Right of use assets	16	8,746	7,025
Receivables	18	44	45
Total non-current assets		59,714	55,229
Current assets			
Inventories	17	130	120
Receivables	18	7,834	6,495
Cash and cash equivalents	19	22,800	18,392
Total current assets		30,764	25,007
Current liabilities			
Trade and other payables	20	(21,876)	(21,193)
Borrowings	21	(2,878)	(2,510)
Provisions	22	(1,900)	(1,403)
Total current liabilities		(26,654)	(25,106)
Total assets less current liabilities		63,824	55,130
Non-current liabilities			
Borrowings	21	(6,128)	(4,742)
Provisions	22	(528)	(560)
Total non-current liabilities		(6,656)	(5,302)
Total assets employed		57,168	49,828
Financed by			
Public dividend capital		49,399	40,562
Revaluation reserve		2,578	6,557
Other reserves		10,196	10,196
Income and expenditure reserve		(5,005)	(7,487)
Total taxpayers' equity		57,168	49,828

The accompanying notes form part of these financial statements.



.....
Date: 25 June 2026

Therese Patten

Chief Executive

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2026

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2025 - brought forward	40,562	6,557	10,196	(7,487)	49,828
Surplus/(deficit) for the year	-	-	-	(776)	(776)
Impairments	-	(1,204)	-	-	(1,204)
Revaluations	-	483	-	-	483
Public dividend capital received	8,837	-	-	-	8,837
Other reserve movements	-	(3,258)	-	3,258	-
Taxpayers' equity at 31 March 2026	49,399	2,578	10,196	(5,005)	57,168

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2025

	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	Total
	£000	£000	£000	£000	£000
Taxpayers' equity at 1 April 2024 - brought forward	38,273	6,757	10,196	1,087	56,313
Surplus/(deficit) for the year	-	-	-	(8,574)	(8,574)
Impairments	-	(380)	-	-	(380)
Revaluations	-	180	-	-	180
Public dividend capital received	2,289	-	-	-	2,289
Taxpayers' equity at 31 March 2025	40,562	6,557	10,196	(7,487)	49,828

Information on reserves.

Public Dividend Capital

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

Revaluation reserve

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

Financial assets reserve

This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevocable election at recognition.

Other reserves

Other reserves of £10.196 million represent the value of assets from the former Bradford Community Health NHS Trust (which dissolved and became Bradford District Care NHS Foundation Trust). The assets were excluded from the initial PDC for the Trust and therefore need to be shown as 'Other reserves'.

Income and expenditure reserve

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

Statement of Cash Flows

	Note	2025/26 £000	2024/25 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(591)	(9,072)
Non-cash income and expense:			
Depreciation and amortisation	5	6,399	6,418
Net impairments	6	2,823	8,890
(Increase) / decrease in receivables and other assets		(1,314)	1,267
(Increase) / decrease in inventories		(10)	(32)
Increase / (decrease) in payables and other liabilities		1,263	824
Increase / (decrease) in provisions		465	792
Net cash flows from / (used in) operating activities		9,035	9,087
Cash flows from investing activities			
Interest received		1,038	1,457
Purchase of PPE and investment property		(10,163)	(11,084)
Net cash flows from / (used in) investing activities		(9,125)	(9,627)
Cash flows from financing activities			
Public dividend capital received		8,837	2,289
Capital element of lease rental payments		(3,258)	(3,148)
Capital element of PFI, LIFT and other service concession payments		(96)	(381)
Interest paid on PFI, LIFT and other service concession obligations		(4)	(18)
PDC dividend (paid) / refunded		(981)	(968)
Net cash flows from / (used in) financing activities		4,498	(2,226)
Increase / (decrease) in cash and cash equivalents		4,408	(2,766)
Cash and cash equivalents at 1 April - brought forward		18,392	21,158
Cash and cash equivalents at 31 March	19	22,800	18,392

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the 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.

Accounting convention

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

Note 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.

The Trust has delivered the agreed forecast for 2025/26, reporting an adjusted surplus of £2.021m. Through the financial statements and financial performance indicators, the Trust can demonstrate strong financial management and a clear understanding of its underlying financial position. The Trust's liquidity remains very strong with £22.8m cash balances at the year-end.

After consideration of the funding agreed through 2026/27 commissioning contracts, including investment in Mental Health services and the risk assessment of the efficiency programme, the Directors have a reasonable expectation that the NHS Foundation Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, these accounts have been prepared on a going concern basis.

Note 1.3 Interests in other entities

The Trust does not hold any interest in other entities, associates, joint ventures or joint operations.

From 2013/14 NHS Trusts were required to consolidate the results of Charitable Funds over which they considered they had the power to exercise control in accordance with International Accounting Standards (IAS) 27 requirements. The Trust is not required to consolidate as the value of the Bradford District Care Foundation Trust Charitable Fund is not material. The closing balance of the Charitable Fund at 31st March 2026 was £350k (£332k at 31st March 2025).

The Trust is the Corporate Trustee of the Charity and is governed by the law applicable to Trusts, principally the Trustee Act 2000 and the Charities Act 2011, as amended by the Charities Act 2022. The Trust Board of Directors has devolved responsibility for the ongoing management of the funds to the Charitable Funds Committee, which administers the funds on behalf of the Corporate Trustees.

Note 1.4 Revenue from contracts with customers

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

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

The timing of the satisfaction of performance obligations relates to the typical timing of payment (i.e. credit terms). Due to the nature of the Trust's block contract arrangement with commissioners, there is no impact to revenue recognition under IFRS 15.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the 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 trusts for NHS-funded secondary healthcare.

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.

Mental health provider collaboratives

NHS led provider collaboratives for specialised mental health, learning disability and autism services involve a lead NHS provider taking responsibility for managing services, care pathways and specialised commissioning budgets for a population. BDCFT do not act as lead provider for NHS England commissioned services, however, are party to the agreements with West Yorkshire lead providers. The provider collaboratives in place during 2025/26 include Adult Secure Services, Adult Eating Disorders, Children and Young People inpatient services and Perinatal services.

Other lead provider contracts

NHS led provider contracts for specialist community dental services involves a lead NHS provider taking responsibility for managing services, care pathways and commissioning budgets for a population. As lead provider Bradford District Care NHS Foundation Trust is accountable to NHS West Yorkshire ICB and as such recognises the income and expenditure associated with the commissioning of services in these accounts. The lead provider arrangement commenced in 2025/26.

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 Trust's interim performance does not create an asset with alternative use for the Trust, and the 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 Trust recognises revenue each year over the course of the contract.

Note 1.5 Other forms of income

Grants and donations

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

to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the 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.

Note 1.6 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 financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the 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 scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the 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 and when they become due.

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

Note 1.7 Expenditure on other goods and services

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

Note 1.8 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 trust
- it is expected to be used for more than one financial year
- the cost of the item can be measured reliably
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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 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 are determined as follows:

- Land and non-specialised buildings – market value for existing use
- Specialised buildings – depreciated replacement cost on a modern equivalent asset basis.

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the 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 and, where capitalised in accordance with IAS 23, borrowings costs. 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.

Depreciation

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

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

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 and grant funded assets

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

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

Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

PFI and LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position' by the trust. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16 (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the PFI liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to PFI and LIFT liabilities in 2023/24

IFRS 16 liability measurement principles were applied to PFI, LIFT and other service concession arrangement liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

The Trust had one PFI scheme that was included on the Statement of Financial Position relating to the Horton Park Centre. The Horton Park lease was in operation from 2000/01 and was for a period of 25 years, and ended in June 2025. The lease included a unitary payment for the provision of building maintenance, facilities management, services and insurance. The building did not transfer to the Trust at the end of the contract term.

The property was treated as an asset of the Trust and was subject to revaluations and depreciation in accordance with Trust policies. Horton Park was accounted for under the IFRIC12 arrangements and initially fell into the IFRS 16 measurement principles to PFI liabilities.

As the Trust's PFI scheme was nearing the end of the contract and the liability was not material, the application of IFRS 16 measurement principles to PFI liabilities was not adopted. For those NHS organisations who chose this route, there was still a requirement to continue to report under the existing IFRIC 12 arrangements, ensuring the accounts still reflect the remaining liability.

Note 25 of the annual accounts reflects the position for Horton Park, in relation to the unitary payment, liability and future obligations

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 are shown in the table below:

	Min life Years	Max life Years
Buildings, excluding dwellings	5	49
Plant & machinery	5	20
Transport equipment	7	10
Information technology	2	5
Furniture & fittings	1	7

Note 1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the 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 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 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.

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 over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives of intangible assets

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

	Min life Years	Max life Years
Information technology	5	5
Software licences	2	2

Note 1.10 Inventories

Inventories are valued at the lower of cost and net realisable value. The cost of inventories is measured using the first in, first out (FIFO) method. This is considered to be a reasonable approximation of the fair value due to the low levels and turnover of stocks.

Note 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 Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Cash balances exclude monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts. Note 19 provides additional detail.

Note 1.12 Financial assets and financial liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and 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 or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets and liabilities are classified and subsequently measured at amortised cost, through income and expenditure.

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.

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The 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).

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.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 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 trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Recognition and initial measurement

At the commencement date of the lease, being when the asset is made available for use, the 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 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 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 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 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 Trust as a lessor

The 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 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

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the 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.

Note 1.14 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rates effective from 31 March 2026:

		Nominal rate	Prior year rate
Short-term	Up to 5 years	3.64%	4.03%
Medium-term	After 5 years up to 10 years	4.22%	4.07%
Long-term	After 10 years up to 40 years	5.32%	4.81%
Very long-term	Exceeding 40 years	5.07%	4.55%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective from 31 March 2026:

	Inflation rate	Prior year rate
Year 1	2.5%	2.60%
Year 2	2.0%	2.30%
Into perpetuity	2.0%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at Note 22.1 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to 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.

Note 1.15 Contingencies

Contingent assets (that is, 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 23 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 23.

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.

Note 1.16 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. 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 trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the 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 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 by the Department of Health and Social Care.

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 Department of Health and Social Care (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 of the audit of the annual accounts.

Note 1.17 Value added tax

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

Note 1.18 Corporation tax

The Trust is not within the scope of Corporation Tax.

Note 1.19 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption. The Trust incurred costs on the climate levy of £16.5k in 2025/26.

Note 1.20 Foreign exchange

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

Where the trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:

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

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

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

Note 1.21 Third party assets

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

Note 1.22 Losses and special payments

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

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

Note 1.23 Gifts

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

The Trust has received no gifts exceeding £300,000 in 2025/26.

Note 1.24 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.25 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.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – 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 £37.6m 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 all 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 £35.3m at 31 March 2026. The impact of this change may be material, but this can not currently be quantified.

Note 1.26 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. These estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates as the estimates and underlying assumptions

are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised.

The following is an assumption 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:

Valuation of land and buildings

The asset valuation exercise was carried out in March 2026 with a valuation date of 31 March 2026. The valuation has been prepared in accordance with the Royal Institute of Chartered Surveyors (RICS) Valuation – Global Standards, which incorporate the International Valuation Standards (“IVS”) and the RICS UK National Supplement (the “RICS Red Book”), edition current at the Valuation Date. It follows that the valuation is compliant with IVS.

IFRS16

Leases have been reviewed in line with IFRS16 to determine whether the Trust has a right of use asset. Note 1.13 describes how the Trust determines the lease term of a right of use asset with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise. In determining the lease term to apply in relation to IFRS16, the Trust has reviewed the future planned service delivery for the purpose of calculating of borrowings and the Right of Use valuation. The Right of Use valuation is disclosed in note 16.1.

Note 2 Operating Segments

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

A significant Segment is one which:

- Represents 10% or more of the income or expenditure of the entity; or
- Has a surplus or deficit which is 10% or more of the greater, in absolute amount, of the combined surplus of all Segments reporting a surplus, or the combined deficit of all Segments reporting a deficit; or
- Has assets of 10% or more of the combined assets of all Operating Segments.

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

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

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.

Note 3.1 Income from patient care activities (by nature)	2025/26	2024/25
	£000	£000
Mental health services		
Income from commissioners under API contracts* ¹	134,722	128,902
Services delivered under a mental health collaborative	7,958	7,738
Other clinical income from mandatory services ²	2,428	3,896
Community services		
Income from commissioners under API contracts* ¹	56,798	49,703
Income from other sources (e.g. local authorities) ³	32,648	19,503
All services		
National pay award central funding**	-	83
Additional pension contribution central funding***	11,072	10,495
Total income from activities	245,626	220,320

*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 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**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.

***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.

¹ The main source of movement of £12.9m for API contracts relates to:

- Annual net tariff uplift of £4.6m for 2025/26, of which the majority relates to funding of the consolidated pay inflation;
- Additional investment which has been made in line with the Mental Health Investment Standard of £1.8m;
- Other developments of £1.1m from our main commissioner NHS West Yorkshire Integrated Care Board (WY ICB);
- Additional surge income for Mental Health inpatient demand was received during 2025/26 of £5.3m."

² The reduction on other clinical income from mandatory services of £1.5m is mainly due to due to a transfer of funding from Better Start Bradford to NHS West Yorkshire ICB of £0.8m, non recurrent income of £0.5m for Najurally Centre in 2024/25 and a reduction in Speech and Language income from schools of £0.2m.

³ The increase in the 'income from other sources' relates mainly to the new lead provider agreement for the Trust which commenced on 1st April 2025, where the Trust is now the host for the Community Dental Services lead provider contract. This new arrangement involves sub contracting with other providers who previously directly contracted with the NHS West Yorkshire Integrated Care Board and has resulted in additional gross income of £11.5m for the Trust which is related to other providers; and £1.3m relates to funding for inflationary uplift, running costs and additional development funding.

Note 3.2 Income from patient care activities (by source)

	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England ¹	12,077	11,509
Integrated care boards ²	208,149	182,503
Other NHS providers ³	9,674	9,946
Local authorities	14,099	13,960
Non-NHS: overseas patients (chargeable to patient)	57	18
Non NHS: other ⁴	1,570	2,384
Total income from activities	245,626	220,320
Of which:		
Related to continuing operations	245,626	220,320

¹ Income from NHS England includes funding to cover the increase in cost of employers contributions to the NHS Pension Scheme, with the increase in funding reflecting the centrally funded contribution rate increase in 2024/25 to 2025/26.

² The main increase in Integrated Care Board income relates to net inflation uplift of £4.8m, other investments of £1.1m, Mental Health Investment Standard of £1.8m, additional surge income for Mental Health inpatient demand was received during 2025/26 of £5.3m and the new lead provider arrangements for Community Dental Services of £11.5m for other providers and £1.3m for the Trust.

³ Other NHS providers includes West Yorkshire Provider Collaborative arrangements.

⁴ Non NHS other income has decreased due to a transfer of funding from Better Start Bradford to NHS West Yorkshire ICB of £0.8m.

Note 3.3 Overseas visitors (relating to patients charged directly by the prov

	2025/26	2024/25
	£000	£000
Income recognised this year	57	18
Cash payments received in-year	57	18

Note 4 Other operating income

	2025/26			2024/25		
	Contract	Non-contract	Total	Contract	Non-contract	Total
	income	income		income	income	
	£000	£000	£000	£000	£000	£000
Research and development ¹	895	-	895	1,194	-	1,194
Education and training	5,209	563	5,772	4,791	557	5,348
Non-patient care services to other bodies ²	2,912		2,912	5,162		5,162
Other income	1,099	-	1,099	1,230	-	1,230
Total other operating income	10,115	563	10,678	12,377	557	12,934
Of which:						
Related to continuing operations			10,678			12,934

¹Research & Development income has reduced by £0.3m due to the Diamonds research project ending.

² Non patient care income movement is due to one off income received in 2024/25.

Note 4.1 Profits and losses on disposal of property, plant and equipment

The Trust had no asset disposals during 2025/26.

Note 5 Operating expenses

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies ¹	11,064	4,687
Purchase of healthcare from non-NHS and non-DHSC bodies ¹	17,209	15,148
Staff and executive directors costs ²	192,599	180,953
Research and development - staff costs ²	745	667
Remuneration of non-executive directors	149	139
Supplies and services - clinical (excluding drugs costs)	6,467	6,475
Supplies and services - general	1,712	1,460
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	1,581	1,462
Inventories written down	(10)	-
Consultancy costs	528	533
Establishment	3,116	3,147
Premises ³	7,701	6,746
Transport (including patient travel)	911	755
Depreciation on property, plant and equipment	6,399	6,418
Net impairments	2,823	8,890
Movement in credit loss allowance: all other receivables and investments	66	83
Change in provisions discount rate(s)	(30)	19
Fees payable to the external auditor		
audit services- statutory audit	209	182
Internal audit costs	110	116
Clinical negligence	778	803
Legal fees	224	78
Insurance (as a policy holder)	247	267
Research and development - non staff	360	763
Education and training	1,397	1,436
Expenditure on short term leases	-	5
Variable lease payments not included in the liability	3	3
Redundancy ²	55	145
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	148	559
Hospitality	2	3
Losses, ex gratia & special payments	45	40
Other	287	344
Total	256,895	242,326
Of which:		
Related to continuing operations	256,895	242,326

Notes:

¹ Purchase of Healthcare from NHS and Non-NHS reflects the change in costs for the new lead provider arrangements for the West Yorkshire Community Dental Service that commenced in 2025/26. Additional income received for the lead provider contract is shown in note 3.

² Total Staff costs amount to £193.4m an explanation of headline changes is provided at Note 7 Employee benefits.

³ Premises costs have increased reflective of digital infrastructure investment of £0.4m; increase in reactive maintenance costs of £0.2m and additional computer licence costs associated with staff increases of £0.3m.

Note 5.1 Other auditor remuneration

There is no other auditor remuneration paid to the external auditors during 2025/26 (2024/25: nil).

Note 5.2 Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £1,000k (2024/25: £1,000k).

Note 6 Impairment of assets

	2025/26	2024/25
	£000	£000
Net impairments charged to operating surplus / deficit resulting		
Changes in market price	2,823	8,890
Total net impairments charged to operating surplus / deficit	2,823	8,890
Impairments charged to the revaluation reserve	1,204	380
Total net impairments	4,027	9,270

Accounting policy 1.8 provides reference to the accounting treatment of impairment to assets within the financial statements. The table below illustrates the key impacts on asset values arising from impairments following the 2025/26 revaluation exercise:

Property, Plant & Equipment	Impairments	Reversal of Previous Impairments	Total
	£000	£000	£000
<u>Buildings excluding dwellings:</u>			
Lynfield Mount Hospital - Whole site	582	(783)	(201)
New Mill, Saltaire	970	-	970
Airedale Centre for Mental Health	951	-	951
Others	97	-	97
<u>Land</u>			
Lynfield Mount Hospital - Whole site	1,220	-	1,220
Airedale Centre for Mental Health	40	-	40
Horton Park	640	-	640
Others	310	-	310
Total	4,810	(783)	4,027

Note 7 Employee benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages ¹	142,739	136,138
Social security costs	17,893	13,692
Apprenticeship levy ²	672	647
Employer's contributions to NHS pensions	27,938	26,436
Temporary staff (including agency) ³	5,189	6,041
Total staff costs	194,431	182,954
Less: Costs capitalised as part of assets	1,032	1,189
Total staffing costs in Operating Expenditure - note 5	193,399	181,765

¹The Trust salaries and wages costs include £500k relating to permanent staff who are on secondment to other external organisations (£734k in 2024/25).

¹Salaries and wages costs have increased by £4.9m reflective of the pay settlement for 2025/26. In addition, recruitment to substantive posts previously covered by temporary staffing and additional staffing for funded service growth has seen costs increase by c£1m.

² The Apprenticeship Levy scheme was introduced by the UK Government on 6 April 2017 and requires all employers operating in the UK with an annual paybill of more than £3 million to invest in apprenticeships via the Levy. The levy represents 0.5% of the Trust's total pay bill.

³ Temporary staff costs have reduced aligned to targeted recruitment activity for nursing and medical staff.

Note 7.1 Average Number of Employees

	2025/26	2024/25
	WTE	WTE
Medical and dental	125	151
Administration and estates	860	951
Healthcare assistants and other support staff	641	863
Nursing, midwifery and health visiting staff	1,154	1,269
Scientific, therapeutic and technical staff	704	787
Total	3,483	4,020
Of which:		
Number of employees engaged on capital projects	19	43

Note 7.2 Retirements due to ill-health

During 2025/26 there were 7 early retirements from the trust agreed on the grounds of ill-health (4 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £636k (£475k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 8 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.

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 at 31 March 2023, 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 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of 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 cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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

From July 2013, the Trust offers an alternative pension scheme to all employees who are not eligible to be members of the NHS pension scheme. This includes employees who are members of the NHS pension scheme through another role outside of the Trust and those that are not eligible to join the NHS pension scheme.

The auto-enrolment was carried out in July 2016. Every three years all eligible employees are auto-enrolled in either the NHS or alternative pension scheme. The auto-enrolment exercise was carried out in July 2019, July 2022, and in July 2025, following this process, all employees who meet the criteria for the alternative pension scheme are enrolled each month on a continuous basis, unless they specifically opt out. The next auto enrolment takes place in July 2028.

The alternative pension scheme is a defined contribution scheme operated by the National Employment Savings Trust (NEST). Employee and employer contribution rates are a combined rate of 8% (with a minimum 3% being contributed by the Trust).

In the period to 31 March 2026, the Trust made contributions totalling £47,178 into the NEST fund (£63,223 in 2024/25).

Note 9 Finance income

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

	2025/26	2024/25
	£000	£000
Interest on bank accounts	1,038	1,457
Total finance income	1,038	1,457

Note 10.1 Finance expenditure

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

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on lease obligations	262	110
Finance costs on PFI, LIFT and other service concession arrangements:		
Main finance costs	4	18
Total finance costs	266	128

Note 10.2 The late payment of commercial debts (interest) Act 1998

The Trust incurred no interest or other payments relating to the late payment of commercial debts.

Note 11 Other gains / (losses)

There were no disposal of assets in 2025/26.

Note 12 Intangible assets

The Trust has no intangible assets in 2025/26 (none in 2024/25).

Note 13.1 Property, plant and equipment - 2025/26

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation/gross cost at 1 April 2025 - brought forward	4,636	34,691	2,145	2,734	415	26,881	1,864	73,366
Additions	-	2,862	4,094	929	-	1,691	7	9,583
Impairments	(2,210)	(2,601)	-	-	-	-	-	(4,811)
Reversals of impairments	-	784	-	-	-	-	-	784
Revaluations	-	(562)	-	-	-	-	-	(562)
Valuation/gross cost at 31 March 2026	2,426	35,174	6,239	3,663	415	28,572	1,871	78,360
Accumulated depreciation at 1 April 2025 - brought forward	-	-	-	1,972	301	21,168	1,766	25,207
Provided during the year	-	1,045	-	195	13	1,988	33	3,274
Revaluations	-	(1,045)	-	-	-	-	-	(1,045)
Accumulated depreciation at 31 March 2026	-	-	-	2,167	314	23,156	1,799	27,436
Net book value at 31 March 2026	2,426	35,174	6,239	1,496	101	5,416	72	50,924
Net book value at 1 April 2025	4,636	34,691	2,145	762	114	5,713	98	48,159

Note 13.2 Property, plant and equipment - 2024/25

	Land £000	Buildings excluding dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	5,041	34,887	2,323	2,690	350	25,021	1,846	72,158
Additions	-	7,358	2,145	44	65	1,860	18	11,490
Impairments	(455)	(8,945)	-	-	-	-	-	(9,400)
Reversals of impairments	-	130	-	-	-	-	-	130
Revaluations	50	(1,062)	-	-	-	-	-	(1,012)
Reclassifications	-	2,323	(2,323)	-	-	-	-	-
Valuation/gross cost at 31 March 2025	4,636	34,691	2,145	2,734	415	26,881	1,864	73,366
Accumulated depreciation at 1 April 2024 - as previously stated	-	-	-	1,766	295	19,279	1,702	23,042
Provided during the year	-	1,192	-	206	6	1,889	64	3,357
Revaluations	-	(1,192)	-	-	-	-	-	(1,192)
Accumulated depreciation at 31 March 2025	-	-	-	1,972	301	21,168	1,766	25,207
Net book value at 31 March 2025	4,636	34,691	2,145	762	114	5,713	98	48,159
Net book value at 1 April 2024	5,041	34,887	2,323	924	55	5,742	144	49,116

Note 13.3 Property, plant and equipment financing - 31 March 2026

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	2,426	35,174	6,239	1,496	101	5,416	72	50,924
Total net book value at 31 March 2026	2,426	35,174	6,239	1,496	101	5,416	72	50,924

Note 13.4 Property, plant and equipment financing - 31 March 2025

	Land	Buildings excluding dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	3,996	34,617	2,145	762	114	5,713	98	47,445
On-SoFP PFI contracts and other service concession arrangements	640	74	-	-	-	-	-	714
Total net book value at 31 March 2025	4,636	34,691	2,145	762	114	5,713	98	48,159

Note 14 Donations of property, plant and equipment

The Trust has not received any donated property, plant or equipment during the year.

Note 15 Revaluations of property, plant and equipment

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

In 2016/17 the Trust moved to an alternative asset valuation method, informed by an external property advisors and valuers, Cushman & Wakefield. This involved a review of all land and buildings (at component level) in the Trusts portfolio, including the remaining economic life of each asset. The revaluation exercise is performed annually.

Cushman & Wakefield have sufficient current knowledge of the relevant markets, and have the skills and understanding to undertake the valuation competently. As partners, Cushman & Wakefield has overall responsibility for the valuation. They are in a position to provide an objective and unbiased valuation and are competent to undertake the valuation and have undertaken the valuation acting as an External Valuer, as defined in the RICS Red Book.

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

During 2025/26 a comprehensive and full valuation was undertaken by Cushman & Wakefield, an independent RICS valuer, in accordance with RICS guidance. This provided asset valuations effective as at 31st March 2026. Key impacts arising from the revaluation are summarised in the following table and generate a net aggregate decrease of £2.903m; of which £0.081m was charged to the Revaluation Reserve, and £2.823m was charged to the Statement of Comprehensive Income.

There is no change to the accounting policy for specialised assets as depreciated replacement cost (DRC) valuations based on modern equivalent assets, and the Trust's application of the policy in the 2025/26 accounts is consistent with that used in 2024/25.

	TOTAL	Charged to Statement of Comprehensive Income	Charged to Revaluation Reserve
Asset Revaluation Exercise	March 2026	March 2026	March 2026
	£000	£000	£000
<u>Buildings excluding dwellings:</u>			
Airedale Centre for Mental Health	(893)	(951)	58
Lynfield Mount Hospital - Whole site	602	427	175
New Mill, Saltaire	(970)	(970)	-
Others	(72)	(63)	(9)
<u>Land</u>			
Airedale Centre for Mental Health	(40)	-	(40)
Lynfield Mount Hospital - Whole site	(1,220)	(1,220)	-
New Mill, Saltaire	-	-	-
Others	(310)	(45)	(265)
SUBTOTAL (Impairment) / Valuation Increase	<u>(2,903)</u>	<u>(2,823)</u>	<u>(81)</u>
Comprising:			
Impairment charged to I&E	(2,823)		
Impairment to Revaluation Reserve	(81)		
TOTAL (Impairment) / Valuation Increase	<u>(2,903)</u>		

Revaluation Reserve

The Trust's Revaluation Reserve decreased by £3.978m during 2025/26, mainly as a result of the expiration of the Trust's PFI Lease at Horton Park and the March 2026 asset revaluation exercise. The movements in the Revaluation Reserve are shown in the table below:

	£000
Revaluation Reserve 01/04/2025	6,557
Expiration of Horton Park PFI Lease - Impairment of Land Value to Nil	(640)
Expiration of Horton Park PFI Lease - Transfer Remaining Revaluation Reserve to I&E Reserve	(3,258)
Asset Revaluation 31/03/2026 - Impairments	(564)
Asset Revaluation 31/03/2026 - Increases	483
Revaluation Reserve 31/03/2026	<u>2,578</u>

Note 16 Leases - Bradford District Care NHS Foundation Trust as a lessee

This note details information about leases for which the Trust is a lessee.

The Trust has a number of leases which are accounted for under IFRS16. These leases relate to Properties and Trust vehicles (vehicles leased for employees' personal use under Salary Sacrifice or Salary Deduction schemes are excluded).

The Property leases summarised below include leases with NHS Property Services, Community Health Partnerships and commercial landlords.

Note 16.1 Right of use assets - 2025/26

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	15,566	479	16,045	13,191
Additions	5,126	44	5,170	593
Remeasurements of the lease liability	(184)	(56)	(240)	(191)
Disposals / derecognition	(84)	-	(84)	-
Valuation/gross cost at 31 March 2026	20,424	467	20,891	13,593
Accumulated depreciation at 1 April 2025 - brought forward	8,762	258	9,020	7,083
Provided during the year	2,993	132	3,125	2,146
Accumulated depreciation at 31 March 2026	11,755	390	12,145	9,229
Net book value at 31 March 2026	8,669	77	8,746	4,364
Net book value at 1 April 2025	6,804	221	7,025	6,108
Net book value of right of use assets leased from other DHSC group bodies				4,364

Note 16.2 Right of use assets - 2024/25

	Property (land and buildings)	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	16,144	384	16,528	13,686
Additions	-	112	112	-
Remeasurements of the lease liability	312	-	312	292
Disposals / derecognition	(890)	(17)	(907)	(787)
Valuation/gross cost at 31 March 2025	15,566	479	16,045	13,191
Accumulated depreciation at 1 April 2024 - brought forward	5,835	124	5,959	4,656
Provided during the year	2,927	134	3,061	2,427
Accumulated depreciation at 31 March 2025	8,762	258	9,020	7,083
Net book value at 31 March 2025	6,804	221	7,025	6,108
Net book value at 1 April 2024	10,309	260	10,569	9,030
Net book value of right of use assets leased from other DHSC group bodies				6,108

Note 16.3 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 21.

	2025/26	2024/25
	£000	£000
Carrying value at 1 April	7,156	10,677
Lease additions	5,170	112
Lease liability remeasurements	(240)	312
Interest charge arising in year	262	110
Early terminations	(84)	(907)
Lease payments (cash outflows)	(3,258)	(3,148)
Carrying value at 31 March	9,006	7,156

¹ In accordance with note 1.13 of our accounting policies, The Trust has remeasured the liability for its IFRS 16 leases, based on revised lease payments and with effect from 1st April 2025. This resulted in a total decrease to lease liabilities of £0.24m. Of this, £0.191m relates to leases with NHS Property Services and Community Health Partnerships. The remaining £0.049m relates to leases with commercial landlords.

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 5. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 16.4 Maturity analysis of future lease payments

	Of which leased from DHSC group		Of which leased from DHSC group	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,878	2,074	2,414	1,980
- later than one year and not later than five years;	4,311	2,403	4,742	4,217
- later than five years.	1,817	-	-	-
Net lease liabilities at 31 March 2026	9,006	4,477	7,156	6,197
Of which:				
Leased from other DHSC group bodies		4,477		6,197

Note 17 Inventories

	31 March 2026 £000	31 March 2025 £000
Drugs	120	110
Energy	10	10
Total inventories	130	120
of which:		
Held at fair value less costs to sell	-	-

Inventories recognised in expenses for the year were £0k (2024/25: £0k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £0k).

Note 18.1 Receivables

	31 March 2026 £000	31 March 2025 £000
Current		
Contract receivables	6,098	4,316
Allowance for other impaired receivables	(265)	(199)
Prepayments (non-PFI)	1,510	1,496
PDC dividend receivable	43	19
VAT receivable	309	745
Other receivables	139	118
Total current receivables	7,834	6,495
Non-current		
Other receivables	44	45
Total non-current receivables	44	45
Of which receivable from NHS and DHSC group bodies:		
Current	4,428	2,550
Non-current	44	45

Note 18.2 Allowances for credit losses

	2025/26	2024/25
	All other receivables £000	All other receivables £000
Allowances as at 1 April - brought forward	199	116
New allowances arising	29	54
Changes in existing allowances	37	29
Allowances as at 31 Mar 2026	265	199

Note 18.3 Exposure to credit risk

The Trust receives the majority of its income from Integrated Care Boards (ICBs), Local Authority, NHS England and statutory bodies and therefore the credit risk is negligible.

Note 19 Cash and cash equivalents movements

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

	2025/26	2024/25
	£000	£000
At 1 April	18,392	21,158
Net change in year	4,408	(2,766)
At 31 March	22,800	18,392
Broken down into:		
Cash at commercial banks and in hand	214	108
Cash with the Government Banking Service	22,586	18,284
Total cash and cash equivalents as in SoFP	22,800	18,392
Total cash and cash equivalents as in SoCF	22,800	18,392

Note 19.1 Third party assets held by the trust

Bradford District Care NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties and in which the trust has no beneficial interest. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2026	31 March 2025
	£000	£000
Bank balances	85	89
Total third party assets	85	89

Note 20 Trade and other payables

	31 March 2026	31 March 2025
	£000	£000
Current		
Trade payables	4,506	6,816
Capital payables	598	1,178
Accruals ¹	8,524	6,352
Receipts in advance and payments on account	949	101
Social security costs	2,082	1,644
Other taxes payable	1,860	1,682
Pension contributions payable	2,346	2,187
Other payables	1,011	1,233
Total current trade and other payables	21,876	21,193
Of which payables from NHS and DHSC group bodies:		
Current	2,015	1,516

¹ The movement in accruals relates to £1.4m for the new lead provider contract for West Yorkshire Community Dental Services; and £0.7m increase in the annual leave accrual.

Note 21 Borrowings

	31 March 2026 £000	31 March 2025 £000
Current		
Lease liabilities	2,878	2,414
Obligations under PFI, LIFT or other service concession contracts	-	96
Total current borrowings	2,878	2,510
Non-current		
Lease liabilities	6,128	4,742
Total non-current borrowings	6,128	4,742

Note 21.1 Reconciliation of liabilities arising from financing activities

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2025	7,156	96	7,252
Cash movements:			
Financing cash flows - payments and receipts of principal	(3,258)	(96)	(3,354)
Financing cash flows - payments of interest	-	(4)	(4)
Non-cash movements:			
Additions ¹	5,170	-	5,170
Lease liability remeasurements	(240)	-	(240)
Application of effective interest rate	262	4	266
Early terminations	(84)	-	(84)
Carrying value at 31 March 2026	9,006	-	9,006

¹ Of the £5.17m additions to Lease Liabilities, £3.75m related to the new IFRS16 lease for the Horton Park Centre (previously reported under PFI/LIFT schemes).

	Lease Liabilities £000	PFI and LIFT schemes £000	Total £000
Carrying value at 1 April 2024	10,677	477	11,154
Cash movements:			
Financing cash flows - payments and receipts of principal	(3,148)	(381)	(3,529)
Financing cash flows - payments of interest	-	(18)	(18)
Non-cash movements:			
Additions	112	-	112
Lease liability remeasurements	312	-	312
Application of effective interest rate	110	18	128
Early terminations	(907)	-	(907)
Carrying value at 31 March 2025	7,156	96	7,252

Note 22 Provisions for liabilities and charges analysis

	Pensions: injury benefits ¹	Legal claims ²	Redundancy ³	Other ⁴	Total
	£000	£000	£000	£000	£000
At 1 April 2025	567	97	641	658	1,963
Change in the discount rate	(30)	-	-	-	(30)
Arising during the year	53	36	1,079	684	1,852
Utilised during the year	(53)	-	(378)	(1)	(432)
Reversed unused	-	(50)	(263)	(612)	(925)
At 31 March 2026	537	83	1,079	729	2,428
Expected timing of cash flows:					
- not later than one year;	53	83	1,079	685	1,900
- later than one year and not later than five years;	212	-	-	3	215
- later than five years.	272	0	0	41	313
Total	537	83	1,079	729	2,428

¹ Injury Benefits provisions of £537k (previous year £567k) reflect an estimated liability for 4 individuals based on information provided by the NHS Pensions Agency. The discount rate used in the calculation of the above provisions changed during 2024/25, from 2.40% as at March 2025 to 2.95% as at March 2026.

² Provisions for legal claims shown above include employer's liability claims managed on the Trust's behalf by NHS Resolution equivalent to £83k (previous year £97k).

³ Redundancy provision of £638k relates to the provision associated with fixed term contracts, £303k relates to West Yorkshire Mental Health Hub, £77k for the restructure of the management and leadership roles within Children's Community Services and £60k relates to Corporate Services.

⁴ Other provisions relate to clinicians who are members of the NHS Pension Scheme and who, as a result of work undertaken in the tax year 2019/20 (only), face a tax charge in respect of growth in their NHS pension benefits above the annual allowance for pensions, and who will be eligible to have this charge paid by the NHS Pension Scheme. This is funded via NHS England, which can be seen by an equal and opposite entry within non-current receivables.

⁴ Other provisions also include employment related equal pay claims.

Note 22.1 Clinical negligence liabilities

At 31 March 2026, £5,040k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Bradford District Care NHS Foundation Trust (31 March 2025: £4,101k).

Note 23 Contingent assets and liabilities

	31 March 2026 £000	31 March 2025 £000
Value of contingent liabilities		
NHS Resolution legal claims	(31)	(39)
Net value of contingent liabilities	(31)	(39)

The Trust has no contingent assets in 2025/26 (£nil in 2024/25).

Note 24 Contractual capital commitments

	31 March 2026 £000	31 March 2025 £000
Property, plant and equipment	598	1,178
Total	598	1,178

Note 25 On-SoFP PFI, LIFT or other service concession arrangements

The Trust had one remaining PFI scheme that was included on the Statement of Financial Position in 2025/26, relating to the Horton Park Centre.

The Horton Park lease was in operation from 2000/01, and was for a period of 25 years until 2025/26. The lease included a unitary payment for the provision of building maintenance, facilities management, services and insurance. The lease officially expired in July 2025.

The property was treated as an asset of the Trust and was subject to revaluations and depreciation in accordance with Trust policies. At the conclusion of the PFI scheme in July 2025, a new lease came into effect for Horton Park. This lease is accounted for under IFRS16 along with the Trust's other property leases.

Note 25.1 On-SoFP PFI, LIFT or other service concession arrangement obligations

The following obligations in respect of the PFI, LIFT or other service concession arrangements are recognised in the statement of financial position:

	31 March 2026 £000	31 March 2025 £000
Gross PFI, LIFT or other service concession liabilities	-	100
Of which liabilities are due		
- not later than one year;	-	100
Finance charges allocated to future periods	-	(4)
Net PFI, LIFT or other service concession arrangement obligation	-	96
- not later than one year;	-	96

Note 25.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

Total future commitments under these on-SoFP schemes are as follows:

	31 March 2026 £000	31 March 2025 £000
Total future payments committed in respect of the PFI, LIFT or other service concession arrangements	-	240
Of which payments are due:		
- not later than one year;	-	240

Note 25.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2025/26 £000	2024/25 £000
Unitary payment payable to service concession operator	248	958
Consisting of:		
- Interest charge	4	18
- Repayment of balance sheet obligation	96	381
- Service element and other charges to operating expenditure	148	559
Total amount paid to service concession operator	248	958

Note 26 Financial instruments

Note 26.1 Financial risk management

IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The Trust actively seeks to minimise its financial risks. In line with this policy, the 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 Trust in undertaking its activities.

Credit risk

"The Trust receives the majority of its income from ICBs, Local Authority, NHS England, and statutory bodies therefore credit risk is negligible.

Surplus cash is generally held in a Government Banking Service (GBS) account. Dependant on interest rates, surplus cash balances may be invested with the National Loans Fund (NLF) as permitted by HM Treasury. The Trust mitigates the risks surrounding treasury management by investing in low risk banks/ government backed investors.

Liquidity risk

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

The Trust mainly finances its capital expenditure from internally generated funds of depreciation and cash. In 2025/26, the Trust received £8.837m in Public Dividend Capital (PDC), to finance capital expenditure on specific capital projects.

Interest rate risk

With the exception of cash balances, the Trust's financial assets and financial liabilities carry nil or fixed rates of interest. The Trust monitors the risk but does not consider it appropriate to purchase protection against it. The Trust is not exposed to significant liquidity risk.

Price risk

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

Foreign currency risk

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

Note 26.2 Carrying values of financial assets

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2026		
Trade and other receivables excluding non financial assets	5,931	5,931
Cash and cash equivalents	22,800	22,800
Total at 31 March 2026	28,731	28,731

	Held at amortised cost £000	Total book value £000
Carrying values of financial assets as at 31 March 2025		
Trade and other receivables excluding non financial assets	4,279	4,279
Cash and cash equivalents	18,392	18,392
Total at 31 March 2025	22,671	22,671

Note 26.3 Carrying values of financial liabilities

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2026		
Obligations under leases	9,006	9,006
Trade and other payables excluding non financial liabilities	13,059	13,059
Total at 31 March 2026	22,065	22,065

	Held at amortised cost £000	Total book value £000
Carrying values of financial liabilities as at 31 March 2025		
Obligations under leases	7,156	7,156
Obligations under PFI, LIFT and other service concession contracts	96	96
Trade and other payables excluding non financial liabilities	14,684	14,684
Total at 31 March 2025	21,936	21,936

Note 26.4 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 March 2026 £000	31 March 2025 £000
In one year or less	15,937	17,206
In more than one year but not more than five years	4,311	4,742
In more than five years	1,817	-
Total	22,065	21,948

Note 26.5 Fair values of financial assets and liabilities

Due to the nature of the Trusts financial assets and liabilities (mainly payables, receivables and cash), book value is considered a reasonable approximation of fair value.

Note 27 Losses and special payments

	2025/26		2024/25	
	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses ¹	1	-	-	-
Other losses ²			1	-
Total losses	1	-	1	-
Special payments				
Compensation under court order or legally binding arbitration award	5	28	7	38
Ex-gratia payments	15	17	22	2
Total special payments	20	45	29	40
Total losses and special payments	21	45	30	40
Compensation payments received				

¹One case of £20 reported in 'Cash Losses' in 2025/26, relating to counterfeit bank notes being received at a dental clinic.

²One case of £315 reported in 'Other Losses', relating to misplaced belongings of a service user whilst on one of the inpatient wards.

Note 28 Gifts

The Trust has received no gifts exceeding £300,000 in 2025/26.

Note 29 Related parties

The Trust is a Foundation Trust, a public interest body authorised by NHS Improvement, 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 Trust.

The Department of Health and Social Care is regarded as a related party. During the year the Trust has had a number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. The entities with which there were material transactions are listed below.

The Trust manages charitable funds on behalf of the Bradford District Care Trust Charitable Fund whose accounts are published on the Charity Commission website. The Trust made no charge to the Charitable Fund for this service in 2025/26.

All transactions below are with the Trust's main providers and commissioners and are for the provision of healthcare services, with the exception of NHS Resolution who supplied legal services.

	Receivables	Payables
	2026	2026
	£000	£000
NHS West Yorkshire Integrated Care Board (ICB)	2,644	745
NHS England (includes education and training income)	157	-
Airedale NHS Foundation Trust (including AGH Solutions)	10	29
Bradford Teaching Hospitals NHS Foundation Trust	19	221
Leeds and York Partnership NHS Foundation Trust	411	36
South West Yorkshire Partnership NHS Foundation Trust	854	14
Bradford City Council	417	24
NHS Resolution	-	6
	4,512	1,075
	Income	Expenditure
	2025/26	2025/26
	£000	£000
NHS West Yorkshire Integrated Care Board (ICB)	207,872	-
NHS England (includes education and training income)	6,477	2
Airedale NHS Foundation Trust (including AGH Solutions)	102	1,879
Bradford Teaching Hospitals NHS Foundation Trust	946	2,077
Leeds and York Partnership NHS Foundation Trust	1,682	700
South West Yorkshire Partnership NHS Foundation Trust	8,160	391
Bradford City Council	14,179	218
NHS Resolution	-	908
	239,418	6,175

Note 30 Prior period adjustments

There are no prior period adjustments.

Note 31 Events after the reporting date

There are no events that have occurred after the reporting period which have a material impact on these financial statements.

Statement of director's responsibilities in response of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of HM Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, other items of comprehensive income and cash flows for the year. In preparing those accounts, the directors are required to:

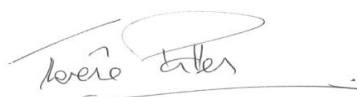
- Apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury
- Make judgements and estimates which are reasonable and prudent
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts and
- Prepare the financial statements on a going concern basis and disclose any material uncertainties over going concern/

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the trust and to enable them to ensure that the accounts comply with requirements outlined in the above-mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

The directors 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 trust's performance, business model and strategy

By order of the Trust Board



.....
Date: 25 June 2026
Therese Patten
Chief Executive



.....
Date: 25 June 2026
Mike Woodhead
Chief Financial Officer

Chief Finance Officer Certificate

I certify that the Trust Accounts Consolidation schedules have been compiled and are in accordance with:

- The financial records maintained by the Trust and
- Accounting standards and policies which comply with the Department of Health and Social Care's Group Accounting Manual and
- The template NHS provider accounting policies issued by NHS England, or any derivation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

I certify that the TAC schedules are internally consistent and that there are no validation errors.

I certify that the information in the TAC schedules is consistent with the financial statements of the Trust.



.....
Date: 25 June 2026
Mike Woodhead
Chief Financial Officer

Chief Executive Officer Certificate

I acknowledge that the accompanying TAC schedules, which have been prepared and certified by the Chief Financial Officer, as the TAC schedules which the Trust is required to submit to NHS England

I have reviewed the schedules and agree to the statements made by the Chief Financial Officer above.



.....
Date: 25 June 2026
Therese Patten
Chief Executive

14. Auditors Statement

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF BRADFORD DISTRICT CARE NHS FOUNDATION TRUST REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Bradford District Care NHS Foundation Trust ("the Trust") for the year ended 31 March 2026 which comprise the Trust Statement of Comprehensive Income, Trust Statement of Financial Position, Trust Statement of Changes in Taxpayers' Equity and Trust Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2026 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by NHS England with the consent of the Secretary of State in February 2026 as being relevant to NHS Foundation Trusts and included in the Department of Health and Social Care Group Accounting Manual 2025/26; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006 (as amended).

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to either cease the Trust's services or dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks associated with the continuity of services provided by the Trust over the going concern period.

Our conclusions based on this work:

- we consider that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate; and
- we have not identified and concur with the Accounting Officer's assessment that there is not, a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time

they were made, the above conclusions are not a guarantee that the Trust will continue in operation.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud (“fraud risks”) we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee, internal audit and inspection of policy documentation as to the Trust’s high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust’s channel for “whistleblowing”, as well as whether they have knowledge of any actual, suspected, or alleged fraud.
- Assessing the incentives for management to manipulate reported financial performance because of the need to achieve financial performance targets delegated to the Trust by NHS England.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any unusual or unexpected relationships.
- Reading the Trust’s accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, we performed procedures to address the risk of management override of controls in particular the risk that Trust management may be in a position to make inappropriate accounting entries. On this audit we did not identify a fraud risk related to revenue recognition due to the block nature of the funding provided to the Trust during the year. We therefore assessed that there was limited opportunity for the Trust to manipulate the income that was reported.

We also identified a fraud risk related to completeness of expenditure recognition and we consider this would be most likely to occur through understating accruals and pushing back expenditure to 2026-27.

We performed procedures including:

- Identifying journal entries to test based on risk criteria and comparing the identified entries to supporting documentation. These included journals reducing expenditure at the end of the year, unusual cash combinations and journal entries posted by senior finance staff.
- Assessing whether the judgements made in making accounting estimates are indicative of a potential bias.
- We inspected a sample of invoices of expenditure, in the period after 31 March 2026, to determine whether expenditure has been recognised in the correct accounting period.
- We performed a year-on-year comparison of accrual categories in the prior year and current year and challenged management where the movement was not in line with our understanding of the entity.

Identifying and responding to risks of material misstatement related to compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the Accounting Officer and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the Accounting Officer and other management the policies and procedures regarding compliance with laws and regulations.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements, including the financial reporting aspects of NHS legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as fraud may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect noncompliance with all laws and regulations.

Other information in the Annual Report

The Accounting Officer is responsible for the other information, which comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work:

- we have not identified material misstatements in the other information; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared, in all material respects, in accordance with the NHS Foundation Trust Annual Reporting Manual 2025/26.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 139, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the 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 either cease the services provided by the Trust or dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

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 our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not 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 aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities.

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained more fully in the statement set out on page 139, the Accounting Officer is responsible for ensuring that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Under Section 62(1) and paragraph 1(d) of Schedule 10 of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We are also not required to satisfy ourselves that the Trust has achieved value for money during the year.

We planned our work and undertook our review in accordance with the Code of Audit Practice and related statutory guidance, having regard to whether the Trust had proper arrangements

in place to ensure financial sustainability, proper governance and to use information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- we issue a report in the public interest under paragraph 3 of Schedule 10 of the National Health Service Act 2006; or
- we make a referral to the Regulator under paragraph 6 of Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or a director or officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of expenditure which is unlawful, or is about to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in these respects.

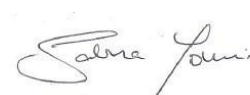
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

DELAY IN CERTIFICATION OF COMPLETION OF THE AUDIT

As at the date of this audit report, we are unable to confirm that we have completed our work in respect of the trust accounts consolidation pack of the Trust for the year ended 31 March 2026 because we have not received confirmation from the NAO that the NAO's audit of the Department of Health and Social Care accounts is complete.

Until we have completed this work, we are unable to certify that we have completed the audit of Bradford District Care NHS Foundation Trust for the year ended 31 March 2026 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the NAO Code of Audit Practice.



Salma Younis

for and on behalf of KPMG LLP

Chartered Accountants

Leeds

26 June 2026

Appendix 1: Information about Board of Directors as at 31 March 2026

Register of Interests - Board of Directors - 2025								
Name	Directorships, including Non-executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies)	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this information is already in the public domain - this does not include personal or private information such as membership of political parties or voting preferences).	Declarations made in respect of spouse or co-habiting partner, or close associate.
Non-executive Directors								

	Services (declared 23/03/2024)							
Simon Lewis	Nil	Nil	Nil	ASDA Foundation trustee/non- Executive Director (declared 23/05/2024)	Barrister: instructed to act for a wide range of people and organisations (including national and local public sector organisations, including relevant local authorities). This also includes acting on behalf of the General Medical Council. (declared 23/05/24)	Barrister: instructed to act for a wide range of people and organisations (including national and local public sector organisations, including relevant local authorities) (declared 23/05/24)	Independent Member of the ACAS Council (i.e. the Advisory, Conciliation and Arbitration Service: a non- departmental public body of the Department for Business, Energy and Industrial Strategy (BEIS)). (declared 23/05/24)	Burley Oaks Primary School: employee (declared 23/05/24)
						ASDA Foundation: trustee/non- executive director. (declared 23/05/24)	Board member of the Bar Standards Board (i.e. the regulatory body for barristers and some others in the legal services market). (declared 23/05/24)	
							Fee-paid Deputy District Judge (including private family law cases, which can involve input from CAFASS, local authorities, NHS organisations, etc). (declared 23/05/24)	
							Newly-appointed fee-paid Tribunal Judge (mental health tribunal). Clearly: I would not sit on cases involving applications from service users at BDCT. (declared 23/05/24)	

						Court Examiner. <i>(declared 23/05/24)</i>
						Junior Counsel to the Crown. <i>(declared 23/05/24)</i>
						England and Wales Cricket Board: chair of national safeguarding panel. <i>(declared 23/05/24)</i>
						The Football Association: independent chair of disciplinary/regulatory panels. <i>(declared 23/05/24)</i>
						British Cycling: independent chair of disciplinary/regulatory panels. <i>(declared 23/05/24)</i>
						England Boxing: independent chair/member of disciplinary panel. <i>(declared 23/05/24)</i>
						ACCA (the global accountancy body): independent member of disciplinary/regulatory panels. <i>(declared 23/05/24)</i>
						General Optical Council: independent statutory case examiner in fitness to practise (or similar) cases. <i>(declared 23/05/24)</i>
						Phone-Paid Standards Authority: Independent Chair of Code Adjudication Panel <i>(declared 23/05/24)</i>
						University of Bradford – Lay Member of Council <i>(declared 23/05/24)</i>
						Premier League Independent Oversight Panel <i>(declared 23/05/24)</i>

Alyson McGregor	Nil	Nil	Nil	Altogether Better (NHS hosted organisation): Director (<i>declared 06/03/24</i>)	Nil	Nil	Nil	Nil
				Health Foundation Common Ambition Programme Advisory Group: Expert Advisor (<i>declared 06/03/24</i>)				
Mark Rawcliffe	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Sally Napper	Nil	Nil	Nil	Nil	Consultancy work within Hospice Sector (<i>declared 09/02/24</i>)	Nil	Nil	Nil
Linda Patterson	Nil	Nil	Nil	Nil	Nil	Nil	Independent Governor London Metropolitan University (<i>declared 01/03/24</i>)	Nil
							Trustee Royal Society of Medicine (<i>declared 01/03/24</i>)	
							Fellow of Royal College of Physicians of Edinburgh and London (<i>declared 01/03/24</i>)	
							Registered with General Medical Council (<i>declared 01/03/24</i>)	

Executive Directos								
Therese Patten							Place Chief Executive Lead, Bradford District & Craven	North Yorkshire County Council: Practice Supervisor (Family Assessment and Support Team) <i>(declared 07/03/24)</i>
							West Yorkshire Integrated Care Board, Accountable Officer, BdC Place	
				NHS Providers: Trustee <i>(declared 07/03/24)</i>			NHS England National Director role, Place Development	
	Nil	Nil	Nil		Nil	Nil		
Phil Hubbard	Nil	Nil	Nil	Nil	Nil	Bradford District & Craven Quality Committee <i>(declared 04/03/24)</i>	Place based lead as part of the Place based system as Director of Nursing and Quality distributed leadership team <i>(declared 04/03/24)</i>	Langtry Langtons: Employee <i>(declared 04/03/24)</i>
Ian MacBeath	Nil	Nil	Nil	Nil	Nil	Bradford District Council <i>(declared 01/03/24)</i>	Nil	Nil
Tim Rycroft	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Mike Woodhead	Nil	Nil	Nil	Nil	Nil	Bradford District & Craven Finance Committee	Place based lead as part of the Place based system as Director of Finance	Close associate of MD of Elite Consulting Ltd*
Kelly Barker	Nil	Nil	Nil	Nil	Nil	Bradford District & Craven Quality Committee <i>(declared 28/03/24)</i>	Nil	BDCFT: employee <i>(declared 28/03/24)</i>

						Bradford District & Craven Finance Committee (declared 28/03/24)		
Bob Champion	Nil	Nil	Nil	Nil	Nil	Nil	Employer representative on NHS Staff Council. Member of West Yorkshire Integrated Care Board, People Board (declared 01/03/24)	Nil
Farhan Rafiq	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Dr Salim Uka	Nil	Nil	Nil	Trustee for Overgate Hospice in Halifax	Overgate Hospice	Nil	Nil	Nil

- *NB Elite Consulting are currently engaged in providing temporary programme management support for the Lynfield Mount capital redevelopment scheme. MW removed himself from the interview and selection process and from the executive decision making panel.

Appendix 2: Information about Council of Governors as at 31 March 2026

Name	Directorships, including Non-Executive Directorships, held in private companies or PLCs (with the exception of those of dormant companies).	Ownership, or part ownership, of private companies, businesses or consultancies likely or possibly seeking to do business with the NHS.	Majority or controlling shareholdings in organisations likely or possibly seeking to do business with the NHS.	A position of authority in a charity or voluntary organisation in the field of health and social care.	Any connection with a voluntary or other organisation contracting for NHS services.	Any substantial or influential connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the Trust, including but not limited to lenders or banks.	Any other commercial or other interests you wish to declare. This should include political or ministerial appointments (where this is information is already in the public domain – this does not include personal or private information such as membership of political parties or voting preferences).	Declarations made in respect of spouse or co-habiting partner, or close associate
Elected Governors								
Arshad Ali	Director of a Health & and Social Care Training company - Seven Circles Ltd Chair of Bradford Stop The War Coalition	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Mufeed Ansari	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Connor Brett	Nil	Nil	Nil	Nil	Nil	Nil	Trustee for Dementia Friendly Keighley	Nil

Sue Francis	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Michael Frazer	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Umar Ghafoor	Umar Ghafoor Trading Ltd – Director	Nil	Nil	CEO – Manningham Project Ltd	Nil	Nil	Nil	Nil
	Exceed Academies Trust – Trustee/Director							
Terry Henry	Nil	Nil	Nil	Nil	Nil	Nil	Trustee for Fountains Church Bradford	Nil
Paul Hodgson	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Aurangzeb Khan	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Imran Khan	Awaiting submission							
Mike Lodge	Nil	Nil	Nil	Nil	Nil	Nil	Nil	Nil
Linzi Maybin	Nil	Nil	Nil	Lead and founder of Happy Teeth Outreach Lead dentist for VITA	Health Education England: Trainee Dentist Leader	Nil	Nil	Nil
Hannah Nutting	Awaiting submission							

Trevor Ramsay	Nil	Nil	Nil	Nil	Trustee of Vital (User-led Mental Health Advocacy Charity) Member of Disabled People's Action Group-Equality Together Presenter on Bradford Community Broadcasting and Phoenix Radio Member of Healthy Minds		Involvement Partner-Bradford District Care Trust Co-optee of Health & Social Care Overview and Scrutiny Committee	Nil
					Calderdale and Healthy Minds Forum Member of Yorkshire Sorteria Network Member of Diamonds Voice			
Tabaro Rwegema	Awaiting submission							
Joyce Thackwray	Thackwray Building Contractors - Partner	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Emmerson Walgrove	Director, Bradford Cyrenians Director/Trustee, Sigt Airedale Trustee, Prism Youth Project and Independent School	Nil	Nil	Nil	Volunteer, Equality Together	Nil	Involvement Partner, Bradford District Care NHS Foundation Trust Deputy Chair, The City of Bradford Festival of Talent Chairman, Speakout Bradford and District Chair and Trustee of Keighley Sea Cadets	Nil
Appointed Governors								
Deborah Buxton	Barnardo's Assistant Director Children's Services	Nil	Nil	Nil	Nil	Nil	Nil	Nil

Cllr Andy Brown	Councillor Aire Valley Ward North Yorkshire Council	Shareholder in Smith and Nephews, Filtronic PLC, Surgical innovations group, Greencoat PLC, Vistry Group, Abingdon Health Ltd	Nil	Nil	Nil	Nil	Green Party member and Councillor for the Aire Valley Ward North Yorkshire Council	Nil
Cllr Alison Coates	Awaiting submission							
Robert James	Nil	Nil	Nil	Nil	Nil	Nil	Dean of the Faculty of Life Sciences at University of Bradford	Nil
Cllr Sabiya Khan	Awaiting submission							

Appendix 3: Feedback on our Annual Report and obtaining a copy of the Annual Report and/or Annual Accounts

It is important our Annual Report is easy to read and understand and is available in a variety of versions including other languages and large print. We would value your feedback on this year's report. Please complete the feedback form below and post the page to the address shown below. Alternatively, you may email your comments to corporate.governance@bdct.nhs.uk

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

If you would like to obtain a copy of the Annual Report and/or Annual Accounts, please contact the Corporate Governance team.

Corporate Governance Team
 Bradford District Care NHS Foundation Trust
 New Mill
 Victoria Road,
 Saltaire
 BD18 3LD

